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University of Helsinki
and
National Institute for Health and Welfare,
Finland

Reproductive medicine in St Petersburg

*A study of reproductive health services and gynaecologists'
professional power and knowledge*

Meri Maaria Larivaara

ACADEMIC DISSERTATION

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Supervisors

Research Professor Elina Hemminki
National Institute for Health and Welfare
Helsinki, Finland

Professor Elianne Riska
Swedish School of Social Science, Faculty of Social Sciences
University of Helsinki
Helsinki, Finland

Docent Anna Rotkirch
Population Research Institute
Väestöliitto – Finnish Family Federation
Helsinki, Finland

Reviewers

Professor Emerita Tuula Waskilampi
Institution of Public Health and Clinical Nutrition, Faculty of Health Sciences
University of Eastern Finland
Kuopio, Finland

Docent Sirpa Wrede
Helsinki Collegium for Advanced Studies
University of Helsinki
Helsinki, Finland

Opponent

Professor Johanne Sundby
Section for International Health, Medical Faculty
University of Oslo
Oslo, Norway

Abstract

Background. Since the late 1990s Russia has seen rapid social change in terms of population decline and low fertility. The health service system has been reformed. A mandatory health insurance system has been constructed and the development of the private sector has taken place. In the field of reproductive health services attitudes towards maternity care, birth control, and termination of pregnancy have undergone considerable change. At the same time new technologies have become available. Access to reliable contraception has improved and the number of induced abortions has declined, but the use of unreliable birth control methods continues to be common practice. Previous studies have reported that many patients are dissatisfied with the quality of health services in the public sector.

Relatively little is known about reproductive health providers' knowledge, attitudes and practices concerning family planning. Information about providers' roles in reproductive health promotion is scarce and scattered. Previous literature points to missed opportunities in reproductive health counselling and low patient involvement in clinical decision-making.

The objective of this study was to increase the current understanding of the obstacles that limit the extent and effectiveness of reproductive health counselling in the public sector out-patient services in urban Russia. The specific aims were (1) to describe how the delivery of women's reproductive health services is organised in St Petersburg, (2) to analyse the challenges in women's reproductive health services as perceived by health administrators and practising gynaecologists, (3) to analyse gynaecologists' views and practices concerning preventing, planning, and monitoring pregnancy, and (4) to examine gynaecologists' perceptions of the provider-patient relationship.

Material and Methods. The data of this study are qualitative, consisting of semi-structured interviews and observations. The data were collected between January and May 2005. The data collection consisted of four parts: (1) semi-structured background interviews with administrative personnel and medical professors (N=9), and managers of women's out-patient clinics (N=9), (2) a pilot study involving observations (N=3) and semi-structured interviews (N=2) at a women's out-patient clinic, (3) observations (N=17) and semi-structured interviews (N=12) at two women's out-patient clinics, and (4) visits and comparison interviews (N=4) at five women's out-patient clinics. The main method of data analysis was content analysis.

Results. The women's clinics provided a variety of services ranging from preventative gynaecological check-ups and contraceptive counselling to monitoring of pregnancies and treatment of gynaecological complaints. More than 40 per cent of the patient visits concerned monitoring pregnancy, whereas contraceptive counselling was the primary purpose of the visit in only a small number of cases. Women's clinics suffered from a low level of formal funding, which has resulted in user charges in breach of the mandatory health insurance legislation. The clinics had also developed commercial services to

improve their financial situation. Many of the study participants were concerned about equal access to health services and the decline of health promotion.

The gynaecologists were well-informed about the latest contraceptive methods and had a positive attitude towards promoting their use. They offered contraceptive counselling to many patients, but the coverage was not 100 per cent among women of reproductive age. The depth of contraceptive counselling varied considerably. In about two-thirds of the observed cases patient involvement was low and counselling was provider-centred, but in approximately a third of the cases patient preferences influenced the clinical decision-making process. Gynaecologists regarded the use of reliable contraception as a means of protecting future fertility and avoiding terminations and as a sign of responsible and morally respectable womanhood. Gynaecologists held a medicalised view of pregnancy planning, promoting gynaecological examinations and diagnostic tests before pregnancy. In practice they emphasised specialist knowledge and risk management in monitoring pregnancy, although they thought their work should ideally combine medical expertise and maternal caretaking.

The practising gynaecologists felt that there were many gaps in the provider-patient relationship and that patients did not pay enough attention to reproductive health matters. The gynaecologists expressed patient-centred and holistic ideas about patient work in interviews, but patient involvement was limited during the observed clinical encounters. The gynaecologists emphasised medical authority in interviews, but they also wished for warm and trusting provider-patient relationships.

Conclusions. The study results suggest that mandatory health benefit packages should be defined in detail and that reforms are needed to the compensation provided by mandatory health insurance to women's clinics. The results indicate that gynaecologists need continuing education in patient-centred counselling and treatment and in how to involve patients in clinical decision-making. The results point to several implications for future research including the need to broaden models of the provider-patient relationship to incorporate mutual liking and trust in the existing models of patient involvement.

Abstract in Finnish

Tausta. Viimeisen kahdenkymmenen vuoden aikana sosiaalinen muutos on ollut Venäjällä nopeaa ja siihen on liittynyt väestön kutistuminen ja matala syntyvyys. Terveyspalvelujärjestelmää on uudistettu. Pakollinen terveysvakuutus on otettu käyttöön, ja yksityinen sektori on kehittynyt. Lisääntymisterveyspalveluissa asenteet äitiyshuoltoon, ehkäisyyn ja raskauden keskeytyksiin ovat muuttuneet huomattavasti. Samaan aikaan uusia teknologioita on otettu käyttöön. Luotettavan ehkäisyn saatavuus on parantunut ja raskauden keskeytysten määrä vähentynyt, mutta epäluotettavia ehkäisymenetelmiä käytetään edelleen yleisesti. Aikaisempien tutkimusten mukaan potilaat ovat tyytymättömiä julkisten terveyspalvelujen laatuun.

Lisääntymisterveyspalvelujen ammattihenkilöiden perhesuunnitteluun liittyvästä tietotasosta, asenteista ja käytännöistä tiedetään suhteellisen vähän. Ammattihenkilöiden roolista lisääntymisterveyden edistämiseksi on vähän ja hajanaista tietoa. Aikaisempi kirjallisuus on tuonut esiin, että tilaisuuksia antaa lisääntymisterveysneuvontaa jätetään käyttämättä ja että potilaiden osallisuus kliinisessä päätöksenteossa on vähäistä.

Tämän tutkimuksen tavoite oli lisätä ymmärrystä niistä esteistä, jotka rajoittavat lisääntymisterveysneuvonnan laajuutta ja tehokkuutta julkisen sektorin avoterveydenhuollon palveluissa Venäjän urbaaneilla alueilla. Täsmällisemmät tavoitteet olivat (1) kuvata, kuinka naisten lisääntymisterveyspalvelut on järjestetty Pietarissa, (2) analysoida naisten lisääntymisterveyspalvelujen haasteita terveydenhuollon virkamiesten ja käytännön työtä tekevien gynekologien näkökulmasta, (3) analysoida gynekologien raskauden ehkäisyä, suunnittelua ja seurantaan koskevia näkemyksiä ja käytäntöjä sekä (4) tarkastella gynekologien näkemyksiä lääkäri-potilassuhteesta.

Aineisto ja menetelmät. Tutkimusaineisto on laadullinen ja koostuu puolistrukturoiduista haastatteluista ja havaintoaineistosta. Aineisto kerättiin vuoden 2005 tammikuusta toukokuuhun ulottuvalla ajanjaksolla. Aineisto koostuu neljästä osasta: (1) terveydenhuollon virkamiesten ja lääketieteen professorien (N=9) sekä naisten poliklinikoiden johtavien lääkäreiden (N=9) puolistrukturoiduista haastatteluista, (2) havaintoaineistosta (N=3) ja puolistrukturoiduista haastatteluista (N=2) muodostuvasta pilottiaineistosta yhdellä naisten poliklinikalla, (3) havainnoista (N=17) ja puolistrukturoiduista haastatteluista (N=12) kahdella naisten poliklinikalla, ja (4) vierailuista ja verrokkihaastatteluista (N=4) viidellä naisten poliklinikalla. Pääasiallinen analyysimenetelmä oli sisällönanalyysi.

Tulokset. Naisten poliklinikat tarjosivat erilaisia palveluita ehkäisevistä gynekologisista terveystarkastuksista ja ehkäisyneuvonnasta raskauden seurantaan ja gynekologisten vaivojen hoitoon. Yli 40 prosenttia potilaskäynneistä liittyi raskauden seurantaan. Ehkäisyneuvonta oli käynnin pääasiallinen syy vain muutamilla käynneillä. Naisten poliklinikat kärsivät matalasta virallisesta rahoituksesta, minkä vuoksi ne olivat ottaneet käyttöön palvelumaksuja, jotka olivat vastoin pakollista terveysvakuutusta koskevaa lainsäädäntöä. Poliklinikat olivat kehittäneet myös kaupallisia palveluita parantaakseen

taloudellista asemaansa. Monet tutkimukseen osallistuneet henkilöt olivat huolissaan terveyspalvelujen tasa-arvoisesta saatavuudesta ja terveydenedistämistyön vähenemisestä.

Gynekologit tunsivat hyvin uusimmat ehkäisy menetelmät ja he suhtautuivat myönteisesti niiden käytön edistämiseen. He tarjosivat ehkäisyneuvontaa monille potilaille, mutta neuvonta ei kattanut kaikkia hedelmällisyysikäisiä naisia. Ehkäisyneuvonnan perusteellisuus vaihteli huomattavasti. Noin kahdessa kolmasosassa havainnoiduista tapauksista potilaan osallisuus päätöksenteossa jäi vähäiseksi ja neuvonta oli lääkärikeskeistä, mutta noin kolmanneksessa tapauksista potilaiden toiveet vaikuttivat kliiniseen päätöksentekoon. Gynekologien näkökulmasta luotettava ehkäisy oli keino suojella tulevaa hedelmällisyyttä ja välttää raskauden keskeytyksiä sekä vastuullisen ja moraalisesti kunniallisen naiseuden tunnusmerkki. Gynekologien näkemys raskauden suunnittelusta oli medikalisoitunut, ja he pitivät tärkeänä gynekologista tutkimusta ja diagnostisia testejä ennen raskautta. Käytännön työssä he painottivat asiantuntijatiedon ja riskien hallinnan merkitystä raskauden seurannassa, vaikka heidän mielestään heidän työssään tulisi yhdistyä lääketieteellinen asiantuntijuus ja äidillinen huolenpito.

Potilastyötä tekevät gynekologit kokivat, että lääkäri-potilassuhteessa oli paljon vaikeuksia ja että potilaat eivät kiinnittäneet riittävästi huomiota lisääntymisterveyskysymyksiin. Gynekologit toivat esiin potilaskeskeisiä ja kokonaisvaltaisia näkemyksiä potilastyöstä haastatteluissa, mutta potilaiden osallisuus jäi vähäiseksi havainnoiduilla vastaanottokäynneillä. Gynekologit korostivat lääketieteellistä arvovaltaa haastatteluissa, mutta he toivoivat myös lämpimiä ja luottamuksellisia lääkäri-potilassuhteita.

Johtopäätökset. Tutkimuksen tulosten perusteella pakollisen terveystakuun piiriin kuuluvat palvelut tulisi määritellä eksplisiittisesti ja yksityiskohtaisesti. Naisten poliklinikoiden pakollisesta terveystakouksesta saamaa rahoitusta tulisi myös uudistaa. Tulosten perusteella gynekologit tarvitsevat jatkokoulutusta potilaskeskeisestä neuvonnasta ja hoidosta sekä siitä, kuinka osallistaa potilaita kliinisessä päätöksenteossa. Tulokset osoittavat, että lisätutkimusta tarvitaan. Potilas-lääkärisuhdetta käsitteleviä malleja olisi tärkeä laventaa kattamaan molemminpuolinen tykkääminen ja luottamus, kun ne tällä hetkellä painottuvat potilaan autonomian asteen tarkasteluun.

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List of original publications

This thesis is based on the following publications:

- I Larivaara Meri, Dubikaytis Tatiana, Kuznetsova Olga, Hemminki Elina. Between a rock and a hard place – The question of money at St. Petersburg women's clinics. *International Journal of Health Services* 2008;38(2):357-377.
- II Larivaara Meri. Pregnancy prevention, reproductive health risk, and morality – A perspective from public sector women's clinics in St. Petersburg, Russia. *Critical Public Health* 2010;20(3):357-371.
- III Larivaara Meri. "A planned baby is a rarity:" Monitoring and planning pregnancy in Russia. *Health Care for Women International* 2011;32:515-537.
- IV Larivaara Meri. Gynaecologists' ideas of the provider-patient relationship at public sector women's clinics in Russia. Submitted to *Critical Public Health*.

The publications are referred to in the text by their roman numerals.

1 Introduction

In the 1990s, after the collapse of the Soviet Union, the reproductive health situation in the countries of the former Soviet Union caused both national and international concern and consequent interest in improving the situation. Reasons for the concern were the high frequency of induced abortion, sexually transmitted infections, the low use of reliable contraception, and high infant and maternal mortality. This unsatisfactory reproductive health situation coincided with rapid and unstable social change, when new norms and values emerged alongside new economic and social structures.

Access to high-quality and confidential family planning, including reliable birth control methods and safe termination of unwanted pregnancy, is an essential reproductive right of women. It guarantees them autonomy over their own reproduction. The organisation of these services conveys a great deal about the values that are prevalent in a society. Both lay (Voznesenskaja 1986; Makarova 1989; Berg 1999) and professional (e.g. Kon 1995) literature suggests that reproductive health services in the Soviet Union were often experienced as bureaucratic and unpleasant, even humiliating. The studies that were conducted in the Russian federation in the 1990s drew a dark picture in general, suggesting that services were changing slowly and women continued to experience reproductive health services as unfriendly and inattentive.

Against this background, a research project that would explore challenges related to current reproductive health services in Russia and gynaecologists' views and practices concerning family planning and childbearing was an attractive idea. What made the research even more intriguing was the opportunity to conduct it as part of a larger project where many related topics would be studied to provide understanding of the wider public health and social context. The latter proved to be the case throughout the study project; a number of insights and inspirations are owed to interaction with the other researchers who participated in the REFER (Reproductive health and fertility patterns in Russia – a comparative approach) project of which this study is an independent part.

REFER was a multidisciplinary research consortium that studied reproductive health and family forms from a comparative perspective in Russia/St Petersburg, Estonia, and Finland. The project was carried out at the National Research and Development Centre for Welfare and Health (STAKES; current National Institute for Health and Welfare (THL)) and at the University of Helsinki's Departments of Sociology and Social Policy. It was conducted in collaboration with St Petersburg Medical Academy of Postgraduate Studies and the European University at St Petersburg in Russia and Tartu University in Estonia. Data were collected on reproductive health, sexual behaviour, population discourse, and reproductive health services in Russia/St Petersburg, Estonia and Finland. In order to understand the role of societal changes, the consortium made comparisons over time and between countries. Unlike most of the REFER project, this study does not involve a comparative design. This academic dissertation is a summary of work that has been published in four original research articles.

2 Study context

In this chapter I provide the reader with basic information on the context in which this study took place. The chapter is divided into four parts: (1) the organisation of health services, (2) users' perspective on health services in general, (3) childbearing and birth control practices, and (4) a description of the medical profession in Russia.

Part of the previous literature referred to deals with St Petersburg, and part with the whole of Russia. St Petersburg is in many ways a special area compared with the rest of the country. It is the second largest city after Moscow and it is wealthier than many other parts of the country. There are a number of universities and institutes of higher education in St Petersburg and the population has a higher than average level of education compared with the whole country. The city also has various industries. The city has a large group of industrial workers on the one hand, and students and an academic population on the other. Consequently, some of the observations concerning the whole country cannot be applied to St Petersburg and vice versa.

This contextual chapter is mostly based on previous literature, but I have provided additional insights gained from my own fieldwork. These will be pointed out as they occur in order to distinguish the author's interpretations from those presented in earlier publications.

2.1 Organisation of health services

The Soviet healthcare system was funded according to the so-called 'residual principle' (Curtis et al. 1995; Twigg 1998; Tragakes and Lessof 2003, pp. 65-68). This meant that state funding was first directed to priority areas such as certain industries and military forces and allocations to health care were made from what was left over. It has been estimated that the share of GNP devoted to health in the later years of the Soviet Union was about 2.4 to 3.5 per cent. In the literature it is observed that the healthcare system suffered from continuous underfunding (Curtis et al. 1995; Twigg 1998; Tragakes and Lessof 2003, pp. 65-68).

Starting from the 1920s and 1930s the Russian healthcare system was extended to provide the entire population with comprehensive services (Tragakes and Lessof 2003, pp. 118-127). Services for hospitals and polyclinics were budgeted on the basis of bed days and the number of patient visits. Surveillance programmes were extensive, resulting in effective control of infectious diseases. The prevention and treatment of those chronic diseases typical of developed countries showed poorer results than in many other countries (Twigg 1998; Tragakes and Lessof 2003, pp. 22-25). Services were divided into narrow specialties, and medical specialists were in charge of services that in many other countries were allocated to general practitioners or nursing staff (Tragakes and Lessof 2003, pp. 22-25). In the previous literature, the system has been criticised for emphasising quantity at the expense of efficiency, for producing incentives for long in-patient stays and high frequency of visits to polyclinics, and for creating too many in-patient facilities (Twigg

1998; Tragakes and Lessof 2003, pp. 22-25). Although attempts have been made to shift resources from in-patient care to out-patient services, the number of bed days per 1000 population is still two to three times higher than the figure reported in Western countries and the average stay is 1.5 times longer than in EU countries (Shishkin and Vlassov 2009).

There was universal and equal access to health services in the Soviet Union. The system consisted of a number of parallel service systems. For instance, in addition to general health services, military personnel and workers of certain branches of industry were entitled to separate services (Curtis et al. 1995; Tragakes and Lessof 2003, pp. 118-127). Later, it was claimed that the system of parallel services created inequality in the access to and quality of services (Curtis et al. 1995; Tragakes and Lessof 2003, pp. 118-127).

At the end of the 1980s a healthcare reform was launched by means of an experimental model for funding, the so-called New Economic Mechanism (Twigg 1998; Tragakes and Lessof 2003, pp. 68-70). The model was implemented from 1987 to 1991 in three pilot areas, including the city of Leningrad (now St Petersburg). The aim of the new model was to strengthen primary care. The model was evaluated as successful in improving efficiency and quality of care, encouraging other regions to adopt similar reforms. The experiment was brought to a close in 1991, when the Soviet Union ceased to exist (Twigg 1998; Tragakes and Lessof 2003, pp. 68-70).

The newly restored Russian federation continued to reform the healthcare system it inherited from the Soviet Union. Mandatory health insurance was signed into law in 1993 (Tragakes and Lessof 2003, pp. 70-71). The key objectives of the mandatory health insurance were to preserve the universal access and comprehensive population coverage of the socialist period, to secure funding for health services, and to improve the efficiency and quality of services (Curtis et al. 1995, 1997; Twigg 1998, 1999, 2000; Tragakes and Lessof 2003, pp. 70-71).

Mandatory health insurance in Russia separates pooling, purchasing, and provision of care (Tragakes and Lessof 2003, pp. 38-41). The Russian Federation consists of 89 federal regions, St Petersburg being one of them. Each federal region has established a territorial health insurance fund to pool the mandatory health insurance money within its region. In addition, the federal health insurance fund equalises resources within the whole country. Employers disburse a payroll tax to the territorial health insurance fund and to the federal fund, and local governments make contributions to the health insurance fund for the non-working population (Curtis et al. 1995; Twigg 1998, 1999; Tragakes and Lessof 2003, pp. 38-41, pp. 70-75). The payroll tax was 3.4 per cent to the territorial fund and 0.2 per cent to the federal fund until 2005, when the payment to the territorial fund was reduced to 1.8 per cent (the change took place when I was collecting the research data and I learned about it from my informants).

Private insurance companies or branches of the territorial health insurance fund are responsible for purchasing (Curtis et al. 1995; Twigg 1998, 1999; Tragakes and Lessof 2003, pp. 38-41, pp. 70-75). They receive health insurance money from the territorial health insurance fund on the basis of risk-adjusted capitation. Healthcare providers charge insurance companies or branches of the territorial health insurance fund on a fee-for-service basis for medical services within the minimum mandatory health insurance benefit

package defined by the federal government. The fees paid by insurance companies and branches of the territorial health insurance fund are based on annually renegotiated tariffs agreed by the territorial fund, local health authorities, local government, and medical associations (Curtis et al. 1995; Twigg 1998, 1999; Tragakes and Lessof 2003, pp. 38-41, pp. 70-75). Figure 1 in the original publication I of this dissertation illustrates how pooling, purchasing, and provision are separated in the Russian mandatory health insurance system.

Employers and citizens take out health insurance contracts directly with private insurance companies or branches of the territorial health insurance fund. Health services within the mandatory health insurance benefits package should be free-of-charge at the point of service for patients who can present a valid mandatory health insurance certificate, but in reality under-the-counter payments are common (Curtis et al. 1995; Field 1995; Rozenfeld 1996; Twigg 1998, 2002; Tragakes and Lessof 2003, pp. 91-106; Aarva et al. 2009). A cross-sectional national survey conducted in 2001 reported that 19 per cent of those who had consulted a health professional had made informal payments, in the form of money, gifts, or both (Balabanova et al. 2004). A population-based survey of 2006 in Tyumen and Lipetsk revealed that around 15 per cent of respondents had made informal payments in the past three years (Aarva et al. 2009). Private health insurance may be used to cover services outside the mandatory health insurance benefit package (Curtis et al. 1995; Field 1995; Rozenfeld 1996; Tragakes and Lessof 2003, pp. 106-107).

The implementation of the insurance-based system has taken different routes in different parts of the Russian Federation, resulting in a variety of local adaptations (Curtis et al. 1997; Twigg 1999, 2000). In 2004 mandatory health insurance covered 94 per cent of the adult population but cover was lower amongst the poor, unemployed, and unhealthy, and people outside the main cities (Perlman et al. 2009). Most of the insurance resources are consumed to pay for hospitalisation and visits to physicians, while smaller share is spent on prevention and health promotion (Axelsson and Bihari-Axelsson 2005). According to another study (Fotaki 2006), nearly half of the population felt that mandatory health insurance had failed to improve the quality of services. The same study reported that information about health insurance and patient rights in the population varies regionally, but is generally insufficient (Fotaki 2006).

As regards St Petersburg, the mandatory health insurance system was implemented during the first half of the 1990s. The city's health insurance fund was created to redistribute employer contributions and to balance differences between different districts of the city, depending on the strength of the local economy. In addition, a public fund was established to finance specific health programmes, the purchase of expensive medical equipment, and the repair of medical facilities (Curtis et al. 1995). In the spring of 2005, when the data of this study were collected, there were 20 private insurance companies and one branch of the territorial health insurance fund functioning within the mandatory health insurance system in the city.

After the Soviet Union broke up, a private sector developed relatively quickly in certain fields of health services, including gynaecology, dentistry, ophthalmology and pharmaceutical supplies (Tragakes and Lessof 2003, pp. 41-42, pp. 62-63). During the data collection of this study I observed that a number of private clinics offered women's

health services in St Petersburg. The REFER survey on women of reproductive age in St Petersburg reported in 2004 that 57 per cent of the respondents had visited a physician during the past 12 months and 18 per cent of them had visited a private clinic (Kesseli et al. 2005).

After the data collection of this study, national initiatives to develop health care were implemented (Shishkin and Vlassov 2009). In the autumn of 2005 a national project on health was launched in Russia. The project aimed to improve treatment for specific conditions, to supply equipment to out-patient and emergency health care facilities, to raise the wages of primary care staff, to build high-tech medical centres, to expand provision of high-tech care, and to create targeted interventions regarding high mortality from road trauma, cardiovascular diseases, cancer, and low birth rates. In 2008 the federal government organised a public discussion on a plan for development of health care up to 2020. The plan seeks to increase average lifespan to 75 years (it was about 63 years in 2008), to specify the types of medical services, drugs, and technologies provided within public services, and to modernise mandatory health insurance. In 2008 the public sector pay system was reformed. Within the new pay system, employees' salary can be determined according to the volume and quality of their work (Shishkin and Vlassov 2009).

2.2 User's perspective on general health services¹

Brown and Rusinova (1997, 2000; Rusinova and Brown 2003) have reported results from surveys on users' views of health services in St Petersburg. The results show that people are dissatisfied with the outdated or non-existent medical technology. People do not believe that the public sector provides them with high-quality health services to which everybody has equal access. The professional skills of healthcare personnel are questioned and medical staff working in the public sector are accused of being unkind and inattentive towards patients (Brown and Rusinova 1997, 2000).

Brown and Rusinova (1997; Rusinova and Brown 2003) have also analysed the variety of strategies that patients use when trying to locate better services. Many people believe that the best guarantee of reliable services is to visit a physician with whom they are acquainted or who knows personally someone with whom they are acquainted. At the same time, patients with sufficient financial resources resort to private health services or commercial services offered by the public sector. Educational level and economic position have an influence on strategies preferred by patients. Highly educated people often know personally a physician or someone who knows a physician. They prefer using their personal networks to locate a physician. Patients with lower education but high income use commercial services more commonly. This probably reflects the fact that they do not

¹ *The studies that I have been able to locate on user perspectives on health services are critical of how patient rights are realised in the Russian healthcare system. It is possible that they present the situation as graver than it actually is, as the researchers may have chosen to focus on points where development measures are needed.*

have similar networks to those of people with higher education, but it may also reflect different values (Brown and Rusinova 1997; Rusinova and Brown 2003). Salmi (2003) gives a more detailed description of how teachers use their personal networks when seeking health services. It is also common practice for patients to combine different strategies, visiting for example a familiar physician, but still paying extra money unofficially in order to guarantee the quality of services (Brown and Rusinova 1997; Rusinova and Brown 2003; Salmi 2003).

2.3 Childbearing and birth control patterns among Russian women

Childbearing and birth control patterns are influenced by the reproductive health services, but they also form the context where reproductive health services are delivered. Therefore, in this chapter I will illuminate central historical and social developments in the childbearing and birth control patterns among Russian women.

Since the nineteenth century Russian women have entered motherhood early and almost universally. Throughout the twentieth century they commonly gave birth in their early twenties and less than ten per cent of women remained childless (Kesseli 2008). During the first half of the twentieth century, the total fertility rate declined rapidly in Russia and was below a replacement level of 2.1 by 1966 (Frejka and Ross 2001). During the 1980s, however, fertility increased and reached 2.23 in 1987 (see Kesseli 2008). Motherhood has been and continues to be a central and expected part of a Russian woman's life, even though since the early socialist period Russian women have participated actively in the labour force (Attwood 1996; Zdravomyslova 1996; Rotkirch 2000). The traditional childbearing pattern was enforced in the Soviet Union by reproductive health policy and services together with various social policy measures such as housing policy, maternity leave and benefits, childcare facilities, and longer holidays and shorter working-hours for mothers (Zdravomyslova 1996).

Termination of pregnancy was legalised in the Soviet Union in 1955.² A small fee was charged, but otherwise induced abortion could be obtained freely during the first twelve weeks of pregnancy and after that point when the continuance of pregnancy or birth would harm the mother. Reliable contraceptive methods continued to be poorly accessible and of low quality throughout the Soviet period until the late 1980s (Remennick 1991, 1993; Kon 1995, pp. 178-193). The official health policy emphasised the side-effects of oral contraceptives and in 1974 the Ministry of Health banned the widespread use of oral contraceptives (Remennick 1991, 1993; Kon 1995, pp. 178-193; UN 2002, p. 56). Condom and so-called natural methods – rhythm method, withdrawal, and vaginal douches – were the main contraceptive methods used (Popov et al. 1993). Termination of pregnancy became a significant method of birth control (Remennick 1991, 1993), but women used it more to space and stop births than to postpone the first birth (Kulakov et al.

² *The termination of pregnancy had been legalised in the Soviet Union in 1920, but it was prohibited again by law from 1936 to 1955.*

1997). Despite the easy access to termination of pregnancy, policymakers actively warned about the risks of abortion and encouraged motherhood (Kon 1995, pp. 178-193; Rivkin-Fish 1999). Women often felt that they were faced with degrading and judgemental treatment in the health services when having their pregnancies terminated. Use of analgetics was also insufficient, making the experience of induced abortion physically painful (Kon 1995, pp. 178-193).

In the early 1990s, immediately following the collapse of the Soviet Union, Russia experienced a sharp decline of fertility. Since then, the total fertility rate has remained at around 1.3 – way below the replacement level (Barkalov 2005; Kesseli 2008; Zakharov 2008). Simultaneously a slight postponement of first births has taken place, but the mean age at first birth was still 24 in Russia in 2004 (Kesseli 2008). Combined with diminishing life expectancy and increasing mortality, low fertility has resulted in a declining population and public concern about a so-called 'population crisis' or a 'dying nation' (Vishnevsky 1996; Rivkin-Fish 2006). Policymakers have attributed low fertility to socioeconomic uncertainty, disintegration of family values, and women's poor reproductive health. They support the latter idea typically by maternal mortality statistics (Isola 2008a, 2008b), that indeed reveal higher maternal and perinatal mortality in Russia than in Western Europe, for example (WHO 2009; for St Petersburg see Gurina et al. 2006).³ A significant policy measure to increase fertility was the new demographic programme announced by President Putin in 2006. It introduced a maternal capital payment that a mother receives when her second child turns three years old (Rotkirch et al. 2007; Isola 2008b).⁴ Policymakers have also suggested that improving the quality of maternity care is one solution to the low fertility problem (Isola 2008a, 2008b).

Since the end of the 1980s reliable contraceptive methods have become available in Russia. According to the REFER survey conducted in St Petersburg in 2004, financial problems formed an obstacle to contraceptive use for 5.6 per cent of women (Kesseli et al. 2005, pp. 88).⁵ The use of reliable contraception has not increased much, however, and

³ *The WHO statistics for 2006 report 28.8 maternal deaths per 100,000 live births in Russia in 2006, whereas the equivalent figures for the United Kingdom, Germany and neighbouring Finland were 6.7, 6.1, and 6.8 respectively. The tendency is similar when it comes to perinatal mortality, although differences are smaller (9.0 perinatal deaths per 1,000 births in Russia in 2006 in comparison with 8.2 in the UK in 2004, and 5.6 in Germany and 3.0 in Finland in 2006) (WHO 2009).*

⁴ *The maternal capital sum for a mother and two children was 250000 rubles in 2007 and it is indexed annually for inflation. At the same time as the introduction of the maternal capital sum the monthly childcare benefits for children under 18 months were raised to 1500 rubles for the first child and 3000 rubles for the second (Rotkirch et al. 2007). Wage-earning and working mothers in Russia are also entitled to maternity leave of three months after delivery. The public sector also provides childcare facilities, as it used to do during the socialist period, but many people feel that the level of public sector childcare facilities has deteriorated since the collapse of the Soviet Union.*

⁵ *In spring 2005, I visited several pharmacies and asked the prices of different contraceptive methods. Oral contraception cost 80 to 450 rubles, vaginal ring 380 to 450 rubles, and contraceptive patches approximately 500 rubles a month in the pharmacies of St Petersburg city centre. The fee for emergency oral contraception was approximately 100 rubles. The prices for intrauterine devices (IUDs) varied from*

many women still do not use contraception but rely rather on unreliable, so-called natural, methods. Not using contraception or using unreliable methods is common practice compared with European countries (Chalmers and Sand 1998; Rankin-Williams 2001; Sherwood-Fabre et al. 2002; Regushevskaya et al. 2008; Perlman and McKee 2009; Regushevskaya et al. 2009a). The results of a national longitudinal monitoring survey reveal stable frequency of unreliable method use (20 per cent of sexually active women) and non-use of any method (25 per cent) between 1994 and 2003. At the same time the use of barrier methods increased from 9 per cent to 21 per cent, whereas IUD (intrauterine device) use declined from 34 per cent to 21 per cent (Perlman and McKee 2009). As regards St Petersburg, the use of effective contraceptive methods did not increase and the use of unreliable methods did not decrease substantially between 1996 and 2004. The REFER survey conducted in St Petersburg in 2004 reported that approximately 60 per cent of sexually active women had used a reliable contraceptive method at the time of last intercourse, whereas almost a third had used an unreliable method and 10 per cent had not used any method (Regushevskaya et al. 2009a). The results were essentially the same as those of a survey conducted in St Petersburg in 1996 (Haavio-Mannila and Kontula 2003).

The number of induced abortions has decreased by more than half in the whole country since the peak of the early 1990s, but it still remains high in comparison with countries in Western Europe (WHO 2009; see also Sherwood-Fabre et al. 2002; Regushevskaya et al. 2009b). The number of induced abortions reached its highest peak in 1993 when 2159.52 induced abortions per 1000 live births were registered. After that the level of abortions decreased steadily to 950.94 in 2006 (WHO 2009). In the REFER survey in 2004, more than half (55 per cent) of fertile and sexually active women reported having had at least one abortion and one-third two or more abortions. The proportion of women who had had an abortion increased depending on age. Other risk factors were low education, children, a history of multiple partners, first sexual intercourse when younger than 18 years, and insufficient use of reliable contraception (Regushevskaya et al. 2009b). The validity of Russian abortion statistics has been questioned as the system for collecting abortion data changed twice in the 1990s and it is difficult to estimate the trends reliably (Popov 1996; Regushevskaya 2009, pp. 17-18). The social grounds for obtaining abortion were restricted in 2003 (Regushevskaya 2009, p. 16).⁶

2.4 Medical profession in Russia

Riska (2001) has analysed the position of physicians in Russia from a comparative perspective, using North America and Scandinavia as reference regions. According to her, the profession in Russia during socialist rule developed in a different direction from that in

270 to 1000 rubles for an IUD made of copper to 7400 rubles for a hormonal IUD. Termination of pregnancy in the study clinics varied between 2.500 and 3.500 rubles, depending on the method used.

⁶ *The current abortion law in Russia states that abortion may be legally performed on request in the first 12 weeks of pregnancy, for social reasons up to 22 weeks, and for medical necessity and with the woman's consent at any point during pregnancy (Regushevskaya 2009).*

the West. In the 1920s, the Russian medical profession lost the autonomy usually associated with the medical profession in western countries. Physicians were no longer able to control the production and interpretation of medical knowledge, the contents of medical education, the recruitment of new students, or the conditions of work and remuneration. They had limited opportunities to influence health policies, as well. The profession was feminised rapidly; more than 60 per cent of physicians were female by the year 1940. During the 1990s, Russian physicians' professional status remained different from that of their colleagues in the West. They did not organise themselves into professional associations that would have influenced their working conditions and their professional standing (Riska 2001, pp. 73-86). During the socialist period, the salaries of physicians were lower than those of industrial workers (Tragakos and Lessof 2003, p. 25). According to the data that I collected during this study, the salaries in health care have remained low, especially in the public sector.⁷

There is little research on Russian physicians' experience of and perspective on their professional role in public health services. Most of the studies published in English examine the Russian medical profession on the basis of previous literature, statistics, or criticism directed at the profession by other actors in Russian society (e.g. Field 1991; Riska 2001, pp. 73-86). In his analysis of the problems of the Soviet medical profession, Mark Field (1991) called Soviet physicians a 'hybrid' profession, because they were politically powerless but clinically powerful with regard to their patients. Field suggests that an indifferent and formal 'nine-to-five medicine' emerged in the Soviet Union as a reaction to the high numbers of patients that physicians were expected to see, to the low salaries allocated to them, and to the bureaucratic state system (Field 1991). Michele Rivkin-Fish (1997, 2005) conducted an ethnographic study at maternity hospitals in St Petersburg in the 1990s. She suggests that, stripped of political influence and material power, the profession's primary site for exercising social dominance and experiencing power became the clinical context (Rivkin-Fish 1997, 2005). An interview study conducted in Moscow among physicians of different specialties reports a different view; the majority of the physicians who participated in the study said that they were committed to their work and felt empathy towards their patients (Kauppinen et al. 1996).

⁷ In spring 2005, a gynaecologist working in the public sector women's clinics earned approximately 190–250 € per month, depending on the length of his/her professional career. The manager of a clinic was paid roughly 300 € per month. Physicians themselves estimated that at that time an average salary in St Petersburg would have been 300 € per month. In the private sector, physicians made an average of 400 € per month (Larivaara 2008a). In 2007, the average monthly salary in the whole country was \$392 in health care and \$596 in industry (Shishkin and Vlassov 2009).

3 Literature review: research on providers and provider-patient relationships in reproductive health services in Russia and CEE

This literature review concentrates on articles reporting empirical analysis of research material or systematic reviews that examine (1) providers' knowledge, attitude and practices towards family planning, and (2) patient involvement and provider-patient relationships in reproductive health services in urban Russia and Central Eastern European post-socialist countries (later CEE countries). Empirical reports and systematic reviews were chosen as they were expected to provide the most reliable information about the research topic. The decision to focus on studies conducted in post-socialist contexts with sufficient socio-historical closeness to St Petersburg was made in order to collect literature comparable to the subject of this dissertation and contextually relevant for formulating its aims. Grouping CEE countries together, however, is in many ways problematic, because the countries differ from one another in terms of culture, religion, history, ethnicity, and politics. With regard to reproductive health services in CEE countries, the differences were striking even under state socialism, ranging from relatively free abortion services in many CEE countries to the prohibition of abortion in Romania under Ceaușescu, and from the limited availability of reliable contraceptive methods in most of the CEE countries to access to western birth control in Hungary even in the socialist period. What seems to be a common feature of CEE countries is that in the post-socialist period starting from approximately the early 1990s women's reproductive rights and health issues have gained a strong symbolic meaning as the subject of political power struggles (Kliment and Cupanik 1999; Gal and Kligman 2000a, pp. 15-36, 2000b; Alsop and Hockey 2001; Mishtal 2009).

Studies published between 1990 and 2010 in the English language were included. The literature search was originally conducted for the period between 1980 and 2010, but only three articles of potential relevance were identified from the 1980s and they were not accessible, having been published in small Eastern European medical journals. Owing to the limited number of articles on Russia or CEE countries, books and reports were selected if they met the other inclusion criteria. To expand the literature on Russia, studies that focused on other aspects of reproductive health services but reported observations on provider-patient relationships as spin-offs were also included. Extending the literature review to studies published in Russian would have been useful, as many Russian scholars still publish mostly in Russian, but unfortunately this was not possible owing to my lack of fluency in Russian.

The literature search was conducted by using the Medline (Ovid) database (MeSH Terms). Searches were also performed on the following online databases: Academic Search Elite & SocINDEX, ERIC (CSA), and Science Direct (Elsevier). In addition, the reference lists of the reviewed articles, books, and reports were searched manually. Furthermore, articles, books and reports on Russia or CEE countries that had been identified previously through Internet or personal communications were included even if they did not appear in the literature search.

Different combinations of the following search terms were used: [family planning services OR reproductive health services OR patient / client participation / involvement OR doctor / provider / physician / professional - patient / client relationship / communication OR agency relationship OR condom OR contraception OR family planning OR hormonal contraception OR induced abortion OR intrauterine device OR oral contraceptive] AND [Russia OR Soviet Union OR USSR OR Eastern Europe OR Central Eastern Europe OR Bosnia OR Bulgaria OR Croatia OR Czech Republic OR Estonia OR Hungary OR Latvia OR Lithuania OR Poland OR Romania OR Serbia OR Slovakia OR Slovenia] They were first evaluated according to the title and then according to the abstract to decide whether they met the inclusion criteria.

Reproductive health services and provider-patient relationships are broad and value-laden topics. The perspectives used in research literature vary according to time, place, and the viewpoint taken by the researcher(s). This literature review is structured in two parts according to the perspectives used in the literature search:

1. Provider's knowledge, attitude and practices regarding family planning
2. Patient involvement in clinical decision-making and provider-patient relationships in reproductive health services

Each part will begin with a review of literature from Russia and proceed to the literature from CEE countries. Conclusions to the whole literature review will be given in a separate chapter. The concluding chapter is structured around the following four questions:

1. What aspects of the topic have been studied?
2. What are the key results?
3. What kind of time trends can be identified in the topics of the studies and in the results?
4. What kind of gaps can be identified in the existing literature?

The literature reviewed is summarised in Tables 1 and 2.

3.1 Providers' knowledge, attitudes and practices regarding family planning

The literature from Russia on providers' knowledge, attitudes and practices regarding family planning consists of 12 different publications based on seven different data sets (Table 1). The data were collected between the early 1990s and 2003. Only two data sets included systematic research data on health providers (Visser et al. 1993a, 1993b; Rivkin-Fish 1997, 1999, 2000, 2004, 2005). One more data set included interviews and observations with reproductive health providers, but the data were collected for situation analysis and were not described in detail. Thus it was impossible to estimate whether it was systematic enough for research purposes (Stephenson et al. 1997). The remaining four studies relied on second-hand data reported by patients (Kulakov et al. 1997; Client Perceptions... 1998; Sherwood-Fabre et al. 2002; David et al. 2007). Only one of the data sets was collected in the 2000s (David et al. 2007). Furthermore, only one of the data sets included systematic observations of clinical work, conducted in an in-patient setting

Table 1. Review of studies on providers' knowledge, attitude and practices towards family planning in urban Russia and in CEE countries from 1990 to 2010; description of the study and main results

Reference / Country	Data and method	Data collection year	Main results of the publication
Russia, articles (listed by year of data collection)			
Visser et al. 1993a	Survey of 375 gynaecologists in three symposia in Moscow (40 % of respondents), Tomsk (35.5 %), and Tzhevsk (24.5 %)	Not given in the article (estimated to be from the early 1990s)	Fifty-five per cent of respondents had training in family planning. Thirty-seven per cent of respondents were familiar with the different mechanisms of oral contraceptives. Fifty-eight per cent of respondents reported leaving the final choice of contraceptive method to the patient. Thirty-three per cent reported giving patients a limited choice and five per cent reported making the choice for the patient.
Visser et al. 1993b	Survey of 375 gynaecologists in three symposia in Moscow (40 % of respondents), Tomsk (35.5 %), and Tzhevsk (24.5 %)	Not given in the article (estimated to be from the early 1990s)	Fifty per cent of respondents reported prescribing oral contraceptives often, and fifty-nine per cent of respondents reported prescribing intrauterine devices often. Seventy-five per cent considered oral contraceptives, intrauterine devices, and male and female sterilisation to be reliable contraceptive methods. Fifty per cent considered the rhythm method, withdrawal, the cervical mucus method, and vaginal douches to be unreliable contraceptive methods.
Stephenson et al. 1997	Situation analysis based on statistics, participation in a consensus conference on family planning and maternity care, interviews with an unspecified number of health planners and healthcare providers, and visits to maternity homes, women's clinics, and the city's new family planning centre	1990–1993	Women were denied their preferred contraceptives because of contraindications listed in official guidelines. Family planning services were not integrated into routine prenatal or postpartum services or routine gynaecological care. Providers reinforced women's misconceptions of oral contraceptives and intrauterine devices. Providers generally made little attempt to give family planning counselling to women patients

Rivkin-Fish 1999	Ethnography, fieldwork in St Petersburg; analysis of health education lectures given by reproductive health providers	1994	Lectures were based on the assumption that sexuality and reproduction are part of medical expertise. Reproductive health providers who gave the lectures were ambivalent about promoting individual autonomy and controlling sexual expression and reproductive patterns. Moral overtones were prevalent in the lecture contents.
Rivkin-Fish 2000	Ethnography, fieldwork in St Petersburg; analysis of a WHO project and the encounters between project workers and local reproductive health providers	1994	Foreign experts were unable to attain the perspective of the local reproductive health providers or to understand the historical roots of the existing clinical interaction patterns. Local reproductive health providers struggled to maintain medical authority for complex social and historical reasons and rejected the foreign experts' ideas about patient autonomy as not applicable to the St Petersburg context.
Rivkin-Fish 2004	Ethnography, fieldwork in St Petersburg; analysis of reproductive health activism of health providers	1994, 2000	Reproductive health activism has become a site for personal growth and the strengthening of nuclear families owing to complex historical, social, and political dynamics.
Sherwood-Fabre et al. 2001	Survey of 2000 women in Ivanovo, Perm, and Yekaterinburg; population-based survey at the beginning of a development project to implement an integrated programme of family planning education and services and to increase physicians' and women's contraceptive knowledge and change contraceptive use; second survey three years later	1996, 1999	The article reports among other things women's experiences of contraceptive counselling. The project did not result in significant increase in the likelihood of women receiving family planning counselling or being more involved in the choice of birth control method, and changes were not systematic.
David et al. 2007	A face-to-face standardised questionnaire interview repeated three times at 20 health centres during three weeks of fieldwork with women who had just had a termination of pregnancy (n = 489, 559 and 527), Novgorod and Perm oblasts; interviews were completed at the beginning of, during, and after a development project that included training courses for reproductive healthcare providers aiming to reduce the number of unwanted pregnancies and repeat terminations of pregnancy	2000, 2002, 2003	Over the three-year period the number of post-abortion clients who reported receiving contraceptive counselling from their providers on the day of the abortion increased from 41 % to 92 %. The quality and contents of the counselling were not evaluated.

Russia, books	
Rivkin-Fish 2005	<p>Ethnography, fieldwork in St Petersburg</p> <p>1994, 2000</p> <p>Providers' struggle for medical authority in clinical work is explained by historical, social, and political dynamics. Normative attitudes towards sexual and reproductive health practices and family planning were common among reproductive health providers.</p>
Russia, other (listed by the year of data collection)	
Rivkin-Fish 1997, an unpublished dissertation	<p>Ethnography, fieldwork in St Petersburg</p> <p>1994</p> <p>Providers' struggle for medical authority in clinical work is explained by historical, social, and political dynamics. Normative attitudes towards sexual and reproductive health practices and family planning were common among reproductive health providers.</p>
Client Perceptions...., 1998, a working paper	<p>Data were collected in the cities of Vladivostok and Novosibirsk from four focus groups with a total of 32 participants in each city (one with women's clinic patients aged 15 to 20, one with women's clinic patients aged 20 to 30, one with postpartum women, and one with husbands of postpartum women). Focus group discussion covered general impressions and satisfaction with services, experience of breastfeeding and contraception, sources of information on maternity care, breastfeeding, and contraception.</p> <p>1996</p> <p>Women showed negative attitudes towards contraceptive methods other than the intrauterine device. Their attitudes were based on their physician's advice. Participants reported difficulties in obtaining family planning information that would meet the needs of patients. The authors conclude that there is a need for more careful family planning counselling at reproductive health services.</p>
Kulakov et al. 1997, a WHO Europe report	<p>A face-to-face standardised questionnaire interview with 352 women who had just had a termination of pregnancy in Moscow and the Moscow region; a pilot study on the epidemiology of induced abortion</p> <p>1996</p> <p>Fifteen per cent of urban respondents and 13 % of rural respondents reported having been counselled on contraception before beginning their sexual life. Forty-five per cent of urban respondents and 36 % of rural respondents reported having been counselled on contraception after deliveries or terminations of pregnancy.</p>

CEE countries, articles (listed by year of data collection)			
Johnson and Horga 1993 / Romania	Structured interviews of 1,000 women and qualitative data from semi-structured in-depth individual interviews with 80 women and 35 gynaecologists and five group interviews with women and five with gynaecologists in five hospitals in three culturally different regions of Romania	1991–1992	Most providers agreed that it was easier, safer, and less expensive to use contraception than to use abortion to prevent unwanted births. Providers insisted that a woman's legal right to termination of pregnancy should be protected. Ninety-three per cent of providers wanted to have more information about contraceptive methods. Providers felt that it was not their job to educate the population about family planning.
Johnson et al. 1996 / Romania	Structured interviews of 1,000 women and qualitative data from semi-structured in-depth individual interviews with 80 women and 35 gynaecologists and five group interviews with women and five with gynaecologists in five hospitals in three culturally different regions of Romania	1991–1992	Providers insisted that a woman's legal right to termination of pregnancy should be protected. Providers felt that it was not their job to educate the population about family planning.
Visser et al. 1993c / the former Czech and Slovak Federal Republic	Survey of 240 gynaecologists who visited a national gynaecological congress, response rate 66.7 %	1992	Eighty-three per cent of the respondents regarded induced abortion as more harmful to health than the use of any type of contraception. Seventy-eight per cent thought family planning services should be provided by every gynaecologist. Fifty-one percent of the respondents were familiar with all the main mechanisms of oral contraception. Sixty-five per cent reported leaving the final choice of contraceptive method to the patient, 25 % reported giving directive counselling, 9 % reported giving patient a limited choice and none reported making the choice for the patient.

<p>Johnson et al. 2004 / Romania</p>	<p>A strategic assessment employing a participatory, qualitative methodology; over 500 people, including healthcare professionals, service users, and representatives of public institutions, non-governmental organisations, and political parties, were interviewed from 145 institutions in 25 cities, towns, and villages in Romania about the actions needed to prevent unwanted pregnancies, to reduce abortion-related morbidity and mortality, and to improve the quality, accessibility, and availability of induced abortion and contraceptive services</p>	<p>2001</p>	<p>Some of the family doctors involved in the strategic assessment felt ill-equipped to provide or uncomfortable about providing contraceptive services. Family doctors had been trained only to provide oral and injectable contraceptives and condoms. Infection prevention practices were uneven. Physicians did not counsel or discuss contraception use after termination of pregnancy and only in a few places were women referred to family planning clinics after an induced abortion.</p>
<p>Jaruseviciene and Levasseur 2006 / Lithuania</p>	<p>Twenty in-depth interviews regarding factors affecting adolescent reproductive health care with a diverse sample of general practitioners; focus on the role of general practitioners in providing reproductive health services for teenagers</p>	<p>2003</p>	<p>General practitioners have insufficient training and low perceived support for reproductive health services. They are unwilling to provide reproductive health services for teenagers.</p>
<p>Sedlecky and Rašević 2008 / Serbia</p>	<p>A survey of all the 1,139 members of the Gynaecology and Obstetrics Section of the Serbian Medical Society, response rate 27 %</p>	<p>2006</p>	<p>Thirty-eight per cent of respondents reported that they personally used usually either coitus interruptus or no contraceptive method at all. Seventy-seven per cent advised women not to use oral contraceptives for longer than two years. Eighty-nine per cent thought that oral contraceptives could improve a woman's quality of life. Fifty-one per cent did not prescribe oral contraceptives to girls aged 18 or younger. Sixty-seven per cent thought that gynaecologists could most effectively help to decrease the number of induced abortions in Serbia by promoting reliable contraception.</p>

CEE countries, other	
<p>Lember et al. 1999, a letter to the editor / Estonia</p>	<p>Survey of a random sample of primary care doctors (n = 346, response rate 67 %)</p>
<p>Lüdicke et al. 2001, a field action report / Romania</p>	<p>A description of a training programme for eight obstetrics-gynaecology specialists from main university centres to improve reproductive health training in Romania</p>
<p>Not given in the publication (estimated to be from the 1990s)</p>	<p>Altogether 54 % of respondents agreed with the statement 'Family planning should be an essential part of my work as a doctor' and 65 % with the statement 'A GP is competent to take care of family planning'.</p>
<p>Not given in the publication (estimated to be from the late 1990s and early 2000s)</p>	<p>The study provides a description of a training programme that was designed to help participants acquire improved knowledge in reproductive health, aid preparation of teaching materials and plan training for physicians who work in the family planning network in Romania. The training programme was evaluated to be successful as subsequent training courses were arranged in Romania in 2000 and in 2001.</p>

(Rivkin-Fish 1997, 2005), whereas the rest relied on self-reported (Visser et al. 1993a, 1993b) or second-hand data (Kulakov et al. 1997; Client Perceptions... 1998; Sherwood-Fabre et al. 2002; David et al. 2007), or involved less systematic observations (Stephenson et al. 1997). As a whole, the literature can be described as being heterogeneous and insufficient for drawing a systematic overview of the current knowledge, attitudes, and practices of reproductive health providers regarding family planning.

Despite its non-systematic nature, the literature is consistent in reporting three observations. First, physicians in different parts of the country had inadequate and sometimes misguided knowledge of reliable contraceptive methods in the first half of the 1990s (Visser et al. 1993a, 1993b; Stephenson et al. 1997). A survey from the early 1990s reported that less than 40 per cent of gynaecologists were familiar with different mechanisms of oral contraceptives and half of them considered the rhythm method, withdrawal, vaginal douches, and the cervical mucus method as unreliable methods of contraception (Visser et al. 1993a, 1993b). The data are from the same period, making it impossible to estimate any time trends in physicians' knowledge on contraceptive methods.

Second, providers' attempts to promote reliable use of contraception have not been sufficient in the context where unwanted pregnancies are common and knowledge of reliable contraceptive methods is low among the population (Kulakov et al. 1997; Stephenson et al. 1997; Client Perceptions... 1998; Sherwood-Faber et al 2002; David 2007). For example, a survey carried out in 1996 in the Moscow region reported that only 36 per cent of women had been counselled on contraception by their physician after a termination of pregnancy (Kulakov et al. 1997) and another study reported that in 2000 in the Novgorod and Perm regions only 40 per cent of women received counselling after an induced abortion (David et al. 2007). The literature included two intervention studies that aimed at increasing the likelihood of women receiving family planning counselling. The first of them failed to achieve its goal and the post-intervention survey suggested that a number of opportunities for counselling were missed by health providers (Sherwood-Faber et al. 2002). The latter was more successful and resulted in an impressive increase in the frequency of counselling (David et al. 2007). The ethnographic study conducted in the 1990s in St Petersburg revealed that a small number of gynaecologists were actively engaged in educational activities to reduce the number of induced abortions, suggesting that there is variety among reproductive health providers' efforts to influence the current situation of family planning (Rivkin-Fish 1999, 2005, pp. 91-119). The studies do not reveal a consistent time trend in physicians' activity in family planning counselling, although the article relying on the most recent data set of an intervention study reported a positive change after the intervention (David et al. 2007).

Third, the literature depicts overall a picture wherein health providers tend to have an authoritative and normative attitude towards family planning counselling (Visser 1993a; Rivkin-Fish 1997; Client Perceptions... 1998; Rivkin-Fish 1999, 2000, 2004, 2005). In a survey from the early 1990s, 58 per cent of gynaecologists reported leaving the final choice of method to the patient, but a majority of them (54 per cent of the total sample) described their counselling style as directive. An ethnographic study of St Petersburg examined the providers' struggle for authority over family planning and their normative

attitudes towards birth control, motherhood and willingness to submit to specialist authority in reproductive health matters (Rivkin-Fish 1997, 1999, 2004, 2005). The data are from the 1990s and do not reveal any consistent time trend in physicians' attitudes.

The literature from CEE countries on providers' knowledge, attitudes and practices consist of eight different publications that are based on seven different data sets (Table 1). The data were collected between 1991 and 2006, and they are available from Estonia (Lember et al. 1999), Lithuania (Jaruseviciene and Levasseur 2006), Romania (Johnson and Horga 1993; Johnson et al. 1996; Lüdicke et al. 2001; Johnson et al. 2004), Serbia (Sedlecky and Rašević 2008), and the former Czech and Slovak Federal Republic (Visser et al. 1993c). Six data sets included survey material or interviews with health providers (Johnson and Horga 1993; Visser et al. 1993c; Johnson et al. 1996; Lember et al. 1999; Lüdicke et al. 2001; Johnson et al. 2004; Jaruseviciene and Levasseur 2006; Sedlecky and Rašević 2008), and two of them interviews with service users as well (Johnson and Horga 1993; Johnson et al. 1996, 2004). Overall, the data are sporadic and it is not possible to construct a reliable analysis of the situation in CEE countries. Romania was the only CEE country where it was possible to locate more than one study. It has probably attracted more research interest than the other countries owing to the prohibitive abortion policy under Ceaușescu and the subsequent high level of induced abortions.

The data from two Baltic region countries – Estonia (Lember et al. 1999) and Lithuania (Jaruseviciene and Levasseur 2006) – were collected in the particular setting where reproductive health services were formerly provided by gynaecologists, but attempts were made to encourage general practitioners to provide them. In Estonia, more than half of the general practitioners thought that family planning should be an essential part of their work and nearly two-thirds of them felt competent in terms of family planning (Lember et al. 1999). In Lithuania, the study was confined more narrowly to the general practitioners' role in providing reproductive health services for teenagers. In qualitative interviews the general practitioners were unwilling to provide teenagers with reproductive health services and felt that they did not have enough training to do so (Jaruseviciene and Levasseur 2006).

In the former Czech and Slovak Federal Republic a survey study on gynaecologists' knowledge, attitudes and practices was performed in 1992. The gynaecologists were insufficiently informed on oral contraception, but the majority of them showed positive attitudes towards providing family planning services. Nearly two-thirds also reported that they left the final choice of contraception to the patient (Visser et al. 1993c). A similar study was conducted in Serbia nearly 15 years later (2006), reporting insufficient knowledge on oral contraception among gynaecologists (Sedlecky and Rašević 2008).

The Romanian case seems to be the best-studied among the CEE countries. A relatively large study with different methods of data collection was conducted in 1991-92. The results reveal that gynaecologists needed more information about contraceptive methods, they had positive attitudes about the use of contraception by the population and they regarded women's legal right to termination of pregnancy important. The study reported, however, that gynaecologists felt it was not their job to educate the population about family planning (Johnson and Horga 1993; Johnson et al. 1996). Ten years later another large study was conducted in Romania. According to this study family doctors had

insufficient training for providing contraceptive services, and post-abortion contraceptive counselling was deficient (Johnson et al. 2004). Another study in Romania was a description of a training programme for gynaecologists. It reported positive results in increasing family planning training in the early 2000s (Lüdicke et al. 2001).

3.2 Patient involvement and provider-patient relationships in reproductive health services

Patient involvement and provider-patient relationships in reproductive health services in Russia were discussed in 14 publications based on nine different data sets (Table 2). The data were collected between 1991 and the late 2000s. Seven data sets (nine publications) consisted of survey or interview data on service users (Ivanov et al. 1995; Chalmers et al. 1998a, 1998b; Client Perceptions... 1998; Ivanov and Flynn 1999; Ivanov 2000; Callister et al. 2007; Temkina and Zdravomyslova 2008; Callister et al. 2009). One data set (four publications) included clinical observations and qualitative interviews with both service users and health providers (Rivkin-Fish 1997, 2000, 2004, 2005). One more publication was based on personal experience and observations of a reproductive health service consultant and did not include systematic research data (Chalmers 1997). Only one study was conducted in an urban area other than St Petersburg (Client Perceptions... 1998). Altogether the studies provide a comprehensive and consistent picture of service user experiences of patient involvement and provider-patient relationships in reproductive health services – albeit mostly prenatal and delivery services – in St Petersburg. Health provider perspectives and actual observations of patient involvement remain limited, however.

User experiences of prenatal care were examined in a survey study in 1994. Slightly over half of the respondents had positive experiences of prenatal care and the physician-patient relationship. Seeing the same physician throughout prenatal care increased the likelihood of patient satisfaction. Yet nearly half of the respondents had negative experiences, mainly owing to inconvenience related to frequency of visits and laboratory tests (Ivanov and Flynn 1999; Ivanov 2000). A baseline survey in 1995 and its follow-up in 1997 reported decreasing satisfaction in patients' experience of delivery, although hospitals had adopted family-oriented practices in between (Chalmers et al. 1998a, 1998b). Qualitative studies from the 1990s reported more problems in provider-patient relationships from the user perspective – such as being afraid, not liking to visit the physician, not liking the way they were treated, not receiving good service, lack of trust in providers, use of different informal strategies in order to secure individual and kind treatment (Ivanov et al. 1995; Rivkin-Fish 1997, 2005).

The data from 2000s do not report any remarkable change in user experiences of reproductive health services in St Petersburg. A qualitative study among women who had recently delivered reported that women felt having been involved in decision-making during labour and birth, but they expected more advice and support from medical and midwifery personnel (Callister et al. 2007). Participants in another study experienced reproductive health services as uncomfortable mainly owing to the way in which patients

Table 2. Review of studies on provider-patient relationships in urban Russia and in CEE countries from 1990 to 2010; description of the study and main results

Reference / Country	Data and method	Data collection year	Main results of the publication
Russia, articles (listed by year of data collection)			
Ivanov et al. 1995	Ethnography, fieldwork in St Petersburg	1992	Fifty per cent of the respondents reported that they had not looked forward to prenatal care for the following reasons: services were not good during an earlier pregnancy, long waiting times, frequent exams, were afraid, did not like visiting the physician, and did not like how they were treated.
Ivanov and Flynn 1999	A survey of 464 women living in St Petersburg who were hospitalised after delivery in nine maternity hospitals in St Petersburg, response rate 86 %	1994	Fifty-three per cent of the respondents reported having looked forward to their prenatal care visits usually because they found their physician to be friendly and caring. Forty-seven per cent reported not having looked forward to the visits and the main reasons were too many laboratory analyses and visits being time-consuming. Seventy-one per cent of women saw the same physician for all their prenatal care and women who had a regular source of care were more likely to consider services as convenient. Negative experiences with healthcare providers decreased women's satisfaction with services.
Ivanov 2000	A survey of 464 women living in St Petersburg who were hospitalised after delivery in nine maternity hospitals in St Petersburg, response rate 86 %	1994	Fifty-three per cent of the respondents reported having looked forward to their prenatal care visits and the main reason was that they found their physician to be friendly and caring. Forty-seven per cent reported not having looked forward to the visits and the main reasons were too many laboratory analyses and visits being time-consuming. Seventy-one per cent of women saw the same physician for all their prenatal care and women who had a regular source of care were more likely to consider services as convenient. Negative experiences with healthcare providers decreased women's satisfaction with services. Women with higher income and with a regular source of care tended to be more satisfied with physicians' behaviour.

Rivkin-Fish 2000	Ethnography, fieldwork in St Petersburg; analysis of a WHO project and the encounters between project workers and local reproductive health providers	1994	Providers' perspective on provider-patient relationships suggests that the provider knows best and the patient should be subordinate to expert authority. Providers' perspective is explained by the historical, social, and political context.
Rivkin-Fish 2004	Ethnography, fieldwork in St Petersburg; analysis of reproductive health activism of health providers	1994, 2000	Reproductive health activists strive to educate reproductive health providers to be more sensitive to patient needs and wishes in clinical decision-making in order to create trusting provider-patient relationships. Activists' attempts were based rather on the desire to change people's interactions in a kinder and more polite direction (moral education) than to promote patient autonomy.
Chalmers et al. 1998a	A survey of 193 women who gave birth in 11 maternity hospitals in St Petersburg	1995	Eighty-one per cent of respondents reported that physicians provided excellent or good support in labour.
Chalmers et al. 1998b	A baseline and follow-up study of a development project; two hospital assessment forms completed by chief doctors of 11 maternity hospitals in St Petersburg in 1995 and in 1997, a survey of 193 women who gave birth in the same maternity hospitals in 1995 and a survey of 220 women who gave birth in the same maternity hospitals in 1997	1995, 1997	Although family-oriented measures were taken by the hospitals, fewer respondents reported at the follow-up survey that they had enjoyed their overall birth experience very much or to some extent: 55 % in 1995 and 43 % in 1997.
Callister et al. 2007	Thematic interviews with 24 women who had given birth in the past six months, St Petersburg	Not given in the article (estimated to be from the 2000s)	Study participants reported being involved in decision-making during labour and birth. They expected advice from medical and midwifery personnel. Some study participants felt that physicians' and midwives' behaviour was not supportive.
Callister et al. 2009	A descriptive qualitative outcome evaluation of a special clinic, the Women's Wellness Centre, in St Petersburg; 20 semi-structured interviews with clients of the clinic who had given birth in the past six months	Not given in the article (estimated to be from the 2000s)	Women reported that the personnel including physicians were positive and caring and that the care was comprehensive and attentive.

		<p>Study participants experienced the visits to public sector services as uncomfortable owing to lack of comfort and privacy, emotional neglect and objectification, paternalistic attitude of physicians and nurses, and organisational disorder. They felt unable to trust the services or the providers. The respondents felt that physicians could be dishonest and careless or they might exaggerate diagnoses for commercial reasons. They considered private services more reliable and better organised and they felt that their physical, emotional, and social demands were more likely to be met in private services. Respondents employed the following strategies to find a trustworthy and kind physician: mobilising social networks, obtaining medical knowledge, personalising the relationship with the doctor by giving monetary rewards and gifts, or combining different strategies.</p>
<p>Five participants' diaries and 22 in-depth interviews with female reproductive health service clients; respondents were middle-class women of reproductive age who had post-secondary education; most were private-sector professionals or ran their own small business</p>	<p>2005–2006</p>	
<p>Russia, books (listed by the year of data collection)</p>		
<p>Personal experience and observations of a health psychologist who has worked as a consultant for a maternal and child health project in St Petersburg</p>	<p>From 1991 onwards</p>	<p>Maternity care is technically-oriented and expert-centred. Health providers show lack of concern for a mother's psychosocial and emotional needs and privacy.</p>
<p>Ethnography, fieldwork in St Petersburg</p>	<p>1994, 2000</p>	<p>There are power inequalities between providers and patients in reproductive health services, with patients having little autonomy over the clinical process. Interactions are shaped by strict hierarchical norms. Women patients often become targets of normative discipline by reproductive health providers. Patients feel unable to trust providers and they want more trustworthy provider-patient interaction. Patients strive to secure individual and kind treatment through personalising provider-patient relationships. Physicians are frustrated about patients' lack of information, unhealthy living habits, and attitude towards their health. Physicians expect patients to be subordinate to expert authority. Physicians want and appreciate warm and personal provider-patient relationships. Despite the general pattern some provider-patient relationships were satisfying and fulfilling for both parties.</p>
<p>Rivkin-Fish 2005</p>		

Russia, other
(listed by the year
of data collection)

There are power inequalities between providers and patients in reproductive health services, with patients having little autonomy over the clinical process. Interactions are shaped by strict hierarchical norms. Women patients often become targets of normative discipline by reproductive health providers. Patients feel unable to trust providers and they want more trustworthy provider-patient interaction. Patients strive to secure individual and kind treatment through personalising provider-patient relationships. Physicians are frustrated about patients' lack of information, unhealthy living habits, and attitude towards their health. Physicians expect patients to be subordinate to expert authority. Physicians want and appreciate warm and personal provider-patient relationships. Despite the general pattern some provider-patient relationships were satisfying and fulfilling for both parties.

Rivkin-Fish 1997,
an unpublished
dissertation

Ethnography, fieldwork in St Petersburg

1994

Data were collected in the cities of Vladivostok and Novosibirsk from four focus groups with a total of 32 participants in each city (one with women's clinic patients aged 15 to 20, one with women's clinic patients aged 20 to 30, one with postpartum women, and one with husbands of postpartum women); focus group discussion covered general impressions and satisfaction with services, experience with breastfeeding and contraception, sources of information on maternity care, breastfeeding, and contraception

**Client
Perceptions...**
1998, a working
paper

Women reported predominantly positive experiences of physicians' well-meaning and attentive attitudes. Attitudes towards young women and women in need of induced abortion were reported to be judgemental. Privacy and confidentiality were not respected during clinical encounters.

1996

CEE countries, articles (listed by the year of data collection)

<p>Johnson and Horga 1993 / Romania</p>	<p>Structured interviews of 1,000 women and qualitative data from semi-structured in-depth individual interviews with 80 women and 35 gynaecologists and five group interviews with women and five with gynaecologists in five hospitals in three culturally different regions of Romania</p>	<p>1991–1992</p>	<p>Providers thought that women were too casual about abortion. Women wanted gynaecologists to initiate conversations about contraception and 69 % of providers reported having noticed this. Several gynaecologists thought that 'women were to blame' because they did not know what to ask for in respect of either abortion or contraceptive services.</p>
<p>Johnson et al. 1996 / Romania</p>	<p>Structured interviews of 1,000 women and qualitative data from semi-structured in-depth individual interviews with 80 women and 35 gynaecologists and five group interviews with women and five with gynaecologists in five hospitals in three culturally different regions of Romania</p>	<p>1991–1992</p>	<p>Providers thought that women were too casual about abortion. Women thought that high-quality abortion care would be quick, gentle, and discreet, would include supportive behaviour from providers, and would involve a relatively painless procedure. Seventy-two per cent of women reported that other women gave gifts to physicians who performed their abortion. Thirty-nine per cent of women thought that gifts would not ensure better treatment, whereas 31 % thought the opposite. Women wanted gynaecologists to initiate conversations about contraception and 69 % of providers reported having noticed this.</p>
<p>Scanlan et al. 1996 / Hungary</p>	<p>A survey of 428 women in one community setting, response rate 86 %</p>	<p>Not given in the publication (estimated to be from the early or mid-1990s)</p>	<p>Fifty-two per cent of the respondents reported being satisfied with the care received, while 23 % were dissatisfied. Written comments reported inappropriate behaviour towards patients, long waiting times, and lack of hygiene. Fifty-two per cent of respondents were satisfied with the healthcare staff, while 19 % were dissatisfied.</p>

<p>Johnson et al. 2004 / Romania</p>	<p>A strategic assessment employing a participatory, qualitative methodology; over 500 people (healthcare professionals, service users, representatives of public institutions, non-governmental organisations, political parties) were interviewed from 145 institutions in 25 cities, towns, and villages in Romania about the actions needed to prevent unwanted pregnancies, to reduce abortion-related morbidity and mortality, and to improve the quality, accessibility, and availability of abortion and contraceptive services</p>	<p>2001</p>	<p>Physicians provided little information to women about termination of pregnancy or contraception. Women's basic human needs and privacy were neglected in abortion services.</p>
<p>Jaruseviciene et al. 2006 / Lithuania</p>	<p>Twenty in-depth interviews about factors affecting adolescent reproductive health care with a diverse sample of general practitioners; the focus was on providers' attitudes to confidentiality for adolescents in reproductive health-related matters</p>	<p>2003</p>	<p>Providers' decision whether to respect confidentiality was influenced by legislative framework, societal attitudes towards adolescent sexuality, institutional factors, and providers' relationship with the adolescent's family, and their personal attitude towards sexual and reproductive health issues.</p>
<p>Todorova et al. 2006 / Bulgaria and Romania</p>	<p>Semi-structured interviews with 50 healthcare providers in each country, including general practitioners, gynaecologists, and cytologists; the focus was on providers' constructions of the role of women in cervical cancer screening</p>	<p>Not given in the publication (estimated to be from the early 2000s)</p>	<p>Several discourses in providers' construction of women's responsibility for prevention of cervical cancer were identified: responsible women were seen as intelligent and cultured, non-attenders as irresponsible and negligent, women were seen as needing monitoring and sanctioning, and as victims of healthcare reforms.</p>
<p>Lazarus et al. 2008 / Lithuania</p>	<p>A survey of a random sample of 607 general practitioners, response rate 74 %</p>	<p>2005</p>	<p>Forty-nine per cent of respondents knew of the legal standards protecting the confidentiality of adolescents in health care. The respondents thought that the most important measure to improve confidentiality in adolescent health care would be the development of an explicit legal framework.</p>

CEE countries, books	<p data-bbox="248 194 357 856">Personal experiences and observations of a health psychologist who has worked as a consultant in Estonia, Czech Republic, Hungary, Latvia, Poland, and Romania</p> <p data-bbox="248 856 357 1047">Chalmers 1997, a book article</p> <p data-bbox="248 1047 357 1237">From 1991 onwards</p> <p data-bbox="248 1237 357 1675">Maternity care is technically-oriented and expert-centred; health providers show lack of concern for mothers' psychosocial and emotional needs and privacy.</p>
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were treated by medical and nursing personnel and because they were unable to trust health providers. They felt that private services were more reliable and better organised than public ones and that their physical, emotional, and social demands were more likely to be met by private services. Use of different informal strategies to secure reliable and kind treatment continued to be common (Temkina and Zdravomyslova 2008). An evaluation of the treatment at the Women's Wellness Centre in St Petersburg – a special clinic with supposedly a more patient-centred approach to services – reported different kinds of results: service users found the care comprehensive and attentive and the personnel positive and caring (Callister et al. 2009).

An ethnographic study of the 1990s in St Petersburg suggests that reproductive health providers had an authoritative attitude towards their patients and commonly felt frustration towards their patients' living habits and attitude towards their health. Yet the study reveals that physicians valued warm and personal provider-patient relationships (Rivkin-Fish 1997, 2000, 2005). Observations conducted in the same period reported that clinical interactions were hierarchical, care was expert-centred and technically-oriented, and health providers showed little concern for patients' psycho-social and emotional needs and privacy (Chalmers 1997; Rivkin-Fish 1997, 2005). The picture is uneven though, and a small number of health activists were engaged in educating providers to be more sensitive to patient needs and wishes during clinical encounters (Rivkin-Fish 2004).

The literature from CEE countries on patient involvement and provider-patient relationships in reproductive health services is scarce. Eight different publications were identified and they were based on seven different data sets (Table 2.) The data extend from 1991 to the 2000s. There are research publications available from Bulgaria (Todorova et al. 2006), Hungary (Scanlan et al. 1996), Lithuania (Jaruseviciene et al. 2006; Lazarus et al. 2008), and Romania (Johnson and Horga 1993; Johnson et al. 1996, 2004; Todorova et al. 2006). One data set is based on a survey on service users (Scanlan et al. 1996), three on survey and interview data on health providers (Jaruseviciene et al. 2006; Todorova et al. 2006; Lazarus et al. 2008), and two include data on both service users and health providers. In addition, a book chapter was based on personal experience and observations of a reproductive health service consultant in Estonia, Czech Republic, Hungary, Latvia, Poland, and Romania (Chalmers 1997). The data are not systematic and do not allow a trustworthy analysis of the situation in CEE countries. Romania is the exception, with three different studies conducted in the country (Johnson and Horga 1993; Johnson et al. 1996, 2004; Todorova et al. 2006).

Chalmers (1997) reported her personal experiences and observations as a reproductive health service consultant in Estonia, Czech Republic, Hungary, Latvia, Poland, and Romania between 1991 and 1997. According to her, maternity care was technically-oriented and expert-centred throughout the area, and health providers tended to neglect women's psycho-social and emotional needs (Chalmers 1997). A survey of service users that was conducted in Hungary before 1996 reported that slightly more than half of the respondents were satisfied with the healthcare personnel and the care received, and almost one-fifth was not satisfied with the personnel and nearly a quarter dissatisfied with the care. The reasons for dissatisfaction were inappropriate behaviour towards patients, long waiting times, and lack of hygiene (Scanlan et al. 1996). With regard to the providers'

perspective, semi-structured interviews in Romania and Bulgaria revealed several discourses on women's responsibility over their own health in relation to cervical cancer screening, some of the discourses being normative whereas others saw women as victims of healthcare reforms (Todorova et al. 2006). The two studies from Lithuania focused on providers' attitudes to confidentiality of adolescents' reproductive health care (Jaruseviciene et al. 2006; Lazarus et al. 2008).

As regards Romania, studies are focused on induced abortion services and contraceptive counselling. One study reports that women expect gentle and supportive behaviour from providers in induced abortion services. Giving gifts to physicians in abortion services is common and almost one-third of the female respondents expected to do that to improve treatment, whereas nearly 40 per cent thought the opposite. Women expect their gynaecologist to initiate conversation about contraception, which is recognised by nearly 70 per cent of the providers (Johnson and Horga 1993; Johnson et al. 1996). Yet according to another study physicians provided little information to women about termination of pregnancy or contraception (Johnson et al. 2004). Furthermore, normative attitudes towards women are not unusual among reproductive health providers in Romania (Johnson and Horga 1994; Johnson et al. 1996, 2004; Todorova et al. 2006).

3.3 Conclusions of the literature review

The literature review revealed that publications on providers' knowledge, attitude and practices towards family planning, and patient involvement and provider-patient relationships in reproductive health services in urban Russia and Central Eastern European post-socialist countries are scarce – at least in the English language. The quality of publications varies from peer-reviewed high-quality articles to working papers and descriptions of personal experiences. Different research methods have been applied both in Russia and in CEE countries, ranging from provider and user surveys to qualitative interviews, observations, and ethnography, but data are sporadic and do not give a full picture of the situation in the countries examined. Direct observations in particular are scarce, and conclusions are commonly drawn on the basis of second-hand or self-reported data.

Certain general observations can be made on the basis of the literature review, however. As regards providers' knowledge, attitudes and practices in Russia, researchers were interested in the providers' level of knowledge on family planning in the early 1990s, but the early results were not followed up in later research. Providers' counselling activity continued to raise interest among researchers for the time span covered by the literature review. The data are consistent in reporting low levels of counselling activity in the 1990s, but it is difficult to estimate the situation in the 2000s. Studies also consistently describe an authoritative, directive and normative counselling style among providers, but data are not available from the early 2000s onwards. As regards CEE countries, the data are too scattered and sometimes too context-bound to allow reliable analysis of any trends.

When it comes to patient involvement and provider-patient relationships, user experiences from prenatal and delivery services in St Petersburg are reported in a

relatively large number of studies. It seems that qualitative methods reveal more problems than survey methods from the user perspective. Nevertheless, it can be concluded that patients are less than satisfied with the way they are treated in prenatal and delivery services in St Petersburg. Observations and studies on provider perspective are scarce, but they support the general picture reported in user studies, suggesting that provider-patient relationships are problematic in terms of authority, trust, patient-centredness, and patient involvement. Again, the studies from CEE countries are too few and spread over too large a number of countries to allow any definite conclusions to be drawn. Yet the topics chosen by researchers suggest that they are worried about problems such as confidentiality, counselling activity, patient involvement, and sensitivity to patients' needs.

When we look at the literature review, it is clear that a provider perspective is under-represented in Russian literature, whereas data on user perspective in prenatal and delivery services in St Petersburg are fairly comprehensive. Furthermore, data on user perspectives on contraceptive counselling and induced abortion services are limited in St Petersburg. There are fewer data from other parts of urban Russia – not to mention the rural areas – and little attention is given to the generalisability of the St Petersburg data to other parts of the country. Direct observations of patient involvement and provider-patient relationships are absent, with the exception of a single ethnographic study. The literature on CEE countries provides few references for comparison, as the data are even more scarce and random. A common feature of many publications on Russia and CEE countries is a critical perspective that seems to imply that researchers expect something to be wrong in terms of providers' knowledge, attitudes, practices, patient involvement, or power balance between the provider and the patient in clinical interactions.

4 A model of patient involvement in clinical decision-making

4.1 Patient involvement in provider-patient relationships

Until the second half of the twentieth century the most prevalent model for clinical decision-making throughout the world was paternalistic. It was assumed that the provider knew best and the patient had to comply with the treatment decisions made by the provider (Charles et al. 1999; Sullivan 2003). Gradually, towards the end of the century, the international debate on health services and health policy resulted in new conceptualisations of the provider-patient relationship and patients' role in clinical decision-making (Charles et al. 1999; Sullivan 2003).

Various models have been developed to analyse the provider-patient relationship and the core processes of clinical decision-making. These models have been applied in medical education and as analytical tools to direct health professionals towards more patient-centred orientation in their clinical work. The literature gives the impression that researchers are driven by the idea that a higher level of patient involvement is valued (see Thompson 2007).

Charles et al. introduced their model of shared decision-making in the late 1990s (1997, 1999). It focuses on provider-patient interaction and the selection of treatment measures. Charles et al. distinguish three different types of clinical decision-making: paternalistic, shared, and informed. The key differences between them are the flow, direction, type, and amount of information exchange, deliberation, and decision about the course of treatment action. The model was rather influential in the 2000s and has been the subject of further development and refinement (see e.g. Entwistle and Watt 2006; Wirtz et al. 2006). Thompson (2007) summarised the different types of clinical decision-making as: (1) paternalism, (2) shared decision-making, (3) professional-as-agent, and (4) informed decision-making. He comments that these are all variations of professional-determined patient involvement and can be arranged along a power continuum from a low level of patient power to higher levels (Thompson 2007; see Figure 1).

Today the idea that patients should be involved in clinical decision-making is widely accepted in international health policy. The argument for patient involvement is twofold: patient involvement is valuable in its own right, but it is also an essential instrument in achieving compliance with treatment and, thus, good health results. Patient involvement is typically combined with the idea of patient choice and patient empowerment. The consensus on the significance of patient involvement is reflected in various types of international and national normative statements or clinical guidelines. The Declaration of Alma Ata emphasises the participation of patients, their families, and communities in primary health care (WHO 1978). The idea has been reinforced in different WHO documents. For example, the World Health Report of 2008 stated that people-centredness is one of the four sets of primary healthcare reforms that are needed for an effective response to today's health challenges. The report defines people-centred primary care as person-centred, comprehensive, integrated, providing continuity of care, incorporating

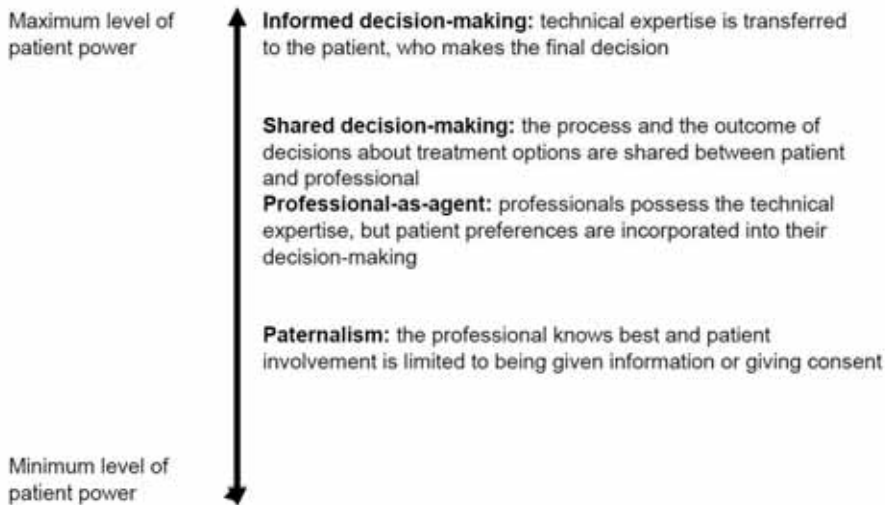


Figure 1. Variations of professionally-determined patient involvement along a power continuum from maximum level of patient power to minimum level of patient power (adapted from Thompson 2007)

participation of patients, families and communities, empowering patients, and showing understanding of patients' concerns and beliefs, and of illness (WHO 2008, pp. 41-56). Similar ideas can be identified in various international and national reports and guidelines in different countries, not only in relation to primary care (e.g. Department of Health 2001; WHO 2005; General Medical Council 2009).

Despite the broad consensus between health providers, policymakers and researchers that patient involvement is essential in high-quality health services, research has repeatedly shown that patients' preferences for involvement in decision-making differ greatly (e.g. Vick and Scott 1998; Ford et al. 2003; Entwistle et al. 2004; Thompson 2007). This is acknowledged both in the clinical guidelines and in more theoretical literature, where it is typically recommended that flexibility in decision-making process is needed in order to respect the individual preferences of patients (e.g. Charles et al. 1999; WHO 2008; General Medical Council 2009). It must be pointed out, though, that the everyday reality in health services often falls short of the ideal – it is a relatively common event in clinical practice that patients' expectations about their role in decision-making are not met (e.g. Ford et al. 2003; Bryan et al. 2006; WHO 2008; Karnieli-Miller and Eisikovits 2009).

4.2 Reproductive health services as a special case of provider-patient relationships

The ideal of patient involvement or participation in clinical decision-making has been even stronger in reproductive health services than in many other spheres of health services. Especially in the field of family planning active engagement of patients in the choice of contraceptive method has been recognised as one of the key components of effective counselling, which is reflected in the use of the word 'client' rather than 'patient'. As Shelton (2003, p. 111) put it, 'An empowered contraceptive is a more successful contraceptive'.

In terms of research evidence, studies from different countries have shown that compliance with contraception improves with increased patient involvement and factors such as activation, facilitation of partnership, patient-centredness, responsiveness to patients' attitudes and emotions, use of empathy and positive regard, physician informativeness and review of plans (Delbanco and Daley 1996; Lipkin 1996; Foster and Hudson 1998; RamaRao and Mohanam 2003; Fisher et al. 2006; Fisher and Black 2007; Nobili et al. 2007). Recently, studies directly observing contraceptive counselling have been conducted in the developing world rather than in the developed countries. They suggest that patient-centred visits are associated with greater patient satisfaction and method continuation, although patients generally play a passive role in consultation (Kim et al. 1999, 2001; Abdel-Tawab and Roter 2002; Kim et al. 2005; Kırımoglu et al. 2005). On the other hand, a systematic review of the evidence about the effectiveness of counselling in clinical settings to prevent unintended pregnancy in the United States concluded that the previous literature did not give reliable answers to questions about effectiveness of counselling and did not give strong guidance for recommendations about clinical practice (Moos et al. 2003). Male involvement in reproductive health has gained increasing attention in the literature lately (e.g. Nikula 2009). Male involvement in contraceptive choice has been increasingly recognised, although counselling practices may not be prepared to serve sexually active couples (e.g. Becker and Robinson 1998).

A number of organisations or projects have developed guidelines and recommendations for good quality and ethical counselling in reproductive services, the organisation of service delivery, and national policies (see e.g. Hardon et al. 1997, pp. 31-50; FIGO Committee... 2002; ACQUIRE Project 2006; WHO 2007). These represent the ideals of provider-patient interactions in reproductive health services and may not be realised in clinical practice. Internationally they are widely shared and accepted as principles that should guide counselling work. As an example of these ideals, Appendix 1 presents the guidelines for successful contraceptive counselling developed by the World Health Organization and its collaborators.

4.3 Studying Russia with conceptual tools from the international literature

As pointed out at the end of the Chapter 3 of this summary, a common feature of the studies published is that scholars expect something to be wrong and – further refined – less developed or missing in Russian and CEE reproductive health services, whether it is the providers' level of medical education or the extent of patient involvement in clinical decision-making. Reading between the lines, there seems to be a hidden allusion that we in the West already have the ideal or are at least better or more advanced in relation to the ideal. Similar attitudes apply to many health development projects, as exemplified by Rivkin-Fish's description of a WHO project in St Petersburg (Rivkin-Fish 2000, 2005, pp. 35-65). Our biases or their possible consequences are not commonly addressed in health research, but social scientists tend to be more sensitive to them. Feminist scholars, for example, have made attempts to grasp the West-East divide in the fields of feminist movement and women's studies in a number of commentaries in different publications (e.g. *European Journal of Women's Studies* 1994; Busheikin 1997; Einhorn and Gregory 1998; Petö 2001). Their writings underline the significance of analysing Eastern European development in its own right instead of seeing it as inferior to and bound to follow the Western path, albeit a couple of steps behind.

A comparative perspective is inevitable in my study. Coming from Finland, I cannot escape making comparisons between Russia and Northern European welfare states – often in favour of the latter. Being a physician, I am not able to avoid comparisons between clinical practices in St Petersburg and what I have learnt during my education and clinical career. Therefore, I have chosen to take the international or Western ideas of provider-patient relationships as the starting-point for examining provider-patient relationships in this summary. Yet at the same time I wish to avoid making normative comparisons between international ideas and Russian practices or repeating how certain ideals are lacking in St Petersburg. Instead, I make a genuine effort to look at my research data, see how they differ from the international ideals, and identify what is specific to the Russian case, and why it is. Furthermore, I examine how well the model of patient involvement in clinical decision-making presented by Thompson (2007) fits the data from St Petersburg: is it useful as an analytical tool for the data or is something else needed?

5 Aims of the study

The overall aim of this research project was to increase the current understanding of the obstacles that limit the extent and effectiveness of reproductive health counselling in urban Russia. This study fills part of the existing gap in the literature by providing data on provider perspectives on reproductive health services in urban Russia.

The specific aims are:

1. To describe how the delivery of women's reproductive health services is organised in St Petersburg (I, II, III)
2. To analyse the problems and challenges in women's reproductive health services as perceived by health administrators and practising gynaecologists (I, IV)
3. To analyse gynaecologists' views and practices concerning preventing, planning and monitoring pregnancy (II, III)
4. To examine gynaecologists' perceptions of provider-patient relationships (II, III, IV)

The scope of the study was restricted to reproductive health services in the public sector, because the private sector is still too expensive for most of the women in St Petersburg. Out-patient services were chosen, as they have significant potential for health promotion. Among the health providers, gynaecologists rather than midwives or nurses were selected as the subjects of the study, because the latter do not usually work independently with patients in urban centres such as St Petersburg.

6 Material and methods

My professional roots are anchored both in cultural anthropology and in medicine. Anthropology came first and provided fairly extensive methodological training, involving five months of fieldwork in rural Tanzania (Larivaara 1999). Thus, it appeared reasonable to conduct ethnographic research in this study project as well. As the data collection progressed, it became obvious that I would not be able to achieve the criteria traditionally associated with ethnographic research, i.e. in-depth fieldwork, contextualisation, understanding the local meaning system, and providing thick description (see Honkasalo 2008). I was able to spend only a limited period of time in the field and my Russian language was basic. I simply was not able to produce thick description in the Geertzian sense of the expression (Geertz 1973, p. 21). Consequently, my study evolved to be closer to applied medical anthropology (e.g. Franklin and Lock 2003; Trostle 2005), where relatively short fieldwork with limited research questions is conducted using the same methods as in traditional ethnographic research and maintaining the ethnographic interest of understanding from within instead of from a distance (Honkasalo 2008; see also Larivaara 2008b).

The methods of data collection for this study consist of semi-structured interviews and observations (Dahlgren et al. 2004, pp. 69-86; Silverman 2000, pp. 31-40). Semi-structured interviews were deemed to be a suitable method, as they allow flexibility when new and unexpected issues emerge. At the same time, the use of a semi-structured interview schedule guarantees that the same topics are covered with each participant (Dahlgren et al. 2004, pp. 77-86). As regards observations, they were crucial in order to understand what was actually happening in the everyday work of women's clinics and to locate potential gaps between interview data and actual practices (Dahlgren et al. 2004, pp. 71-76; Silverman 2000).

The data collection consisted of four parts: (1) semi-structured background interviews with administrative personnel and medical professors (N=9), and managers of different women's clinics (N=9), (2) a pilot study involving observations (N=3) and semi-structured interviews (N=2) at a women's out-patient clinic, (3) observations (N=17) and semi-structured interviews (N=12) at two women's out-patient clinics, and (4) visits and comparison interviews (N=4) at five women's out-patient clinics. The interviews with gynaecologists form the most essential part of the data, but background interviews, observation notes, and other field notes were needed to provide a perspective on the conditions that frame the gynaecologists' everyday work and to analyse how the interview and observation data support each other.

The data were collected between January and May 2005, when I spent approximately 13 weeks in St Petersburg. The data collection was conducted together with Russian research assistants who also worked as interpreters. All the data are summarised in Tables 3 and 4. More details of data collection are available in Appendixes 2 to 5.

6.1 Data collection

Background interviews

Semi-structured interviews were conducted with health administrators, medical professors and managers of different women's clinics. A more detailed description of the study participants is given in Table 3. They were contacted personally by a senior member of the research team to request preliminary consent. If a positive answer was received, a letter of introduction (Appendix 3) describing the study was sent and a research assistant followed up with a phone call to arrange an appointment for the interview. In cases of refusal, attempts were made to find another participant from the same organisation or in a similar position. The interview schedule (Appendix 4) was divided into four different blocks of questions: (1) healthcare administration, (2) financing of health services, (3) organisation of women's health services, and (4) general and specialist medical training, and continuing education. Only one block was covered with each participant, but each block was covered with at least two participants. Finally, each participant was asked to identify the strengths and weaknesses of the healthcare system in general and women's health services in particular and to generate ideas for reforming women's health services. The interviews were relatively short and concise, lasting between 25 and 75 minutes with an average of 36 minutes. Each of the participants had a private office where the interview was conducted, and the only people present were the participant, the research assistant and I. The interviews were not tape-recorded, because it was anticipated that the participants might be reluctant in that case to discuss the weaknesses of the current healthcare system or express criticism towards it. Notes were taken during the interview and completed immediately afterward. The background interviews give a rough, overall view of the structure and the ideal functioning of health services in St Petersburg. It was difficult to obtain critical views or information about the actual functioning of services. Saturation of data was not reached with regard to participants' opinions of the current system.

The pilot study

The pilot study involved observations and interviews at a women's clinic that had previously collaborated with the REFER project (see Introduction). Three gynaecologists were observed for four hours each on three subsequent days and two gynaecologists were interviewed. The manager of the clinic recruited gynaecologists for observations and interviews. The results of the pilot have been included with the main data, as only minor changes were made to the observation methods. The interview schedule was shortened and some topics were left out of it after the pilot. The observation and interview methods are described in more detail below together with the observations and semi-structured interviews at the data collection clinics.

Table 3. *Summary of the study participants*

Type of data collection and data source	Number of study participants
Background interviews	
City Committee of Public Health, Representatives of	
Department of Economy	1
Out-Patient Services	1
Division of Health Services	1
District departments of public health	
Directors of district departments of public health	1
Medical universities	
Professors of gynaecology and obstetrics ¹	2
Professors of adolescent health ¹	1
Youth clinics ²	
Managers of youth clinics	2
Women's clinics	
Managers of women's clinics	9
Total	18
Observations with gynaecologists	
Pilot	3
Clinic A	8
Clinic B	9
Total	20
Interviews with gynaecologists	
Pilot	2
Clinic A	5
Clinic B	5
Comparison interviews	4
Total	16

¹ All the professors represent the same medical university.

² This study does not cover the services provided by youth clinics.

Observations and semi-structured interviews at data collection clinics

The majority of the observation and interview data on gynaecologists was collected at two women's clinics, clinic A and clinic B. They were selected because of their large size and connections with the REFER research team. Altogether 17 gynaecologists in their daily work were observed, and 208 clinical encounters took place. The research assistant and I observed the clinical work as onlookers, asking questions of gynaecologists between patients. Sometimes the gynaecologists asked me questions or commented on the case while the patient was in the office. They often volunteered comments after the patient had left. During the observations, the research assistant and I made field notes that were discussed each day after the observation period. Notes were also made about the follow-up discussions. A standardised observation recording schedule was not developed, because the aim was to provide a picture of the real-life naturalistic setting (Briggs et al. 2003) and to maintain flexibility in recording unexpected topics.

Semi-structured interviews with ten gynaecologists were conducted after the observations. The interview schedule covered gynaecologists' views about contraception, induced abortion, timing of childbirth, and women's sexual behaviour, and which women's health problems were perceived by them as urgent and topical (Appendix 5). Questions about provider-patient relationships were not asked during the observations and interviews, but the topic arose frequently when other aspects of clinical work and women's health problems were discussed. Eight of the interviews at the data collection clinics (and half of the total number of interviews) were conducted by the research assistant in my presence to save time and to allow the study participants to speak freely without interruption because of translation. Interviews were tape-recorded and transcribed. None of the gynaecologists refused to participate in the observations, but some of the older gynaecologists declined to take part in the interviews owing to lack of time.

Visits to other clinics and comparison interviews

Five other women's clinics were visited and four gynaecologists – each at a different clinic – were interviewed in order to assess whether the clinics used in the study were any different from the other clinics in St Petersburg. The sites for the visits were chosen according to the existing network of the REFER research team. The interview schedule was the same as in the study clinics and the interviews were tape-recorded and transcribed.

Notes about observations and interviews with practising gynaecologists

The observations at the pilot and at the data collection clinics lasted approximately four hours each, but the whole observation period was not spent in clinical work, as the gynaecologists always took their half-hour lunch or tea break during the observations. Although this resulted in missing some clinical cases, it provided an excellent opportunity for conversation with the study participants. Each study participant was seeing patients in

Table 4. *Summary of patient visits observed during the study*

Patient visits by purpose of visit	Number of visits	Number of visits by women of reproductive age¹
Post-delivery check-up	4	4
Confirming pregnancy	16	16
Contraception	3	3
Gynaecological complaint	79	52
Termination of pregnancy	3	3
Medical certificate	17	8
Monitoring pregnancy	69	69
Preventative check-up	17	10
Total	208	165

¹ Includes all women aged 15 to 45 and three women in their late 40s who still had regular menstruation and used or were advised to use contraception.

an office where there were no other physicians working. In principle, the only persons present during the observations were the gynaecologist, the nurse, the patient, the research assistant and I. At data collection clinic B, two gynaecologists were seeing patients without having a nurse to assist them. Gynaecologists at the pilot clinic, however, often had two patients inside the office at the same time. In these cases, the nurse typically gave the final practical treatment instructions to the patient, while the gynaecologist was already interviewing or examining the next patient. At the pilot clinic, the gynaecological chair was located behind a shade, providing some privacy to the patient during the gynaecological examination. At the data collection clinic A, the gynaecological chair was not protected from the sight of other people inside the room or those opening the door and entering. At the data collection clinic B, the gynaecological chair was located in a separate examination room situated between two gynaecologists' offices and shared by two gynaecologists. During one of the observations, the other gynaecologist (not the one whom we were observing) kept the door of her office to the examination room open all the time, which made it possible for us to hear a considerable number of the conversations conducted in the other office. In addition, it was not uncommon for other members of the clinic personnel to enter the office during the appointments to run something past the gynaecologist or the nurse.

The interviews with the gynaecologists were typically conducted in an empty office, meeting room, or coffee room. Thus, the only persons present during the interview were the gynaecologist, the research assistant and I. Another gynaecologist was present for about 20 minutes during one of the interviews that took place in a clinic coffee room. Her presence disturbed us, as she kept on commenting on the topics of the interview. The length of the interviews with translation varied between 77 and 117 minutes, with an average of 95 minutes. The length of the interviews conducted by the research assistant in my presence varied between 55 and 77 minutes, with an average of 65 minutes. Two of

the interviews conducted during the visits to other clinics needed to be shortened, as the study participant was not prepared to spend enough time on the interview. They lasted for 20 and 39 minutes and covered only parts of the interview schedule.

Gynaecologists and clinics participating in the study

The age of the gynaecologists who were interviewed and observed varied from 27 to 60 years. Half of the participants interviewed were younger than 36 years, a quarter were aged 36 to 45, and a further quarter were older than 45. Observations included more elderly gynaecologists, but their exact age was not recorded in all cases. All the gynaecologists who were observed and interviewed were women. This is in line with the gender structure of the profession in the country, as a majority of Russian gynaecologists are women. The pilot and study clinics are all located in suburbs of St Petersburg and each serves women from a variety of social backgrounds. All three clinics employ ten district gynaecologists and serve a population of 50,000 to 60,000 women. Consequently they provide typical examples of women's clinics in St Petersburg suburbs. Comparison visits to five clinics confirmed that the study clinics had better than average material resources and had a good reputation among representatives of other clinics. Yet the comparison interviews were similar to those completed at the clinics used in the study, indicating that similar views were likely to be repeated at different clinics throughout the city. A good level of saturation was reached with regard to the observations and the interviews with gynaecologists and visits to the women's clinics.

6.2 Data analysis

All the data have been computerised. The tape-recorded interviews were transcribed into texts and the Russian parts of the interviews were translated into English by a professional translator. In the text form the data contain 43 pages of free-form diary notes, 48 pages of notes from background interviews, 205 pages of observation notes on clinical work, and 251 pages of interviews in English with practising gynaecologists (approximately 2876 letters per page with spaces included). The analysis of the interview data relies primarily on English translations, but I have checked the essential passages and wordings from Russian transcripts and discussed their interpretation with Russian colleagues.

The data were analysed with the help of the qualitative data analysis program Atlas.ti. The data were first read a number of times to provide a general sense of the whole data set and to suggest how to structure the data into research articles. Five main themes were selected: (1) the organisation of women's health services and their major problems from the perspective of the participants, (2) gynaecologists' views and practices of contraception and contraceptive counselling, (3) gynaecologists' views and practices of

induced abortion and abortion counselling,⁸ (4) gynaecologists' views and practices of pregnancy planning and monitoring, and (5) gynaecologists' experiences of provider-patient relationships.

Conventional content analysis was used as the method of interview data analysis (Hsieh and Shannon 2005). The aim was to discover both manifest and latent contents in the data (Graneheim and Lundman 2004). Coding and categorisation of interview data were done inductively, by locating and condensing meaning units and labelling them with codes (e.g. 'obstacles in contraceptive counselling' or 'need to convince patients'). As normative overtones were ample in the data, I usually defined the code further by describing the nuance in participants' talk: for example 'understanding', 'scolding', 'approving', or 'moralising'. Then I began to make notes on regularities emerging from data, to compare the codes and group them into subcategories (e.g. 'risk to health and future fertility' or 'non-compliance with gynaecologist's recommendation') and categories (e.g. 'health/fertility' or 'low health culture'). Typically, the final steps of data analysis were completed while I wrote and rewrote the research articles. The writing process involved going back to the data and specifying or reorganising the coded passages. An example of the coding and categorising process is given in Table 5.

The visits that were observed were classified according to the purpose of the visit stated by the patient at the beginning of the appointment (quantitative classification). The contents of the visits were largely analysed with conventional content analysis, but directed qualitative content analysis (Hsieh and Shannon 2005) was used for analysing gynaecologist-patient interaction patterns.

6.3 Ethical considerations and study methods

The research plan was reviewed and approved by the research ethics committees at the National Research and Development Centre for Welfare and Health (STAKES) in Finland and at the St Petersburg Medical Academy for Postgraduate Studies (MAPS) in Russia. The results have been reported in such a way that individual study participants or women's clinics cannot be identified in the data. Yet a major ethical concern remains: the voluntariness and privacy of the study participants and that of the patients during the observations. The health administrators and medical professors by virtue of their position could probably have refused to participate in the study if they had felt so inclined, but the situation was different for the practising gynaecologists and their patients.

It is difficult to estimate to what extent the participation of the gynaecologists was voluntary, as they may not have had a genuine opportunity to refuse after the clinic manager had agreed to participate in the study. In many cases the gynaecologists seemed to be a little tense or reserved at the beginning of the observation period, but the rapport always became natural and relaxed after initial reservations, often after we had had time to discuss their work and the patients as well as the study. Two gynaecologists pointed out

⁸ *The results on termination of pregnancy have been published in Finnish in a research article that is not part of this summary (Larivaara 2008b).*

Table 5. An example of inductive coding and categorisation process

Examples of data extracts	Code	Subcategory	Category
'One more story. A woman comes, "Do I need gloves? Are gloves needed?" "Right, gloves are needed in this office". She goes to a shop, buys gloves, comes here, undresses, puts on the gloves and lies down on the gynaecological chair. So, I mean, well, if... I ask her, "Is this so unfamiliar to you?", and with no uneasiness she leaves, buys new gloves and says, "Imagine that, I've put them on".			
'Now many women understand that there is no point in just hoping. I mean almost all try to use something [some contraception]. However, sometimes their methods cannot be considered to be contraception. Well, not reliable methods. They still use withdrawal, and sometimes they believe that after sexual intercourse a woman must go and shower. We try to explain that this is not so effective'	Ignorance	Ignorance	
'Absolutely illiterate. ... They don't have the right information about the rhythm method, because they don't know what the menstrual cycle is. They are informed about condoms, but boys cannot use them, therefore so many times I have had to withdraw condoms from vaginas, how many times have I had to extract fragments of condoms, ... They have no idea about withdrawal, because their partners are young. At least such methods of contraception... They don't know about anything'			
'First of all, if we ask, "Is there one sex partner?" we tend to get the answer "One". "For how long?". "Two or three weeks". So, one sex partner for the young girl means that she doesn't date several boys at the same time. So, there is one. After two weeks there is still one, but it is a different one'.			
'Many women become accidentally pregnant. But on the whole they don't regret it. I mean they are less afraid of abortions than of responsibility for the future child. Well, a typical situation is, "So I remembered that my period didn't start. Doctor, maybe I am pregnant? But I don't want to have this baby".. I mean, well, if a woman comes for abortion, the situation is, "Did you use contraception?" "No, what for?" '	Irresponsibility	Irresponsibility	Inadequate health culture
'We cannot say that there is little information of this kind [on contraception and induced abortion]. There is a lot of this information at the clinics and everywhere. But whether they read it, this is the question. Maybe they throw it in the next dustbin'.			
'And then many people actually work and they... they are tired and they really do not have time. They have other priorities'.			
'Because there is no time. And because, good Lord, because after forty they have children and grandchildren, a load of problems, and no time for themselves at all'.	Women do not attend		
'They have to come here once a year. In reality women themselves, I believe, are not so aware that they would remember to come once a year. As a rule, they come because their employers make them'.			

<p>'Well, a woman comes to a gynaecologist and she is told, "You have erosion, it should be treated". She doesn't do anything about it. She knows that she has it [erosion] and that she should come [to be treated]'.</p>	<p>Women do not follow advice</p>	<p>Non-compliance</p>	
<p>'I mean it is enough to visit a doctor once a year and to have a smear for cytology to prevent cancer development. Yes, cytology smears from a young age. ... We insist that a woman comes once a year. ... It means that women who have developed forms of cancer are women who haven't visited a gynaecologist for ten, fifteen twenty years.... Therefore, on the whole, they are to blame themselves. Per se, they are to blame; they are to blame for their early death'.</p>			
<p>'It all depends on the mentality of a woman and her surroundings. Because, naturally, I tell her that during pregnancy ideally you should take three courses of Magnesium. She goes to the drugstore, and it seems too expensive to her, and she doesn't buy it. Or her neighbour tells her, "Magnesium didn't help me, so don't take it". So, if she doesn't do what I advise her to do, it is very difficult to evaluate the problems with her pregnancy'.</p>			
<p>'The issue goes back to the past when different type of pills were used. ... Although all has changed now. And still there are other specialists, not too well up in this matter, who just convince women, urologists, for example, that they have thyroid gland disease [and cannot use oral contraception]. We have to make the women change their mind'.</p>	<p>Need to convince</p>		
<p>'There is a certain group of women, who... they want to use only condoms, and no other contraception even if they have indications, indications not just for contraception, but for treatment, for instance, indications for using hormonal medicines. But you know, there are only a few of them, and probably this is determined by the... our level of culture, general level of culture. Because, in principle, it is always possible to convince an educated person, right, to demonstrate the benefits of this or that contraceptive in contrast to barrier contraception'.</p>			
<p>'First of all, I talk to her, I mean, about keeping the baby. We find out the reasons why she wants to have an abortion. I mean sometimes it happens that we succeed in talking them out of it. I have had many who had babies with no problems. And they remained quite happy about the baby. I mean that I first try to persuade them that, well, if they got pregnant then they have to have a baby'.</p>			

that patients might not want to have us in the office during the appointments. Afterwards I interpreted this as reluctance to participate, as neither of them made careful attempts to obtain informed consent from their patients. None of the gynaecologists refused to participate in the observations, but two older gynaecologists refused to give an interview supposedly because of their busy timetables. The gynaecologists did not hesitate to express critical views or talk about personal experiences with patients during the observations. In the interviews as well gynaecologists seemed to speak openly.

Obtaining patients' permission for observations was difficult. The original plan was to leave information flyers in the waiting area, but the personnel at the pilot clinic considered it more suitable to tape a flyer to the door of the office. It soon became obvious that the patients had not read the information beforehand. Therefore, in the two study clinics the gynaecologists were asked to inform patients about the research and ask for consent at the beginning of each appointment. They informed patients most of the time, but this was not always done in such a way that a patient would have had a genuine opportunity to refuse to participate in the study. Most of the patients, however, seemed to take no notice of the presence of the research assistant and me, and when they were properly asked for their consent, none of them disagreed. The usual answer was that it was all right, because we were female researchers. In about half of the offices the gynaecological chair was protected from sight by shades or was in a separate room, allowing patients privacy despite our presence. Furthermore, privacy rules in general were different from those I had expected. During appointments other members of the clinic personnel might drop into the office without knocking on the door. As described above, at the pilot clinic there were typically two patients in the office at the same time, one talking with the gynaecologist and the other with the assisting nurse.

In qualitative research it often happens that the relationship between the study participants and the researcher involves some mutual exchange, so that not only are the study participants giving to the researcher (their time, their private thoughts and experiences), but the researcher also gives something in return. I gave the study participants small symbolic gifts (see Appendix 2, Compensating for data collection), but the opportunity to discuss health services and clinical issues with a foreign colleague may have been quite as important for the gynaecologists. They asked me many questions about Finnish health services and clinical practices, about patient behaviour and what it is like to be a physician in Finland (for more details see Appendix 2, Researcher position). Thus not only did they give information to me, but I did the same for them, at least to some extent. Another example of giving something in return is that I have published some of my research results in Russian in a collection of articles on women's studies in St Petersburg (Larivaara 2009).

Unfortunately, there was not a similar opportunity for this kind of exchange with the patients whose privacy was intruded by the observations. In their case, I can only hope that the research assistant and I were able to show enough respect and gratitude towards them during the observation.

An essential ethical test of any research project is whether the study was needed or whether its results can be useful. This study probes a topic that has generally been little studied, although information from different sources indicates that it would be relevant to

know more about how women's health services work in practice in Russia in order to help to improve them. It was a conscious choice to conduct observations combined with interviews in order to see what was actually happening during the appointments and to reveal possible gaps between what is reported in KAP surveys or interviews and what can be observed during patient visits. The results can be applied in development projects and in continuing education. I have been collaborating with the St Petersburg Medical Academy of Postgraduate Studies, which provides continuing education for doctors of different specialties in North-Western Russia. This collaboration enhances the possibility that the results of this study will be useful in real life, as well.

7 Results

7.1 Organisation of women's health services in St Petersburg (I, II, III)

Primary health services in St Petersburg are provided by a network of neighbourhood polyclinics that traditionally serve the adult population of a certain area. In addition to the neighbourhood polyclinics, health services in certain specialist fields are provided at specialist neighbourhood polyclinics such as paediatric polyclinics, youth clinics, and women's clinics. More advanced specialist services for women's health issues are provided at the gynaecology departments of general hospitals or at specialised centres such as the Centre for Reproduction and Family Planning. There are nine maternity hospitals in the city that provide delivery services and in-patient treatment for pregnant women. Some specialised medical institutes also have maternity departments. In addition to public sector services, a number of private clinics provide women's health services ranging from out-patient services to deliveries and surgeries.

Administratively St Petersburg is divided into 18 districts, and each district hosts one or more public sector women's clinics (41 in all in the spring of 2005), where patients can make an appointment to see a gynaecologist without referral from a general practitioner at the neighbourhood polyclinic. During the Soviet era, women's clinics served the women who were registered as residents in the area of a particular clinic. Today patients can choose their clinic and their gynaecologist, but most women continue to go to their neighbourhood clinic and their district gynaecologist.

The services provided by women's clinics typically include preventative gynaecological check-ups, diagnostic services and out-patient treatment for gynaecological complaints, contraceptive counselling, limited (for payment) abortion services, monitoring pregnancies, and day hospital for monitoring patients after induced abortion or other small gynaecological operations and for monitoring pregnant women in need of closer observation. In addition, the clinics usually offer services from a range of specialists in related fields, which may be accessed with a referral from a gynaecologist. Women's clinics may also offer commercial services that are not covered by mandatory health insurance (for more details see Chapter 7.2.).

Counselling and monitoring contraception as well as planning and monitoring pregnancy are provided by gynaecologists at women's clinics. Monitoring pregnancy constitutes the largest share of physician's work. Of the 208 visits that were observed for this study, 43 per cent concerned monitoring pregnancy. The second largest share of the visits was due to gynaecological complaints (38 per cent), while contraceptive counselling was seldom the primary purpose for a visit (see Table 4). Thus, contraceptive counselling usually took place on the back of other clinical work.⁹

⁹ *In Russia, a prescription is not needed in order to purchase birth control, and women can buy different methods from pharmacies without a doctor's recommendation.*

During observations, a typical appointment lasted about 10 to 15 minutes, which meant that conversations with patients were often hurried and partly conducted simultaneously with physical examination and paper work. An assisting nurse was usually present throughout the visit. Her responsibility was mainly to look after instruments, to measure blood pressure, and to manage some of the paperwork.

The work of women's clinics is overseen and guided by city district health department units, whereas hospitals work under the direct surveillance of the St Petersburg City Committee on Public Health. The City Committee on Public Health is the main executive body in health services in St Petersburg. It is accountable to both the Governor and the City Legislative Assembly.

7.2 Problems and challenges in the delivery of women's health services (I)

The problems in women's health services were mainly perceived by the study participants to be related to financial challenges or patients' attitude towards their own health. The latter will be discussed in Chapter 7.5, and the former will be examined in this chapter.

The interviews with administrative personnel, professors, and clinic managers revealed a constant struggle between health service legislation and actual practices. The public sector health services suffer from permanent lack of finance and as a consequence a variety of strategies have been developed to make ends meet. I will analyse the problem from three different perspectives: (1) unofficial user charges, (2) clinic-based subsidiary systems for patients with low income, and (3) commercial services provided by public sector women's clinics.

One objective of the mandatory health insurance system was to introduce market mechanisms into health services. At the time of the data collection any competition between health service units was crippled by the existing system of negotiating insurance transfers from health insurance companies to health service units. A four-member board consisting of the head of the City Committee on Public Health, the director of the territorial health insurance fund, a member of the association for health service units, and a member of the association for health insurance companies negotiated the annual tariffs for various services. With insufficient financing available, the board merely calculated how much money was available and divided it formulaically between the different services. For example, since the autumn of 2004, insurance companies have paid women's clinics a fixed amount of money per gynaecologist visit regardless of the nature of the visit. The tariffs were centrally determined and no space for competition remained. The compensation per visit was so small that gynaecologists needed to see five or six patients an hour to cover personnel salaries during the time of data collection. The interviewees said that the insurance transfers were insufficient for paying for diagnostic tests, laboratory reagents, and other daily supplies needed to run the health service units.

As a solution to deficient financing, health service units introduced user charges even for patients with a valid mandatory insurance certificate. These out-of-pocket payments were paid to the clinic and were estimated to contribute 11 to 15 per cent of the city

healthcare budget in 2005. In principle, the user charges were in breach of the mandatory health insurance legislation that states that services in the minimum mandatory insurance package should be free of charge for the patient at the point of delivery. The City Committee on Public Health, however, was unable to restrict the spread of user charges, as it could not allocate enough public money to health services units. The district departments for public health provided some control over and transparency in the user charge system by setting maximum levels of user charges. At women's clinics fees were charged for certain diagnostic procedures and a list of charges approved by the district department for public health was available for the patients – usually posted on the wall next to the cashier's office.

It seems that health service units have also created different systems to help patients who cannot afford user charges. Clinic A that participated in this study issued a certain number of vouchers per month to each gynaecologist to distribute to patients who were in need of diagnostic services and who could not pay the service fees. Furthermore, the gynaecologists at both clinic A and clinic B were in the habit of negotiating free procedures for less wealthy patients. As part of their clinical work, they estimated their patients' financial assets and had, in practice, become responsible for selecting those in need of subsidised or free-of-charge services.

At the time of the data collection, public sector polyclinics had an opportunity to offer commercial services that were not covered by mandatory health insurance. These services fell somewhere between public and private health services. For polyclinics, commercial services provided an additional source of income that could be used to supplement insufficient mandatory health insurance funds and to raise the salaries of personnel (mainly physicians). For patients, they were an opportunity to have longer appointment and nicer facilities, but at a lower price than at private clinics. According to the norms, commercial services offered by public health service units should be the kind of services that are not covered by mandatory health insurance. Yet in practice the commercial services were often merely a more luxurious alternative to the free-of-charge services. While acknowledging the inadequate funding of women's clinics, the City Committee on Public Health did not intervene. On the contrary, commercial services were expected to expand. Some participants estimated that commercial services at women's clinics in conjunction with the growing private sector would provide 50 per cent of women's health services in St Petersburg in the future.

As described above, the mandatory health insurance system did not work as expected. Different actors in the healthcare system were aware of the contradiction between the legislation, norms and practices. Furthermore, many study participants perceived various types of payment as a threat to equality and equity in health care. None of them questioned the ideal of equal and universal access to comprehensive health services. Yet many study participants saw benefits in the user charges and commercial services. They were seen to offer more choice to service users and they were expected to rationalise the use and improve the quality of services. The gynaecologists at women's clinics were more critical of the service fees and commercial services. A small number of them thought that user charges might rationalise the use of health services, whereas the majority did not see any benefits in service fees.

The practicing gynaecologists and other study participants also had a different view of the system whereby health service units receive compensation according to the number of visits. Gynaecologists worried that during short encounters patients might not disclose all the necessary medical information or health-related worries relevant to the appointment. They also expressed a deep concern about the lack of opportunities for health counselling and preventative work. The other study participants also acknowledged that there were no incentives for preventative care and health counselling, but they were more positive about the compensation system, expecting it to bring efficiency to clinical work.

7.3 Views and practices concerning preventing pregnancy (II)

The gynaecologists who participated in the study shared a unanimously positive attitude to all types of contraceptive methods ranging from the most recent innovations such as the vaginal ring and contraceptive patches to more traditional ones such as the intrauterine device and condom. Simultaneously, they held a negative view of termination of pregnancy owing to the risk to women's reproductive health. The gynaecologists were worried that induced abortion might result in infertility or potential problems in later pregnancies. They thought that termination of pregnancy was unavoidable only when a mother's health was at risk or the unborn baby was severely handicapped.

Only four gynaecologists of the 16 who were interviewed, all of them younger than 45, commented that termination of pregnancy was the wrong thing to do. Two of them supported this statement with Christian views. Other gynaecologists simply stated that using reliable contraception showed a responsible attitude towards one's health, whereas termination of pregnancy meant risking one's future reproductive function.

The gynaecologists typically distinguished 'modern' contraceptive methods – oral contraceptives, vaginal ring, contraceptive patches, intrauterine device, and condoms – from 'natural' methods – withdrawal, rhythm, and vaginal douching. Modern birth control methods were often described as healthy, correct, progressive, and normal in comparison with natural methods. Certain methods within the reliable birth control options ranked above others because of the related health risks. Aside from health-related factors, gynaecologists seemed to have a general preference for the most recent innovations. They mentioned the vaginal ring and contraceptive patches as the most progressive methods compared with oral contraceptives and condoms. The rhythm method and withdrawal seemed to form a grey area for the gynaecologists, not being contraception proper, but still 'better than nothing'. The gynaecologists often stated explicitly that they did not regard natural methods as contraception. Yet in other contexts they would comment that knowledge about natural methods was a signal of 'at least' some kind of awareness of reproductive biology or birth control among women or young girls.

All the gynaecologists felt that contraceptive counselling was an important part of their work with women of reproductive age, even though women do not need a prescription from a physician to purchase birth control. They said that women seldom come to a gynaecologist for contraception, partly because no prescription is needed to buy various methods. They stated that as part of their routine of taking medical history they ask each

woman of reproductive age what kind of contraception she uses. They also described how they give counselling to all those women who do not use any reliable method. Many gynaecologists felt that it is their responsibility as experts to choose the right method for each woman. They pointed out that women cannot obtain enough information about the benefits and side-effects of various effects and thus they should consult a gynaecologist before starting to use contraception.

The observation data (N = 208 visits) included only three visits where the patient stated contraception as the reason for her visit. There were 75 visits where the woman was of reproductive age and not pregnant or planning pregnancy. In 29 of these cases, the woman had already visited the gynaecologist recently or at least in the last year. Thus, even though contraception was not discussed during the observed visit, the gynaecologist might have discussed it in an earlier visit and the woman might have received sufficient counselling. As regards the remaining 46 cases, contraception was discussed in more than 80 per cent (38 cases) of them. In the majority of these cases (32) counselling was adequate in the sense that need for contraception was discussed and recommendations given, when needed. Six women left the appointment without a recommendation for contraception, although they were sexually active and were not using a reliable method (see Figure 1 in the original publication II). The frequency of counselling did not differ in terms of the observation clinic or the age of the gynaecologist or patient.

In 38 observation cases where contraception was discussed, a gynaecologist initiated the conversation in half the cases, whereas a patient opened the topic in nearly one-third (11) of the cases. As regards the rest, observation notes are not detailed enough to reveal who made the first move.

The depth of counselling varied considerably. Typically, the gynaecologist asked whether the woman was sexually active, what kind of relationship(s) she was in, and what kind of contraception she was using, and then recommended a single method and instructed the woman how to use it. Little time was spent discussing the woman's questions, worries, or preferences.

Yet in about one-third of the cases counselling was more thorough, more than one method was considered and the woman's wishes or uncertainties were discussed. Even in these cases, the gynaecologist usually made the final choice. One young gynaecologist made considerable efforts to engage her patients in clinical decision-making. She described the different methods available, their benefits and drawbacks, and encouraged the woman to choose what seemed most suitable for her. In one case, the patient felt uncomfortable in the situation and kept on asking the gynaecologist to choose what was best for her. There were, however, a small number of patients who entered the office with clear opinions and exact questions for their gynaecologist. According to my observations, gynaecologists were comfortable with proactive patients, although they retained their role as final decision-makers.

7.4 Views and practices concerning planning and monitoring pregnancy (III)

The gynaecologists who participated in the study regarded it as important that couples should plan pregnancy beforehand. For them, planning pregnancy meant that a woman and preferably her partner would be examined before the woman became pregnant. The gynaecologists felt that this kind of 'medical planning' was needed in order to evaluate the possible health risks involved in pregnancy such as a woman's potential chronic diseases, genetic risks in the woman's and the partner's families, and the woman's age. Furthermore, they explained that various types of hidden infections were common and needed to be treated before pregnancy. This concerned not only sexually transmitted infections but also bacteria associated with normal genital flora.

The gynaecologists in this study thought that the medical planning of pregnancy had emerged in Russia sometime in the 1990s, when various tests became more common and 'people became more conscious about health issues'. The physicians valued the increasing health consciousness of some of their patients who were committed to planning their pregnancy by participating in medical examinations, but most of them agreed that this kind of pregnancy planning remained rare. They thought that the women who came to be examined before getting pregnant had usually suffered a miscarriage or complications in their previous pregnancies.

In the interviews it became obvious that gynaecologists regarded the medical planning of pregnancy as the appropriate pregnancy planning. Their reactions to 'lay planned' pregnancies varied during the appointments. Some of the physicians said neutrally that it would be good to plan pregnancy together with a physician, whereas others did not even mention medical planning to the patient. A couple of physicians showed their disapproval rather openly, telling women that it is their responsibility to plan pregnancies properly.

Health risks also worried gynaecologists when they considered the timing of pregnancy. At the time of data collection, the Russian maternity care system classified pregnancies of women older than 25 as risk pregnancies. All the gynaecologists pointed out that from a physiological point of view a woman should not be much older than 25 when becoming pregnant for the first time. They were trying to strike a balance, however, between this medical perspective on the one hand and a more holistic view on the other. Many of them thought that it was better if women first finished their studies, found employment, and established a permanent relationship, preferably marriage, before giving birth. The gynaecologists often referred to the financial instability, difficult housing situation, and unstable relationships of younger women, arguing it was better to wait until the mid- or late twenties before having children. Moreover, many physicians pointed out that they prefer working with more mature pregnant women despite the potential physiological risks related to these pregnancies. They felt that women in their late twenties and thirties comply with medical recommendations more readily and are more responsible compared with younger pregnant women. More mature pregnant women were thought to be health-conscious and interested in learning about the physiological aspects of pregnancy.

At the time of the data collection the guidelines for pregnancy in Russia recommended that a woman should visit her gynaecologist 10 to 15 times during a normal pregnancy (see Table 4 in the original publication III). The monitoring schedule directed attention towards certain physiological parameters that indicate the biomedical well-being of the baby and the pregnant woman, whereas comprehensive psychosocial support for the pregnant woman or the expecting couple received less consideration. This is reflected in the observation data where emphasis on medical expertise, various measurements, and their results received a lot of attention during the visits, as well as prescriptions of nutrient supplementations, whereas neither patients' private life was discussed nor the patients' feelings about pregnancy and future motherhood. Owing, however, to the frequent monitoring, the gynaecologist-patient relationship was sometimes warmer and more personal with pregnant women than with other patients. In such cases patients sometimes chit-chatted about their children, work, studies, and partners. These cases were a minority, though, and in the majority of cases medical expertise guided the content of the monitoring visits.

7.5 Gynaecologists' perceptions of the provider-patient relationship (II, III, IV)

Gynaecologists emphasised the importance of an individual approach to each patient: a physician should be able to treat women as individuals, taking into consideration their particular situation in life. Consequently, they found it important to learn about patients' overall social and family situation in order to treat their medical problems properly or to help them in their overall situation. Gynaecologists often emphasised their own role as broadly skilled specialists who can instruct women in various non-medical questions as well. They were willing to look at their patient's health from a holistic perspective and perceived their own role, ideally, as broadly supportive of aspects of everyday life. Indeed, the majority of the gynaecologists felt that their expertise assigned them with responsibility for their patients' overall well-being. Yet gynaecologists were aware that they could not make women follow their advice. This posed a dilemma in how to look after such patients. Accepting broad responsibility was typically combined with a feeling that it is a physician's role to make the clinical decisions and that women only need to comply with the physician's advice.

There were some differences in the interviews between the younger and the more mature gynaecologists. Younger gynaecologists more often explained how they work to develop an understanding alliance with their patients, whereas older ones told openly how they sometimes reprimand and scold their patients for risky health behaviour. Some of the younger gynaecologists took a critical standpoint towards their older colleagues' behaviour, suggesting that it scared the patients away. They felt that a physician should respect a patient's right to a private life and focus on the problems that bring the patient to an appointment. Younger gynaecologists also emphasised the significance of trust in physician-patient relationships more often. They felt better equipped – either owing to their age or to their personal attitude – to respond to their patients' emotional needs than

their more mature colleagues. Some of them believed that patients actually avoid older gynaecologists who may be more commanding and less willing to be involved in personal interaction. Some of the younger gynaecologists contradicted the traditional view of the physician taking the clinical decisions and stated that each woman should be responsible for herself. On the other hand, more mature gynaecologists often described proudly their long-term physician-patient relationships and seemed to esteem relationships where there was personal intimacy between the physician and the patient.

Gynaecologists felt that work with patients was very challenging owing to what they referred to as 'poor health culture' (*nizkaya kul'tura zdorovya*). The talk about health culture was constructed around ignorance, responsibility, and compliance with medical advice. Gynaecologists often described the general population as well as their female patients as ignorant, lacking basic knowledge about medicine, the functioning of their own body, and how to promote health. Gynaecologists felt that, owing to their patients' ignorance, they need to spend a lot of time in explaining things that patients should know before coming to the appointment. They also felt that they need to correct patients' false impressions and misunderstandings. The gynaecologists also explained that patients' lack of responsibility in terms of their own reproductive health was a considerable problem in clinical work. Gynaecologists complained that women do not pay attention to their own health and medical advice until they fall ill or notice symptoms of an illness. The study participants maintained that women do not consider whether their intended actions may be harmful to their health and they do not participate in preventative medical check-ups. Gynaecologists also maintained that women commonly neglect medical advice about surveillance visits, medication, or health behaviour. They described how patients discuss health issues with their friends and relatives, compare experiences, and simply choose to follow lay advice. Conversations with gynaecologists gave the impression that they need to be prepared for neglect of or refusal to accept medical advice. As a contrast to these experiences, gynaecologists valued highly patients who were willing to comply with their advice. In the data, the poor health culture was repeated as a key issue that seemed to help gynaecologists to make sense of their frustrating experiences in clinical work.

The interview data draw a picture wherein gynaecologists would be willing to develop individual provider-patient relationships where they would pay comprehensive bio-psycho-social attention to their patients' health problems and situation in life, but could not realise this aim owing to a poor health culture that results in patients' ignorance, carelessness and reluctance to follow medical advice. Furthermore, the gynaecologists felt that their attempts to pay personal attention to each patient were rendered impossible by the institutional context in which they were required to see five to six patients per hour.

In Chapter 4 I discussed models of patient involvement that have been applied in international literature. When trying to locate the gynaecologists' ideal provider-patient relationship in the power continuum in Figure 1 that presents models of patient involvement, one faces problems. The Russian gynaecologists' ideal provider-patient relationship would perhaps best be categorised as the professional-as-agent model, but the power continuum neglects other perspectives that seem important to the participants of this study. First, the model does not address Russian gynaecologists' difficult experience of poor health culture. Second, and perhaps more importantly, concentrating on the power

continuum means that the emotional quality of the provider-patient relationship is neglected. On the basis of the interviews in this study, the Russian gynaecologists favour a warm and maternal tone in provider-patient interaction. This observation seems rather natural in the Russian context, where women tend to be seen as carers and nurturers and thus suited to working as physicians (Harden 2001).

Gynaecologists' ideal individualistic approach to patients is somewhat distant from the clinical practices described in previous chapters on preventing, planning, and monitoring pregnancy. In practice their working style is perhaps best described as paternalistic:¹⁰ the physician knows best and patient involvement is limited to receiving information, giving consent and complying with medical advice. Only occasionally did they discuss patients' personal relationships or everyday living circumstances during the clinical encounters. Thus, there is a gap between the ideals and practices of the provider-patient relationship.

¹⁰ Use of the term 'paternalistic' is problematic in discussion of female gynaecologists in Russia. Nevertheless, I use it consistently throughout the text, as it is the term used by the international literature to describe a provider-patient relationship that is characterised by a low level of patient influence and the recognition of the physician's authority over the medical decision-making.

8. Discussion

8.1. Main findings in the view of the literature review

As summarised at the end of the literature review, many gaps exist in the literature on providers' knowledge, attitudes and practices towards family planning, on the one hand, and patient involvement and provider-patient relationships in reproductive health services, on the other hand, in urban Russia and Central Eastern European post-socialist countries. This study aimed to increase our knowledge and understanding of the situation in urban Russia.

According to the literature review, researchers used survey methods in the 1990s to study providers' knowledge, attitudes, and practices regarding family planning, but the results have not been followed up. The results of this study suggest that interest in knowledge and attitudes towards contraceptive methods, although acute in the 1990s, has lost its significance over time. The gynaecologists who participated in this study had up-to-date knowledge of different contraceptive methods and had a positive attitude towards recommending them to their patients. The only concern in terms of knowledge and attitudes was their ambivalence in relation to the rhythm method and withdrawal.

Previous studies have reported low levels of counselling activity in the reproductive health services in the 1990s in Russia (Kulakov et al. 1997; Stephenson et al. 1997; Client Perceptions... 1998; Sherwood-Fabre et al. 2002), with a single observation of more active counselling after intervention in the early 2000s (David et al. 2007). The studies from CEE countries are too scarce for comparisons to be made. In the interviews in this study, gynaecologists emphasised that they give contraceptive counselling to each sexually active patient of fertile age who is not planning pregnancy. The observations revealed that the coverage was better than in previous studies, but still not 100 per cent. Thus, this study adds to the previous knowledge by showing that gynaecologists are highly aware of the need for active contraceptive counselling and this awareness is often realised in actual practice, although the counselling activity needs to be increased. Earlier studies described providers' counselling style as authoritative, directive, and normative (Visser et al. 1993a; Rivkin-Fish 1997; Client Perceptions... 1998; Rivkin-Fish 1999, 2000, 2004, 2005). This can still be observed in the interview and observation data of this study, although there were weak signals that more patient-centred attitudes and practices are entering the field.

Patient involvement and provider-patient relationships were relatively well studied from a user perspective in the prenatal and delivery services in St Petersburg (Ivanov et al. 1995; Rivkin-Fish 1997; Chalmers et al. 1998a, 1998b; Ivanov and Flynn 1999; Ivanov 2000; Rivkin-Fish 2000, 2004, 2005; Callister et al. 2007; Temkina and Zdravomyslova 2008; Callister et al. 2009), whereas systematic direct observations and providers' perspectives relied on a single study in St Petersburg (Rivkin-Fish 1997, 2000, 2004, 2005). Studies from other parts of Russia and from CEE countries were too sporadic for reliable conclusions to be drawn.

This study extended current knowledge to family planning services and to provider perspectives in out-patient services where the potential for interventions in women's reproductive health behaviour is greatest. It revealed that patient involvement is rather low in contraceptive counselling and planning and monitoring pregnancy in St Petersburg. Yet there were individual cases where patients took more initiative and providers responded to this. Furthermore, observation data included a gynaecologist who actively tried to increase patient involvement in clinical decision-making. The results uncovered differences between the interview and the observation data, demonstrating differences in providers' ideals and practices. First, clinical interactions were often focused on biomedical aspects of birth control or pregnancy, whereas during the interviews the gynaecologists were vividly aware of and concerned about the challenging social circumstances of their patients. Second, clinical encounters were typically provider-centred, although in the interviews gynaecologists emphasised the significance of individual concern for each patient and the provider's role as an expert on a variety of medical and non-medical issues in patients' everyday life. The data of this study suggest that these differences are at least partly the result of short appointment times in women's clinics and providers' experience that they cannot be sure that patients will collaborate with the gynaecologists to strive for better health.

The previous literature suggested that patients commonly face normative and moralising attitudes in reproductive health services in urban Russia (Rivkin-Fish 1997; Client Perceptions... 1998; Rivkin-Fish 2000, 2004, 2005; Temkina and Zdravomyslova 2008) and in some CEE countries (Johnson and Horga 1993; Johnson et al. 1996; Todorova et al. 2006). In this study, gynaecologists repeatedly argued that Russian women should care for their reproductive health better than they currently do. In their opinion, fostering reproductive health in order to secure future fertility equated with being a responsible and morally respectable woman. Gynaecologists emphasised that the use of reliable birth control methods was a means of avoiding the harmful health consequences of induced abortions. Similarly, arguments for 'medically planned' pregnancy and compliance with medical advice during pregnancy were essentially supported by the significance of securing healthy pregnancy. The links between health, risk, and morality are familiar from the international sociological literature (see e.g. Zola 1972; Illich 1976; Lupton 1993; Williams 1998; Crawford 1999; Williams 1999; Clarke et al. 2003; Broom and Whittaker 2004) and will be discussed in more detail in Chapter 8.3.

The results of this study also suggest that perhaps a change is taking place in providers' attitudes and practices concerning patient involvement and provider-patient relationships in Russian reproductive health services. Young gynaecologists emphasised the role of trust in the provider-patient relationship and underlined an individual and empathetic working style more than their older colleagues. They criticised their older colleagues' ways of working and assumed that patients prefer younger gynaecologists owing to their less normative attitude towards patients' health behaviour. Yet one should remember that the observations showed younger and older gynaecologists treating their patients in a very similar manner. Thus, it seems that so far the change is happening mostly in the attitudes of the younger generation of gynaecologists, but not yet in their work with patients.

Nevertheless, it can be concluded that attitudes towards provider-patient relationships are not uniform among gynaecologists.

8.2 The model of patient involvement in clinical decision-making and main findings on the provider-patient relationship

Chapter 4.3 discussed the problems that West-European and North-American scholars face when studying Russia or Central Eastern European countries – or almost any geographical area outside Western Europe or North America –, and the importance of studying Russian development on its own right was pointed out. A model of patient involvement in clinical decision-making was reviewed in Chapter 4.1. It was taken as the starting-point for studying Russian practices. The idea was not to use it as a reference point or golden standard, but to examine how well it fits the data of this study and whether the model is useful for analysing the data.

The idea of the provider-patient relationship in international literature is based on the ideal of patient autonomy, whether it is expressed in terms of patient involvement, patient choice, patient empowerment or another similar phrase. The ideal is present in different international guidelines (e.g. WHO 1978; Department of Health 2001; WHO 2005, 2008; General Medical Council 2009) and especially in the guidelines for family planning services (e.g. Hardon et al. 1997, pp. 31-50; FIGO Committee... 2002; the ACQUIRE Project 2006; WHO 2007), where studies suggest that greater patient involvement results in improved patient satisfaction and method continuation (e.g. Kim et al. 1999, 2001; Abdel-Tawab and Roter 2002; Kim et al. 2005; Kırımhoglu et al. 2005). Previous literature suggests that patient autonomy has not gained a strong foothold in the Russian context (Chalmers 1997; Rivkin-Fish 1997; Chalmers et al. 1998a, 1998b; Rivkin-Fish 2000, 2005; Temkina and Zdravomyslova 2008). The results of this study reveal, however, that even if patient autonomy is not a norm among practising gynaecologists it is something they are thinking about and reacting to when talking about poor health culture, for example.

Figure 1 in Chapter 4.1 presents Thompson's (2007) summary of the variations of patient involvement in clinical decision-making and arranges them on a power continuum from low levels of patient power to higher levels. It was concluded at the end of Chapter 7.5 that the Russian gynaecologists' ideal provider-patient relationship may be best identified as the professional-as-agent model, but that this kind of model is too one-sided to convey the whole picture. What seemed to be missing were the emotional quality of the provider-patient relationship and the conceptualisation of the frustration that providers feel with the phenomenon that they identify as poor health culture.

In the original publication IV, the gynaecologists' frustration with the poor health culture was examined, and it was concluded that the gynaecologists feel that they cannot trust their patients. Rogers's (2002) analysis of the meaning of trust for provider-patient interaction reveals why trust is essential in clinical interactions. Rogers argues that if a patient is distrusted in clinical interaction the power balance will shift even further towards the physician. Thus, trust and patient autonomy are integrally related to one

another, and trust enhances the recognition of patient autonomy during a clinical encounter (Rogers 2002).

As regards the emotional quality of the provider-patient relationship, liking the patient has been a taboo in medical literature, although previous research suggests that liking has a very positive effect on the provider-patient relationship and treatment results and that patients tend to sense surprisingly accurately whether the provider likes them or not (Hall et al. 2002). The older gynaecologists in particular who participated in this study referred proudly to long-term provider-patient relationships where patients revealed issues in their personal life to the gynaecologist. Rivkin-Fish (1997, 2005) has described examples of Russian gynaecologists becoming remarkably close to their patients at a maternity hospital (Rivkin-Fish 1997, 2005). Clearly these are cases where mutual liking must have played a significant role in the provider-patient relationship.

In Chapter 7.5 it was described how the gynaecologists who participated in this study saw themselves ideally as benevolent maternal figures that look after a variety of everyday issues in their patient's lives. This was seldom realised in clinical practice. I argue that the ideal of maternal caretaking presented by the gynaecologists in this study includes three essential and interrelated dimensions. They are mutual trust, mutual liking, and balance of power between the provider and the patient. The ideal maternalistic provider-patient relationship that practising gynaecologists wish for would materialise in a situation (1) where the patient trusts the provider to treat her in her best interest and the provider trusts the patient to collaborate in the joint effort of achieving the patient's good health, (2) where provider and patient feel mutual liking, and (3) where, owing to the patient's feelings of liking and trust, the patient is willing to hand over the clinical decision-making power to the provider.¹¹ Thus, it would be important to include other aspects of the provider-patient relationship than mere balance of power in a model analysing provider-patient relationships and the failure to reach an interaction satisfying both patients and providers.

8.3 Results in the social and historical context

The organisation of health services and financial challenges

The first objective of this study was to describe how the delivery of women's health services is organised in St Petersburg, as published descriptions did not exist beforehand. The basic structures of the health services have remained the same for many decades, but new developments have taken place during the post-socialist period, including the

¹¹ *The ideal provider-patient relationship would also allow women physicians to fulfil the more general cultural ideas prevalent in Russia of women as certain kind of physicians, i.e. gentle, patient and caring (Harden 2001).*

development of the mandatory health insurance system and the emergence of commercial services both at public sector facilities and at private clinics.

The results reveal the failure of the mandatory health insurance system in St Petersburg to bring market mechanisms into health care financing and in pooling sufficient financial resources to provide universal and comprehensive health services free-of-charge at the point of delivery. As a solution to the lack of financial inflow, women's clinics have developed user charges and commercial services, questionable within the mandatory health insurance system. The local health administration responsible for monitoring health providers does not intervene and even appears to legitimise these informal practices, as it acknowledges the impossible financial situation of health service units.

The current situation of empty promises for a comprehensive health care that is free-of-charge for the whole population as guaranteed by the Russian constitution and the reality of user charges creates grey zones between the formal system and practices which are likely to undermine further the low trust in public health care that is already widespread in the population (e.g. Brown and Rusinova 1997; Salmi 2003; Rivkin-Fish 2005). It is worth noting that inconsistencies between the formal system and informal practices are not a new phenomenon in Russian health services. Soviet healthcare management promised equal access to comprehensive and good-quality health services, but in reality equality was compromised by higher-quality parallel services available only to some members of society such as certain categories of workers or the military (Curtis et al. 1995; Field 1995; Twigg 1998; Tragakes and Lessof 2003). Informal payments by patients to health professionals existed also during the Soviet times (Curtis et al. 1995; Field 1995; Tragakes and Lessof 2003). As Burawoy and Verdery (1999) argue about post-socialist contexts, the past enters the present continuously, not as a legacy of a socialist past but as a novel adaptation to the new social context. This view is illustrated in my data in the continuous juxtaposition of the formal system and informal practices at the level of general administration and at the level of women's clinics.

Previous studies have reported how patients use various informal strategies in order to secure access to better quality treatment and to less expensive or free-of-charge treatment (Brown and Rusinova 1997, 2000; Rusinova and Brown 2003; Salmi 2003; Rivkin-Fish 2005). The results show that individual gynaecologists can influence their patients' chances of receiving free-of-charge services. Gynaecologists estimate their patients' ability to pay during short appointments on little evidence, which increases the unpredictability of the system from patients' perspective. Previous studies also point to the quality of the personal relationship between the physician and the patient when receiving free-of-charge services (Salmi 2003; Rivkin-Fish 2005). All these studies raise the question of arbitrariness: from patients' perspective, luck alone may determine the amount of money they end up paying.

Understanding the provider-patient relationship in context

Previous studies have described how women patients in St Petersburg want friendlier and more individual care from reproductive health services (Rivkin-Fish 2005; Temkina and

Zdravomyslova 2008). The gynaecologists in this study were aware of this desire and seemed to be willing to respond to it, but studies that focus on patients' experiences suggest that somehow this willingness is not expressed or conveyed to patients during appointments. Earlier studies have attributed this to physicians' lack of professional power in relation to health services and policies (Field 1991; Rivkin-Fish 1997).

I have focused on the grassroots-level data of this study and on gynaecologists' personal experiences. For them the problem was what they called poor health culture – ignorance, lack of responsibility and unwillingness to comply with medical advice among their patients. The discourse on poor or lack of health culture is common among Russian lay people and medical professionals, and it can be seen in Russian health policy documents of recent years. Typically, in different data sources poor health culture equates to unhealthy living habits, illiteracy, and the wrong kind of attitude among the population (Rivkin-Fish 1997; Palosuo 2000; Aarva et al. 2006; Isola 2008a, 2008b). In policy documents, concern is expressed about the low level of health culture and demands made for individuals to be more responsible for their own health (Aarva et al. 2006). The roots of this discourse can be traced back to the socialist propaganda that strove to construct a new Soviet citizen. A good citizen had to possess culture (*kul'tura*) or to have acquired 'culturedness' (*kul'turnost'*). In everyday discourse, *kul'tura* and *kul'turnost'* were applied to construct social differences and to manifest power differences (Rivkin-Fish 1997, 2005). For the gynaecologists of this study the poor health culture meant that they could not trust their patients to collaborate with them in the patients' best interest.

Patients' and providers' mutual lack of trust needs to be understood in the wider post-socialist context. It has been claimed that socialist societies suffered from a lack of generalised trust (Misztal 1996). During the late-socialist era in Russia, obligations to personal networks became more significant than professional obligations and people became loyal to their personal network rather than to the state or society (Shlapentokh 1984; Ledeneva 1998). Personal networks contributed to the lack of generalised trust by underlining the difference between the trustworthy 'us' within the network and the perhaps not so reliable 'them' outside (Salmi 2006). In this sense, the mutual lack of trust in women's clinics observed in this study is part of a wider phenomenon (see also Temkina and Zdravomyslova 2008).

Despite the prominent talk about poor health culture, both young and more mature gynaecologists observed that health behaviour had improved in the recent years. According to them, younger patients knew more about reproductive health and actively sought information. A larger proportion of young patients was said to assume responsibility over preventative health behaviour and follow physicians' advice more carefully. Yet the gynaecologists portrayed a polarised picture of their patients: at one end were the health-conscious and responsible patients and at the other end the ignorant and the careless. This may indicate that some of the younger women can apply the information available more effectively or are in a better position to look after their health than the rest. It may also signal that, in certain social groups, preventative health behaviour and higher awareness of health issues is becoming a symbol of a new, modern lifestyle, but the change has not spread far and may not spread at all to all social groups. This interpretation is supported by findings among young, educated women in St Petersburg who are active in

seeking medical information and who wish to be responsible for their reproductive health and treatment (Temkina and Zdravomyslova 2008).

Normative attitudes and emphasis on new medical technologies

One of the problems raised by other scholars is the authoritative and normative attitude of providers towards their patients in Russia. Reproductive health care in Russia has been and continues to be characterised by high regard for specialisation and technology, and emphasis on expert authority in clinical interactions (Chalmers 1997; Belozërova 2002; Rivkin-Fish 2005). Vincent Navarro (1977) has argued that these features were symbols of high-quality services in all health care in the Soviet Union by the 1970s (Navarro 1977, pp. 23-24, p. 112). Women's experiences of in-patient pregnancy monitoring and birth have been typically marked by feelings of vulnerability and powerlessness, and women have created different strategies to safeguard themselves from maltreatment (Rivkin-Fish 2005; Angelova and Tëmkina 2009). The regard for expertise and new technology could be observed in the data of this study in relation to contraceptive methods and planning pregnancy.

The gynaecologists who participated in this study took a strong moral stand on the use of reliable birth control, medical planning and careful monitoring of pregnancy, and termination of pregnancy (for more details on termination of pregnancy, see Larivaara 2008b). Access to reliable contraception improved considerably in the late 1980s and the early 1990s in Russia, making it possible for women actually to plan pregnancies. The emergence of new medical technologies typically produces new individual responsibilities for managing one's health (see e.g. Clarke et al. 2003). This is especially visible in maternity care where the idea that women are responsible for pregnancy outcomes can be located in professional and lay discourses in different contexts, although cultural variation in its formulation is wide (Ivry 2007). In Russia, where technology and medical expertise have traditionally been well regarded, it may follow quite logically that an opportunity to plan pregnancies leads to the extension of medical expertise and technology (e.g. diagnostic tests) to the area of pregnancy planning. It is noteworthy, however, that lay people do not share or may not even be aware of the physicians' notion of planned pregnancy. As a matter of fact, ordinary men and women feel that the first pregnancy should happen naturally and by chance as 'a fruit of love' without detailed consideration and planning (Rotkirch and Kesseli 2010).

The strong emphasis on motherhood as an anticipated, almost self-evident, part of a woman's life should be understood against the Russian social context, where the significance of motherhood was reinforced by government propaganda in the 1980s and has retained its grip on people's minds and practices (Attwood 1996; Rotkirch and Haavio-Mannila 1996; Rotkirch 2000; Rivkin-Fish 2005). The gynaecologists in this study traced the emergence of medical planning to the 1990s, when fertility declined rapidly and concern about low fertility became articulated in public with increasing urgency (Vishnevsky 1996; Rivkin-Fish 2006). With policymakers blaming low fertility partly on the poor reproductive health of fertile age women (Isola 2008a, 2008b), increasing the role

of expertise and technology in maternity care may be an attempt to improve pregnancy outcomes and fertility figures and, thus, an attempt to respond to political demands. Politics may be intertwined with gynaecologists' attitudes in other ways as well. Many gynaecologists in this study contrasted the use of reliable contraception and medical planning of pregnancy with Soviet birth control practices, and perceived them as a token of a new kind of reproductive culture (see also Rivkin-Fish 2005 and, for similar discourses in Eastern and Central European post-socialist countries, Gal and Kligman 2000a, 2000b).

8.4 Methodological considerations

The literature review revealed that qualitative studies showed up more problems in patient involvement and provider-patient relationships than did quantitative methods. Before this study, research using direct and systematic observations in reproductive health services in St Petersburg was limited to a single ethnographic study at a maternity hospital (Rivkin-Fish 1997, 2005). Yet observation is essential in uncovering what is actually happening when a provider meets a patient. The combination of interviews and observations was proven to be successful in revealing differences in gynaecologists' ideals and actual practices. Thus, the methodologies played a significant role in gaining insight into the study topic.

There are some limitations, however, that are related to the qualitative data collection and analysis. First, collecting qualitative data is slow, and results in a smaller number of participants than that in quantitative research. Thus the question to what extent the results can be generalised needs to be tackled differently. As regards the data on gynaecologists, some data were collected at eight women's clinics out of the city's 41 clinics. This is a relatively large proportion of the whole and, despite the study clinics having a better than average reputation in terms of quality of treatment and financial resources, similar views were repeated in comparison interviews to those in the interviews at data collection clinics. Also, the interview and the observation data were well saturated in the end. Thus, it is likely that similar views would have been repeated in other women's clinics in the city as well. The data on the reproductive health service system remained more limited and views about the strengths and weaknesses of the current system did not become saturated. Therefore, this part of the data can be applied in building a rough overall picture of the current reproductive health services, but does not provide a well-balanced and generalisable view of the benefits and drawbacks of the existing system.

As studies are scarce in other parts of Russia than St Petersburg, it is important to consider to what extent the results of this study can be applied to the rest of the country. The delivery of reproductive health services is organised in essentially the same way in other urban centres and thus many of the problems faced by the gynaecologists in their clinical work are likely to be the same. St Petersburg, however, is one of the wealthiest regions in Russia and the population has a higher than average level of education. Therefore, it is possible that the problems revealed by this study may be more serious in other urban areas both in terms of the financial difficulties of the reproductive health

service system and in terms of the difficulties gynaecologists face in clinical interactions. The mandatory health insurance system has been implemented in a variety of ways in different parts of the country, and the related results are not generalisable.

My insufficient skills in the Russian language form a major limitation for the study methodology. Had I been fluent in Russian, interactions with the participants would have been more natural and no translation would have been needed, and the diary notes on provider-patient interactions could have been more detailed. The data analysis could have been more nuanced if it had not relied mainly on translated passages. I have, however, debated and reflected on the data analysis with Russian colleagues, which strengthens the validity of the analysis. Moreover, part of the data analysis for the original publication IV was conducted by one of the research assistants and me. Our interpretation of the data was essentially the same, which indicates that the language barrier did not have a significant influence on the results.

The ability of study participants to trust the researcher is essential in producing qualitative data as it influences what the participants disclose in the interviews and how they act during observations. The gynaecologists who participated in the study did not hesitate to express critical views during interviews and observations, which suggests that they felt able to trust the researcher. During the observations they seemed to behave freely and to assume that the researcher shared their view of various aspects of patient behaviour. This also indicates that the presence of the researcher did not change their behaviour considerably. Health administrators and medical professors seemed more reserved during the interviews and, consequently, this may influence the quality of that part of the data.

The data were analysed mainly inductively by means of content analysis. The method treats the meaning units present in the data, whereas more theoretically directed analysis might have violated the original meanings present in the data.

Originally, I considered returning to the field and holding complementary interviews with some of the gynaecologists. This would have made it possible to test some of my interpretations with the study participants. Owing to financial issues and work schedules this idea was abandoned, which is a pity, as it might have enriched the results of the study.

Over the decades, publishing internationally has grown more and more important in health service research, whereas publishing nationally and for smaller audiences is valued less. Yet it is of value to national scholarly debate that some articles are published in national language at national research forums. Consequently, I have written two articles, one as a book chapter in a collection of Finnish research articles on Russia (Larivaara 2008a) and another in a Finnish peer-reviewed national journal (Larivaara 2008b). Furthermore, when conducting research in a foreign country and mainly publishing in a language and in forums not accessible to the study participants, it is important to write something in the language of the country of data collection as well. Therefore, I have published one book chapter in Russian – on contraception and induced abortion counselling, and provider-patient relationships – in a collection of articles on women's studies published in St Petersburg (Larivaara 2009). It will, I hope, make some of my results more easily available to the participants in this study.

9. Conclusions and practical implications

The study revealed a number of issues that call for measures to be implemented in the health service system and clinical work at women's clinics in St Petersburg. Furthermore, the study raises questions that need to be addressed in future research in St Petersburg and in Russia. In this final chapter I will draw together conclusions from the study results and point out the most relevant practical and research implications.

Health service system

Owing to the insufficient financing of health services, women's clinics and other health service units are charging user fees to holders of valid mandatory health insurance certificates. Local health administration approves these informal user charges by regulating their levels, although such charges should not apply to those who are insured by mandatory health insurance. Individual gynaecologists have become responsible for selecting the patients who need subsidised services. Health service units receive financing on a fee-for-service basis; at women's clinics a certain fee is charged per each visit to a gynaecologist. The fee for a visit is so small that gynaecologists are required to see five to six patients per hour. The results suggest that the following adjustments are required in the health service system:

- ❖ Services within the mandatory health benefit package need to be defined explicitly and either more financial resources need to be directed to health service units or the benefit package needs to be adjusted to the available finance in order to avoid informal user charges that further undermine public trust in health services.
- ❖ Gynaecologists should not be responsible for deciding which patients are entitled to subsidised services. A transparent and equal practice needs to be designed for allocating subsidies if user charges remain in use.
- ❖ The fee-for-service compensation from mandatory health insurance to women's clinics needs to be changed so that compensation per visit is adjusted to the content of the visit and gynaecologists have a possibility to spend more time in patient-centred health promotion, counselling, and treatment, when this is needed.

Clinical work at women's clinics

Gynaecologists felt that a major problem in their work was their patients' reproductive health behaviour and the challenges of influencing patients' reproductive health choices. Most of the gynaecologists who participated in this study worked according to a paternalistic model of the provider-patient relationship, although they acknowledged a need for more patient-centred counselling and treatment. Gynaecologists promoted reliable contraception, but they had ambivalent attitudes towards the unreliable rhythm method and withdrawal. In maternity care they were striving to medicalise pregnancy

planning beyond evidence-based medicine practices.¹² These observations suggest a need for the following measures:

- ❖ Gynaecologists need continuing education in patient-centred counselling and treatment. Particularly, more education is needed in how to involve patients in clinical decision-making and how to motivate patients to change their health behaviour.
- ❖ Evidence-based medicine should be integrated into clinical practices in order to avoid promotion of ineffective practices and use of unnecessary diagnostics and treatments.

Future research

The results revealed a gap between gynaecologists' ideals and the practices of clinical work, proving the combination of interviews and observations to be a powerful method in pinpointing discontinuities between what people say and what they actually do. The literature review suggested that qualitative methods brought up more problems in reproductive health services than quantitative methods did. The implications for future research are:

- ❖ Studies involving direct observations and in-depth analysis of provider-patient interaction are necessary in order to tackle the problems in provider-patient relationships in reproductive health services in St Petersburg.
- ❖ Intervention studies would be useful in determining how best to improve provider-patient relationships in St Petersburg.
- ❖ Systematic research data from different kinds of post-socialist contexts are needed in order to establish the magnitude and distribution of the challenges that have been revealed by this study and previous research in St Petersburg.
- ❖ Models for studying provider-patient relationship patterns need to be broadened from those focusing on the balance of power between the provider and the patient to encompass other relevant aspects of provider-patient relationship such as mutual liking and trust. Broader models are likely to be useful not only for St Petersburg and other parts of Russia, but for different kinds of contexts.

¹² *A study conducted in other parts of Russia suggests that evidence-based medicine has not been rooted in Russian maternity care, where ineffective or even harmful practices and medications continue to be used (Danichevski et al. 2008; Danishevski et al. 2008).*

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Appendix 1: An example of guidelines for family planning counselling

WHO et al.'s (2007) guidance on successful family planning counselling as an example of international consensus on good-quality counselling in reproductive health services

Tips for successful counselling

- Show every client respect, and help each client feel at ease.
- Encourage the client to explain needs, express concerns and ask questions.
- Let the client's wishes and needs guide the discussion.
- Be alert to related needs such as protection from sexually transmitted infections including HIV, and support for condom use.
- Listen carefully. Listening is as important as giving correct information.
- Give just key information and instructions. Use words the client knows.
- Respect and support the client's informed decisions.
- Bring up side-effects, if any, and take the client's concerns seriously.
- Check the client's understanding.
- Invite the client to come back any time for any reason.

Counselling has succeeded when

- Clients feel they got the help they wanted.
- Clients know what to do and feel confident that they can do it.
- Clients feel respected and appreciated.
- Clients come back when they need to.
- And, most importantly, clients use their methods effectively and with satisfaction (WHO et al. 2007).

Appendix 2: Details of material and methods

The data collection process of the background interviews

The original plan was to complete background interviews with administrative personnel, professors, and clinic managers before moving to other parts of the data collection. Consequently, findings from background interviews could have been applied in designing and focusing the latter parts of data collection. To begin with, I developed a list of administrative personnel and professors to be interviewed about the organising and functioning of the reproductive healthcare system and its current advantages and disadvantages. A senior member of the REFER team commented on and completed the list (see Table 1 in the original publication I). On the basis of this list the senior member of the REFER team chose people in suitable administrative positions whom she knew personally on the basis of their previous co-operation. On her advice, the initial plan to approach the participants by letter was abandoned, and instead she contacted the participants personally to ask them to participate. Only after the personal contact were they sent a letter and contacted by phone to make an appointment for the interview. In cases of refusal another participant from the same organisation or in a similar position was approached. This procedure was thought necessary to get the participants to participate, because many were difficult to reach. The use of personal contacts notably delayed the process, however, and, therefore, the background interviews could not be used in designing the latter parts of data collection. Another drawback was that, because of personal negotiations, I lost control over the process of contacting participants and refusals and the process of recruitment. Altogether nine interviews were held, which was enough to provide a general picture of the current organisation of health services and their financing. The majority of the administrative personnel, professors, and clinic managers had previous personal or professional connections with the senior member of the REFER team. As a consequence, it is not possible to estimate to what extent their opinions can be generalised to the St Petersburg health administrators and medical professors, not to mention those from other parts of Russia.

Getting access to the women's clinics

The manager of the pilot clinic and the members of the REFER group had had previous research collaboration before my data collection. The manager of the pilot clinic was also personally acquainted with several other head doctors of women's clinics in the city. On the basis of her network and the selection criteria,¹³ two clinics were chosen for data collection. The manager of the pilot clinic contacted both clinics by phone, after which I visited the clinics together with a Russian colleague. An agreement for data collection was

¹³ *The criteria for selecting the clinics were as follows: (1) one would work independently and one would be connected to a maternity hospital, (2) an average level of services, and (3) large size. The first criterion was interesting from the funding perspective, as clinics connected to maternity hospitals benefit from shared budgetary resources with maternity hospitals, whereas those working independently have no additional sources to rely on in case of financial hardship. The financial differences between the clinics are beyond the scope of this summary, however.*

reached with one working independently (clinic A) on the first visit. The other clinic worked in conjunction with a maternity hospital and did not refuse openly to participate in the project, but as negotiations were prolonged, we contacted one more clinic (clinic B), which was also connected to a maternity hospital and agreed to allow me to collect data. Both study clinics had experience of international projects or collaboration, which probably influenced their readiness to collaborate. In addition to data collection clinics, five other women's clinics were visited in order to assess whether the clinics used in the study were different from the other clinics in St Petersburg. The sites for the visits were chosen with regard to the existing network of the manager of the pilot clinic and members of the REFER team. The original plan was to visit a larger number of women's clinics in order to compare the study clinics with the other clinics in the city. The significance of personal networks in Russian society has been pointed out in several social science studies (e.g. Harden 2001; Salmi 2006) and it became clear in the data collection of this study as well. After visiting five clinics whose managers were connected to the research network, the limits of my network became obvious and I could not cover all the clinics that I had originally wished to visit. Harden (2001) has also described challenges in establishing official links to hospitals and recruiting physicians for qualitative research interviews.

Compensating for data collection

The Russian members of the REFER team advised before the data collection that it would be suitable in the Russian context to offer some financial compensation for data collection. We discussed the proposal with the international research team and decided that financial compensation was not acceptable from the ethical perspective. Each participant in the background interviews, however, received a small gift of insignificant monetary value (a Kivi candle holder by Finnish design brand Marimekko) as an expression of gratitude after the interview. When contacting the pilot and study clinics, we offered to compensate the clinics for the lost visit income resulting from participation in the study. The sum we paid was small, 5 € per observation day and 15 € per interview. In one clinic, the manager chose to buy new curtains for the clinic facilities with that money, and in the second clinic, the money was distributed to the staff as extra salary. Each gynaecologist who participated in the data collection received a copy of the book *Evidence-Based Clinical Guidelines* (in Russian, edited by Ilkka Kunnamo and published by John Wiley & Sons Ltd) after the observation day. The gynaecologists who participated in the comparison interviews also received the book after the interview.

Language barrier

My insufficient skill in the Russian language was a major limiting factor in the study. Translation was necessary, which slowed down interaction and made it cumbersome. I worked with two research assistants, one of them assisting with the background interviews and the other with the clinical data collection. The former research assistant did not have prior experience of qualitative methodology, which made it difficult for him to understand the study design and his role as an interpreter during the background interviews. Furthermore, his language skills were not tested properly beforehand and turned out to be insufficient for detailed translation. As the interviews were not tape-recorded, it was not

possible to patch the gaps afterwards. The other research assistant who participated in the data collection at women's clinics was a sociologist and skilful in qualitative research methods. She had a natural ability to establish contact with the participants and include me in the conversations despite translation. Originally her role was to help with practical arrangements, to interpret, and to record conversations between physician and patient during the observations, but owing to her excellent methodological skills and her genuine interest in the research topic, her role in data collection became much more substantial. We shared numerous inspiring conversations on alternative interpretations of the data and on the implications of study findings.

Researcher position

The data collection at women's clinics was influenced by my nationality, education, and gender. Being a foreigner – a Finn – separated me from the study participants, and being a physician enhanced building a rapport with them, which was significant during the short data collection period. When introducing myself, I always said that I was a physician and a social scientist. The participants referred to my medical background on many occasions by talking about us as colleagues. Some of them knew Russian colleagues who had migrated to Finland and worked there as physicians. Many participants had some prior knowledge about Finnish health services and were eager to know more about the Finnish healthcare system, physicians' salaries and social status, and clinical practices in gynaecology. This allowed some mutuality and sharing that enhanced rapport, although I typically tried to answer shortly and neutrally, and offered to discuss Finnish health services at the end of the interviews. The participants made a lot of comparisons between Finnish and Russian service systems. They often challenged the Finnish method of organising services. When giving interviews and talking informally during observations, the participants were telling things to a foreign colleague. They expected Russian society to be less organised than Finnish society. Patients in Finland were expected to invest more time, energy, and money in their health than those in Russia. The participants kept on repeating how difficult it is to work as a physician in Russian conditions. It is possible that my being a physician amplified this experience in the data, as it may be natural to expect that a colleague will understand the challenges of treating patients in such conditions. Sometimes the participants also expected me to understand something immediately, because I was a physician. They were sometimes surprised when asked to explain why they work in certain ways with their patients. It is likely that my being a woman enhanced the data collection, as all the participants at women's clinics were women and the patients found it easier to let a female researcher observe their appointments.

Appendix 3: Letter of introduction for background interviews

Dear Recipient

We are conducting a research project on the reproductive health services in St Petersburg. We would be grateful for an opportunity to interview you because your expertise in health care is valuable for our research. The interview will last approximately one hour. A member of our research group [name omitted] will contact you by phone within two weeks to schedule an appointment for the interview.

We are part of a multinational Russian-Finnish-Estonian research project that compares reproductive health and fertility patterns in Russia/St Petersburg, Finland and Estonia (web-link: http://www.valt.helsinki.fi/staff/rotkirch/RH_&_fertility_patterns). As part of the project we are studying reproductive health services. The emphasis is on comparing the views and practices of medical doctors who provide these services, but we are also interested in the organisational aspects of the delivery of reproductive health services. We expect that the results of the research will be helpful in developing reproductive health services and in planning continuing education for health professionals.

The research in St Petersburg is conducted jointly by STAKES (National Research and Development Centre for Welfare and Health, Finland) and MAPS (St Petersburg Medical Academy for Postgraduate Studies). The research group working on this specific part of the project consists of Elina Hemminki, MD, Research Professor (STAKES, Finland), Meri Vuorenkoski, MD, MA (STAKES, Finland), Olga Kuznetsova, MD, Professor (MAPS, St Petersburg), Tatiana Doubikaites, MD, Assistant Professor (MAPS, St Petersburg), and Anatoli Lebedev MD, MPH, PhD (MAPS, St Petersburg).

Our research consists of three parts. First, we will interview reproductive health experts and people in charge of reproductive health services in St Petersburg. Second, we will observe the work of medical doctors at women's consultations. Third, we will interview medical doctors who handle women's consultations. This request for interview relates to the first part of the research.

In the interview we would like to discuss the administrative organisation and the financing of health services, access to reproductive health services, organisation of women's health services, the education and work division of specialists, and the role of public and private reproductive health services. Furthermore, we are interested in your assessment of the strengths and weaknesses of the current system, as well as your suggestions for future development. We would also like to hear how specific health problems can be addressed in health services in St Petersburg (utilising the high prevalence of induced abortion as an example).

The contents of the interview are absolutely confidential and will be utilised only for research purposes. We would appreciate it very much if you commented on the interview notes in Russian after they have been produced in electrical form.

Yours sincerely

Meri Vuorenkoski, MD, MA, Researcher, STAKES

Olga Kuznetsova, MD, Professor, MAPS

Elina Hemminki, MD, Research Professor, STAKES

Уважаемые господа,

Мы проводим исследовательский проект о предоставлении медицинских услуг, связанных с репродуктивным здоровьем в Санкт-Петербурге. Мы были бы благодарны Вам за участие в данном проекте потому, что Ваша компетентность в данном вопросе неопределима для данного исследования. Время, необходимое для проведения интервью – примерно один час. Член нашей исследовательской группы [the name omitted] свяжется с Вами по телефону в течении двух недель для того, чтобы договориться о времени проведения интервью.

Мы являемся участниками международного Российско-Финско-Эстонского исследовательского проекта, который сравнивает репродуктивное здоровье в Санкт-Петербурге (Россия), в Финляндии и в Эстонии. Одной из частей проекта является исследование организации медицинских услуг, связанных со здоровьем женщин. Основной целью проекта является сравнение точек зрения практикующих врачей, предоставляющих медицинские услуги женщинам и изучение распределения услуг, связанных с женским здоровьем. Мы надеемся, что результаты исследования помогут развить сеть услуг, направленных на улучшение сексуально-полового здоровья населения, а также планировать дополнительное обучение для повышения квалификации медицинских работников.

Исследование в Санкт-Петербурге совместно проводят СТАКЕС (Национальный центр изучения и развития социального обеспечения и здравоохранения, Финляндия) и СПб МАПО (Санкт-Петербургская медицинская академия последиplomного образования). В исследовательскую группу, занятую в данной части проекта, входят: Элина Хемминки - д.м.н., профессор (СТАКЕС, Финляндия); Мери Vuorenkoski - к.м.н., магистр антропологии, научный сотрудник (СТАКЕС, Финляндия); Ольга Кузнецова - д.м.н., профессор (СПб МАПО, Санкт-Петербург); Татьяна Дубикайтис – к.м.н., магистр общественного здравоохранения, зав. НИЛ Центр по оценке технологий в здравоохранении, (СПб МАПО, Санкт-Петербург) и Анатолий Лебедев - к.м.н., магистр общественного здравоохранения, доцент кафедры (СПб МАПО, Санкт-Петербург).

В ходе нашего исследования мы будем интервьюировать специалистов в области женского здоровья и людей, отвечающих за предоставление услуг, связанных со здоровьем населения в СПб. При проведении интервью мы хотели бы обсудить вопросы административной организации и финансирования услуг, связанных с женским здоровьем, вопросы доступности их получения, а также обсудить роль государственных и частных медицинских учреждений, оказывающих услуги в сфере женского здоровья. Кроме того, нас интересует Ваши предложения для будущего развития системы здравоохранения.

Содержание интервью абсолютно конфиденциально и будет использовано только для исследовательских целей.

С уважением

Meri Vuorenkoski (М. Vuorenkoski), к.м.н, STAKES

О.Ю. Кузнецова, д.м.н. профессор, проректор СПб МАПО

Elina Hemminki (Э. Хемминки), д.м.н. профессор STAKES

Appendix 4: Interview schedule for background interviews

My name is Meri Vuorenkoski. I am a medical doctor and a social scientist. I am doing research at STAKES, which is a national research and development centre for welfare and health in Finland. This is [name omitted] who will help with interpreting.

Thank you for giving your time and meeting us today. I realise you are very busy with many obligations. I am grateful for this opportunity to meet with you. I am working in a research group that studies women's health in St Petersburg, Estonia and Finland. My research will focus on medical doctors' views about women's health issues, but I also need to understand something about the health services in St Petersburg and more specifically about women's health services. That is why we so much appreciate your sparing the time for this interview. Your expertise is of great value for this research. In the light of my research, I will write a report which I hope will be useful for developing women's health services further in St Petersburg.

I will be taking notes, as I will not be able to remember everything afterwards. I hope this does not bother you. I should like the session to be more like a discussion and not just I asking questions and you giving answers. If you want to ask me something, please feel free to do that. Would you like to ask me something now?

A. Individual Part [in each interview only one of the four topics below will be covered, but each topic will be covered with at least two different people]

Administrative organisation of health services

- Would you please describe the key actors or organisational units in healthcare administration? [Check the following: Governor and her office, City Legislative Assembly, City Committee of Public Health (ask them to describe the structure in more detail), District Health Department, Territorial Health Insurance Fund, Sanitary-Epidemiology System]
- What are the responsibilities of these actors or organisational units? [Check each]
- What kind of things do these actors or organisational units do in practice [Check each]
- How are the people in these organisational units appointed? [Check each; probe by whom and on what grounds (professional expertise / political grounds)]
- To whom are they accountable for their actions? [Check each]
- Are there any other organisations or people who are influential in the planning and management of health services?
- What are the differences between the Soviet era and the present? [Probe de-centralisation]
- We have now discussed the administration of health services in general. Would you please describe the role of these actors or organisational units in women's health services?
- What are the responsibilities of these actors or organisational units in women's health services? [Check each]

- Are there any other organisations or people who are influential in the planning and management of women's health services?
- How large a proportion of the health care services are provided by the private sector in St Petersburg?
- What specialties are most commonly represented in the private sector? [Probe women's health]
- Are there any estimates about how large a proportion of women's health services is delivered by the private sector in St Petersburg?
- In terms of public health services and women's health, are there any estimates of how large a proportion of services delivered by women's consultations are public services and how large a proportion of them are private services?
- What are the differences between the Soviet era and the present? [Probe privatisation]

Financing of health services

- Would you please describe the roles of mandatory health insurance, voluntary health insurances and out-of-pocket payments in the financing of health services in St Petersburg?
- What services are covered by what financial sources? [Check each payment option]
- Are there any other ways of financing health services in St Petersburg, something that I did not ask about?
- Are there any health services that do not fall under the mandatory health insurance scheme? What?
- Can these services be covered by voluntary health insurance or out-of-pocket payments?
- Who are the key players in negotiating what is covered by the mandatory health insurance?
- On what grounds do they make their decisions?
- Are there any social groups that remain uninsured by mandatory health insurance?
- How is their health care organised?
- In terms of women's health, are there any health services that outwith the scope of mandatory insurance coverage? [What services? for whom? why? who makes the decisions?]
- What are the differences between the Soviet era and the present? [Probe population coverage, the range of benefits, cost-effectiveness and evidence-based principles]
- On what basis is the insurance money allocated to individual health service units? Is it based, for example, on capitation or fee-for-service or something else?
- Is this system also applied in the case of women's consultations? [If a fee-for-service principle is applied, probe payments for different services]
- How large a proportion of health care financing approximately comes from health insurance and user charges?

[The questions in italics are asked only if the existence of user charges is admitted]

- *For what kind of services are user charges paid?*
- *Is this system problematic? Why? [Probe access problems]*

- *Are these charges set by individual healthcare units or is there some kind of district or city level central policy?*
- In terms of the financing of public health services, what are the differences between the Soviet era and the present?

Organisation of women's health services

- Would you please describe where (in which health service units) women's health services are provided?
- Who owns the health service units where these services are delivered?
- Who is in charge of the management of these healthcare units?
- To whom is the management accountable?
- What reproductive health services are offered in these different units? [family planning, following pregnancies, birth / delivery, post-delivery counselling, birth control, induced abortion, STI treatment, infertility treatment; if the interviewee does not open up, ask specific questions like 'if a woman is pregnant against her will and wants an abortion, where will she go first, where next?', etc.]
- There seems to be a lot of variation in women's consultations. Some are independent and others work as part of polyclinics or maternity hospital. Also their size can vary a lot. Can you please explain why there is so much variation?
- Are there any characteristics that are common to all women's consultations?
- How long are the waiting times in general for women's health services in St Petersburg? [Probe variation according to different districts, emergency appointments]
- Are there any recommendations for acceptable waiting times?
- Can the women choose their own gynaecologist or are they assigned to certain gynaecologists automatically (e.g. by family name or address)?
- In terms of women's health services what are the differences between the Soviet era and the present?
- How are doctors' salaries met in women's health services? Do they for instance receive a fixed monthly salary, or is it based on capitation, fee-for-service or some other principle? [Probe hospitals and women's consultations]

[The questions in italics are asked only if doctors receive a fee-for-service salary]

- *For what kind of services do doctors receive these fee-for-service payments in their salary?*
- *Is this system problematic? Why? [Probe bias in some medical practices]*
- *Are these charges set by individual healthcare units or is there some kind of district or city level central policy?*
- How large a proportion of doctors' income comes from salary paid by the clinic and additional payments paid directly to the doctors by patients?

[The questions in italics are asked only if it is admitted that some money is paid by patients]

- *For what kind of services do doctors receive direct payments from the patients?*
- *Is this system problematic? Why? [Probe bias in some medical practices]*
- *How much approximately are these payments? [Probe appointment, investigations, procedures]*

- *How are they agreed upon between the patient and the doctor?*
- *Can they influence patients' access to care?*
- What is the average monthly salary of a medical doctor working in women's consultations?

Professionals and education

- What is the professional training of doctors who work in women's health services like?
- After specialisation, do the doctors themselves decide where they want to work or are they appointed to certain workplaces?
- What are the most popular workplaces? Why?
- What kind of continuing education is there in St Petersburg for gynaecologists or obstetricians?
- How are the subjects for continuing education selected?
- Is continuing education mandatory or voluntary?
- What other groups of healthcare professionals work in public sector women's health services?
- What kind of professional training do they have? [Probe what level of education and how many years for each group]
- What kind of work do they do?
- Do you think this division of work between doctors and these other professionals will remain the same in future?
- Are there any estimates about how large a proportion of gynaecologists and obstetricians work in private clinics in St Petersburg?
- Are the same doctors working in both the public and the private sector?
- What makes doctors choose to work in the private sector?
- Are there any differences between the doctors who work in private clinics and the doctors who work in public health care?
- Are there any clinical guidelines that have been developed for health care in St Petersburg (or Russia in general)?
- Who produced these guidelines?
- What are they based on?
- Is it mandatory for doctors to follow these guidelines or are they more like recommendations?
- Have such guidelines been developed for women's health problems?
- For what problems?
- How is the utilisation of guidelines monitored?

B. General Part [Asked of each interviewee]

- In terms of health care in St Petersburg, what are the strengths of the present health care system in your opinion?
- What kind of problems do you see in the healthcare system today? [Probe access, user charges, doctor-centredness]
- In your opinion what are the strengths of women's healthcare services in St Petersburg?

- And the weaknesses?
- If you could influence the future of women's health care in St Petersburg, what kind of changes would you like to make?
- Is there anything else you would like to add?

Thank you for answering my questions. I am really grateful for your help. This discussion has given me lots of valuable information.

I will write a summary of the topics that we have been talking about. It will be based on this interview and other interviews on the same topics. I would appreciate it very much if you gave your comments on the Russian summary. You may also make some corrections, if they are needed. Would you like to receive a copy of the summary? [Get contact information]

If you are interested in my work, I can also send you an English summary of my research report. It will take two to three years, though, before it is ready. Would it be more convenient if I posted or e-mail a copy? [Get contact information]

Thank you very much again. I am grateful for this opportunity to hear your expert opinions on this topic.

Appendix 5: Interview schedule for gynaecologists

My name is Meri Vuorenkoski. I am a medical doctor and a social scientist. I am doing research at STAKES which is a national research and development centre for welfare and wealth in Finland. This is [name omitted], who will help with interpreting.

Thank you for giving your time and meeting us today. I am working in a research group that studies women's health in St Petersburg, Estonia and Finland. I am interested in medical doctors' views about women's health issues. I will write a research report which I hope will be useful for developing women's health services further in St Petersburg.

I would like to record our discussion, as I will not be able to write down everything that we say, and I do not want miss anything. The tape will be translated into text later. I will take the tape and the text to Finland with me and it will be preserved at STAKES. Your name will not appear in the tape or in any information attached to the tape. This research is being conducted with the European University of St Petersburg. The members of their Gender Study programme will also have a copy of the text and can use it in research, but they will not know your name or contact information. This interview will be used only for research purposes.

I am familiar with some of the women's health statistics from St Petersburg, and our project has devised a survey questionnaire for women. It is also valuable to know what medical doctors who are specialists in women's health and who work with patients think about these issues. It is important what you personally and as a medical doctor specialising in women's health think. This is important because in your work you see many women and learn about their health behaviour. I am interested in what you can tell me about women's health behaviour based on your experience at work. I am interested in your work with women and about practices concerning family planning.

Please say if you do not understand any of the questions. We will try to clarify them. Also, feel free to say what you think. This is not about how much information or knowledge you have got, but your views about these things. There are no right or wrong answers. I hope this session will be more like a discussion, and not just I asking questions and you giving answers. If you want to ask me something, please feel free to do that. Would you like to ask me something now?

[Start recording]

Beginning

I would like to know something about your background first.

- How many years have you worked as a gynaecologist?
- How long have you been working at this clinic?
- How old are you? I hope this question does not offend you. It constitutes important background information.
- What kind of problems do women usually bring to you? [Probe pregnancy, symptoms of disease, infertility, health certificate, contraception]
- Has this changed during the last 15 to 20 years?

[From this point on keep in mind questions of womanhood / femaleness and tie this to other topics: 'What is proper behaviour for a woman?' Survey results can also be used as examples to get ideas.]

Birth control / contraceptives

- Are there problems with contraception in your daily work?
- What kind of problems? [Probe health, financial and availability problems, lack of knowledge, partner's approval]
- What is the women's attitude to contraception? [Probe concerns with health problems, information, financial issues, availability, partner's approval]
- What kind of contraception do your patients use? [Probe pills, other hormonal methods, IUD, condoms, other barrier methods, rhythm, other natural methods such as vaginal washes]
- Why do they choose these methods?
- What kind of changes have there been in your work on contraception during the last 15 to 20 years?
- What do you think about these changes?
- Sometimes patients who are sexually active and want to avoid pregnancy do not use any birth control method. Why does this happen, in your opinion?

Pregnancy / induced abortion

- What is the general procedure if a woman comes because her period is late and she thinks she may be pregnant?
- When you think about your patients, how many women are happy and want to continue with their pregnancy?
- What influences this?
- Do women generally plan their pregnancies?
- Has this changed during the last 15 to 20 years?
- When should a woman become pregnant, in your opinion? [Probe age and life situation]
- Why?
- What about when a woman does not want to have a child? What is the general procedure for abortion? [Probe abortion and mini-abortion]
- Is this part of your work? [Probe what parts of the process]
- How often every month [or week] do you meet patients who want to have an abortion?
- Could you please describe the last case? [Or a typical case, if a long time has elapsed]

[Ask about different aspects of the case such as age, marriage, other children, how many pregnancies, living situation, working, the process in detail, why did the woman want an abortion, what was the doctor's opinion, was there any counselling about contraception]

- Why do women usually need an abortion? [Probe why not contraception and why not give birth]
- Have there been any changes in abortion during the last 15 to 20 years?

- Have you ever had a case where the woman wants to continue the pregnancy, but you do not recommend it?
- Can you please describe one such case?
- What about when the woman wants to have an abortion, but you advise her to continue the pregnancy?
- Can you please describe one such case?

Changes in childbearing patterns / postponing pregnancy

Today in St Petersburg the birth rate is lower than it was 15 years ago and women are giving birth to their first child at an older age.

- What do you think about this development? [Probe both as a medical doctor specialising in women's health and personally]
- Why has this happened? [Probe generally and thinking about own patients; probe reasons such as contraception, education, work, financial situation, social change]
- Has this caused any problems for women?
- What kind of problems?

Sexual behaviour [Can be sensitive, do not persist if doctor is reluctant to speak]

- Has the sexual behaviour of the people in St Petersburg changed in your opinion during the last 15 years?
- How?
- What do you think about these changes? [Probe generally and as a medical doctor specialising in women's health and personally]

Women's health

- In your opinion, what are the most urgent women's health problems in your city?
- Why?
- What is the best way to improve the situation in relation to this problem?
- Who is responsible for this?
- How can you improve the situation at your work?

Finishing

We have now discussed many things about women's health and I do not have any more questions.

- Is there anything else that you would like to add to what we have discussed?
- Is there anything you would like to ask me now?

Thank you for answering my questions. I am grateful for your help. If you are interested in my work, I can send you an English summary of my research report. Would it be more convenient if I posted or e-mailed a copy? [Get contact information]

