THE EXPERIENCE OF PREGNANCY IN THE COVID-19 PERIOD IN GREECE

Vasiliki Saini

August 2022

The page was left intentionally blank

Utrecht University

Master Course: Cultural Anthropology: Sustainable Citizenship

The experience of pregnancy in the COVID-19 period in Greece

Student: Vasiliki Saini

No. 0060747

Supervisor: Drs Berfin Yurdakul

August 2022

Acknowledgements

I would like to thank all the agentive women who trusted me and decided to share with me their pregnancy experiences during the coronavirus period. I thank each one of you separately!

Contents

Word count: 21,257 main text

List of illustrations and figures

Introduction

Introduction

My first encounter with pregnant woman's subjectivity in the coronavirus period was through a close friend of mine who recently became a mother but was pregnant during the period following the recommendation of COVID-19 vaccination to pregnant women, namely after May 2021 in Greece. I remember we were strolling down a busy street in central Athens right after the temporary lift of COVID-19 measures and the opening of cafes and restaurants that followed in the Christmas period this year (2021-2022). We sat outdoors on a bench with two cups of hot tea at hand, well-dressed and masked as musketeers, since she could not sit inside a cafe shop because we were unvaccinated. There, on a warm Athenian night, she confided to me her concerns and misgivings about getting vaccinated during her surrogacy and her fear of being objected to an unwanted caesarean section in case she got infected in the ninth month of her gestation. She intended to act preventively since she did not want to risk her fetus's health from any implications of the COVID-19 vaccination and have a natural birth. Concurrently she was angry by the state of exception discourse towards those who selected to remain unvaccinated in their effort to protect and safeguard their fetuses' health and the unpreparedness of the health system to deliver babies in case the mother gets infected from coronavirus with natural birth in any maternity hospital and not only in designated ones. From her narrative, I understood that the state confronted these women as hygienic subalterns whose voices and concerns remained unheard. This interpretation of her narrative triggered me and led me to the decision to better explore the experience of being pregnant during the coronavirus.

The research lasted three months, from 10 February 2022 to 10 May 2022, and my participants were pregnant women during the coronavirus period. To be more specific, for the purposes of this thesis, I considered pregnant women during the corona pandemic, women who were pregnant when WHO declared "the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)" as a global pandemic on 11 March 2020 (WHO 2020b), and women who got pregnant during the first and second pandemic period. As the first coronavirus period, for the purposes of this thesis, I defined the one which started when the WHO declared the COVID-19 outbreak a global pandemic on 11 March 2020 (WHO 2020b), and the second one, after the Hellenic Society of Obstetricians and Gynecologists (HSOG) issued COVID-19 vaccination

recommendation to pregnant women by no 57 guideline in May 2021 until the completion of the research.

The COVID-19 period officially commenced in Greece in March 2020, following the diagnosis of the first COVID-19 case on February 26. On 22 March, the government introduced restrictions on unnecessary movements throughout the country (Parlapani et al., 2020). On March 10, with officially 89 confirmed cases and 0 deaths, all schools and universities were closed. From that very day, new regulatory measures were gradually introduced to mitigate the risk of exponential virus transmission. During the general lockdown, citizens were allowed to leave their house only for specific purposes, and after they had filled out a special movement permit handed out by the Greek civil protection or after having texted a designated number, they set out for this purpose (Parlapani et al. 2020).

The outbreak of COVID-19 found the healthcare system in Greece in an already precarious situation. Since 2010, the public health care system has been severely affected by the neoliberal austerity measures driven and imposed by Troika (Kousi, Mitsi and Simos 3, 2021,4). These neoliberal measures resulted in an under-funded public health system (PHS) and understaffed due to the imposed freeze on hiring (Giannopoulou and Tsobanoglou 2020). More specifically of the healthcare system situation in Greece, over the period 2009–2015, the NHS suffered cuts of more than €7 billion, while under 5% of GDP (EUR 9.1 billion) was allocated to health in 2019 as public spending is still bound by fiscal constraints (Siettos et al., 2021). Primary care, which could be particularly useful to identify patients at risk and avoid flooding hospitals with mild COVID-19 cases, is underdeveloped and fragmented as NHS's services are disproportionately located in urban areas (Siettos et al., 2021).

Another indication of the deconstruction of the PHS due to the implementation of neo-liberal policies was the initial persistent unwillingness by the state to subside the cost of the PCR and RAPID tests. At the outbreak of COVID-19, the cost of a single PCR test was 100€. Consequently, the only medium to measure the coronavirus spread was inaccessible to most of the population. Pregnant women and their partners had to

undergo this cost continuously, and during, at least the first general lockdown period, any ‘’voice’’[1] of resistance, at least physical one was absent

Voicing our opposition to state decisions is not rare in Greece, especially after 2010. Following that date, meaning two years after the financial crisis, the anti-state mobilisation was frequent and took the form of recurrent strikes, sit-ins, occupations of government buildings and protests in squares of large urban centres. (Sotiropoulos 2019,17) Another way that we still express our opposition to the state is by ‘’exiting’’ the country. Especially in the years following the financial crisis, brain drain has been almost the norm. However, there are still people ‘’loyal’ to the state, a remnant of past periods, which are connected to the state through political clientelist relations.

Currently, from the onset of the coronavirus period until the time of the writing of this thesis, it could be claimed that what is left today regarding after the state-society relations from “loyalty” to “voice” and “exit” is a mix of all three of them, which have emerged as alternative arrangements since the eruption of the economic crisis (Sotiropoulos 2019,17). In this context, during the coronavirus period, biocitizenship has been defined from above and designed to construct a normative body (Happe et al.2018,4) due to the health uncertainty that the COVID-19 virus has caused to states and citizens. In this framework, pregnant biocitizens perform biocitizen from above as docile individuals.

Biocitizenship and how it was performed by the interviewees was one of the theoretical concepts that I had framed in my theoretical background in the research protocol but also emerged from women’s narratives, especially in terms of vaccination anxieties regarding the vaccination against COVID-19 during pregnancy. The other core concepts of their narratives, which were interlinked to their experience of being pregnant during the coronavirus period, were the concepts of “**mothering**” and “**obstetric violence**”.

All these concepts constitute thematic areas of **critical medical anthropology** (CMA) research. CMA takes a critical stance in the study of biomedical culture and therefore adopts a critical view in the examination and studying of the “technocratic model” of childbirth, which defines the pregnant and birthing body as inherently problematic and potentially dangerous to the fetus (Macdonald 2006,235), and

[1] I employ A. O. Hirschman’s distinction about the relations between state- society. According to him there are three options “exit, voice and loyalty” (Sotiropoulos 2019,2).

transform physicians and those in the medical field to "authenticities". CMA, therefore, links political and societal levels of analysis by maintaining a focus on the micro-experience of the individual, but within the context of the macro-structures that influence political and social life (Newnham, Pincombe and McKellar 2016,2).

In my thesis, the micro-experiences of an individual are the experiences of each one of the interviewees during the health coronavirus emergency and how it was framed by state policies. This experience is depicted and analysed in the findings, following the presentation of the methodology I deployed. In other words, the structure of this thesis consists of three parts. I dedicated the first part on ethics, where I explicitly declare my agreement with the AAA and DAA code of ethics and state my positionality regarding the population I studied. In the second part, I present the methodology I employed for the data collection and analysis and my population. The third part embeds the findings.

In brief, in the methodology part, I adopted Marcus' (1995) multi-sited fieldwork imperative on "**follow**": the **People**; the **Thing**; the **Metaphor**; the **Plot**, **Story**, or **Allegory**; the **Life** or **Biography**; the **Conflict** (Airoldi, 2018) and I employed an online ethnography approach. To implement this, I conducted eighteen in-depth semi-structured interviews using Voice over Internet Protocol (VoIP) technologies, namely the Zoom conference platform, Skype software, Viber, WhatsApp, and Messenger instant messaging apps, following the interviewees' preferences. Additionally, I conducted netnography through online observation of Facebook mothers' groups, YouTube platforms, and social media profiles of the policy-making bodies regarding pregnancy and COVID-19 in Greece.

To analyse the data, I initially employed the three perspectives of the body as they were defined by Douglas and Scheper-Hudges in the paper "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology" (1987) by classifying the body as the individual body, social body, and the body politic. Additionally, I employed the constructivist grounded theory approach (CGT) as developed by Charmaz.

In the population section, I introduce the population to the readers, define it, and provide information regarding its location, the reasons that I focused on the Greek population only and how I traced them.

In the third part of the thesis, I present findings from the online fieldwork. The findings were based on the **interviewees**' narratives and the **netnography,** interlinked to the **archival analysis**. The outcome was disaggregated into three chapters for analysis's purposes. Each chapter consists of subchapters with graphic language titles and depicts an emotional moment in the narratives of the interviewees.

I open the presentation and analysis of the findings by discussing the concept of **mothering** and how my interviewees experienced it during the coronavirus period. I employ this concept as the umbrella concept with which the **obstetric violence** the **COVID-19 vaccination anxieties** are interrelated in the interviewees' experiences. Hence the rationale behind the order of the chapters is to illustrate the experience of pregnancy during the coronavirus period from the general situation of pregnancy and the concept of being a mother, to more specific topics that emerged because of the pregnancy situation during the coronavirus period, namely the fear of obstetric violence because of a potential the coronavirus infection and the COVID-19 vaccination anxieties.

In the first chapter, I examine the concept of mothering predominantly, and secondly, the concept of motherhood. The way the interviewees experienced them, how they negotiated their subjectivities through them, and on which ground they performed their agency as biocitizens in the corona state of exception.

In the second chapter, I present the fear and anxieties provoked by the risk of a potential enactment of obstetric violence in the name of biosecurity. The fear of obstetric violence stemmed from the biomedical protocols and guideline 43 of the HSOG (Hellenic Society of Obstetricians and Gynecologists) on the obstetric provision of care during the COVID-19 pandemic, which provided that in case a woman in labour is infected with COVID-19, she will be transferred to a designated reference hospital alone, without her partner and the health professionals that followed her pregnancy to give birth, usually submitted to a caesarean section. To deal with this fear and anxiety, my interviewees employed agentive practices and tactics, as I will present in the chapter.

In the third chapter, I approach the issue of COVID-19 vaccination of pregnant women by employing the analysis of Melissa Leach and James Fairhead on vaccination anxieties since their approach is more inclusive and permitted me to analyse both

vaccine uptake and refusal. Negative forms of vaccine anxieties are related to vaccine hesitancy, meaning the delay in acceptance or refusal of vaccines despite the availability of vaccine services (WHO 2019). Analysing anxieties involves understanding what people are anxious about or for, their logic, and how these "framings" translate into action (Leach & Fairhead, 2008,39) concerning biopolitical measurements in the COVID-19 period. Vaccine anxieties, seen as worries, can interpret public refusal or dissent (Leach & Fairhead, 2008,3) from COVID-19 vaccination. Vaccine refusal is more about avoidance than active opposition and signals one's subversive opposition to the status quo (Sobo 2016). Vaccine anxieties, under a positive frame, imply a striving for something and recognising its cruciality to ensure wellbeing.

Finally, for transparency reasons to the readers and to protect, as I have committed in the letter of consent, the anonymity of the interviewees, I used pseudonyms when I quoted their narratives, and I avoided any reference to the places of residency of the participants in the main text.

Part 1. Ethics

Ethics

For this research, I adopted and applied the Ethical Guidelines of both the **American Anthropological Association** (AAA) (2012) and the **Dutch Anthropological Association** (DAA) (2018). Starting from the principle of "Do no Harm", I have to declare that I pondered adaptation and adoption of this principle as imperative to my research. Since the Greek government has characterised my research population, namely pregnant women during the COVID-19 prolonged period under the **Law 4682/2020**, as a vulnerable group, my personal concerns and considerations about my target group's potential physical and psychological harm, such as their health safety and any potential negative impact on their mental health, led me to the strict implementation of the content of the "Do no Harm" principle. The way to do so was to trace my target group through online Facebook mothers' groups and my social network and interview them through digital platforms of their preference. The digital platforms I employed were mainly Zoom/WhatApp/Messenger, and one interview was conducted via telephone, as I have mentioned as well in the data collection section. The background thought and consideration was to ensure zero exposure of my participants to any potential COVID-19 infection caused through physical meetings. Therefore, I decided to comply with any provided governmental social distance measures and adopt more restrictions, acknowledging that this might affect the communication between the participants and me. Still, for the sake of the "**Do no Harm**" principle in the due period of a pandemic, I decided to sacrifice the traditional physical interaction for a digital one, following as well the recommendations of the research protocol reviewer Professor Rebecca Bryant, as I have described in the methodology section.

Regarding the principle of "**Integrity**" of the DAA, or the principle of "Be open and Honest Regarding Your Work", as the AAA named it, and the critical concept of "transparency", I fully embrace and implemented it. I employed a twofold approach. As a first step, I posted online in the selected Facebook mothers' groups the informational letter of my research. The same letter was received by the participants who approached me from my social network. I opened the informational letter by explicitly stating my identity as a master's student in the Master course: Cultural Anthropology: Sustainable Citizenship of Utrecht University and the topic of my thesis, namely the experience of pregnancy during the COVID-19 period. In the following paragraphs of the informational letter, I informed participants about the research

method, namely the interview, that she would unfold her narrative. The duration of such a narrative through an interview could last 45 minutes, and I explicitly stated in the informational letter that participation in this research was voluntary. The participant had the right to stop the interview or withdraw her narrative whenever she felt without any sanction. I was also specific about the freedom of choice regarding the preference between several digital platforms of communication that a participant could employ. I also encouraged them to consult any person they thought suitable about my research topic before responding to me. My supervisor's name and conduct details were embedded in the informational letter for transparency reasons and to ensure my identity as a master's student in case a participant was willing to cross-check it. My conduct details, namely my university and personal emails and my telephone number, were included in the text too. Continuing regarding the informational letter, I provided a brief reference to how the data would be stored and managed and who would have access to it. I closed the informational letter with the sentence that whoever would like to participate would receive a letter of informed consent before the interview. The rationale behind the closure sentence was to enable participants to think about their decision without any pressure on the one hand and, on the other hand, to ensure that those who would participate would be more prepared to provide me with their free, informed consent.

Obtaining informed consent constitutes the third principle of both the DAA and AAA. Following the requirements of my research topic and the social distancing state guidelines due to the contagiousness of the contemporary coronavirus, I proceeded to acquire the informed consent of my research participants following their receipt of the informational letter. I requested participants to send me the informed consent letter before each interview. In case they did not do it, I did not insist because my intention was for them to feel free and secure, as much as this was feasible from the first visual online contact, to confide in me their experience. Instead, I was open to clarifying any potential questions they had beforehand via message or email, no matter if they had signed the letter of informed consent or not before the onset of an interview, after introducing myself in front of the camera, I informed them each time orally about the scope of the study, about what had triggered me to select this topic, the potential duration of an interview, their right to stop the interview whenever they wanted to, their right not to answer any question they feel uncomfortable with, their right to withdraw

their consent any time, during and after the completion of the interview, the way I will manage the data and the time keep them in my acquisition, how I will ensure their anonymity, the Greek Law 4624/2019 which transposed the EU regulation and therefore prohibits the leaking of any of their data, which other person might have access to the data, the duration of the research, the reference protocol number of approval by the ethics committee of the Utrecht University and the voluntarily character of their participation. Therefore, for transparency reasons, I informed them again and continued requesting their consent every time before the onset of an interview. I also asked for their consent to record their interview before initiating the recording. None of the participants refused to have their interview recorded. Therefore, all participants were informed about the recordings' onset and completion. Only one participant asked me to clarify if the videos of the recordings would be displayed in the presentation of the thesis or on any other occasion. To be honest, such a question had slipped my mind, but I assured her that I would use only the transcript and anonymise it, not the interview's visual product. Only then I started recording that interview. All participants provided me with both their oral and written consent.

As I mentioned above, each participant was informed orally for a second time before the interview about the content of both the informational letter and the letter of consent in a more casual and friendly way to enable them to feel more comfortable with me. Following the description of the fourth principle of the DAA and AAA ethical guidelines, I explicitly informed them about data management, ownership, and access to data. I was the only person that managed their data since I was the sole researcher. Each interview was anonymised and coded after the numerical consequence, interview 1, interview 2, etc. No demographic data were used in any part of the analysis to ensure the anonymity of the participants. The only person apart from me who was provided access to the data, and only after a formal request, was my appointed supervisor Drs Berfin Yurdakul, who did not make use of this right. Additionally, I informed them, both in writing and orally, that I would keep the data in my acquisition for one year, and after that, I would destroy them. Regarding the accessibility of the data, and after the request of most of the participants, I have committed to sharing with them my thesis after the completion of the approval process at Utrecht University.

Last but not least, regarding the sixth principle of the AAA on the protection and preservation of my records, and more specifically the interview records, I stored them

in a way that was accessible only to me. I acknowledge that their content did not describe any medical crime; however, to ensure the participants' confidentiality, I took the proper measures to keep the records safe and inaccessible to third parties.

Positionality

In terms of my positionality, I have to declare that I do not consider pregnant women as a vulnerable group and the birthing body as inherently problematic and potentially dangerous to the fetus (Macdonald 2006,235) as the biomedicine discourse sustains. As a feminist who has not yet acquired mothering experiences, restricting this concept to the role of being a mother, I considered and approached them as **agentive subjects** that have to formulate and perform their role within a social frame that might perceive them as docile and vulnerable individuals. I ponder them as subjects being in a continuum of renegotiating their personhood and reclaiming their motherhood through their practices and acts of mothering, trying to balance their priorities in a supplementary way, namely them and their fetuses, instead of the explementary position of the fetus towards them. I also contest the rationale of the Council **Directive 92/85/EEC** on the introduction of measures to encourage improvements in the safety and health at work of pregnant workers and workers who have recently given birth or are breastfeeding, as it was incorporated in the Greek legislation in the Presidential Degree **176/1997**, which defined pregnancy as a disease.

What was important to me from the drafting of the research protocol since the completion of the research in this research was for pregnant women and women who experienced pregnancy in the coronavirus period to feel safe and liberated to articulate their experiences in the way they selected to without any misgivings.

Part 2.

Methodology

Population

For the purposes of this thesis, I defined my target group, namely pregnant women during the coronavirus period, as women who were pregnant when the WHO declared "the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)" as a global pandemic on 11 March 2020(WHO 2020b), and women who got pregnant during the first and second pandemic period. As the first coronavirus period, I defined the one which started when the WHO declared the COVID-19 outbreak a global pandemic on 11 March 2020 (WHO 2020b), and the second one, after the Hellenic Society of Obstetricians and Gynecologists (HSBG) issued COVID-19 vaccination recommendation to pregnant women by no 57 guideline in May 2021.

My intention was to explore their experience and listen to their narratives in alignment. Contrary to the biomedical discourse that considers the pregnant and birthing body as inherently problematic and potentially dangerous to the fetus (Macdonald 2006,235) and pregnant women as a vulnerable group, I ponder them as agentive subjects, as agents of their bodies. Therefore, I decided to record their discourse and give a stance to the narratives of those women who were pregnant during the first and the second period of the coronavirus period and pregnant during the duration of the research, as I declare in the first paragraph of this section.

I decided to refer to my target group as pregnant women and not persons even in the research protocol, acknowledging that there are transgender men who could be pregnant. However, always having in mind that probability, I was prepared to adjust if I met a pregnant person who identified herself as other than a woman, but I did not meet any transgender pregnant person. All the research participants identify themselves as women, using the pronunciation "she".

I conducted eighteen interviews in total. Seventeen of them were Greek citizens from the administrative regions: Attica, Crete, East Macedonia and Thrace, Central Macedonia, West Macedonia, Peloponnese and South Aegean, apart from one who was a Cypriot citizen residing in Cyprus, all of them Greek native speakers. At the time of the interviews, most women resided in urban centres. Only three of them resided in the countryside. Two women were pregnant during the research, and sixteen were not currently pregnant but during the two defined coronavirus periods. All have graduated from tertiary education, twelve hold a master's degree, and one is a Drs. Only one of

them lost her work during her pregnancy during the coronavirus, but she resigned since the manual nature of her work did not allow her to be present at the work premises, and she could not telework neither. The age group had a broad range from 28-42. Six of them already have a child, and twelve of them are first-time mothers. Four were not vaccinated during the pregnancy, and the rest were vaccinated with mRNA vaccines, except for one who got vaccinated with a viral vector vaccine. Three of them decided to give birth at home, six to deliver in a public hospital with a specialized maternity ward, and the rest gave birth at a private maternity hospital. Six underwent a caesarean section, agreeing with their obstetricians and not due to a coronavirus infection. Luckily none of them was COVID-19 positive during the labour. Regarding their marital status, only one was in a civil partnership, and the rest were married.

I traced the participants through Greek online Facebook mothers' groups that my social network, namely relatives and friends, proposed to me and introduced me to some of them. The reason I limited the location to Greek online Facebook groups was multiple: firstly, I reside in Greece, so I am familiar with the cultural framework, even if sometimes being a home anthropologist could pose a challenge of "otherness". In my case, the "other" was me since I do not belong to the broader group of women having experienced pregnancy. Secondly, I intended to study the situation in my homeland since I find it more challenging to study my cultural background. Additionally, having adopted the applied anthropology aspect, I considered that the findings could contribute to a potential adjustment of policymaking to the needs of pregnant women, especially during the coronavirus period, since their discourse would now be public.

In terms of the environment selection of tracing the participants of the research, I followed the recommendations of the research protocol reviewer Professor Rebecca Bryant to focus on online communities only to find my participants and avoid any contact with them due to the precarity of the coronavirus period regarding any potential infection. So, my initial proposed method to approach a midwife's clientele and follow her to her visits to meet pregnant women in person had to alter in order my research protocol to be approved. I will provide more details in the data collection section. Hence, I initially focused only on online mothers' communities or groups, and since I have a profile on Facebook, I quested groups there.

To navigate myself more successfully in Facebook online mothers' groups, and due to the limited time of conducting the research, namely only three months, I turned to my social network to recommend me online mothers' groups on Facebook. Following their suggestions, I turned to the following Facebook "momslife"[2] ,"Γυναίκα-έμβρυο-γέννα-βρέφος-παιδί-θηλασμός(Woman-embryo-child lactation)" [3], "Εθελοντική Ομάδα Υποστήριξης Θηλασμού Αττικής (Volunteers Supporting Lactating Group-Athens)" [4], and "Γέννηση χωρίς βία (Birth without violence)"[5].

As I mentioned, I started the quest of my group online. The second strategy I employed was to quest participants through my interlocutors' network. As interlocutors, I define my social network of friends and family, with whose assistance I managed to attract more participants. My interlocutors were people of trust with whom the potential participants could address and ask for more information about me as a person, independently of the research. It was a way to ensure more trust from the participants's part. To the participants I provided them with the informational letter with the main focus on their experience as pregnant women during the coronavirus period.

A third medium to attract more participants came from those women I had interviewed already and either volunteered to suggest me to some other friends or acquaintances women that had experience pregnancy during the coronavirus period or requested from them if they could suggest me to potential participants. Either way, some women were willing to assist me, and in this way, I found more participants to share their experiences with me through their narratives.

Regarding the relationship with the participants it was improved during time and interview after interview. I also have to stress the support, recognition and new ideas that I received from the participants. Some of them, especially those with similar academic experience, proposed I should not hesitate to turn again to them in case I had some points that would need further clarification during the data analysis, a gesture that I deeply appreciated it.

[2] Momslife https://www.facebook.com/groups/1014566959035092
[3] Γυναίκα-έμβρυο-γέννα-βρέφος-παιδί-θηλασμός https://www.facebook.com/groups/208881252997061
[4] Εθελοντική Ομάδα Υποστήριξης Θηλασμού Αττικής https://www.facebook.com/AttikiThilasmos/
[5] Γέννηση χωρίς βία https://www.facebook.com/groups/320870168492073

Data collection

To approach the target group and in my attempt to actively listen to their pregnancy experience during the COVID-19 period and empathize with them, I adopted Marcus' (1995) multi-sited fieldwork imperative on "follow": the People; the Thing; the Metaphor; the Plot, Story, or Allegory; the Life or Biography; the Conflict (Airoldi, 2018). I employed an online ethnography approach, following the recommendation of the research protocol reviewer Professor Rebecca Bryant to focus only on online communities to find my participants because the involvement of a health professional might cause problems with the ethics committee approval. So, she advised me to delete any reference to midwife and conduct only online ethnography. For clarification reasons, I have to give more details in this part regarding my initial principal research question and methodology and how both of them had to alter due to the research protocol approval process and the requirements of the field, all applied after informing my supervisor Drs Berfin Yurdakul accordingly.

My initial main research question was "How are pregnant women being affected by COVID-19 vaccination governmental discourse in relation to their situation?" and I intended to examine it, as the subsidiary questions, deploying offline and online participant observation applying suitable qualitative methods and techniques. The offline part included the cooperation with a midwife to follow the coronavirus stories of her clientele accompanying her on her visits to her clients (pregnant women). Since this was rejected by the research protocol reviewer, as I previously referred to, I had to limit the research only to online observation and interviews. Regarding interviews, as I will refer to them more thoroughly next to this section, in order to safeguard my participants' health and safety and apply in practice the principle of "Do no harm", I chose to conduct them only online, even if the protocol reviewer had no objection to conducting them offline as well. However, I have to mention that the online tactic facilitated conducting interviews from different parts of Greece, and it was also the preferred way by all participants for health and safety reasons.

The advantages of online ethnography, especially during the COVID-19 period, are multiple. It might bring memories of the "armchair anthropologists" period, but I

agree with Podjed (2021) and argue that this perception is inaccurate. Social distancing and self-isolation as the "new normal" require adaptations, exploring new methods and techniques of study and collection of data, or the further and broader implementation of already developed methodological approaches such as online ethnography. According to Hammersley and Atkinson (2019,139), the social relationships of many people are digitally mediated, especially in the COVID-19 pandemic era.

As a methodological approach, online or digital ethnography construes the field as a network of interconnected sites, explores the messy webs of interconnection across online and offline spaces, and participates in multiple frames of meaning-making (Ghosh 2020). All of Marcus' suggested strategies of multi-sited fieldwork can be applied. Additionally, the five key principles of this approach may indicate the multiple techniques that a researcher can employ in cyberspace. For instance, as a mode to engage with the digital, multiplicity has a clear impact on the research, the interlocutors, and the researcher (Ghosh 2020). Non-digital-centricness, as the second principle, reminds the researcher that relationships cannot be purely digital even if research is conducted online (Ghosh 2020) since the interaction is still among humans. Openness as a principle refers to research questions, institutional contexts, and ways in which the participants in the research engage with it (Ghosh 2020). The fourth principle of reflexivity applies in online ethnography and ethnography *in situ.* The unorthodox principle enables anthropologists to go beyond academia, beyond disciplines, and beyond the standard (Ghosh 2020).

I initially performed an online ethnography on Facebook mothers' groups to approach my target group. Using my social network, as informants, I addressed four Facebook mothers' groups, namely, "momslife, "Γυναίκα-έμβρυο-γέννα-βρέφος-παιδί-θηλασμός (Woman-embryo-child-lactation)", "Εθελοντική Ομάδα Υποστήριξης Θηλασμού Αττικής (Volunteers Supporting Lactating Group-Athens), and "Γέννηση χωρίς βία (Birth without violence)", as I have already mentioned in the population section. Three of them accepted me as a member and permitted me to upload the informational letter. In the first two groups, I posted the informational letter with a specific reference to the vaccine discourse of pregnant women regarding COVID-19, using more approachable language and following the recommendations of the research protocol reviewer Professor Rebecca Bryant about the usage of simpler language in the

informational letter. The difference with the last group was that I posted after the administrators approved my request to become a member. Learning from the lack of response in the aforementioned groups, I employed a different strategy for the fourth one, namely the "Γέννηση χωρίς βία (Birth without violence)". I sent the group administrators the informational letter before posting it, requesting them to answer me if they agreed with the content and if it was in alignment with the group's code of ethics.

The counterproposal of their part was to recommend that I delete any reference to vaccination against COVID-19 during pregnancy in the informational letter to receive any answers, since the COVID-19 vaccination topic had provoked heated discussion following the initial recommendation of COVID-19 vaccination by the HSBG one year earlier. The argumentation of the administrators regarding the aforementioned amendment to my direction led me to the second alteration to my research protocol. This time I had to change the main research question from "How do pregnant women are affected by COVID-19 vaccination governmental discourse in relation to their situation?" to "**How do pregnant women experience pregnancy during the coronavirus period**?". The vaccination aspect was only a dimension of the research, not the main part. This amendment allowed women to narrate their experience in their way.Before this alteration of research direction, I informed my supervisor Drs Berfin Yurdakul who consented to it and commented that the vaccination against COVID-19 topic was not that crucial to pregnant women as at the period that was first recommended.

To follow the people, the life history as a special case of following plot (Marcus 1995), I managed to conduct eighteen interviews in total. According to the participant's request, seventeen were carried out online, and one was by telephone. The interviewees also decided on what time the interview would be conducted. Mothers with very young infants usually proposed me to have the interview late at night to ensure that the baby was fed and asleep.

The conducted interviews were primarily formal, and the type was in-depth, open-ended semi-structured ones. I selected this type of interview since this type focuses on the interactively produced meanings and emotional dynamics of the interview itself, and though the focus is on the participants' story, the researcher's words, thoughts, and feelings are also considered (Ellis et al. 2010). To conduct the

formal interviews, I developed an interview guide based on semi-structured questions, which adjusted to every interview's needs. Each interview started with the general question, "How is it to be pregnant during the coronavirus period? and whenever it was necessary, I navigated the participants by asking them the semi-structured questions prepared. What mattered to me the most was allowing the participants to articulate their stories and how they felt more comfortable. Hence, the way they provided me with their answers was either in a life-story narrative or more like a question-answer style. I reassured those participants who expressed their worries about whether they had responded in the "proper" way that there is no such thing as a "proper" way.

Consequently, I remained flexible regarding the order of the questions and, occasionally, the content itself, based on the participants' narratives and recommendations. I considered it more like an ongoing process, as the outcome of the communication between the participant and me, rather than something solidified and predetermined. I let the field whisper to me its magic. The outcome was to become a more confident interviewer after each interview, and this confidence was channelled to the participants, despite our digitally mediated communication, and their narratives became progressively more enriched in data. Following the recommendation by Alexia Maddox in "Doing fieldwork in a Pandemic (Lupton 2020), before the closure of each interview, I asked participants if they would like to add something more that I might have overlooked as a way to engage them once more in the discussion and show my appreciation to their contribution to my research. As it was proved, all participants had something to add. The time we talked about their pregnancy experience during the COVID-19 period stimulated their memory, and more details and even more targeted information were shared with me after permitting them to put themselves in my shoes. I acknowledge that their recommendations and ideas assisted me in becoming a more focused listener and, therefore, a better researcher.

The mediums that I proposed to the interviewees to carry out the interviews were the Voice over Internet Protocol (VoIP) technologies, namely the Zoom conference platform, Skype software, Viber, WhatsApp, and Messenger instant messaging apps, since they enable the replication features of face-to-face interviews (Lo Iacono et al., 2016) by allowing for real-time interaction involving sound and video (Archibald et al., 2019). The real-time nature of the exchanges can resemble the "honesty" of onsite interviews as the dynamic environments prevent participants from overthinking their

answers or considering the most socially desirable responses (Mann and Stewart, 2000 in Howlett,2021). Video calling also allows researchers to access verbal and nonverbal cues, providing an equally authentic experience to in-person interviews (Sullivan, 2012, in Howlett,2021**).**

To follow Marcus' Metaphor and Conflict, I conducted netnography through online observation of Facebook mothers' groups posts and YouTube platforms, and social media profiles of the policymaking bodies regarding pregnancy and COVID-19 to collect data from promotional initiatives such as videos and spots regarding the experience of pregnancy during the coronavirus taking into considerations the dimension of vaccination against COVID-19 during pregnancy in Greece. COVID-19 vaccination anxieties and how mass media and the governmental discourse towards the hesitant ones turned people to online communities. Participants use pseudonyms in those communities, which give the sentiment of avoiding surveillance and safeguarding freedom of expression. This "deindividuation" may stem from the desire for someone to maintain her/his/@ privacy, comfort, and freedom to create a new image (Muslimin 2020, 493). The concealed risk is a reduction in private self-awareness and accountability, resulting in lower self-regulation and concern for the reactions of others, and is brought about by an individual not being identifiable or distinguishable in a group (Omernick and Sood 2013). Therefore, I chose to be a "lurker" and not a participant in those online groups to observe how different discourses unfold on COVID-19 vaccination anxieties in pregnancy expressed in these groups without my intervention.

For archival analysis, I conducted research also on biomedical guidelines published by international, European, and local biomedical bodies, such as WHO, CDC, ECDC, the Greek Ministry of Health, the Greek National Public Health Organization, and the Greek Hellenic gynaecological and obstetrician society. Furthermore, online research on scientific papers using keywords such as pregnancy and COVID-19, COVID-19 guidelines, vulnerable groups, obstetric violence, vaccination anxieties, resistance, and any other concept the field indicated to me, as I will present in the findings. I employed Google Scholar, PubMed, WorldCat engines, and anthropological journals for this research.

Triangulation

To triangulate the data, I deployed three different methods of collecting the data as they were described in detail in the data collection part. In brief, I repeat them here as well. I started by conducting archival analysis of online research on biomedical guidelines published by international, European, and local biomedical bodies and scientific papers using keywords such as pregnancy and COVID-19, COVID-19 guidelines, vulnerable groups, obstetric violence, vaccination anxieties, resistance, and any other concept the field indicated to me, as I will present in the findings. Then I proceeded to conduct online semi-structured in-depth interviews, and I also employed netnography through online observation of Facebook mothers' groups and YouTube platforms and social media profiles of the policymaking bodies. The row of research methods was not necessarily linear, but I would support that it was supplementary and interlinked.

Data analysis

I proceeded to the coding of data, employing the theoretical framework that I had initially used to navigate myself to the field, namely Foucault's theory on biopolitics and how biopolitics is understood in the Foucauldian sense, meaning how biocitizenship disciplines and controls subjects even as it affords them certain rights (Shapiro 2019, 358), being in a COVID-19 state of exception, as Agamben demarcated it. Within this neoliberal state of exception scenery, I employed the three perspectives of the body as they were defined by Douglas and Scheper-Hudges in the paper "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology" (1987) by classifying the body as the individual body, social body, and the body politic.

Additionally, I employed the constructivist grounded theory approach (CGT) as developed by Charmaz, which enables the field to speak, namely, to uncover and explain patterns and variations through the constant comparison of the data (Bitsch 2005). This approach allowed me to consider and assess all possible theoretical understandings of the collected data, including my new theoretical constructions (Charmaz 2017) and my positionality, by developing tentative interpretations of the data through constructing codes (Charmaz 2017). The result was the emergence of additional theoretical concepts for data analysis. These concepts were "mothering", "obstetric violence", and "vaccine anxieties".

Firstly, to create the codes, I had to transcribe the interviews and scrutinize the content of the data collected through ethnography. For the transcript of the interviews, I used the HappyScribe transcription software since it provided transcription in Greek. However, editing the interviews was a step that I could not avoid since the transcription was not accurate enough. Nonetheless, this process was productive since I acquired the first aspect of potential codes. After editing interview transcripts, I employed NVivo to code the interviews and online observation data further, considering the theoretical framework and the new data from the field, following Charmaz's constructivist grounded theory. NVivo software package allows detailed analysis of specific topics within other broader issues; once you have all the information encoded, it provides a systematic process in research, increasing the validity and reliability of the study (Zapata-Sepúlveda et al., 2011, 382).

Part 3.

The voice from the field-Findings

Chapter 1. Performing mothering in Pandemic

Pandemic, my love!

> "**PANDEMIC**! It's a PANDEMIC". A young doctor rushed out the door of the haematological ward overtaking and ignoring us, screaming in despair, "It's a pandemic!" For a moment, we kept staring at each other, wondering what was happening. And then we were petrified when hearing, "We shut up everything, we cease every protocol". That was the first day of the official announcement that the country was officially entering the state of a health emergency. It was the initiation day of my IVF (in vitro fertilisation) process as well. On the day of ovary harvesting, the government announced a curfew. We left our house at six in the morning that day without having any papers on us justifying our movements. Fortunately, nobody stopped us! Three other couples in the same situation were stopped by the police and arrived at the hospital utterly freaked. Not to mention the scarcity of medicines, the injections, all imported from Italy. IVF during a pandemic, no, don't try it!" as Barbara colourfully narrated to me.

I was shocked at hearing this narrative and put myself in her place. How I would have reacted when my IVF depended on it, and this process could not proceed because of the pandemic. How despaired and helpless, borrowing the characterisation made by one of the interviewees.

Emotions of fear, anxiety (Molgora and Accordini 2020, Draganovic, Bosankic and Ramic 2021, Parlapani et al. 2020), stress and feelings of despair, anger and alienation were experienced during the coronavirus pandemic by pregnant women, according to their narratives, when they had to concurrently negotiate maternal distress, namely women's response to the transition to motherhood, related to the changes to their bodies, roles, relationships and social circumstances; birth experiences; and the demands, challenges, losses and gains associated with being a new mother (Draganovic et al.2021,50). The most prominent of all emotions were fear and anxiety.

> According to Mary's narrative: "I was anxious for both of us, but principally I was afraid of any potential complication to the fetus. Until

then, it was not sure what might happen to the fetus if its mother got infected by the coronavirus. Is it transmitted to the child, or is it not? Will it get harmed?"

Fear about their health and the health of their fetus and/or newborn was strongly related to how interviewees perceived their role as mothers and how this was performed as mothering. Starting by delving into the concept of mothering, **mothering** refers to female experiences of mothering, which are female-defined and centred, potentially empowering women (Jiao 2019,542) and transcends all three perspectives of the body, namely the **individual**, **social** and the **body politic** (Scheper-Hudges 1987) Even though mothering may include other actors except from mothers, such as nannies, fathers, grandmothers, aunts, sisters, foster mothers, adoptive mothers, surrogate mothers, stepmothers, coparents, females from the same human community or nonhuman primate group, teachers, and wet nurses (O'Reilly 2010), for the purposes of this thesis I limited the potential actors to human-mothers.

Under the concept of mothering, maternity is no longer seen as a fixed, static state; instead, it is viewed as a set of ideas and behaviours that are mutable and contextual (Jeremiah 2006,21). It is a culturally informed activity shaped by and shaping the work and authority structures within which women live (Barlow and Chapin 2010, 330). It is a kind of work that involves protection, nurturance, and training (Jeremiah 2006,24). It is a form of ethical behaviour, relational subjectivity and expressivity (Jeremiah 2006,27). This perspective **ascribes agency to mothers**, giving rise to the view of mothering as a socially engaged enterprise (Jiao 2019, 542), allowing women to experience their personhood, in this case, **motherselfhood** (Chandler 1998 in Jeremiah).

Personhood has two aspects. One relates to formal ideas and culturally established concepts and regarding motherselfhood is related more to motherhood as an institution, namely, to the patriarchal institution of motherhood that is male-defined and controlled and is deeply oppressive to women and which aims at ensuring that that potential—and all women—shall remain under male control (Rich in O Reily 2004,2). It is the practice that assigns mothers sole responsibility for **motherwork** but gives them no power to determine the conditions under which they mother (O' Reilly 2004,5) and comes as the obligation and responsibility to place the fetus' needs as primary, as their "first maternal duty" (Cummins 2014, 41).

The other aspect of personhood refers to the **practice**, namely what people actually do and how they negotiate interactions in their lives (Strathern and Steward 2011 ed. Mascia-Lees 2011,389). I predominantly focused on the second aspect to explore their "**Now-Time**" (Strathern and Steward 2011 ed. Mascia-Lees 2011) encoded in their memories' experiences through their narratives regarding how they performed mothering as pregnant women and new mothers and how they enact their agency in a state of exception, such as the one imposed during coronavirus period. Their agency regarding mothering during the coronavirus was related to the way they opposed to or complied with the biopolitical measures applied during the COVID-19 period, namely self-isolation, social distancing, restriction of movements, curfews and lockdowns, closed borders, mandatory vaccination, tested and quarantined people in the name of biosecurity (Manderson et al. 2021,128). The opposition or compliance was instantiated through acts and practices. Additionally, I have to declare that even though I prefer to attribute the concept of mothering to my participants, I occasionally employ the concept of motherhood whenever it emerges in the participants' narratives. I consider these two concepts complementary and interrelated since they are under constant conceptualisation as cultural terms.

I started by examining the motherselfhood mothering dimension. **Motherselfhood** was experienced in multiple ways by the interviewees. Some women sustained that they enjoyed being pregnant during the coronavirus period, others experienced it as a lonely time, and others had mixed feelings. The subjective way of experience was related to multiple factors. Some women yearned to have a child, so the moment they achieved this, no matter if they experienced it in the coronavirus period, they decided to relax and savour this period with their partner. Due to teleworking and diminished work commitments, they had time to devote to their pregnancy.

> As Susana said, "Teleworking acted as a relaxing factor to me. I had my own rhythms. I spent enough time with my partner in tranquillity. I did not feel that I missed something because I was unable to do anything due to the lockdown. I did not feel the restrictions of pregnancy so much as well due to curfew measures".

Others, because of the curfew measures and the uncertainty caused by COVID-19, expressed that they missed their pregnancy; they did not experience it as they had imagined. The imaginary of pregnancy was lacking. Location and the period of

coronavirus were other parameters that affected the interviewees' experience, as I present later in the text.

Starting the exploration from those who had time to savour their pregnancy, a term Nicky used and engraved on my mind was the adjective "**fearless**".

> ''My pregnancy made me feel "fearless," Nicky said and continued, "since I surrogate a baby, even if I got infected by the coronavirus, I do not think that something bad will happen to me. Maybe I was frivolous, but this was how I felt, that I am protected since I will bring a child into this world".

Her narrative made me recall what Cohen-Shabot supported in her paper (2015, 233) regarding the labouring body and its resemblance to a healthy, powerful body that has much more in common with the dancing, running, or erotic body than it does with the pathological body in need of cure and healing. I imagined that interviewee as a pregnant Jean Grey from the Marvel Comics Universe, representing life that has not yet been born and the forces of creation and destruction[6]. In this case, only a creature of creation. However, this fearless woman had incorporated the biomedicine discourse that classifies pregnant women as a vulnerable population, especially during the COVID-19 period and allowed herself to be pampered by her surroundings making use of this as an argument to justify the savouring of pampering. Nicky's exact words were:

> ''Being pregnant constitutes a vulnerable situation in a woman's life. So, I deserved to be taken care of by the others, and indeed they pampered me. I savoured their interest''.

Another metaphor that Nicky used was following the findings on "Live experiences of pregnancy and motherhood in the Bosnian women during COVID-19" (2021) regarding the strengthening of family tights during the coronavirus curfew. She used the term "**nest**" for being together with the members of her nuclear family and spending time together.She described this feeling of the nest as follows:

---

[6] "Phoenix Force (Earth-616)." Marvel Database. Accessed June 30, 2022. https://marvel.fandom.com/wiki/Phoenix_Force_(Earth-616).

> "We were strong in our nest. I was teleworking, my husband was teleworking, we were together. It was not the common practice in the pre-COVID-19 period".

The switching to teleworking facilitated the bonding of the family members and allowed her to relax and enjoy her pregnancy since her work requirements had been diminished. Hence, she was more in control of how to practise mothering.

Another interviewee, Pauline, referred to the bonding between her and her fetus during the coronavirus period.

> ''I was alone at home, and I could take care of myself and the embryo, sine the embryo makes a lot of things in the belly. It is amazing to carry a living being inside you; you are experiencing all of these alone, so you feel them more intensely''.

In this context, she experienced her mothering as relational, as Jeremiah (2006,24) puts it, she developed interaction with the fetus as a desiring subject without the daily stress of the pre-COVID-19 period. Hence, she commenced practising mothering as pregnant, preparing herself for her new relational identity.

Nonetheless, some participants expressed frustration because they thought they missed their pregnancy experience due to coronavirus restrictions.

> "I did not understand my pregnancy. I missed all its beauty, meaning going for walks, taking exercise, "enjoying my belly and my last period without children and responsibilities. I didn't enjoy it. We had a lockdown. Around us, people got sick, so we had to distance ourselves to avoid getting sick", according to Zoe.

In her case, the coronavirus period operated dissuasively to experience the pregnancy as she had imagined.

The imaginary of a pregnancy period emerged through various narratives. It was connected mainly to the social aspects of surrogation, the relational ones. Interviewees were disappointed because they could not share their experiences or joy with their close relatives and friends. They could not share their social body (Scheper-Hudges and Lock 1987), their new subjectivity as mothers who practise mothering. Pregnancy is considered a major liminal transition for women, as a role transition to mothers in a short period (Sohn and Bye 2014, 66). My interviewees could only partially formulate their new subjectivities as mothers-to-be. It seemed like they were not able to fully engage in the social engagement aspect of mothering (Jiao 2019, 542) since they felt

that the rite of passage to maternity could not complete. This loss of the imaginary of pregnancy was harsher during the first period of the coronavirus. Zoe shared with me her experience on this:

> "I couldn't enjoy my pregnancy. I once told my partner that a friend of mine had a photo shooting of her pregnant belly, and I would like to do something similar, and he replied: Are you serious? What will we text? That we are doing the photo shoot for exercise? Think rationally".

There were cases where no one had seen these women pregnant. There is a prejudice in Greece regarding pregnancy. It is a common practice for pregnant women in the first three months of gestation to avoid announcing their pregnancy for fear of a miscarriage. During the coronavirus period and the unexpected new situations that everyone had to adjust to, the announcement was skipped, not because women did not want to share their new condition, but because they wanted to show it off instead of saying it. They wanted to have this intimate moment with their close ones.

> As Barbara said, "The funny part was that no one saw me pregnant. I started telling some close friends that I was pregnant in the seventh month, but no one from my friends had seen me pregnant. If it weren't for the coronavirus, I had planned to see my friends during the Christmas holidays, and I wouldn't have to tell them anything since they could see my condition. However, because of the coronavirus, nobody saw me pregnant''.

Still, it did not work this way, especially during the first period of coronavirus, where everything was covered by unpredictability, uncertainty and fear of contamination. In the global north, this network is based on the perception of common descent, which in turn implies some sort of "sharing of life experiences and sociohistoric circumstances that might be remembered, relived, celebrated or passed on to its descendants" (Rezende 2011). In this sense, pregnancy may be seen as a liminal stage in which kinship relations become reconfigured, invoking the participation of various members through actions, knowledge, and emotions (Rezende 2011). In other cases, the curfew measures prohibited any movement. Therefore, their close family and friends might be aware of the pregnancy; however, they could not have physical contact with them, touch pregnant women's transforming bodies, and establish an

intergenerational relationship between a fetus and its grandparents. As Ismini colourfully pointed out:

> "It was such a massive change in my life, and there was no mirroring of it from the outside".

The mirroring of a situation or a transition period like the pregnancy requires a counterpart so that the pregnancy becomes a social event, and the counterpart, due to curfew and restrictive measures, is met with hardships''.

In the following part, I describe the deficit of the social aspect of pregnancy and how it was conveyed by the participants' narratives.

Not even a shower party!

Imagine entering a room in a maternity hospital right after the birth of a child. The smell of the flowers suffocates the air, piles of fluffy teddy bears in the colours of rose and blue, colourful bags with baby clothes and accessories are packed outside the door, while noisy, talkative, smiley individuals are chatting about the arrival of the new baby. A version of a Greek shower party. Inside the room, the newly giving birth mother sits on her bed trying to breastfeed her infant, while the proud father and her mother stand at her side. New social roles and identities are established for everyone present in the room at that moment with that ritual practice. And then, there was the COVID-19 outbreak.

The scenery now is different: empty corridors filled with silence, and only the sound of a crying infant may break it. Inside the rooms, the new mothers are accompanied only by their partners, and only if they cannot be present, a close relative substituting them. The social event becomes more private and restricted to the primary members of the nuclear family, contributing to a more substantial unmediated bonding among them. This is how many interviewees who gave birth in a maternity hospital described the new normal.

> As Mirto characteristically put it: "It had a positive aspect: prohibiting visitors to the maternity hospital. It felt nicer than my first birth since no distant relative could enter the room. This time we were alone with my husband and baby".

However, there have been narratives that missed this type of sociality, stressing the loneliness of the couple right after childbirth, standing there alone without their support network. They missed this mini celebration in the maternity hospitals' corridors, their chance to share their joy of delivery with relatives and friends. The lack of sharing of these moments was mentioned, especially by first-time mothers. A gathering outside a maternity room celebrating the social event of birth constituted a **Now-Time** experience (Strathern and Steward 2011 ed. Mascia-Lees 2011) for them. Its absence was equated to a gap in their lived experiences, the undone that they would be unable to recall and therefore pass on to their children, as Pauline described to me:

> ''When I gave birth, it was a little bit depressive at the hospital because we were alone with my husband. Only my mother could visit us. I remember when my sister gave birth in the same hospital some years ago; there were flowers, relatives, and balloons outside the room. In my case, unfortunately, this was not the case. We were alone with my husband''.

Hence, the prohibition of such gatherings in maternity hospitals acted for the coronavirus mothers as a lack of recognising of motherhood as an institution since they did not have the opportunity to experience this type of ritual.

Eat candies!

> "I was sitting alone and unaccompanied, due to COVID-19 protocols, in the waiting room of the radiologist's office to monitor my baby's development. I was alone, and I pretended to be cool. Well, I was not! I was damn anxious!
>
> "My dear, everything is fine. The baby's development is the proper one, but I cannot see his nose", said to me the physician.
>
> I froze. The nose is an indication of DOWN syndrome, I thought.
>
> "You cannot leave until we see his nose on the screen. So, please go outside and start eating candies and chocolates and come back!" the physician requested me.

> And I stepped out of his office to the empty waiting room, devouring candies like a lunatic.
>
> And the baby turned.
>
> "Everything is ok. Look at the baby's nose. He is ok." The physician reasuured me.
>
> And I burst into tears! I hadn't realised how freaked I was".

That vignette is indicative of Barbara's stressful experience, placing the fetus' needs as primary as her "maternal duty" (Cummins 2014, 41) in the technocratic model of birth, and the deficit of control over her own body, as her complacency with the provided biomedical orders were indicative of the way the institutional motherhood is incorporated in women's identity, even if not consciously. Additionally, being there alone, without her partner, hindered her from experiencing the **relational aspect of mothering**. Most of the participants in the research had to attend their prenatal medical visits alone without their partners.

Prenatal health care appointments within the frame of medicalisation of pregnancy and motherhood as an institution are considered a prerequisite to ensure fetus health. According to the no 43 Hellenic Society of Obstetricians and Gynecologists (HSOG) guideline in the prenatal care paragraph explicitly states that any hygienic rules provided by any medical association in Greece regarding the preventive COVID-19 measures during medical examinations, tests and appointments should be followed. These measures include wearing a mask, medical tests only after an appointment and the unaccompanied physical presence of the person who has the medical appointment. However, there were variations related to which coronavirus period a woman was pregnant, where she resided, if she had to undergo medical tests, and whether the appointment took place in a private office or public hospital. Usually, in the first year of COVID-19 and shortly after the initiation of vaccination to pregnant women, namely May 2021, the measures were stringent, so the health professional applied them. Later on, there was more flexibility regarding pregnant women's partners' presence during prenatal care appointments. Pregnant women, due to the health emergency and the fear of contagion that was systematically promoted in the state discourse, behaved as docile biocitizens, performed biocitizenship from

above, constructing a normative body (Happe et al.2018,4), and complied with hygienic measures.

Nonetheless, independently of the coronavirus period, the interviewees stressed the importance of the presence of their partner, especially at ultrasounds appointments. I will borrow the term "**pregnant couples**" as it was employed by Claudia Barcellos Rezende in her paper "The experience of pregnancy; subjectivities and social relations" (2011), since I think it is the most suitable one to describe how the interviewees considered the presence of their partners in the prenatal care appointments. In the pregnant couple, the partner (men in the original text, but I choose to use the term "partner" as a more inclusive one) is expected to participate in the choice of medical specialists, attend appointments and exams, birth preparation courses, labour and delivery (Rezende 2011,535). In most cases, this was not feasible, causing annoyance to the pregnant women. Georgia's narrative depicts this irritation.

> "I felt that it was not fair for my husband. It is bad to treat the father of the child this way. Father's child has every right to watch the baby in ultrasounds, to talk with the physician, as much as the mother has. He is not only a sperm donor. He is half responsible for the creation of the baby. It is unfair what is being done".

Some of them, within the frame of agency, improvised and used their cellphone cameras during the ultrasound examination to share that parenting moment with their partners who were not allowed to be present.

> "My partner was not allowed to be present at the perinatal appointments, so I used video calls from my cellphone so he can see me during the medical examination because I was stressed. You know these medical tests could be very stressful".

On other occasions, in response to the sentiment of injustice, couples' needs to create shared memories and the need for social expression of imminent parenthood, there were health professionals who, in exception, after having empathised with the pregnant women, permitted the presence of their partner in the appointments occasionally and mainly in private offices.

No matter what the health professional would do during a prenatal appointment, the mothers to be should remain healthy, and to achieve that they proceeded to the adaption of extra self-regulated measures as I will present in the next section.

Living in a fishbowl!

> "I wanted to travel for work reasons to another city, but I didn't do it. What if I got infected because of the trip? How would my partner deal with it? I was thinking about what was the more responsible thing to do for doing. Not to mention that I was perceived as a member of a vulnerable group because of my pregnancy. So, I did not go".

The above-mentioned slightly paraphrased narrative of Rosie is indicative of the way the majority of the participants thought and acted during COVID-19 in order to safeguard their health and the health of the fetus. To do so, they implemented multiple preventive measures as mothering strategies.

These measures were either to **self-regulate** themselves, regulate their immediate social environment, or both. I interpreted their strategies as **agentive**, which nonetheless stemmed from docile bodies in a predetermined COVID-19 biopolitical framework. According to Sawicki (1999), the notion of docility does not necessarily mean passivity; instead, docility is about creating bodies that are useful in policing themselves. Sawicki (1999), for instance, argues that discipline aims "to render the individual both more powerful, productive, useful, and docile." In this way, the body becomes a productive part of the machine that drives society (Cummins 2014, 35). Hence, pregnant women policed themselves during the coronavirus period by implementing preventive measures. Implementing such measures were linked to the **emotions of fear and anxiety** that my interviewees experienced during the coronavirus period, and it was a way to deal with the uncertainty of the coronavirus and the implications on their health and the health of the fetus.

> Lila's narrative is characteristic: "I was anxious about my health and the health of the fetus, but mainly about the probability of any complications to the fetus that they didn't know about. When I was pregnant, it was unknown what might happen to the child if the mother got sick from covid."

It seemed like the docile bodies had no alternative but to proceed to even stricter practices to deal with the unknown, especially during the first period of the coronavirus**.** **Self-regulation measures**, I would dare to sustain acknowledging my intersubjectivity, were related to the anticipation of a successful surrogation outcome; they were in alignment with the exertion of biocitizenship from above during the coronavirus, a biocitizenship which was constructed and designed to construct a normative body (Happe et al.2018,4). The discourse of selflessness as central to ideal motherhood affected women's perceptions of their optimal choices (Shabot and Korem 2018, 392) in safeguarding the health of the fetus and the baby. The types of implemented self-regulated measures were multiple and depended on the coronavirus period, the age of pregnant women, and whether women were pregnant or/and first-time mothers or not.

In a health emergency period, where pregnant women's bodies and behaviours have been attempted to be regulated through confinement regulations, pregnant women have been conceptualised—according to the risk discourse—as doubly at risk since they were responsible for more than their own bodies (Wilson 2019,500). They were requested to act as self/individual risk managers on a public health issue, trusting at the same time the governmental, quite often, controversial discourse about their safety.

Fear and anxiety were more prominent during the first period of COVID-19; consequently, the self-regulation measures were stricter on most occasions, especially in first-time mothers between the ages of 35-42, since they were more in anticipation of a child. Therefore, their self-regulated practices embedded confinement in the house with the sole companion of their partner, rare movements almost exclusively to perform prenatal care appointments, seldom interactions with family members outside their nuclear family, and implementation of extra hygienic measures through, for instance, the purchase of specialised equipment. As Zoe referred to me:

> I communicated through video and telephone calls, but I didn't have any help. I didn't allow anyone to enter the house. There was a breakdown in the geyser, and I told them you would repair it outside the house; otherwise, he should wear a mask, take off his shoes and wash his hands.

If Zoe was highly cautious before the childbirth, Dioni became utterly cautious right after the birth, by the arrival of the newborn to the house and until it turned one month old. Following the recommendations given to her and her spouse by the medical staff of the maternal hospital about the risk of COVID-19 infection to new infant health,

she transformed the house into an almost sterilised place. Disinfection became a prerequisite for the entrance and exit from the house, and grandmothers were obliged to wear disposable robes. As for her husband, he had to take a shower in a different residency before entering their house due to the nature of his work. After the shower, he had to put on a disposable robe too. Any social interaction apart from the three mentioned members was forbidden. Even the groceries took place only online.

In almost all cases, close relatives respected the decisions of the pregnant, which prioritised their child's benefit, followed the restrictive measures meticulously and kept a distance to safeguard the newborn's health. In only one case, in anticipation of a grandchild, a grandmother could not help herself and visited the newborn within his first week to "pay her respect", paraphrasing the interviewee's narrative about the "royal baby" visit.

The limited visits among close relatives were applied to vice versa; namely, when a new-baby family was a COVID-19 positive case, the new parents took all the preventive measures to avoid exposure elderly parents to COVID-19 infection. The avoidance of the use of the residency elevator was an indicative strategy.

Exceptions to the measures mentioned above took place. Few couples were cautious, but they did not take any additional preventive measures other than the imposed one by the state of exception and allowed visits to their houses even during the first coronavirus period.

> Tina was one of these few cases. "We were not from these families that got afraid. So, some people were visiting us".

Regarding the work and the way interviewees perceived it as a precarious condition or not, there were variations. Some women stopped their work, using that Law 4682/2020: "Urgent measures to prevent and limit the spread of coronavirus", which embedded them in the vulnerable groups, or made use of the leave regarding a threatened pregnancy to minimise any potential exposure to COVID-19 infection to the work environment and during their movements from and to work. Those who continued to work performed teleworking using online Voice over Internet Protocol (VoIP) technologies, namely the Zoom conference platform, Skype, and any other online teleworking environment. In cases that the type of participants' work necessitated the meeting with clients physically, pregnant women and new mothers took all the

preventive measures, namely mandatory mask-wearing of high efficacy, open windows, distancing, prohibition of physical contact, well-ventilated space and occasionally face shield mask and equipment for air sanitation. Nonetheless, there were two cases where women decided to continue to work, one in the first period during the general COVID-19 lockdown and the other in the second period with the implementation of mini lockdowns. In the case of Georgia, who chose to go to work amid the general coronavirus lockdown, work was perceived as a distressing factor in coronavirus confinement.

> "I continued to go to work at the hospital until the last moment, until the eight-month, by my own choice. I just wanted to go somewhere, go out of the house, and I chose not to come out as a person belonging to a vulnerable group".

Relevant to pregnant women who had another child in preschool age, such as Dioni, Elli and Marcella, they decided either not to send it to the nursery school or to limit their attendance to avoid exposure to COVID-19 and to other viruses, mainly during the autumn and winter months. Marcella, in particular in fear of a potential premature birth, decided, with her husband, to keep her toddler home away from nursery school and practice home-schooling.

My interviewees, as active agents of their condition, did not limit themselves to the adoption of self-regulated measures but proceeded to the adaptation of self-care measures as an expression of nurturing agentive practices to ensure their well-being, facilitating the experience of mothering during the stressful coronavirus period.

I didn't cut off from mister "psy"!

> "I did not stop my psychotherapy. I kept going, and I think that if I was not already in therapy, I would have started it during the coronavirus period".

This part of Barbara's narrative describes only a way that pregnant women selected to perform **self-care strategies,** and it is indicative of the application of **coping strategies** to deal with the double complex situation, meaning pregnant in a pandemic. Self-care strategies and coping strategies were representation of agentive **practices of motherselfhood**, namely what the participants actually did and how they negotiated

interactions in their lives (Strathern and Steward 2011 ed. Mascia-Lees 2011,389), to mitigate both the emotions of fear and anxiety that COVID-19 uncertainty provoked to them, and to safeguard their health and the health of their fetus/baby.

I employ the definition of the Oxford Living Dictionary regarding the concept of the "**self-care**" as the most suitable applied in the COVID-19 period, following the argumentation of Butler et al. (2019,107-108) regarding the application of self-care strategies as mitigation strategies to take proactive steps to enhance resilience and overall wellbeing, and not strictly connected to work-related settings. Hence, the Oxford Living Dictionary defines self-care as "the practice of taking action to preserve or improve one's own health, wellbeing and happiness, particularly during periods of stress", like the coronavirus period.

Individual self-care strategies indicate a way pregnant women practice their **agency** to cope with the "**abnormality**" of the coronavirus period for the benefit of their wellbeing. How they performed and experienced their personhood as pregnant women, namely how they did and negotiated interactions in their lives (Strathern & Steward 2011 ed. Mascia-Lees 2011,389) during the COVID-19 period. There are multiple categorisations regarding self-care individual practices. For the purposes of this research, and in relation to the findings, I focused only on three of them, namely the **physical**, **psychological**, and **emotional** coping strategies, excluding the work-related ones. Physical self-care can be thought of as actions to promote one's physical wellbeing (Bloomquist 2016, 293).

Starting from the **physical mitigation strategies**, some interviewees referred to their attempts to undertake mild physical exercise, namely walking, since it was the only thing permittable the period of the imposition of harsh coronavirus measures regarding the restriction of movement. During the period of general and mini lockdowns, especially during autumn, winter and early spring months of the two years and more of the coronavirus period, my interviewees could only walk outside and not participate in any other form of physical activity since any other physical exercise in athletic indoors centres were not permitted since those premises were closed. Especially during mini-lockdowns, they walked outdoors either alone or accompanied by friends. As Nicky said:

"Walking with friends was an outlet from the coronavirus situation".

Regarding the **emotional copying strategies,** interviewees referred to meetings with friends, attending social events, going on holidays and biosocialising in cyberspace. Meetings with friends usually took place in open spaces, keeping distances and wearing masks occasionally, and under the prerequisite, the lift of movement restrictions. As Ioli said:

"We met with friends without kissing and hugging each other".

Some interviewees perceived the deficit of expressing physical affection as an expression of respect for a woman carrying a baby amid a pandemic. Rebecca, who joined a social event to mitigate the emotional pressure of being pregnant during the COVID-19, described how the rest of the guests treated her.

> "Who was going to approach a pregnant woman with her belly visible to kiss her? No, this cannot happen. I was in the seventh month; my pregnancy was noticeable".

In this case, she stressed to me that she had pondered on both the objective and subjective dimensions of risk, and she participated in it only when she was guaranteed by the organisers that her health state would not be endangered, meaning that all the guests and the priest of the baptism were vaccinated.

Decompressive was also the decision of some interviewees to go for holidays during summertime, especially in 2020. So, the motivation was the same, but the subjectivities varied due to how pregnant couples had decided to experience pregnancy during the COVID-19 period. Those who had internalised the governmental discourse to a larger degree and, due to previous misfortunes regarding miscarriages, had adopted extra self-regulation measures and consequently decided to be on holidays, but in an isolated and protective way.

> "The only thing we did was go from our room to the beach and back. In the restaurant, we were sitting apart and at a distance from other clients to be able to take the mask off. We tried to make our holidays as safer as possible due to COVID-19", Rebecca mentioned.

On the other hand, others were more relaxed relevant the infectiousness of the virus and decided to visit an island but avoided mingling with other people in small alleys, following the recommendations of their health professionals.

Attempts to socialise in the physical world entail risk due to the pandemic. Consequently, some participants decided to perform digital mediated **biosociality**. Rabinow first used this concept to conceptualise new social groupings in

the context of the Human Genome Initiative in the USA and France by examining how genetic knowledge and techniques bring about a literal redefinition of self and social identity (Petryna 2003, 14). In this sense, as Rabinow subsequently suggested (2008), it might be considered an experimental tool for examining the interface between recent developments in the life sciences, social practices, and individual and collective subjectivities (Valle 2015). Pregnant women are not suffering from any rare disease, albeit the attempts to medicalise their pregnancy period. Instead, as some interviewees did, they organised into online groups to share their common experiences, concerns, and general knowledge. The need to socialise and communicate with women in a similar situation was significant according to Ismini's following narrative:

> "I found one group which prepared women for pregnancy experience, and I joined it. It helped me a lot, even if it was once per week; it helped me to be able to share my experience of pregnancy and to talk about it."

It was the need to share maternal experiences that led some of the interviewees to exert biocociality. As Friedman sustained in her book "Mommy blogs and the Changing Face of Motherhood", moms blogs and groups, in this case, give mothers a voice, and foster conversation and participation in a community (Friedman 2013,11), allowing them to perform new forms of maternal subjectivity. It was like an answer to the quest of belonging to the social group of pregnant women in confinement. This is characteristically described in the following Sousana's narrative:

> "We did it all through Zoom. We did not have any human interaction. I missed being with other people, especially with other moms who are pregnant too. I missed being with people who feel how I feel. I looked forward to our online meetings, the bonding among us, even if it was through ZOOM".

Hence, online moms groups operated as a substitute for relationality in physical space, fostering the need of pregnant women to belong to a group where they could share their feelings, emotions, anxieties, questions, and empathise. Hence, in this case, belonging constituted by and through emotional attachments and was considered the belonging as emotion mediating in creating subjectivities, collectivities and places (Halse 2018).

Another type of emotional copying strategy was the initiation of foreign language lessons as a way to communicate with the rest of the world, according to Pauline.

Communication with their social networks, meaning relatives and friends, was also transferred online or through telephone calls, especially during the first period of the coronavirus. It was the indicated way to keep safe all parts and, at the same time to provide emotional support, even if it was digitally mediated.

Some participants found support in therapy. Psychotherapy constitutes a psychological copying strategy. Some participants were already in psychotherapy before the outbreak of the coronavirus. However, they continued it during the COVID-19 pandemic to cope with the challenging situation of being pregnant during the coronavirus period. As Ismini told me:

"I was already in therapy and I continued it through skype".

Other psychological copying strategies related to mothering practice since it allowed them to experience personhood included intensification of literature reading. The articulated argument was that after the baby's arrival, personal time would have been too limited, so reading was an expression of her present personhood as a pregnant woman who was not a mother yet and therefore prioritised her needs first.

Two participants mentioned work as a copying emotional measure to cope with the confinement during their pregnancy. In one case, the interviewee, even if she could make use of the Law 4682/2020 provision that excluded working pregnant women in healthcare since there was not any vaccination developed until the beginning of 2021, refused to use it, and continued to go to work. It was a way to tackle confinement. The other one, even if she selected to isolate herself, she transferred her work online. It was an outlet for her to cope with self-isolation.

Chapter 2: In the fear of Obstetric violence

Cut me not!

> "My pregnancy period was quite a stressful period regarding COVID-19 infection. More particularly, I was trying not to get infected with the coronavirus. Especially during the last month, because my doctor had informed me that in case I got infected and I was in my month, namely I could give birth at any time, I would give birth only to a designated reference hospital, without my doctor, and I would be submitted to a caesarean section. I did not want this to happen to me".

The above narrative was characteristically repeated by all participants, maybe not with the exact words, but definitely what scared all the interviewees was to give birth in a designated reference hospital alone without their partners and health professionals, in fear of being submitted to an unwilling caesarean section, namely in fear of facing the risk of obstetric violence. **Obstetric violence** was legally defined for the first time by the state of Venezuela in 2007 in an effort to prevent violence toward women (Shabot and Korem 2018, 386) during childbirth. Even if there is not yet a globally accepted definition, the definition provided by the Venezuelan state is comprehensive and coherent. The ''Organic Law on the Right of Women to a Life Free of Violence'' defines obstetric violence as the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanised treatment, abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women (Cohen-Shabot 2015, 237), mistreatment and abuse within childbirth (Smith-Oka 2021,1). Only in 2019, the United Nations used the term for the first time extensively in a report of the Special Rapporteur on violence against women, its causes and consequences (Espinoza-Reyes and Solís, 2020, 190).

Obstetric violence is rooted in a system of multifold power hierarchies, such as providers versus patients (Perrotte et al. 2020,1546). It is embedded in a patriarchal system of regulation and control over women's bodies. Therefore, it is a form of gender-based violence since it appears to be unique in being directed almost exclusively at women and being experienced by women (Cohen-Shabot 2015,241).It is also a type of

structural violence because it undermines a woman's sense of self, her core being since it makes women into moral objects rather than subjects (Cohen-Shabot 2015, 235).

Among its key characteristics are **discrimination**; **physical**, **verbal**, **emotional**, or **psychological mistreatment** and **abuse**; **lack of consent to medical procedures**; **routine use of medically nonindicated procedures**; **neglect or poor rapport with caregivers**; **the denial of companionship during labour; broader issues of infrastructural scarcity** (Smith-Oka 2022, 2); and especially during the coronavirus period, **immediate separation and isolation from the** new-born, and the **prevention of breastfeeding** (Sadler et al. 2020,46). Physical abuse includes the caesarian section and instrumental deliveries. The argument employed by the physicians in cases of caesarean section is the protection of fetal life; upon its implementation disregard patient consent, and they use it as a legal tool that protects them by placing their intent on preserving the baby's safety and any acts done to the mother as justifiable in that intent (Perrotte et al. 2020, 1555). Mothers who do not consent to certain acts or offer alternatives to their physician's recommendations are perceived as guilty of not putting the baby's safety first (Perrotte et al. 2020, 1555).

Therefore, obstetric violence is linked to the medicalisation of pregnancy and childbirth and the biopower exerted on pregnant women to surveillance and regulate their bodies. Within this biopolitical rationale framework, the National Public Health Organisation in Greece (NPHO) issued the first guidelines regarding managing pregnant women being infected or suspected of being infected by the SARS-CoV-2 coronavirus in March 2020. Pregnant women with a confirmed infection should be treated exclusively at designated reference hospitals and, if possible, with available negative pressure infrastructure in a delivery room, ward, and neonatal unit. The number of health professionals involved should be kept to a minimum. Everyone should be trained to implement infection control measures and properly use and dispose of personal protective equipment. The decision about the time and type of childbirth is individualised depending on the clinical condition of the pregnant woman, gestational age and the fetus's condition. In the case of a pregnant woman with infection and initiation of spontaneous delivery with smooth progress, the possibility of vaginal delivery is given to reduce the second stage of childbirth as applying the mask to the pregnant woman can complicate the expulsion process. Induction of labour is an option for cases where the conditions are favourable, but labour should be accelerated in time

if there is no progression or if the clinical picture of the mother deteriorates or if there are signs of fetal malformation. An emergency caesarean section should be performed in cases of fetal malformation and septic shock or multiorgan failure of the pregnant woman (NPHO 2020).

In December 2020, HSOG, in guideline no 43 on the obstetric provision of care during the COVID-19 pandemic, in the healthcare management algorithm, recommends that in case a COVID-19 symptomatic pregnant woman in labour, she will be transferred to a designated reference COVID-19 hospital to give birth. Vaginal delivery in COVID-19 pregnant women requires isolated areas and specialised staff with the necessary logistical infrastructure.

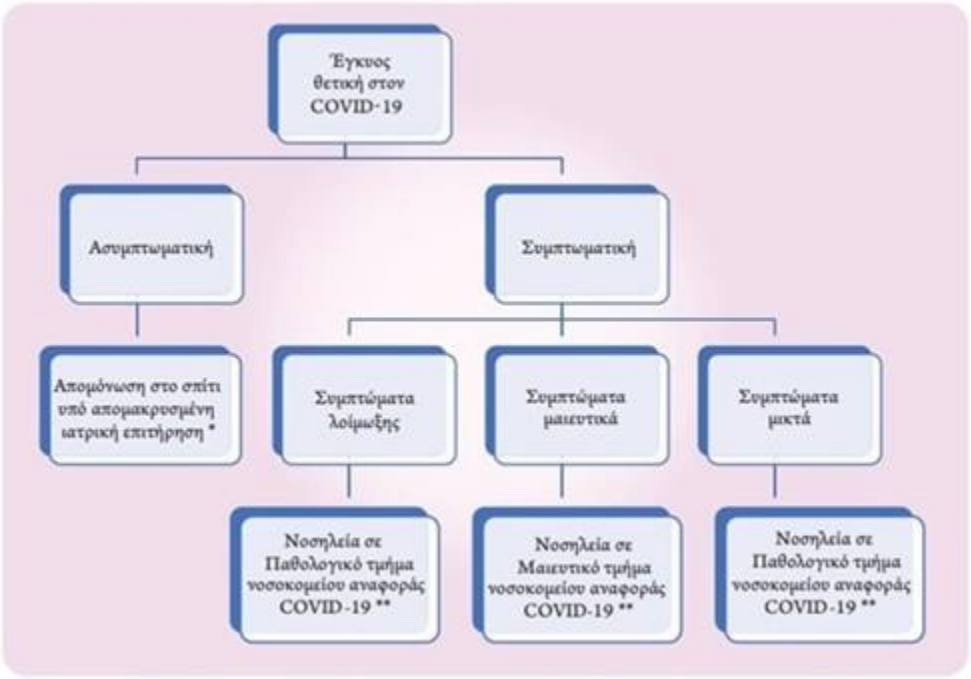

Figure 1. The healthcare management algorithm (HSOG, 2020, 4).

Therefore, there are no contraindications for vaginal delivery in COVID-19-positive pregnant women (HSOG 2020,4). However, in the same document, its authors (all male health professionals) acknowledged that caesarian sections in the designated reference hospitals occur due to the existing Greek data of the PAN-COVID Registry. Still, they were due to problems in the health management of the cases (HSOG 2020,4). Independently of this clarification in the document, the common practice in Greece in

any other period regarding deliveries is a caesarean section; six out of 10 births are caesarean section births (Antoniou et al. 2021).

At this point, I describe an implementation of biopolitics in the coronavirus regarding pregnancy delivery during the coronavirus period. In the name of biosecurity, pregnant women in labour positive to COVID-19 have been forced to comply with the no 43 guideline of the state and give birth to a designated health infrastructure alone, without the health professionals they trust, and under the risk of a caesarean section, being treated as sick persons who cannot perform their normal roles in society and therefore threaten social stability (Christiaens and Teijlingen 2009,6). Participants' narratives repeatedly stated the risk of obstetric violence as one of their main concerns. Consequently, they attempted to remain uninfected from COVID-19 at least during the very last month of their pregnancy to ensure that they would be transferred to a designated reference COVID-19 hospital, alone, unaccompanied, without the assistance of their health professionals, under the almost certainty to be subjected to caesarian section.

> ''The doctor had told me that if I were positive for COVID-19, they would take me alone unaccompanied without him and my husband to Attiko hospital (the designated reference hospital in Athens for COVID-19-positive pregnant women), and I would give birth to another doctor.''

In the announcement of this probability, Barbara freaked out as she repeated to me twice.

This medicalisation of pregnancy thus beomes a particular form of power over these bodies, as Foucault (1977 in Petersen et al.) has argued. This process also turns obstetricians into significant actors during pregnancy, displacing the earlier importance of family participation (Rezende 2011). The "violence workers" (Lebron 2018), in this case, have been state's institutions, which use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor and control reproductive behaviours and practices" (Morgan and Roberts 2012 in Castro and Savage 2019,124).

As Mirto suggested to me, having in mind the different locations of the Utrecht University concerning Greece;

> "I would suggest to a pregnant woman to leave Greece and not give birth here. If so, she will undertake a caesarian section, and they will take the baby away from her".

I have to note that this participant was a victim of obstetric violence in the past, and she was psychologically traumatised because of it.

In this case, they would be admitted to designated reference hospitals if they were COVID-19 positive. The fear of obstetric violence was always present and grounded in the biopolitical health protocols like guideline 43 of HSOG. There they would be alone, a potentiality that reinforced their anxieties.

Apart from sensing fear of obstetric violence, there were two cases in which this emotion, independently of COVID-19 infection, was instantiated into an embodied experience. In the first case, Zoe, who is health literate as a healthcare professional, understood immediately that the obstetrician initiated performing the "Kristeller manoeuvre", and she reacted immediately.

The ''Kristeller manoeuvre" involves the application of manual pressure to the uppermost part of the uterus directed towards the birth canal in an attempt to assist spontaneous vaginal birth and avoid prolonged second stage or the need for operative delivery during the second phase of labour (Hofmeyr et al. 2017). It is associated with an increased risk of LAM avulsion when applied to women during their first vaginal delivery (Youssef et al., 2019) and is not recommended by the WHO (2018, 5). Therefore, it can be characterised as a form of physical obstetric violence. In this case, Zoe was in prolonged labour, and the medical professional attempted to perform it without her consent to speed up the delivery. The healthcare professional, at that point, tried to cancel her epistemic authority, her embodied capabilities, and her sense of being a particular individual in labour (Shabot 2016, 235), acting paternalistically as the unquestionable authority in the room (Kukura 2018, 775). Her agentive resisting reaction and her explicitly stated refusal, hopefully, stopped him from continuing to exert this harmful manoeuvre. I am sharing their graphic dialogue in the delivery room, and she narrated it with me.

> ''I told him if you want your hand and you do not want me to put it …, I told him something ugly, don't you dare to exert Kristeller on me. I am aware of what you are doing, it is malpractice, and I am going to...

No, he told me, I wasn't going to. I

responded, ''cut this crab to me''.

However, what was interesting and inconsistent in her case, was that the obstetrician had denied subjecting her to a caesarian section due to her medical record and insisted on natural birth, even when she, being exhausted and desperate by the prolonged labour, asked him to proceed to either a medication supply or a caesarian section, encouraging her to keep trying. Nonetheless, he attempted to perform another physical form of obstetric violence to speed up the delivery. Part of their dialogue regarding the caesarian section highlights this contradiction:

"Cut me, kill me, and let the baby live. I cannot stand it any longer".

He told me: Put your hand here. Here is the head. It is projecting one hour now; you just cannot puss correctly because you are exhausted".

The response of the particular physician, either when he refused to undergo the pregnant woman in a caesarean section or the moment he attempted another type of obstetric violence, was indicative of his effort to actively manage labour and delivery for fear of a ''pathological potential'' (Brubaker and Dillaway 2009,36), even within the frame of a shared decision-making model.

Unfortunately, that was not the case in the story of Martha, who was subjected to obstetric violence. The team of health professionals that supervised her pregnancy proposed that she should proceed to a caesarean section or to induction of pregnancy for the benefit of the infant to come. She decided for the infant's merit to consent to caesarean section as it the less dangerous for the fetus. Up to this point, everything could be a typical scenario of a caesarean section decision to safeguard a healthy baby. However, there have been many inconsistencies. Starting from the delivery day, one of the health professionals responsible for the baby's health did not present himself. So, one of the arguments for a scheduled birth meeting based on the argument that all medical specialists would be there to ensure the successful delivery both for the mother and the infant was debunked. Secondly, the infant was registered as preterm and its mother as diabetic. None of the aforementioned was accurate, according to the interviewee. Later she found out that the more preterm an infant is registered, the more

funding a health care infrastructure/hospital receives from the state, and she felt that she was trapped and used by her health professionals.

By and large, women often fell victim to motherhood's perception as an institution, a patriarchal, male-defined and controlled institution (Ross Lynda 2017, 5), with health professionals as the main actors and pregnant women in substitute roles. Being a substitute, the particular participant followed the guidelines provided by healthcare professionals to her as an ultimatum to safeguard the infant's health, embodying the role of being a good mother. Martha summarised her story in a few lines as follows.

> ''They took advantage of the fact that I was alone, unaccompanied and vulnerable as a first-time birth mother. They offered me this choice (the caesarean section) which, later, I realised that it was unjustifiable, but at that moment, it seemed reasonable. If my husband were present in the delivery room and I had a rational voice present, I would not have permitted them to proceed with the surgery".

Another component of obstetric violence that this participant mentioned in her narrative was her companion's absence in the delivery room. Since a caesarean section is classified as surgery, third parties apart from the patient and the medical staff are excluded. However, the prohibition of pregnant women's companions was also observed in cases of natural birth, and it was provided in the NPHO guidelines (2020). More specifically, according to the guidelines, visits should be limited to a single person who will also apply the protective measures, who is not allowed to be present in the delivery room (NPHO 2020), even if the birth is natural (mine comment), contrary to the WHO guidelines. WHO provides that all pregnant women, including those with suspected, probable or confirmed COVID-19 positive, are strongly recommended to have access to a companion of choice during labour and childbirth since that person is considered that it will give support in practical and emotional ways to the woman in labour (2020a,1-2). The benefits of labour companionship may contribute to decreased caesarian sections and more positive health indicators for babies in the first five minutes (WHO 2020a, 1-2).

In Greece, the situation regarding a companion's presence in the delivery room is blurry. According to women's narratives, there was no pattern or a norm that would

ensure the presence of pregnant women's companions either in the delivery rooms or their staying in the rooms or even on the premises of a hospital. There were variations, but a general assumption was that the rules were more lenient in private maternity hospitals, and it was interlinked to the period of the coronavirus. However, a prerequisite in all cases was a negative PCR test on the part of the companion, apart from the pregnant woman. If the test was negative, the maternity hospital was a private one, and the birth was natural, then the partner was fortunate enough to get permission to be present in the delivery room. In the case of Dioni, that was the case:

> ''Hopefully, I gave birth to a private maternity hospital. At the delivery moment, they took me right away to the delivery room without having the final results from the PCR. My husband managed to sneak into the delivery room almost simultaneously without the PCR result. The doctor managed to put him in from the back door until the results of his own test''.

All women mentioned that they wanted their partners present in the delivery room during childbirth. As one noted, "the feeling of loneliness during the labour was my fear". This fear and anxiety Zoe managed to overcome by vigorously demanding the presence of her partner in the delivery room during labour in a public hospital. She even threatened the hospital staff that she intended to leave the hospital if her partner was not present in the delivery room. An exemption was made for her since she was a health professional and one of the few vaccinated persons at that period. It was the very first coronavirus period in a public hospital. According to her testimony, the rest of the pregnant women who gave birth in that hospital were not permitted to have their companions present in the delivery room.

Hopefully, all participants were allowed to rooming in and had their new-borns with them. In cases where their companions were allowed to be with them in the room, that was perceived as helpful, supportive and an antistress determinant, especially to first-time mothers.

Chapter 3: COVID-19 Vaccination anxieties

The punishment of the vaccine!

‘’The punishment of the vaccine’’ were the exact words of Ioli regarding the state’s discourse on the general COVID-19 vaccination of the population and pregnant and lactating women, with her lit face popping out a dark background. She had just put her baby daughter to sleep and she apprehended Foucault’s biopower discourse in Agamben’s state of exception in only one sentence. In the name of biosecurity, the state, in line with physicians, implemented the ultimate biopolitical dream (Sarasin 2020), promoting horror and fear (Duque Silva and Del Prado Higuera 2021, 504) of the side effects of a potential contagion in pregnant women. COVID-19 vaccination has been promoted as the most effective protective biomedical measure against hospitalisation and severe illness in pregnant women.

More specifically, in May 2021, the HSOG issued guideline no 57 on immunising women in gestation against SARS-CoV-2. The guideline informed pregnant women that, according to recent epidemiological data, there ws an increased risk of severe illness and death for pregnant women infected by the coronavirus. In particular, pregnant women are considered more likely to show symptoms, be hospitalised in intensive care units, and need ventilators compared to non-pregnant women of the same age (Riad et al. 2021, 2). Risk factors for severe illness from COVID-19 and death during pregnancy are the mother’s age≥35 years old, obesity, diabetes, cardiovascular disease, or respiratory disease. In addition, the initial SARS-CoV-2 infection also appears to have a potentially adverse effect on the outcome of pregnancy, increasing the number of preterm childbirth and stillbirth (HSOG 2021,2). Moreover, antibodies have been traced in breast milk following the mother’s vaccination. Therefore, the HSOG recommends vaccinating pregnant women with comorbidities and lactating women with mRNA vaccines (2021, 9).

> Rebecca’s situation left her no alternative but to get vaccinated, as she shared with me: “I got vaccinated because I had gestational diabetes and thrombophilia. The doctors who followed my case informed me that my health status was at high risk of serious illness from the coronavirus. So, they persuaded me to get vaccinated, despite my misgivings”.

In the following part, I examined more thoroughly the vaccine anxieties of pregnant women relevant to COVD-19 vaccination.

Yes, **boss!**

> ‘’My gynaecologist, member of the Greek Gynecological COVID-19 Committee, when I called him to ask him about my misgivings vaccination regarding the AstraZeneca stemming from how the mass media had presented it, as not the safest one, he asked me.
>
> Where did you hear that information about AstraZeneca? In the news? Please, let the nonsense and go take the shot; it is the only way we can protect ourselves, in your case, to protect you and the baby’’’, he said me.
>
> “Yes, boss!” I replied and I went to get vaccinated”.

In the particular vignette, Barbara debated whether she should get vaccinated. It expressed how she had complied with the biomedical discourse over COVID-19 vaccination during pregnancy. She fully trusted the authenticity of her physician as being in an asymmetrical power relation with him. Additionally, from her narrative, I discerned her vaccine anxieties, which in this case emanated from the promotion of fear and horror (Duque Silva and Del Prado Higuera 2021, 504) of COVID-19 contagion and the potential implications of the AstraZeneca vaccine by the mass media.

Anxieties are forms of active reflection experienced in place of another emotion difficult for the person to feel or express, like fear in this case. Anxieties can take negative forms, such as worry, concern, or fear -but also positive forms-as desire or striving (Leach and Fairhead, 2008,39). Negative forms of vaccine anxieties are related to vaccine hesitancy, meaning the delay in acceptance or refusal of vaccines despite the availability of vaccine services (WHO 2019).Vaccines’ anxieties seen as worries can interpret public refusal or dissent (Leach and Fairhead, 2008,3) from COVID-19 vaccination in this case. Vaccine anxieties, under a positive frame, imply a striving for something and recognising its cruciality to ensure wellbeing (Leach and Fairhead, 2008,39). The participants in this research independently experienced positive and negative anxieties, whether they proceeded to get vaccinated or not, based on the perception of risk regarding coronavirus contagiousness and infectiousness.

Interviewees' perception of coronavirus risk, either objective or subjective, was influenced by multiple determinants. Professional hesitancy, as was described through the interviewees' narratives, such as the following one by Dioni:

> ''I recall that he (her physician) told me there was uncertainty regarding the vaccine safety during pregnancy at that period, and he suggested me to wait a little bit since I was in the last month of the pregnancy and the vaccination recommendation had started; only before two months.''

was one key determinant of objective risk regarding the causality and harmful effects (Boholm 2015,161) of the coronavirus, and it was linked to therapeutic nihilism, respect for patient autonomy, and shared decision-making (Chervenak 2022, 1).

Therapeutic nihilism directs the obstetrician to avoid any clinical interventions during pregnancy to avoid teratogenic effects that might be unknown (Chervenak 2022, 1), and it was prominent at the outbreak of the pandemic and until the period that international health organisations such as the WHO commenced the recommendation of COVID-19 vaccination to pregnant women, due to lack of data regarding any side-effects to pregnant women and their fetuses. In the case of Greece, some physicians recommended to pregnant women who were in the last months/trimester when the COVID-19 vaccination was recommended to pregnant women, namely after May 2021, to wait and get vaccinated during lactation to have even more data and avoid any harm.

> "The platform has just opened for my age group, but I did not get the dose before the delivery because the physician told me that the shot should have a time distance of twenty days from the caesarian section to ensure that any side effects would be from the caesarean sections and not from the vaccine. Finally, I got vaccinated 20 days after the childbirth", Ismini shared with me.

Regarding respecting the autonomy of pregnant women, there were physicians, especially until and shortly after the no 57 guideline of the HSOG, who recommended the vaccination but did not insist on it, like in the case of Marcella.

> "My doctor didn't ask me if I was vaccinated. I asked him about getting vaccinated when I ran the seventh month of pregnancy, and he told me that it would be good to get vaccinated before the eight-month to create

> antibodies and have them passed on to the fetus. But he didn't pressure me to get vaccinated because he knew that we were (her and her family) confined at home. The truth is that when I decided to discuss it with him since he had not made any implications, I was afraid of what he would tell me or if he would make me feel guilty. Instead, he was discreet, and he answered me, "This is the data. It is up to you what you are going to decide and do". I was relieved by his answer".

Other physicians followed the shared decision-making strategy, namely the joint process in which healthcare professionals work together with their clients to reach a care decision (Chervenak 2022,3).

> "When we saw (Rosie and her obstetrician) that I was pregnant, she told me that she wanted me to take care of two things immediately; one was to get vaccinated with the flu vaccine and the other one to get vaccinated against the coronavirus, but to avoid to uptake them together. So, I focused on coronavirus vaccine uptake. I had done my research before I got pregnant regarding which vaccine was the most suitable one for those who wanted to obtain a child, so when my physician told me about it, I trusted her".

Most of the interviewees that decided to proceed to vaccination trusted their healthcare professionals was a repetitive argument. In my case, similar to Brownlie and Howson's research on trust and MMR vaccination, confidence was not only based on knowledge but also on a "leap of faith" that could only be possible because pregnant women in my research had a relationship with professionals on familiarity (Dube 2013,1769).

My interviewees, in general, trusted their healthcare professionals. What they had no confidence in or expressed their misgivings about it, independently whether they got vaccinated or not, were the government and the pharmaceutical industry. This deficit of trust was strictly connected to the subjective perception of risk and the cultural specificity of the deficit of confidence in the current right-wing government and to the profiteering of the pharmaceutical industry on COVID-19 vaccination. Subjective risk acknowledges that people's beliefs and opinions often deviate from scientific assessments (Boholm 2010,161). People understand and judge risks in terms of emic,

locally defined values and concerns (Stoffle et al. 1991,612 in Boholm 2010,161). In Beck's contemporary risk societies, reflexive scientization is predominant, meaning that scientific scepticism has been extended to science itself and fueled the disenchantment of science (Peretti-Watel et al. 2015,6). As a result, there is a process of demonopolisation/feudalisation of scientific knowledge, with conflictual equalisation tendencies in the gradient of rationality between experts and lay people. Sciences, quasi-sciences and pseudo-sciences are competing for sources producing a flood of overspecialised, hyper-complex, contradictory findings (Peretti-Watel et al. 2015,6).

Consequently, distrust toward science is no longer a sign of ignorance or even obscurantism but is endorsed by highly educated individuals (Peretti-Watel et al. 2015,6). Beck also pointed out the increasingly important issue of conflicts of interest, i.e., situations in which scientists or experts are perceived as untrustworthy because of their financial links to industries (Peretti-Watel et al. 2015,6). In alignment with Beck's untrustworthiness in science due to economic links to industries, in my research, the deficit of trust in the pharmaceutical industry was extensively described, and according to Elli, it was the limited distribution of data about the side effects of vaccinated pregnant women that nurtured her distrust. Therefore, the lack of transparency was implicated. According to her:

> "My healthcare professionals listened to my misgivings with respect without directing me in one or another decision regarding the vaccination since there was a deficit of data based on clinical studies regarding the side effects of vaccination on pregnant women and their fetuses since pharmaceutical companies did not publish this data. It was only after a court case in Texas, I think, that the pharmaceutical companies were obligated to disclose their data; otherwise, they would not have informed us about anything".

The underlining emotion, in this case, was the fear of harm both to pregnant women's body and their fetuses. The perception of risk, even though it was subjective, was well-founded in the suspicion of concealed side effects provoked by vaccination uptake. The perception of lack of transparency and openness in information (Leach and Fairhead 2008,29) generated doubt and uncertainty, which provoked fear and led to

vaccination refusal. What she requested was transparency and openness in information (Leach and Fairhead 2008,29).

In the same line, Ioli shared with me that:

> "Since I do not take paracetamol during pregnancy and lactation period, and since I do not use make-up and chemical deodorant to protect my child, I refuse to accept such an intrusion into my body. I ponder that all these have a negative impact on the child, so until I stop breastfeeding, I will not do it".

In her case, it was a matter of body ownership and protection of its boundaries by the invasion of a regulatory state. Without acknowledging it, she disputed the core element of biopower and its agents' attempts to police the bodies through the imposition of COVID-19 biopolitics strategies. In both cases, the intimidating biopower coronavirus discourse met resistance through refusal.

On the other hand, some participants exerted agentive mothering, but in reverse, namely, they were anxious about the thought of potential infection for them and their fetus and/or newborn that they pursued to get vaccinated. In one case, an interviewee proceeded with vaccination one month before the official recommendation by the HSOG for pregnant women to ensure their wellbeing and their fetus, using her professional identity as a healthcare worker.

> "I got vaccinated in April since the platform had opened for me in January (2021) as a healthcare professional. However, since the data on the vaccine protective efficacy was insufficient, to be honest, I confined myself".

Other determinants that affected the positive aspect of COVID-19 vaccination to pregnant women were their age, potential comorbidity, and the trimester of the pregnancy in interrelation to the period of the coronavirus. A participant with comorbidities mentioned that even though she had misgivings about being vaccinated during pregnancy, she chose to trust her physicians since she was at risk of being hospitalised if she got infected in a designated COVID-19 reference infrastructure. She did not want to experience this possibility. She characterised the vaccination as a "light at the end of the tunnel". Additionally, she already had a previous traumatic experience

and yearned for this child. Regarding the trimester of the pregnancy, those who were in the later coronavirus period and decided to get vaccinated during the pregnancy expressed concerns about the safest trimester. One participant decided to delay the vaccination suggested by her physician until she reached the eighth month of pregnancy for her fetus to gain the appropriate weight.

Name it slow violence

The fear of **slow violence of potential COVID-19 infection to the fetus's health** was implicated, even if it was not named as a concept, in all narratives, regardless of whether the interviewees were vaccinated. Slow violence, defined by Nixon (2011), is the violence that occurs gradually and out of sight, a violence of delayed destruction that is dispersed across time and space, an attritional violence that is typically not viewed as violence at all. In this case, it was the fear of potential harm to the fetus in different scenarios. In the first scenario, pregnant women potential teratogenesis and unforeseen consequences to the fetus and infant health in the probability of a COVID-19 infection led them to decide not to uptake the extremely speedy produced and not tested enough vaccine, neither during the surrogacy nor during the lactation period. In another script, the hypothesis was not to get vaccinated during pregnancy, resulting in the adoption of even harsher self-monitored preventive measures, exerting agentive practices since those measures were perceived that were adopted by their own initiatives, and to get vaccinated during the breastfeeding period to transmit coronavirus antibodies to the infant. In an alternative scenario, women got vaccinated during pregnancy, especially when the pregnancy took place in late 2021 and 2022, namely almost after a year of the official vaccine recommendation to pregnant women by the Greek state and international health bodies.

In all cases, pregnant women exerted biocitizenship practices in fear of slow violence to the health of the fetus in case of her getting infected during pregnancy and to deter obstetric violence. Rosie's case is characteristic:

> "I wanted to get vaccinated with the third dose ten days before my appointment. I told them that I was pregnant, but they told me (in the vaccination centre) that this was not a reason to get vaccinated sooner until an employee addressed the director, informing him about my frequent

> contact with people due to my profession. Hence, it was urgent to get vaccinated before the onset of my clients' appointments. So, they accepted it, and I cancelled my scheduled appointment online and simultaneously, they rescheduled the third dose for the same day."

Not all the interviewees that got vaccinated had the same perception. Some informed me that they got vaccinated because they had to comply with the coronavirus biopolitics strategies and, more specifically, the restrictions in movements to non-vaccinated ones. Nicky informed me that:

> "In general, I was against the vaccination. I didn't want to get vaccinated, but from September (2021), it was like a one-way road. You couldn't move around, so I did it because I had no choice".

The oxymoron in this narrative is that in a liberal democracy, one of its basic concepts, "choice," could not be performed by its citizens.

Another woman added that what bothered her was dividing people into vaccinated and unvaccinated ones and the rivalries and accusations that have emerged among people. The term "**miasma**" was used by another to refer to how the mainstream mass media, following the state discourse, presented those who denied getting vaccinated. The metaphor used by the interviewee was indicative of how she was experiencing her choice not to get vaccinated and the emotional burden of it. The scaremongering employed by the mass media, in line with the state discourse regarding mandatory vaccination, led almost all participants to abstain from getting informed by them, as a small act of resistance, independently they were in favour or against vaccination or were obliged to get vaccinated. The following quotes by two different participants are indicative:

> ''I chose not to get informed by the mainstream mass media whose propaganda was highly intimidating.''

> ''The information the mainstream mass media provided was the personification of horror''.

Most of them turned to selected online renowned press such as the Guardian or YouTube channels of independent researchers, biomedical webinars, and official websites of international and American health organisations such as the WHO and

CDC. I admit that I followed the same practice to resist the misinformation of Greek mass media.

The frustration and annoyance of the division of people regarding the vaccine uptake were confirmed when I conducted online observation in three online moms' Facebook groups. The texts were posted less than one year ago when the HSOG recommended the vaccination against COVID-19 to pregnant women. In general, women there expressed the same fears and anxieties as my interviewees. Most of them requested unity against the promoted by the state and mass media division to vaccinated and non-vaccinated people. Still, a post from one member of the "moms life" group indicated the internalised state discourse of the necessity of biopolitics strategies, accepting the imposition of a state of exception without any intention of doubt. According to that post,

> ''whoever wanted to retain the right to be unvaccinated amid a pandemic should recognise the right of the state to protect those citizens who wanted to get vaccinated from a contagious virus. Those who desire to use the right not to get vaccinated should accept the consequences of the state's attempts to restrict the spreading of the virus. The temporary deprivation of rights was the last pressure measure from the state''.

On the other hand, another woman defying the efficiency of the vaccines sustained that if vaccines were a solution, then there would have been a lift of patents, so everyone globally to have the right to get vaccinated, implying her distrust of the pharmaceutical industry and to those on policy-making centres who supported the protection of patterns in a pandemic.

Apart from the state discourse on pregnant women's vaccination promoted by the mass media, some interviewees reported being pressured to get vaccinated either by their work or their family members. Their family members expressed their concerns about their health and the fetus's health, even though, in the end, they had to respect pregnant women's decisions. In one case, the pressure from the work was imposed after childbirth in return to the post. Then the employer of Martha pressured her to get vaccinated before her return to the post.

> ''I work in a kinder garden, and the employer had informed the staff in the summertime (summer 2021) that whoever was not vaccinated to consider

herself fired. I was the only one who was unvaccinated, and each time I returned to work, they recommended me to get vaccinated''.

That was also linked to the certification of disease issued for those who were unvaccinated but got infected and the lift of measures. Regarding the contagiousness of the coronavirus, some participants mentioned that apart from getting infected in the last month of their pregnancy due to the fear of obstetric violence, they would not allow the potentiality of getting infected to determine their life. Actually, one of the interviewees was sick with coronavirus when I interviewed her. During the interview, Nancie had her face covered with a mask, but I did not think that she might be ill since the mask was an imposed biopolitical strategy, not in our private residency, but many people wear it indoors even in the thought of potential infection of another resident of the house. It was only after my question about her thoughts concerning vaccination that she informed me that she was currently a COVID-19 patient with mild symptoms and did not intend to get vaccinated.

In general, the interviewees said it was the fear of slow violence of COVID-19 complications to their health and fetus health that motivated the vaccination uptake of those who proceeded to get vaccinated, whereas the same fear operated as deterring factor to others. The underlying fear of the unknown prevailed in both cases.

Conclusions

Conclusions

Being pregnant during the coronavirus pandemic was challenging for pregnant women since they had to cope with the unknown and the unprecedented COVID-19 situation and concurrently practice mothering, while being liable to the risk of contamination and its health implications. Risk, whether subjective or objective, traversed all their practices and acts. The fear of structural and slow violence motivated them to act, namely the risk of obstetric violence and COVID-19 vaccinations' unknown implications. According to the interviewees' narratives, these types of risks provoked the emotions of fear and anxiety, as well as feelings of despair, anger, and alienation, which led them to adopt multiple mitigation strategies to ensure a safe mothering experience during the coronavirus period. The way they implemented these strategies and the reasons for each strategy selection formulated the enactment of mothering or motherhood, or both, since these concepts of maternity operated complementarily to the interviewees, as well the way they practice biocitizenship it through acts and practices. Examples of these strategies will be presented in the text that follows.

Starting from how pregnant women perceived maternity and therefore practised mothering, motherhood or both, there were variations between the first coronavirus period and the one that followed, after the initiation of vaccination recommendation to them by the state and health care authorities both on a national and international level. In the first period of coronavirus, where everything was novel and unfamiliar, living and experiencing uncertainty became the norm. The concept of motherhood was more prevalent through the promotion and prioritization of the fetus's health over the pregnant woman's health, not necessarily in practice but verbally, since the fetus's health cannot be ensured without a healthy pregnant woman. However, in the discourse of the interviewees, the fear of any potential implications to the fetus as a consequence of potential COVID-19 infection of the surrogate mothers was dominant, especially among those women who had experienced fertility complications in the past. Nonetheless, they exerted agency by adopting self-regulated preventive measures extra to the imposed ones by the state, as well as **coping strategies** to deal with the double complex situation, meaning pregnant in health uncertainty, to safeguard their health status and well-being, expressing their agency towards the unknown of a potential COVID-19 infection.

I acknowledge the oxymoron of being agentive in the COVID-19 state of exception, having incorporated the dominant discourse about the potentially severe illness of COVID-19 and potentially lethal complications, but that it was what pregnant women experienced. They were agentive but docile in the meaning of Sawicki's (1999) bodies that are not passive but are useful in policing themselves, and that is what actually took place; they policed themselves and those around them through the implementation of preventive measures in their attempt to cope with the fear of contamination. In other words, they performed mothering but were motivated by the discourse of ideal motherhood, transforming themselves into individual risk managers, complying with the state's neoliberal request of "individual responsibility" for a public health issue. In a sense, the implementation of self-regulated measures constitutes a type of biopolitics measures being drafted by the biocitizens themselves to self-monitor their lives.

Concerning the fear and anxiety of obstetric violence, pregnant women expressed their agency through strategies and tactics, performing mothering and motherhood again concurrently in an interrelated way. Their agentive performativity was related to the adoption of preventive measures to abstain the risk of an unavoidable admission to a COVID-19 designated reference hospital in case they were COVID-19 positive in the ninth month of their pregnancy, where they would be alone, unaccompanied and without the health professionals that they trusted, and most probably they would be subjected to a caesarean section. They complied with their health professionals' discourse about the risk of being admitted to a designated COVID-19 reference hospital; a discourse in alignment with the no 43 HSOG biomedical guideline. Hence, they performed agency but, in a way similar to the maternity experience, their agency was within the frame of a docile biocitizen who trusted the biomedical health professionals that cooperated with, but not necessarily the state and its implied threats for obstetric violence. Regarding the applied agency tactics, they were obligated to perform them as an imminent response to acts of obstetric violence in the delivery room. Those tactics were unscheduled, but they expressed their explicit refusal and, resistance to an unwanted caesarean section and their demand to ensure the presence of their partner in the delivery room.Hence, in fear of obstetric violence, pregnant women practised both mothering and motherhood, as biocitizens, in their attempt to negotiate with the biopower enacted by the state and biomedicine.

I observed a similar pattern, meaning practising both mothering and motherhood, concerning vaccine anxieties of pregnant women during the COVID-19 pandemic. Regarding the performance of either mothering, motherhood or maybe both simultaneously, the starting point was the same; to safeguard fetus health and themselves. To those who proceeded to get vaccinated, vaccination was perceived as a protective measure against the risk of a severe illness which would require hospitalization. However, misgivings were expressed by all women at least until the publication of data regarding COVID-19 vaccines safety during pregnancy. Even their healthcare professionals advised them to wait until the publication of more data and then get vaccinated within the frame of professional hesitancy. This strategy on the part of the health care professionals had a positive outcome because pregnant women trusted them, and in a leap of faith, they got vaccinated during the lactation period, following their health professionals' advice. In one case, a woman decided to get vaccinated even before the no 43 recommendation by the HSOG, trusting the recommendations already published by the CDC and the WHO, an agentive practice, again within the frame of biopolitics, with the difference that it indicates an act of mistrust to the local state and biomedicine. Biocitizenship practices was also enacted for those who did not proceed to COVID-19 vaccination. In the act of refusal to both state and scientific discourse, they did not get vaccinated in their attempt to ensure the health of the fetus and themselves. In this way, they performed mothering and resisted the dominant state and biomedical discourse.

By and large, what emerged from this research was that being pregnant had multiple interpretations by the interviewees who often oscillate between mothering and motherhood. Nonetheless this oscillation they remained active agents of their novel situation, even in the uncertainty of the coronavirus, applying various agentive practice, which is actually the main contribution of this research regarding the perception of pregnant women as agentive actors.

The limitations of this research are connected to the provided time spent in the field. I perceived that the participants needed more time to open themselves; even if they were willing to share their experiences with me, most felt more relaxed when I stopped recording. This is connected to trust, which needs time to be established. Hence my recommendation is in case of future research, the researcher to ensure to spend more than three months in the field.

Abstract

Being pregnant during the coronavirus pandemic was challenging for pregnant women since they had to cope with the unknown and the unprecedented COVID-19 situation. The state and the biomedical discourse classified them as a vulnerable group due to the increased risk of severe illness and death for pregnant women infected by the coronavirus. My scope was to explore the embodied experiences of pregnant women during the coronavirus and bring into the foreground their agentive practices and tactics implemented during the COVID-19 period. To examine their counter-discourse, mitigation strategies and how they articulated their agency, I adopted the online ethnography approach through qualitative methods, namely archival analysis, netnography, and online interviews. I conducted eighteen online formal semi-structured in-depth interviews. I carried them out synchronously by deploying the Voice over Internet Protocol (VoIP) technologies. I performed netnography by approaching four moms' Facebook online groups, of which three accepted me as a member and by navigating to state official websites and official biomedical sites to record their discourse about pregnancy and pregnancy in relation to COVID-19 vaccination. The research findings highlighted how concepts of mothering and motherhood were articulated and experienced by pregnant women. The emotion of fear and anxiety were predominant in pregnant women, and both of them stemmed from the risk of potential enactment of obstetric violence in case a pregnant woman was COVID-19 positive during the last month of her pregnancy. Another form of violence that caused fear and anxieties was the fear of COVID-19 vaccination slow violence, from potential implications to the development and health of the fetus. The risk of both these types of violence led them to practice and act biocitizenship from above and from below.

Key words: COVID-19, mothering, obstetric violence, vaccine anxieties

Bibliography

Airoldi, Massimo. 2018. “Ethnography and the Digital Fields of Social Media.” *International Journal of Social Research Methodology* 21 (6): 661–73. https://doi.org/10.1080/13645579.2018.1465622.

American Anthropology Association. n.d. “AAA Statement on Ethics - Learn and Teach.” Www.americananthro.org. https://www.americananthro.org/LearnAndTeach/Content.aspx?ItemNumber=22869.

Antoniou, Evangelia, Eirini Orovou, and Maria Iliadou. 2021. “Cesarean Sections in Greece. How Can We Stop the Vicious Cycle?” *World Journal of Advanced Research and Reviews* 12 (1): 375–77. https://doi.org/10.30574/wjarr.2021.12.1.0502.

Archibald, Mandy M., Rachel C. Ambagtsheer, Mavourneen G. Casey, and Michael Lawless. 2019. “Using Zoom Videoconferencing for Qualitative Data Collection: Perceptions and Experiences of Researchers and Participants.” *International Journal of Qualitative Methods* 18 (1): 1–8. https://doi.org/10.1177/1609406919874596.

Barlow, Kathleen, and Bambi L. Chapin. 2010. “The Practice of Mothering: An Introduction.” *Ethos* 38 (4): 324–38. https://doi.org/10.1111/j.1548-1352.2010.01153.x.

Berge, Lukas. 2020. “Biopolitics and the Coronavirus.” *Netherlands Journal of Legal Philosophy* 49 (1): 3–6. https://doi.org/10.5553/njlp/.000097.

Bitsch, V. 2005. “Qualitative Research: A Grounded Theory Example and Evaluation Criteria.” Edited by Vera Bitsch. *Journal of Agribusiness* 23 (23). https://doi.org/10.22004/ag.econ.59612.

Bloomquist, Kori R, Leila Wood, Kristin Friedmeyer-Trainor, and Hea-Won Kim. 2016. “Self-Care and Professional Quality of Life: Predictive Factors among MSW Practitioners.” *Advances in Social Work* 16 (2): 292. https://doi.org/10.18060/18760.

Boholm, Åsa. 2003. “The Cultural Nature of Risk: Can There Be an Anthropology of

Uncertainty?" *Ethnos* 68 (2): 159–78. https://doi.org/10.1080/0014184032000097722.

Butler, Lisa D., Kelly A. Mercer, Katie McClain-Meeder, Dana M. Horne, and Melissa Dudley. 2019. "Six Domains of Self-Care: Attending to the Whole Person." *Journal of Human Behavior in the Social Environment* 29 (1): 107–24. https://doi.org/10.1080/10911359.2018.1482483.

Castro, Arachu, and Virginia Savage. 2018. "Obstetric Violence as Reproductive Governance in the Dominican Republic." *Medical Anthropology* 38 (2): 123–36. https://doi.org/10.1080/01459740.2018.1512984.

Charmaz, Kathy. 2017. "Special Invited Paper." *International Journal of Qualitative Methods* 16 (1): 160940691771935. https://doi.org/10.1177/1609406917719350.

Chervenak, Frank A., Laurence B. McCullough, and Amos Grünebaum. 2022. "Reversing Physician Hesitancy to Recommend COVID-19 Vaccination for Pregnant Patients." *American Journal of Obstetrics and Gynecology* 226 (6): 805–12. https://doi.org/10.1016/j.ajog.2021.11.017.

Chun Tie, Ylona, Melanie Birks, and Karen Francis. 2019. "Grounded Theory Research: A Design Framework for Novice Researchers." *SAGE Open Medicine* 7 (1): 205031211882292. https://doi.org/10.1177/2050312118822927.

Cohen Shabot, Sara. 2015. "Making Loud Bodies 'Feminine': A Feminist-Phenomenological Analysis of Obstetric Violence." *Human Studies* 39 (2): 231–47. https://doi.org/10.1007/s10746-015-9369-x.

Council Directive 92/85/EEC of 19 October 1992. *On the Introduction of Measures to Encourage Improvements in the Safety and Health at Work of Pregnant Workers and Workers Who Have Recently given Birth or Are Breastfeeding (Tenth Individual Directive within the Meaning of Article 16 (1) of Directive 89/391/EEC).*

Cummins, Molly. 2014. "Reproductive Surveillance: The Making of Pregnant Docile Bodies." *Kaleidoscope: A Graduate Journal of Qualitative Communication Research* 13 (1). http://opensiuc.lib.siu.edu/kaleidoscope/vol13/iss1/4.

Draganović, Selvira, Nina Bosankić, and Jasmina Ramic. 2021. "The Lived Experiences of Pregnancy and Motherhood in Bosnian Women during COVID-19." *European Journal of Psychology Open* 80 (1-2).

https://doi.org/10.1024/2673-8627/a000004.

Dubé, Eve, Caroline Laberge, Maryse Guay, Paul Bramadat, Réal Roy, and Julie A. Bettinger. 2013. "Vaccine Hesitancy." *Human Vaccines & Immunotherapeutics* 9 (8): 1763–73. https://doi.org/10.4161/hv.24657.

Duque Silva, Guillermo Andrés, and Cristina Del Prado Higuera. 2021. "Political Theology and COVID-19: Agamben's Critique of Science as a New 'Pandemic Religion.'" *Open Theology* 7 (1): 501–13. https://doi.org/10.1515/opth-2020-0177.

Dutch Anthropological Association.2018. n.d. "Antropologen Beroepsvereniging (ABv), "ETHICAL GUIDELINES''."

Ellis, Carolyn, Tony E. Adams, and Arthur P. Bochner. 2010. 'Autoethnography: An Overview'. Forum Qualitative Sozialforschung / Forum: Qualitative Social Research 12 (1). Https://Doi.org/10.17169/Fqs-12.1.1589.

Espinoza-Reyes, Ester, and Marlene Solís. 2020. "Decolonizing the Womb: Agency against Obstetric Violence in Tijuana, Mexico." *Journal of International Women's Studies* 21 (7): 189–206. https://vc.bridgew.edu/jiws/vol21/iss7/14.

Friedman, May. 2013. *Mommyblogs and the Changing Face of Motherhood*. University of Toronto Press. https://doi.org/10.3138/9781442665231.

Ghosh, Banhishikha. 2020. "Digital Ethnography during the COVID 10 Pandemic." *Zurich Open Repository and Archive, University of Zurich* 25: -. https://doi.org/https://doi.org/.

Giannopoulou, Ioanna, and George O. Tsobanoglou. 2020. "COVID-19 Pandemic: Challenges and Opportunities for the Greek Health Care System." *Irish Journal of Psychological Medicine* 37 (3): 1–5. https://doi.org/10.1017/ipm.2020.35.

Halse, Christine. 2018. "Theories and Theorising of Belonging." *Interrogating Belonging for Young People in Schools*, 1–28. https://doi.org/10.1007/978-3-319-75217-4_1.

Hammersley, Martyn, and Paul Atkinson. 'Ethnography Principles in Practice. Chapter 7.' Essay. In Ethnography: Principles in Practice. London: Routledge, 2019.

Hammersley Martyn, and Paul Atkinson. 2019. *Ethnography : Principles in Practice*. New York: Routledge.

Hansen, Thomas Blom, and Finn Stepputat. 2006. "Sovereignty Revisited." *Annual*

Review of Anthropology 35 (1): 295–315. https://doi.org/10.1146/annurev.anthro.35.081705.123317.

Happe, Kelly E, Jenell M Johnson, and Marina Levina. 2018. *Biocitizenship : The Politics of Bodies, Governance, and Power*. New York: New York University Press.

Hofmeyr, G Justus, Joshua P Vogel, Anna Cuthbert, and Mandisa Singata. 2017. "Fundal Pressure during the Second Stage of Labour." *Cochrane Database of Systematic Reviews* 5 (5). https://doi.org/10.1002/14651858.cd006067.pub3.

Howlett, Marnie. 2021. "Looking at the 'Field' through a Zoom Lens: Methodological Reflections on Conducting Online Research during a Global Pandemic." *Qualitative Research* 22 (3): 146879412098569. https://doi.org/10.1177/1468794120985691.

HSOG (Ελληνική, Μαιευτική, and Γυναικολογική Εταιρεία). 2020. "Κατευθυντήρια Οδηγία No 43,ΣΥΣΤΆΣΕΙΣ ΜΑΙΕΥΤΙΚΉΣ ΦΡΟΝΤΙΔΑΣ ΚΑΤΆ ΤΗΝ ΠΑΝΔΗΜΊΑ COVID-19." https://hsog.gr/wp-content/uploads/2021/11/all.pdf.

———. 2021. "Κατευθυντήρια Οδηγία No 57 ΑΝΟΣΟΠΟΊΗΣΗ ΈΝΑΝΤΙ SARS-COV-2 ΚΑΤΆ ΤΗΝ ΚΎΗΣΗ." https://hsog.gr/wp-content/uploads/2021/05/Vaccine.pdf.

Januszek, Sławomir M., Anna Faryniak-Zuzak, Edyta Barnaś, Tomasz Łoziński, Tomasz Góra, Natalia Siwiec, Paweł Szczerba, Rafał Januszek, and Tomasz Kluz. 2021. "The Approach of Pregnant Women to Vaccination Based on a COVID-19 Systematic Review." *Medicina* 57 (9): 977. https://doi.org/10.3390/medicina57090977.

Jeremiah, Emily. 2018. "Motherhood to Mothering and Beyond, Maternity in Recent Feminist Thought." *Journal of the Association for Research on Mothering and Community Involvement* 8 (1): 21–33.

Jiao. 2019. "Mothering and Motherhood: Experience, Ideology, and Agency." *Comparative Literature Studies* 56 (3): 541. https://doi.org/10.5325/complitstudies.56.3.0541.

Kousi, Timokleia, Lefkothea-Christina Mitsi, and Jean Simos. 2021. "The Early Stage of COVID-19 Outbreak in Greece: A Review of the National Response and the Socioeconomic Impact." *International Journal of Environmental Research and Public Health* 18 (1). https://doi.org/10.3390/ijerph18010322.

Kukura, Elizabeth. 2018. “Obstetric Violence.” *Georgetown Law Journal* 106 (3): 721–802.

Law 4624/2019.*Hellenic Data Protection Authority (HDPA), Measures for Implementing Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the Protection of Natural Persons with Regard to the Processing of Personal Data, and Transposition of Directive (EU) 2016/680 of the European Parliament and of the Council of 27 April 2016, and Other Provisions., 137 § (2019).* 2019.

Law 4682/2020. *Ratification: A) of from 25.2.2020 Legislative Act “Measures Are Taken to Prevent and Limit the Spread of Coronavirus” (AD 42), B) from 11.3.2020 Legislative Act “Urgent Measures to Deal with Adverse Effects of COVID-19 Coronavirus and the Need to Limit It Dissemination ”(A΄ 55) and C) of 14.3.2020 Legislative Act “Urgent Measures to Deal with It the Need to Limit the Spread of COVID-19 Coronavirus ”(AD 64)(Edited).* 2020. Vol. Official Gazette A 76 03-04-2020 § (2020).

Leach, Melissa, and James Fairhead. 2007. *Vaccine Anxieties : Global Science, Child Health and Society*. London: Earthscan.

LebrónMarisol. 2019. *Policing Life and Death Race, Violence, and Resistance in Puerto Rico*. Oakland, California University Of California Press.

Lo Iacono, Valeria, Paul Symonds, and David H.K. Brown. 2016. “Skype as a Tool for Qualitative Research Interviews.” *Sociological Research Online* 21 (2): 1–15. https://doi.org/10.5153/sro.3952.

Lupton, D. (Editor) (2021) Doing Fieldwork in a Pandemic (Crowd-Sourced Document), Revised Version. Available At: DOING FIELDWORK in a PANDEMIC.

Lynda Rachelle Ross. 2016. *Interrogating Motherhood*. Edmonton, Ab Au Press.

Macdonald, Margaret. 2006. “Gender Expectations: Natural Bodies and Natural Births in the New Midwifery in Canada.” *Medical Anthropology Quarterly* 20 (2): 235–56. https://doi.org/10.1525/maq.2006.20.2.235.

Manderson, Lenore, Nancy Jean Burke, and Ayo Wahlberg. 2021. *VIRAL LOADS : Anthropologies of Urgency in the Time of Covid-19.* S.L.: Ucl Press.

Marcus, G.E. 1995. “Annual Review of Anthropology.” *Annual Review of Anthropology*, no. 24: 95–117. https://doi.org/10.1146/anthro.672.

Mascia-Lees, Frances E. 2011. *A Companion to the Anthropology of the Body and*

Embodiment. Chichester, West Sussex, U.K. ; Malden, Ma: Wiley-Blackwell.

Molgora, Sara, and Monica Accordini. 2020. "Motherhood in the Time of Coronavirus: The Impact of the Pandemic Emergency on Expectant and Postpartum Women's Psychological Well-Being." *Frontiers in Psychology* 11 (October). https://doi.org/10.3389/fpsyg.2020.567155.

Muslimin, M. 2020. "The Use of Pseudonym in Social Media." *Proceedings of the International Conference on Community Development (ICCD 2020)*. https://doi.org/10.2991/assehr.k.201017.108.

National Public Health Organisation (NPHO). 2021. "ΟΔΗΓΙΕΣ ΕΜΒΟΛΙΑΣΜΟΥ ENANTI TOY IOY SARS-COV-2. Https://Eody.gov.gr/. Https://Eody.gov.gr/Wp-Content/Uploads/2021/02/Odigies-Emvoliasmou-Sars-Cov-2-202102.Pdf ." 2021.

Newnham, Elizabeth C., Jan I. Pincombe, and Lois V. McKellar. 2016. "Critical Medical Anthropology in Midwifery Research." *Global Qualitative Nursing Research* 3 (1-6): 233339361667502. https://doi.org/10.1177/2333393616675029.

Nixon, Rod. 2011. "'Introduction' + Chapter 1 'Slow Violence, Neoliberalism, and the Environmental Picaresque'. In Slow Violence and the Environmentalism of the Poor. Cambridge, MA: Harvard University Press. Pp: 1-67." 2011.

O'Reilly, Andrea. 2004. *From Motherhood to Mothering : The Legacy of Adrienne Rich's of Woman Born*. Albany: State University Of New York Press.

———. 2010. "Abortion." *Encyclopedia of Motherhood.SAGE Publications* 1: 1–13. https://doi.org/10.4135/9781412979276.n2.

Omernick, Eli, and Sara Owsley Sood. 2013. "The Impact of Anonymity in Online Communities." *2013 International Conference on Social Computing*, September. https://doi.org/10.1109/socialcom.2013.80.

Parlapani, Eleni, Vasiliki Holeva, Panteleimon Voitsidis, Apostolos Blekas, Ioannis Gliatas, Georgia N. Porfyri, Adrianos Golemis, et al. 2020. "Psychological and Behavioral Responses to the COVID-19 Pandemic in Greece." *Frontiers in Psychiatry* 11 (11). https://doi.org/10.3389/fpsyt.2020.00821.

Peretti-Watel, Patrick, Jeremy K. Ward, William S Schulz, Pierre Verger, and Heidi J Larson. 2015. "Vaccine Hesitancy: Clarifying a Theoretical Framework for an Ambiguous Notion." *PLoS Currents*. https://doi.org/10.1371/currents.outbreaks.6844c80ff9f5b273f34c91f71b7fc28

9.

Perrotte, Violette, Arun Chaudhary, and Annekathryn Goodman. 2020. "'At Least Your Baby Is Healthy' Obstetric Violence or Disrespect and Abuse in Childbirth Occurrence Worldwide: A Literature Review." *Open Journal of Obstetrics and Gynecology* 10 (11): 1544–62. https://doi.org/10.4236/ojog.2020.10110139.

Petersen, Alan R, and Robin Bunton. 2006. *Foucault, Health and Medicine*. London ; New York: Routledge.

Petryna, Adriana 2002 *Life Exposed: Biological Citizens after Chernobyl. Princeton: Princeton University 22 Press*. n.d.

Phoenix Force (Earth-616)." n.d. Marvel Database. Accessed August 9, 2022. https://marvel.fandom.com/wiki/Phoenix_Force_(Earth-616).

Podjed, Dan. 2021. "Renewal of Ethnography in the Time of the COVID-19 Crisis." *Sociologija I Prostor*, March. https://doi.org/10.5673/sip.59.0.10.

Presedential Degree. n.d. *Π.Δ.176/1997 : Μέτρα για την βελτίωση της ασφάλειας και της υγείας κατά την εργασία των εγκύων, λεχώνων και γαλουχουσών εργαζομένων σε συμμόρφωση με την οδηγία 92/85/ΕΟΚ*.

Reader, John. 2021. "Review of Giorgio Agamben (2021). Where Are We Now? The Epidemic as Politics." *Postdigital Science and Education* 4 (2): 590–94. https://doi.org/10.1007/s42438-021-00247-3.

Regulation (EU) 2016/679 *of the European Parliament and of the Council of 27 April 2016 on the Protection of Natural Persons with Regard to the Processing of Personal Data and on the Free Movement of Such Data, and Repealing Directive 95/46/EC (General Data Protection Regulation), Official Journal of the European Union L 119/1 § (2016).* n.d.

Rezende, Claudia Barcellos. 2011. "The Experience of Pregnancy: Subjectivity and Social Relations." *Vibrant: Virtual Brazilian Anthropology* 8 (2): 529–49. https://doi.org/10.1590/s1809-43412011000200026.

Riad, Abanoub, Anna Jouzová, Batuhan Üstün, Eliška Lagová, Lukáš Hruban, Petr Janků, Andrea Pokorná, Jitka Klugarová, Michal Koščík, and Miloslav Klugar. 2021. "COVID-19 Vaccine Acceptance of Pregnant and Lactating Women (PLW) in Czechia: An Analytical Cross-Sectional Study." *International Journal of Environmental Research and Public Health* 18 (24): 13373. https://doi.org/10.3390/ijerph182413373.

Sadler, Michelle, Gonzalo Leiva, and Ibone Olza. 2020. “COVID-19 as a Risk Factor for Obstetric Violence.” *Sexual and Reproductive Health Matters* 28 (1): 1785379. https://doi.org/10.1080/26410397.2020.1785379.

Sawicki, Jana. 1999. “3.6 ‘Disciplining Mothers: Feminism and the New Reproductive Technologies.’” *Feminist Theory and the Body*, May, 190–202. https://doi.org/10.1515/9781474471770-024.

Scheper-Hughes, Nancy, and Margaret M. Lock. 1987. “The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology.” *Medical Anthropology Quarterly* 1 (1): 6–41. https://doi.org/10.1525/maq.1987.1.1.02a00020.

Schmelz, Katrin, and Samuel Bowles. 2021. “Overcoming COVID-19 Vaccination Resistance When Alternative Policies Affect the Dynamics of Conformism, Social Norms, and Crowding Out.” *Proceedings of the National Academy of Sciences* 118 (25). https://doi.org/10.1073/pnas.2104912118.

Shabot, Sara Cohen, and Keshet Korem. 2018. “Domesticating Bodies: The Role of Shame in Obstetric Violence.” *Hypatia* 33 (3): 384–401. https://doi.org/10.1111/hypa.12428.

Shapiro, Andrew. 2019. “Biocitizenship: The Politics of Bodies, Governance and Power.” *New Genetics and Society* 38 (3): 358–60. https://doi.org/10.1080/14636778.2019.1586526.

Shook, Lydia L., Thomas P. Kishkovich, and Andrea G. Edlow. 2021. “Countering COVID-19 Vaccine Hesitancy in Pregnancy: The ‘4 Cs.’” *American Journal of Perinatology*, October. https://doi.org/10.1055/a-1673-5546.

Siettos, Constantinos, Cleo Anastassopoulou, Constantinos Tsiamis, Georgia Vrioni, and Athanasios Tsakris. 2021. “A Bulletin from Greece: A Health System under the Pressure of the Second COVID-19 Wave.” *Pathogens and Global Health*, February, 1–2. https://doi.org/10.1080/20477724.2021.1881372.

Smith-Oka, Vania. 2022. “Cutting Women: Unnecessary Cesareans as Iatrogenesis and Obstetric Violence.” *Social Science & Medicine* 296 (March): 114734. https://doi.org/10.1016/j.socscimed.2022.114734.

Sobo, Elisa J. 2016. “Theorizing (Vaccine) Refusal: Through the Looking Glass.” *Cultural Anthropology* 31 (3): 342–50. https://doi.org/10.14506/ca31.3.04.

Sohn, MyungHee, and Elizabeth Bye. 2014. “Pregnancy and Body Image.” *Clothing and Textiles Research Journal* 33 (1): 64–78.

https://doi.org/10.1177/0887302x14557809.

Sotiropoulos, Dimitri A. n.d. “State-Society Relations in Greece before and after the Recent Economic Crisis.” Https://Sites.tufts.edu/Karamanlischair/Files/2019/05/CGK-Working-Paper-2019-06-State-Society-Relations-May.pdf. The Fletcher School of Law and Diplomacy, Tufts University.

Sternsdorff-Cisterna, Nicolas. 2015. “Food after Fukushima: Risk and Scientific Citizenship in Japan.” *American Anthropologist* 117 (3): 455–67. https://doi.org/10.1111/aman.12294.

Sturm, Circe. 2017. “Reflections on the Anthropology of Sovereignty and Settler Colonialism: Lessons from Native North America.” *Cultural Anthropology* 32 (3): 340–48. https://doi.org/10.14506/ca32.3.03.

Taylor, Melanie M., Loulou Kobeissi, Caron Kim, Avni Amin, Anna E. Thorson, Nita B. Bellare, Vanessa Brizuela, et al. 2020. “Inclusion of Pregnant Women in COVID-19 Treatment Trials: A Review and Global Call to Action.” *The Lancet Global Health* 0 (0). https://doi.org/10.1016/S2214-109X(20)30484-8.

Valle, Carlos Guilherme do, and Sahra Gibbon. 2015. “INTRODUCTION - HEALTH/ILLNESS, BIOSOCIALITIES and CULTURE.” *Vibrant: Virtual Brazilian Anthropology* 12 (1): 67–74. https://doi.org/10.1590/1809-43412015v12n1p067.

WHO. 2020. “Companion of Choice during Labour and Childbirth for Improved Quality of Care.” Www.who.int. September 4, 2020. https://www.who.int/publications-detail-redirect/WHO-SRH-20.13.

Wilson, Rose. 2019. “The Institutional Embedding of Maternal Vaccination and Its Effect on Vaccination Acceptance during Pregnancy.” *Journal of Anthropological Research* 75 (4): 498–523. https://doi.org/10.1086/705944.

World Health Organisation (WHO). 2022a. “Coronavirus Disease (COVID-19): Pregnancy and Childbirth.” Www.who.int. March 15, 2022. https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-covid-19-pregnancy-and-childbirth.

———. 2022b. “Interim Recommendations for Use of the Pfizer–BioNTech COVID-19 Vaccine, BNT162b2, under Emergency Use Listing.” Www.who.int. March 21, 2022. https://www.who.int/publications-detail-redirect/WHO-2019-nCoV-vaccines-SAGE_recommendation-BNT162b2-2021.1.

World Health Organization (WHO). 2018. *Who Recommendations on Intrapartum Care for a Positive Childbirth Experience.*

Youssef, A., E. Montaguti, M. G. Dodaro, R. Kamel, N. Rizzo, and G. Pilu. 2019. "Levator Ani Muscle Coactivation at Term Is Associated with Longer Second Stage of Labor in Nulliparous Women." *Ultrasound in Obstetrics & Gynecology* 53 (5): 686–92. https://doi.org/10.1002/uog.20159.

Zapata-Sepúlveda, Pamela, Félix López-Sánchez, and María Cruz Sánchez-Gómez. 2011. "Content Analysis Research Method with Nvivo-6 Software in a PhD Thesis: An Approach to the Long-Term Psychological Effects on Chilean Ex-Prisoners Survivors of Experiences of Torture and Imprisonment." *Quality & Quantity* 46 (1): 379–90. https://doi.org/10.1007/s11135-011-9551-9.