Birthing at European Union Borders: A qualitative multi-method study of perinatal Afghan women's experiences on the move through Serbia

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I, Esther Madhulika Sharma, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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ABSTRACT

Decades of instability in Afghanistan have resulted in large-scale migration of Afghans yet few legal routes to safety exist. Pregnancy and birth continue while on the way for some Afghan women making state-unauthorised journeys to the European Union (EU). This study aimed to explore the lived experiences of Afghan women in Serbia during the perinatal period, with a focus on understanding their interactions with, and the provision of, maternity care.

I collected qualitative data between 2021 and 2022 (unstructured observations in spaces occupied by Afghan women, narrative interviews with Afghan women, and semi-structured interviews with providers of perinatal care and support). Data were analysed using open coding, thematic narrative analysis, and reflexive thematic analysis respectively. I also conducted a public engagement project using a co-developed webcomic to visually elicit questionnaire responses from Serbian health professionals and women's civil society members about their awareness and opinions of childbearing Afghan women in Serbia.

My findings revealed how the EU migration regime filters down to Serbian migration governance, which reproduces harms to perinatal Afghan women in Serbia. I showed the obstetric violence experienced by Afghan women during labour and birth, and the role played by non-clinical actors in bridging the gap between women and clinical care providers. I also foregrounded the creative agency enacted by Afghan women in resistance to bordering practices that attempt to halt or decelerate their entry into the EU.

This study makes a significant original contribution to the discourse on maternity and migration, and understandings of maternal and newborn health needs of Afghan women migrating through Serbia.

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ABBREVIATIONS

CASP	Critical Appraisal Skills Programme
CBS	Critical border studies
Covid-19	Coronavirus disease 2019
CSO	Civil society organisation
DRC	Democratic Republic of Congo
EU	European Union
FGM	Female genital mutilation
HIC	High-income country
HIV	Human immunodeficiency virus
IDI	In-depth interview
INGO	International non-governmental organisation
IOM	International Organization for Migration
KIRS	Serbian Commissariat for Refugees and Migration
LMIC	Low- and middle-income country
LSHTM	London School of Hygiene and Tropical Medicine
NGO	Non-governmental organisation
OBGYN	Obstetrician-gynaecologist
OCHR	United Nations Human Rights Office
PIS	Participant Information Sheet
RA	Research assistant
SDG	Sustainable Development Goals
SSI	Semi-structured interviews
UK	United Kingdom
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children’s Fund
USA	United States of America
VAW	Violence against women
WHO	World Health Organization

COVID-19 IMPACT STATEMENT

How disruption caused by Covid-19 has impacted the research

This research study was disrupted by Covid-19 in direct and indirect ways. I initially planned to spend six months in Serbia to conduct fieldwork including participant observations, and in-person interviews. However, Covid-19-related lockdowns and travel restrictions both in the UK and in Serbia led to shorter and delayed field visits, further complicated by UK school closures resulting in caring responsibilities for my children. Covid-19 impacted Afghan women in Serbia, which in turn indirectly, disrupted my data collection. Firstly, all those staying in refugee camps were subjected to military-enforced 24/7 quarantine, with tight restrictions on visitors. This, had I been able to travel to Serbia for fieldwork, would have limited my access to spaces occupied by Afghan women and made recruitment far harder. Moreover, informal conversations suggested that the effect of the quarantine was to push more refugees to travel rapidly through Serbia without registering with the Serbian state or staying in camps, although there is (to the best of my knowledge) no empirical data available to support this anecdotal evidence. Rapid travel through Serbia often renders Afghan refugees invisible, making it far harder to access potential participants. Covid-19-related delays to my field visits resulted in far fewer Afghan women being present in camps by the time of my second field visit, which also coincided with the Taliban takeover of Afghanistan in August 2021.

How the planned work would have fitted within the thesis' narrative

Conducting fieldwork over a six month period would have enabled me to embed myself in the community of Afghan women in Belgrade to a greater extent, as well as respond rapidly to perinatal Afghan women travelling through other parts of Serbia, to recruit them for interviews. Spending greater time with both Afghan women and relevant actors would have possibly allowed me to form a greater depth of relationship with them that could have led to deeper understandings of factors shaping Afghan women's perinatal experiences in Serbia. For example, I may have observed small day-to-day acts of resourcefulness or solidarity enacted by Afghan women that I asked women about in interviews but that they did not recall. Moreover, spending more time in the 'field' may have led to the influence of my presence as a researcher on social interactions diminishing somewhat over time, providing greater insights into everyday behaviours and social interactions. Additionally, spending more time in Serbia would have enabled me to conduct more interviews in-person, rather than remotely, which may have produced a different kind of data in some cases. I may also have had greater opportunities to interact with Afghan women in-person during the perinatal period if my field visits had not been delayed, providing contemporaneous insights into lived perinatal experiences.

Summary of any decisions / actions taken to mitigate for any work or data collection/analyses that were prevented by Covid-19

In order to mitigate for the inability to conduct fieldwork over six months, I shifted my methods to incorporate two shorter visits to Serbia, and remote interviewing methods by phone or video conferencing platforms where necessary. I also recruited a Research Assistant for a four month period to provide information about the local situation for refugees in Serbia between my first and second field visits, when I had returned to the UK.

PREFACE

I arrived at London Heathrow Airport Terminal 5 arrivals with plenty of time to spare. I was 28 weeks pregnant with our first child and was eagerly awaiting the arrival of my husband from Dubai. We had been living in Dubai for nearly a year having previously been living in Afghanistan, where we originally met – I was travelling to and from Kabul and he was working. I left Dubai one month ahead of him, returning to London to organise our flat, leaving him to finish up his work. As the arrivals from the London-bound Dubai flight started to trickle through the gate, I kept a close eye out for him. No, not him yet, but any moment he would appear. I waited and waited, enviously watching other passengers being greeted by their loved ones in London, and walking away to get out of the airport. His phone was still switched off. The last few passengers emerged and then it was quiet. I imagined that there was maybe a problem with his luggage arriving, or some other hiccup along the way. Nothing prepared me for the phone call I was about to receive.

After waiting over an hour my phone rang. "Is that Esther Sharma?" the voice on the end of the phone asked. "I'm a border force officer, and I'm calling you to let you know we've detained your husband." My heart simultaneously sunk and went into my throat, and I felt utter confusion. "We're about to interview your husband and will need to phone you back later to confirm that your story matches with his." the voice continued. Trying not to panic, I returned to my car to avoid further hefty parking charges and started driving around the perimeter fence. Seven hours later, my Kabul-born, US husband was released from detention and so began a long and arduous process to understand why he was detained, and what this meant for his right to live in the UK, and our relationship.

We were fortunate to have the financial resources and a wonderful immigration lawyer who walked us through every step of the journey to my husband gaining UK citizenship six years later. There never was a clear reason for my husband being detained, instead of being let through border control with the six-month tourist visa to which US citizens are entitled on arrival to the UK – our immigration lawyer said that it only ever occurs at Terminal 5, and put it down to a possible diplomatic spat between the Brits and Americans at that time. When my husband returned from his UK citizenship ceremony neither of us wanted to celebrate. We were just relieved we could move forward with our lives, and destroy a filing cabinet's-worth of evidence that we had been carefully storing to prove the legitimacy of our relationship and evidence of my husband residing in the UK.

This story is neither remarkable nor uncommon. It was however, an experience about which I had previously been ignorant. Once our lives were settling down, with my husband's right-to-live in the UK secured, his first permanent work contract in the UK under his belt, our two small children finally

sleeping through the night, and eventually some headspace for me, questions began forming in my mind. How could it be that we, of US and UK citizenship, with the financial resources to hand, have experienced so much stress over the past 6 years? What must it be like for people seeking to settle in the UK without such privileges? I started to reflect deeply on my years of work as a midwife in London, mainly based in the community, visiting families from every walk of life imaginable. I remembered feeling so helpless as a student midwife in the late 1990s when a Rwandan woman was wheeled onto the postnatal ward with her newborn, having had a caesarean section alone with no friend or family by her side, and a vacuousness filling her eyes. I recalled caring for women from former Yugoslav countries as a newly qualified midwife, and debates raging amongst colleagues about whether families arriving to the UK were genuinely Kosovan or whether they were really Albanians taking advantage of the situation. I will never forget the Chinese-Uyghur couple who I met for their first antenatal appointment, who had become separated while fleeing from China, but joyously reunited in London and now expecting a baby. When I was working as a caseloading midwife, I felt embedded in the north London Somali community – I would go from house to house - the same 'aunty' would re-appear, maybe providing informal support to women, and on one occasion, a woman whose birth I had recently assisted, ran over to a young Somali woman living nearby and in turn assisted with the birth of her baby who made an unexpectedly sudden appearance at home. When I later started working as a community midwife at a different London hospital in 2007, I was incensed by the 'pep talk' myself and colleagues were given by the Overseas Visitor Officer as part of our induction. This was the first time I was being directly asked to ascertain the immigration status of women in my care, so that costs could be recovered for those deemed not to be entitled to NHS treatment. I never did ask such questions of women – their immigration status remained unknown to me and the hospital.

I thought too about the countless stories I had heard from women in Afghanistan, while I had been working there in a voluntary capacity as a midwife, about *raft o āmad* (going and coming), particularly perilous stories of fleeing the country over tricky mountainous terrain into Iran during the first Taliban takeover, and then returning after the US-led invasion of 2001. I remembered how globally scattered many families were, and greatly diverging tales that were told to me of how others were continuing to leave the country.

It was as I was reflecting upon all these things, while also considering undertaking a doctoral degree that I listened to the BBC Radio 4 sociology programme, 'Thinking Allowed', in which the authors of Migrant City (Back and Sinha 2019), a book about migrants in London, were being interviewed. This was a pivotal 'penny dropping' moment in which suddenly all my recent ponderings came together, acting as the catalyst that eventually resulted in this thesis.

CHAPTER 1- INTRODUCTION

Overview

My doctoral research explores what is it like for Afghan women to be pregnant, give birth, or have a newborn baby, while in the Republic of Serbia (hereon referred to as Serbia) – a country at the peripheries of the European Union (EU) through which they sojourn to reach a place of safety. In the public arena, migration is highly politicised, and gendered aspects of migration can be subject to stereotyping, lacking in nuance. While academics, activists and non-governmental organisations (NGOs) have extensively documented testimonials from people (mainly men) on the move, less attention is paid to refugee women experiencing childbearing while (im)mobile. With such limited knowledge about these experiences, understanding what policy and practice measures may address maternal and newborn health needs for women on the move remains challenging. This study seeks to contribute to the current discourses about perinatal experiences of refugee women during migration, by exploring Afghan women's lived experiences of childbearing and their interactions with maternity care, and perspectives of providers of perinatal health and support. I focus in this study on maternity care rather than maternal health care, in recognition of the fact that maternity care encompasses care of the mother-baby dyad. Employing multi-method qualitative research methods provides a rich, layered, and nuanced exploration of this topic. Through this thesis, I take the reader on a journey of a different kind, for which the stakes are considerably lower. I start the journey in this introductory chapter, by providing a background to Afghan mobility to Europe and describing the landscape of Serbia – a country through which many Afghans travelling overland to EU countries traverse. I examine the existing, albeit scarce, empirical evidence regarding perinatal experiences of women on the move, and then discuss this study's aims and its scholarly contribution. I end the chapter by setting out the thesis structure and the contribution that it makes.

A word on nomenclature

Before diving further into this chapter, I want to take a moment to consider some aspects of nomenclature in this thesis. Words matter, and especially so in migration where language and terminology have been used to divide, inflame, score political points, and portray pity. Terms used to categorise people who cross territorial boundaries fail to capture the complexities and nuances inherent in these journeys. In the 1970s, Europeans travelling overground to Afghanistan were commonly referred to as 'hippies', and today, white people from high-income countries who move to another country are 'expats'. Yet those from the Global South travelling to high-income countries are assigned quite different labels such as 'immigrant' or 'economic migrant', words that have become

highly emotive. Such labels are deliberately employed to imply differing degrees of deservingness. The (mis)use of terminology is commonly reflected in academic scholarship also – in health research, studies about 'migrants' abound and yet closer inspection reveals that the term 'migrants' is used selectively to focus on only migrants from low- or middle-income countries, not only homogenising diverse groups of people, but also reproducing stereotypes of who counts as a migrant and what treatment they deserve (De Souza 2004).

Departing from the highly emotive use of language to describe Afghan women, I have adopted loose and flexible terminology in this thesis. I refer to people who are forcibly displaced, forced migrants, and refugees interchangeably, although as far as possible I try to be specific, using 'Afghan women' as to describe with greater precision the group of women to whom I am referring. My use of the term 'refugee' is not based upon a legal definition of someone whose asylum case has been accepted, but rather in line with the UNHCR (2023a) definition of someone "…forced to flee conflict or persecution who cross an international border", seeking international protection for a range of human or natural reasons (Zetter 2014). Whilst my terms of choice give an indication of the forces driving people to leave home countries, I fully recognise that mobility is hugely complex, spanning a wide range of factors causing people to leave one country and move to another. Indeed, I use the terms 'mobility' and 'migration', to reference a non-exceptional state, recognising that transborder movement is and has been a regular way of life for centuries (Fontanari 2018). Furthermore, Afghans who migrate are not passive actors (as the term tends to imply) subject to external circumstances, but rather those who enact agency during migratory journeys (Krause and Schmidt 2020, Monsutti 2010). But while I acknowledge the normalcy of mobility, and Afghans' long-standing history of mobility, I also simultaneously acknowledge that being forced to leave home because of a complex interplay of social, political, and economic factors is not a choice that is taken lightly, described eloquently in the now well-known words of the poem "Home" by Warson Shire (2017):

no one leaves home unless

home is the mouth of a shark

no one leaves home until home is a sweaty voice in your ear

saying-

leave,

run away from me now

i dont know what i've become

but i know that anywhere

is safer than here

Thesis rationale

Childbearing is a significant life event. Not only does childbearing involve enormous biophysical changes for women, but it also a social and cultural process that goes beyond a bodily transformation. A complex web of environmental, cultural, societal, and political factors determine a woman's experience of the perinatal period (defined in this thesis as the period from conception through to six weeks post-birth) and her newborn's early experiences of life.

Migration is widely recognised as impacting on childbearing. Migrant-related maternal health research is often difficult to synthesise due to its complexities and the heterogeneity of migration categories employed in studies (Wickramage *et al*. 2018) and variations in maternity care provision (how maternity care is provided, by whom, where it is located, and what constitutes maternity care). There is some evidence suggesting the impact of forced migration worsens perinatal outcomes, with a greater likelihood of preterm birth, pre-eclampsia, gestational diabetes mellitus, lower Apgar scores, and a small for gestational age infant (Akselsson *et al*. 2020, Alnuaimi *et al*. 2017, Gibson-Helm *et al*. 2015, Kandasamy *et al*. 2014, Vural *et al*. 2021). Conversely, Agbemenu *et al*. (2019a) found that African refugee women in the US had favourable outcomes compared with US-born women, with higher rates of vaginal births, fewer preterm births, and fewer low birth weight infants, attributed to the 'healthy immigrant effect' (the phenomenon in which health outcomes are better for immigrant populations than those born in the country of study, attributed to being those able to successfully travel and settle in a host country already being healthier individuals). Vural *et al*. (2021) similarly found that Syrian refugee women in Türkiye were less likely than Turkish women to have a caesarean section. More recently a study set in Australia found that some perinatal outcomes among refugee women were worse compared with Australian-born women, while others were better (Yeshitila *et al*. 2024), demonstrating again the equivocacy of the evidence regarding perinatal outcomes for forcibly displaced women.

The causal mechanisms that may result in poorer perinatal outcomes among some forcibly displaced women are not fully understood. Quality antenatal care commenced in early pregnancy, is critical for reducing adverse maternal and newborn health outcomes, yet some studies have shown that refugee women were more likely to have reduced levels of antenatal care (Agbemenu *et al*. 2019a, Tittle *et al*. 2019). Further, Malebranche *et al*. (2020) found that antenatal care initiation was later among asylum-

seeking women than state- or privately-sponsored refugees, suggesting that forcible displacement itself may not explain variations in outcomes, but that structural factors, such as specialist support provided for sponsored refugees that facilitates access to antenatal care contributes to improved access to, and engagement with antenatal care.

Evidence showing that forcibly displaced women experience poorer maternal mental health than women born in the host country is clearer. In a systematic review Stevenson *et al*. (2023) found that the prevalence of perinatal depression, perinatal anxiety, and post-traumatic stress disorder (PTSD) were higher among migrant than non-migrant women, and that perinatal depressive disorders were higher among forcibly displaced women than economic migrants. Migratory stressors, reduced social support, and migratory-related traumatic events are thought to be contributing factors (Ahmed *et al*. 2017, Rees *et al*. 2019, Vigod *et al*. 2017). Poor perinatal mental health is associated with interfering in mother-infant attachment and lowered emotional, social and cognitive development in infants and children (Stein *et al*. 2014).

It is important to note that the vast majority of studies examining aspects of perinatal health and wellbeing have been conducted in high-income country settings among forcibly displaced women who are seeking international protection, or have already gained refugee status. There is a dearth of studies exploring how migratory journeys impact childbearing, and therefore a limited understanding about maternal and newborn health needs for those during migration (Sharma *et al*. 2020).

This thesis seeks to contribute to the corpus of knowledge, through exploring Afghan women's perinatal experiences while on the move through Serbia to Western Europe.

Aim and objectives

The aim of my qualitative multi-method study was to explore the experiences of Afghan women in Serbia during the perinatal period, with a focus on understanding their interactions with, and the provision of, maternity care. The objectives to achieving the aim that this thesis addresses are to:

- identify and synthesise the literature pertaining to the experiences of forced migrant women during the perinatal period;
- understand the migratory circumstances experienced by perinatal Afghan women travelling through Serbia;
- explore how Afghan women in Serbia experience the perinatal period and maternity care in Serbia;
- understand the experiences and perspectives of clinical and non-clinical actors providing perinatal care and support actors to Afghan women during migration through Serbia.

Contextual background

In this section, I set out the relevant background, setting the scene for my thesis. I situate my research study within its broader context, justifying my decisions to focus on Afghan women as study participants and Serbia as a study setting.

Raft o āmad: Afghan Mobility

Afghanistan has played an important role in the exchange of goods and ideas between Asia and Europe, where it famously sits at the crossroads between the two continents. As such, it has seen a perpetual movement of populations for trading, agricultural and military purposes over centuries (Hanifi 2000). This mobility has led to Afghans developing efficient and effective transnational networks, resulting in a constant *raft o āmad* (going and coming), and mobility as normal, not exceptional (Monsutti 2010, Saidi 2017). Aided by the advancement of communication technologies, these global networks enable the maintenance of social ties, activities and identity across borders (Saidi 2017). Importantly, they have also been identified as a coping strategy for households, allowing financial risk to be spread, through the sending of remittances from those who have migrated to recipient family members who have stayed, therefore supporting livelihoods (Monsutti 2008). Interconnected with these drivers for migration are those of education, family reunification, and employment opportunities (Crawley *et al*. 2016a). However, Afghan mobility, both internal and trans-border, has also been fuelled by natural disasters in the form of flash floodings, landslides, heavy snowfall, and earthquakes destroying infrastructure, homes, and agriculture, as well as causing direct injury and loss of life (OCHA 2024). Futhermore, decades of armed conflict has led to forced displacement - Afghanistan has been a nation at war seven times since its formation in 1919 (Sadr 2014).

The first of many conflicts in recent history occurred when the Soviet Union invaded Afghanistan in 1979 to bolster the communist government formed by a coup in the previous year. Afghan mujahedeen fighters, backed by the US, UK, and others, resisted the Soviet invasion, leading to a civil war. The conflict ignited a large-scale displacement of Afghans throughout the 1980s with over five million Afghans becoming displaced, mostly into neighbouring Iran and Pakistan (Rubin 1996). Several years after the withdrawal of Soviet troops from Afghanistan in 1989, the mujahedeen took control of Kabul, provoking a large-scale repatriation of Afghans from neighbouring countries. However, in-fighting between various mujahedeen factions led to more conflict, hence the initial appetite among some Afghans for the then newly-formed Taliban, who brought stability albeit through a restrictive interpretation of Islamic law. During the Taliban's initial rule of Afghanistan of 1996 to 2001 following the civil war, girls education was prohibited (although Afghan women ran 'underground' schools in

resistance to the restrictions the Taliban had imposed), the health system was poorly functioning, and there were systematic human rights abuses (Maley 1997, Rasekh *et al*. 1998). By 2000, Afghanistan had the world's second highest maternal mortality ratio of 1346 per 100,00 live births (The World Bank 2024). Taliban rule prompted another round of displacement of Afghans both into neighbouring Iran and Pakistan as well as globally (Ruiz 2004).

Afghanistan was largely ignored by the Global North during the first Taliban rule. However, the attack on the US World Trade Centre prompted the US invasion of Afghanistan to go after Al-Quaeda who were deemed to be responsible for the attack and were being harboured by the Taliban in Afghanistan. During this US-led invasion of 2001, the US and its allies poured in vast amounts of aid - Afghanistan has been one of the highest recipients of aid globally, comprising 40% of its gross domestic product in 2012 (Hogg *et al*. 2012), funding of which achieved quick wins but failed to secure stability or strengthen infrastructure (Brick Murtazashvili 2020, Nemat and Bose 2020). However, a notable successes was a significant reduction in maternal and neonatal mortality and the commencement of a nation-wide midwifery training programme (Speakman *et al*. 2014). Between 2000 and 2020, the estimated maternal mortality ratio fell to 620 per 100,000 live births, the neonatal mortality rate fell from 61 to 35 per 1000 live births and between 2010 and 2020, births attended by skilled professionals nearly doubled from 34% of births to 64% (The World Bank 2024). The period during the US-led invasion saw a resurgence in permanent and temporary Afghan citizens returning to the country, illustrating further the notion that migration is not an exceptional state, but rather that mobility is a strategy to adjust to evolving circumstances (van Houte and Davids 2014). Afghan diaspora brought with them knowledge and skills, that enabled capacity-building (Kuschminder 2014). The US-led coalition had failed to complete its mission of 'reconstruction' in Afghanistan. In 2014, the US-led coalition began to hand over defence to Afghan security forces, but security continued to decline, with an increase in civilian fatalities as a result of US-led airstrikes, sectarian violence or anti-government militant campaigns (Crawford 2020, Nemat and Bose 2020). Despite a peace process from 2018 to 2020 Afghanistan ranked lowest on the Global Peace Index (Vision of Humanity 2020) and 49% of Afghans lived below the national poverty line (Asian Development Bank 2024).

The sudden withdrawal of remaining US-led troops in Afghanistan in 2021 saw a rapid takeover of the country by the Taliban. The Taliban have re-installed a system of gender apartheid, banning girls from education, removing women from nearly all forms of public life, and forbidding women to leave the home without a male escort (Barr 2024), and are responsible for mass atrocities against ethnic Hazara people (Hakimi 2023). The country faces a humanitarian crisis, with decades of conflict and natural disasters overlayered by draught, an economic crisis, and a removal of almost all Afghan women from the workforce (OCHA 2023). It is estimated that in 2023 28.3 million people in Afghanistan required

humanitarian assistance to survive, of which 17 million faced acute hunger (OCHA 2023). Despite pledges from a number of countries to evacuate those who worked with the US-led coalition that are at risk under the new Taliban regime, evacuation pathways have been slow and many have been stuck in interim camps. Others remain in Afghanistan, unable to access visas that would relocate them to countries where they can apply for asylum (Latifi *et al*. 2023).

UNHCR (2024a) data suggest that globally 110 million people were forcibly displaced in mid-2023. A total of 36.4 million people were categorised by UNHCR as needing international protection of which 17% (6.1 million) were from Afghanistan, constituting the second-highest refugee group globally (UNHCR 2024a). Neighbouring Iran and Pakistan alone host the largest number of forcibly displaced Afghans despite recent mass forced returns of Afghans from Pakistan back to Afghanistan (UNHCR 2023b). Afghan mobility is far from linear but rather, multi-directional and fluid, encompassing both voluntary and forced movement with a myriad of overlapping motivations (Dimitriadi 2018).

Geymzadan: Afghan migration to Europe via the Western Balkans

To seek international protection, a significant number of Afghans move to Europe, representing for some "…a quest for meaning, social recognition and a re-appropriation of their lives" (Scalettaris *et al*. 2021, p.8). Over the past five years, Afghans have constituted one of the largest populations of forcibly displaced people entering the EU, with 110,811 asylum applications having been made in 2023 (down from 132,598 the previous year) (European Union Agency for Asylum 2024). The failure of the EU to provide legal routes to international protection for many Afghans has resulted in self-organised journeys being taken overground with the frequent assistance of smugglers; a process referred to in Dari language as *geymzadan* (playing 'the game') (Vještica and Dragojević 2019). Travelling overland typically involves passing through Iran and Türkiye, across the Mediterranean Sea to Greece and then through the Western Balkan region before re-entering the EU and Schengen Zone (and less commonly through Central Asia and Russia to Ukraine and the EU) (Stanzel 2016). The common trajectory of travel is shown below in Figure 1, however, these journeys are far from linear – pushbacks (the state-enforced returns across one or more borders, that often employ violent tactics) are commonplace, resulting in multiple attempts to cross borders or the renegotiation of border crossings, leading to circuitous journeys within and between countries (Augustová 2023, Davies *et al*. 2023, Rydzewski 2020). Engaging with smugglers is a means to facilitate travel. Journeys are often staged, as migrants gather funds to pay smugglers for each onward leg of the journey, and frequently protracted as opportunities in each country are re-assessed, legal status re-defined and border crossings negotiated (Kuschminder 2018, Lønning 2020). One report estimated that when travelling to Europe, Afghans spend an average of three and a half years in Iran before travelling onward (Mixed Migration Centre 2018). Indeed, data from 2015-2018 shows that globally, migration for refugees is protracted by an

average of 20 years, with Afghans making up the largest proportion of refugees who have been in protracted migratory situations for more than 35 years (The World Bank 2019), demonstrating the temporal as well as the spatial dimensions of forcible displacement.

The Western Balkan region has become an established migrant passage into the EU yet is a contested politicised and securitised borderscape, subject to international and regional relations, and the EU's creation of the region as a buffer zone for unwanted immigration (Solarevic and Bozic 2018, Stojić Mitrović and Vilenica 2019). Failure of non-EU Balkan countries to enact asylum procedures or integrate migrants perpetuates onward migration (Kilibarda 2017). Yet the immigration regime of 'fortress Europe' and its declining adherence to the international protection regime - the 1951 Refugee Convention and its 1967 Protocol in conjunction with the 1948 Universal Declaration of Human Rights - have restricted safe transit possibilities through the Balkans into the EU (International Rescue Committee 2021).

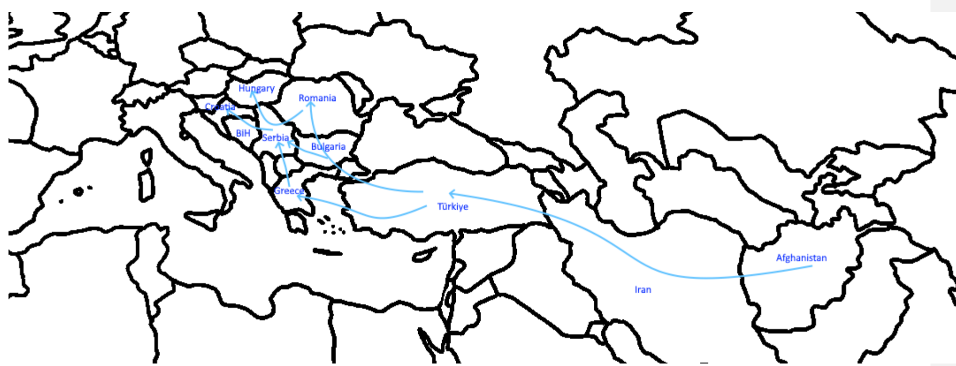

Figure 1 Commonly taken routes from Afghanistan to EU via Serbia

Serbistan: Serbia as a transit country

Serbia is an established transit country for people travelling without state authorisation seeking to enter EU member states. However, its history as a site of mobility is not new. An exhaustive history of Serbia as a transit zone is beyond the scope of this thesis, but I offer some notable examples to illustrate my point. During the years when modern-day Serbia was split between Ottoman and Habsburg rule, the Great Migrations of the Serbs occurring during the 17th and 18th centuries saw large numbers of Serbs moving to modern day Hungary and Croatia. The Second World War saw the Middle East Relief and Refugee Administration coordinating a large-scale movement of refugees from Europe through the Balkan Route including modern-day Serbia to refugee camps in Syria, Palestine,

and Egypt. Later, the 1950s saw the construction of the Brotherhood and Unity Highway, starting at the Greek border, traversing through former-Yugoslavia (including modern-day Serbia) to the Southern Austrian border. This route enabled large numbers of people to travel from Türkiye via Serbia to seek work in German and Austrian factories (Hess and Kasparek 2022). Moving forward, the Balkan conflict of the 1990's resulted in modern-day Serbia hosting large numbers of internally displaced people from across former-Yugoslavia: hosting refugees is within the historical memory of many Serbians. Indeed Serbia hosted 550,000 refugees from former Yugoslav states and a further 200,000 refugees from Kosovo during the 1990's (United States Committee for Refugees and Immigrants 1998). These wars adversely impacted the economy of modern-day Serbia, and it remains a middle-income country, from which significant numbers of people leave for improved livelihood opportunities, although efforts have been made to encourage return migration (OECD 2022). It therefore occupies a position as both a country *to* which people migrate, *from* which people migrate, and *through* which people migrate. In 2012, relaxation of Schengen Zone visa restrictions resulted in a new wave of people from former Yugoslav countries and Albania passing through Serbia into Hungary, joined shortly afterwards particularly by Syrians and Somalis (EWB Archives 2017).

The so-called Western Balkan Route came to media attention in 2015, when a *de facto* humanitarian corridor was opened between Greece and Hungary, enabling people to move freely and quickly overland from Greece to North Macedonia, Kosovo, Montenegro, Albania, Serbia, Bosnia and Herzegovina, entering the EU at its contiguous countries - Croatia, Hungary, or Romania - before moving onwards to western EU member states to seek international protection. Fuelled by home-country conflict and instability, Syrians, Afghans, and Iraqis comprised the largest groups of people to pass through Western Balkan countries, including Serbia, at that time. During this period, Serbia extended hospitality to people on the move through its territory, and humanitarian logics prevailed. However, this was tightly controlled – people were granted permission to travel between Greece and Hungary and were channelled into taking specific routes, where international NGOs had arrived to provide humanitarian aid and United Nations High Commissioner for Refugees (UNHCR) organised buses to transport people from Southern Serbia to the Hungarian border. However, by the end of 2015, Hungary had closed its borders, erecting a razor-wire fence and employing mechanisms of border surveillance. People travelling through Serbia were transported to the Croatian border instead. In early 2016, the EU and Türkiye agreed a deal of cooperation, which incentivised Türkiye to halt state unauthorised crossings between Türkiye and Greece, in an attempt to reduce onward migration into the EU, part of a suite of externalised measures implemented by the EU. Further to the EU-Türkiye deal, Croatia, Macedonia, and Slovenia all closed their borders to people on the move, resulting in large numbers of people becoming 'stranded' in Western Balkan countries. In Serbia, continuing its

programme of border externalisation, the EU took advantage of Serbia's goals for EU accession to demand controls that would halt or decelerate the flow of people making state-unauthorised journeys into the EU. With the assistance of EU funding (Ministry of Labour Employment Veterans and Social Affairs n.d.), the number of transit and reception centres across Serbia were upscaled and the asylum system was ostensibly strengthened. Moreover, around this same time, the Serbian state *de facto* outlawed the provision of humanitarian aid to those living outside state-run camps, instead formalising a system of camp-based refugee support - a move that Cantat (2020) argues was key to the Serbian state aligning with EU migration governance. Scholars have foregrounded how these events represented a shift in Serbia's approach from a humanitarian to securitarian logic, prioritising its relationship with the EU and protection of its borders over the rights of people on the move (Cantat 2020, Stojić Mitrović and Vilenica 2019).

Numbers of people on the move through Serbia have fluctuated over the course of this study, albeit showing a trajectory of steady decline. For example, UNHCR (2024b) estimated that there were 16,944 new arrivals in Serbia between January and March 2023 compared with 5759 in the same period in 2024. However, these figures do not account for people who remain hidden to authorities as they transit thought Serbia. People arriving without state-authorisation in Serbia can register with authorities under the pretext of intending to seek asylum (without requiring an individual to proceed with seeking asylum), which grants them access to state-run accommodation (hereon in referred to by their colloquial name, camps) and healthcare. There are currently 19 camps, managed by the Commissariat for Refugees and Migrants (KIRS). These camps, some of which are former military barracks (Jovanović 2020), have specific designations and can be used for accommodating men-only, family-only, unaccompanied minors, or Ukrainians, although these designations have changed on numerous occasions throughout the course of my study. Some people on the move through Serbia (exact numbers are unknown, but significant numbers are evidenced by NGOs providing humanitarian assistance to people staying outside camps) opt to avoid registering with authorities, concerned that it will decelerate their journeys, staying instead in makeshift camps usually located close to border crossings, to facilitate onward trans-border journeys (Jordan and Minca 2023a).

Health and maternity care in Serbia

Serbia's health system is predominantly provided for by the state although there is also a thriving private health sector. Serbians contribute to a National Health Insurance Fund yet the health system is chronically underfunded and corruption and out-of-pocket payments are commonplace (Arsenijevic *et al*. 2015, Bjegovic-Mikanovic 2019). The maternal mortality ratio in Serbia of 12 per 100,000 live births is higher than other Western Balkan countries, that average 9.5 per 100,000 live births (Nguyen *et al*. 2023).

Whilst there is an adequate network of publicly funded maternity facilities, care itself is widely accepted to be lacking and described as technocratic (Pantović 2019) – that is, a paradigm that understands childbearing as a solely physiological process requiring medical management (Davis-Floyd 2001). Women with uncomplicated pregnancies who are using state-funded maternity services are referred to a gynaecologist in a primary care facility for antenatal care. Those with complications of pregnancy are referred for antenatal care provided by an obstetrician-gynaecologist (OBGYN) at a secondary- or tertiary-level care health facility depending on the arrangements in their local area. Women may opt to have private antenatal care, in which case they contact an OBGYN of their choice directly. Most women (including those who had privately provided antenatal care) give birth in a state-run hospital facility, with an OBGYN as the main care provider, with assistance from nurse-midwives. While the state places no legal restrictions on women giving birth at home, the requirement of maternity care providers to attend homebirth is not mandated (Simic and Jerinic 2014). Once discharged from hospital, patronage nurses (akin to health visitors in the UK) provide postnatal care in the mother's home, although the nature of this care varies widely and its focus is on the health and wellbeing of the newborn (UNICEF n.d.). Over the past two decades, midwives have been stripped of their ability to be lead intrapartum carers, this role having been taken over by obstetricians, and there is no professional body exclusively for midwives in Serbia (Zlatanović *et al*. 2021).

There is a paucity of research focussing on maternity care experiences in Serbia but the very limited existing evidence suggests that mistreatment within maternity care is commonplace (Arsenijevic *et al*. 2014, Janevic *et al*. 2011, Pantović 2022a) and satisfaction with care is low (Lazzerini *et al*. 2022). Nonetheless, anecdotal evidence of obstetric violence is rife and leading to civil society campaigns to humanise birth (Boljanovic 2008, Stojanovic and Vladisavljevic 2021). The birth trauma experienced by some women in hospital facilities resulted in some women giving birth at home without assistance (freebirthing) (Freebirth Society 2024). The limited evidence on maternity care experiences aligns with research and reports from other Eastern European countries, that shines a light on the mistreatment of women during labour and birth and the use of informal payments to acquire improved care (Baji *et al*. 2017, RODA 2015).

I turn now to consider access to health care for people on the move through Serbia. Migrants in Serbia should be able to access essential health services, including maternity care, according to the Sustainable Development Goal 3.8 (United Nations 2016) that sets out targets including access to essential health services for all by 2030. However, people on the move are well known to experience systemic barriers to accessing healthcare (Abubakar *et al*. 2018). To address this, the World Health Organization (WHO) published an assessment of health-system capacity in Serbia to manage sudden large influxes of migrants (World Health Organization 2015). It suggested that all people on the move

were entitled to use state-run health services irrespective of the status of their registration with Serbian authorities, and that all those entering state-run accommodation receive a medical examination on arrival. However, notably only a "small number of migrants" (World Health Organization 2015, p.3) were interviewed in preparing this report, thus failing to adequately account for migrants' experiences of receiving healthcare. Additionally, it has not been updated, although the Serbia WHO office published a paper outlining the interventions they had implemented in collaboration with the Serbian Ministry of Health (Pusztai *et al*. 2018). In this paper, the authors highlighted that while healthcare was being provided to all people on the move irrespective of their registration status, healthcare costs were only covered for those granted asylum. They called for healthcare costs to be extended to cover those who have been state-registered, recognising the challenge of healthcare provision to those not state-registered, in addition to the insufficient numbers of interpreters to enable communication between health workers and patients (Pusztai *et al*. 2018).

In a study examining uptake of healthcare services by people on the move through Serbia between 2015 and 2016 Santric-Milicevic *et al*. (2020) posited that Serbia's healthcare system was able to adapt and respond to the increased numbers of people on the move, by correlating increases in numbers of new arrivals with increases in health service utilisation and diagnoses of medical conditions. Another study found that healthcare was accessed by people staying in camps via doctors working within camps, who would then organise onward hospital referrals if necessary, bypassing waiting lists to receive appointments relatively quickly, and importantly that further support with accessing healthcare was obtained through trusting relationships that had been developed with cultural mediators working for NGOs (Buch Mejsner *et al*. 2021).

Other published research relating to healthcare in Serbia for people on the move has focussed on (un)accompanied minors (Topalovic *et al*. 2021), oral health (Mandinic *et al*. 2021), and disability (Badali 2021). Studies examining the impact of on Covid-19 on people on the move through Serbia focussed mainly on the way it produced (im)mobility, rather than on its health effects (Šantić and Antić 2020). However, Graham (2021) explored the provision of alternative digital sexual and reproductive health resources for women locked down in camps, finding that online videos were perceived as acceptable and well-accessed. Notably there is an absence of studies exploring any aspect of maternal or newborn health or healthcare among people on the move through Serbia, representing a significant gap in the literature.

The United Nations High Commissioner for Refugees (UNHCR) monitors migration flows closely in the Western Balkans region. Despite this, there is a stark paucity in sex-disaggregated migration data in and around Europe. The WHO Regional Office for Europe (2018) estimated that women and children

make up 55% of all categories of migrants entering Europe, with 10% already pregnant. As I will now discuss, migration is transformative for women and yet insufficient data results in the invisibility of women (and in relation to this study, their reproductive health needs) in policy-responses (Kraly 2018).

Forced displacement and (childbearing) Afghan women

Having examined Afghan mobility in Serbia and Serbian maternity care, I turn now to consider forced displacement and Afghan women, focussing on the perinatal period.

There is a growing literature on women and trans-border movement, sometimes referred to as the "feminisation of migration" (Salih 2011, p.2). This literature departs from hegemonic androcentric understandings of migration that assumes women are passive in migration, dependent upon their husbands, and subjected to male decision-making, thus rendering women's agency invisible (Sunata and Özsoy 2022). Instead, the nuanced and complex ways in which women are affected by forced displacement differently to men are revealed. Forcibly displaced women are at risk of gender-based violence, sexual exploitation, trafficking and human rights abuses while journeying (Freedman 2016b, Grotti *et al*. 2019, Vještica and Dragojević 2019). On arrival in a country in which women wish to seek international protection women are often faced with gaps in systems that are inadequately organised to protect forcibly displaced women (Fiddian-Qasmiyeh 2014, Refugee Council 2019). However, women are not solely at risk of being victimised; they actively navigate migration to improve their circumstances, welfare, and for their safety (Chemlali 2024, Sunata and Özsoy 2022).

There is little knowledge specifically relating to the impact of forced displacement on Afghan women during childbearing – a limited number of studies exploring this issue have been set in Iran and Australia. Studies suggest that poorer obstetric outcomes among Afghan women in Iran were associated with lacking adequate health insurance (Dadras *et al*. 2020, Yaghoubi *et al*. 2022), and that Afghan women commonly experienced discrimination from, and poor communication with health professionals (Mohammadi *et al*. 2017). Studies in Australia highlighted the impact of social aspects of Afghan women's childbearing. Russo *et al*. (2015) found that Afghan women experienced difficulties in emotionally adjusting after birth due to social isolation following separation from kinship networks, but that forming new social connections and the relationship with their infant aided emotional adjustment after birth. Underscoring the value Afghan women placed on social relations, Shafiei *et al*. (2012) found that positive interactions with health professionals formed an important component in the satisfaction of their care. These interactions were dependent on interpreters for Afghan women unable to speak English, as well as acquiring information about how to navigate maternity services and access maternity-related information (Riggs *et al*. 2020).

Looking at the broader literature on migration and health can shed further light on how migration can impact childbearing for Afghan women, although much of this literature is one-dimensional coming from a single discipline, such as public health. Pre-migratory factors are shown to determine the impact of migration on health generally (Abubakar *et al*. 2018, Hanefeld *et al*. 2017) – current health indicators relating to Afghanistan are limited since the Taliban takeover but pre-Taliban data show it to be among countries with the worst health status (World Health Organization 2021). Additionally, previous data showed that non-communicable disease was a cause of death for 37% of adults (Saeed *et al*. 2020) and communicable disease accounted for around 60% of outpatient visits at health facilities (Ikram *et al*. 2014). Further sex-aggregated data is needed to understand fully how these diseases specifically affect women. Armed conflict affects women and children disproportionally (Singh *et al*. 2021). In Afghanistan decades of war and the resultant weakened economy, erosion of health and education systems, and downturns in women's rights adversely affected women's health (Massahikhaleghi *et al*. 2018, Mirzazada *et al*. 2020). The 'maternal migration effect' (Binder *et al*. 2012) describes sub-optimal pre-migratory maternity events which influence maternal health in host countries. Such sub-optimal events occur in Afghanistan as a result of a complex web of socio-cultural determinants, provision of, and access to maternity services and disrespectful or poor-quality care (Arnold *et al*. 2018, Najafizada *et al*. 2017). A small pilot study among women in Afghanistan found that 87% of participants had symptoms of postnatal depression (Tomlinson *et al*. 2020). Under current Taliban rule women are forbidden to leave the home without a male escort, not only creating barriers to accessing maternity care for women, but also hindering midwives and female health workers from delivering maternity care, alongside a significant deterioration in maternal and newborn health care provision (Glass *et al*. 2023). Women who have had adverse or negative maternity experiences in Afghanistan may therefore carry these experiences into future pregnancies at various stages of migration or at arrival in a country in which they seek asylum. While sub-optimal pre-migratory events can impact maternal health in host countries, the concept of the 'maternal migration effect' (Binder *et al*. 2012) can be extended to include not only *pre*-migratory events, but also *migratory* events, that have the potential to affect future pregnancies. During this stage of migration, empirical evidence shows that those whose migration involves living in refugee camp settings the geographic location of maternity services, lack of available transportation, fear of personal safety, healthcare costs and host country registration requirements and their restrictive policies can act as barriers to accessing maternity care (Furuta and Mori 2008, Lalla *et al*. 2020). Additionally discriminatory and disrespectful maternity care of women in host countries has been highlighted: a study of Afghan women in Iran, who had near-miss maternal morbidity, found that women's concerns were not listened to, they were verbally abused, and experienced a lack of communication from health professionals (Mohammadi *et*

al. 2017). The sequalae of such sub-optimal pre-migratory and migratory events may reach into future pregnancies, both physically and psychologically (Greenfield *et al*. 2019).

Given the global scale of human mobility, it is imperative that those providing maternity care to forcibly displaced women have an awareness of potential pre- and migratory events, to give appropriate and sensitive care in subsequent pregnancies. In a systematic review exploring models of maternity care for migrant (including forcibly displaced) women in high-income countries, the provision of bicultural health advisors, specialist or multidisciplinary care provision, and psychological interventions, among others were identified (Rogers *et al*. 2020). The review found that key components of models of care that were positively evaluated by refugee and migrant service users and health providers included effective communication, practical and psychosocial support, assistance with navigating systems, and systems of care that were culturally responsive, flexible, accessible, and offered continuity of carer (Rogers *et al*. 2020). However, the authors noted that many of the included studies insufficiently examined the extent to which models of care improved perinatal health outcomes.

Why focus on Afghan women?

Over the course of my doctoral research, I was frequently asked why I chose to focus on Afghan women in this study. I have several reasons. Firstly, my decision to focus on Afghan women was a starting point in my doctoral research. Having lived in Afghanistan, and gathered anecdotal narratives of women's birth experiences for my work, I was keen to formalise the collection of these experiences in a research context. However, the security situation in Afghanistan prohibited setting my doctoral research there, and so I looked at other contexts in which to conduct my research (I discuss my rationale for selecting Serbia as the study setting in Chapter 2). Secondly and more importantly, I wanted to depart from health research that lumped together migrant women without attention to how country of origin intersects with mobility to shape maternity experiences. For example, aspects of the health of women from Poland living in the UK is likely to widely differ from those from Syria in the UK. Focussing on Afghan women enabled contextualisation of their mobility to a greater extent. However, I acknowledge that Afghan women are also ethnically, educationally, economically, socio-culturally diverse, factors also affecting mobility. I discuss later in Chapter 2 how I accounted for these diversities to avoid homogenising and reproducing stereotypes of Afghan women. Finally, the decision was pragmatic, given the small-scale and limited budget of this study. The logistics of conducting this research across multiple languages was not feasible and I hoped that having basic Dari-speaking language skills and degree Afghan cultural understanding would be helpful in conducting this study. Nonetheless, similarly to Schmeidl (2023) I have also been extremely mindful of my outside 'gaze' and limits to my role in knowledge production about Afghan women in this doctoral study – I explore this in greater depth in the 'Positionality and reflexivity' section of Chapter 2.

An interdisciplinary thesis

To address the topic of inquiry, this thesis required an interdisciplinary approach, that has affected and shaped every aspect of my doctoral study. In this section, I will set out what interdisciplinary research has to offer, which disciplines I engaged with, and how they benefited my study.

There is much debate about what constitutes interdisciplinary research (Huutoniemi and Rafols 2017), and while terms such as 'cross-disciplinary', 'trans-disciplinary' and 'inter-disciplinary' have been distinctly defined (van Teijlingen *et al*. 2019), they are often used interchangeably (Woollen 2019). However overall, interdisciplinary research is considered to be distinct from research that is bound to one academic field, and it extends beyond multi-disciplinary research in which research is conducted using a range of academic fields without these disciplines integrating in any way (Klein 2010, Lyall *et al*. 2011). Lyall *et al*. (2011) state that interdisciplinary research is that which, "… approaches an issue from a range of disciplinary perspectives, and the contributions of the various disciplines are acknowledged and integrated to provide a holistic or systemic outcome…" (p.14). It encompasses breadth (the breadth of knowledge generated by more than one discipline), integration (coherently amalgamating knowledge from discrete academic fields) and transformation (the potential for change brought about by transcending the boundaries of a single discipline) (Huutoniemi and Rafols 2017).

In this study, I draw upon two academic disciplines: midwifery and migration studies, both in of which are interdisciplinary in their own right. Prior to embarking on a discussion about these disciplines and how I used them in this thesis, I wish firstly to contend that migration studies and midwifery are indeed academic disciplines, albeit relatively nascent ones. Following the lines of argument proposed by Krishnan (2009) about what constitutes an academic field, both have specific objects of research, a corpus of knowledge pertaining to these objects of research and concepts that organise them, lexicons used in relation to the research objects, and finally both are taught subjects in the academy.

Midwifery is a nascent discipline that is arguably currently under-developed (Eri *et al*. 2020), but draws largely on health sciences, public health, anthropology, and sociology. Midwifery understands pregnancy and birth as a biopsychosocial event, shaped by culture and social processes, constituting a significant life-changing event for women rather than a solely biomedical process (McCourt 2014, Saxbe 2017). This is further captured in the words of Chadwick (2018) who argues, "Birth is always embedded, emergent and in relation to sociocultural norms, local material structures, physiologies, intersectional and transnational relations of power. Birth is situated at the crossroads of body, socio-materiality, physiology, discourse, language, and geopolitics." (p.3). Philosophically, midwifery care and practice is focused on the midwife-woman relationship, woman-centred care, and salutogenic (emphasising facilitation of good health rather than preventing risks) (Eri *et al*. 2020). To this end,

midwifery care can also constitute subversive acts in the face of technocratic systems of care (Hawke 2021, Newnham and Buchanan 2023). Midwifery research is well-positioned to explore experiences of, and examine dynamics of power encountered by, women during childbearing (Newnham *et al*. 2016).

Migration studies is a rapidly growing discipline that seeks to understand the movement of humans, in all its forms, its socio-cultural, political, and economic impacts, and the circumstances encountered by migrants at each stage of their journey (Zapata-Barrero and Yalaz 2018). It is a well-established interdisciplinary academic field, rooted in the social sciences, that draws on the disciplines of geography, sociology, political sciences, and anthropology among others, and is continually expanding to include additional disciplines (Scholten *et al*. 2022). It is worth noting that the nationalism underpinning traditional migration studies has come under criticism: De Genova (2013) contends that, "… if there were no borders, there would indeed be no migrants – only mobility." (p.255). Additionally, scholars working with the discipline of migration studies have the potential to form part of the apparatus of migration regimes by reinforcing the migrant-citizen binary, and calling for continuous reflexivity of researchers to our complicity in reproducing state power (Garelli and Tazzioli 2013).

In the same way that Kivits *et al*. (2019) contend for interdisciplinarity in investigating and tackling global public health challenges to look beyond individual and health systems solutions, interdisciplinarity in this study provides insights into maternal health challenges that encompass social, political, and economic factors. In doing so, an interdisciplinary approach necessitates marrying methods and theories from these two aforementioned disciplines. In this thesis, using an interdisciplinary approach entailed drawing from a wide range of literature, and engaging with theoretical approaches from both disciplines, to inform my study. Specifically, I selected the theoretical lenses of feminism (specifically, decolonial feminism) from midwifery and critical border studies (CBS) from migration studies, which in turn informed my research methods (discussed in greater depth in the 'Theoretical orientation' section of Chapter 2).

Lyall *et al*. (2011) liken the undertaking of interdisciplinary research to embarking on a journey, often on paths that have been seldom, or never, trodden, and for which the destination is unknown, unlike mono-disciplinary research which has a clearly defined roadmap. Throughout this study, I was aware of the challenges and pitfalls of taking an interdisciplinary approach, specifically the challenges of ensuring I was conversant with the key concepts and current issues in migration studies having come from a different academic background, and the risk of the study becoming too broad by mixing disciplines, at the expense of a depth of exploration. Nonetheless, interdisciplinarity in this thesis provided the benefits of understanding the phenomena of Afghan women's perinatal experiences from

multiple academic perspectives. Moreover, using interdisciplinarity in my research was a means to understand and address real-world problems, examining the multifarious intertwined forces that work to impact perinatal experiences, avoiding the siloed approach that single-discipline research can create (Bergman-Rosamond *et al*. 2022, Kendall and Langer 2015). I engaged with theoretical approaches from midwifery and migration studies to elucidate the complexities of perinatal experiences, at both the micro- and macro-levels (Kivits *et al*. 2019). In turn, these theoretical approaches informed my research methods and the key areas for discussion, providing research recommendations that speak to a range of audiences from diverse professional backgrounds. I also took a flexible approach to the ways in which I presented my work, both in written and oral communications of my research, adjusting my approach and use of discipline-specific terminology to best fit my audience. Importantly, I carefully considered when writing this interdisciplinary thesis that I blended the approaches of both disciplines to tell a coherent story throughout.

Thesis Structure

The second chapter of this thesis sets out the research methods I employed. It explains the theoretical approaches that informed this study, the study design and research methods. Here, I also reflect on my position as a researcher, and how this affected the knowledge produced in this thesis, as well as the ethical considerations, and how these shaped the way in which I conducted this study.

In the third chapter of my thesis, 'Navigating New Lives: A scoping review and thematic synthesis of forced migrant women's perinatal experiences' (Sharma *et al*. 2020), I explore the existing literature on perinatal experiences of forcibly displaced women. In synthesising the literature, I found that women were required to negotiate structural barriers when interacting with maternity services, yet that woman-centred maternity care had the potential to provide valuable support to women at a time when many experienced multiple changes to their networks of social support.

Chapter 4 is the first of three chapters in which I present my main empirical findings. In this chapter, I discuss the contextual factors in Serbia that were interwoven with Afghan women's perinatal experiences. In this chapter, the uncertainty of journeys that women made, and the hardship and violence they encountered during these journeys is laid bare. I also show how hospitality in Serbia for Afghan women is contradictory, and how the Serbian hospitality-hostility continuum is dependent on hierarchies of deservingness. I depart from stereotypes of Afghan women as being passive in their trans-border mobility, to show how some play an active role in decision-making and how they resist state efforts to keep them away from EU borders.

I follow this with Chapter 5, in which I centre Afghan women's narratives. Here, I reveal ways in which their childbearing experiences are deeply embedded within their broader narratives of trans-border

mobility and the negative consequences for women as a result of staying in sub-standard refugee camps. I foreground the zones of structural control that women wee required to navigate, particularly at health-system and migration governance levels, and unpack ways in which women were required to advocated for themselves. Finally, I show the comfort that having a newborn brought to some women.

Chapter 6 comprises a published paper entitled, 'The nexus between maternity care and bordering practices: a qualitative study of provider perspectives on maternal healthcare provision for Afghan women migrating through Serbia to western Europe' (Sharma *et al*. 2024a). The paper explores the experiences and perspectives of providers of perinatal care and support to childbearing Afghan women in Serbia. I highlight how participants consider quotidian living for refugees in Serbia to impact childbearing experiences of Afghan women, the challenges of providing maternity care and support to a highly mobile group and how maternity care is accessed, and the risks that perinatal Afghan women face during onward travel. I also reveal the backdrop of constant changes under which service providers negotiated to provide care and support to childbearing Afghan women. I contend in this chapter that regional geopolitics trickles down to create exclusionary systems of perinatal care and support to Afghan women in Serbia.

The final findings chapter in my thesis, Chapter 7 is another published paper, '"When a story gets a face…": visual elicitation of Serbian perspectives on Afghan refugee women's maternity experiences in Serbia' (Sharma *et al*. 2024b). I discuss in this paper a public engagement project that I conducted as part of my doctoral research that involved the development of a webcomic that illustrates common threads running through Afghan women's narratives of their perinatal experiences in Serbia. I explore the awareness and opinions of Serbian health professionals and members of Serbian civil society organisations (CSOs) regarding childbearing Afghan women in Serbia, using the webcomic as a visual elicitation. In this paper, I show how respondents who viewed the webcomic considered childbearing Afghan women to face multiple challenges while in Serbia and that Serbian maternity care for Afghan women is inadequate.

Finally, in Chapter 8 I bring together all the doctoral study findings into one discussion, placing my findings into the context of existing scholarly work. I also discuss the strengths and limitations of this research and present recommendations for migration policy, the treatment of Afghan women in Serbia, clinical maternal and newborn health care practice, and future research.

Contribution of thesis

This thesis makes several important contributions. Its key argument is that childbearing experiences, and provision of maternal and newborn healthcare and support for forcibly displaced Afghan women

on the move through Serbia, is significantly shaped by bordering processes that keep subaltern people away from EU borders irrespective of the harms caused as a result.

This study is the first to examine any aspect of perinatal experiences or care for forcibly displaced women transiting through non-EU South Eastern Europe, and therefore makes a significant original contribution to the corpus of knowledge on this topic, both within its specific geospatial context, but it also to the broader literature pertaining to perinatal experiences for forcibly displaced women. This study addresses the deleterious effects of the EU border regime on maternal and newborn health, through measures of deterrence that include direct and indirect violence and exclusionary systems of maternity care. This thesis not only contributes to the academic discourse, further the (mis)treatment of forcibly displaced women and their infants at the margins of the EU has direct relevance to practices and policies governing local and regional migration policy, and those relating to maternal and newborn healthcare systems.

The interdisciplinary approach to this study offers a means to understand Afghan women's perinatal experiences from a plurality of vantage points. The theoretical lenses of decolonial feminism and critical border studies with which I engaged to understand perinatal experiences offer a novel approach to unravelling the complexities of intertwined perinatal and migratory experiences. Using these approaches has informed my methods to centre women's voices, and understand how bordering practices rooted in colonial legacies intersect with gender and race to ultimately create hierarchies of deservingness to care. By doing so, it addresses a need for maternal and newborn health research to look beyond health systems to wider geopolitical forces that intertwine with perinatal experiences thus also making a theoretical contribution.

CHAPTER 2- METHODOLOGY

Introduction

The aim of this study is to explore the lived experiences of Afghan women in Serbia during the perinatal period, with a focus on understanding their interactions with, and the provision of, maternity care. In this chapter, I embark by setting out the philosophical foundations and theoretical orientation of this study that informed the research methodology. I discuss the research methods I used for data collection and analysis, addressing also cross-language data collection. I then describe a public engagement project before considering my positionality and reflexivity and ethical issues.

Philosophical foundations

All research is embedded within certain assumptions (Braun and Clarke 2022), described by Guba and Lincoln (1982) as value systems. These philosophical foundations or value systems comprise ontology (the nature of reality), epistemology (ways of knowing), axiology (the researcher's values and beliefs), and methodology (how research is conducted), with each of these influencing the other in turn (Guba and Lincoln 1982, Kelly *et al*. 2018). In this study, engaging with an ontology of relativism allowed me to consider the multiple realities of human experience that are subjectively situated. Taking into account these multiple realities, and resisting epistemologies that reproduce refugee vulnerability by viewing participants as merely objects of research (Bragg 2022), I took a social constructivist standpoint. Social constructivism considers both researcher and participants as active agents in constructing knowledge, situated in a particular social context, and privileges participants' collective, intersubjective realities rather than searching for the 'truth' or universality (Boyland 2019, Labonte and Robertson 1996). This is especially apposite in refugee research, in an era when the truth of refugee accounts are sought out by immigration authorities in order to sift 'genuine' from 'bogus' protection claims, and when the media universalises refugees as either vulnerable victims or threatening invaders (Amores *et al*. 2020, Smith 2017). Using social constructivism in this study allowed the creation of complex, nuanced, and rich personal realities in this study, to understand Afghan women's perinatal experiences in Serbia, privileging participants' knowledge. By doing so, I departed from colonial legacies of western epistemic superiority (Davies *et al*. 2023, Kerr 2014). My axiological stance is defined by my belief that as a researcher I am intrinsically bound to this research and therefore the knowledge produced in this thesis is intersubjective. As such, my values, beliefs, and ethical conduct are woven throughout this thesis. I consider that knowledge produced in this study is secondary to the dignity, rights, and wellbeing of participants, summed up by the phrase 'prioritising people' in my professional body's Code of Conduct (Nursing and Midwifery Council 2024).

Additionally, I view research of this nature to be deeply political – I do not attempt to remain neutral, but rather use this research as a platform to document and amplify injustices that occur during migration, thus situating myself as a scholar-activist.

Theoretical orientation

Theory plays a critical role in research. Theoretical approaches shape research design and underpin research methods, as well as informing the interpretation of research findings (Kelly 2010). In this study, I employed decolonial feminism and critical border studies to act as a "guiding lens" (Braun and Clarke 2022, p.189) throughout the study.

Decolonial Feminism

Midwifery has long been underpinned by feminist approaches (Barnes 1999, Yuill 2012). It dovetails with philosophies of midwifery care in which woman-centred, individualised and holistic care is emphasised (van Teijlingen 2005) and is widely applied in midwifery research (for example, Feeley *et al*. 2020, Hawke 2021, Westergren *et al*. 2019). At its broadest, feminisms are concerned with, "understanding and improving the lives of women" (Woodiwiss 2017, p.15). This seemingly simple notion is developed by Enloe (2004) who stated, "One of the starting points of feminism is taking women's lives seriously. 'Seriously' implies listening carefully, digging deep, developing a long attention span, being ready to be surprised." (Enloe 2004, p.3). Feminism perceives maternal bodies as sites of patriarchal control and power, shining a light on the subjugation of women's childbearing bodies. Feminist approaches are critical to understanding and tackling the power hierarchies present within maternity care. It does so by paying attention to women's voices and perspectives in addition to systems of care that facilitate or limit the provision of woman-centred care, and situating maternity care within its broader sociocultural context rather than isolating it as a biomedical event. Feminist approaches are particularly apposite when addressing power differentials between maternity care providers by acknowledging, valuing, and centring the voices, needs and experiences of women. This woman-centred approach is therefore subversive when enacted by midwives (Hawke 2021). However, not all feminisms consider subaltern women's voices, which can be ignored or trivialised in systems of maternity care, or who can be subjected to disrespectful maternity care (Peter and Wheeler 2022).

Indeed, white feminisms have come under criticism by women of colour for focusing on, and privileging white women and women from the Global North, failing to take into account the diversity of women globally, but instead lumping them together as a homogenous group (Lourde 2003, Vergès 2021, Zakaria 2021). Mohanty (2003) criticises these kinds of feminisms for socially constructing a flattened representation of women from the Global South, who she describes as being typified as

ignorant, uneducated, domestically-oriented, in contrast to the modern, educated, liberated, white western woman, thus pointing us to the importance of representation in feminism. In response to this, decolonial feminists have challenged dominant perceptions of voiceless, powerless, and racialised women (Vergès 2021, Zakaria 2021), by focusing on dialogues with under-represented women, situated in their realities, providing space for their voices to be heard (Manning 2021, Rodrigues 2022). Decolonial feminism is not a feminism that emerged from a decolonisation agenda *per se*, but is a feminism that recognises that it is not gender alone that results in women's oppression, arguing if that were the case, women globally would all be equally oppressed. Rather, decolonial feminists highlight the multidimensional factors of gender, race, and colonialism that intersect to create systems of power and oppression and perpetuate inequalities (hooks 1984, Vergès 2021). Therefore decolonial feminism overlaps with intersectionality, (a concept described by Crenshaw (1989) to describe how race and gender, alongside other social categories, can interact to create disadvantages) while seeking to understand how geopolitics and historic colonial legacies continue to perpetuate systems of power that shape subaltern women's lives (Manning 2021, Wagner 2021) Decolonial feminism gives space to these subaltern women's experiences and voices (Manning 2021, Mendoza 2016).

With this in mind, linking together decolonial feminism and migration, I will now unpack the historical and geopolitics of colonial legacies to show how they intersect with gender and race to reproduce the unequal mobilities for subaltern women that contribute to inequalities (Pallister-Wilkins 2023).

Historical colonisation of large parts of the Global South by western Europe for the expropriation of local resources involved the management and control of indigenous people to secure and maintain power held in the hands of white men (Tuck and Yang 2012). These colonisations were built on racial hierarchies; notions of white men's supremacy and domination over white women and dehumanised and subjugated black and brown people considered to be inferior and made to be disempowered (Pallister-Wilkins 2022). Colonisers (white men) were free to travel within and across imperial boundaries. Yet imperial control inextricably involved controls on movement of colonised populations, creating inequalities in freedom of movement along lines of race and gender (Al-Wazedi 2021, Pallister-Wilkins 2023). Transport infrastructures were built by the colonised, creating, "new forms of mobility injustice as they served the interests of capital and white men's mobility" (Pallister-Wilkins 2023, p.25).

As imperial projects came to an end in the 20th century, the borders of former imperial nations became fortified because of fears that multiracial societies would disrupt the status quo, thus they continued to exert control over mobilities of non-white people (Hampshire 2005). This nationalism in

western Europe led to the creation of new border controls and the implementation of passport and visa requirements to cross borders, that privileged the movement of some while limiting that of others. The formation of the European Economic Area, the forerunner to the European Union, and subsequently the Schengen Zone, enabled those with mobility privileges to travel freely without documentation within the zone, but also led to the fortification of its external borders – Fortress Europe (Almustafa 2022). Picozza (2021) contends that it is these very border regimes that have kept unwanted bodies out of the Union and therefore, "refugees are not the product of crises external to Europe; they are a product of "Europe" itself – as both a project of global domination and a fragmented geopolitical assemblage" (Picozza 2021, p.7), also shifting away any of Europe's responsibility in the creation of a 'refugee crisis' (Almustafa 2022).

Layering colonial legacies on gender and race, Vergès (2021) asserts that resisting "femoimperialism" (p.17) involves challenging dominant perceptions of voiceless, powerless, and racialised women. In the current political climate worldwide, in which the lives of migrants from the Global South are pitied and dehumanised (Mohanty 2003), employing a decolonial feminist lens in this study, amplifying the voices of marginalised and under-researched women, is an apposite approach.

Whilst there is no singular way to conduct decolonial feminist research (Thorn and Varcoe 1998), decolonial feminist research tries to centre under-represented women's voices and experiences, legitimising these as knowledge, seeking to reduce the power imbalance between researcher and participant by minimising hierarchies, and respecting participants (Landman 2006, Lokot 2019, Parr 2015, Tuhiwai Smith 2004). Valuing all lived experiences and knowledges equally by engaging with, and making space for perspectives of subaltern women, decolonial feminist research challenges the superiority of normative production of knowledge from the Global North (Manning 2021, Tuhiwai Smith 2004). Further, feminist research understands that, "…the unit of inquiry is not a discrete being… but the shifting and co- constitutive relations between them." (van den Berg and Rezvani 2022, p.24), highlighting the relational dimension of feminist research that breaks down the understanding of participants of 'others' but finds solidarities between the researcher and researched. It is these threads running through decolonial feminist research with which I engaged throughout the study, and which deeply informs it.

Critical border studies

Critical border studies (CBS) is a theoretical approach stemming from migration studies that interrogates bordering practices and processes occurring in spaces at and away from state boundaries, exploring the effect they have, and on whom (Parker and Vaughan-Williams 2012). Conventionally, borders are considered to be material, static geographical lines, delineating political boundaries. At

its most fundamental level, CBS questions and problematises the conceptualisation of territorial boundaries as fixed, positing that borders can be found not solely at territorial boundaries, but inside or beyond state borders, through the implementation of transnational bordering practices and processes (Parker and Vaughan-Williams 2012). In this way, borders can be seen as dynamic, overlapping, and changeable, appearing and disappearing. The uneven enactment of bordering processes renders them exclusionary, marginalising, and restrictive: people deemed to be desirable or deserving of entry to a nation-state are included, but those who are not are excluded, creating socially dynamic spaces at and around borders (Brambilla 2010, Watkins 2017). Thus borders are polysemic, meaning different things to different people and CBS elucidates how the complexities and breadth of experiences of borders vary widely along racialised, social and gendered lines (Stierl 2019). Border controls follow people: citizenship and immigration status privileges certain groups by enabling international travel, while for others, crossing borders is unauthorised (McCorkle 2020). Bordering practices are not only enacted by states, but by increasingly diverse actors, as immigration measures are insourced by governments to everyday citizens (Back and Sinha 2019, Rumford 2006). Engaging with CBS enables an apprehension of not only the conspicuous elements of bordering on perinatal Afghan women, but shines a light also on bordering practices otherwise rendered invisible.

Women leaving Afghanistan are subject to uneven and exclusionary bordering practices. Those able to leave the country via state-authorised routes need to be deemed eligible for a resettlement scheme, as defined by the host country (those who are ineligible are deemed undeserving of taking state-authorised routes). Additionally, biometric data is often required from the receiving country prior to travel – impossible for those with restricted mobility within Afghanistan (Taylor 2022), and funds to travel to the receiving country's closest embassy may be required in order to complete visa interviews (Parvaz 2022, Taylor 2022).

In the EU context, the sequalae of bordering practices have been shown to be a continuum of violence towards migrant groups deemed 'undesirable'. 'Slow violence' has been conceptualised to describe psychological and physiological effects of bordering practices on asylum seekers (Mayblin *et al*. 2020, Meier 2020) and violence leading to deaths at Europe's Mediterranean frontier has been well documented (Kovras and Robins 2016). Borders and healthcare research has primarily focussed on territorial borders, but the global trend toward migrant hostility towards migrants has prompted interrogation of the impacts of bordering practices on healthcare provision and its consequences on recipients of care. For example, governments are increasingly insourcing immigration measures (Back and Sinha 2019): National Health Service staff in Italy and the UK are required act as gatekeepers to free healthcare by ascertaining patients' immigration status, to establish those not entitled who should be charged (Perna 2017, Rassa *et al*. 2023). This exposes health professionals to ethical

dilemmas in their duty to provide healthcare (Feldman *et al*. 2019), and deters some people from seeking care (Britz and McKee 2016).

Bringing theoretical approaches together

Decolonial feminism and CBS converge at the point where legacies of colonialism create systems of power that perpetuate uneven mobilities along gendered and racialised lines. By bringing CBS into theoretical dialogue with decolonial feminist approaches, I engage theoretical lenses in this study that centre the voices of women, exploring ways in which intersecting social factors, histories, geopolitics, and bordering practices, shape the experiences of perinatal Afghan women in Serbia. Moreover, engaging both theoretical approaches provides a novel way to understand perinatal experiences beyond the individual and health-system approaches that are more commonly explored in maternity experience research (for example, McLeish and Redshaw 2019, Rayment-Jones *et al*. 2019). For the purposes of this study, theoretical approaches with an emphasis on individual- or health system-level factors can certainly shed light on personal or health system experiences but may be at risk of neglecting or limiting the influencing wider structural factors at play. Decolonial feminism and CBS helped to shape the research methodology, which I now discuss.

Research methodology

Research questions

This research attempted to answer the following research questions:

- What are the migratory circumstances experienced by perinatal Afghan women travelling through Serbia?
- How do Afghan women experience the perinatal period and maternity care in Serbia?
- What are the experiences and perspectives of clinical and non-clinical actors providing perinatal care and support to Afghan women during migration through Serbia?

Study design

The locus of this study was understanding the experiences of Afghan women in Serbia around the childbearing time. A qualitative study design was therefore selected. Qualitative methodologies are those that seek to understand social phenomena and focus on meaning (Braun and Clarke 2013, Marshall and Rossman 2011), doing so by documenting and interpreting “the messiness of real life” (Braun and Clarke 2013, p.20). Using qualitative methodologies in this study enabled me to gain a multi-layered and rich understanding of the phenomena I was studying, within a context laden with complexities, from participants’ frame of reference (Schweitzer and Steel 2008; Marshall and Rossman

2010; Morawska 2018). Furthermore, employing a qualitative methodology allowed a degree of flexibility, to adapt the research process throughout the course of the study (Pultz 2018). This served to mitigate some of the risks that I anticipated might occur when conducting this precarious research study by enabling flexibility, such as allowing me to take an iterative approach during data collection or adjusting the location of data collection. Additionally, one of the potential risks of the research study of which I was conscious prior to collecting data pertained to my inability to recruit sufficient Afghan women - including multiple qualitative methods at the outset of the study ensured that I would have sufficient data to complete this study by not having to rely entirely on data collection from solely one method. However, it was always my intention to privilege the voices of Afghan women as far as possible throughout this study; integrating other perspectives ensured study feasibility in addition to providing a multi-faceted exploration of Afghan women's perinatal experiences in Serbia.

Research methods

This section outlines the multiple methods I employed (unstructured observations, narrative interviews, and semi-structured interviews), in addition to discussing issues of conducting interviews in other languages, examining my own positionality and reflexivity, and exploring the ethical issues pertaining to research methods.

Study site

Wanting to explore Afghan women's perinatal experiences while on the move to the EU, but still outside the EU, I selected Serbia as a study site. Regionally Serbia hosts among the highest number of refugees (UNHCR 2022) and its extensive state-run accommodation and camp-based refugee support provided me with potential opportunities for access to research sites and participants. Furthermore, at the start of the study, an NGO in Serbia offered to partner with me, creating opportunities for fieldwork and access to participants (essential to the study's success and will be discussed later in more detail). The NGO is an international organisation, with a permanent presence in Serbia, with programmes focussed on issues pertinent to the Serbian population, which as homelessness, education, and women's empowerment in addition to meeting the needs of migrants in Serbia.

Informal conversations with relevant actors

Between March 2019 and December 2022, I was in regular contact remotely with a wide-range of actors who were working with people on the move in the Balkan region, either directly on the field or indirectly in management roles. I discuss this (often concealed) aspect of the research here, because my data collection became contingent upon it. Initially, informal conversations helped me build rapport and relationships with relevant actors, scope out the study and research questions, and importantly led to identifying a partner NGO. Over time, these conversations became critical to the

research, enabling me to develop relationships with a network of actors who would assist in identifying and gaining physical access to the spaces occupied by Afghan women in Serbia, as well as facilitating access to, and recruitment of Afghan women to the study. Furthermore, I continued to hold informal conversations with actors during the entirety of the data collection phase – the majority of these actors did not meet the inclusion criteria for participating in interviews, but they nonetheless provided me with crucial updates on the situation for Afghan women in Serbia, in a rapidly shifting geo-political landscape giving me 'eyes and ears' on the ground when my ability to be in Serbia in-person was constrained by Covid-19. A total of 23 informal conversations were held with relevant Serbian-based actors (NGO actors, health professionals, academics, and activists) over a 33-month period, between March 2019 and December 2022. Conversations held in the early stages of the study helped to narrow the research focus and co-design research questions. Those held during the data collection phase of the study enabled me to iteratively refine my data collection tools by ensuring that they reflected the changes that were occurring in Serbia in addition to generating opportunities for recruitment through raising awareness of my research.

Data collection

> *"Everyday life will never adjust to your research plan; the only way forward is to adapt your plan and ways of going about things to the rules of everyday reality."*
>
> (Blommaert and Jie 2020, p.3)

I had originally planned to spend 6 months in Serbia as part of the data collection phase of my study. However, Covid-19 and the ensuing lockdowns and uncertainties around travel meant that I had to adapt my methods, spending less time in Serbia, and relying on remote methods of data collection. I collected data between August 2021 and December 2022.

Narrative interviews with Afghan women

Rationale for narrative methods

Methods of narrative inquiry are concerned with stories that represent meaningful human experience, events, and emotions, situated in socio-political contexts (Reissman 2008). Narrative interviewing is widely recognised in feminist research as situating participants and their voices centrally in research, moving away from 'othering' participants, and addressing power dynamics between the researcher and participant (Handforth and Taylor 2016, Smith 2017, Lockwood *et al*. 2019). Importantly, narrative interviews employ a conversational tone, avoiding a style of formal interviewing which forced migrants are often subjected to by immigration authorities (Smith 2017). Additionally, they provide a space for meaning-making; for women to construct *their* narratives on *their* terms, enabling

co-produced knowledge of *their* experiences, thus going beyond the confines of current discourses or topics pre-determined according to the researcher's priorities (van Liempt and Bilger 2018, Rainbird 2014, Smith 2017). Therefore, narrative interviewing aligns well with decolonial feminism in its approach to centring women's perspectives and giving (albeit incompletely) power to women to shape knowledge production. It is for these reasons that I chose to use narrative methods when interviewing Afghan women. Whilst narrative inquiry shares many features with phenomenology – also concerned with understanding lived experiences – I chose in this study to use narrative inquiry over phenomenology. This decision was driven by the fact that phenomenology is primarily concerned with the phenomenon under examination, rather than how individuals' experience that phenomenon (Tuohy *et al*. 2013). Furthermore, phenomenology requires researchers to 'bracket out' existing beliefs or knowledge about the phenomena to clearly understand them (Laverty 2003) – a process that did not fit with my theoretical approaches that provided me with particular lenses which I engaged throughout my study. However, key to this study was indeed understanding ways in which Afghan women experience childbearing while on the move through Serbia, therefore employing phenomenology would have limited explorations of the topic under inquiry.

Sampling and recruitment

My inclusion criteria were Afghan women over 18 years of age, who had in the past 5 years been pregnant, given birth or had a baby up to 6 weeks old while in Serbia. Women who were known prior to being interviewed to have experienced perinatal loss while in Serbia were excluded. Some participants were Afghan, but had settled in Iran, either as children or as adults, and had migrated from Iran, rather than Afghanistan, to Serbia. These participants were not excluded from the study, because they were still Afghan women whose stay in Iran can be seen *a posteriori* as being part of their migratory journey, albeit extremely protracted.

I used purposive and snowball sampling to identify potential Afghan women participants, which proved to be a particularly challenging aspect of conducting this study. Initially, the NGO with whom I partnered introduced me to several potential participants, some of whom I was able to recruit. Subsequently, recruitment took place in a variety of ways. For example, on one occasion I was walking with another participant from the partner NGOs Woman's Centre to the bus stop, when we came across a group of Afghan women en route to the Woman's Centre, to whom I was introduced and was eventually able to recruit. Another time, an NGO actor whom I had recently interviewed put me in contact with an Afghan woman who she was supporting in a camp and had recently given birth. A Farsi-speaking Research Assistant (Farsi is similar enough to Dari to be understood by Afghan women) who worked with me for a short time assisted with the recruitment of several participants both during

my field visit to Serbia in addition to recruiting several other participants from her network after I had left Serbia. I discuss her role in further detail later in this chapter. Additionally, some participants and NGO actors who knew about my research also put me in contact with other Afghan women who I was able to recruit to the study.

In total, I recruited 15 Afghan women to the study and interviewed them over a 15-month period (from August 2021 to December 2022). I conducted eight of these interviews face-to-face and the remainder were held remotely by WhatsApp. Only one was in the perinatal period at the time of being interviewed (having recently given birth) – although she was willing to take part in a follow-up interview, I lost contact with her as she continued to travel. The other 14 participants had given birth in Serbia, or travelled through Serbia with a newborn 18 months to 5 years previously.

Data collection tool and approach

I developed a topic guide (see Appendix 1) to use as an aide-memoire for prompts during interviews if necessary although as far as possible, the participants guided the conversation during interviews. The topic guide was developed from the research questions, and informed by the literature review (Sharma *et al*. 2020) and informal conversations with relevant actors, but questions were deliberately kept as broad and open as possible to allow participants to steer and shape the interview. In addition, I discussed the topic guide with two forcibly displaced Afghan refugee women in the UK to gain their feedback prior to commencing data collection.

An opening question, "Tell me about what it was like for you to be pregnant / give birth / have a newborn baby in Serbia" was used to set the stage for the conversation – for most women, this opening question was sufficient for them to narrate their experiences, although a few required additional promptings. The topic guide also covered questions pertaining to experiences of childbearing while on the move, women's feelings on learning they were pregnant and feelings of having a newborn, and experiences of maternity care. The initial three face-to-face interviews I conducted provided an opportunity to pilot the interview process and topic guide – although I did not make any changes to the topic guide, these pilot interviews allowed me to refine my interview technique, specifically with respect to conducting in-depth interviews with an interpreter.

I chose not to collect any demographic data as part of the interview process. The rationale behind this decision was three-fold; firstly, that I did not want participants, who were often living with precarious citizenship status, to feel concerned in any way about how I may (mis)use their data, secondly, because I did not want interviews to be reminiscent of interviews with authorities in which such information is often collected, and thirdly, because it would not contribute to meeting the study

aims. Similar concerns have been voiced in other studies involving refugees (Bagelman and Gitome 2021, Bloemraad and Menjívar 2022). There were however, numerous occasions when women voluntarily provided some demographic information to me without prompting, either during or outside the interview.

Building rapport pre-interviews

Building a level of trust and rapport with participants prior to interviews, whether in-person or remotely, was extremely important. For interviews conducted in-person, I met the participants on several occasions prior to interviewing them, so we could get to know each other. For interviews conducted remotely, I had at least one video call with participants for the same purpose. These meetings and video calls were informal in nature, during which I was able to use my conversational Dari language skills to build rapport. Additionally, having a Farsi-speaking Research Assistant working with me during the first field visit, and for four months afterwards, provided a bridge of trust between myself and participants recruited for in-person interviews, as she already had an established relationship with them. Additionally, I built confidence and trust by respecting cultural norms, for example, I wore culturally-appropriate clothes, followed traditional rituals of greeting women, and distinguished myself from other actors, such as NGO or state actors (Ritchie 2019).

Conducting interviews

Having completed ethical procedures (discussed later in this chapter), a meeting time at the convenience of each participant was arranged for the interview. I conducted in-person interviews in a meeting place offering privacy and which suited the participant, for example a meeting room within the camp or an NGO woman's centre. I had initially been concerned about participants' childcare during interviews, as I did not wish for this to be a concern for women during interviews, but in fact in all cases of in-person interviews, there was some kind of arrangement women were able to make with relative ease (such as NGO staff looking after children in an activity session, husbands and friends taking care of children, or very young children being present during the interview). For interviews taking place remotely, I gave participants the choice as to which means to be interviewed. For most, WhatsApp video was the platform of choice, but one participant opted for a WhatsApp call without video. These took the form of a three-way call, between the interpreter, the participant, and myself, each in our separate locations. Prior to remote interviews, I suggested to women that they chose a time and location for the interview when they could ensure privacy, although in reality, I could often hear some background noise. In these cases, to ensure that women were not in a position where they felt uncomfortable or compromised during the interview, I regularly asked them if they still wished to continue with the interview or if they would rather re-schedule for another time. Additionally, I

deliberately avoided prompting during remote interviews on topics that may have been particularly sensitive as I could not guarantee women were in a private space. I was careful to establish whether participants had sufficient internet connectivity to make video calls without incurring additional data usage costs. There was only one occasion when a participant did not have enough data for a video call, but we stayed in touch using WhatsApp messaging and several months later, she informed me that she had changed her data plan and was able to have a video call without incurring extra charges. I offered to all participants a transfer of mobile data to cover the costs of mobile data, but all women declined. Participants were given or sent a small gift (shampoo or hand soap) as a token of appreciation for their participation.

Interviews averaged one hour 14 minutes, varying in length from 26 minutes to three hours 40 minutes. All interviews took place with an interpreter (I discuss interpreting and translation issues later in this chapter) and were audio recorded. I deliberately chose not to take field notes during in-person interviews as it quickly became apparent that this may hinder the flow of the interview, and my ability to actively listen and respond sensitively to participants as they were speaking. Instead, I made detailed notes and reflections as soon as possible post-interviews. I initially transcribed interviews myself verbatim, providing me with an opportunity to immerse myself in the interview data, during which I made notes of patterns or anything striking which arose. However, during this process, I became aware that long sections of speech had been truncated and summarised during translation, an issue noted by other researchers when using interpreters (Lusambili *et al*. 2021). For this reason, I engaged a translator to work through the interview audio recordings and transcripts, correcting and adding to the text where necessary, capturing the nuances of the speech as far as possible.

Shifting plans

Initially, I had planned to conduct all interviews in-person during an extended visit to Serbia. I had hoped to recruit Afghan women during pregnancy, conduct a number of follow-up interviews throughout their pregnancy and postnatal period, in addition to accompanying them to maternity care appointments for participant observations to understand their interactions with healthcare providers. However, in reality, complicated by shortened visits to Serbia due to Covid-19-related travel restrictions and lockdown policies in Serbia and the UK, I was not able to recruit any Afghan woman who were pregnant in Serbia – all those participating except one had already given birth at least one year previously. Furthermore, due to having to pivot my methods to include remote recruitment and interviewing, the one woman who I recruited during the perinatal period (who had given birth two weeks earlier) was interviewed remotely. Another factor which affected my original plan to conduct

serial interviews with women during the perinatal period was the speed at which some women were travelling through Serbia; on two occasions while I was in Serbia I was informed that an Afghan woman was pregnant or had a newborn had arrived in a camp, but by the time I had made arrangements to travel to the camp with an interpreter, she had moved on. As a result I did not conduct multiple interviews with each Afghan women – all interviews were one-time interviews only.

The unintended retrospective nature of most interviews offered the benefits of the participants being able to narrate the full story of their perinatal experiences in Serbia also having had (at least in theory) time to reflect on their experiences (Reissman 2008). The possible disadvantages of retrospective interviews relate to the extent to which events can be recalled accurately, and reconstructed post-event (Lewis and McNaughton Nicolls 2014). However, it can also be argued that qualitative interviews are not merely a process of transferring information, but are always temporally constructed and highly contextualised, however near or far from the event the interview takes place (Braun and Clarke 2021).

Semi-structured interviews with service providers

Semi-structured interviews were employed when interviewing service providers. Using semi-structured interviewing was valuable because it enabled participants to express their thoughts, opinions, and feelings on the topic in question, in an in-depth manner, but also ensured that key topics were covered during the interview (Yeo *et al*. 2014). Here, I deliberately held to a non-specific definition of a 'service provider': broadly speaking I wanted to gain diverse perspectives from those who had either provided direct clinical perinatal care to Afghan women (doctors and nurse-midwives), or had provided non-clinical support (such as NGO actors running reproductive health programmes or cultural mediators) without placing suppositions on what kinds of actors might be involved. Follow-up semi-structured interviews were conducted six months later to understand how the provision of support for Afghan women during the perinatal period changed over time, and the factors impacting those changes. Demographic data were collected on participants age, sex, nationality, and number of years working with refugees and migrants, in addition to their role in supporting Afghan women and type of organisation to which they were connected within their role.

Sampling and recruitment

My inclusion criteria were those providing perinatal care or support to Afghan women, or who had done so in the past five years, and were over 18 years of age.

I used purposive sampling and snowballing to identify potential participants. Initially, purposive sampling involved mapping local and international NGOs from web searches, who were, at the time

of recruitment, or had previously, provided direct support to Afghan women in Serbia, during the perinatal period. I then contacted NGOs, mainly by email, but some by WhatsApp message. Of those who responded, I set up initial meetings for recruitment purposes (explaining the purpose of the study and what is involved in participation), in addition to building rapport prior to being interviewed for those who met the inclusion criteria and wished to participate. To assist with the recruitment of health professionals who had direct experiences of providing maternal or newborn health care to Afghan women in Serbia, I engaged second Research Assistant; a Serbian woman who was finalising her medical training and spoke English (hereon in referred to as the 'Serbian Research Assistant' to distinguish her from the Research Assistant helping with recruitment and interviewing of Afghan women). Additionally, she had a network of doctors she was able to contact for recruitment to the study. After being interviewed, participants were invited to a 6-month follow-up interview.

Data collection tool and approach

Initially, I developed a topic guide (see Appendix 2) based on the informal conversations I had, existing empirical evidence, including my literature review (Sharma *et al*. 2020), as well as theoretical knowledge informed by CBS. This topic guide was iterative in nature, with previous interviews informing future interviews. The topic guide included questions about the nature of participants' involvement, and that of their organisation, in providing perinatal care or support to Afghan women, perceptions of maternity care for, and perinatal experiences of Afghan women in Serbia, the impact of Covid-19 on the provision of perinatal care and support, and the role of borders and mobility in service provision. The topic guide for follow-up interviews (see Appendix 3) focussed on reviewing participants' roles (in case they had changed), and asking participants about any changes to the perinatal care and support they were providing to Afghan women, including impacts to their work of the Ukraine war and the Taliban takeover of Afghanistan.

Conducting interviews

Interviews were conducted at a time of the participants' choosing. All except two interviews were conducted remotely, using a video conferencing platform of the participant's choice. This was usually Zoom but on two occasions took place using WhatsApp video call. The purpose of field visits was not to conduct in-person service provider interviews, however, the opportunity arose to do so on two occasions, and were conducted at a location of the participants' choosing. Potential participants were informed that interviews would last approximately 45-60 minutes. Some service providers chose to be interviewed during their working day and had to end the interview after a defined time period due to their work commitments. Others participated during evenings or weekends with fewer time limitations or were keen to be interviewed for a longer period of time.

There was a degree of nervousness among some informant participants. Despite explaining the ethical principles of confidentiality and anonymity prior to participation, and reminding them of these principles at the start of the interview, there was still a sense among some participants that they were representing their organisation during the interviews. An example which illustrates this point was that participants spoke very freely and openly about their work during initial meetings I had with them to discuss the possibility of participation, but once the interview had commenced, their communication with me switched to a far more formal style. Some participants seemed to relax throughout the interview, whereas a small number did not. In these cases, I found that interview data tended towards being descriptive with less expression of feelings and opinions.

Most participants spoke English, but two requested the assistance of an interpreter, issues of which I discuss later. One participant did not consent to have the interview audio recorded, so I manually wrote down what was spoken, concurrent to the interview. All other interviews were audio recorded.

I conducted 24 interviews with 21 service providers (three participated in a follow-up interview). All except two interviews were conducted remotely. Service providers' roles in providing perinatal care and support for Afghan women were diverse, and it was common for service providers to have volunteered or worked in a variety of roles, with a number of different organisations, reflecting the short-term funding of NGO projects. Only three of the service providers interviewed were or had been in roles providing direct clinical care to perinatal Afghan women and/or their newborns – two of these were nurses working outside the Serbian healthcare system whose role included providing non-clinical care to perinatal Afghan women, and one was a medical doctor providing generalised care. Further details of participant characteristics are shown in Chapter 6. Initial interviews varied in length from 40 minutes to two hours 18 minutes, with an average of 1 hour 8 minutes. Follow-up interviews were shorter, ranging from 25 minutes to one hour five minutes, averaging 43 minutes.

Unstructured observations

Rationale for unstructured observations

Observational research is a qualitative research method with roots in anthropology. It involves a researcher immersing themselves witnessing and recording behaviours of people in their naturalistic settings to gain insights into a particular social or cultural community (Jibril 2018). It offers the benefits of observing non-verbal behaviour, behaviours or beliefs of which people may not be aware, and those that are socially challenging (Fetters and Rubinstein 2019, Lewis and McNaughton Nicolls 2014). Observational research produces thick descriptions of what is seen in the 'field' from which interpretation are derived. Traditionally, observational methods have relied on a researcher spending time – months or even years – in the context that they are observing, immersing themselves ('hanging

out') in the community under observation. However, there has been a recent shift towards a greater flexibility in the way fieldwork and observations can be conducted, in response to the colonial lens historically applied by white anthropologists, the increasingly digital world that enable remote ethnographic methods to be employed, and in acknowledgement of the barriers to long-term fieldwork for researchers with caring responsibilities (Cox *et al*. 2024, Forberg and Schilt 2023, Uddin 2011).

The purpose of unstructured observations in this study was to provide rich, contextual data, enabling me to collect data and explore the circumstances, social setting, physical environment, and interactions in which Afghan women in Serbia and providers of perinatal care and support were functioning (McNaughton Nicolls *et al*. 2014, Mulhall 2003). These unstructured observations constituted field visits to public spaces occupied by Afghan women as well as participant observations of NGO actors working in spaces occupied by Afghan women.

Conducting unstructured observations

Unstructured observations took place during field visits to Serbia. I conducted two field visits to Serbia, covering a total of 5 weeks. The first was in August 2021 and the second in March 2022. In an ideal situation, I would have been able to visit spaces occupied by perinatal Afghan women freely, spending significant amounts of time 'hanging out' with women (Rodgers 2004). In reality, whilst I was able to visit public spaces, such as parks, transportation hubs, and open-access NGO spaces, access to spaces occupied by Afghan women in camps was tightly controlled, even when I accompanied NGO actors. Permission needed to be sought from the Commissariat for Refugees and Migration to enter any of the refugee camps. This permission is notoriously difficult to gain as a foreign researcher, but an NGO actor was able to provide me with the information I required, which led to permission to access the camps being granted to me. Visits to the camps were mostly with an NGO for practical reasons – some of the camps were not accessible by public transport, although over time, as I got to know the camp staff, I was able to visit the camp in Belgrade alone. My visits to the camps were 'overseen' by the camp managers – it was not possible to walk around the camp alone. For example, in Belgrade, the camp managers would control my movement within the camp by asking me to sit and meet with participants in a particular room. Aside from visiting the camps, one NGO had a woman's centre in Belgrade from which activities for refugee women were held, but this was only open at certain times, and at the end of the activities, women often had to rush back for lunch at the local camp, which was only served at a particular time. Additionally, entering spaces of health provision was challenging. In one camp I was disallowed from visiting the camp clinic, and entering a maternity hospital required long negotiations between the Serbian Research Assistant who was

assisting me with my visit, and two security guards. Visiting informal refugee settings outside the camps was prohibitive as NGOs operating in these contexts were working in very sensitive environments with frequent police monitoring, and my presence could have endangered their work.

These issues of access to study sites are not uncommon among researchers. Similar to my experience, Amundsen *et al*. (2017) also noted the importance of building strong relationships with individuals (gatekeepers) who can facilitate initial and ongoing access to research sites, which takes time, trust and mutual understanding between the researcher and gatekeepers. The extent to which knowledge can be generated is therefore contingent on the extent to which research sites can be accessed, highlighting the power dynamics between researchers and gatekeepers (Amundsen *et al*. 2017). In this study, taking time to build key relationships, being sensitive to the additional time burden placed on gatekeepers when they were assisting me with access to research sites, being flexible to fit around others' timetable when planning field visits, and adopting a friendly and open demeanour to counter gatekeepers' suspicions were all helpful strategies in gaining access to research sites, intrinsically linked to which was subsequent access to research participants located at sites of field visits. If I was able to spend longer in Serbia building relationships with gatekeepers, I may have had access to either more research sites or less surveillance at the sites that I visited, or both.

Conducting observations is intersubjective – as a researcher in the 'field', my presence shaped the social setting I witnessed (McNaughton Nicolls *et al*. 2014). For example, when visiting a camp and talking with some Afghan women, the camp manager thew some brand new, plastic-wrapped clothing over to them – they looked at each other in disbelief and giggled, later explaining to me that never before had they been offered clothing by the camp manager, attributing the gesture directly to my presence in the camp. Throughout the field visits, I was considered about the way in which I conducted and presented myself. For example, I deliberately wore clothing which was respectful of Afghan culture. I conversed with women in Dari during informal conversations. I took public transport rather than taxis to visit the camp and women's centre in Belgrade, offering me unexpected opportunities. For example, while waiting to catch a bus to one of the camps, I saw two very young Afghan children whom I had met previously at the bus stop, with neither parent visible. Concerned, I quickly phoned their mother to ascertain the situation. Soon afterwards, to my relief, their father appeared and we all took the bus to the camp together, where the children's mother came out to meet us. Small instances like this enabled me to build connections and some level of trust over a short space of time.

Where possible and appropriate, I made brief notes about notable events during observations, but the majority of my extensive field notes were typed-up at the end of the day. My field notes included detailed descriptions about the physical environment, the people I observed, their social interactions,

and other notable details, as well as my thoughts, feelings, and reflections on what I observed (McNaughton Nicolls *et al*. 2014).

Research Assistants

During the data collection phase of this project, I had two Research Assistants (RAs) who were of invaluable assistance in recruitment, access to relevant spaces, and interpreting. Both the RAs worked with me for short periods of time due to my limited budget and commitment to paying them fairly for their work.

During my first field visit, I was introduced to a woman who was initially able to interpret for Afghan women. She had lived experience of being a refugee and was now working for a refugee-support NGO in Serbia. With some of the funds I had received from a Doctoral Travelling Scholarship, I was able to recruit her to work as a RA for a short period. Her working with me bridged an important relational, cultural, and spatial gap between myself, Afghan women, and spaces they occupied, due to her insider knowledge of the refugee landscape in Serbia, access to wide network of Afghan women, and ability to mediate culturally between myself and Afghan women during recruitment and interviews. I provided her with an overview of the research aims and training on all stages of the recruitment process, how to conduct narrative interviews, and on participant confidentiality. Over a five-month period that critically coincided with the Taliban takeover of Afghanistan, she assisted me with recruitment of Afghan women and interpreted for in-person interviews during my field visits. As Afghan women knew her both as someone who had both lived experience of being a refugee in Serbia accommodated in camps and also with valuable access to NGO resources, she was trusted by them, and was able to introduce me to them as a trusted friend. I had planned that she would be able to recruit and interview Afghan women in-person once I had left the field. This did not materialise, but nonetheless she provided me with regular updates on the situation for Afghan women in Serbia once I had left the field, and also connected me remotely with potential participants. She also shared with me her personal and intimate experience of camp life that diverged from accounts provided by both Afghan women and service providers in its brutal honesty and insider perspective. Her working with me was invaluable and critical to the success of data collection in the early stages of the study. It also gave rise to some research and ethical dilemmas. For example, there were occasions she knew about and shared relevant information about participants that they had chosen not to disclose to me. Nonetheless, working with an in-country diaspora researcher and negotiating some of the accompanying entanglements early on in the crucial formative stages of data collection contributed to decolonising knowledge production in this study (Douedari *et al*. 2021).

The second RA with whom I worked was a Serbian-British woman, who was completing medical school in Serbia. Primarily, we worked together on the public engagement project, when she was instrumental in disseminating the online questionnaire to Serbian health professionals, drawing on her extensive professional network. However, during my second field visit to Serbia she also assisted in gaining access to a large maternity hospital, and arranging meetings for me with obstetricians working there, to identify health professionals who had provided care to Afghan women who could be recruited to the main part of this study. Straddling both Serbian and British cultures, she provided critical insights into the Serbian health system and why I experienced challenges in recruiting health professionals for interviews. She also assisted with interpreting during two service provider interviews.

The insider insights of both RAs undoubtedly played a role in shaping this study, leading me to iteratively pursue certain lines of inquiry and shaping affording me opportunities to probe their understandings of certain phenomena. Reflecting on my experience of working with the two RAs, I concur with Turner (2010) that they were integral actors in this study, as were the interpreters with whom I worked, which I shall now discuss in further depth.

Cross-language data collection

The majority of those participating in this study either spoke English as a second language (ESL) or spoke no English at all, so issues pertaining to conducting cross-language data collection were important considerations. Prior to interviews, all ESL or non-English speaking participants were offered help with interpreting during interviews. All the Afghan women whom I interviewed took up the offer of a Dari-English interpreter. Service providers who had ESL or spoke no English were offered a Serbian-English interpreter during interviews - an offer taken up by only two participants.

A total of four individuals interpreted during interviews. The Serbian RA interpreted during remote interviews with service providers. The Farsi-speaking RA interpreted during in-person interviews in Serbia with Afghan women, but was not available to interpret for remote interviews due to a change in her work commitments. Two other Dari-speaking women were engaged to interpret for remote interviews (depending on their availability), both of whom had lived experience of forced displacement from Afghanistan having trained and worked as medical doctors in Afghanistan, but had gained some citizenship rights in the countries in which they were settling. For the purposes of interpreting during interviews, the role of the RA and interpreters did not differ (the difference with the RA being that they also assisted with recruitment and access). Additionally, a Dari translator, a qualified midwife living in Afghanistan, assisted with translating and transcribing all interviews conducted in Dari into English. I briefed all those who were interpreting or translating by discussing

an overview of the research, the purpose and structure of the interviews and their role when interpreting or translating.

The significant role that interpreters play in research is often minimised. I acknowledge that in this study, those interpreting and translating were not merely passive bystanders whose sole role was to independently transmit messages between researcher and researched, but rather, they played an active role in shaping the interview and therefore in knowledge production (Turner 2010). Some scholars have drawn attention to the 'writing-out' of interpreters and translators in academic research, calling for greater acknowledgement of researcher-interpreter power dynamics, their positioning, as revealed through researcher reflexivity, and inclusion in written research outputs (Temple 2005, Turner 2010). Additionally, it is argued that transparency about interpreter roles in knowledge production is aligned with the philosophical stance of social constructivism and decolonial feminist approaches that I use in this study, as it renders visible ways in which interpreters shape knowledge production (Squires 2009). Therefore a discussion about the intersubjective nature of knowledge production in studies that reply upon interpreters or translators is vital (Turner 2010).

Acting as interpreters or translators meant acting as cultural brokers, and it is inevitable that the way in which was participant meaning was relayed to me was filtered through the social, cultural, and political beliefs of the interpreter or translator (Temple 2005). This is neither necessarily a benefit nor drawback, but an acknowledgement of the intersubjective nature of knowledge produced in this study. This was further highlighted though the varying relationship which the interpreters had with participants. For example, on occasions when there was a pre-existing relationship between the participant and interpreter, the relational dynamic was such that the interview resembled a conversation between the two of them, with myself as a bystander. In these instances, it was not uncommon for the person interpreting to take a particularly active role in shaping the interviews by asking relevant follow-up questions due to the fact they already knew certain aspects of women's narratives, and interjecting during interviews to elaborate or explain a particular phenomenon to me that the participant was discussing. Conversely during interviews when the interpreter was previously unknown to participants, a different dynamic ensued in which the participants where speaking to me primarily, through the interpreter. Even then, the interpreter was not a passive vessel for communication, but would occasionally prompt the participant for further detail, clarify meanings with me or provide me with relevant contextual information.

One specific example of the ways in which participant meanings were conveyed to me when I conducted narrative interviews with the help of interpreters was the completeness of the translation during the interviews. Before commencing the interviews, participants were asked to speak in short

sections to enable as full an interpretation as possible. However, as some Afghan women become more immersed in recounting their experiences throughout the course of the interview, it was very common for them to speak in long sections. Often, some of these longer sections of narratives involved them recounting difficult experiences, and it was not appropriate to constantly ask them to stop to allow the interpreter to translate. As a result, interpreters needed to paraphrase longer sections of speech back to me in English, inevitably losing some of the nuance and detail of what was spoken by participants. To address this, interviews with Afghan women were also translated and transcribed verbatim, enabling a fuller transcription of interviews to be produced prior to data analysis. Nonetheless, I also acknowledge the complexities of language and the inevitability that some linguistic details or concepts may not translate directly into English or could be subject to multiple understandings (Squires 2009).

A further practical aspect of cross-language interviewing was that after conducting the first few narrative interviews with Dari-English interpreters, I realised that I needed to also define some key terms used in the interview questions. For example, I realised that some questions were being understood and interpreted in ways that carry a different meaning from that which I had intended, so I talked with the interpreters to find suitable phrases in Dari to better reflect the questions' meanings.

Most service provider participants whose first language was not English declined the offer of an interpreter during interviews as they felt they were able to sufficiently communicate with me in English. Whilst this was generally the case, I noticed that on some occasions participants struggled to adequately express themselves, particularly when discussing technical information or when trying to convey emotional responses to situations. This limited my ability on some occasions during interviews to fully explore what these participants were trying to express.

When conducting unstructured observations, I observed participants speaking a range of languages in the spaces I visited, although because of the focus of my study, Dari and Serbian were the predominant languages spoken, and English was often used as an intermediary language between NGOs and refugees. Whilst I was able to understand to some extent those speaking Dari, there were some occasions when I was completely unable to understand what was being said. However, I noted ways in which words were spoken and non-verbal communication in these contexts. Additionally, when conducting observations in spaces in which an NGO cultural mediator was present, the cultural mediator would sometimes provide ad-hoc interpreting.

Data analysis

Preliminary analysis started as soon as data collection begun. Making notes during field visits and after interviews, on notable impressions, keeping a reflective diary throughout data collection, and

transcribing service provider interviews myself to become immersed in the data, aided this preliminary analysis. I also re-visited audio recordings of all interviews, listening to these alongside reading transcripts to familiarise myself with these data. Each data collection method warranted a different approach to analysis, which I detail in this section. Imperative in qualitative research is transparency. With that in mind, although I present my approach to the process of data analysis in a linear form here, it was in reality a circuitous process, tacking back and forth between the data, existing knowledge, and my theoretical approaches, and revisiting my analyses as I wrote up my findings.

Analysis of narrative interviews

Aligning with narrative inquiry approaches, I used narrative analysis to analyse interviews I conducted with Afghan women. Narrative analysis is a grey area, with no defined step-by-step process, but rather a range of varied approaches taken (Miller 2017, Squire *et al*. 2014). Nonetheless, it offers the advantages of being, "…able to see different and sometimes contradictory layers of meaning, to bring them into useful dialogue with each other, and to understand more about individual and social change" (Squire *et al*. 2014, p.1). Further, it is a method of analysis in which the meanings and intersubjectivities in narratives are sought out, in order to understand what people's stories tell us about the socio-political factors shaping them (Eastmond 2007, Ntinda 2017). Whilst akin to other methods of qualitative analysis, as a case-based method of analysis narrative analysis differs insofar that it seeks to understand individuals' lived experiences while also keeping narratives intact in their context (Weiss and Johnson-Koenke 2023). This contrasts with, for example, thematic analysis, in which line-by-line coding picks apart individual narratives to identify common themes across the dataset (Braun and Clarke 2022).

Of the various narrative analysis methods available, I chose to employ thematic narrative analysis (TNA). The focus of TNA is (though not exclusively) on the 'what?' of the topic under investigation in narratives rather than the 'how?' - how discourses are constructed in narrative accounts (Reissman 2008). TNA maintains the case-based approach of narrative analysis, searching for thematic commonalities across narrative accounts, influenced by research aims and theoretical frameworks (Reissman 2008). Employing this method of analysis enabled me to inductively understand Afghan women's perinatal experiences in a robust but nuanced way, without fracturing their narratives, y*et al*.so developing themes common across cases.

Similar to all narrative analysis methods, no single series of steps in conducting TNA has been developed. I opted to use the analytic devices proposed by Connelly and Clandinin (1990), described as broadening, burrowing, storying, and re-storying. *Broadening* refers to examining "…what else we know about the storytellers and their local and general circumstances" (Mishler 1986, p.244). In this step, I created a table summarising participants' characteristics, perinatal experiences, and migratory

circumstances, to which I could refer throughout analysis. Following this, I moved to *burrowing*, the stage in which attention is given to details of emotions and events in participants' narratives, and how these are connected, from participants' perspectives (Connelly and Clandinin 1990). To do this, I interrogated each participants' narrative in depth, marking transcripts with notes on particular events, feelings, or questions about their lived experiences (Kim 2016). The final stage of *storying and re-storying* to bring to the fore notable aspects of participants' narratives (Kim 2016), which I did by re-visiting narratives and creating synopses of participants' stories. Having excavated narratives using these three analytic steps, I then to sought to identify and develop thematic commonalities across narrative cases. Tacking to and fro between the narrative transcripts, the table of participant characteristics, and the narrative synopses, I broke narratives down into manageable sections, identifying meta-narratives within each section of data, and looked for commonalities across meta-narratives, which I then developed into overarching themes. Writing up the findings was an integral part of the analysis process, as I carefully, and with trepidation, considered how to (re)present Afghan women's narratives in this thesis. Using thematic narrative analysis enabled me to present exemplars of themes as mini-vignettes, providing narrative context, rather than dropping snippets of quotes into the findings with less human context, as would be the case if I had used thematic analysis.

Analysis of informant interviews

Semi-structured interview data from informant interviews were analysed using reflexive thematic analysis (RTA) (Braun and Clarke 2022). The rationale for selecting RTA was that it provided a systematic means to develop themes based upon the analysis patterns across an entire dataset, whilst critically reflecting upon how my positionality and role as the researcher situated me in the analytic process (Braun and Clarke 2022). Embedding reflexivity into the analysis process aligned with the reflexive approach I took throughout the entire study.

I followed the six steps to reflexive thematic analysis outlined by Braun and Clarke (2022). Firstly, I familiarised myself with the data by listening to interviews when transcribing them, and then re-reading transcriptions, during which I made notes on anything that stood out. Due to losing contacting with many service providers during the data collection phase, member checking of interview transcripts with participants was not feasible. Secondly, the transcripts were anonymised and imported to NVivo v.12 (QSR International 2020), where I coded them line-by-line. This involved assigning labels to small sections of data to reflect their meaning. Thirdly, I developed initial themes by collating codes that signified wider patterns of meaning. I reviewed and refined these themes in the fourth stage, to ensure they represented the overarching story that I wanted to tell from the data. In the penultimate stage, I finalised and named themes and sub-themes, and finally I wrote-up the

analysis findings, bringing together themes and sub-themes with data extracts to create a clear and comprehensive story to answer my research questions.

Analysis of unstructured observations

I analysed field notes from unstructured observations using open coding to develop themes and sub-themes (Emerson *et al*. 2011). The process of analysis started during data collection, when I briefly recorded notable events, behaviours, or social interactions while conducting observations. Writing up field notes as soon as possible after the observations formed an important part of the analysis, as I started to look at patterns in the data, making notes in the margins of the field notes. I later read and re-read my field notes as a data set to identify "avenues of inquiry" (Emerson *et al*. 2011 p.175), motifs running throughout the data, and variations. From here, I developed codes, which were label describing sections of the data, and then looked across the dataset to examine how these codes related to one another and could be collated to form themes (Emerson *et al*. 2011, Spencer *et al*. 2014). I reviewed and revised these themes several times to ensure they reflected the dataset.

Integrative analysis

To answer my first research question, "What are the migratory circumstances experienced by perinatal Afghan women in Serbia?", I conducted an integrative analysis that wove together multiple methods of narrative interviews with Afghan women, semi-structured interviews with providers, and unstructured observations of Afghan women's spaces in Serbia, identifying patterns across the three sets of data to understand how they fit together and related to each other (Bamford *et al*. 2018, Dupin and Borglin 2020). Similar to Ramsey *et al*. (2022), using integrative analysis enabled me to gain multi-layered perspectives by integrating three separate but interrelated datasets, to answer a research question. I listed all themes and sub-themes from each dataset and then grouped and re-grouped them inductively until new themes and sub-themes were formed. The integrative analysis therefore synthesised the themes developed when datasets were analysed individually, bringing together data from multiple perspectives. For example, when conducting the reflexive thematic analysis of service provider interviews, the theme, *Sub-standard accommodation* was developed. In the integrative analysis this theme was synthesised with themes from narrative and observation data (such as *The impact of encampment on maternal wellbeing*) from which the theme *Spaces of fallback* was developed.

Public Engagement

Public engagement is a critical element to research, enabling dissemination of research findings beyond academia. As an activist-researcher, disseminating findings to a diversity of audiences was, and continues to be, an integral component of my project, to amplify Afghan women's voices and contribute to evidence that can be used in policy-making. Additionally it can provide a platform for

those from the Global South to take part in international conversations about issues relevant to them (Cohen *et al*. 2008). I carried out a public engagement project (see Chapter 7) that aimed to understand the awareness and attitudes of Serbian health professionals and women's civil society organisations about the perinatal experiences of Afghan women in Serbia, using a webcomic to elicit online questionnaire responses (Sharma *et al*. 2024b). Aligned with the decolonial feminist lens that I adopt in this study, the webcomic was co-developed with Afghan women and graphically depicted Afghan women's perinatal experiences in Serbia, to centre participant voices and visually challenge stereotypical portrayals of non-white refugee women (Sharma *et al*. 2024b).

Positionality and reflexivity

It is widely acknowledged that researchers are active agents, producing knowledge which is situated (Bukamal 2022, Lumsden 2019). As a researcher I had a *position* that shaped every stage of the study - being reflexive critically acknowledges my role in knowledge production (De Souza 2004), demonstrating the interconnectedness between positionality and reflexivity (Bukamal 2022). Positioning includes personal factors and beliefs (age, gender, ethnicity, life experiences, linguistics, immigration status, political stances, among other factors) that shape research by impacting firstly, access to participants, secondly, the relationship between researcher and participants, and thirdly, the way in which research is interpreted (Berger 2015). Maintaining reflexivity by critically acknowledging my positioning throughout the research process can not only increase the quality of research through creating transparency and trustworthiness, but to some extent can also contribute to some extent to address negative effects of power imbalances between the researcher and researched (Berger 2015, Lokot *et al*. 2023, Marshall and Rossman 2011).

Researcher positionality in relation to participants can be considered to be on a continuum between insider (when the researcher belongs to the group being researched) and outsider (when the researcher shares no attributes with study participants) (Bukamal 2022). I conducted this research largely as an outsider, but with some points of convergence with participants' experiences. As a woman of mixed Indian and white British decent, I found myself in the same position as Gatter (2021), as my "… appearance grant[s] me white privilege, but I do not navigate space from a fully white perspective" (p.14). I also came to this research with professional experiences as a midwife, personal experiences of motherhood, and lived (privileged) experience of the UK immigration system. My background as a midwife offered me professional credibility among participants, and for Afghan women, being able to share our experiences of motherhood provided a degree of commonality. Having lived in Afghanistan where I also gained conversational Dari language skills positioned me with some cultural insights. Additionally, I was (and am) against exclusionary EU border policies, and therefore sympathetic towards the situation in which participants were, or had previously been. These

factors were all points of convergence, albeit minimal, with experiences of Afghan women participants. Being able to converse in their language, and having lived in Afghanistan appeared to be important in building initial rapport with women, and my professional background appeared to increase my credibility as a researcher studying this topic among all participants. Additionally, being a woman was important when interviewing Afghan women, as it is often considered by them as inappropriate to discuss pregnancy and birth with men. However, there is no doubt that my immigration status (a British passport holder), with the benefits, freedoms, and security it brings, and without my own lived experience of being a refugee, set me distinctly apart from Afghan women participants. To this end, I considered myself as an outsider in this study

I felt this power imbalance most acutely after conducting interviews – after women had shared their narratives with me, trusting that by doing so, their voices and experiences would be made visible. It was, and remains, in my power to analyse their narratives in a respectful manner, represent their voices accurately in research accounts, and disseminate the research findings within and beyond the realms of academia. Here, researcher positionality and reflexivity blurs with ethical issues. Not wishing to 'steal' the stories of participants (Pittaway *et al*. 2010), I was keen to maintain some level of contact after interviews, in addition to sharing key findings with them, all the more possible in the virtual world in which we now inhabit.

I often found myself in a paradoxical position during this study. One the one hand, alongside other migration scholars I saw myself as a scholar-activist, as conceptualised by Bashiri (2024) as "… critical, reflexive, normative, and active scholarly engagement with a commitment to create social and political change within or beyond the academic realm and mainly in accordance with the principles of social justice" (p.87). I sought to document and bring to light experiences of subaltern women which have previously been subject to little attention and scrutiny, without any attempt to pretend that my positionality in this research is neutral (Davies *et al*. 2023, De Genova 2013). Yet on the other hand, there was no denying that I was part of the refugee machinery, the multifaceted industry which has arisen from human displacement, including non-state organisations such as the International Organization for Migration, NGOs and of course, researchers (Morris 2021). The fact that this doctoral research study is of personal benefit sits uncomfortably with me, y*et al*.so drove me to finding creative and accessible ways to share my findings, both within and outside academia.

I tried to remain reflexive throughout the research process, constantly reflecting on how my positionality shaped the research study at each stage. For example, when designing this study, I was determined to steer away from methods which would reify and reproduce the stereotype of refugee women as passive victims (Lokot *et al*. 2023). I wanted to find, during interviews, ways in which

women expressed their agency and enacted resourcefulness. However, my agenda appeared to differ from that of participants, who were often keen to share the difficulties they endured, often commenting after interviews had ended that they were glad to have the opportunity to share these difficult experiences so that others would know what they had lived through. In this way, following the tradition of narrative interviewing in which participants have flexibility to shape their narratives, I needed to set aside some aspects of my research agenda, to enable participants express what was important for them in the interviews. Similarly, my natural instinct as a midwife during the process of analysis was to highlight details of clinical maternal and newborn health care, and yet often women brushed over this detail in the interviews, focussing instead on other experiences (often about their migratory journeys and living conditions in Serbia) that they wished to foreground.

While I have thus far discussed positionality and reflexivity at a personal level, I was in fact working with a team, that included the two RAs (who also acted as interpreters as well as assisting with recruitment), two interpreters, and a translator. My positionality in this study was necessarily altered by the relational dynamics that existed when interacting with women alongside the RAs or interpreters. Their positionality, as insiders from the perspective of their overlapping lived experiences, culture, and language, affected the ways in which I related to participants – they shared commonalities with participants that I did not. While I was fully dependent upon the assistance of the team during data collection, the power imbalance between them and I was elucidated when I received several work reference requests, showing the significant work experience that doing so had constituted. This power differential was further amplified by my secure UK citizenship status versus their mostly low- or middle-income (and sometimes precarious) citizenship. Nonetheless, I was dependent upon their skills to interpret, facilitate introductions to potential participants, or provide insights from their insider perspectives. Congruent with the experience of Baily (2018) I found that building a trusting relationship with them, which grew throughout the process of data collection, was critical to the production of knowledge in this study.

Ethical considerations

Much scholarly attention has been given to research ethics among forcibly displaced people in response to the potential for research to reproduce deleterious structures that render people vulnerable and explore how researchers can adhere to the ethical principle of 'do no harm' (Krawczyk and Dieudonné 2023, Pittaway *et al*. 2010). Taking a humane ethical approach (Zadhy-Çepoğlu 2023) was of utmost importance in this study and I wove ethical considerations throughout the research design. Pertinent to this study were issues of firstly procedural ethics, secondly practical ethics, and thirdly academic responsibility (Daley 2021, Deps *et al*. 2022), which I will now discuss in turn this section.

Procedural ethical considerations

Turning first to procedural ethics, I followed processes outlined by the London School of Hygiene and Tropical Medicine's and University of Belgrade Faculty of Medicine's ethics review committees, both of which granted ethical approval for this study prior to data collection commencing.

I developed three Participant Information Sheets (PIS) outlining information about the study, what is involved in participation, how to withdraw from the study (at any stage), processes for ensuring anonymity and confidentiality, each with an accompanying consent form - one for narrative interviews with Afghan women, another for semi-structured interviews with service providers, and yet another for those participating in unstructured participant observations. The former was translated into Dari and the latter two into Serbian, and all were back-translated into English to ensure accuracy.

Ethical approvals were obtained for both in-person interviews in Serbia and remote interviews with participants, on the understanding that Afghan women could be highly mobile and crossing borders unpredictably and rapidly during the course of recruitment and participation. Literate participants received a copy of the PIS prior to interview. After giving them time to consider participation, I also discussed the contents of the PIS with them to ensure their understanding of participation, providing also an opportunity to answer any questions. For these participants, when interviews were conducted in person, the participant signed the consent form and received a copy, and in the case of remote interviewing, a copy of the consent form with the participant's name and date of consent was emailed to them. For those with insufficient literacy to fully understand the PIS, the PIS was discussed with the participant via an interpreter, in advance of interviews, and I gave participants time to consider participation. I then reviewed the PIS again with them, answered any questions they had, and took audio-recorded verbal consent from them, completing a copy of the consent form for my records. In the case of interviews with Afghan women conducted remotely, I met (via video call) participants several times to get to know them, and provided a brief explanation of the study, using my basic Dari-language skills, and then arranged a three-way video call with an interpreter who translated the contents of the PIS and consent form. They also interpreted their questions and my responses about participation, which often concerned the video or audio recordings of their interviews being posted by me on social media. For all participants, consent was gained not only for study participation, but also for audio-recording interviews, and indeed one participant did not give consent for their interview to be audio-recorded so handwritten notes were made during the interview instead. Additionally, I sent a WhatsApp message with names of phone numbers of whom to contact if they had any concerns about participation. All those involved in interpreting for interviews signed a confidentiality agreement.

All unstructured participant observations occurred in-person. Not knowing in advance of fieldwork the nature of the observations, I needed to negotiate the ethical considerations as they arose. In situations when I was accompanied while conducting pre-arranged observations (such as when I observed NGO-facilitated women's workshops or visited camps with an NGO actor), I provided a PIS to the individual accompanying me in advance of the observations to allow time for questions, and then later took consent, a signed copy of which I emailed to the participant for their records. Wherever possible, verbal consent was obtained: I introduced myself to those in the spaces I was observing, providing a brief overview of the study, what I was observing, and offering the opportunity for non-participation. However, there were many occasions when this was not practical. First, spaces occupied by Afghan women were also visited by women from other countries who spoke a range of languages. These women were not the focus of my observations and I did not have the means to communicate in all these languages (it was not uncommon for NGO actors to be working without interpreters). Secondly, there were instances when I was conducting observations in workshops in which women were coming and going - interrupting the workshop to introduce myself and the purpose of my visit and gain verbal consent would have been extremely disruptive. Nonetheless, I made every attempt to approach each observation with sensitivity, respecting the rights, dignity, and privacy of those I observed (Tarrant *et al*. 2017).

I gave Afghan women the choice of adopting a pseudonym instead of their real name when providing consent, in case of concerns about anonymity. I took further measures to ensure participant anonymity: I allocated a pseudonym for all Afghan women when writing up findings, and I assigned a participant ID to service providers. Any identifiable interview data was redacted. Participant observations frequently involved interactions with others – whilst institutional ethics was approved for these observations, I was careful to ensure that I adhered to the principles of ethical conduct, and ensured that my role as a researcher from London was made clear. Pseudonyms were used in field notes, and I did not include any information in my field notes that might identify either participants or others with whom they interacted during observations. Confidentiality was maintained by limiting data access to myself, my research supervisors, and in the case of Afghan women's interview data, a translator (who signed a confidentiality agreement). All signed completed consent forms, interview audio files, and typed-up field notes were uploaded to the LSHTM restricted-access secure server as soon as possible post-data collection, following which I deleted interviews from the audio recording device and destroyed signed consent forms and handwritten notes.

Taking the time to discuss and answer questions about anonymity and confidentiality was very important in this study – several Afghan women initially expressed concern that their recorded interview might be posted on social media, and a few service providers were concerned about their

interviews being shared with their managers, but a detailed discussion of measures I was implementing to ensure confidentiality and anonymity reassured them sufficiently to participate.

Practical ethical considerations

Whilst these processes were rigorous, I regard ethical issues in this study to be far broader than purely procedural matters, and I will now discuss relational and practical aspects of ethics that I considered. By 'practical ethics' I mean the messy and unpredictable work of ethics in reality (Clark-Kazak 2023, Deps *et al*. 2022). Here, I draw again on the decolonial feminist approach to this study, echoing other scholars who contend that feminist approaches can provide a framework for ethics of care in refugee research (Clark-Kazak 2023, Lokot *et al*. 2023). The relational aspect of feminist research reinforces caring and reciprocal relationships with participants (Clark-Kazak 2023, Zadhy-Çepoğlu 2023). Here, I found I was able to draw on relational skills I had developed when providing midwifery care for a diversity of women, to conduct ensure women felt comfortable during interviews and conduct them with sensitivity. Employing narrative methods when interviewing Afghan women was an ethical choice as it provided participants a means to guide interviews in accordance with what they were comfortable discussing with me. In this way, I was able to conduct interviews with Afghan women in a manner respectful of what they chose to share or not share, reducing harm in interviews by not asking them to recall traumatic experiences beyond what they chose to share with me. This was especially important because of the potential for interviews to re-activate past or current trauma (De Haene *et al*. 2010, Hugman *et al*. 2011), and it resulted in occasions when I intuited that further probing would have been insensitive or unwanted, resulting in some aspects of interviews left under-explored (van Liempt and Bilger 2018).

The relational aspect of feminist research also influenced my understanding of consent: I viewed consent not as a one-off procedure, but rather a continual discussion and negotiation (Hugman *et al*. 2011). For example, on one occasion a participant revealed information that was highly intimate and sensitive – I asked how she felt about that forming part of the interview, to gain consent for including it, and on reflection she decided that she wanted that specific part of the interview to be withdrawn. I remained reflexive to keep aware of power imbalances that may have increased the potential for coercion, rendering consent doubtful (Clark-Kazak 2023). Moreover, employing narrative methods enabled the co-creation of knowledge production by placing participants as active agents in telling their stories rather than passive participants from whom data is 'extracted', reifying notions of refugees as helpless victims (Eastmond 2007, Smith 2017). There were occasions when women became visibly upset during interviews. In these situations, I tried to empathetically walk a fine line. I tried not to shy away from emotions expressed by women, but rather by pausing and giving them space to express their emotions, avoiding rushing in with words to attempt to make them 'feel better',

I acknowledged how they were feeling, as women re-told intimate and difficult stories, but also offered them an opportunity to discontinue or pause the interview, or re-schedule for another time. I had a list of organisations to which I could refer women for further unpaid support, although none of them took up this offer. I also offered all women a follow-up call to debrief post-interview. Again, none of the women took up this offer, but the benefit of taking a relational approach in this research meant that I was able to stay in contact with most participants to varying degrees (some changed their number, or clearly did not wish to remain in contact), also mitigating the extractive nature of 'stealing their stories' (Pittaway *et al*. 2010), never to be seen or heard of by them again.

It was not only participants for whom I had to consider principles of 'do no harm' during participation, but also the team with whom I worked. Two interpreters, a translator, and a RA assisted me during interviews with Afghan women or translated interview audio-recordings, all of whom had varied lived experience of forcible displacement, and for whom interviews may have re-activated trauma, so I built-in time to debrief with them. A particular aspect of practical ethics arose, that I had not previously anticipated. That was the disclosure of sensitive information about two Afghan participants from NGO actors (sometimes more than one actor, in addition to the Farsi-speaking RA, independently from another), that participants had chosen not to reveal to me during interviews. This unequivocally and starkly demonstrated to me the power that narrative interviews give to participants - to share or withhold information on their terms, and shape their narratives in such a way as they wished me to hear. From an ethical perspective, while the information that was disclosed to me was extremely relevant to the research, I had to discount it from this study, to respect participants' rights to dictate their narratives on their own terms. Information about themselves that women chose not to share with me was often deeply personal and intimate. As someone with whom they had no pre-existing relationship, they may have either not felt comfortable sharing these details with me, or may have felt too ashamed to do so, despite the interpreter (in both cases the Farsi-speaking RA) being aware of their situation in her role as an NGO actor.

A further practical ethical aspect of research I considered was that of reciprocity - that participants should benefit in some way from the research, and that benefits of participation are offset by costs of doing so (Pittaway *et al*. 2010). Reciprocity was a difficult line to tread, and posed ethical dilemmas for me. Pittaway *et al*. (2010) compellingly propose participatory action research as a means of incorporating reciprocity into research design, yet as a self-funded student with few financial and human resources available, possibilities for 'giving back' to participants beyond a small token gesture were limited. I was aware of the time and emotional demands of participating – I made clear to women that they could spend as little or as much time being interviewed to minimise the burden of participation. After interviews, many participants told me they were grateful for the opportunity to

share their experiences, and that they were glad there is concern for Afghan women (especially considering the Ukraine war and associated shift in focus away from Afghans to Ukrainians). All women were offered a small token of appreciation to the value of £5 for taking part in interviews. I had initially thought that a transfer of mobile phone data would be most useful, but all Afghan women said they did not need additional data. Women living in Serbian camps requested shampoo, which I purchased and gave to them as a token of appreciation. I arranged delivery of hand soap and cream to thank women who participated remotely.

Prior to commencing data collection, I was conscious of the possibility of being viewed by women as someone who would be able to assist them in some way – a power dynamic that may have constituted coercion in participation. I was careful to explain my researcher role clearly to women prior to interview. However, in reality it appeared that Afghan participants were very savvy as to who could or could not help them, and did not appear to view me as someone who had any power to assist their migratory journeys. Only on one occasion did any of the Afghan women I met ask me directly for help, which was in the form of money, and I felt comfortable to give her money equating to the value of the small thank you gift I otherwise would have given her for taking part. However, there were several occasions when women asked me for advice on matters relating to their children's health, and I was able to signpost them for further assistance.

Academic responsibility

The final element of ethics in this study was that of academic responsibility (Daley 2021). Drawing attention to the emergence of migration studies as being rooted in policy, Zadhy-Çepoğlu (2023) echoes other scholars in calling for epistemologies that manoeuvre away from reproducing harm and further vulnerablising refugee communities (Daley 2021, Davies *et al*. 2023). In addition to the above ethical considerations, enacting academic responsibility, led me to carefully consider issues of representation of Afghan women and their voices not only in this thesis and other academic outputs, but in non-academic contexts also. For example, I resisted the use of fallible legal categories in this study, which reinforces policy-makers' paradigms (Bakewell 2008), and paid attention to how I represented Afghan women participants in my writing. Davies *et al*. (2023) highlight the 'politics of knowledge' at borders, showing how states can seek to conceal and eliminate border violence knowledge, but that both academics and activists have the potential to redefine *whose* knowledge is worthy and that knowledge can be leveraged as a form of resistance against border violence. To this end, I consider that privileging and amplifying Afghan women's experiences in this study was, and continues to be, an academic responsibility as well as a political act of solidarity, and resistance to hegemonic portrayals of both people on the move and childbearing Afghan women.

CHAPTER 3- NAVIGATING NEW LIVES: A SCOPING REVIEW AND THEMATIC SYNTHESIS OF FORCED MIGRANT WOMEN'S PERINATAL EXPERIENCES

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Primary Supervisor	Dr. Diane Duclos		

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SECTION E

Student Signature	Esther Sharma
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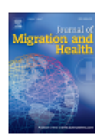

Navigating new lives: A scoping review and thematic synthesis of forced migrant women's perinatal experiences ☆

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ABSTRACT

Background: For health systems and maternity services to respond effectively to forced displacement, an understanding of the lived experiences of women seeking protection during childbearing is required. This study aim was to systematically review existing literature on the perinatal experiences of forced migrant women.

Methods: We conducted a scoping review including MEDLINE, CINAHL Plus, Web of Science and PsychINFO databases and manual search of references. Included studies were quality-assessed and analysed using inductive thematic synthesis.

Findings: In total 39 studies were included, involving 624 forced migrant women in 12 countries. Three inductive themes were: (1) "The nature of being a forced migrant," describing multiple liminalities experienced by women; (2) support during the perinatal period, showing women's (re)negotiation of shifting kinship and support networks; and (3) interactions with maternity services, revealing variations in maternity care experiences.

Conclusion: Findings highlight the systemic power structures forced migrant women must (re)negotiate during the perinatal period and the supportive and empowering role maternity services can play through provision of woman-centred care. Further research is needed to understand the lived perinatal experiences of forced migrant in low-income and transit country contexts.

Background

Over the past 30 years, interest and literature concerning women and migration has grown. The global movement of women has remained steady since the 1960s, now accounting for 48% of all migrants, with the majority of these women in the childbearing years (International Organization for Migration, 2020). Women on the move are exposed to particular health-related vulnerabilities including sexual exploitation, violence and reduced access to reproductive health services (World Health Organization, 2018) but remain under-researched. Pregnancy, childbirth and the six weeks after birth, (hereon in referred to as the perinatal period) continue to be experienced by women who are migrating (World Health Organization, 2019). Obstetric outcomes for forced migrant women are unclear, largely due to heterogeneity in migrant categories and contexts between studies, rendering evidence synthesis problematic. Nonetheless, there is clear evidence that perinatal mental health is worsened across all groups of migrants, contributing factors of which are thought to include social isolation, traumatic events before or during migration and stressors related to immigration regulations (Collins et al., 2011; Fellmeth et al., 2017; Anderson et al., 2017).

This study focuses on the perinatal experiences of women who are forcibly displaced and seeking protection, that is to say, forced migrant women. Whilst recognising the difficulties in defining groups of people whose mobility is complex in motivation and trajectory, the term 'forced migrant' has been chosen as a term to encompass people in need of protection for the purposes of this systematic review and literature synthesis. While it is a loosely-defined concept, its use recognises the need to go beyond the precise legal definition of 'refugee' as defined by the 1951 Refugee Convention (those who leave their country due to persecution on the grounds of race, religion, nationality, membership of a particular social group or political opinion), to include involuntary mobility for a complexity of man-made or natural reasons (Zetter, 2014).

Previous reviews have focused on the perinatal experiences of migrants generally (Pangas et al., 2019) or in specific countries or regions

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Previous reviews have focused on the perinatal experiences of migrants generally (Pangas *et al*. 2019) or in specific countries or regions (Fair *et al*. 2020, McKnight *et al*. 2019, Schmied *et al*. 2017). The aim of this review was to synthesise the literature pertaining to the experiences of forced migrant women during the perinatal period. Objectives were to: (i) identify the extent and quality of the existing literature; (ii) generate themes and consider their implications; and (iii) highlight gaps and areas for further research.

Methods

Study design

We conducted a scoping literature review (Arksey and O'Malley 2005) and thematic synthesis (Thomas and Harden 2008) . Scoping review methods are detailed in Woodward *et al*. (2014). This enabled

aggregation of qualitative data on participants' experiences, from which analytical themes can be developed. it is well suited to a woman-centred approach as it enables understanding of lived experiences from participants' perspectives.

Search strategy

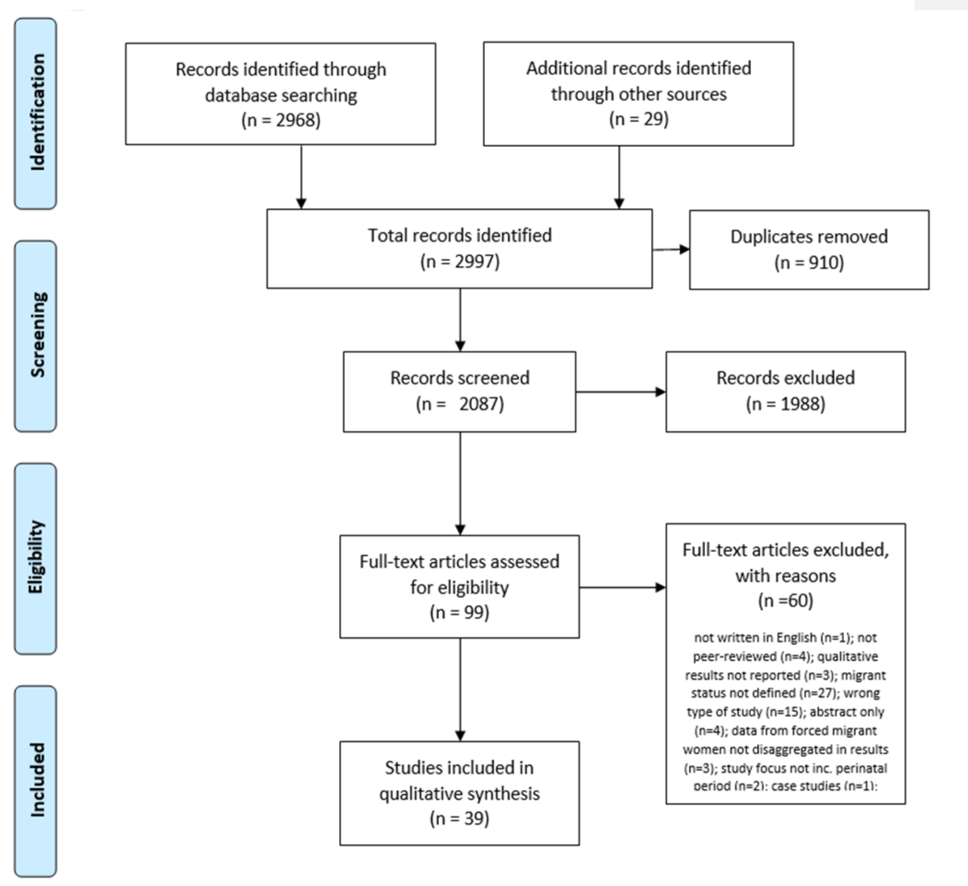
ES conducted the literature search and selection process followed methods outlined by Arksey and O'Malley (2005) in July 2020 with supervision from DD and NH. To answer the question, "What is known from the literature about the perinatal experiences of forced migrant women?", the search included all eligible sources up to 31 July 2020 in four online databases (i.e. MEDLINE, CINAHL Plus, Web of Science and PsychINFO) and further manual and Google Scholar searches to ensure all relevant articles were included. The main search terms were "forced migrant", "perinatal "and "experiences "with key- words related to these search terms used.

Eligibility and screening

ES screened studies for inclusion with guidance from DD. Inclusion criteria were all peer-reviewed studies published in English, using qualitative methods and including forced migrant women participants. Mixed-method studies were included, but only qualitative results were synthesised. Studies including data from other groups (e.g. health professionals, fathers) or migrant typologies were included if data relating to forced migrant women were identifiable. Studies across a range of countries and contexts were included, to reflect the varying contexts of women's perinatal experiences during migration with study context identified in this synthesis. Studies focussing on internally-displaced women, grey literature, and conference abstracts were excluded. Descriptive pieces, studies focussed exclusively on motherhood (after the 6-week postnatal period), reproductive or neonatal health, or perspectives of fathers and healthcare providers, were excluded.

Initial database and manual searches yielded a total of 2968 records (Fig. 2). Removing duplicates and screening the titles and abstracts resulted in 99 articles for full-text screening, leaving a total of 39 studies for inclusion in the thematic synthesis.

Figure 2 Flow diagram of literature search and screen



Quality assessment

We used the Critical Appraisal Skills Programme (CASP) (2018) tool to assess quality, though this was not used as a filtering tool for exclusion, as even low-quality qualitative studies can yield valuable insights (Hannes 2011).

Data synthesis

First, all text in the findings section of papers was included in analysis, using NVivo v12 (QSR International 2020). Only data directly relating to forced migrant women's experiences was inductively coded, including primary quotations and the author's text. Second, codes were grouped into descriptive themes. During coding, a pattern fitting the Ecological Model (Bronfenbrenner 1979) was noted, so this model was used to provide a priori descriptive themes of five symbiotic systems;

individual, interpersonal, organisational (relating to health or maternity services), political and cultural (relating to the host country). Third, by looking at patterns and relationships across the descriptive themes and codes, as well as looking back at the primary data fragments, analytical themes and sub-themes were developed.

Findings

Study characteristics

Table 1 summarises the 39 studies included. 33 studies were conducted in high-income countries (Australia, Canada, Germany, Ireland, Sweden, USA, UK) and 6 studies were conducted in in low/middle-income countries (Kenya, South Africa, Sudan, Thailand, Türkiye) with 3 of these in neighbouring country refugee camps. In total, 624 forced migrant women participated. A diversity of perinatal experiences were explored, allowing for wide-ranging experiences to be synthesised.

Table 1 Summary of Study Characteristics

First author (publication year)	Study aim	Study setting	Data collection	Analysis	Participants
Agbemenu (2019b)	To explore mechanisms of avoidance of obstetric interventions	USA	Interviews, focus groups (FGDs)	Thematic analysis	Somali refugee women (n=40)
Ahmed (2017)	To explore women's experiences of expecting or having a baby after resettlement from a mental health perspective.	Canada	Questionnaire, FGD	Thematic analysis of FGDs; SPSS for questionnaire	Pregnant or postnatal Syrian refugee women (n=12)
Asnong (2018)	To develop a better understanding of adolescent pregnancy, including sexual and reproductive health knowledge and family and community support structures.	Refugee camps in Thailand	In-depth interviews (IDI)	Thematic analysis	Pregnant Myanmar adolescents (n=20)

Bader (2020)	To examine African origin mothers’ infant care values and practices related to feeding, carrying, and daily activities following resettlement.	USA	Semi-structured interviews (SSI)	Open coding to develop themes, axial coding of relationship between themes	Refugee mothers (with infants <24m-old) from DRC and Burundi (n=10)
Briscoe (2009)	To explore the experience of maternity care by refugee and asylum seekers.	UK	Collective case study design using IDI	Decontextualization, display, data compilation	Refugee and asylum-seeking women (n=4)
Bulman (2002)	To understand the reality faced by women in their contacts with maternity services.	UK	SSI, FGDs	Unclear	Somali refugee women receiving caseload midwifery care (n=12); midwives (n=NA)
Byrskog (2016)	To explore how women understand and relate to violence and wellbeing during their migration transition and their views on being approached with questions about violence in antenatal care.	Sweden	SSI	Thematic analysis	Somali refugee women who gave birth in Somalia or Sweden (n=17)
Carolan (2007)	To explore factors that facilitate or impede the uptake of antenatal care.	African Women’s Clinic, Australia	Observations, SSI	Generation of categories and themes, coding data, offering interpretation and alternative explanations	African refugee women (n=10); clinic staff (n=NA)
Chulach (2016)	To explore the experience of pregnancy from the perspective of HIV-positive refugee women.	Canada	SSI	Interpretive phenomenological analysis	HIV-positive refugees who experienced pregnancy in

					Canada in past 5yrs (n=4)
Correa-Velez (2012)	To report the findings of a model of maternity care for women from refugee backgrounds,	Maternity Hospital, Australia	Surveys with open-ended questions (by peer interviewers); maternity records audit	Quantitative data - SPSS; qualitative data -thematic analysis	African-born refugee-background women (n=23); hospital staff (n=168); maternity records (n=83)
Furuta (2008)	To understand factors leading to risk behaviours.	Eritrean refugee camp in Sudan	IDI	Unclear	Eritrean women who gave birth within 2 years (n=10)
Gallegos (2015)	To explore the experience of breastfeeding.	Australia	SSI, FGDs	Thematic analysis	Women from Burundi, DRC, Liberia, Sierra Leone, who gave birth in home country or Australia (n=31)
Gewalt (2018)	To investigate women's experiences and perceived needs whilst living in state-provided accommodation, with a particular focus on psychosocial factors.	Asylum Centres, Germany	Exploratory case study; 21 SSI during pregnancy, 9 follow-up interviews	Thematic analysis	Pregnant asylum-seekers (n=9)
Henry (2020)	To explore how perinatal conceptions, premigration experiences, health literacy, and language skills influence women's perceived needs and expectations of care.	Germany	SSI	Content analysis	Asylum-seeking women from Iraq, Syria and Palestine, who were pregnant or gave birth in Germany (n=12)

Herrel (2004)	To understand women's perinatal experiences, education needs, effective ways to increase attendance at prenatal visits, and appropriate approaches to childbirth education.	USA	FGDs	Unclear	Somali women who gave birth in USA (n=14)
Hufton (2016)	To explore issues surrounding infant feeding practices and the experiences of health professionals in helping these women to reach the best outcomes for themselves and their infants.	UK	SSI, FGDs	Framework analysis	Refugee women (n=30); maternal health-workers (n=9)
Joseph (2019)	To understand how women navigated breastfeeding in face of familial disconnections and the wider healthcare negotiations.	Australia	IDI, participant drawings	Thematic analysis and modified critical visual analytical framework	Vietnamese (n=16) and Myanmar (n=22) refugee mothers with infant <1yr-old, who gave birth in Australia or transit countries; Myanmar grandmothers (n=2)
Joseph (2020)	To understand how mothers situated their infant feeding perspectives.	Australia	IDI, participant drawings	Thematic analysis and modified critical visual analytical framework	Vietnamese (n=16) and Myanmar (n=22) refugee mothers with infant <1yr-old, who gave birth in Australia or transit countries; Myanmar

					grandmothers (n=2)
Kibiribiri (2016)	To examine disparities in the quality of prenatal care received by pregnant refugee women and local pregnant women attending the same primary healthcare facilitates.	Primary healthcare facility, South Africa	Cross-sectional mixed-methods using surveys, IDI, maternity records audit	Quantitative data - SPSS; qualitative data - patterns, themes & contradictions	South African or refugee mothers (n=220); refugee mothers with infant <6m-old (n=16)
Kingsbury (2018)	To describe personal social network of women who have given birth in the United States.	USA	SSI	Egocentric analysis of personal social network data; qualitative data - descriptive open coding	Nepali-origin Bhutanese refugee women who gave birth in USA within last 2yrs (n=45)
Koruku (2018)	To determine the birth experiences of women, and their transition to motherhood in Türkiye.	Türkiye	SSI	Thematic analysis	Syrian refugee women who gave birth in Türkiye (n=7)
Kulig (1990)	To identify the cultural knowledge of women, and how it relates to contraception usage and prenatal care.	Canada	Ethnographic interviews	Unclear	Cambodian refugee women who conceived in Southeast Asia (n=12)
Lalla (2020)	To understand women's experiences of insecurity in a refugee camp.	Kenyan refugee camp	Ethnographic SSI	Inductive and deductive coding	Oromo refugee women who gave birth in the camp (n=20)
LaMancuso (2016)	To study of women's perinatal care.	USA	SSI	Template Style analysis	Karen refugee women who gave birth in Thailand, Myanmar or USA within 3yrs (n=14); Karen doulas, community

					leaders, 6 clinic representatives (n=8)
Lephard (2016)	To explore the maternity care experiences of local asylum-seeking women to inform local services.	UK	SSI	Thematic analysis	Asylum-seeking women who gave birth in UK within 1yr (n=6)
Lowe (2019)	To explore women's experiences of forced migration, kinship, and reproductive health	Kenya	Ethnographic SSI and observations	Not stated	Somali women and men and healthcare providers (n=NA)
McLeish (2005)	Describes the maternity experiences of asylum seekers in England.	UK	SSI	Not stated	Asylum-seeking women, pregnant or gave birth within 18m (n=34)
Murray (2010)	To explore the experiences of African refugee women who gave birth in Brisbane, Australia.	Australia	SSI	5 step analysis of the essences	African refugee women who gave birth in Brisbane in past 5yrs (n=10)
Nabb (2006)	To explore the provision of maternity care while in emergency accommodation in the UK	UK	IDI, SSI	Not stated	Maternity care providers (n=5); pregnant asylum-seekers (n=15)
Ngum Chi Watts (2015)	To solicit the lived experiences of young refugee women who have experienced early motherhood in Australia.	Australia	IDI	Thematic analysis	African refugee adolescent mothers (n=16)
Niner (2013)	To understand how pregnancy and birth was experienced both before and after resettlement.	Australia	Case studies from narrative ethnographic interviews	Thematic analysis	Karen refugee women who recently gave birth (n=8)
Nithianandan (2016)	To investigate barriers and enablers to implementing evidence-	Australia	SSI	Thematic analysis	Health-workers (n=28) and refugees with

	based, nationally recommended perinatal mental health screening and inform sustainable implementation of a screening and referral programme, in women of refugee background.				current/ previous pregnancy (n=29)
O'Shaughnessy (2012)	To explore the impact of the intervention on the quality of the mother-infant relationship, foregrounding views of mothers and babies (in the mothers' minds).	UK	Questionnaires, FGDs, videos	Thematic analysis; videos scored by Infant CARE-Index	Asylum-seeking new mothers with infants <1y-old (n=NA)
Riggs (2017)	To explore experiences of group pregnancy care.	Australia	FGDs	Thematic analysis	Karen refugee women who had group pregnancy care (n=19)
Riggs (2016)	To investigate understandings of maternal oral health, dental priority groups and information provision from women, dental and maternity care providers.	Australia	FGDs	Thematic analysis	Afghan or Sri Lankan refugee women who gave birth in past 3yrs (n=24); dental staff (n=19); midwives (n=10)
Russo (2015)	To explore women's experiences throughout pregnancy, birth, and into the early stages of motherhood.	Australia	FGDs, SSI	Thematic analysis	Afghan refugee women who gave birth in Australia (n=38)
Stapleton (2013)	To identify facilitators and barriers to the delivery and quality of care of a specialist antenatal clinic for	Australia	Chart and database audit; surveys, SSI, FGDs	Quantitative data - Excel and SPSS; qualitative data - thematic analysis	Records from specialist clinic (n=190); service-users (n=42); staff

	refugee-background women.				(n=160); women in 4 FGDs (n=18)
Tobin (2014)	To gain insight into women's experiences of childbirth in Ireland while in the process of seeking asylum.	Ireland	IDI	Narrative analysis	Refugee and asylum-seeking women who experienced pregnancy or birth (n=22)
Yelland (2014)	To investigate women and men's experience of the way that health professionals approach inquiry about social factors affecting families having a baby in a new country, and investigate how health professionals identify and respond to the settlement experience and social context of families of refugee background.	Australia	SSI, FGDs	Thematic analysis	Afghan refugee men (n=14) and women (n=16) with an infant 4-12m old; health-workers (n=34)

Quality assessment

Table 2 shows results of study assessment using the CASP (2018) tool, which revealed mixed quality of included studies. The common study weaknesses were failing to address issues of reflexivity and the way in which the role of researchers or research assistants may have influenced the study. This is particularly pertinent when bicultural or community research assistants were used (Nithianandan *et al*. 2016, Riggs *et al*. 2016, 2017, Russo *et al*. 2015) as participants may have been concerned about revealing or discussing sensitive issues with other community 'insiders'. Ethical issues were another common study weakness – discussions about the impact of the study on participants were often not addressed. In both of these cases, it is possible that the word count of papers limited the amount of discussion that was possible.

Table 2 CASP quality appraisal by source

First author (publication)	Aims	Methods	Design	Recruitment	Data collection	Reflexivity	Ethics	Analysis	Findings
Agbemenu (2019b)	✓	✓	✓	✓	✓	×	✓	✓	✓
Ahmed (2017)	✓	✓	×	✓	✓	✓	✓	✓	✓
Asnsong (2018)	✓	✓	✓	✓	✓	×	✓	?	✓
Bader (2020)	✓	✓	✓	✓	✓	×	✓	?	✓
Briscoe (2009)	✓	✓	✓	✓	✓	×	✓	?	✓
Bulman (2002)	✓	✓	✓	✓	?	?	×	?	?
Byrskog (2016)	✓	✓	✓	✓	✓	×	✓	✓	✓
Carolan (2007)	✓	✓	?	?	?	×	×	×	×
Chulach (2016)	✓	✓	✓	?	✓	×	✓	✓	✓
Correa-Velez (2012)	✓	✓	?	×	?	×	?	?	×
Furuta (2008)	✓	✓	×	×	×	×	×	×	×
Gallegos (2015)	✓	✓	✓	?	?	×	×	?	✓
Gewalt (2018)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Henry (2020)	✓	✓	✓	✓	✓	×	✓	✓	✓
Herrel (2004)	×	✓	?	?	?	×	×	×	×
Hufton (2016)	✓	✓	✓	✓	?	×	?	?	✓
Joseph (2019)	✓	✓	✓	✓	✓	✓	✓	✓	✓

Joseph (2020)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kibiribiri (2019)	✓	✓	✓	✓	?	×	?	×	✓
Kingsbury (2018)	✓	✓	✓	✓	✓	×	?	✓	✓
Koruku (2018)	✓	✓	✓	×	?	×	?	?	✓
Kulig (1990)	✓	✓	?	?	?	×	×	?	✓
Lalla (2020)	✓	✓	✓	✓	✓	✓	✓	✓	✓
LaMancuso (2016)	✓	✓	✓	✓	✓	✓	?	✓	✓
Lephard (2016)	✓	✓	✓	✓	✓	×	?	?	✓
Lowe (2019)	✓	✓	?	?	?	×	×	x	x
McLeish (2005)	×	✓	?	✓	?	×	×	×	×
Murray (2010)	✓	✓	✓	✓	?	×	?	✓	×
Nabb (2006)	✓	✓	?	?	?	×	?	×	×
Ngum Chi Watts (2015)	×	✓	?	✓	?	×	?	✓	×
Niner (2013)	✓	✓	?	✓	?	×	×	×	×
Nithianandan (2016)	✓	✓	✓	✓	?	×	?	✓	✓
O'Shaughnessy (2012)	✓	✓	?	?	?	×	×	×	✓
Riggs (2016)	✓	✓	✓	✓	?	×	?	?	✓
Riggs (2017)	✓	✓	✓	✓	✓	✓	×	?	✓
Russo (2017)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stapleton (2013)	✓	✓	?	?	?	×	×	✓	✓
Tobin (2014)	✓	✓	✓	✓	✓	×	?	✓	✓
Yelland (2014)	✓	✓	✓	✓	✓	×	?	✓	×

Thematic analysis

The overarching themes are: (1) the nature of being a forced migrant; (2) support during the perinatal period; and (3) interactions with maternity services. Although findings are described as discrete themes and sub-themes, in reality, they are synergistic and overlapping, demonstrating the complex lived experiences of forced migrant women during the perinatal period.

The nature of being a forced migrant

Liminality

The transition from one state of being to another or being 'betwixt and between', was experienced by forced migrant women around the childbearing time repeatedly; socio-culturally, economically, legally, physiologically, and spatio-temporally. Separation from home country socio-cultural structures, coupled with the loss of rituals associated with rites of passage from pregnancy to motherhood, often resulted in feelings of loss and grief (Joseph *et al*. 2019, Niner *et al*. 2013, Russo *et al*. 2015). An Afghan refugee woman who gave birth in Australia captured this:

> *"Having a child was such an important time. It was a time when we ate the best food, we get massages every day and were treated with the best of everything. Here we are left to look after ourselves…"* (Russo *et al*. 2015, p.7)

Liminal citizenship status was experienced not only as a source of stress in itself, but also imposed protracted insecure living arrangements, lack of hygiene and cleanliness, overcrowding and with the stress of possibly being re-housed (Briscoe and Lavender 2009, Gewalt *et al*. 2018, Hufton and Raven 2016, Korukcu *et al*. 2018, Lephard and Haith-Cooper 2016, McLeish, 2005, Nabb, 2006). As an asylum seeker in the UK described:

> *"I stayed in the hotel for 2 months— eating sandwiches and I was on crutches. I can't go downstairs 'cause I was on top [floor]. There were scary people. Men smoking, hanging round. So I can't go in dining room."* (Lephard and Haith-Cooper 2016, p. 132)

Across contexts, these everyday insecurities were frequently expressed by many women as powerlessness and loss of control, preventing them from participating in host country life (Gewalt *et al*. 2018, Hufton and Raven 2016, Korukcu *et al*. 2018, Lalla *et al*. 2020). For some, religious beliefs provided hope and comfort in adversity (Chulach *et al*. 2016, Niner *et al*. 2013, Riggs *et al*. 2017). Transitioning to motherhood after birth (whether for the first or sub- sequent time), represented for many, movement towards a redefined identity and reconnection to themselves, thus bringing to conclusion the liminal state of pregnancy (Byrskog *et al*. 2016, Chulach *et al*. 2016, Korukcu *et al*. 2018, Ngum Chi Watts *et al*. 2015, Riggs *et al*. 2017). Children provided a raison d'etre ;

> *"We cling to our children to survive hard times. They make us forget the pain of war."* (Korukcu *et al*. 2018, p.5)

Less frequently, divergent perspectives indicated the burden of having a newborn (Korukcu *et al*. 2018, Ngum Chi Watts *et al*. 2015).

Trauma

Previous pregnancy or birth-related trauma was described by women. In one study, the ongoing trauma experienced by a woman who was forced to give birth in the open after her refugee camp was destroyed was described (Niner *et al*. 2013). Other participants spoke of trauma caused by witnessing or being victims of rape (Briscoe and Lavender 2009, Lalla *et al*. 2020, Tobin *et al*. 2014), or labouring during bombing and shootings (Henry *et al*. 2020).

> *"Even during that time people were raped things like that. So I ended up becoming pregnant …but just now and then I keep thinking about it [said in almost a whisper]. It hurts.*" (Briscoe and Lavender 2009, p.19).

Trauma could be reactivated during birth in a host country. A refugee woman described feeling that she was "*in a place where people are slaughtered*" (Niner *et al*. 2013, p.544) during her birth in Australia, which resulted in postnatal anxiety and hallucinations. In the same study, another woman described how her "*heart was shaking* " (Niner *et al*. 2013, p.543) when some difficult news was communicated to her in labour.

Support and kinship

Changing family dynamics

Women described the shift in family dynamics they experienced as a result of their forced migration, and its implications during the perinatal period. The absence of sharing the joy of pregnancy (Tobin *et al*. 2014), support in labour (Henry *et al*. 2020, Hufton and Raven 2016, Lephard and Haith-Cooper 2016) or with breastfeeding (Gallegos *et al*. 2015, Hufton and Raven 2016, Joseph *et al*. 2019), and assistance with caring for other children (Gallegos *et al*. 2015) was noted by participants. In two studies, this was identified as a cause of poor perinatal mental health (Henry *et al*. 2020, Riggs *et al*. 2017). Immigration regulations that kept women and their extended families from being able to visit one another were described by one participant as feeling "*like a bird in a cage*" (Ahmed *et al*. 2017, p. 7). While transnational connections with family, seeking advice and support over the phone were identified in some studies (Chulach *et al*. 2016, Henry *et al*. 2020), the extent to which these ties were maintained and the role they played for women during the perinatal period did not appear to be widely explored. As a result of family separation, a number of studies showed that women had to rely on their partners for support in a manner they would not have expected in their home country (Byrskog *et al*. 2016, Henry *et al*. 2020, Herrel *et al*. 2004, Riggs *et al*. 2017), necessitating renegotiation of gender roles, exemplified by a participant as:

> *"If you were at home would you have your men around at birth? No, No it's just here [in Australia]."* (Stapleton *et al*. 2013, p.264).

In the absence of extended family, many women sought support, friendship and advice from those from the same country of origin (Bader *et al*. 2020; Kingsbury *et al*. 2018; Russo *et al*. 2015). However, issues of privacy within communities were often cited as a concern, specifically relating to violence, depression and HIV status (Ahmed *et al*. 2017, Chulach *et al*. 2016, Yelland *et al*. 2014).

Role of formal support

In addition to kinship networks formed among those from the same country of origin, a number of studies found that women also relied on health professionals for support, in the form of practical help, listening, reassurance, empathy and encouragement (Gewalt *et al*. 2018, Joseph *et al*. 2019, Kingsbury *et al*. 2018, Lephard and Haith-Cooper 2016, McLeish, 2005, Riggs *et al*. 2017, Yelland *et al*. 2014). This was particularly noticeable among participants who had access either to specialist services or models of care promoting continuity, in which trusting relationships with professionals had been formed. One woman spoke poignantly of this:

> *"When I see V [community midwife] [had] come [to] see me, I was like, all my family [has] come to see me!"* (Lephard and Haith-Cooper 2016, p.133)

Groups offered a space for forced migrant women to not only gain information and reassurance from professionals but also locate and build kinship networks (Chulach *et al*. 2016, O'Shaughnessy *et al*. 2012). These included a mother-infant therapeutic group (O'Shaughnessy *et al*. 2012) and group antenatal care (Riggs *et al*. 2017), both facilitated by multi-disciplinary teams with bi-cultural workers, as well as a community support group for HIV-positive women (Chulach *et al*. 2016).

Interactions with maternity services

Navigating the system

Women's access to maternity services was marked in studies by having to navigate the system. Barriers to accessing maternity services were numerous. Entitlement to state-provided maternity care (Lephard and Haith-Cooper 2016) and methods of referral to maternity services (McLeish 2005, Nabb 2006, Murray *et al*. 2010) could be a source of confusion. In a refugee camp, study participants identified financial barriers in the form of maternity care costs or bribery:

> *"They [nurses and refugee nursing assistants] asked me, 'Are you Ethiopian or Somali?' then I had to give them 'kitu kidogo' [translated from Swahili as 'a little something']." (*Lalla *et al*. 2020, p.13).

Location and transportation were a significant barrier to accessing maternity services which in some instances resulted in women being unable to attend antenatal care (Carolan and Cassar 2007, Chulach

et al. 2016, Correa-Velez and Ryan 2012, Furuta and Mori 2008, LaMancuso *et al*. 2016, Lephard and Haith-Cooper 2016, McLeish 2005, Niner *et al*. 2013). In refugee camps, the impact of being far away from the nearest hospital with limited access to transport was described by women as being extremely challenging and even fatal (Furuta and Mori 2008, Lalla *et al*. 2020).

Using maternity services

A dichotomy emerged between satisfaction and lived experiences of maternity care. Many women who had migrated to high- or middle-income countries expressed satisfaction with their maternity care overall, but this was usually framed in contrast to their previous maternity experiences in resource-poor settings with higher maternal mortality rates and gratitude for being taken care of within the host country health system (Bader *et al*. 2020, Henry *et al*. 2020, Korukcu *et al*. 2018, LaMancuso *et al*. 2016, Niner *et al*. 2013, Riggs *et al*. 2017). In spite of this satisfaction, women in many studies identified being stigmatised and receiving disrespectful or discriminatory care, due to being foreign, their skin colour, immigration status or being unable to speak the host-country language (Agbemenu *et al*. 2019b, Chulach *et al*. 2016, Herrel *et al*. 2004, Lalla *et al*. 2020, McLeish 2005, Niner *et al*. 2013). They felt their needs were disregarded, they were treated rudely or as inferior to host-country women and, particularly with reference to female genital mutilation (FGM), put on display and 'othered' (Agbemenu *et al*. 2019b, Stapleton *et al*. 2013).

> *"I feel like that doctor did not look after me very well… I am not sure if it is because we are refugees that they don't treat us very well. ... I didn't say anything and I have to thank him for helping me give birth... Maybe he looks down on us because we can't speak the language."* (Niner *et al*. 2013, p.545)

Authors of several studies recognised that low expectations of care, cultural understandings of medical paternalism and feelings of beholdeness to the host country acted as contributing factors to this dichotomy (LaMancuso *et al*. 2016, Niner *et al*. 2013). Conversely, specialist and continuity models of maternity care were positively regarded by women (LaMancuso *et al*. 2016, Murray *et al*. 2010, Riggs *et al*. 2017) who placed a high value on the trusting relationships that were formed because, "*there's someone there for you… so you don't feel nervous*" (Riggs *et al*. 2017, p. 149). Women who didn't experience continuity of care found having to explain or express themselves to health professionals "*really exhausting telling each one*" (Murray *et al*. 2010, p.465).

Feeling understood

Women's interactions with maternity services and encounters with health providers were characterised by perceptions of misunderstandings due to health professionals' lack of communication

and cultural awareness. Language was significant in women not feeling understood. In a number of studies women did not understand what was happening to them due to language barriers (Briscoe and Lavender 2009, Henry *et al*. 2020, Herrel *et al*. 2004, Kibiribiri *et al*. 2016, McLeish 2005, Niner *et al*. 2013, Tobin *et al*. 2014) and on some occasions, unfounded assumptions were made about their level of understanding:

> *"I asked them, "[Can] we cancel the meeting until we get an interpreter… I didn't understand you and you didn't understand me." She said, "No, it's OK, we can go on—you understand English.""* (Lephard and Haith-Cooper 2016, p.134)

The issue of interpreters was central to women's feelings of being understood, with an emphasis on the suitability of interpreters (Agbemenu *et al*. 2019b, Correa-Velez and Ryan 2012, Herrel *et al*. 2004, Lephard and Haith-Cooper 2016, McLeish 2005, Murrary *et al*. 2010, Niner *et al*. 2013, Tobin *et al*. 2014). For example, when family members were relied upon to interpret, or a male interpreter was provided, women felt uncomfortable or were not able to engage fully.

> *"I was assisted by a stranger and furthermore he was a man. I had no choice. I was being selective in my responses to the healthcare worker."* (Kibiribiri *et al*. 2016, p.153)

As a result, the disempowerment and disconnectedness of women from decision-making about their care or treatment were evidenced (Bulman and McCourt 2002, Correa- Velez and Ryan 2012, Riggs *et al*. 2016), leading to feelings of loss of control, fear, and for some women, trauma. Women described having procedures without fully understanding what or why these were taking place. For women whose home-country understandings of operative birth was associated with maternal mortality or who had experienced past trauma, a lack of shared decision-making in their care could be traumatising, as illustrated here:

> *"There was no interpreter. A few minutes later, two nurses came and tied me up and I could not move. I was scared and thought, ''Something's wrong now,'' and ''That's it. That's the end of everything.'' I felt like I was in a place where people are slaughtered."* (Niner *et al*. 2013, p.544)

Complex and disempowering dynamics with health professionals made it difficult for some women to question their care, due to fear of mistreatment and the verbal and non-verbal disrespect they felt which left women uncomfortable and ashamed (Murray *et al*. 2010, Tobin *et al*. 2014).

A lack of cultural awareness among health professionals was also seen as a contributor to women not feeling understood in many of the included studies. Attendance by a female doctor (Murray *et al*. 2010, Riggs *et al*. 2017) and understanding of FGM (Bulman and McCourt 2002, Lephard and Haith-

Cooper 2016, Murray *et al*., 2010, Stapleton *et al*., 2013) are examples of cultural safety highlighted by study participants. Additionally, there were tensions between women's cultural norms and practices and the biomedical model of maternity care or western cultural norms experienced in high-income countries (Bader *et al*. 2020, Galegos *et al*. 2015, Joseph *et al*. 2019, Jospeh *et al*. 2020, Kulig 1990, Niner *et al*. 2013, Riggs *et al*. 2017, Stapelton *et al*. 2013). As one participant said:

> *"I felt like I was judged by my doctor…I wanted to do things according to my tradition but I was expected to do things differently." (Russo et al. 2015, p.6).*

There were occasional examples of women's strategies of resistance to the biomedical model (Agbemenu *et al*. 2019b, Lowe 2019), but these were not commonplace in the literature.

(Dis)empowerment through information

Women commonly felt they lacked information (Henry *et al*. 2020, Herrel *et al*. 2004, Niner *et al*. 2013, Riggs *et al*. 2017, Stapleton *et al*. 2013), leaving some to rely on family members or home country experiences, resulting in confusion. For example, in one study (Henry *et al*. 2020), an Iraqi refugee woman describes giving birth alone at home in Germany due to lack of information about who to contact in labour. Conversely, where provided, women in a number of studies in high-income countries articulated the empowering effect that increased education and understanding had for them, saying that it helped them to "*feel stronger*" (Riggs *et al*. 2017, p.148), with a greater sense of control and self-efficacy as mothers (Murray *et al*. 2010, O'Shaughnessy *et al*. 2012).

Discussion

This review is unique in its examination of the literature specifically pertaining to perinatal experiences of forced migrant women globally. This study has several strengths. Using strict eligibility criteria enabled the lived experiences of forced migrant women specifically to be synthesised, in a range of contexts acknowledging their circumstances as distinct from women migrating voluntarily. Using thematic synthesis allowed us to develop new understandings from qualitative primary data while preserving context (Thomas and Harden 2008) . This method draws on critical realism, accepting objective knowledge while seeking to understand how these interplay with lived experiences, a perspective valuable in seeking to understand maternity experiences and migration (Bakewell 2010, Barnett-Page and Thomas 2009, Walsh and Evans 2014). Our three overarching analytical themes show women negotiating and renegotiating intersecting factors impacting upon their lived experiences in the perinatal period.

Being a forced migrant showed the multiple liminal spaces occupied by women simultaneously. Protracted immigration regulations often held women in this 'in between' space, reproducing

vulnerabilities rather than providing the protection that was being sought. The postnatal reconnection to identity for some women speaks to cultural ideals and expectations of women as mothers as well as the ability to exert agency in mothering in order to carve out new familial identities (Green 2005, Lockwood *et al*. 2019). The traumas experienced by women are congruent with findings from other studies, which evince the higher risks of psychosocial distress and post-traumatic stress disorder among women who have experienced conflict, FGM, rape or violence (Alsheikh Ali 2020, Behrendt and Moritz 2005, Marie *et al*. 2020). Birth and associated health-related practices have potential to trigger re-traumatisation (Sperlich *et al*. 2017). However, this review found insufficient consideration of potential traumatisation among maternity providers. While trauma-informed practices are not widely adopted, ensuring that women are equal partners in their care and that informed consent occurs is a valuable step that clinicians and allied professionals can incorporate into their practice to reduce the risk of re-traumatisation (Sperlich *et al*. 2017).

Support and kinship situated the childbearing time within its social context. The link between social support and psychological wellbeing during the perinatal period is well established (Glazier *et al*. 2004, Webster *et al*. 2011) and psychosocial interventions can protect against maternal depression (Morikawa *et al*. 2015). However, perinatal mental health services are often under-used by migrant women, either due to structural barriers in accessing services or reluctance because of a lack of understanding or stigma surrounding mental health issues (Giscombe *et al*. 2020, Heslehurst *et al*. 2018). This highlights the need for greater provision of perinatal mental health services that are accessible and embedded into maternity care provided to forced migrant women.

Female support during labour is the norm in many cultures and associated with fewer interventions (Hodnett *et al*. 2013, Madi *et al*. 1999), yet this review showed that female support was lacking and in some instances partners had to take up this previously unfamiliar role. Several studies identified health professionals as being a source of support, which was experienced as compassionate care. Compassionate care is a key constituent of respectful maternity care (Renfrew *et al*. 2014), which is a right for all women around the childbearing time (White Ribbon Alliance 2011) but not universally experienced by all forced migrant women in this review.

Interactions with maternity services, demonstrated the variations in care women experienced. Maternity care which was disrespectful and racist, failed to account for women's language or cultural needs, or failed to incorporate informed decision-making, produced anxiety and fear. In contrast, trusting relationships with maternity care providers and provision of accessible information to help navigate birth and motherhood gave women greater control and confidence and was a source of support. Woman-centred models of maternity care, in which decisions are made with not for women

and promote continuity of carers and women's capacities in the perinatal period, have been identified as a framework for providing quality maternity care for all (Renfrew *et al*. 2014) and therefore must also be provided for forced migrant women. Taking a woman-centred approach involves going beyond biomedical needs to accepting and respecting cultural needs. Women living in refugee camps were shown in this review to experience greater insecurity and further reduced access to maternity services, but further studies are needed to explore the perinatal experiences of women who have been forcibly displaced to neighbouring or transit countries. Using qualitative research methods, including in-depth interviews and observations will provide rich and nuanced perspectives in such contexts. The focus of this research must shift from being framed by a discourse of victimhood to understanding agency and resilience in transient settings. Additionally, further research is needed to understanding women's resourcefulness in the reproductive sphere, which will contribute to developing strengths-based approaches in maternity services.

Limitations

There are a number of limitations to this study. First, the decision to include studies with small sample sizes (<15 participants, with no justification given for the sample size) and poorer methodological quality may have introduced some bias. However, inclusion of CASP quality assessment helped to mitigate this. Second, the choice of search terms in this review may have excluded studies that identified forced migrants in other ways, although conducting a manual search reduced this possibility. Finally, coding the data and developing themes with a second researcher may have reduced the possibility of bias in synthesising the evidence.

Conclusion

This thematic synthesis shows the intersecting challenges of being a forced migrant woman during the perinatal period, demonstrates the important role of social support, and considers the potential for maternity services to empower women. Systemic power structures, specifically those relating to immigration regulation but also those at an organisational-level within maternity services, are demonstrated as women navigate a period of liminality, changing kinship networks, and their sense of self.

Updated literature review

Since writing and publishing my literature review there has been a significant corpus of new peer-reviewed literature on the topic of forcibly displaced women's perinatal experiences. In this section, I update my literature review by identifying new literature meeting inclusion criteria I used in my original literature review, and discussing how these recent contributions add to the conversation about perinatal experiences of forced migrant women.

I identified 16 new eligible studies, published 2020-2024. Unlike the original literature review in which the majority of studies were conducted in high-income country settings, less than half (n=7) of these were conducted in high-income countries. Four were conducted in the UK, of which one recruited refugee women of any background to understand their maternity care needs (Evans *et al*. 2022), one focussed on experiences of destitution during pregnancy of refugee women (Ellul *et al*. 2020), another on maternity experiences of asylum-seeking women living in an Initial Accommodation centre (Filby *et al*. 2020), and another on the experiences of asylum-seeking women attending an NGO perinatal support service (Bosatta *et al*. 2024). Two studies were conducted in Australia, one exploring maternity care of newly-arrived African women (Due *et al*. 2022) and the other exploring violence- and trauma-informed antenatal care among Karen refugee women (Toke *et al*. 2024). A study conducted in Canada explored barriers to breastfeeding among refugee mothers (Hirani 2024).

Nine studies were conducted across a number of low- or middle-income countries, four in Lebanon among Palestinian, Iraqi and Syrian refugee women (Akesson *et al*. 2023, Alnaji *et al*. 2023, Howe *et al*. 2024, Kabakian-Khasholian *et al*. 2022), two in Kenya among Somali women residing in refugee camps (Bagelman and Gitome 2021, Kituku *et al*. 2022), one in Chad among Sudanese women residing in refugee camps (Ngarmbatedjimal *et al*. 2024), and two in Türkiye among Syrian (Toker and Aktaş 2021) or Afghan (Kuru Alici and Ogüncer 2024) refugee women. The fact that more published studies were conducted in transient spaces demonstrates a shift in knowledge production, now encompassing a greater corpus of knowledge about forcibly displaced women's perspectives about their perinatal experiences in liminal transit spaces.

The primary locus of eight studies was maternity care experiences (Due *et al*. 2022, Evans *et al*. 2022, Filby *et al*. 2020, Kabakian-Khasholian *et al*. 2022, Kituku *et al*. 2022, Ngarmbatedjimal *et al*. 2024, Toke *et al*. 2024, Toker and Aktaş 2021). Similarly to my original scoping review findings, these studies foregrounded the importance to women of continuity of carer, and the difference that supportive, kind, culturally-sensitive, and compassionate care made to women (Due *et al*. 2022, Evans *et al*. 2022, Filby *et al*. 2020, Kituku *et al*. 2022, Ngarmbatedjimal *et al*. 2024, Toke *et al*. 2024, Toker and Aktaş 2021). In several studies, traditional birth attendants or doulas were viewed positively as care

providers by women, as they were able to provide the social and cultural aspects of supportive care that women valued during a time of heightened insecurity (Bagelman and Gitome 2021, Kituku *et al*. 2022), in addition to advocating for women and providing vital intrapartum support (Bosatta *et al*. 2024). The disempowering effect of communication barriers, disrespectful and discriminatory care, not being listened to, and traumatic experiences of clinical care were also highlighted in several studies (Due *et al*. 2022, Evans *et al*. 2022, Kabakian-Khasholian *et al*. 2022, Ngarmbatedjimal *et al*. 2024, Toke *et al*. 2024, Toker and Aktaş 2021). Findings from three of the newly-identified studies, relating to women's experiences of maternity care, that did not arise in my literature review is the intrapartum control of women in which women faced numerous restrictions during labour and birth enacted by health professionals, detrimentally affecting women, including restrictions on movement, food, and fluid intake, having a companion during labour and birth, and the separation of newborns from their mothers post-birth (Hirani 2024, Kabakian-Khasholian *et al*. 2022, Toker and Aktaş 2021).

Two studies examined the intersection of women's living conditions and perinatal experiences (Ellul *et al*. 2020, Filby *et al*. 2020): inadequate hygiene and sanitation, insufficient funds for nutritious food, lack of access to cooking facilities, and inadequate facilities for the safe storage or preparation of infant feeds were raised by participants. Whilst one of these studies only described women's living conditions (Filby *et al*. 2020), Ellul *et al*. (2020) explored perinatal women's felt impact of destitution, showing how it negatively affected their mental health. This topic of mental health was only specifically explored in one study (Alnaji *et al*. 2023) in which the common experience of poor maternal mental health, and yet the stigma attached to seeking help, was highlighted.

Building on the findings of other studies identified in my scoping review (Howe *et al*. 2024) highlighted the challenges that precarity and removal from social support and kinship networks had on young forcibly displaced mothers in South Sudan and the Kurdistan Region of Iraq, and the stress that they experienced resulting from uncertainties about the future. However they also found that despite the challenging material circumstances under which these women were living, motherhood was beneficial for women's emotions, providing them with a sense of purpose and happiness. Ruptured kinship networks and loss of psycho-social and emotional support was also experienced by refugee mothers in Canada, who felt that this isolation was an impairment to breastfeeding (Hirani 2024), and among childbearing Syrian women displaced in Lebanon (Akesson *et al*. 2023).

To sum up, this updated literature review has identified recent studies that build on the existing findings of my published literature review, it re-iterates the nature of being a forced migrant on childbearing experiences, the challenges associated with disruptions to social support, receipt of disrespectful maternity care, the benefits of supportive care, and the sense of purpose offered by

motherhood. These studies also add to the findings from my scoping review by showing the stigma of help-seeking for poor mental health and by highlighting the control of women – whether that be the enactment of hospital policies or political governance over women's bodies in liminal spaces of displacement.

CHAPTER 4 - CONTOURS OF JOURNEYING THROUGH SERBIA FOR PERINATAL AFGHAN WOMEN EN ROUTE TO WESTERN EUROPE: A QUALITATIVE MULTI-METHOD STUDY

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Student ID Number	145071	Title	Ms
First Name(s)	Esther		
Surname/Family Name	Sharma		
Thesis Title	Birthing at EU Borders: a qualitative multi-methods study of perinatal Afghan women's experiences on the move through Serbia		
Primary Supervisor	Dr. Diane Duclos		

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Stage of publication	Not yet submitted

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SECTION E

Student Signature	Esther Sharma
Date	05/07/2024

Supervisor Signature	Diane Duclos
Date	05/07/2024

Introduction

Serbia is well-established as a country through which refugees travelling overland without state authorisation pass en route to western European Union (EU) countries (Bobić and Šantić 2020). The so-called 'Balkan corridor' passes from Southern EU member states, through former-Yugoslav countries including Serbia, to western Europe. Between 2015 and 2016, governments granted and channelled the movement of large numbers of refugees, predominantly from Syria, Afghanistan and Iraq along this route (Border Violence Monitoring Network 2023a), forming what has been termed a humanitarian corridor, but was arguably in fact a securitised management of the flow of people, aiming to control and direct their movement in particular ways (Hess and Kasparek 2022). During this period, there was a large influx of international humanitarian organisations, providing humanitarian aid. By 2016, EU member states implemented a series of border closures that ended the authorised overland passage from Greece to Croatia or Hungary and the Serbian state shifted from a humanitarian to a securitarian logic, protecting its borders, in response to EU funding Serbia for managing migration away from EU borders (Jovanović 2020).

Volatile security for over 40 years in Afghanistan, coupled with the Taliban takeover in 2021 has fuelled decades of migration by Afghans. Iran and Pakistan host the largest number of Afghans (UNHCR 2023c). Afghans wishing to reach western EU countries to seek asylum, family reunification and improved livelihood opportunities (Buz *et al*. 2020), who cannot access formal resettlement schemes, travel overland, a process known as '*the game*' (Vještica and Dragojević 2019). Crossing territorial borders from Afghanistan usually involves engaging with smugglers to facilitate travel. However, costs are high and journeys are often multi-staged and protracted, as funds are gathered to pay for each section of the journey (Vještica and Dragojević 2019). Greater financial means enables fast travel through Serbia, for example by travel by car with few stops (Mandić 2017). Those without access to such funds have the option to register with state authorities and be accommodated in state-operated asylum or transit centres (hereinafter referred to as 'camps'). Others stay in informal settlements ('squats') close to EU borders, to expedite border crossings into EU member states (Stojić Mitrović and Vilenica 2019). However, crossing borders into the EU often leads to illegal deportations by EU border authorities, known as 'pushbacks', resulting in repeated attempts at border crossings and arduous, circuitous journeys (Augustová 2023).

During 2022 there were 44,859 state-registered Afghans in Serbia (International Organization for Migration 2023). A recent survey of Afghans in Serbia showed that conflict was the primary driver for migration. It also found that over 80% of Afghans arrive in Serbia with assistance from smugglers and that Germany, France and Belgium were their top three intended destination countries (International Organization for Migration 2023). However, 100% of these survey respondents were male. UNHCR

reports quarterly on refugees in Serbia, and data exist on countries of origin, but these data do not disaggregate by sex (UNHCR 2023d). This highlights the paucity of data about Afghan women in Serbia, that renders invisible within reporting mechanisms. Peer-reviewed studies conducted in Serbia focussing on refugee perspectives have either privileged men's perspectives (Buch Mejsner *et al*. 2020, Levy *et al*. 2017, Rydzewski 2020) or not explicitly stated whether female participants were included in the study (Jordan and Minca 2023b), highlighting the need for further research to make visible women's experiences. Pregnancy and birth continue during migration into EU member states (World Health Organization Regional Office for Europe 2018), yet no studies to date have been conducted to understand refugee perinatal women's experiences in Serbia.

The aim of the study was to understand the migratory circumstances experienced by perinatal Afghan women travelling through Serbia.

Methods

Study design

I employed a qualitative design, engaging with three methods to provide multi-layered and rich perspectives. I conducted unstructured observations in a range of spaces occupied by Afghan women in Serbia, such as asylum and transit centres (hereafter referred to as 'camps'), non-governmental organisations (NGO) projects attended by Afghan women, and public spaces that form part of the route of travel. I undertook narrative interviews in Serbia and remotely with Afghan women who had travelled through Serbia en route to western Europe, and been pregnant, given birth, or had a newborn while in Serbia. I also held semi-structured interviews with providers of perinatal care and support to Afghan women in Serbia.

Theoretical underpinnings

In this study, I drew on two theoretical lenses through which to understand the broad, contextual migratory circumstances experienced by perinatal Afghan women travelling through Serbia.

The first theoretical lens was decolonial feminism. Decolonial feminism challenges dominant perceptions of voiceless, powerless, and racialised women and is inherently intersectional as it seeks to understand how multidimensional systems of power and oppression, including race, gender, and poverty interconnect to create exclusions and inequalities (Vergès 2021). I used a decolonial feminism as a theoretical lens to prioritise perspectives from Afghan women who are often 'othered', as a means to value all knowledge from diverse communities equally (Manning 2021). This approach provided me with a means to analyse how race and gender intersect with systems of power to understand how colonial legacies continue to shape the everyday lives of forcibly displaced childbearing women.

Furthermore, decolonial feminism required me to engage with reflexivity and positionality at each stage of the study, to move away from approaches that create categories of otherness and to some extent shifting the power imbalance away from the researcher to the researched.

I brought a decolonial feminist approach lens into dialogue with the second theoretical lens: critical border studies (CBS). CBS is a way of understanding borders as not solely static nation-state boundaries, but as practices and processes that are applied extra- or intra-territorially (Parker and Vaughan-Williams 2012). These bordering processes are designed to welcome those privileged with authorisations to cross borders, but to exclude people deemed by states to be undesirable and undeserving, along social, gendered, and racialised lines (McCorkle 2020, Stierl 2019). CBS interrogates the effect that bordering practices have, and on whom (Parker and Vaughan-Williams 2012). Engaging with CBS in this study necessitated interrogating how perinatal Afghan women encountered bordering practices to provides insights that go beyond the local level in Serbia, to the broader geopolitical forces at work.

Participant sampling and recruitment

To identify and recruit Afghan women, I used convenience sampling and snowballing via NGOs or through introductions from existing participants. Eligibility criteria were having been pregnant, given birth or had a newborn while in Serbia at any point in the five years prior to interview, and being over age 18. Women who were known prior to being interviewed to have experienced perinatal loss while in Serbia were excluded. Prior to interview, I took time to get to know Afghan women participants informally, building rapport and trust.

To identify and recruit service-providers, I used purposive and snowball sampling. Potential participants were identified through internet searches of clinic and NGO personnel and contacted by email for recruitment to semi-structured interviews. Eligibility criteria was providing direct perinatal support or healthcare to Afghan women in Serbia currently, or in the past five years.

Consent processes

All potential participants received either a written participant information sheet in English, Dari or Serbian, or a full verbal explanation covering the content of the participant information sheet, with the help of an interpreter, prior to interview. I provided time and opportunity for participants to consider and to ask questions before providing written or verbal informed consent (e.g. for remote interviews or illiterate participants). I ensured that all participants understood that their interview data would remain confidential and anonymous.

Data collection

I collected data between August 2021 and December 2022, with the assistance of a Farsi- and a Serbian-speaking Research Assistant (RA). I conducted observations during two field visits, covering a five-week period. The aim of these observations was to gain an insight into the physical context of the research topic, and ways in which Afghan women interacted with their physical and social environment in Serbia, thus providing a richer understanding than solely conducting interviews would have offered (McNaughton Nicolls *et al*. 2014). Spaces occupied by Afghan women were selected on a practical basis and included camps in various locations across Serbia, NGO projects, and public spaces. Access to camps was negotiated and necessary permissions were sought, and when on site, my visits were to varying extents controlled – I did not have free access to enter or 'hang out' with Afghan women or NGO staff in camps. Although an interpreter was not specifically required for these observations, on most occasions there was someone present who could provide interpretation if necessary. I made detailed field notes as soon as possible after observations.

I conducted narrative interviews either face-to-face or remotely using a platform of the participants' choice, which in all cases was WhatsApp. I developed a topic guide to use as a conversation starter ("Tell me about your experience of being pregnant / giving birth / having a newborn baby while you were in Serbia") and aide memoir during interviews, based upon the existing evidence. However, I avoided using the topic guide after the conversation starter, allowing participants to guide the conversation as much as possible, to enable them to construct and shape their narratives on their terms (Woodiwiss 2017). All interviews were conducted with the help of a Dari-speaking interpreter or a Farsi-speaking Research Assistant who also helped with interpreting, who had been briefed about the study and the nature of the interview. Participants were offered the opportunity to debrief with myself and the interpreter after the interview. All interviews were audio-recorded, and translated and transcribed by a translator to ensure that as much as possible of the detail and nuances of conversations were recorded.

I conducted semi-structured interviews from August 2021 to October 2022, in person in Serbia or remotely via a platform of the participants' choice (Zoom, WhatsApp video or WhatsApp voice call). I developed topic guide, that was iterative in nature, based on the literature and informal conversations. I offered English interpretation to all service providers – three interviews were conducted with help from a Serbian Research Assistant. All were audio recorded except one typed during the interview at the participant's request, and transcribed verbatim.

Interviews were conducted at times and locations of participants' choosing to improve privacy. Participants were assigned pseudonyms or identification numbers and identifiable material was redacted from transcripts to ensure anonymity.

Analysis

I analysed interviews with Afghan women narratively. There is no singular agreed set of steps to follow when conducting narrative analysis (Reissman 2008). I drew on the approach of broadening, burrowing, and re-storying (Connelly and Clandinin 1990). For this, I listened to, and re-read audio recordings and transcripts respectively, to become familiar with the data. I *broadened* by tabulating the main features of each participant and their narratives, to examine each narrative's wider context, which also served as a helpful aide memoir during analysis (Kim 2016). I *burrowed* by breaking each narrative into meaningful sections and identified the meta-narratives in each section, keeping segments of data intact rather than breaking them up line-by-line for coding (Kim 2016). Finally, I *re-storyed* narratives by creating a synopsis of each participant's narrative, and adding comments, to further identify meta-narratives. I then identified overarching themes from the meta-narratives.

I analysed semi-structured service-provider interview transcripts and field notes from unstructured observations using reflexive thematic analysis (Braun and Clarke 2022), as described in Sharma *et al*. (2024a). I re-read transcripts to ensure familiarisation, then coded line-by-line in NVivo v.12 (QSR International 2020). I then developed initial themes and sub-themes from the codes, which I further refined and finally named (Braun and Clarke 2022).

I inductively analysed field notes from unstructured observations using open coding (Emerson *et al*. 2011). I re-read notes to ensure familiarisation, developed codes from the dataset to label the data, and collated these codes to develop themes (Emerson *et al*. 2011). I then reviewed and revised these themes, ensuring they reflected the dataset.

Following methods of data analysis in other multimethod qualitative studies, I conducted an integrative analysis, to identify patterns across datasets and understand how they fit together and relate to each other (Bamford *et al*. 2018, Dupin and Borglin 2020). I did this by listing all themes and sub-themes and grouping and re-grouping them inductively until new themes and sub-themes were formed. Themes developed from this integrative analysis synthesised those developed when data were analysed separately by initial methods.

Reflexivity

This study was shaped by the identity of myself as a researcher and those who were interpreting (De Souza 2004). Locating the positionalities of all involved in the research process acknowledges how

identities, experiences and social positions influenced power dynamics and the production of knowledge (De Souza 2004). Primarily, as a British passport holder with resources to access safe and fast transportation across territorial borders, I was instantly set apart from Afghan women with precarious citizenship status and no access to such safe means of travel. Additionally, being a researcher from respected western European academic institution gave me a certain credibility that afforded me access to research sites. However, those who were interpreting had at the very least a shared cultural background with research participants that altered the three-way researcher-interpreter-participant relational dynamics providing a social and cultural bridge between participants and I. Furthermore, interpreters or RAs (who also interpreted) with a pre-existing relationship with participants took a greater role in shaping interviews by prompting and interjecting conversations based upon their pre-existing knowledge of participants' circumstances and experiences.

Ethics

The London School of Hygiene and Tropical Medicine Observational Research Ethics Committee (reference 26211-1) and University of Belgrade Faculty of Medicine Ethics Review Board (reference 1322/VII-12) provided ethical approvals.

Findings

A total of 15 Afghan women and 21 service-providers participated. We did not collect demographic data for Afghan women, to protect their anonymity while they were living in highly precarious circumstances. Service-provider characteristics are detailed in Sharma *et al*. (2024a).

The three themes that I developed were: (1) *Uncertain journeys*, with sub-themes of *Leaving home* and *Journeys of suffering*; (2) *Contradictory hospitality* with sub-themes of *Socio-economic and political climate, Spaces of movement, Spaces of fallback, Impact of encampment on maternal wellbeing, and Sub-standard camps as least worst option;* and (3) *Onward journeys as acts of resistance.*

Uncertain Journeys

Leaving home

Muzhda spoke quietly yet assuredly to the interpreter and I as she explained how the long and difficult journey from Afghanistan to Germany started.

> *"There were five people in the car. We were going to our relatives' house; he [her husband] had the phone in his hand, and I was going behind him with the children. A car stopped and two men got out of the car and attacked my husband with a knife, my husband defended himself. That night we decided to get out of Afghanistan. Someone had an enmity with him.*

It was my decision that I left Afghanistan. I moved with smugglers. I did not have a passport. I went to Nimroz and then from Nimroz to Iran. One of my brothers-in-law was killed last year in Iran. When I left Afghanistan, I left a lot of fear and terror and these things."

Muzhda's short narrative on leaving her home shows the violence experienced not only by her but her wider family, prompting a rapid decision to migrate. Although she travelled to Europe with her husband and children, also being pregnant while on the way, the emphasis she placed on herself as the primary decision-maker in her family's migration was apparent throughout her narrative, challenging the often-held stereotypes of Afghan women as powerless to make decisions or enact agency in relation to migration.

Her journey was the geographically longest and most circuitous of all the women I interviewed, travelling with her family from Afghanistan through Iran, Türkiye, Greece, Balkan countries, and then through the EU into Croatia, Italy, France, Belgium and finally Germany, mostly on foot with remote assistance from a smuggler on the phone, and being pregnant for sections of the journey. Her journey, which seemed interminable at the time, highlights the chronic uncertainties of migration.

Afaq also recounted having to leave Afghanistan suddenly, despite being nine months pregnant at the time, because her husband was in the police force and at risk in Afghanistan. She describes here the decision to travel to Europe and the initial journey from Afghanistan:

"My husband said, "Look, everybody goes to the borders! Let's leave here, we cannot do anything here and we can't tolerate it here either. We cannot live in Iran or Afghanistan, Let's go to Europe." No matter what will happen, we had to move. It was my ninth month [of pregnancy]. We left everything behind, our home and life. We came on the way to the mountains on the way to smuggling and the smugglers dropped us off on the way to the border we walked for seven hours at night, and in the morning, we arrived on the way to the border. It was my ninth month I couldn't walk anymore. Finally my husband bought me a horse; I rode on the horse that night until the morning."

Being heavily pregnant did not deter Afaq's husband from taking the long and arduous route out of Afghanistan, leaving behind all that was familiar, informing us of the desperation that drove their departure.

Leaving home was not a topic I specifically asked participants about and some participants did not discuss the circumstances under which they left Afghanistan, although many expressed their desire for a better life in Europe for their children. However, most women described their journey immediately prior to arriving in Serbia. Thinking about Serbia as a transit country means that by definition, journeys

occurred before and after Serbia, and while it is the country in which this study is set, discussing journeys before and indeed after transiting through it provides important context beyond solely its territorial boundaries. Furthermore, Afghan women's accounts of pregnancy and birth were narrated within the context of the migratory journey, a theme to which I will return, but worth highlighting here, as it shows the over-arching centrality of leaving Afghanistan and seeking protection and settlement as being the most important narrative to the women I interviewed.

Journeys of suffering

Journeys to Serbia were multifarious, but all marked by suffering – both personal and witnessed. In addition to the arduous journey described by Muzhda, other participants described the bodily impact of walking extremely long distances, often without suitable footwear, and over rough terrain or through rivers, lacking food and water (loads needed to be kept light and therefore prohibited carrying food and water), enduring freezing weather during winter months, and having to run from border police. Journeys also took an emotional toll on participants, particularly the uncertainty of reaching a safe location, in addition to the uncertainty of the safety of the journey itself. Several participants spoke of suffering in the form of trauma of witnessing rape and death during their journey. Furthermore, several participants described the sufferings experienced during migratory journeys as part of what it means to be Afghan, highlighting the felt lack of choice Afghans have about experiencing such hardships. The following narratives encapsulate these multiple sufferings.

Picking up Afaq's narrative again, she described how she travelled quickly through Serbia, with her immediate family, avoiding the delays associated with staying in camps. After travelling from Afghanistan through Iran and onto Türkiye, she gave birth in a hospital in Türkiye (a new experience for her, as her previous two children had been born at home in Afghanistan), self-discharging the following morning to continue her journey. Her journey from Türkiye to Serbia took place during first month after birth, having left Türkiye when her baby was five days old. She and her family took a boat from Türkiye to Greece, having spent the night before sleeping on a beach. Realising the dangers of the boat crossing, she strapped her newborn to her, explaining that she did this so that if they fell into the water they would die together. From Greece, she passed quickly through the Balkan region, including Serbia, in a bus with a larger group of around 14 people, stopping just for just one or two nights. During our interview, Afaq emphasised the physical exhaustion of having to continue her journey having just given birth, "*I was just saying to myself I wish we could arrive sooner. Because I was sick and I have to hold my baby in my arms…".* The reality of possible drowning for her and her newborn was not lost on Afaq, highlighting the uncertainty of safe passage she faced in that moment.

In contrast, both Maleka and Saleha's journeys were far longer. Both arrived in Serbia from Bulgaria, described by many women as one of the worst countries through which to transit, with descriptions of having to stay in a *zandon* (prison), refugee camps in which the treatment of humans was so brutal that they were colloquially referred to as prisons.

Maleka was pregnant when she arrived in Serbia. Here, she describes the financial expense incurred to travel from Bulgaria to Serbia, the physical suffering she incurred during the lengthy journey on foot and then in an overcrowded car, and the resulting enormous anxiety she felt on the safety of her pregnancy:

> *"I left Bulgaria in fifth month of pregnancy, I faced to many challenges on the way. I walked and hiked through the mountains for more than 26 hours. I was really exhausted and my feet were painful, honestly, they didn't work anymore. It was very bad. The smuggler said it would be two or three hours walking. We paid approximately 1700-1800 Euros per person. Then three hours walking changed to 26 hours walking and we went seven or eight hours by car inside Serbia to its capital after passing Bulgaria borders. We went to Serbia's capital by car. The car was not suitable for sitting, the smuggler had removed the car's chairs and 25 people were sitting on the floor of the car. 25 people included women, children and men inside a small car without chairs. I was pregnant and I was sitting next to the door and I thought I would lose my baby. We people of Afghanistan suffered a lot and still suffer."*

Similarly, Maryam also travelled on foot for long periods of her journey, journeying into Serbia from Bulgaria with a smuggler. She, along with her family, were part of a large group of around 30 travelling together, half of whom were Kurds and half Afghan. She describes at one point the group being unexpectedly abandoned by the smuggler for a day, so they had to walk through the forest in the snow, during which she broke off from her narrative to describe at some length the death of a woman who was part of their group. By evening they saw their smuggler again, who took them in a car to a smugglers house overnight, and then again in a car for several days onto Belgrade. She experienced many traumatic events during her journey which she described, saying:

> *"… I saw the rape of a child, I saw death and I saw human bones. They put guns on my children. I passed many days in the prisons, from the Bulgarian prison to the Serbian prison, which was its camp."*

In addition to illustrating the immense suffering Maryam experienced during migration, her quote further emphasises the uncertainty of travel. These are examples of the numerous accounts of bodily and psychological hardship, distress and trauma told by women. It is worth noting that during

narrative interviews, most women only shared with me experiences that were related to the topic, generally avoiding retelling (though sometimes alluding to) superfluous distressing stories, suggesting that they had oriented themselves to looking forward rather than dwelling on past griefs.

Serbia: Contradictory hospitality

Narratives revealed the mixed feelings about Serbia as a host country for those transiting, indicating the contradictory, inconsistent and ambivalent hospitality experienced in the various spaces Afghan women occupied while in Serbia.

Service provider perspectives on Serbia as a host country varied along lines of country of origin. Those from high-income countries viewed it as a country of violence and hostility, in contrast to one participant from a low-income country who felt that there were many aspects of Serbia that were an improvement on their home country. Among Serbians, there was ambivalence, recognising that many aspects of Serbia as a host country were sub-optimal but that in comparison, it surpassed other surrounding countries, as exemplified here:

> "*But in comparison with what was done in Croatia, Hungary specifically, in Romania, Serbia really was, was something else - much better, so to speak. Even though I'm saying this with reserve, because I think it's not fully true. It was not that humane - there were many, many rather inhumane, how shall I say… I don't know… The thing is that Serbia is a transit country, so for Serbia, references were not a problem. They were not planning to stay in Serbia. They were just crossing through Serbia."* (Non-clinical service provider, participant 19)

This quote also underlines Serbia's position as a transit zone, rather than a country in which Afghan women wish to settle.

Socio-economic and political climate

In relation to the health system, service providers felt that women had mistaken expectations of Serbia as being a wealthy country with ample funding, in line with that of neighbouring EU countries, as described here:

> *"… they were having complaints because they, they [Afghan women] think they are in Europe so, so they need to get 100% of medical health care, but it was not like that because Serbia, Croatia, Bulgaria, they are poor countries and they don't have this much some financial, they are not so rich to have like amazing hospitals like Germany."* (Non-clinical service provider, participant 21)

Additionally, some participants noted the lack of availability of medication, as well as the under-preparedness of health systems and health professionals to the refugee response. The following quote

illustrates this by raising the issue of doctors' lack of understanding of the administrative processes for providing refugee health care:

> "*Maybe the second biggest challenge is that system is not working well, you know because of their documents, paperwork and everything. I just remember we get to hospital, everything is going fine, find person, you know the person who is providing health care. Also everything is good but he's just looking at this, um like, "Oh, what, what should I do with these documents?"…. They [doctors] understand the health problems and everything. But the thing that they maybe should be more familiar with is just how the paperwork started working..."* (Non-clinical service provider, participant 16)

Memories of conflict within and around Serbia, and of hosting internally displaced people during the Yugoslav war in the 1990s were called to mind by several participants, who empathised with those arriving from conflict zones because of their own experiences, as typified here:

> *"When we speak about refugees from former Yugoslavia, what is similar? Because they all had to flee from the country and from war. And traumas are there, you know, war, trauma, torture, rape. And consequences of that are, you know, you can see that in these refugees."* (Non-clinical service provider, participant 33)

Considering refugee support in Serbia more broadly, some service providers highlighted public attitudes towards migrants as a factor impacting its provision. For example, one talked about low-level hostility towards migrants and refugees from the local community resulting in relocating a refugee project. Another spoke of an anti-migrant right-wing group who regularly vandalised migrant squats. Furthermore, police raids on squats, during which migrants were rounded up moved into camps, closely followed anti-migrant protests, suggesting police action was in direct response to demands of such groups, as explained here:

> *"Serbian police has regular raids of Belgrade in border areas which are literally raids. They go through the parks, the squats, informal settlements too. Through the hostels and some of the houses and just take everyone to one spot and put them in a bus and transfer them forcibly to Preševo, which is an open camp still, but in the far south of the country"* (Non-clinical service provider, participant 9)

The conflicting attitudes of refugee solidarity and far-right nationalism complicate Serbia's relationship with the refugee community it hosts, for however long or short a time.

Moreover, some participants felt that waning global interest, after the so-called 'EU migrant crisis' of 2016, contributed to reduced funding for NGO refugee support programmes, leading to the closure of programmes for women, including those focussed on reproductive health, ending, as expressed here:

> *"Back in 2015, the refugees were a big, big topic…. But the very next year, in March 2016, that was when politicians decided to close the borders…. And from that moment on, the topic simply became less and less important in the media. It was not that dramatic anymore… After the border closed it changed. It was more about, 'They are not refugees, they are economic migrants. They are illegally crossing the borders'."* (Non-clinical service provider, participant 19)

Another aspect of Serbia's hospitality raised by service providers was the poorly-functioning asylum system, rendering it extremely difficult for Afghan women to seek and obtain international protection in Serbia. The asylum system was perceived as being overly bureaucratic and disbelieving of applicants. A participant described the difficulties of working with asylum authorities for this reason:

> *"I mean it's difficult with asylum authorities here, because they are not that much sensitised, let's say like that. They usually start from the point where they don't believe any person, they think that they're all lying, that whatever… It's really difficult to work with those people."* (Non-clinical service provider, participant 25)

Another informant further illustrates the problematic asylum system by explaining the rarity for Afghans to receive refugee status in Serbia:

> *"Yeah, I don't know any Afghan family that stayed in Serbia. One Afghan family received citizenship. That was a big, big chaos in Serbia. One family… received it, but then they, once they received the citizenship, they moved to a different country in Europe. So I haven't seen Afghan people that are staying in Serbia."* (Non-clinical service provider, participant 3)

Spaces of movement

This theme describes spaces occupied by Afghan women in Serbia that facilitate onward movement due to proximity to borders or access to smugglers, and elucidates ways in which women are penalised by the Serbian state in these spaces.

I walked through the central shopping area in Belgrade, across a busy dual carriageway and down a steep cobbled path before arriving at 'Afghan Park', so-nicknamed after the congregation of significant numbers of Afghans and other migrants in it during 2015-16. Afghan Park is conveniently located next to the bus station, where one can catch buses across and beyond Serbia. The train station was also formally next to the park but is now relocated. It is a modest-sized, manicured park, set out in a square

with paths crossing it in a X-pattern. Indeed, X marks the spot, because it is here that refugees can find or meet a smuggler to take them on from Serbia into western Europe. The park was not busy - there was a group of young Afghan men hanging out on another bench, chatting amongst themselves, and another couple of Afghan men sitting on a wall behind me, with an occasional Serbian passing through the park. Around the corner from the park, the slogan "migrants not welcome" had been graffitied on a wall (Figure 3).

Figure 3 Migrants not welcome graffiti

Strategically located opposite the park was the office of an NGO providing outreach services to migrants. I had arranged to meet a staff member there. While I waited in the entrance area of the open plan office, divided into sections by display boards, I could see the office was filled with material supplies, information posters in Farsi and Arabic, large sheets of paper covered in Post-it notes from workshops, and photographs of their work. Room dividers created a limited amount of screening for private conversations. My meeting started and the staff member explained that most of their work involved outreach to migrants in Afghan Park, providing basic non-food items, and signposting to relevant support services. She elaborated, saying she frequently met Afghan women in Afghan Park, several of whom had been pregnant, who she would invite to speak with her privately in her office to provide information and a safe space to talk. Only having a few hours with women before they continued their journey, she aimed to identify those affected by violence, those who are minors, or those who are pregnant. I enquired what she would do when coming across a pregnant women, to which she explained that the only route to receiving maternity care was sending the woman to a camp, to which they were often reluctant to go, as it decelerates travel. She commented that recently, more

women seemed to have been travelling with their children as part of a larger group, but without their husbands, who had gone on ahead of them.

One such example of a pregnant woman continuing to travel during pregnancy was Najiba. Najiba was introduced to me via WhatsApp by an NGO actor. She travelled from Afghanistan with her family. Having married and become pregnant in Türkiye, her husband was suddenly deported back to Afghanistan. The family continued their journey, passing through Serbia. I interviewed Najiba when her baby was one month old. At that time, she was staying in a camp in rural southern Serbia, where she and her newborn, along with her brother, had been placed. Previous to giving birth she, along with her extended family group, was staying on the Serbia-Hungary border in tents, hoping to imminently cross into Hungary, with the aim of reaching a western European country to give birth. Najiba explained to me that when she was admitted to hospital for some health problems she experienced during pregnancy, the police deliberately damaged the tents of her family members, precipitating the remaining family to cross the Serbian border, arriving eventually in Austria. Najiba's brother remained behind with her in Serbia.

By staying in tents in Serbia's border regions, Najiba and her family hoped to expedite their journey, avoiding formal accommodation which would contain and impede travel, yet they experienced hostility from the Serbian police. Opting to stay outside camps also limited Najiba's access to maternity care, for which there was no provision for women staying outside formal accommodation (camps). Najiba later gave birth in hospital in Serbia (after her brother repeatedly requested a nearby camp manager to help), a month earlier than expected, which she attributed to the large amount of walking while crossing borders. I was able to stay connected with Najiba for a short while by WhatsApp after the interview. Despite attempts to control their movement into the EU, within several days of interviewing her, she, along with her newborn and brother, had gone on the game, crossing to Bosnia Herzegovina to get to Croatia, demonstrating their agency in the face of movement restrictions. It was mid-winter, a time when many chose not to travel because of adverse weather conditions. Their determination to travel demonstrates their resistance to restrictions on their movement, but also the risks of having to cross borders in the postnatal period, with a newborn. Despite regular contact in the first few weeks after she left Serbia, I noticed that my messages were no longer being received and I lost contact with her.

This hostility towards refugees staying outside camps was elaborated during interviews and informal conversations with NGO actors. NGO actors working among communities located outside camps informed me that these communities were typically located in abandoned buildings in northern Serbia, close to borders with Hungary, Croatia or Romania. These squats recently had water and electricity

supplies cut off by the state. They were often divided by language (e.g. Farsi, French/Arabic) and controlled by gangs, who demanded payments for staying in the squat and for using 'their' border crossing. Crossing into Hungary over the razor-wire fence was not an option for families, so they favoured squats close to river crossings. One NGO actor explained that women were often (although not always) rendered invisible in these spaces: the NGO would visit the squat to distribute non-food items (such as clothing, tents, nappies), but not enter it, and typically men would receive supplies on behalf of women. Several informants raised concerns about untreated health conditions of those living in squats, highlighting scabies - quickly transmitted through shared blankets - and the suspected rapid spread of Covid-19 due to many people living in cramped conditions. Impacts on newborn health were discussed:

> *"There's no access to clean water. Apart from what [the NGO] brought and some areas we went to once a week, there's no access to clean water. So stomach bugs, diarrhoea was a massive thing there, dehydration in children as well was a massive thing that we saw there and this is through the dirty water. And particularly those who were on game, so even if they were provided clean water while they were living in squats, they'll go on game – now they can't carry all this water. So yeah, diarrhoea in children and babies were a big thing."* (Clinical service provider, participant 31)

Service provider participants explained how the Serbian state had *de facto* outlawed provision of NGO health care to anyone living outside camps, who also had no access to free state-run health care, other than very limited emergency treatment. A participant described how these state restrictions were subverted by NGOs, and the consequences:

> *"So we'd go to the squats – sometimes it was over 100 people, erm, and we'd provide medical care, either inside the squat or sometimes outside the squat. At the beginning we went by ourselves… we decided to go to the areas most in need, by ourselves, but then following, I think like 3 and a half weeks in, two of us were actually caught by the Serbian police, held at gunpoint and we were pushed forwards into Hungary rather than pushed back. So following this and following the police identifying our car, erm, we were extremely at risk and so we started working solely with [another NGO] and under their registration with the fact that our medical bags, when the police came and checked us we would remove all evidence we'd been providing medical care and be handing out food and non-food items."* (Clinical service provider, participant 31)

The worsening of living conditions due to no running water and *de facto* outlawing of health care for those living outside camps clearly demonstrates the negative health impact on these communities.

Spaces of fallback

When women were not proactively attempting border crossings, they would enter spaces I describe as spaces of fallback. By this, I mean that entering these spaces was not women's primary goal – occupying spaces of onward movement was their priority. But when onward movement was curtailed, women entered and re-entered these spaces, which in turn often caused further curtailment of journeys. Observations and interviews evinced that entering a fallback space, most commonly a camp, may have been due to an unsuccessful attempt at going on the game, cold weather, poor health or injury, lack of financial resources to pay for onward movement (whether taxi fares or a smuggler), being pregnant, or having a newborn. Therefore these spaces also represented spaces of waiting: waiting for the next opportunity to travel, waiting for winter to turn to spring and summer, waiting for babies to be born and grow old enough to go on the game, waiting to gather money for the next leg of the journey, waiting for applications to travel using legal routes to be accepted, or waiting to gather the emotional and physical strength to try again. Therefore, waiting did not constitute empty or endless periods of time with no purpose, but rather entering fallback spaces constituted preparation for the next leg of the journey. Fallback spaces varied widely in the hospitality they provided, as the following observations illustrate.

I visited the women's centre in Belgrade. It was a long warehouse-type building, running perpendicular to the house in which the staff had their offices. One end of the women's centre was dedicated to children (Figure 4). There was a large table and chairs at which children could sit and do colouring and other craft activities, along with several sofas. Two walls were lined with toy storage and the third was covered with children's artwork. In the corner, screened off to divide it from the rest of the room and to create some privacy was a UNICEF-funded 'mother and baby corner', in which was some basic baby equipment, such as cots, nappy changing tables and a highchair, a sofa, and basic equipment including nappies, wipes and clothing (Figure 5). At the other end of the room, clothes for refugees to take were being set out on two long trestle tables, and another long table with chairs around it was being set up for the day's craft activity for the women who would attend. As the women arrived at the women's centre, the staff (one project manager and two cultural mediators, speaking Arabic or Farsi) and I greeted them with handshakes and kisses. The women and their children had arrived that day from the camp in Belgrade by bus, as the NGO minibus which usually transported them to and from the camp had broken down. The women described themselves as being Afghan, Iranian and Kurdish, and two Burundian women also dropped by briefly. The children quickly settled into playing with the toys and colouring, and the women found chairs and sat down to chat. One woman explained that even just a five-minute break from looking after her child felt like a luxury as she was with her child constantly in the camp. Another woman showed me the injuries she had

sustained to her feet and legs from recent border crossing attempts. There was little interest in the craft activity that had been prepared for them.

Figure 4 Women's centre

Figure 5 Mother and Baby Corner within the Women's Centre

After a while, one woman connected her phone to a large speaker and some of the women began to dance to a song in Farsi, with the words "hashtag love" recognisable in English, laughing as they danced. As the session came to an end and the women and their children were leaving, one of the NGO staff discretely slipped nappies and sanitary pads into the hands of some of the women, acknowledged by a nod from the recipients, with an air of embarrassment at having to be gifted such basic supplies. The centre was a fallback space in which women were able to access material supplies, but moreover, provided an opportunity to break from the demands of 24/7 motherhood and momentarily relax, seeming to put aside the challenges of camp life and disruption to their journeys that led them to occupy this space in the first instance. I visited this women's centre several times during my first field visit. By the time I returned seven months later, the centre had closed due to lack of funding.

In stark contrast to the welcoming environment of the women's centre was the camp in Krnjača from which the women had come (Figure 6). The nearest bus stop for the camp was on a busy dual carriageway, outside central Belgrade. From the bus stop, the camp was a ten minute walk down a quiet, rough track, surrounded by wasteland and fly-tipped waste, at the end of which was a Roma

settlement. It was surrounded by a perimeter fence, with a guard stationed at the entrance and comprised a collection of long thin barracks, laid out in rows, with a path through the centre, leading to camp offices and surrounded by grass. There were few people outside during the multiple visits I made. My visits were highly controlled. On arrival, having shown my passport to the entry guard, I was escorted through the barracks by the security guard at the camp entrance to the barrack housing the camp office building. During my initial visit, when I explained to camp staff the purpose for my visit, I was told quite clearly that no Afghan women who had given birth in Serbia were staying at the camp. However, when I explained I had previously met some of them at the women's centre, I was instructed to sit in a side room and several of them were brought to me by the camp manager, who allowed me to talk with them. This level of control over my visits was reflective of the controlling environment of this particular camp that participants later explained to me in interviews. I attempted to visit the medical clinic on the camp site, but was told very clearly by camp managers that I must not do so, until they had sought further permissions, which they never did.

Figure 6 Camp in Krnjaca, Belgrade

However, not all camps I visited were similarly bleak, nor did I observe similar levels of control, reinforced during interviews with Afghan women. Visiting a camp on the Croatian border revealed stark differences between camps. This camp was located in a small town next to a railway station. Rather than being restricted to sitting in the camp office, I was shown around the camp by the manager, during which time a young couple carrying backpacks were leaving the camp to go on the game, and

were waved off by the camp staff, rather as if they were going on holiday. The camp manager explained that many who leave, return days, weeks or months later if they are caught by border police and forcibly deported back to Serbia. The camp comprised a very large house-like building, several smaller outbuildings, and a large, empty overflow tent (Figure 7). It was evident that an effort had been made to make the camp a pleasant environment – for example, planters with flowers were dotted around. On the veranda of the house, some children were sitting painting, and there was a small but steady flow of people milling around. To one side of the main building was an outbuilding with two rooms, housing a mother and baby corner and medical clinic (Figure 8). My visit took place during the summer and the camp manager informed me that the camp was under-occupied because many refugees were either going on the game or staying in informal squats in border areas. However, in winter they expected the camp would fill, as people tended not to travel during cold weather. This highlighted the seasonal nature of movement and both the agency of refugees in choosing whether to occupy spaces of movement or fallback and the relaxed camp attitude in permitting coming and going.

Figure 7 Camp in Sid

Figure 8 Medical clinic located in the Sid camp

During one visit, I was introduced to some Afghan women who were staying at the camp. One of the women looked as though she was elderly but the NGO staff later told me she was in her 30s, attributing events during travelling from Afghanistan to Serbia to be so traumatic that they contributed to her appearance beyond her years. She and her husband were staying in a small room in one of the outbuildings. Although I did not go inside, the door was open when she pointed out the room to me, revealing a large fridge in the room. I commented on how good it must be to have a fridge and she explained that her husband goes out to work every day on the black market, income from which they were able to buy a fridge, as well as save up for their onward journey. She also then tenderly pointed to her wrist, on which hung a gold bangle, informing me that her husband had gifted it to her after she was robbed of all her jewellery en route to Serbia. Despite their temporal stay in Serbia, and plans to move on to the EU, they were not passively lingering, but were active agents in taking steps to move towards their goal, by gaining the financial and psychological resources for their onward journey.

The stark difference between these two camps was reproduced across Serbia, and was also highlighted by service providers, as exemplified in the following quote:

> *"However, again, some women are satisfied or happier that they're now in certain camps compared to the last camp that they were living in, because sometimes maybe the facilities and the other camp was much worse in comparative to the camp that they're living in currently or vice versa. So there's a lot of discrepancies between camps and the actual standards of living within those camps as well."* (Non-clinical service provider, participant 17)

In describing spaces of fallback, the contrast between spaces occupied by Afghan women was apparent in the extent to which they were welcomed. Whilst these were temporal spaces of waiting, and represented journeys that had been disrupted, they were also spaces where quotidian life continued, albeit with constraints. For example, many women spoke about camp managers placing restrictions on cooking stoves in living quarters, which hindered their ability to cook foods they enjoyed that were more nutritious than camp food. Another example was women's ability to come and go. While theoretically they could do so as they wished within fixed hours, the remote geographical location of some camps meant it was not safe to do so. One woman explained that there was no phone signal within the camp itself, due to its remoteness, and the only way to make a phone call was by walking twenty minutes along an isolated forest road to the nearest town. On one occasion when walking into the town to make a phone call, she was sexually assaulted.

Impact of encampment on maternal wellbeing

All Afghan narrative interviewees had stayed in Serbian camps at some point, though for varying lengths of time, and the overwhelmingly negative impact of encampment on pregnancy or postnatal period was mentioned by almost all. Camp environments and accommodation were critical to how women felt when first learning they were pregnant, and their sense of wellbeing throughout pregnancy and the perinatal period. Camps were frequently described as overcrowded, lacking privacy, unsanitary, insufficiently heated during cold winter months, without adequate nutritional provision, and unsafe. These were significant concerns for women on learning of their pregnancy. In many interviews, women were keen to communicate details of camp conditions, as though wanting to use the interview to expose the reality of their living environments in Serbia. The narratives of Fereshta and Farnoush show camp conditions could make childbearing in transit (in)tolerable.

Fereshta left Afghanistan when she was pregnant, travelling with a smuggler, her husband, and other children. They planned to move quickly through Serbia. They waited in a Serbian camp on the Hungarian border, which each day listed a certain number of people or families to be transferred legally into Hungary. However, after waiting over two years, this system of entering Hungary ended. They went repeatedly on the game while she was pregnant but became exhausted by these attempts to leave Serbia. Eventually, after failing to get admitted to several camps, they were accepted by a camp. However, Fereshta found camp conditions very difficult during her pregnancy:

"So, we were in Serbia when I was pregnant with this child, under bad conditions. There was no milk for my son to drink; there wasn't a proper doctor or so; we didn't receive much care; I was not the only one, it was the case with most women. So, at that time we were in the camp, my condition… we were on the journey, we were travelling then we came to the camp, then this son of mine, I also have an older one, he was small then… As I first noticed, I did the test and found out that I was pregnant, I was not happy about it as we were on the journey, my own condition and also our place was not good, also the condition of the camp was not good either; for this reason I was very uncomfortable and cried a lot and I said that I didn't want to have this child or didn't want him to be born… when my child was born; I nevertheless want to thank the Serbian people, whatever kind they were, the people of Serbia were good, for example, even if there was not much care or facilities the people were good to us, their behaviour towards us was good; for example, things were not available for us it was our destiny. Our place was not good. We were in the Preševo camp, you may know the name, we were in this camp; there was a large hall, we didn't have rooms, there we had 2 beds, and we were six [in the family]; families were staying there; there were 120 people in that hall. At that time we were six. We wrapped a curtain around our bed. As they say, we didn't have a home, not a place to sit in, no food to eat; in Serbia our situation was really bad."

Maryam similarly had a negative experience of encampment. She first arrived in Serbia having travelled in a large group of 30 Afghans and Kurds, from Bulgaria with a smuggler. It was winter, and there was a lot of snow (which was their only food and drink while travelling), so on arrival at a camp, she and her family were extremely cold, and their clothing and footwear were soaking wet. There were no dry clothes or shoes provided for her or her children and they were not permitted to leave the camp to purchase new clothes. She illustrates the lack of distinct care for childbearing women in camps by describing the situation of a pregnant woman in the group with whom she travelled:

"… this woman was eight months pregnant after we arrived here, and no one even paid attention to her. They treated her like a normal person. Her feet were very swollen."

She went on to describe the unsanitary camp conditions that resulted in a lice infestation in the camp.

"You had to stand in line for at least an hour to go to the bathroom. If we went to eat, we had to stand for two hours under the snow, or if we need soap or shampoo, which we got hard we had to be in line for about 2 hours. After that everybody in the camp got lice because there was no bathroom and no clothes, so everybody got lice, they all just scratch themselves….when I checked the children, I saw lice all over our bodies." We got lice from the dirty blankets that they had given to other people and other families that had lice so the blankets were infected

> *that they had given to us… They had washing machines but they didn't wash the clothes and they said to us wash them with your hands. How can I describe that? We had to heat the water on the stove like in the old days, wash our clothes like in the old days we had to do everything ourselves, there were many difficult experiences we had there."*

During the interview, Maryam used metaphors like being "*treated like animals*" and "*prison*" to portray the inhumane treatment and loss of dignity she experienced at various points in a camp and during her stay in Serbia. In a moment of reflection, she said,

> *"Sometimes I sit down and I think that it wasn't worth it. According to an Afghan idiom, dying at once is much better than dying a thousand times".*

Unlike Fereshta, who clearly distinguished between Serbian's attitudes towards her and the physical environment, Maryam's experience of encampment was bound up in her treatment by camp staff. For Farnoush, this was also the case, but contrary to the experiences of Fereshta and Maryam, she described practical and emotional support she received as having a significantly positive effect on her wellbeing while staying in a camp around the childbearing time.

Farnoush had four children – two born in Afghanistan, one in Bulgaria and one in Serbia. She arrived in Serbia after a very traumatic stay in a Bulgarian camp. She recounted how she and the baby were well cared for by Serbian camp staff, with the provision of a cot, breast pump, nappies, clothing, and heater, plus a dedicated space for mothers and babies. She described the camp manager as "*a very good person*", bringing a gift for the baby on return from the hospital, and arranging and paying for her son to be circumcised shortly after birth. Furthermore, she valued the emotional support she received at this camp:

> *"… when a women give birth, she didn't just need facilities, she needs care and love. They didn't just give you things you need but they gave you special love when you gave birth to a child there."*

She contrasted this with her experience at the camp in which was staying when I interviewed her, to which she was moved when her baby was six weeks old. She described the camp with great dissatisfaction and unhappiness, suggesting it was the camp conditions that failed to address pregnant women's needs, rather than the maternity care itself. She suggested there was no support or facilities at the current camp for pregnant women accommodated there, unlike her previous camp.

When interviewing women, I asked them to talk about any support they received while in Serbia. Farnoush's experience was an isolated example of support coming from the camp in which she stayed.

Otherwise, women rarely identified specific support they received while staying in camps, instead explaining that everyone within the camp was too busy with their own problems to help others.

Sub-standard camps as a least worst option

The overriding detrimental impact of residing in camps was echoed in service provider interviews, with camp stays nonetheless perceived as preferable for women during pregnancy and postnatally, than informal squats. Service providers acknowledged that most refugees stay in unsuitable accommodation while in Serbia, but accommodation could be unsuitable, to a greater or lesser extent. Conditions in camps were overwhelmingly discussed negatively, with overcrowding, poor hygiene, lack of safety for women and children, violence between camp residents, and drug abuse cited. For example, the following vividly describes camp overcrowding:

> *"Even the accommodation is also unsatisfactory because most of them, most of the families are just given one room. So it would be a very small or compact room. Say two metres by four metres and the husband the wife and if they have more than one child, will all live in that one small quarters. Just imagine living in the, these quarters, and right next to you there's another it's just, you know, small quarter of the small quarter of the small quarter and then when you get out of your accommodation or these, these small little rooms. You're in a corridor and you're looking at the next room. So this corridor is small, it's only a metre and a half in width. So it's not a big corridor. It's very compact. Everybody's on top of everybody. And just imagine you also have a communal wash area or above bathing area. And then just imagine you have to have a communal kitchen as well."* (Non-clinical service provider, participant 17)

Participants highlighted the lack of safety and privacy within camps for women and girls, as typified here in explaining mothers perceived role in protecting their daughters:

> *"I did a lot of workshops with them regarding the safety. Uh, we we also, definitely um, lots of workshops we did and we, we drew a map, uh, where in the places they don't feel safe. Uh, I know that some mother told me that that they are accompanying their daughters while they are having a shower, just to be sure that they are safe because some of the people are, are watching them from above or something like that. So I know that those... I I have seen the showers and the bathrooms and everything, it's, this is under any standard of hygiene or safety or anything, so it's really difficult for them. Also, they don't feel safe, uh, during the night all the time. It's not.... So there is no light or enough light for them, so once it gets dark, that's it for them, they are not outside."* (Non-clinical service provider, participant 15)

Connectedly, violence against women (VAW) was widely considered rife within camps. Many service providers discussed the difficulties for Afghan women subject to intimate partner violence (IPV), citing

examples of women who did not report IPV, despite NGO encouragement, and simultaneously acknowledging that Serbia is unable to address VAW, and numbers of safe houses into which women could be accommodated had been reduced over recent years. Furthermore, risks of VAW remained even if women were relocated to another camp:

> *"… most of them are not safe in the camp. There was a lot of situations where the abuser was in the same room and the same camp, where is the woman who are suffering the violence. But also there is not safe if they are moving them from one camp to another. Uh, because people who are here who are in the camp, they're very connected, no matter which town in Serbia are."* (Non-clinical service provider, participant 2)

The continuation of quotidian living occurring within camps was also discussed, juxtaposing camps as spaces of waiting, and simultaneously spaces in which normal life continues. The following quote illustrates this, summing up after describing several examples of camp residents marrying one another:

> *"So actually we have... We have the life here, you know this is the life. But when you have the lot of people then you have the life every day - someone is dying, someone is getting bored, so someone is, he's sick, someone is healthy… At the end we have weddings here, you know, but with the celebration and things like that."* (Non-clinical service provider, participant 24)

Despite criticisms of camp conditions, there were conflicting opinions among service providers about the suitability of camps for pregnant women, with some saying camps were not good for anyone to stay, whether pregnant or not, while others opined that staying in a camp was a better for women than staying outside during the perinatal period, due to NGO support access:

> *"I think that women who agree to go to camps are in a better situation than those who are hiding, even though they have difficulties when they try to communicate with the healthcare workers or etc, it is still kind of also cleaner environment and uh people from the Commissariat [Commissariat for Refugees and Migration] or from other NGO's will drive them to hospital etc so I think that they are in a little bit better situation then."* (Non-clinical service provider, participant 18)

However, this was more reflective of state restrictions on refugee support provision solely within camps, rather than camp suitability for pregnant women *per se*.

Onward journeys as acts of resistance

All Afghan women I spoke with in camps in Serbia planned to leave Serbia – it was just a matter of when and how. Hope for an improved future for their children was instrumental in giving them the determination required to endure the poor living conditions in Serbia and continue their difficult

onward journeys.

Several Afghan women I met had chosen to remain in camps, seeking a legal route into Europe from Serbia, avoiding the risks of going on the game with infants and young children. However, this entailed dealing with lengthy and bureaucratic processes - constantly filling forms and waiting years for their applications to be assessed. Four such participants I interviewed in Serbia, who had been waiting for several years to enter the EU via legal routes, all made state-unauthorised border crossings within a matter of weeks of the Taliban takeover of Afghanistan, as it was perceived that this event would make European countries more sympathetic towards Afghans seeking protection.

For those who took state-unauthorised journeys into Europe, access to greater financial resources enabled paying for faster and safer journeys, travelling quickly by car through Serbia with minimal breaks, rather than travelling by public transport, by foot or a combination of both. Here, Aryana describes the financial arrangements involved in leaving Serbia, and the factors contributing to her departure:

> *"…we decided that because we were not supported there [in Serbia], they didn't give us a house or somewhere to live, then we had to borrow some money from our family, and we had to call them. My father had land in Afghanistan, he sold it because we need it. We had no way back, we could not go to Afghanistan, and we had to find money to come to Europe."*

As a country on the periphery of Europe, any onward journeys into Europe (whether successful or not) constituted agentic acts of resistance, defying the border control mechanisms designed to keep unwanted and racialised migrants out of EU member states.

Reminding ourselves of Muzhda's account of her long and circuitous journey from Serbia to Germany, and considering other accounts of women's journeys when departing Serbia, many of the motifs of the *Journeys of suffering* sub-theme repeat themselves, as territorial borders were negotiated and crossed (back) repeatedly to reach the country in which women eventually applied for asylum.

It was not uncommon to hear testimonies of EU border police forcibly or violently pushing back Afghan women to Serbia, sometimes across more than one border. For example, Fereshta and her family went on the game repeatedly to try to leave Serbia, while pregnant and with her newborn. Here she describes her interaction with the Croation border police:

> *"…we dropped our baby at the feet of the police, "Please help us, please let us go" but they didn't let us go and then they deport us at 2 o'clock in the night and then they dropped us somewhere we didn't know, and we didn't know where we should go at 2 o'clock in the night."*

The quote illustrates clearly the measures employed by Afghan women to avoid being pushed back to Serbia, having to enact vulnerability by appealing to the border police's sense of moral obligation to innocent children. However, as Fereshta and other women testified, travelling with infants and children did nothing to aid their border crossing if caught by police.

Some women, such as Laila, had a destination in mind, which was based upon her perceptions of state's enforcement of biotechnologies:

> *Laila says she would like to move to Belgium, as they are not strict on fingerprinting. She doesn't have a plan as to how to get there – she'll wait. Her family have tried to get into Romania illegally a few times but have been pushed back. On one occasion she broke her arm and had to have medical treatment in Romania for it. It still causes her trouble.* (Observation notes)

Others were opportunistic in their approach to where to settle. I was in Serbia during the Taliban takeover, and noticed there was a perception among women in the camps that there may be greater sympathy from the EU towards Afghan refugees, and within several months afterwards, all the Afghan women I had met during my field visit had decided to leave Serbia, even those who had been waiting for years to travel to Europe. Gulpari left while I was in Serbia, with her husband and four children. I heard via other women that she had left Serbia and gone to Romania, but after having some difficulties in Romania, she went to Ireland, from where she travelled to the UK but was caught by the police and sent back to Ireland.

When I returned to Serbia for my second field visit, despite several NGOs who had previously granted me access to participants having lost their funding, and no longer working among Afghan refugees, I attempted to make contact with Afghan women staying within the camps. I was surprised to find that no one knew of any Afghan women with small children staying in the camps, especially because I (as had NGO actors working in Serbia) had been expecting large numbers to arrive following the Taliban takeover of Afghanistan. This perplexing situation led me to asking, through informal conversations, why this should be. I was informed that the cost of using smugglers had sharply risen making it far more difficult for families to afford to migrate, possibly exacerbated by the breakdown of financial systems that limited options for transfers of money to pay for smugglers at each leg of the journey.

Discussion

This is the first known study to examine the migratory circumstances experienced in Serbia by perinatal Afghan women, providing a rich account using multiple methods of data collection from diverse perspectives. Engaging with decolonial feminism and CBS offered theoretical lenses that

enabled an interpretation of the findings to reveal how intersecting factors and regional geopolitics enmeshed to shape the hospitality-hostility continuum for Afghan women in Serbia, and the forms of creative agency employed by them in resistance to bordering practices.

Overall, these findings reveal that a lack of safe passage during migration and enactment of migration governance in Serbia is a source of harm to Afghan women during the perinatal period. Specifically, I have shown the uncertainty surrounding the journeys that Afghan women made, the suffering they experienced during these journeys, yet the resistance they displayed when continuing to cross territorial borders, despite measures to deter their maternal bodies from entering the EU. I also foregrounded the inconsistencies of Serbian hospitality Afghan women received while in Serbia, the result of which was largely detrimental to their mental and physical health.

The *Uncertain Journeys* theme evinces the suffering experienced by perinatal Afghan women on the move through Serbia and bears witness to the harms caused by bordering practices, adding to the growing body of knowledge on EU border violence documented by scholars and activists (Augustová 2023, Border Violence Monitoring Network 2023b, Freedman 2016a). Moreover, the findings build on existing knowledge about gendered risks of mobility (Freedman 2016b, Pertek 2022, Stock 2012) by foregrounding dangers to pregnant women, mothers, and newborns directly caused by an absence of safe travel, and limited access to maternity care while on the move. Safe passage is of particular importance for pregnant women or mothers with newborns, yet little attention has been paid to the needs of perinatal women during migration and access to refugee protection mechanisms remain androcentric (Fiddian-Qasmiyeh 2014), further limiting women's opportunities for international protection. Additionally, these findings challenge perceptions that women and infants are immune from violence as they transverse borders (Bosworth *et al*. 2018). Despite the evidence, the EU discredits and ignores harms caused by their externalised bordering practices at EU peripheries, yet the empirical evidence on border violence constitutes a form of resistance to EU efforts to silence marginalised voices (Davies *et al*. 2023).

A decolonial feminist lens reveals in this theme how gender, race, and citizenship status intersect to deprioritise safe passage for forcibly displaced Afghan women travelling towards western Europe through Serbia. Options for safe travel and faster transportation for those making state-authorised journeys (for example, via formal resettlement schemes) in contrast with those relying on illegalised travel facilitators (smugglers) foregrounds the uneven application of protection mechanisms during mobility, and the variations in who is considered deserving of protection, based on citizenship status. The initial EU response to the Ukraine war when Ukrainian refugees were granted safe passage to EU countries, is illustrative of this point, calling into question why their lives were considered more

important than those seeking protection from Africa, Asia, and the Middle East (Øverlid 2022). This brings into sharp relief the colonial legacies of racism inherent in migration policies that deprioritise the protection of black and brown people (Davies and Isakjee 2019, Øverlid 2022).

The theme *Contradictory hospitality* foregrounds the inconsistencies and variances visible in the reception of perinatal Afghan women on the move in Serbia. In the same vein, scholars have used the term 'ambivalent hospitality' to highlight tensions in host country responses to refugees. For example, Christopherson *et al*. (2013) showed how people in Lebanon aspired to welcome displaced Syrians, yet the burden that resulted in doing so placed limits on the hospitality offered. Additionally, Altin and Minca (2016) suggested that hospitality towards refugees in Italy was ambivalent because, while refugees were tolerated, it was contingent on them being hidden within the confines of state-run camps. Studies have elucidated the power relations between the host and the 'other': it being within the gift of the host to decide which 'others' are deserving of being hosted as guests, according to compliance with the hosts' rules (Kyriakidou 2021), and where hospitality fails, hostility enters (Farahani 2021). Within the EU context, refugees are often framed as 'parasites' who have overstayed their welcome, rather than guests to be welcomed (O'Gorman 2006). This study shows how the hospitality-hostility continuum plays out in Serbia, and its impact on perinatal Afghan women.

The sub-theme, *Socio-economic and political climate* highlighted Serbia's limited resources and varying desire to adequately respond to refugees. Significant challenges exist for its health system, compounded by an aging population and the Covid-19 pandemic, and my findings illustrate the limited extent to which universal access to quality healthcare for refugees was embedded in health systems, despite healthcare being theoretically available to all (European Council on Refugees and Exiles 2023, Nguyen *et al*. 2023). Additionally, the inadequately functioning asylum system about which participants spoke, served to disincentivise refugees from seeking settlement in Serbia while still adhering to international protection commitments and fulfilling its obligations to the EU by keeping refugees away from EU borders, thus reinforcing its status as a transit country. This is reflected by its deficient number of successful asylum applications: between 2008 and February 2024, only 114 individuals were granted refugee status in Serbia (UNHCR 2024c).

Findings in this sub-theme also show that there is a degree of solidarity and empathy towards refugees among Serbians, who themselves experienced the effects of war and hosted Yugoslav refugees: one camp that previously hosted Yugoslav internally-displaced people continued to host a small number of Croatian refugees when the barracks were opened up to international refugees (Cupolo 2016). Stojić Mitrović (2019) explains how this shaped the initial state-level reception of refugees in Serbia: "The concept of "we were refugees, too" on the national level, and the potential image of "we are

humane" on the international, became part of official Serbian migration policy" (p.19). Nonetheless, this solidarity co-exists with Serbian anti-migrant sentiment that complicates and fuels the securitarian logic of Serbia's migration governance (Lažetić 2018, Petrović and Ignjatijević 2022).

The *Spaces of movement* and *Spaces of fallback* sub-themes point further to the hospitality-hostility continuum between which Serbia fluctuates. My findings showed that occupying spaces of movement to remain mobile disbenefits Afghan women by limiting their access to basic needs and services, therefore exposing them to direct or indirect harms. Conversely, the state 'privileges' those who fulfil their conditions (registration with state authorities and staying in state-organised accommodation), granting them hospitality in the form of access to maternity care and NGO refugee support services, effectively in exchange for containment and decelerated entry to the EU. This suggests a "hierarchy of deservingness" (Kyriakidou 2021, P.134) to hospitality exists, that is largely a result of externalised EU migration governance in Serbia aiming to reduce numbers of refugees entering the EU, rendering its hospitality conditional and limited.

The influence of EU migration governance on Serbia's migration management has dual intertwined historical and geopolitical roots. Since the 1990s Balkan wars, reified notions of former Yugoslav nations being homogonous, uncivilised region of chaos - the 'Wild East', (Hess and Kasparek 2022) - relative to 'civilised' EU neighbours, underpin EU member states' notions that Balkan countries require management to bring them into order regarding migration (Augustová 2023, El-Shaarawi and Razsa 2019). This is played out as the EU leverages Serbia's agenda of EU accession and financial reliance upon it, revealing an asymmetric power imbalance (Ahmetašević *et al*. 2023, Stojić Mitrović and Vilenica 2019), enabling the EU to enact an externalised border regime within Serbia to deter refugees away from EU borders. Pushbacks from EU borders and containment of refugees in Serbian camps, both of which frequently violate human rights, are strategies that the EU employs to deter immigration (Augustová and Sapoch 2020, Fassin and Defossez 2023). Indeed the EU has given Serbia millions of Euros to manage migration, including financing camps (Contenta 2020), and has installed FRONTEX (EU border agency) patrols within its borders (Border Violence Monitoring Network 2023a). Understanding the relational dynamics between Serbia and the EU contributes to understanding why the Serbian state criminalises *Spaces of movement* located at EU borders or zones of travel: deterring unwanted bodies away from EU borders.

As *the Impact of encampment on maternal wellbeing* and *Sub-standard camps as least-worst option* sub-themes showed, the failure of most camps to offer a safe and appropriate environment for pregnant women or mothers with newborns, while simultaneously being the only way to receive publicly-funded maternity care, detrimentally impacted the maternal and newborn health. Further, it

shows how suffering is reproduced in camps, under the guise of being sites of care, simultaneously fulfilling purposes of containing bodies - a mechanism, "… through which humanitarianism is deployed to secure both life and a liberal political order across multiple scales" (Pallister-Wilkins 2020, p.991). This finding supports advocacy reports in which deficiencies in most Serbian camps were identified (Bressan *et al*. 2024, European Council on Refugees and Exiles 2024), and aligns with the few other studies exploring the camp environment for perinatal women. Grotti *et al*. (2018a, 2019) identified the harsh and overcrowded living conditions for pregnant migrant women in camps in Southern Europe, unbearably cold in winter and overheated in summer with little privacy. A study conducted in a Kenyan refugee camp highlighted the physical lack of safety felt by pregnant women at all levels – within the host community, within the refugee camp, from camp security staff, and when accessing healthcare (Lalla *et al*. 2020).

Unlike EU refugee camps that are increasingly carceral in nature (Kreichauf 2018), this study evinces the lenient and flexible approach adopted in Serbian camps, placing fewer restrictions on movement to and from camps, and recognising the inevitability of onward migration (Collins *et al*. 2022). The broader literature on refugee camps reinforces the need to understand camps not as temporary solutions to crisis, but as enduring spaces, which therefore must address more than only basic needs (Dantas and Amado 2023, Turner 2016). It also supports the findings of this study that that both bare life, in which basic needs and protections of dehumanised residents are not met, and everyday life, in this case, the labour of reproduction and motherhood, co-exist in camps (Katz 2017). This in turn suggests that by giving birth and continuing with the everyday life of motherhood, Afghan women in this study played an active role in shaping and exerting power over their camp experiences, creating a form of a continuation of life in the face of the discontinuation of all other aspects of life.

Despite the uncertainty, harms, and precarity of journeying through Serbia, my findings demonstrate the agency (albeit with considerable constraints) Afghan women enacted by employing strategies of resistance to EU deterrence mechanisms by continuing their journeys, and the endurance they displayed in doing so, fuelled by hope for a better future in western Europe (Rydzewski 2020). In the sub-theme, *Onward journeys as acts of resistance*, the negotiations involved to continue journeys is evident, whether with family to arrange finances, with smugglers to arrange travel, or with border authorities, illustrating how they, "…consciously create space for manoeuvre within state structures and in negotiation with non-state and state actors…" (Mainwaring 2019, p.48). Indeed Stierl (2019) argues that it is precisely these micro-level social interactions that constitute migrant resistance. Women's narratives of resistance in this study places them as active in these social interactions, rather than passive victims, challenging the deeply-held tropes of Afghan women as subservient and powerless (Mohamed Ahmed 2022). And yet enacting agency and challenging state boundaries by

entering EU member states without authorisation often casts them as a 'bad migrant', undeserving of equal protection and rights to those making state-authorised journeys (Mainwaring 2019), yet again highlighting how uneven means of mobility debilitate the lives of "distant others" (Pallister-Wilkins 2023, p.76).

Limitations

The study has a number of limitations. First, due to Covid-19 travel restrictions, the length of time I was able to spend undertaking observations in Serbia was curtailed. More time in Serbia may have yielded richer observational data and differing perspectives. Moreover, my time spent visiting refugee camps was to a greater or lesser degree controlled by gatekeepers, and may have skewed my perspectives. Relatedly, my presence may have altered the behaviours of those I was observing. Secondly, being a researcher from a resource-rich background, able to cross international borders relatively easily, will have afforded me a different perspective when analysing and interpreting data. Finally, this study is specific to a particular group of people in a specific geographical context. While there might be commonalities across other populations in varying contexts, the findings of this study are not generalisable.

Conclusion

By using a multimethod qualitative design and engaging with decolonial feminism and CBS theories I have revealed how bordering practices are shaped by regional geopolitics, that trickle down to impact the everyday lives of Afghan women in Serbia during the perinatal period, and how intersecting factors enmesh to render Afghan women undeserving of adequate hospitality. This study exposed the deleterious effects of bordering practices on childbearing Afghan women and their newborns, enacted at local, national, and regional levels, but also foregrounded their creative agency and resistance to these bordering practices through continued mobility. Rendering these knowledges visible is itself an act of resistance, in the face of a racialised EU migration regime that seeks to obscure the harms that it causes to those considered to be undeserving of protection.

CHAPTER 5- "A THOUSAND DANGERS": AFGHAN WOMEN'S NARRATIVES OF PREGNANCY AND BIRTH DURING MIGRATION AT THE EUROPEAN UNION PERIPHERIES

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Surname/Family Name	Sharma		
Thesis Title	Birthing at EU Borders: a qualitative multi-methods study of perinatal Afghan women's experiences on the move through Serbia		
Primary Supervisor	Dr. Diane Duclos		

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SECTION E

Student Signature	Esther Sharma
Date	05/07/2024

Supervisor Signature	Diane Duclos
Date	05/07/2024

Introduction

The perinatal period represents a significant life event that can be experienced on a continuum - positive experiences of pregnancy and birth are widely recognised as contributing to maternal wellbeing and empowerment, and transition to motherhood, whether for the first or subsequent occurrence (Leinweber *et al*. 2023) while shifting towards negative experiences on the continuum can increase risks of perinatal psychological disorders and disturb bonding and attachment between mothers and their infants (Türkmen *et al*. 2021). The emphasis on positive experiences of pregnancy, birth, and the postnatal period from the World Health Organization (WHO) (World Health Organization 2016a, 2018) has led to greater scholarly attention to women's perinatal experiences. Leinweber *et al*. (2023) further developed WHO definitions of a positive childbirth experience to propose that, "A positive childbirth experience refers to a woman's experience of interactions and events directly related to childbirth that made her feel supported, in control, safe, and respected; a positive childbirth can make women feel joy, confident, and/or accomplished and may have short- and/or long- term positive impacts on a woman's psychosocial well- being." (p.364). Women who are migrating during the perinatal period face specific circumstances that can interfere with their perinatal experiences. This is especially the case for forcibly displaced childbearing women who do not have access to safe and legal travel routes, making instead state-unauthorised journeys.

Although there has been a growth in scholarly work over recent years paying attention to perinatal experiences in transit zones in a range of settings globally, yet it remains an under-researched area. Here, I use the term 'transit zone' to describe spaces through which people intend to pass and move on, during migratory journeys. Examples of such transit zones can include territorial border zones, where informal camps are set up as trans-border crossings are negotiated, refugee camps, in which displaced people inhabit, waiting to return home or travel onwards, or even nation states in which there is no intention to seek international protection. Feminist geographers have understood women's perinatal experiences in transit zones in the context of border regimes (into which they contend that humanitarian care is interwoven) and biopolitics (state's control over people's bodies and lives (Dillon and Lobo-Guerrero 2008)), foregrounding how these filter down to enact upon women's bodies and mobilities to reproduce violence and powerlessness (Bagelman and Gitome 2021, Sahraoui 2020). Taking an anthropological perspective, Grotti *et al*. (2018a) show how sub-standard material conditions in Southern European camps rendered women additionally vulnerable during the perinatal period, compounding gendered harms encountered during travel. Moreover, Lalla *et al*. (2020) found that there was a lack of physical safety within camps for women and girls, including those pregnant or travelling to health facilities for maternity care. Examining access to, and experiences of, healthcare during the perinatal period, there is some, albeit limited, empirical evidence suggesting

that women can struggle to access maternity care while travelling (Panchenko *et al*. 2023) or when staying in refugee camps (Rustad *et al*. 2021). Further, when they do, communication with health professionals can be challenging, due to a lack of translation services or disrespectful and discriminatory due to health provider attitudes (Korukcu *et al*. 2018, Lalla *et al*. 2020). Often distanced from family support during birth and the postnatal period, Korukcu *et al*. (2018) note the difficulties of holding onto cultural beliefs and practices for Syrian refugee women giving birth in Türkiye.

The aim of this study is to explore the experiences of Afghan women in Serbia during the perinatal period, with a focus on understanding their interactions with, and the provision of, maternity care.

Theoretical underpinnings

This study uses a decolonial feminist approach to knowledge production. Although there is a plurality of feminisms, at its broadest feminism is concerned with "… understanding and improving the lives of women" (Woodiwiss 2017, p.15) However, feminisms have been extensively criticised for privileging white women from the Global North and failing to take into account the diversity of women globally, instead lumping them together as a homogenous group (Lourde 2003, Vergès 2021, Zakaria 2021). Mohanty (2003) notes that too often, women from the Global South are typified as ignorant, uneducated, domestically-oriented, in contrast to the modern, educated, liberated, white western woman. For this reason, employing a decolonial feminist lens in this study is apposite, to depart from this stereotyping and flattening of women's experiences, particularly apposite in research involving Afghan women whose identities have been essentialised by the western gaze (Mitra 2020). Decolonial feminists recognise the multidimensional factors beyond gender alone, that intersect to create systems of power and oppression: applying intersectionality requires understanding how gender also intersects with race and colonialism, exposing the ecosystems at work, rather than producing knowledge in siloed categories (hooks 1984, Vergès 2021).

Applying a decolonial lens in this study offers a means to prioritise subaltern women's voices, engaging with research methods that depart from being extractive (rather addressing to some extent the power differentials between the researcher and researched), and examining how race and gender collide with systems of power to disadvantage childbearing Afghan women in Serbia.

Methods

Study design

A qualitative study design was used to provide rich, in-depth, and nuanced perspectives about women's lived experiences (Roller and Lavrakas 2015). Guided by the aforementioned principles of decolonial feminism, I selected narrative inquiry as a method because of its emphasis on centring

participants' voices, enabling them to construct and tell their narratives on their terms, rather than according to pre-determined questions on an interview schedule that makes *a priori* assumptions about what may or may not be significant to them (Eastmond 2007). In this way, narrative inquiry also seeks to redress the uneven power imbalance between myself as a researcher and participants (Lokot *et al*. 2023). Moreover, employing a case-based method avoids the homogenisation and flattening of refugee women's experiences, but rather allows for the commonalities of narratives to experiences to be understood, while retaining their distinctiveness (Eastmond 2007). Narrative inquiry is a discursive practice, in which the interviewer takes a facilitatory role, assisting the participant to make sense of their narrative, yet no less an active participant in the conversation (Reissman 2008). As with other qualitative methods, data from narrative interviews are highly contextual and temporal, even more so for women on the move, and reflect participants' accounts from that moment in time, which rather than being static perspectives, are dynamic, contextually contingent, and temporally-located (Braun and Clarke 2021).

Study setting

Serbia is a commonly traversed transit country for those forcibly displaced from Afghanistan by instability, conflict or natural disasters who travel overland to EU member states. For those leaving Afghanistan who have no recourse to legal routes of travel to the EU, journeys, colloquially referred to as '*the game*', are made overland without state-authorisation (Mixed Migration Centre 2018, 2021), passing through the so-called 'Balkan Corridor' that includes Serbia. Journeys for refugees travelling through Serbia can be circuitous, fragmented, and protracted as borders are continually negotiated, often with assistance from smugglers to facilitate routes and modes of transportation (Jordan and Moser 2020). Journeys may also involve stop-overs (that may be brief or protracted) in formal state-organised accommodation (hereon referred to as 'camps') for varied reasons, ranging from enforced state detention, resting before embarking on the next leg of the journey, stopping to earn money to pay for onward travel, or seeking health care (Collins *et al*. 2022, Sharma *et al*. 2024a). However, some opt to avoid formal accommodation, to gain more freedom, avoiding the restrictions on daily living, allowing more opportunities for economic income, integration, and onward movement (Jordan and Minca 2023a). There were over 44,000 Afghans registered with Serbian state authorities in 2022 (International Organization for Migration 2023). Although this data is not sex-disaggregated, it was estimated that 3% of all new refugee arrivals in Serbia that year were women (UNHCR 2022).

The Serbian publicly-funded healthcare system is available to all citizens and state-registered refugees. Serbian maternity care is publicly funded. Obstetrician-gynaecologists are the lead provider of antenatal and intrapartum care, with assistance from nurse-midwives. Antenatal care takes place in primary health or hospital facilities, and almost all women give birth in hospitals. Nurses provided

inpatient postnatal care, with patronage nurses (akin to UK health visitors) providing newborn care at the mother's home once discharged from hospital. Limited empirical evidence suggests that disrespectful care is ubiquitous (Arsenijevic *et al*. 2014, Janevic *et al*. 2011, Pantović 2022a), which has led to a movement of women calling for maternity care to be more humane (Boljanovic 2008, Stojanovic and Vladisavljevic 2021). State-funded maternity care is available to all state-registered refugees, accessed through doctors based in camps, who refer women for routine or emergency care in local hospitals (Sharma *et al*. 2024a). Non-governmental organisations (NGOs) provide support to Afghan women staying in camps, although specific reproductive, maternal, or newborn health programmes provided directly by NGOs have been defunded or subsumed by the state (Sharma *et al*. 2024a). Afghan women staying outside camps are denied access to publicly-funded routine maternity care, although emergency care is still provided for them, free at the point of use, and the Serbian state has *de facto* outlawed NGOs from providing healthcare to those living outside camps (Sharma *et al*. 2024a).

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Study tools

I created an open-ended topic guide with a small number of questions, which I discussed with two forcibly displaced Afghan women at the development stage to gain feedback. The opening question was, "Tell me about your experiences of being pregnant / giving birth / having a newborn baby while you were in Serbia." In line with the principles of narrative inquiry, as far as possible, from the opening question the participant guided the conversation, but I used the topic guide as an aide memoir for prompting if necessary.

Participant sampling and recruitment

To identify and recruit Afghan women, I used convenience sampling and snowballing. A Research Assistant, NGOs, and existing participants introduced me to potential participants, and I identified other potential participants during visits to camps or other spaces occupied by Afghan women in Serbia. Women were eligible for study participation if they were Afghan, had been pregnant, given birth, or had a newborn baby in Serbia, either at the time of the interview or over the past five years, and were 18 years or older. Women who were known prior to being interviewed to have experienced perinatal loss while in Serbia were excluded.

Consent process

Prior to interview I offered a participant information sheet (PIS) translated into Dari to literate women. For those with insufficient literacy, I provided a full verbal explanation covering the contents of the PIS to all participants, with the help of an interpreter. I gave women time to consider participation and to ask any questions, before providing written or verbal informed consent (e.g. for remote

interviews or illiterate participants). Participants were offered the choice to use a pseudonym when giving consent, to protect their anonymity given their precarious legal status. I ensured women understood that their interview data would remain confidential and anonymous.

Data collection

I collected data between August 2021 and December 2022. I conducted interviews in-person or remotely. For in-person interviews I offered women a time and location of their choice, ensuring privacy. Due to the potentially sensitive nature of the interviews, I talked with women on several occasions prior to interview, to build rapport and trust. I held remote interviews at a time convenient for women, on a platform of their choice – all women chose to be interviewed using WhatsApp video, except one who opted for a WhatsApp voice call. Prior to conducting remote interviews, I suggested to women that they located themselves where their privacy could be maintained. If it became apparent that there were other people in the room during the interview, I offered them the opportunity to pause the interview, and continue another time.

If a woman became distressed or upset during the interview, I offered them a chance to pause, reschedule or stop the interview. All women were provided with an opportunity to debrief after the interview, and a list of organisations to whom women could be referred for ongoing support was drawn up. All interviews were conducted with the assistance of a Dari-speaking interpreter (for remote interviews) or Farsi-speaking Research Assistant (RA) (for in-person interviews) who was briefed in advance about the study and interview procedures. Those interpreting were also provided the opportunity to debrief after interviews, in recognition of the fact that the nature of the interviews may have triggered distress for them. All interviews were audio-recorded, translated, and transcribed.

Data analysis

Anonymised interview data were analysed using narrative analysis. It is recognised that there is no fixed set of steps in narrative analysis, but rather it has been described as a "… family of methods for interpreting texts that have in common a storied form… " (Reissman 2008, p.11), that serves to interrogate and interpret narratives from the perspective of the storyteller (Reissman 2008). Specifically, I employed thematic narrative analysis, that focuses to a greater extent on the topic under investigation than how narratives are discursively constructed (Reissman 2008). Unlike thematic analysis, in which data is coded line-by-line, thematic narrative analysis retains the case-based approach of narrative analysis, avoiding breaking down narratives into small chunks of text, allowing narratives to be preserved in their context (Weiss and Johnson-Koenke 2023). This case-based approach means that data does not fit neatly within each theme, but rather blurs the boundaries of themes; each narrative 'theme' contains more data than that directly relating to the theme to provide

thick and rich descriptions in relation to, and also beyond, the theme, to account for the complex and sometimes contradictory lived experiences of participants. After listening again to interview recordings and re-reading transcripts to familiarise and immerse myself in the data, I followed the interpretive devices proposed by Connelly and Clandinin (1990) as a guide to analysis: broadening, burrowing, and re-storying. In the *broadening* step, I summarised participants' characteristics and migratory circumstances. Moving to *burrowing*, I interrogated each participants' narrative in depth, marking transcripts with notes on particular events, feelings, or questions about their lived experiences (Kim 2016). I finally *re-storied* by creating a synopsis of participants' narratives, to bring to the fore the notable aspects of their narratives. From here, I broadly grouped together common narratives to form themes, that identify commonalities across participants' experiences, while also including cases that vary from these themes.

Ethics

The London School of Hygiene and Tropical Medicine Observational Research Ethics Committee (reference 26211-1) and University of Belgrade Faculty of Medicine Ethics Review Board (reference 1322/VII-12) provided institutional ethics approval.

Reflexivity

The intersubjective nature of this research study demands that I honestly acknowledged and reflected upon the positionings in which myself as a researcher and the interpreters that assisted during interviews shaped this research through our experiences, beliefs, assumptions and values (De Souza 2004). My positionality as a researcher was even more salient when interviewing women in precarious circumstances. I was very conscious of the power dynamic created between participants and myself, as a white-looking, financially secure, UK-passport holder, able to travel freely. To this end, I made efforts to build upon points of commonalities, when getting to know participants prior to interviews, identifying myself as having mixed Asian and British heritage, sharing stories of living in Afghanistan and of motherhood, and using my conversational Dari-language skills as much as possible. Additionally, I made no attempt to neutralise or write out my political views to take a neutral stance in this research. On the contrary, I took a researcher-activist stance, recognising that with privilege comes the responsibility to draw attention to the injustices that occur at, within, and beyond the borders of nation-states (Davies *et al*. 2023). Working with two interpreters and RA who interpreted during interviews further shaped the relational dynamics at work during interviews, in turn shaping the knowledge produced in this study. When interviews were conducted with interpreters or RA previously known to participants, the interpreter played a particularly active role in shaping interviews, asking additional prompts of women based upon their pre-existing knowledge of women's circumstances, which occurred to a far lesser extent when the participant and interpreter had no prior

relationship. Nonetheless, in the latter situation, their presence during interviews is still likely to have altered what and how women expressed their narratives.

Findings

A total of 15 women were interviewed, eight in-person and seven remotely.

I developed four themes: (1) Childbearing is embedded in migration stories, (2) Impact of encampment on maternal wellbeing, (3) Negotiating zones of control, (4) Self-advocacy as a means of getting maternal health needs met, and (5) The comfort of new life.

Childbearing is embedded in migration stories

In many of the interviews, women opened the conversation by framing their perinatal experiences in the context of their migratory journeys. Narratives were often principally stories of migration, with perinatal experiences as sub-plots. That is not to suggest that perinatal experiences were not viewed as being significant, but rather it illustrates the interwoven nature of women's travel on childbearing, and the significant impact of migration on feelings about a new pregnancy, the maternity care received, experiences of birth, and maternal mental health. V*ice versa*, in the same way that journeying impacted childbearing, childbearing also impacted mobility, as seen in some narratives about how their mobility was constrained. Several women had chosen names for their children, born during migratory journeys, that reflected the fact that they had not been born in a place that the families could call home, which further illustrates the prominent place that trans-border journeys occupied for women.

Bibigul: migration fuelled by hope

I was introduced to Bibigul by my research assistant. They had stayed in the same camp in Serbia and kept in touch. Bibigul and I had messaged on numerous occasions prior to our interview, during which I learned that she had grown up in Iran, where her family had fled to escape the first Taliban takeover of Afghanistan. She was educated, and we were able to exchange initial WhatsApp messages in English. During my contact with her, Bibigul was staying in a *heim* (temporary accommodation in Germany for asylum seekers, with shared kitchen and bathroom facilities), with her husband and one son, and was attending regular German lessons, during which childcare was provided for her son. Our interview was held by phone call in a break between her lessons. Bibigul explained that she arrived in Serbia when she was five months pregnant, with her husband and child. She walked with her family from Greece to Serbia, guided by a smuggler, and arrived in the autumn. She described how she struggled with the overcrowded, unhygienic, and cold conditions in the camp, as autumn turned to winter, crying as she recalled how difficult she found it. She and her husband had understood that they would pass through Serbia to Hungary after several months – her feelings of "*hope*" to reach an

EU country were evident but she reflected during the interview on how realistic this expectation was, saying, "*The process takes a long time and we were not thinking….*".

It was on talking through the temporal nature of her journey - waiting in a camp in northern Serbia on the Hungarian border for their turn to be legally authorised to enter Hungary by its authorities - that she describes the birth of her second baby, as a moment of disruption in her journey:

> *"Then we waited until our turn arrived and we could go inside Hungary. I gave birth to my baby there – I remember that my waters broke and I went to the clinic inside of the camp. It was 9.30 when I went to the clinic inside of the camp and then they called the ambulance and they took me to the hospital. Before I gave birth, I always told my husband, "Let's go [to cross the border] ourselves" so before I gave birth I was always telling my husband, "Let's go close to the border and then we can cross the border". Because the weather was very cold there [Serbia], then I had the baby, then it was difficult to go there [to Hungary], so then we stayed there [in Serbia]."*

Her husband was afraid of travelling during the cold weather with a pregnant wife. After giving birth, Bibigul's narrative shifts from desire for onward mobility and the hope of reaching an EU country fuelled by wanting a better future for her children, to hopelessness, being now unable to travel further, and the impact that this had on her mental health:

> *"I was crying every day, so every day I had nothing to do, just crying and be hopeless. When the second baby was born, I was totally depressed. The depression after the birth, it continued for me. While I was in Serbia, this depression was with me. It was very difficult."*

It is evident that Bibigul's narrative of her pregnancy and birth was enveloped in her overarching narrative of migration – a difficult journey that was driven by hope, yet disrupted by pregnancy, causing her hopes to be temporarily inhibited. The impact on her early days of motherhood were clouded by poor mental health because of being constrained in Serbia with hope of onward movement turning to enormous uncertainty.

Muzhda: the "thousand dangers" of journeys with infants

In contrast to Bibigul's protracted transit through Serbia, several participants, including Muzhda, travelled quickly through Western Balkan countries from Greece, staying only briefly (one or two days) in Serbia. Muzhda, a young woman dressed casually in skinny jeans, a tee shirt, and small headscarf, started her interview by quietly yet articulately recounting the difficulties of carrying both a large backpack (without food or water that would add to the load), and her baby, while she was migrating through Serbia. She gave birth to her second child in Greece, explaining that many women got

pregnant so that they could be transferred out of the camp in which they were staying. After she too was transferred, she had wanted to settle in Greece, but had her asylum claim rejected. Along with her family group, she walked from Greece to Serbia, directed by a smuggler remotely, on the phone. She describes the risks of going on the game with her child and newborn:

> *"Generally, this way has a thousand dangers. For example, there is a danger of drowning, you have to cross the river, there is a danger of animals, there is a danger of getting lost, then we faced all this. We got lost with our little child for a whole day and it was very cold, then we thought we would freeze and wouldn't survive with my little child… he would get hungry and he wanted milk. We didn't have enough food to eat so I couldn't breastfeed him enough."*

Navigating the geographies during migration alone was difficult, but travelling with infants made journeys far more arduous, as she described here:

> *"Yes, those who did not have children were very comfortable, but because we had children, there were problems everywhere for us. The smuggler said, 'Give your child sedative syrup, she should sleep'… It was very difficult for me. Because when they said to others, 'Be quick', they were, but we had two little children, and it was the most difficult for us to be quick… I think we were not there [in Serbia] for more than one day…. we were in a park. There was a place where they said that you can take a bath and then the ladies can come and sit here and drink tea. We just went there once… we just went to a place where there was a tea house, they said to have tea and they said that if you want, we will take you to the camps, but we didn't want to stay, so we didn't go."*

Muzhda avoided staying in a camp, because she recognised it as a place of containment, choosing instead to travel swiftly through Serbia. As another participant noted, taking these quicker, uninterrupted journeys through Serbia was only possible for those who had access to greater funds to pay for uninterrupted journeys. However, for Muzhda, continuing her onward journey and avoiding containment in camps that would slow her journey involved dangers and risk-taking, for both herself and her children. These risks were also heightened by the physicality of travelling with children, which slowed her journeys down. In her account, she particularly highlights the cold weather, lack of nutrition for them both, and having to give her baby sedatives to avoid the baby crying and alerting border police. This latter practice appeared to a common tactic by smugglers, and mentioned by other participants, who expressed grave concern for their infants' well-being while medicated.

Afaq: no rest while travelling postnatally

Afaq revealed a bittersweet smile as we sat drinking tea and eating biscuits while talking. She recounted how she also travelled quickly through Serbia, with her immediate family, avoiding the delays associated with staying in camps. Afaq left Afghanistan when she was two months pregnant. After travelling through Iran, she gave birth in a hospital in Türkiye (a new experience for her, as her two previous children had been born at home in Afghanistan), self-discharging from hospital the following morning to continue her journey. Her journey from Türkiye to Serbia took place during first month after birth, having left Türkiye when her baby was five days old. She and her family took a boat from Türkiye to Greece, having spent the night before sleeping on a beach. Realising the dangers of the boat crossing, she strapped her newborn to her, so that, *"… if we fell into the water, we would die together*". From Greece, she passed quickly through the Balkan region, including Serbia in a bus with a larger group of around 14 people, stopping just for just one or two nights, explaining that she did not have a chance to discover what the different transit countries were like, because "*I was just saying to myself I wish we could arrive sooner. Because I was sick and I had to hold my baby in my arms*…". Similarly to Muzhda, she struggled to obtain sufficient nutrition during the journey, which she attributed to having insufficient breast milk for her baby while travelling:

> *"I wished there was a place where I could rest, sleep for a moment, and eat something proper and delicious so that I could breastfeed my child properly. I wish I had milk to breastfeed my child or she would have formula and would be quiet for a moment."*

This quote highlights the additional stress and worry of being a mother to a newborn during arduous and frightening journeys, that Afaq bore, seen in other women's narratives also.

Maleka: long term effects of an arduous journey

Contrary to the narratives of rapid travel through Serbia told by Muzhda and Afaq, Maleka and her family took three years from leaving Afghanistan to arriving in Germany. During her interview, she described her journey in great depth, explaining that she left Afghanistan with six other family members. She commenced her narrative by summarising her experience, succinctly describing the four factors which she found *"… so painful and exhausting for me*" – the noisy camp environment with its lack of privacy, the migratory journey, the pregnancy, and missing her family. Travelling through Iran and Türkiye, where she became pregnant, they then travelled to Serbia via Bulgaria. Echoing similar sentiments from other participants, she explained the difficulties of being in Bulgaria, and the aging effect it had on her:

> *"First five months of pregnancy I was in Bulgaria which was worse than Serbia. Its people behaved badly with refugees. Those five months were exhausting to me, the immigration made me old."*

She later commented that Serbia felt relatively better for her than Bulgaria. From Bulgaria, her family travelled with a smuggler in a group of 25 to 30 people across mountains into Serbia. They were initially told they would walk for three hours but "*three hours walking changed to 26 hours walking*" followed by a seven hour-long car journey to Belgrade, in which everyone was squashed into a car without seats so tightly she thought she would lose the baby. At this point, she pauses in her retelling to reflect on the suffering of Afghans and the lack of value that is placed on their lives, a feeling heightened by her seeing the different treatment Ukrainian refugees have received:

> "*We people of Afghanistan suffered a lot and still suffer. Even they don't care about us here [Germany] because Ukraine is in trouble and they care about Ukrainians… we aren't valuable to them. I don't know why?... Afghans migrate with a lot of troubles but no one cares about Afghans, I don't know what we did that they behave unkindly to us."*

Maleka stayed in a camp in Serbia for the remainder of her pregnancy and to give birth, while simultaneously her mother-in-law became extremely unwell and undertook medical investigations – health-related needs for this family group acted as a disruptor and decelerator to their journey. After giving birth, her family tried many times to cross the Serbian border into Bosnia Herzegovina (where her mother-in-law passed away) and then onwards to Croatia, where she commented that "… *the police behaved badly to us and they beat migrants, they even beat children*". Crossing borders with a small baby entailed capitulating to the smuggler's demands of giving her baby sleeping syrup to ensure the baby did not cry and alert border police, about which she said:

> *"I felt bad. We were always afraid that the amount of medicine for the child would not be too high, which would cause us to lose him. We would always check on him, we were always worried, we would put the child in a sling and if he was quiet for a long time, I would check his breathing."*

As the interview ended, she emphasised the long-term impact that her journey from Afghanistan had on her, despite suggesting that it was overall worthwhile for the sake of her children:

> *"I'm sick physically and mentally and I still haven't fully recovered, the challenges made me so sensitive and I cry at the slightest problem. Nevertheless, I endured the migration challenges because I had two children, I had my family, and mostly because of my children, I said to myself,*

> *I am their mother, with all these problems, I have to bring them to a good place to have a better future."*

It is evident that the responsibility that Maleka felt as a mother took an enormous toll on her personally.

The narratives of Bibigul, Muzhda, Afaq, and Maleka illustrate the suffering that marked women's journeys – both personal hardship as well as witnessing the suffering of others. The bodily impacts of walking long distances, a lack of food and water (loads needed to be kept light and therefore prohibited the carrying of food and water), enduring freezing weather conditions during winter months, and having to run from border police when heavily pregnant took an enormous physical toll on childbearing Afghan women. Journeys also took a great emotional toll on participants, particularly the uncertainty of reaching a location of safety, and concerns about their infant's wellbeing.

In this theme, I have shown how some women's travel ground to a halt for an extended period, as they opted (unsuccessfully) to attempt legal routes to cross from Serbia to the EU, specifically in order to avoid the dangers of crossing irregularly. This posed other challenges, which leads onto the theme, *Impact of encampment on maternal wellbeing* to which I turn next.

Impact of encampment on maternal wellbeing

The environment and conditions of camp accommodation played a critical role in affecting how women felt when first finding out they were pregnant, and their sense of wellbeing throughout the perinatal period. Many participants were keen to communicate details of the camp conditions, as though wanting to use the opportunity to be interviewed to expose their living conditions in Serbia. As we will see from the narratives of Fereshta and Farnoush, camp conditions had the potential to make childbearing in a transit context (in)tolerable.

Fereshta: pregnancy unwanted due to camp conditions

Fereshta left Afghanistan when she was pregnant, because of the deteriorating security situation, travelling for a total of five years with her husband and two other children, with assistance from smugglers. She gave birth to her third child in Greece. They had planned to move quickly through Serbia, but discovered she was pregnant again. Still continuing their journey, they waited in a camp close to the Hungarian border, where, she tells me, there was a 'list' from which each day a certain number of people would be called for legal transfer into Hungary, but after waiting for over two years, this system of entering Hungary appeared to end. Not giving up, they repeatedly attempted border crossings, during which time she was pregnant. She eventually became exhausted by these attempts to leave Serbia. Eventually, after trying to get admitted to several different camps, but being turned

away, they ended up being accepted by one. However, Fereshta found the camp conditions very difficult during her pregnancy, as she described here:

> *"So, we were in Serbia when I was pregnant with this child, under bad conditions. There was no milk for my son to drink; there wasn't a proper doctor or so; we didn't receive much care; I was not the only one, it was the case with most women. So, at that time we were in the camp, my condition… we were on the journey, we were travelling then we came to the camp, then this son of mine, I also have an older one, he was small then… As I first noticed, I did the test and found out that I was pregnant, I was not happy about it as we were on the journey, my own condition and also our place was not good, also the condition of the camp was not good either; for this reason, I was very uncomfortable and cried a lot and I said that I didn't want to have this child or didn't want him to be born… when my child was born; I nevertheless want to thank the Serbian people, whatever kind they were, the people of Serbia were good, for example, even if there was not much care or facilities the people were good to us, their behaviour towards us was good; for example, things were not available for us, it was our destiny. Our place was not good. We were in the Preševo camp, you may know the name, we were in this camp; there was a large hall, we didn't have rooms, there we had two beds, and we were six [in the family]; families were staying there; there were 120 people in that hall. At that time we were six. We wrapped a curtain around our bed. As they say, we didn't have a home, not a place to sit in, no food to eat; in Serbia our situation was really bad."*

Fereshta attributed her feelings of unhappiness upon discovering she was pregnant again, to the fact that she was mid-migration, in addition to the sub-standard camp conditions. She specifically highlighted the lack of maternal health care and the overcrowded conditions offering little privacy, explaining that it was not only herself experiencing these challenges, but other pregnant women also. Moreover, in the above quote, she mentioned briefly the insufficient supply of milk for her son in the camp, a theme she returned to later in her narrative, when she recounted how the camp staff refused to give her formula milk, despite her son being hungry:

> *"… in the nursery [mother and baby corner] they ask us to bring the bottle with you and then they give us a certain amount of milk which they said should have been enough for 4 hours, but between this if we go again and tell them, 'He's crying, he's hungry', they said, 'No, don't come again, I gave it to you just one hour before, don't come again'. There were no clothes, no nappies – they had a lot of support from everywhere, but they didn't give it to us. There was no food – we were not allowed to cook. We had our food from the camp and we know that was the situation with the camp and the food, so yeah, it was not good facilities... I was*

really sad about it [the restricted access to formula milk for her son], and every time I said 'Oh, I wish I was dead and I was not coming in this situation'."

Being unable to adequately provide milk for her son when he needed it was extremely distressing for Fereshta, as illustrated when she explained how she wished she was dead. The extent to which encampment became a site of trauma for Fereshta is clear. In telling her story, Fereshta repeatedly framed her narrative to highlight the seemingly endless suffering that Afghans are forced to endure, in and beyond Afghanistan.

> *"We, the people of Afghanistan are suffering a lot. We are here, the people in Afghanistan – you know what's going on in Afghanistan, the people are in hunger - so it is just, wherever we are, we just suffering."*

She went on to explain that suffering is inherent in being an Afghan, pointing to their lack of choice about experiencing such hardships, that foregrounds ways in which individual lives are impacted by forced displacement resulting from global geopolitics.

Farnoush: camps can be spaces of perinatal support

In contrast to Fereshta's camp experiences Farnoush describes the practical and emotional support she received, positively impacting her wellbeing while staying in a camp during childbearing.

I first met Farnoush at an NGO-run woman's centre. The NGO had suggested that I meet her, and had arranged transportation to bring her from the camp. She was dressed in skinny jeans and an oversized lumberjack shirt, with a small headscarf. She brought her four children with her, two of whom were born in Afghanistan, one in Bulgaria and the youngest in Serbia. She arrived in Serbia having had a very traumatic experience staying in a camp in Bulgaria, where her husband was threatened with deportation. After coordinating with another family, they were able to use a smuggler to cross the Bulgarian border into Serbia, entailing huge risks and anxiety because of the threats made by Bulgarian police:

> *"Bulgarian police had explained to me the Bulgaria law and had said, "If we arrest you one more time while you intend to pass the borders illegally, we will imprison you and your husband apart from your children." He said, "We will imprison you in a place that even doesn't have any free area for you to feel the wind.""*

She and her family were accommodated in a camp on arrival in Serbia. On discovering she was pregnant, unlike Fereshta, Farnoush felt relaxed, having seen that other pregnant women were well looked after in the camp:

"I realized, after three months, I realized that I'm pregnant…. I didn't have anything like fear, stress, or bad thoughts because I understand that my place is good, we are calm, and we are all calm. I didn't see anything negative there. So far, before my pregnancy, I have seen their behaviour was very good with other pregnant women. I already said they cared very well, even when you went to the hospital and you would come after delivery, they bring everything to you before your arrival, for example, the baby bed, the milk pump, everything. They bring everything to your room."

She recounts how she and the baby were materially well cared for by camp staff, with the provision of a cot, breast pump, nappies, clothing, and a heater, plus a dedicated space for mothers and babies within the camp. She described the camp manager as "… *a very good person*", bringing a gift for the baby on arrival home from the hospital, and arranging and paying for her son to be circumcised shortly after birth. Furthermore, she valued the emotional support she received at this camp:

"… when a women give birth, she didn't just need facilities, she needs care and love. They didn't just give you things you need but they gave you special love when you gave birth to a child there."

However, when her baby was six weeks old Farnoush was forcibly relocated to the camp she was staying in when I met her. She described this camp with great dissatisfaction and unhappiness, suggesting that it was the camp conditions – the physical conditions plus the way the camp was managed by staff - that were failing to address childbearing women's needs, rather than the maternity care itself, and that she felt that there was no support or facilities at the current camp for her with a young infant. At the time of our interview, Farnoush and her family had been at the camp for four years, choosing to wait until they could leave Serbia legally, having to engage with lengthy bureaucratic processes. However, concurrent to my meeting Farnoush was the Taliban takeover of Afghanistan, which many Afghans in Serbia perceived would lead to greater sympathy of Afghans arriving in the EU without state authorisation in the EU. After just weeks of interviewing Farnoush, she and her family took a state-unauthorised journey and arrived in Germany.

Negotiating zones of control

Many women whom I interviewed moved between highly controlled zones during the childbearing time in Serbia, in which rights, freedoms and movements were restricted or curtailed. These controlled spaces profoundly impacted their perinatal experiences, and ultimately transformed their maternal bodies as sites of control. Control occurred at multiple levels - at Serbia's borders by border police, enforcing the EU border regime put women and newborns in positions of risking their or their infants' health. The state attempted to control and regulate movement within Serbia, determining in

which camp refugees could stay, and employing dispersal strategies. Accessing free, public health and maternity care was also highly controlled – the only means of access was by referral from doctors in state-run camps (with women reliant on camp staff organising transportation to hospital appointments), resulting in many women struggling to access the maternity services which they felt they needed, at the time in which they needed them. Furthermore, some participants talked about not being allowed to use their own cookers to cook their own food, or use their own heaters during sub-zero winter months, and the restriction in some camps (colloquially called "closed camps") on the frequency and timings at which refugees could come and go. In hospitals, controlling environments left women without a birth companion, created physical barriers between women and their newborns and families, and left some women without the basic necessities after birth.

Najiba: giving birth alone

I interviewed Najiba when her baby was one month old. At that time, she was staying in a camp in rural southern Serbia, where she and her newborn, along with her brother, had been placed. Najiba's story exemplifies the repeated bodily control to which she was subjected at borders, in camps, and in hospital.

Najiba travelled to Serbia with an extended family group, marrying and becoming pregnant in Türkiye. While in Türkiye, her husband was deported back to Afghanistan. In Serbia, along with her extended family group, she was staying on the Serbia-Hungary border in tents, hoping to imminently cross into Hungary, with the aim of reaching a western European country to give birth. When Najiba experienced health problems during her pregnancy, her brother asked the manager at a local camp for assistance with accessing maternity care, but this was denied because the camp was designated for men only. Eventually after repeated requests for help, the camp manager arranged an ambulance to take Najiba to the hospital, although she was required to travel alone. Najiba's family opted to stay in tents, to ensure their journey continued, avoiding formal accommodation which could slow down, their journey to the EU, yet experiencing intimidation from the Serbian police. During her hospital admission, the police damaged the tents of her family members, prompting them to cross the Serbian border, and eventually arrived in Austria whilst Najiba's brother remained behind with her. Najiba's access to maternal health care was restricted because she and her family were not staying in state-run accommodation, illustrating the Serbian state's exclusionary healthcare policies. Najiba later gave birth in Serbia, a month earlier than expected, which she attributed to the large amount of walking while on the game. She experienced a great amount of fear when she was admitted into hospital, due to being alone and unable to communicate with the health workers.

"I was alone in the room, no one else was with me. All the doctors went to sleep and at seven in the morning I cried a lot, I was in pain, and no doctor gave me any medications. I wanted to tell them that I want to come to see my mother and have my mother with me. I was very afraid, I didn't understand their language, I understand English a little bit and I was telling them, but they said that no one is allowed to come with me and take care of me and they didn't allow me to see my family once. Because my mother was very worried, I just wanted to tell my mother I am fine don't worry but they didn't allow me to visit my family. I didn't have a phone and I wanted to make a call so I asked everyone in that hospital for a phone just for one minute. I asked all staff, the doctor, nurses, and anyone but no one gave me their phone for a minute to call to greet my family. My brother told me, I used to come and ask how is my sister, where is her baby, has she had been born or not, but no one answered him. He just said that you are not allowed to enter, and those who answered him, said we don't know either."

Her repeated use of the word "allow(ed)" in this narrative section illustrates the level of control under which she felt when she was hospitalised, restricted from communicating with her family and from having a companion during the labour and birth.

When asked what her feelings were about the maternity care she received in hospital, she commented that she felt she was invisible before the birth, but that afterwards, she was very happy with care from the paediatrician. Nonetheless, she followed up this comment by explaining that initially after the birth, she was not allowed to contact her brother to request him to bring essential supplies for her baby and food and water for her (neither of which the hospital provided). After several days, her brother, who was not granted access into the hospital, bought a phone to the hospital entrance which was passed onto her, and an NGO sent a bag of essential supplies. The controls placed upon Najiba as to who was able to accompany and support her in the hospital, including the lack of an interpreter, resulted in her feeling isolated and frightened. Upon discharge from the hospital three days after the birth, Najiba, her newborn and her brother were transferred to the camp in Belgrade, but opted instead to stay in a private hotel as they were unhappy with the camp conditions. After two weeks, Najiba said she felt in good health and they went on the game. She describes the violent experience they had at the hands of the Hungarian police when they were ten minutes away from reaching the Austrian border. During this episode, her brother was handcuffed, she, with her newborn, was held at gunpoint, and they were detained in a cold police cell overnight. They were then transported in a van, along with others, to various Eastern European borders, and finally they were dropped at the Serbian border. At this point the Serbian police then took them to a camp in a rural area in the south of Serbia, as far from EU borders as possible, and in a location where transportation is difficult to access. This was despite their requests at the time, and also subsequently, to be admitted to a camp

in Belgrade. The EU border regime, enacted by Hungarian border police, endeavoured to control Najiba's movement by using aggressive tactics, inappropriate for a postnatal woman with a newborn, and the Serbian state attempted to regulate their onward movement by placing them as far away as possible from the EU border. Najiba's account was not an isolated one – other participants also recalled their experiences of aggressive or violent behaviour from Hungarian or Croatian border police, despite being pregnant.

I was able to stay connected with Najiba by WhatsApp after the interview. Despite the attempt to control their movement into the EU, within several days of interviewing her, she, along with her newborn and brother, had moved to Bosnia Herzegovina and were planning to cross the border into Croatia. It was mid-winter, a time when many chose not to travel because of the adverse weather conditions. Their determination to travel demonstrates their resistance to restrictions on their movement, but also the risks of having to cross borders in the postnatal period, with a newborn, during the cold winter season.

A further aspect of spaces of control is control by hospitals over mother's access to their newborn. Routine separation of newborns from their mothers caused distress as described by almost all participants who gave birth in Serbia.

Nilofar: separation from her newborn

Nilofar was introduced to me by another participant. She was living in Germany in a *heim* at the time of our interview. Nilofar grew up as a refugee in Iran, where she married her husband. Travelling overland from Iran with smugglers with her husband and son, she finally arrived in Serbia having attempted the southern border crossing 10 to 12 times, during which she sustained foot injuries. She was pregnant when she arrived in Serbia and her experience of giving birth was marked by extreme anxiety owing to the fact that her baby was removed from her at birth, with no explanation given to her as to why, or his whereabouts:

> *"They took me to the hospital, and the baby was born, but they didn't show me the baby. They didn't show the baby and it made my mood very bad. They took the baby to another city without showing me. Because I didn't understand their language and I kept saying, 'Where is my baby?', they were explaining in their own language but I did not understand. I thought God forbid my child was dead because I didn't know they took him somewhere else…. I was not good because I didn't know if my child was alive or dead, and I thought my child was dead."*

Alone in the hospital, with no way to contact her husband, a fellow Serbian inpatient loaned her a phone, enabling Nilofar to contact her brother in Germany who in turn contacted her husband. She

later returned to the camp, even then still believing her baby was dead. Unbeknown to her, the camp manager had already been in contact with the hospital to enquire about the wellbeing of her baby, but this was not communicated to her until after arriving back at the camp. Her baby had been transferred to Belgrade, nine hours away, for neonatal care. She summarised the simultaneous joy upon learning he was alive yet pain being separated from him, saying, "*I was very happy and those seven days passed like seven years for me. I suffered a lot.*". The camp manager called the hospital in which her baby was admitted, daily, to enquire as to the baby's health. Finally, after two months, her baby was returned to her in the camp. She describes the feeling of being reunited with her baby:

> *"Well, it's definitely a very good feeling when someone could have her baby with herself, the baby calms his mother down. I felt peace when he was with me more than the time when we were apart in the hospital. When he was with me, I was sure that now we are together no matter what else."*

Nilofar's narrative shows her felt loss of control after giving birth. The fear about her baby's whereabouts and wellbeing was as a direct result of a communication failure. Conversely, we see in her narrative the "*calm*" and "*peace*" she felt when reunited with him.

Shabna: restricted access to her newborn

I met Shabna when I visited one of the camps in Serbia. She was a younger mother, but unusually was able to communicate in both English and Serbian. She had been staying in the camp for three years with her son but no other family members (her husband having gone ahead to Germany, leaving no word as to whether she could join him), when I met her. She found out that she was pregnant accidentally when she was admitted to hospital in Serbia for abdominal pains, which she attributed to spending three days and nights in a forest in Serbia, and was not happy with the news. She had wanted to terminate the pregnancy, as her husband was still in Bulgaria at the time, and she did not want to be pregnant while continuing her journey. Furthermore, the hospital had performed an x-ray when she was admitted for abdominal pain, and she was anxious that it might have affected her unborn baby. However, her husband did not permit her to terminate the pregnancy. Shabna stayed in a Serbian camp throughout her pregnancy, joined later by her husband. During our interview, she spoke extensively of the challenges of not being able to cook the foods she wanted during pregnancy while she was staying in the camp, as she explains here:

> *"Yes, it was very difficult, it was a camp, and we weren't allowed to cook anything. When I was pregnant, it's natural that when you're pregnant, you crave some things… I couldn't eat and make the things I wanted, because there was neither permission nor facilities. It was very difficult; it was a difficult period."*

Shabna's early pregnancy required juggling, adjusting to, and coping with multiple layers of control: state controls exerted over who can and cannot use safe and fast modes of transportation when travelling to seek protection, leading to her arrival in Serbia in the first instance, her husband's control over her pregnancy, and the restrictions placed by the camp on Shabna cooking her own food in pregnancy.

Shabna's narrative also exemplifies her distress caused by hospital staff's control over access to her newborn in the immediate postnatal period. She was admitted to hospital for a post-dates induction of labour, and eventually had a caesarean section under general anaesthetic. There was no interpreter provided for her and neither did she have a companion with her. During the interview, she did not dwell greatly on her birth experience, instead focussing on the controlling and disrespectful experience of being separated from her baby postnatally, worsened due to having breathing difficulties necessitating a long postnatal admission.

> *"Yes, one thing they did was very bad. When they brought the baby to breastfeed, they took him back very soon. I'm a mother, they didn't leave my baby with me. They just brought him three times, four times a day, for five minutes I would breastfeed, then they took him to another room along with other babies… there was no problem, in the same hospital where I was, all the babies were like that - they didn't bring them to their mothers, you just breastfed them and they took them away again. I really couldn't hug him and hold him. It was hard, I wanted him to be with me, but I couldn't. Then the others who were there would be discharged after three days and leave but I stayed in the hospital more than others because I was sick. They brought my baby tied up with a cloth and I didn't see his hands and feet for 20 days. When the nurse was out I was opening the cloth that was tied up, I wanted to see his feet. But they came and argued. They said that you have no right to open the baby's cloth, just breastfeed him. When I was discharged from the hospital, I came to the camp then I opened his cloth there and saw his feet and hands. He was 20 days old when I came to the camp. it was almost 20 days."*

As Shabna alludes to in the above quote, not only was this forcible separation of her newborn from her extremely emotionally distressing, it also had a disruptive effect on breastfeeding, because she was not able to feed her baby on demand. Furthermore, she was not even allowed to look at her baby – she was utterly disempowered in the early moments of motherhood through the control exerted from hospital staff and processes.

Self-advocacy as a strategy for getting maternal health needs met

Several participants described how they felt their needs were ignored or overlooked. As a strategy for ensuring their needs, or the needs of their newborns were met, it was clear in some narratives that women advocated for themselves, in the absence of anyone else advocating for them.

Maryam: not being taken seriously

I was introduced to Maryam by another participant. She was living in Germany at the time of the interview, like other participants in a *heim*, with just one bedroom for her, her husband and four children. Her three older children were born in Afghanistan and youngest in Serbia. Our interview was held over WhatsApp video call in two halves, as it was extremely long, detailed, and rich. She was one of the few participants who had some reasonable English language skills and mentioned during her interview that she made friends with a lot of NGO actors during her stay in Serbian camps. This is important to note, as it is possible that these factors contributed to her ability to self-advocate during her perinatal period.

Maryam started the interview by explaining that she was experiencing poor mental health in Serbia, for which she was taking tranquilisers. She informed me that her husband was having sex with her, "*to calm me down*" but she was unaware of this because of the effect of the tranquilisers, and unintentionally became pregnant. Having missed her period and intuiting that she was pregnant (without having had a positive test at this point) she informed the camp doctor, but was disbelieved. It was only when showing them a positive pregnancy test, which she had purchased herself, that her pregnancy was acknowledged. Narrating her pregnancy experience, Maryam continues to portray further obstacles to receiving what she perceived as adequate antenatal care, and the self-advocacy strategies she had to employ to get this care. For example, she recounts how she was given medication for a uterine infection by a hospital doctor and needed a follow-up appointment – the only way to get the appointment was through the camp doctor, who was procrastinating:

> *"They [the camp staff] knew what I was going through and still came up with endless excuses, even after the doctor had told them about my situation. It took 25 days and they still didn't take me to the doctor. A lady worked at the UNHCR and she asked about my problems upon a visit. I cried a lot because I was afraid that something happened to my child. I cried and I told her that I was sick, that they didn't take me to the doctor. And even the doctor has said that I might have a miscarriage or the child would be harmed. The doctor said that it's not risk-free and the child might have serious problems. The people who worked in the camp behaved as if I had gotten pregnant on a whim. Yes, they meant that. This lady talked to them, then they*

said, “Okay we will take care of the transportation ourselves.”. They did it, took me to hospital, and I did a check-up.”

Drawing on her resourcefulness, Maryam advocated for herself, taking the opportunity to reach out to an external visitor to the camp (UNHCR staff are not routinely present in camps in Serbia) who in turn facilitated a visit to the hospital for antenatal care.

Later in the pregnancy, Maryam was admitted to hospital, due to a severe respiratory condition causing her breathing difficulties. Her account of her hospital admission is marked by feelings of being overlooked. She experienced a long wait when she was first admitted to the emergency department, with no one coming to check on her, despite her asking. There were misunderstandings about her respiratory condition, that resulted in her being treated in isolation as though she had a communicable disease, which compounded her feelings of being misunderstood and alone. When the time came for her to give birth, she was moved to another hospital. She previously had uterine surgery in Iran (possibly due to a ruptured uterus), which would preclude a subsequent vaginal birth. However, her medical notes were not transferred with her. She attempted to explain to the medical staff in English that she needed to have a caesarean section but there was no interpreter with her and they spoke only Serbian. She was finally able to communicate with them using her phone to translate.

“After I told them my problem and they didn't understand, they tried to deliver the baby normally and I was crying. Finally, I took my phone and wrote in translation in my language to Serbian that I have this problem and I can’t normally give birth to a baby, please help me. During this process, I always called my husband and ask him to go and tell them to send me a translator, do something for me, or call me, and they completely rejected my husband. They [the camp doctor] said, “Don’t come again about this problem, we can't do anything.”. When the main doctor came and I told her everything about these problems. Then she said, “Okay, that's alright, we'll do something.”.

Again, we see Maryam having to self-advocate during labour itself, when she was unaccompanied and without an interpreter, to ensure her safety.

Later in the interview, Maryam described the inadequate provision for sterilisation of bottles in the camp, which led to her daughter acquiring a stomach infection soon after returning to the camp, necessitating hospital admission. Once again, she was disregarded by medical staff, and it was only when she showed them a nappy full of blood that they took her concerns seriously. Eventually she paid herself for the medication prescribed by a hospital doctor, and for a specialist formula milk,

despite her requests that these costs be covered, calling into question the extent to which healthcare is actually freely available to refugees in Serbia.

Throughout the interview with Maryam, there are many occasions when she highlighted the injustice that she felt at being ignored, not taken seriously, not listened to, and the efforts to which she was required repeatedly go, in order to self-advocate, during pregnancy, birth, and after her baby was born.

Gulpari: speaking out

I first met Gulpari at the NGO-run women's centre. She, and her toddler, who was born in Serbia, was introduced to me by NGO staff. She was petite in stature, but far from diminutive in character, immediately coming across as a bubbly and cheerful, yet no-nonsense woman. When I later interviewed her, she explained to me that she arrived in Serbia with her older three children who had been born in Afghanistan and Iran. She became pregnant in Serbia but her family was relocated to a camp that was unsuitable, which proved very difficult for her and negatively impacted her mental health. Articulating her needs to camp staff, the family were subsequently moved to a more appropriate camp. Despite the challenges she faced during her pregnancy, Gulpari describes how being in Serbia with her children helped her to find her voice, realising the importance of speaking out, to advocate for herself and her family:

> *"Yes, I do [speak out]! I am one who says a lot, and will speak [up] now!... I didn't speak at first. I never spoke out until I felt I was forced to talk because of my children."*

This is further illustrated when Gulpari recounted the time she was staying in a camp in a remote area of Serbia, and went into labour:

> *"It was really good in [the] camp until my delivery…. When I woke up, my pain had increased and I was bleeding, I was scared because I wasn't bleeding while giving birth my other children. I thought the baby isn't alive. Then I said to my husband, 'Go and inform the Commissariat [the camp staff, who organise transportation to the hospital].' 'What should I do if the baby is born at home? Maybe something bad has happened, why am I bleeding?', I told my husband and he told them. They stayed in upstairs, my husband said, 'Now they are sleeping' and I swear they don't wake up. I said, 'Please come with me, I will wake them up'. Then we went and I saw they were in the commissariat office in first floor in front of our room. I knocked the door and he woke up but he didn't intend to come, I was frustrated. He asked us what was happened. I said to Jamshid [her husband], 'I know English' then I answered, 'I feel pain in my belly and my baby is about to be born!' He said, 'No problem, no problem, I will let you know*

tomorrow to take you to hospital, now we sleep tonight.' I waited, I waited until tomorrow… I didn't feel much pain but my bleeding had increased. I told Jamshid, 'These dishonourable people never take me to hospital. I am not good, my baby is about to born and if he's born here what should I do?'…. [The camp doctor] gave my medical documents and a note to the commissariat but they are a little lazy and ignore me, you saw that… I took my bag and went to commissariat then I said, 'I have pain in my belly and my baby is about to born. If I face to any problem, I will sue you!' The person whom I woke up ignored me again and did not take me to hospital, and he didn't say anything."

Despite Gulpari self-advocating by using her English language skills and speaking forcefully to the camp staff to request for transportation to hospital, she was still ignored, until later on in the day when she was taken to the hospital.

These two vignettes of Maryam and Gulpari show that they were required to self-advocate repeatedly in order to have their needs met. Their self-advocacy was an agentic enactment, and took the form of employing methods of communication such as using Google translate or threatening legal action to make themselves heard. However, as other vignettes illustrate, not all women had the resources to self-advocate in this way.

The comfort of new life

Returning to two previous narratives, this theme illustrates that contrary to the hegemonic assumption that pregnancy and having a newborn while journeying is burdensome or undesirable, for some women, it was a source of comfort.

Shabna: unexpected happiness after birth

Despite Shabna not wanting to become pregnant, the challenges she faced during pregnancy in the camp, and the separation from her newborn, her overarching experience of becoming a mother was unexpectedly positive:

> *"During pregnancy, I was more stressed and worried about what would happen, and at first, I wasn't happy because I got pregnant, I didn't like it. Later I was worried about whether it would be healthy or not. When he was born, I felt good the moment he was born. I was unconscious, and the moment I regained consciousness, I held him and hug him - it gave me a feeling that made me cry unintentionally. I don't know how can I describe it but you feel something inside when you become a mother. It is a nice feeling to be a mother."*

Nonetheless, she was very aware of the dangers of raising her child in the camp, not letting him out of her sight for fear of childhood sexual abuse:

"Something bad happened here, because of that I am so scared. An old man wanted to sexually abuse a three-year-old girl. A 70- or 80-years old man wanted to abuse a three-year-old child. Because of that, we are very afraid. We are very worried about the children who go out."

The lack of safety for young children in the camp environment, and the consequences of not being able to socialise at a young age, made caring for her son unnecessarily challenging, and further illustrates camps, rather than being places of safety, as sites of harm.

Later in the interview, she repeats this sense of comfort that her son brings to her, saying:

"I came here when he was in my belly, he was almost 40 days, now it's the fourth year, and he is three and a half years. We have been here for four years, which means that if he wasn't here, it would have been very difficult…. When I'm sad, I look at him, then all my sadness disappears, and a smile comes to my face when I look at him."

Gulpari: a longed-for pregnancy

Despite being in a precarious transit context, Gulpari wanted to conceive while she was in Serbia. She described her desire for a baby was to bring a welcome distraction from the stresses of quotidian life during migration, and similar concerns to Shabna in having a baby while still on the move:

"I wanted to have a baby in Serbia. I wanted to get pregnant. I was living in a camp and not feeling mentally well so I thought it would be better to have a baby... I went to the doctor's office and told him I wanted to have another baby but the doctor laughed at me and said, 'You already have three children, why do you want more?'. The name of the doctor was Luka and I said, 'I will have another baby and I'll call it Luka'. The doctor said, 'What if it's a girl?'. I said, 'Don't worry, just send me for checkups.' I spent a year making checkups. Because I had been trying to get pregnant but hadn't been able to get pregnant they made x-rays and ultrasound scans to check up. They gave me some vitamins then one day I was feeling a bit sick and nauseous and a light dizziness so that I visited Doctor Luka at the camp and he ordered me to do a pregnancy test. And then I took the pregnancy test and my daughter said, 'Mum if it turns red you are pregnant' because I didn't understand. I had no idea because I have low blood pressure and so I didn't realize I was pregnant. So I went back to the doctor at the camp and he congratulated me and said, 'OK if it's a boy you need to call him Luka!'. I said, 'That's okay!' I was so happy I was crying. When I got back home my daughter told her father that I was pregnant and they were all very excited about it. but I was a bit afraid and apprehensive

because I could see what the limitations of the camp were, so on the one hand I was happy but on the other hand I was worried having a baby in the camp."

When asked later in the interview again about why she had wanted to get pregnant, she replied,

> *"When I was in Serbia for two years, I was mad for two years. I argued a lot with my husband and I was always angry. When I look at others who had little babies and I don't have. They were busy with their babies but my children had grown up."*

Here, Gulpari expressed the comfort of a newborn in the form of distraction from other difficulties she was facing.

While this was not an emotion expressed by all women, (for example the interview with Bibigul on feeling constrained from onward travel, by having a newborn), it reveals that for some women, pregnancy is desirable, and for those for whom pregnancy was neither desired nor planned, having a newborn may still bring hope in the face of otherwise uncertain circumstances.

Discussion

This is the only known study to explore perinatal experiences of refugee women in Serbia from their perspectives. Informed by a decolonial feminist lens, and using narrative methods, it has enabled women-centred conversations through which meanings of women's perinatal experiences were created. This approach brought to light stories that mattered most to participants (Weiss and Johnson-Koenke 2023) and foregrounded the intersecting systems of power that worked together to (re)produce inequalities in migration and maternity care for Afghan women. This study makes an important contribution to understanding maternal and newborn health needs for forcibly displaced women and their infants, not only pertaining to Afghan women on the move in Serbia, but also providing important context for health providers in countries in which Afghan women apply for asylum. Understanding past perinatal experiences can enable a greater degree of sensitive care provision to women arriving in new countries (Binder *et al*. 2012). Importantly, these findings add to the discourse about maternal health experiences and needs more broadly for forcibly displaced women during migration.

Overall, my findings show the diverse perinatal experiences of Afghan women in Serbia, the commonalities of risks and harms of (im)mobility to women and their newborns, and inadequacies of intrapartum and postnatal care. It reveals the structural and obstetric violence to which perinatal Afghan women are exposed in Serbia in attempts to control and subjugate their maternal bodies. Yet despite these attempts, participants demonstrated their agency as they manoeuvred to mitigate and resist these controls, albeit severely constrained.

Decolonial feminists have elucidated the structural nature of violence against women in all its forms (Lokaneeta 2016, Vergès 2022). It is evident that for perinatal Afghan women, structural violence – harms caused by social structures that prevent people's basic needs from being met (Galtung 1969) - was woven throughout all stages of transit through Serbia, both at EU borders, and within Serbia, even when staying in sub-standard camps purporting to offer protection for refugees (UNHCR 2024d). The themes *Childbearing is embedded in migration stories* and *Impact of encampment on maternal wellbeing* build on the existing literature on gendered risks of migration to which women are exposed (Fiddian-Qasmiyeh 2014, Freedman 2016b, Pertek 2022). Participants' perinatal experiences situated within their journey narratives speak to the enormous impact that migration had on them. Precarity, direct violence, and physical and emotional suffering, along with the uncertainty associated with occupying Serbia as a transit zone, often engulfed childbearing experiences. The interruption of participants' journeys when entering camps to receive maternity care or to avoid the risks of travelling with small children could severely curtail onward travel, as caring responsibilities of motherhood took precedent, thus shaping migratory trajectories (Stock 2012). Uncertainties about onward migration and the ensuing loss of hope about reaching a place of perceived safety had a negative impact on participants' perinatal mental health. While the temporary 'protection' ostensibly offered in camps along with camp-based humanitarian assistance serves EU member states in containing unwanted refugees away from their borders (Rydzewski 2020), it creates spatial confinement and perpetuates temporal uncertainties (Fontanari 2018).

Migration scholars have conceptualised forms of structural violence in which tactics of deterrence to seeking international protection in the EU are employed and state-induced protracted displacement that reproduces precarity as *politics of exhaustion* (de Vries and Guild 2019) and *slow violence* (Hyndman 2019, Mayblin *et al*. 2020) respectively. By framing structural violence in these ways, the role of the state in directly causing, or neglecting to address violence is laid bare. In this case, structural violence enacted in Serbia is largely in response to EU migration governance (as discussed in the previous chapter). The commitment of the EU on the one hand to protecting human rights, while simultaneously exposing forcibly displaced perinatal Afghan women and their newborns to forms of violence at the margins of the EU exemplifies the EU's racialised migration governance, with colonial roots, that legitimises structural violence as a means to keeping 'less-than-humans' away from its borders (Lokaneeta 2016, Tazzioli 2021).

While these forms of structural violence were plainly visible in this study as a mechanism for deterring Afghan women from EU borders, it neither rendered women passive nor immobile. Indeed, disarticulating the logic of the EU border regime, women played an active part in creating opportunities to remain mobile, while simultaneously experiencing the structural violence imposed

by EU member states (Brambilla and Jones 2020, Mainwaring 2019). Their agency, fuelled by hope (Rydzewski 2020), constitutes resistance to deterrence mechanisms when border crossings continued to be made (Stierl 2019).

A further form of violence against women in this study was that of obstetric violence, made visible in the *Negotiating zones of control* and *Self-advocacy as a strategy for getting maternal health needs met* themes. Afghan women accessed the same system of state-funded maternity care used by Serbian women. Their experiences represent a microcosm of the experiences of all women interacting with this system of care, of which limited evidence shows is often disrespectful and technocratic (Pantović 2022a). Yet their experiences were compounded by having made perilous journeys, being in a new country with clinical practices varying from those in Afghanistan where many participants had previously given birth, and mostly unable to communicate with care providers. This was evident particularly during labour and birth, when women were denied interpreters and companionship, and postnatally when newborns and mothers were separated. Obstetric violence is, "… harm inflicted during or in relation to pregnancy, childbearing, and the post-partum period" (O'Brien and Rich 2022, p.2183), that may encompass disrespectful care, the mistreatment of women and newborns, and sub-standard quality of clinical care (Bowser and Hill 2010, Ferrão *et al*. 2022, Sacks 2017). The concept of obstetric violence can be broadened out by examining its causes, namely structural violence, with its roots in racism, colonialism, and paternalism (Sadler *et al*. 2016; O'Brien and Rich 2022). Sadler *et al*. (2016) compellingly argue that situating obstetric violence within structural violence shifts the discussion from one of blaming health professionals for causing obstetric violence, to a broader discussion about the structures of power and oppression that give rise to violence.

Findings in this study reveal a number of ways in which obstetric violence occurred. Firstly, failing to provide translation for women while admitted in hospital prohibited care providers and women communicating. Communication is a foundational aspect of quality maternity care, enabling women to feel respected, building trust and safety at a critical moment in women's lives, and allowing clinical events and procedures to be explained and consent gained (Afulani *et al*. 2017, Bohren *et al*. 2020). However hindered communication can lead to women can feeling afraid, disempowered, or violated as they are removed from decision making about procedures conducted on their bodies (Koster *et al*. 2020, Niner *et al*. 2013, Tobin *et al*. 2014). While the *Self-advocacy as a strategy for getting maternal health needs met* theme shows that some women had the resources to communicate to make themselves heard (although after repeated attempts), this did not extend to all women.

Secondly women in this study were refused a companion of their choice during labour and birth. The presence of a birth companion is clearly shown to provide emotional and physical support during the

intrapartum period, in addition to protecting (to varying degrees) mistreatment and disrespectful care (Balde *et al*. 2020, Kungwimba *et al*. 2013, Shalini Singh *et al*. 2021). Moreover, there is some evidence to suggest that continuous support during labour is associated with improved maternal outcomes (Bohren *et al*. 2017), and having a companion of women's during labour and birth has been recognised by the World Health Organization (WHO) as being an important component of quality care (World Health Organization 2020).

Finally, the common experience of having newborns separated from participants was extremely traumatic for women. This finding is in line with the trauma experienced by women in another study whose newborns were admitted to neonatal intensive care unit post-birth (Nyström and Axelsson 2002). Early skin-to-skin contact soon after birth between mothers and infants (irrespective of mode of delivery) is critical in preparing newborns for extra-uterine life: it has physiological regulatory benefits for the newborn and aiding the establishment of breastfeeding (Bigelow and Power 2020, Moore *et al*. 2016) and benefits infants' gastrointestinal microbiomes (Wiley *et al*. 2023). Past the immediate period after birth, keeping mothers and newborns together, referred to as rooming-in or zero separation (Bergman 2014, Klemming *et al*. 2021), is imperative for continuing bonding and attachment, and the establishment of breastfeeding, as well as being protective against toxic stress in newborns (Bergman 2019, Henderson and Redshaw 2013, Tomori *et al*. 2022).

The theme *Self-advocacy as a strategy for getting maternal health needs met* shows how some women were required to enact agency during childbearing in order to self-advocate for their needs with both hospital and camp staff. Discourses of agency in childbearing have developed largely around empowerment, choice, and control for women in the Global North, in which women's agency is associated with positive childbearing experiences (Dahan and Cohen Shabot 2022, Hall *et al*. 2018). In this study, those participants who had the resources to enact agency to self-advocate were required to do so for their very basic maternal health needs to be met, while still denied positive birth experiences. This reiterates the tensions existing around discourses of birth experiences both globally between the Global North and Global South, and locally between privileged and minoritised women (Chadwick 2018).

The technocratic model of intrapartum care (Davis-Floyd 2001) in Serbian public health systems is dehumanising for any woman giving birth in Serbia, irrespective of citizenship status (Pantović 2022a). For refugee women giving birth in a new country, separated from social support structures, experiencing unfamiliar childbirth practices, and unable to communicate with health professionals, negative care experiences can be compounded (Giscombe *et al*. 2020, Toker and Aktaş 2021). In this study, systems of care that gave rise to gendered violence and mistreatment during childbirth

intersect with race at the point where maternity care collides with racialised migration governance: free healthcare is restricted to those staying within state-run camp accommodation, to decelerate journeys and disincentivise informal camps in EU border areas that facilitate entry to the EU, as a means of keeping unwanted, racialised bodies away from EU member states.

Despite the arduous and distressing migration experiences of participants and of many negative childbearing experiences, for some women (though not all) pregnancy and having a newborn provided comfort and a source of joy, and motherhood provided a route to reclaiming a normality amidst the ruptures to everyday living associated with mobility. This finding is congruent with a study of forcibly displaced Syrian women in Türkiye, that found having a newborn was for some women a source of joy, a distraction from the conflict through which they had lived, and a responsibility that gave them a renewed sense of purpose (Korukcu *et al*. 2018). Moreover, breastfeeding and infant-holding are associated with bi-directional oxytocin release, associated with positive mood states in mother-infant dyads (Bigelow and Williams 2020). That having a newborn while on the move can be a positive experience for some women disrupts tropes of pregnancy as always burdensome and unwanted (Quagliariello 2021), and eschews NGO programming that seeks to universally limit women's fertility for women in transit zones (Bagelman and Gitome 2021), suggesting a more nuanced understanding and approach to reproductive healthcare for women during migration is required.

Limitations

This study has several limitations. Only one participant was interviewed during the perinatal period, all other interviews occurred retrospectively. Recruiting more participants at the time of pregnancy or in the postnatal period may have provided differing perspectives. However, it is also the case that all conversations with women were temporally situated, and how participants made sense of their experiences on one occasion, may have been different to the next (Bruan and Clarke 2021). The analysis and interpretation of data in this study could be criticised as being subject to my own experiences, biases, and worldview, which I acknowledge, recognising the active role I have played in knowledge production (Weiss and Johnson-Koenke 2023). I have addressed validity by maintaining awareness of, and being transparent about my own positionality and reflexivity throughout the research process, documenting and sticking closely to the methods used, and discussing analysis and interpretation with supervisors (Reissman 2008). Using narrative inquiry, as a case-based method, led to some data being omitted that could have identified participants, to maintain anonymity, which would not have been the case if narratives were broken up, for example by using analysis methods that coded data line-by-line. Additionally, committing to principles of narrative inquiry that retains rather than splinters narrative accounts, it was not feasible to include all participants' narratives in this study's findings. Translation of interviews added another layer of narrative construction, which

may have obscured some of the original meanings portrayed by women (Reissman 2008). Finally, the findings of this study are highly temporally and spatially contextual – although commonalities may exist with perinatal experiences of perinatal women in other contexts, these findings have limited generalisability.

Conclusion

It would be inappropriate to sum up by flattening or homogenising the diverse experiences of Afghan women as they traversed Serbia at differing stages of the perinatal period. Nevertheless, this study has brought to light unheard, invisible, and intimate narratives. It shows the deleterious bodily and psychological effects of controlling perinatal Afghan women's bodies at the margins of the EU, and the resistance women enacted when faced with attempts to control their movement. It reveals how migration governance often equates to structural violence against perinatal Afghan women and their newborns, demonstrating a failure to adequately account for maternal and newborn health needs for people on the move. This is compounded by the obstetric violence experienced by Afghan women in this study resulting from dehumanised Serbian systems of maternity care that subjugated their bodies. The agency that women enacted when resisting controls on their migration demonstrates that Afghan women in this study were not passive victims but were active in carving out safety for themselves and their children. It is reprehensible that EU migration regime reproduces the violence from which women were trying to leave behind and that so little attention is paid to their maternal and newborn health needs.

CHAPTER 6- THE NEXUS BETWEEN MATERNITY CARE AND BORDERING PRACTICES: A QUALITATIVE STUDY OF PROVIDER PERSPECTIVES ON MATERNAL HEALTHCARE PROVISION FOR AFGHAN WOMEN MIGRATING THROUGH SERBIA TO WESTERN EUROPE

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Primary Supervisor	Dr. Diane Duclos		

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Supervisor Signature	Diane Duclos
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The nexus between maternity care and bordering practices: A qualitative study of provider perspectives on maternal healthcare provision for Afghan women migrating through Serbia to Western Europe

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ABSTRACT

Serbia is a well-established transit country for Afghans travelling overland to seek protection in Western Europe, and Afghan women continue to experience pregnancy and birth during migration. This qualitative study aimed to explore the perspectives and experiences and of clinical and non-clinical perinatal care and support providers to Afghan women during migration through Serbia, using a critical border studies lens. Semi-structured interviews with 21 Serbia-based providers (conducted August 2021–October 2022 and analysed thematically) provided five inductive themes: (1) contours of life in Serbia for Afghan women; (2) providing maternity care and support to a highly mobile group; (3) enablers and barriers to accessing and using maternity care; (4) risks of onward migration; and (5) supporting women in a landscape of constant change. We identified ways in which regional geopolitics translated to bordering practices that interfered with maternity support provision to Afghan women in Serbia. We argue that non-exclusionary systems of care are needed to ensure women on the move receive adequate maternity support.

1. Background

Afghans have a long history of migration, fuelled by natural disasters and decades of armed conflict (Internal Displacement Monitoring Centre, 2021). Since the Taliban (re)takeover of Afghanistan in 2021, it has experienced renewed humanitarian crisis (OCHA, 2023), widespread human rights violations against women (Human Rights Watch, 2023), and is ranked lowest on the Global Peace Index (Institute for Economics and Peace, 2023). Afghanistan has the world's third-highest refugee population, with over 8.2 million Afghan refugees seeking safety abroad (UNHCR, 2023), and Afghans are among the top two largest asylum-seeking populations in the European Union (EU) (European Union Agency for Asylum, 2023). The dire situation in Afghanistan coupled with EU failure to provide sufficient legal routes to migration has resulted in self-organised, unsafe overland journeys, often with the assistance of smugglers (Crawley et al., 2016; Vještica and Dragojević, 2019). Journeys are often staged and protracted, as migrants gather funds to pay smugglers for each onward segment (Vještica and Dragojević, 2019).

Forced displacement is highly gendered (Fiddian-Qasmiyeh, 2014). During protracted journeys, women are at risk of gender-based violence, sexual exploitation, trafficking, and human rights abuses (Freedman, 2016; Grotti et al., 2019; Vještica and Dragojević, 2019, Anguita Olmedo and Sampó, 2021). For many women, pregnancy continues during migration. Data are sparse but World Health Organization (WHO) Regional Office for Europe (2018) estimates indicate women and children made up to 55% of all migrants entering Europe, with 10% already pregnant on arrival.

Research relating to the perinatal period (ie, pregnancy, birth, the first six weeks postpartum) among forcibly-displaced women focuses on high-income countries where participants are seeking settlement or have been granted refugee status (McKnight et al., 2019; Sharma et al., 2020; Marti Castaner et al., 2021; Kirkendall and Dutt, 2023). Studies examining provider experiences of maternal healthcare provision for women *during* migration are scant (Grotti et al. 2018a, 2019; Scott and Wallis, 2021; Sahraoui, 2020). Exploration of maternity care for migrants travelling through southern Europe foregrounded ways in which women's vulnerablisation shaped interactions with maternity care

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Sharma E, Duclos D, Howard N (2024a) The nexus between maternity care and bordering practices: a qualitative study of provider perspectives on maternal healthcare provision for Afghan women migrating through Serbia to Western Europe**.** *Social Science and Medicine* https://doi.org/10.1016/j.socscimed.2024.116880

Background

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Forced displacement is highly gendered (Fiddian-Qasmiyeh 2014). During protracted journeys, women are at risk of gender-based violence, sexual exploitation, trafficking, and human rights abuses (Anguita Olmedo and Sampó 2021, Freedman 2016b, Grotti *et al*. 2019, Vještica and Dragojević 2019). For many women, pregnancy continues during migration. Data are sparse but World Health Organization (WHO) Regional Office for Europe (2018) estimates indicate women and children made up to 55% of all migrants entering Europe, with 10% already pregnant on arrival.

Research relating to the perinatal period (ie, pregnancy, birth, the first six weeks postpartum) among forcibly-displaced women focuses on high-income countries where participants are seeking settlement or have been granted refugee status (Castaner *et al*. 2021, Kirkendall and Dutt 2023, McKnight *et al*. 2019, Sharma *et al*. 2020). Studies examining provider experiences of maternal healthcare provision for women during migration are scant (Grotti *et al*. 2019, Grotti *et al*. 2018a, Sahraoui 2020, Scott and Wallis 2021). Exploration of maternity care for migrants travelling through southern Europe foregrounded ways in which women's vulnerablisation shaped interactions with maternity care providers (Grotti *et al*. 2018a) and normalisation of emergency solutions for maternity care provision (Grotti *et al*. 2019). Research in a Greek refugee camp found care provision challenges relating to communication barriers, unprepared health systems, and women-only safe spaces among maternity care providers (Scott and Wallis 2021). By interrogating humanitarian action for migrants on the move in Southern Europe, Sahraoui (2020) demonstrated how humanitarian perinatal care is enmeshed with migration management, as care providers exerted control over women's mobility.

Theoretical underpinnings

This study uses Critical Border Studies (CBS) conceptualisation as an interpretive theoretical lens to inform understanding particularly during data analysis and write-up. Conventionally, borders are material, static geographical lines, delineating states. CBS questions and problematises this fixed conceptualisation of territorial boundaries, identifying ways transnational border controls are not applied solely at borders, but are dynamic, structural processes, occurring inside and outside nation-state boundaries, appearing and disappearing, designed to include and exclude, and thus creating socially dynamic spaces at and around borders (Brambilla 2010, Watkins 2017). The complexities and breadth of experiences of crossing borders vary widely along racialised, socialised, and gendered lines and borders are polysemic, meaning different things to different people (Stierl 2019). The uneven enactment of border controls renders them exclusionary, marginalising, and restrictive (Watkins 2017). Border controls follow people, with citizenship and immigration status privileging certain groups by enabling international travel, while preventing border crossings for others (McCorkle 2020). CBS interrogates bordering practices occurring in spaces away from state boundaries, exploring the effect they have, and on whom (Parker and Vaughan-Williams 2012).

CBS therefore understands bordering processes and practices as contested sites of struggle. In the EU, bordering can be viewed as a continuum of violence towards migrant groups deemed 'undesirable.' Scholars have engaged 'slow violence' to describe psychological and physiological effects of bordering practices on asylum seekers (Mayblin *et al*. 2020, Meier 2020), and documented violence leading to mortality in Europe's Mediterranean frontier (Kovras and Robins 2016). The corpus of work relating to borders and healthcare primarily focusses on physical borders, but the global trend in state policies of hostility towards migrants has prompted greater exploration of the impacts of bordering practices on healthcare provision and its consequences on care recipients. For example, governments increasingly insource immigration measures (Back and Sinha 2019): National Health Service staff in Italy and the UK are required to ascertain patient immigration status, thus acting as gatekeepers to determine who is entitled to free healthcare and who should be charged (Perna 2017, Rassa *et al*. 2023). This not only exposes health professionals to ethical dilemmas (Feldman *et al*. 2019) but deters some migrants from seeking care (Britz and McKee 2016). CBS helps in understanding the nexus between provision of perinatal care and support for forcibly-displaced Afghan women in Serbia and bordering practices both at, and away from, territorial borders.

This study, contributing to PhD research exploring perinatal experiences of Afghan women transiting through Serbia, was conducted due to limited evidence on the provision of perinatal care and support for women on the move, to explore challenges and opportunities, and contribute to current discourses on this topic. We aimed to qualitatively explore perspectives and experiences of clinical and non-

clinical perinatal care and support providers to Afghan women migrating through Serbia, using a Critical Border Studies lens. By focusing on Afghan women, we moved away from homogenising perinatal care and support provision, recognising that experiences of providing support for Afghan women in Serbia will differ from that for other populations elsewhere.

Methods

Study design

We used a qualitative design, drawing from in-depth interviews conducted in Serbia and remotely with perinatal care and support providers to forcibly displaced Afghan women.

Study setting

During the so-called 'EU migrant crisis' of 2015-2016, many migrants passed through a de facto humanitarian corridor from south-central to western Europe, through the Western Balkan region. Following border closures in 2016, this corridor no longer exists but Serbia remains an established passage through which Afghans travelling overland into the EU continue to pass (Bobić and Šantić 2020). Travel through Serbia may occur without stopping or be protracted for months or years for those who cannot afford to pay smugglers (Lorenz and Etzold 2022). Those staying in Serbia can register with authorities and be accommodated in state-operated asylum or transit centres (hereinafter referred to as 'camps'), located across the country. Some choose neither to register with Serbian authorities nor be accommodated in camps, staying instead in informal settlements ('squats') in abandoned buildings or tents close to EU borders, to facilitate border crossings and expedite journeys (Stojić Mitrović and Vilenica 2019). Various routes are used by migrants and smugglers from Serbia into Western Europe but illegal deportations by EU border authorities, back through one or more countries into Serbia (known as 'pushbacks') are common, resulting in repeated attempts at border crossings and arduous, circuitous journeys (Augustová 2023).

The initial emergency response in Serbia at the start of the de facto humanitarian corridor caused a large presence of international non-governmental organisations (NGOs) providing humanitarian assistance to migrants passing through the country. However, as the corridor closed, the state shifted from a humanitarian to a securitarian logic, preventing undesirable migration and protecting its citizens (Stojić Mitrović 2019). This led to a reduced and state-regulated humanitarian response, in which NGOs only operate within the terms of the state, with parallel systems of migrant solidarity and support that bypass state regulation outlawed (Stojić Mitrović 2019). This created categories of deservingness among migrants, with the state holding power to control who deserves humanitarian assistance and not all treated equally (Cantat 2021). The same applies to accessing healthcare, including maternity and newborn care, for migrants in Serbia. Only those seeking/granted asylum or

registered with Serbian authorities and accommodated in camps, can access Serbia's public health system largely free of charge (Kovačević 2023, Pusztai *et al*. 2018). Camp residents have access to primary care doctors in camps, who could refer residents to secondary and tertiary care facilities. Any care, including routine maternity care, is not freely available to unregistered people residing outside camps.

Participant recruitment and consent

We used purposive sampling and snowballing to identify and recruit participants. First, we identified potential participants through internet searches of clinic and NGO personnel and contacted them by email for semi-structured initial and follow-up interviews. Interested personnel were eligible if they currently, or in the past five years, provided direct perinatal care or support to Afghan women in Serbia. This included clinical actors (e.g. doctors and nurses providing direct clinical care to pregnant Afghan women) and non-clinical actors with a professional role supporting perinatal Afghan women (e.g. running woman/mother-friendly spaces in refugee settings, mediating for Afghan women during antenatal checks, providing reproductive healthcare in camps). Prior to interview, all received a written participant information sheet in English or Serbian and an opportunity to discuss the study and have questions and comments addressed before providing written or verbal informed consent (e.g. for remote interviews). We ensured participants understood how we would maintain their anonymity and data confidentiality.

Data collection

We developed a topic guide informed by CBS, related literature (Sharma *et al*. 2020), and a preliminary site visit. The topic guide was iterative and included the role in which participants and their affiliated organisations provided care/support to Afghan women, the nature of this support, the impact of Covid-19, and the role of mobility and borders in service provision. Data were collected August 2021 to October 2022. The first author conducted semi-structured interviews, in person in Serbia or remotely via Zoom or WhatsApp and follow-up semi-structured interviews with participants who continued providing perinatal care or support to Afghan women after the initial interview, to understand the impact of the shifting geopolitical landscape over time. We offered Serbian-English interpretation, though most spoke English, and three requested this. Interviews lasted 40-135 minutes. All were audio recorded and transcribed verbatim, except one that was typed during interview at participant request. To improve anonymity, participants were assigned identification numbers and identifiable material was redacted from transcripts. To maintain confidentiality, only co-authors had access to data. To improve privacy, interviews were conducted at times convenient to participants and at locations of participants' choosing for in-person interviews (all chose private rooms at their workplace or in their homes).

Analysis

We used reflexive thematic analysis, to systematically code data and develop themes whilst critically reflecting on the researcher role (Braun and Clarke 2022). Whilst this analysis method is inductive, we engaged CBS "as guiding lens" (Braun and Clarke 2022, p.189), reflecting on ways in which bordering practices marginalise and exclude. ES re-read transcripts to ensure familiarity, uploaded them to NVivo v.12 (QSR International 2020), and coded line-by-line. Codes with commonalities were grouped together to develop initial themes and sub-themes, which were reviewed against meanings from the original data and CBS concepts. Finally, initial themes were re-organised, refined, and (re)named (Braun and Clarke 2022). ES conducted the initial analysis with DD and NH providing critical feedback on analysis to further refine themes.

Ethics

London School of Hygiene & Tropical Medicine Observational Research Ethics Committee (reference 26211-1) in the UK and University of Belgrade (reference 1322/VII-12) in Serbia provided ethics approval.

Findings

Participant characteristics

Table 1 provides participant characteristics. In total, 21 participants were recruited and 24 interviews conducted. Only three follow-up interviews were conducted due to other participants no longer being actively involved in providing perinatal care or support to Afghan women.

Table 3 Informant participant characteristics

ID	Nationality	Age	Sex	Organisation type	Role*	Interview location	Follow-up interview
P1	Serbia	25-34	F	National non-governmental organisation (NGO)	Service provider	In-person and remote	Yes
P2	Serbia	25-34	F	NGO	Service provider	Remote	No
P3	UK	25-34	F	International NGO (INGO)	Volunteer	Remote	No
P4	Serbia	25-34	F	NGO	Service provider	Remote	No
P5	Serbia	25-34	F	NGO	Service provider	In-person and remote	Yes
P6	Serbia	25-34	F	UN agency	Service provider	Remote	No
P7	USA	25-34	F	INGO	Volunteer	Remote	No

P8	Bosnia Herzegovina	25-34	F	INGO	Service manager	In-person and remote	Yes
P9	Serbia	25-34	F	INGO	Service provider	Remote	No
P10	Serbia	25-34	F	INGO	Service provider	Remote	No
P11	Serbia	25-34	M	NGO	Cultural mediator	Remote	No
P12	Serbia	25-34	F	NGO	Service provider	Remote	No
P13	Serbia	25-34	F	NGO	Service provider	Remote	No
P14	Serbia	35-44	F	NGO	Service provider	Remote	No
P15	Serbia	45-54	F	NGO	Cultural mediator	Remote	No
P16	Afghanistan	25-34	F	NGO	Volunteer	Remote	No
P17	Serbia	25-34	F	INGO	Service provider	Remote	No
P18	Serbia	45-54	F	State organisation	Service manager	Remote	No
P19	Serbia	25-34	F	NGO	Service provider	Remote	No
P20	Serbia	35-44	F	State organisation	Service provider	Remote	No
P21	Serbia	25-34	F	NGO	Service provider	Remote	No

*Many participants worked in different settings over time - only their most recent experience is categorised here.

Thematic findings

We identified five inductive themes: (1) Contours of life in Serbia for Afghan women; (2) Providing maternity care and support to a highly mobile group; (3) Enablers and barriers to accessing and using maternity care; (4) Risks of onward movement, and (5) Supporting women in a landscape of constant change. These interrelated themes aid understanding of how bordering practices trickle down and impact the mechanisms through which maternity care and support are provided, the nature of that maternity care, and ways in which it excludes and marginalises certain groups.

Theme 1. Contours of life in Serbia for Afghan women

This theme describes the complex contextual factors participants navigated to provide care and support to Afghan women, which participants recognised as wider determinants of perinatal wellbeing, beyond the solely biophysical. This also highlighted the constraints under which they worked due to bordering practices. Three sub-themes were: (i) Serbia as host country; (ii) Sub-standard accommodation; and (iii) Risky border crossings.

Sub-theme 1.1. Serbia as host country

Participants identified public attitudes towards people on the move, either Serbian or globally, as having a role in NGO funding and activities, including reproductive health programming. For example, one participant spoke about having to relocate a woman's project, attended by perinatal Afghan women, because of host community hostility. Another discussed an anti-migrant right-wing extremist group that regularly vandalised the possessions of refugees living outside camps. Minimal interest in seeking asylum in Serbia among Afghan families was attributed to limited livelihood opportunities and a poorly-functioning asylum system that discouraged settlement and perpetuated mobility. The effects of this on maternity care are discussed in sub-theme 1.2.

Several participants spoke about Serbia's history of hosting refugees during the 1990s Balkan war, or of personally living through conflict, expressing solidarity with refugees arriving from conflict-affected areas.

> *"When we speak about refugees from former Yugoslavia, what is similar? Because they all had to flee from the country and from war. And traumas are there, you know, war, trauma, torture, rape. And consequences of that are, you know, you can see that in these refugees."* (Participant 2)

Such solidarities increased empathy with perinatal Afghan women in Serbia.

Sub-theme 1.2. Sub-standard accommodation

Serbian migration governance mandated that provision of state-run free routine maternity care be limited to women accommodated in camps. Participants discussed how (I)NGO support was also increasingly restricted to being camp-based, while camp conditions were overwhelmingly discussed negatively (e.g. overcrowding, poor hygiene, lack of safety for women and children, violence between camp residents, drug abuse) as hard for perinatal women.

> *"…living in those conditions such as dirty camps. Not all of them are like that, but, uh, it's not so great, definitely, and I imagine it is really difficult. I think that it's really difficult living like that and raising a baby like that."* (Participant 19)

Despite reported camp conditions, participant opinions differed about their suitability for pregnant women, with most saying camps were inadequate but some suggesting they were better than alternatives for refugee women given the additional support they offered:

> *"I think that women who agree to go to camps are in a better situation than those who are hiding [living in squats], even though they have difficulties when they try to communicate with the healthcare workers, etc. It is still kind of also cleaner environment and, uh, people from the*

Commissariat or from other NGO's will drive them to hospital etc. So, I think that they are in a little bit better situation..." (Participant 13)

Some participants discussed women's circumstances in abandoned buildings or tents. Squat locations were highly changeable due to police raids and evictions, but they were close to border crossings so expedited onward journeys. Participants working with refugee communities in squats noted they had fewer interactions with women than with men. Services could only be offered near but not inside squats, so men attended, thus rendering women invisible.

Sub-theme 1.3: Risky border crossings

All participants highlighted border crossings, including motivations to continue onward journeys, seasonality of onward movement, routes, involvement of smugglers, and the role of border enforcement police. A sense of inevitability about crossings was conveyed, while acknowledging the risks women and newborns faced during these journeys (overlapping theme 4).

Onward migration was reportedly driven by hope for a better future in Western Europe. Travel was seasonal (more frequent in warmer weather), with families staying in camps during colder months. Most participants commented that men were decision-makers about when to continue:

> *"… it was not up to them to decide whether they will take that risk [onward transborder movement] or not. It was usually decided by their husband or a man who was in charge of them."* (Participant 14)

However, one participant disputed this:

> *"… no, it was not like their husband was not pushing them, it was completely their choice…If they want to cross the border, also that was their choice."* (Participant 16)

Routes into the EU fluctuated depending upon smugglers' preferences and who was travelling. For example, one participant spoke of young men climbing a smuggler-controlled ladder over the razor-wire fence at the Serbian-Hungary border, explaining this was impossible for families with children who had to use a more distant river crossing. Travelling by foot was common. Many engaged with smugglers, either in-person or by phone, to aid their journey. Engaging smugglers incurred financial costs, so families would save while staying in camps, in addition to receiving funds from family members in Afghanistan. Some cited violence perpetrated by smugglers, yet others noted that not all smugglers were 'villains', despite being financially motivated.

Due to pushback deportations by EU border police, participants noted families would make multiple attempts at border crossings. These pushbacks were often violent and traumatising:

"Yes, when it comes to trauma, the trauma is also there from pushbacks because, er, usually policeman would use some violence… And knowing that they will have to repeat it again. It was just a matter of time that they would start and try again." (Participant 14).

Several participants recognised that multiple traumas, including these violent pushbacks, necessitated an approach to perinatal care and support beyond biophysical care:

"I really think that they needed support, kind words.... because they were usually anxious and afraid… But especially for, for women that were pregnant and that had small children with them... And in a way to listen to their stories, their fears… And it is very important that on some spots there is a human being that accept you as a human being. So, I think that that was important for them." (Participant 2)

This participant emphasises the importance of listening and responding with kindness to perinatal women, as part of humanised care.

Theme 2. Providing maternity care and support to a highly mobile group

This describes specific challenges participants experienced and approaches they took in providing perinatal care and support to Afghan women as an extremely mobile group and highlights the personal demands of this on participants. Two sub-themes were: (i) Maternal and newborn health programmes; and (ii) Narratives of women giving birth 'on the way.'

Sub-theme 2.1. Maternal and newborn health programmes

Participants described specific programmes, most of which were historic. Few functioned at the time of data collection, showing the lack of NGO support for maternal and newborn health.

"…there's no targeted programming [for maternal health], so that goes to say that we are at square one. And it's not just that they're [pregnant women] not on our radar. They're not on the donors' radar." (Participant 5)

Mother and Baby Corners were originally set-up by UNICEF, with support from (I)NGO partners, to provide health and wellbeing advice for infants in camps accommodating families (eg, infant feeding support, weaning information, growth monitoring, supplies for infants). Although focusing on infant care and support, Mother and Baby Corners also provided safe spaces for women to support one another, as described by a participant:

"This corner was especially for mothers and babies - no other people can enter that place. They was free to say everything that they want. It was good to have opportunity to have something or feel vulnerable or they need support…and I think that everybody really make a progress in

healthy way to say, uh to provide the support needed for, for those women and babies who came not just from Afghanistan." (Participant 21)

Some NGOs ran workshops on maternal and newborn health and contraception, providing opportunities for discussion and questions.

"We did a lot of workshops. It was called, "Going to the maternity hospital." And yeah, we did that with the women, preparing them, you know how it will look like in Serbian hospital, because they put you in a separate room, and you are alone, and because they're doing some testings. Maybe that's not common in their country. So, you know, just inform them not to be afraid that they were separated because, I don't know, they're from other country." (Participant 6)

Another project placed gynaecologists in camps to provide sexual and reproductive health, conduct camp-based women's health workshops, and provide pregnancy tests and early pregnancy screening, though not ongoing maternal and newborn healthcare. However, support was not available in all camps.

Sub-theme 2.2. Narratives of women giving birth 'on the way'

Many participants recounted stories illustrating Afghan women's pregnancy or birth while on the move. Participants spoke of women entering camps to rest after giving birth, before continuing a few days later. Others recounted instances of women giving birth in forests, while travelling:

"We had the case with a woman gave birth in the woods and she came to [a camp]. The baby was like 5 days old. And you know they still want to go on, but you talk to them, and she stayed for two days, you know, just to relax and... but they continued, you know, because at that period whatever they, you know, however they felt, if they were exhausted or sick or whatever, they just wanted to go." (Participant 6)

Thus, NGOs needed to rapidly adapt programming in response to changing state migration governance. Many indicated transit times through Serbia had slowed in recent years, with women increasingly staying longer in camps towards the end of their pregnancy and delivering in hospitals. There were also instances of forcible state relocation of perinatal women, with one participant describing forcible relocation of a large group of Afghan families - including newborns - from squats on the northern Serbian border to a camp in southern Serbia to prevent their movement into the EU. However, resisting relocation, the group continued journeying several days later. Participants frequently described challenges of trying to identify and meet perinatal women's needs in this transient context.

"It is challenging to provide support because you can't do anything to keep them in Serbia, in the camp, and to provide all health support or any other kind of support that woman who is pregnant needs… You can't start basically anything, because they will go." (P8)

Some NGOs maintained phone contact with women, to provide remote support despite geographical distance. While describing their work as deeply rewarding, participants highlighted significant personal strain, as supporting women who had experienced multiple traumas took its toll:

"… so many traumas, so many, you know, war stories, so many violence. And it was difficult really, to cope with all of that…" (Participant 2)

Theme 3. Enablers and barriers to accessing and using maternity care

This describes how some participants tried to work around restrictive migration governance that limited maternity care and the barriers that remained. Three sub-themes were: (i) Advocating and mitigating to improve maternity care access; (ii) Camp doctors as maternity care gatekeepers; and (iii) Barriers to maternity care.

Sub-theme 3.1. Advocating and mitigating to improve maternity care access

In response to state restrictions, such as disallowing maternity provision outside camps, non-clinical actors supporting refugee women in camps described a range of mitigating strategies they employed. This included running women's health projects covering aspects of maternal and newborn health (e.g. birth preparation, infant feeding), attending hospital antenatal care appointments with refugees, providing/organising transport for hospital appointments, providing cultural mediation and translation during hospital appointments, and advocating for women with camp doctors. Participants commented on the logistical challenges of hospital appointments, noting how arrangements could easily be missed between the various actors involved.

Another strategy described by non-clinical actors to mitigate access restrictions to maternity care was working collaboratively across agencies:

"And then we would say this lady there was one lady like alone Afghanistan woman, pregnant, she's coming with this train, you know, "Please take care of her because she was in eight months or nine months of pregnancy." So we did er, do that, you know, in some specific cases - we informed the colleagues in [another camp], for example." (Participant 6)

NGO actors providing any healthcare to refugees outside camps were required to navigate state-imposed restrictions on doing so, intense scrutiny from Serbian police, and placing themselves at personal risk:

"… two of us were actually caught by the Serbian police, held at gunpoint… following this… we would remove all evidence we'd been providing medical care, and handing out food and non-food items." (P3)

Some voiced a moral responsibility to facilitate maternity care access for women outside camps:

"For me it comes down to the responsibility I have. I feel the responsibility, but I don't have the exact knowledge to respond to that. So I don't feel comfortable with having the information that she has bled for four days and she's pregnant and not doing anything about it." (Participant 5)

Sub-theme 3.2. Camp doctors as maternity care gatekeepers

Camp doctors were described as gatekeepers to maternity care in camps. Opinions about camp doctors were highly polarised, with some participants describing very negative experiences and others applauding their tireless efforts. Not providing direct maternal or newborn healthcare themselves, they acted as family physicians, referring to hospital doctors for specialist care. Groups of women attended hospital appointments together to enable efficient transportation from camps, raising participant concerns that women might not be able to access non-emergency maternity care outside grouped visits.

An NGO actor described how she frequently phoned camp doctors, trying to bridge gaps between them and women, noting the delicacy needed in relating to camp doctors so as not to cause offence and inadvertently jeopardise the care women received. She explained how labour intensive this could be, along with frustration that she was unable to do more.

Sub-theme 3.3. Barriers to maternity care

Participants noted that Serbia's health system is underfunded and not prepared for refugees, yet women expected similar healthcare as in the EU.

"The main issue is just that the system isn't, the system for healthcare workers in these refugee camps are just not properly organised. And that is a biggest issue for them [pregnant women]." (Participant 9)

During labour and birth, women could not be accompanied, even by translators, resulting in communication difficulties with health-workers:

"A big issue for the Afghanistan women is…lack of communication during the childbirth… when they're supposed to give birth, nobody is there to help to direct them and to explain what is going to happen..." (Participant 9)

Despite the benefits of Mother and Baby Corners in some camps, these reportedly focussed on infant health and did not provide postnatal care. Several participants described the requirement for nurses to visit mothers for postnatal checks, which they did not see happening in camps, suggesting a care gap for refugee women.

Theme 4. Risks of onward movement

This describes migration risks that participants identified for pregnant women and newborns, highlighting how participants were helpless to provide the perinatal care that Afghan women and their infants needed when travelling. In addition to the general risks of border crossings described, specific crossing risks to pregnant women and newborns included miscarriages from walking excessively and violence from border police. A participant described this, with a sense of powerlessness to offer any protection evident:

> *"…we have some situations because, you know that the woman still trying illegally to cross the border… and we know one case that the woman, because of the beating, was in the hospital, and she was eight months pregnant. She's ok and the baby's ok, but it's very difficult when you need to er, when we are speaking about this… we all need to try to protect the people from these violent pushbacks, but in these concrete situations, you can't do anything."* (Participant 8)

Smugglers requiring infants be given sleeping medication to avoid alerting border police was discussed:

> *"Unfortunately, last year during the summer months, what we and my detection team find out that some of the families not only Afghan families, they give the, the sleeping pills to babies in order not to cry while they were crossing the borders."* (P17)

Participants noted that Afghan women rarely travelled alone, instead usually with family or other group, possibly to maintain safety:

> *"… they're always travelling with the male members. It's really hard to find the Afghan woman who travelled by, by herself, really… Even if we are aware that they are not the family members they are saying, 'Oh no, no this is my sister. This is my, you know, wife from my brother'… and it was obvious that they are not, you know relatives, but they do not want to, to share with us."* (Participant 17)

Despite being aware of the risks to women of onward movement during the perinatal period, some considered that directly influencing structural factors causing women to continue migration was beyond the "reach" of NGO actors. Others suggested that maternal and neonatal deaths would remain hidden due to lack of data.

Theme 5. Supporting women in a landscape of constant change

This describes participant challenges in supporting perinatal women in a rapidly shifting geopolitical landscape that influenced changes in migration governance and bordering practices. As refugee support in Serbia moved from crisis to everyday assistance (eg, "…and general narrative is that it's not a crisis anymore. It's been a couple of years" (P5)), the nature of humanitarian assistance evolved, shaped also by Covid-19 and the war in Ukraine. Three sub-themes were: (i) Temporal changes of camp residents; (ii) Transition of refugee support to the Serbian state; (iii) Covid-19; (iv) Russian invasion of Ukraine; and (iv) Funding.

Sub-theme 5.1. Temporal changes of camp residents

Many participants who had worked with refugees for five years or more, spoke about temporal changes they witnessed in camps and how this impacted their ability to support refugee women during the perinatal period.

Firstly, they observed a reduction in numbers of pregnant Afghan women in camps, corresponding to reduced numbers of Afghan women and families. One participant vividly described running a workshop several years previously, in a small room, filled with Afghan women who were pregnant or had newborns, comparing it with the time of interview and suggesting more women now opted for abortion instead of continuing a pregnancy in Serbia. Another reported reason for reduced numbers was that being pregnant or having a newborn was no longer perceived as expediting EU entry. Some noted that having fewer pregnant Afghan women in camps resulted in programme adjustments, with fewer activities planned, whereas others indicated fluctuating numbers did not affect activities.

Secondly, frequent changes to the spaces occupied by perinatal Afghan women affected participant experiences of providing care. Changes to who was accommodated in camps (e.g. camps accommodating families changing to only accommodating single men), or use of temporary buildings forced activities to relocate. A participant supporting Afghan women with newborns described this perpetual change:

> *"… The state organised some reception centres, and then our fieldwork was with them. So we couldn't be there anymore… we started working in [a one-stop centre for migrants] in June 2016. But even before that, [we were] in another place. Also, although it was like an improvised place, it was like a big yard in which different NGOs provide different, different services…. So we did have small, [one-stop shop], that small mother and baby corner in our RV, in, in Belgrade, in central Belgrade but that was soon dismantled, and then we moved to this building where we stayed..."* (Participant 14)

NGO actors described changes in spaces as resulting in having to repeatedly adapt their programmes.

Sub-theme 5.2. Transition of refugee support to the Serbian state

Participants reported that transferring activities from humanitarian agencies to the Serbian state left programming gaps, particularly related to women's health and wellbeing. Mother and Baby Corners were largely non-operational once their management passed to the Commissariat for Refugees and Migration (KIRS):

> *"… there was a huge transition [to the state]… of mother and baby corners… and almost all of them in all of the camps are now extra accommodation or storage spaces… They have been successfully transitioned to the government but… The service is not there."* (Participant P5)

Weakening of Mother and Baby Corners, meant lack of safe spaces for women:

> *"Then this women corner ceased to exist. OK, so there are no more space safe for women where they can come in Belgrade."* (Participant 13)

Participants had mixed views about the transfer of refugee support services to the state, with some suggesting it aided sustainability while also giving excess power to the state.

Sub-theme 5.3. Covid-19

Participants described rapid alterations to perinatal services provision to Afghan women when Covid-19 began, due to simultaneously and rapidly occurring factors. Firstly, there was a sudden swell in numbers within some camps, due to (i) migrants living outside camps being rounded up by police and placed within; and (ii) forcible relocation of refugees between camps leading to severe overcrowding. Secondly, refugees in camps were subject to 24/7 military-enforced quarantine, with NGO access severely curtailed. Thirdly, participants were subject to the same curfews as the public, restricting their ability to travel for work, a period described as "*really chaotic*" (Participant 10).

Due to Covid-19 restrictions, several NGOs adapted to remote phone-based support. Despite being unable to provide in-person activities, some participants recognised that being forced to adjust reaped longer-term benefits:

> *"And that's the kind of silver lining of that period because we... these remote services were… further developed later. And now we have… a designated day to post information useful for parents for mothers, babies and so on."* (Participant 10)

However, making themselves constantly available impacted NGO actors. Several participants described the demands of providing phone-based support any time of day or night, at a time when women needed increased support and participants were also facing Covid-19 challenges.

Another opportunity was identifying women within camps who were trained as focal persons for specific issues (e.g. gender-based violence) and referrals, a Covid-related scheme that continued after lockdowns ended. It was unclear to what extent reorganised activities reached those in need, due to not all women having access to their own mobile phones and questions about the extent to which supplies sent into camps by NGOs were distributed by camp staff to the women for whom they were sent, highlighting tensions between state and non-state actors.

Sub-theme 5.4. Russian invasion of Ukraine

Participants interviewed after the start of the 2022 Ukraine war escalation noted significant impact on the support they could provide. A participant described reproductive health for refugee women in Serbia being deprioritised as the Ukrainian refugee-response was prioritised. Others spoke of staff redeployment to support Ukrainian refugees arriving in Serbia, leaving existing projects with other refugee women understaffed:

> *"…because we are INGO, a lot of our staff are now transferred to the borders with Ukraine. So we are currently under the understaffed yes, so that's, that's how Ukrainian crisis affected us."* (P17)

Sub-theme 5.5. Funding

Reduced project funding due to Covid-19, Ukraine war, and reduced donor interest, alongside short-term funding caused challenges in planning and implementing support, with some insufficiently-funded projects ending. Donor cuts were described as very frustrating, when participants could see positive impacts and struggled to reorganise projects:

> *"Everyone went crazy and we had to reinvent the whole centre in seven days [when funding was cut]. And we were like, 'What are we going to do now? When we, we, we cannot give anything? What, what should we do?'"* (Participant 13)

Nonetheless others remained optimistic that funding would return and closed projects re-start.

Discussion

This study describes experiences and perspectives of clinical and non-clinical actors providing perinatal care and support to forcibly-displaced Afghan women in Serbia. Through analysing these perspectives, we highlighted broader contextual issues for people on the move transiting through Serbia, discussing

political factors, living conditions in camps and informal squats, and challenges of unauthorised border crossings. We highlighted the shifting landscape in which those providing maternity care were operating and the role of non-clinical actors in facilitating Afghan women's use of maternity care. We explored risks to which Afghan women and their infants were exposed when journeying overland. Situating maternity care provision in wider socio-political structures enables connections between its provision and multiple enmeshed local and regional factors.

Engaging a Critical Border Studies lens offered understanding of the nexus between maternity care provision and bordering practices. State policies that regulate and contain maternity care provision within state-run accommodation, as highlighted by participants, constitutes Serbia's migration governance, which responds to asymmetric power relations with the EU. Using externalisation strategies, the EU funds Serbian migration management (EU in Serbia 2021) and deploys FRONTEX (EU border agency) guards at Serbia's borders, enacting extra-territorial bordering practices to attempt a reduction in EU immigration. In turn, Serbia's ambition for EU accession drives enactment of EU migration governance to aid its accession. Therefore, asymmetric macro-level regional relations filter down to migration governance and micro-level day-to-day maternity care provision.

Requiring women to register with authorities and enter (suboptimal) camps to access state-run clinical maternity care serves to contain the maternal body away from EU borders and disrupt onward journeys. This illustrates ways that, "…practices of care are reliant on and engender practices of control..." (Pallister-Wilkins 2022, p.5), that can 'debilitate' rather than 'save' (Pallister-Wilkins 2022). Yet while all forms of state-authorised, camp-based refugee support, including maternity care, is enmeshed with migration governance (Tazzioli and Walters 2019), we also found ways in which some humanitarian actors creatively employed subversive tactics (eg, advocating between women and clinical providers, staying in contact with journeying women by phone, working collaboratively across agencies, providing remote online support during Covid-19 lockdowns) to resist and stretch the boundaries of state border control as an act of solidarity and in response to Afghan women exercising their agency to continue journeying. In this way, these actors tried to mitigate the debilitating effects and 'collateral damage' (Smith *et al*. 2016) of being spatially constrained by migration policies (e.g. providing camp-based support) and not being politically neutral, as Serbian authorities require (Cantat 2020). We do not suggest that these attempts to mitigate the effects of bordering practices removed the risks to which women 'on the move' at Serbia's territorial boundaries were exposed. Mistreatment of migrants at EU borders is well documented. Testimonials of violent pushbacks from EU countries back into Serbia and other border countries are regularly reported by the self-organised Border Violence Monitoring Network (2023b) and evidenced in academic studies (e.g. documenting police violence, damaging mobile phones or tents, stealing money (Augustová and Sapoch 2020, Davies *et al*.

2023)). Deterrence mechanisms at territorial borders result in migrants taking longer, more hazardous journeys to enter Western Europe, often necessitating smugglers and further risks (Crawley *et al*. 2016b, Medzini and Ari 2018).

Funding shortages for NGO-led perinatal health programmes, coupled with *de facto* outlawing of clinical care to those outside camps, limited the role that humanitarian actors could play in providing maternity care and support. Avoiding parallel systems of care in contexts of forced displacement has been advocated as a mechanism for health system preparedness and integration of refugees into mainstream health services (Spiegel 2017). Nonetheless, our findings show how non-clinical actors were vital in facilitating access to clinical maternity care and filling gaps in the underfunded health system by helping women navigate maternity services, bringing to the fore the role of diverse actors and approaches in maternity care. This finding is echoed by Grotti *et al*. (2018b), who found similar 'networks of care' comprising clinicians and state and non-state actors, providing maternity care according to women's varying legal entitlements, when exploring maternity care provision in Southern European transit countries. Similarly, Buch Mejsner *et al*. (2021) noted the trusting relationships developed between migrants staying in Serbian camps and cultural mediators, who played a critical role in supporting migrants' access to healthcare.

The precarity of some participants' work, parallel to the health system yet vital in maternity care provision, was subject to sudden externally-driven changes - often by donors - in response to regional geopolitics. For example, shifts in state and humanitarian project funding, and deployment of staff from existing refugees towards Ukrainian refugees (a trend not unique to Serbia (Redfern 2022)), highlighted uneven perceived deservingness between different people. Widespread criticism of the way non-white bodies were deprioritised by EU member states during the Ukraine response (Bejan and Bogovic 2022, Cénat *et al*. 2022) exemplify these hierarchies of deservingness (Kyriakidou 2021)**.** This further reveals how bordering practices establish exclusionary systems of care, through containment in camps as pre-requite to accessing clinical care, despite Sustainable Development Goal (SDG) 3.8 advocating universal access to reproductive health services (United Nations 2016). Scholars and activists have called for healthcare to be universally available to all migrants, necessitating development of systems, pathways, and funding to translate SDG 3.8 into reality (Abubakar *et al*. 2018, Button *et al*. 2020, Legido-Quigley *et al*. 2019).

In addition to empirical knowledge generation, by putting our findings into dialogue with Critical Border Studies concepts, we offer a theoretical contribution to interpreting the provision of maternity care for forcibly-displaced Afghan women and their infants in Serbia. Whilst our study is highly context-specific, we argue that considering global power relations and structures, and how they engender

bordering practices, provides vital insights into how women and infants on the move fail to receive adequate maternal and newborn care, and are exposed to risks during migration.

Fundamentally, to reduce these risks, both EU and global shifts are needed in the *modus operandi* for Afghans and others seeking sanctuary. While increasing 'safe and legal routes' for forcibly-displaced Afghans seeking EU protection is crucial, these are unlikely to be accessible for all who need to leave Afghanistan (Crisp 2022), so Serbia is likely to remain a transit country for those making state-unauthorised journeys, necessitating continuation of appropriate support. Smaller-scale, local-level changes could better accommodate the maternal and newborn health needs of Afghan women in Serbia. Embedding good practices (eg, birth preparation workshops to help women navigate maternity care, identifying women within camps to act as champions for information dissemination) within all camps will allow more women access this support. Departing from systems of maternity care that privilege immobility (Pallister-Wilkins 2023) will ensure all forcibly displaced women can receive adequate maternity care, in line with SDG 3.8 of achieving Universal Health Coverage for maternal and newborn health (United Nations 2016).

We recognise the limitations of this study. Recruitment of health-workers providing direct maternity care for Afghan women was challenging – inclusion of more health-workers would have provided a wider range of perspectives. Few follow-up interviews were conducted due to many participants leaving their jobs, further to which we lost contact with them. This limited data on how experiences of providing perinatal care varied during events that occurred during data collection (eg, Covid-19, Taliban takeover of Afghanistan, Ukraine war). We built greater trust among participants recruited in person, and these interviews yielded richer data. Conversely, some participants recruited and interviewed remotely were noticeably wary and offered fewer personal opinions. Finally, and most importantly, although perspectives offered by these participants are valuable, and have generated important knowledge, future (planned) studies must explore Afghan women's perspectives.

We showed ways in which bordering practices at and beyond territorial boundaries interfere with provision of perinatal care and support. Although clinical and non-clinical staff supporting Afghan women in Serbia did not directly engage with bordering practices, they operated within the constraints of bordering, implemented because of asymmetrical regional power relations. Yet they manoeuvred, within limitations, to stretch the limits of state-imposed constraints. Collisions of bordering practices with provision of maternal and newborn healthcare, and the exclusionary implications for women in the perinatal period, are not unique to Serbia. However, few attempts have been made to understand how geopolitical power relations are enmeshed with its provision. Forced mobility must not translate into sub-optimal and exclusionary systems of care.

CHAPTER 7- "WHEN A STORY GETS A FACE…": VISUAL ELICITATION OF SERBIAN PERSPECTIVES ON AFGHAN REFUGEE WOMEN'S MATERNITY EXPERIENCES IN SERBIA

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Primary Supervisor	Dr. Diane Duclos		

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RESEARCH ARTICLE

"When a story gets a face. . .": Visual elicitation of Serbian perspectives on Afghan refugee women's maternity experiences in Serbia

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Abstract

Serbia is a country through which many Afghans pass, en route to the European Union. Pregnancy and birth continues for Afghan women while journeying. This study aims to examine the understanding and attitudes of Serbian health professionals and members of women's civil society organisations (CS0) about the perinatal experiences of Afghan women in Serbia, using a webcomic to elicit responses. A total of 38 respondents completed the questionnaire, including health professionals (n = 10), women's CSO members (n = 6), and others (n = 10). The majority had little awareness of the experiences of Afghan women around the childbearing time and for most respondents, viewing the webcomic raised their awareness. Qualitative questionnaire data were analysed thematically, and four inductive themes developed: (1) maternal health provision as inadequate; (2) Afghan women face difficulties in Serbia; (3) solidarity with Afghan women; and (4) the webcomic raises awareness. Webcomics, as a visual modality, may play a valuable role in increasing empathy and awareness of refugee women's perinatal experiences among citizens.

Introduction

In the 1990s, approximately 2.3 million refugees fled the former Yugoslav countries, seeking sanctuary in Western Europe, prompting suggestions that Europe was experiencing a refugee crisis [1]. Since 2015, the former Yugoslav countries (hereon in referred to as Western Balkan countries), have been on the receiving end during the recent so-called 'migrant crisis' (a term deserving of critique, see Almustafa [2]). Among all Western Balkans countries, Serbia hosted the largest number of migrants and refugees in 2022 [3]. However, refugees in Serbia do not generally view Serbia as a country in which to seek international protection on a long-term basis, but rather a country through which they transit to reach the European Union (EU) Schengen Zone. Afghans have consistently comprised one of the largest groups of migrant and refugee populations [3].

Reasons for Afghans' migration to Western Europe are longstanding and multifactorial. Afghans have a history of migration for trading, agriculture, and military reasons [4], resulting

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Introduction

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Reasons for Afghans' migration to Western Europe are longstanding and multifactorial. Afghans have a history of migration for trading, agriculture, and military reasons (Hanifi 2000), resulting in global networks, fostering and facilitating further migration for family and network (re)unification (Monsutti 2010, Saidi 2017). Over the past fifty years, conflict in Afghanistan has exacerbated migration, with an estimated total of 2.4 million Afghan refugees registered with UNHCR at the end of 2021 (UNHCR 2023c). For the purpose of this paper, we use the term 'refugee' to mean, **"…** people who have fled war, violence, conflict or persecution and have crossed an international border to find safety in another country**"** (UNHCR 2023a).

Legal routes to safety within the EU have been, and continue to be, very limited. For that reason, many Afghans have no choice but to seek international protection in the EU by travelling there irregularly by overland routes. These journeys, known colloquially as 'the game', are typically staged and protracted, using smugglers to assist with travelling (Vještica and Dragojević 2019). The risks associated with 'the game' are high and gendered. Women who travel with smugglers are at risk of sexual exploitation, trafficking, and gender-based violence (Ivnik 2017). Western Balkan countries are a common route for Afghans travelling overland. The situation for refugees passing through Serbia has been variable since 2015, with previously *de facto* open borders to the EU now closed, resulting in refugees becoming 'stranded' in Serbia, and having to take greater risks to enter the EU. State-run accommodation (informally referred to as 'camps') is provided for those choosing to register with authorities on arrival in Serbia. Those choosing not to, live instead in informal squats or tents. Access to free emergency health care, including maternity care, is available to those in state accommodation, while healthcare for those living outside camps is restricted by the state to emergency treatment only.

Despite media portrayals of Afghan refugees entering the EU being young men, significant numbers of Afghan women have travelled overland through Western Balkan countries. Exact numbers are not known, due to UNHCR failing to collect adequate sex-disaggregated data. However, it is estimated that women and children make up 55% of all categories of migrants entering Europe, with 10% already pregnant (World Health Organization Regional Office for Europe 2018). Migration is transformative for women. A growing body of migration research recognises women as independent actors in migration and yet insufficient data results in their invisibility (and in relation to this study, erasure of maternal health needs) in policy responses (Freedman 2016b, Gasper and Truong 2014, Kraly 2018).

The lived maternity experiences for refugees on the move, that is women who are transiting from one country to another, no matter how protracted that movement may be, is under-researched (Sharma *et al*. 2020). Most of this research has focussed on women in refugee camps (Furuta and Mori 2008, Kituku *et al*. 2022, Lalla *et al*. 2020).

This study is part of wider research exploring the perinatal experiences of Afghan women on the move in and through Serbia, and the experiences of various actors in Serbia supporting Afghan women during the perinatal period. This study aimed to understand the awareness and attitudes of Serbian health professionals and members of women's civil society organisations about the perinatal experiences of Afghan women in Serbia, using a webcomic to elicit responses.

Methods

Study design

We conducted a visual-elicitation study, using a co-produced webcomic as a medium through which to elicit responses to an online survey. Visual elicitation is a widely-used creative method for stimulating interview responses in qualitative research, with photographs the most common. Bagnoli argues that including the visual elements in research "which rely on other expressive possibilities, may allow us to access and represent different levels of experience." (Bagnoli 2009, p.547).

Our research question was: "What are the awareness and attitudes of Serbian health professionals and members of women's civil society organisations about the perinatal experiences of Afghan women in Serbia?"

Webcomic

Purpose of the elicitation tool

Webcomics use dual forms of text and visualisation and unlike written narratives, are textually light. This, combined with their formation as a series of frames, causes readers to become active agents, using their imagination to fill gaps and between text and frames, thus drawing readers to creating their own meanings (Chute 2008). The power of webcomics is their use of informal language, relatability, and accessibility (de Rothewelle 2019), which are well-suited to communicating stories of human experience and phenomena (Galman 2009). They can aid communication of difficult topics - Chute notes that, "*Comics can express life stories, especially traumatic ones, powerfully because it makes literal the presence of the past by disrupting spatial and temporal conventions to overlay or palimpsest past and present*" (Chute 2011, p.109).

Theoretical stance

We took a decolonial feminist approach to visualisation of participants' lived experiences in the webcomic, seeking to centre participant voices, "… to recognize their [women of the "Global South"] sacrifices, honour their lives in all their complexity, the risks they took and the difficulties and frustrations they experienced…" (Vergès 2021, p.10). Additionally, centring participants' voices in the webcomic challenges the visual tropes of non-white refugee women: the suffering body, passive victim, primitive 'other,' and breeding machine, as can be instrumentalised by the media and humanitarian organisations (Calain 2013, Krstić 2022, Smith 2017). To this end, we planned to co-produce the graphic with interview participants, employing participatory research approaches for those with lived experiences, to shape it according to what *they* perceived as important in this visual re-telling of shared experiences, and to ensure it accurately reflected *their* collective experiences (Pittaway *et al*. 2010). In addition to participation, co-production embodies collaboration, power sharing and equality (Co-Production Collective 2020). However, conducting remote co-production during the Covid-19 pandemic with a group of highly mobile participants living in precarity, and already disproportionately affected by Covid-19, was challenging and we had lower engagement than anticipated. Participating in co-production can be burdensome, even more so when it involves recollecting painful memories (Pittaway *et al*. 2010), so we were cautious not to unduly pressure interview participants to join this additional research.

Co-production and testing

We developed the webcomic over a one-year period. Data generated during 'field' visits to Serbia and interviews informed webcomic development. ES visited the spaces occupied by Afghan women, had informal conversations with Afghan women, in addition to non-governmental organisation (NGO) and state actors, and health professionals, working with Afghan women. She conducted narrative interviews with 11 Afghan women, face-to-face or remotely, to explore their experiences of pregnancy or birth in Serbia, with the assistance of a translator. Narrative interviews were employed as they enable participants to actively reconstruct their experiences, providing an insight into meaning-making in the context of displacement (Eastmond 2007, Smith 2017). A topic guide was developed as an aide memoire, starting with a broad opening question, "Can you tell me what it was like to be pregnant or give birth in Serbia?" but conversation was guided by participants as far as possible. Participation was anonymous and confidential. All participants gave informed consent after a full discussion about involvement and received a small token of appreciation.

Afghan women who had been interviewed were invited to join co-production of the webcomic. Five of 11 interview participants consented. We developed a composite narrative, based on preliminary analysis of narrative interviews, and common threads running through interview participants' collective experiences. Following script development, we engaged an artist to create images for the webcomic based on the script and a set of reference photographs. The artist developed an initial set of images for the central character, "Zohra" and then a draft version of the webcomic. Care was taken throughout creation of images to ensure they would have meaning across cultures. The draft webcomic was translated into Dari (the most widely-spoken language in Afghanistan) and sent to the five women participating in the co-production, with a set of specific questions about their overall impression of the webcomic, its storyline and Zohra's appearance.

Participants were asked to comment, either by text or voice message, including suggestions about any aspect of the webcomic and offered an opportunity for additional debrief afterwards if they wished. Some women included emotional responses to viewing the draft webcomic; "*Very wonderful and painful"* and "*Zohra has many problems in this story, which I have experienced them all!*". Their feedback confirmed that the artist had appropriately depicted Zohra's appearance. For example, one woman commented on Zohra's traditional clothing, "*In my opinion, the dress that Zohra is wearing is appropriate in the [refugee] camp because I used to wear the same dress in many camps in Serbia, there is no security for women and children.*" On overall layout, women indicated there was a lack of flow between images and the text, which prompted a rearrangement to ensure that the webcomic

flowed for those reading it either from right to left or left to right in any of the three languages in which it was produced. Additional practical layout considerations improved ease of readability on mobile devices.

Once alterations were made, the finalised English and Dari drafts were sent to participants for checking. The final English version was then translated into Serbian (Fig 9).

Figure 9 Example webcomic frames in Dari, English and Serbian

NB: The webcomic can be viewed in all three languages at https://birthingontheway.wixsite.com/project/webcomic-english

Online survey

Tool development

An online descriptive exploratory survey was chosen as data collection method, including both closed- and open-ended questions, developed from existing literature on refugee women's perinatal experiences (Fricker 2008), knowledge of the Serbian maternity and health care system and preliminary analysis of field observations, conducted as part of the wider study. Firstly, this method offered the advantages of being able to capture the views and opinions of a large sample in a shortened time period. Secondly, it provided fewer barriers to participation by taking less time to participate than an interview, plus guaranteeing anonymity. Finally, it enabled us to contact health professionals

remotely by email or phone messaging, in a context in which it was difficult to gain physical access to them in health facilities or recruit their participation in research.

The survey was developed in English and translated professionally into Serbian. Survey questions used Likert-scales and free text. Respondents were first asked to rank seven aspects of maternity care (i.e. provision of interpreters, respectful maternity care, information about how to access maternity care, regular antenatal checks, choices about what happens during labour and birth, support with breastfeeding, screening for mental health problems), from 1 (not at all important) to 10 (extremely important). The remaining free-text questions focused on: (1) participant awareness of Afghan women's experiences in Serbia around the childbearing time, pre- and post-webcomic viewing; (2) surprising and unsurprising aspects of Afghan women's experiences as depicted on the webcomic; and (3) opinions on the importance of Serbian maternal health providers understanding of these experiences.

Participant sampling and recruitment

We used a mix of purposive and convenience sampling, given the sampling constraints of online surveys (Fricker 2008). We invited two groups of potential participants in Serbia to complete the survey, between 12 September and 31 October 2022: Serbian health professionals and Serbian women's civil society organisations (CSOs). The rationale for selecting these two groups was due to their common interest in issues pertaining to maternity care in Serbia, whether from a professional or service user perspective. RL-S contacted Serbian health professionals directly to describe the study and provide the link to webcomic and survey, while ES emailed Serbian women's CSOs requesting they distribute the link among their networks.

Data collection

We collected data by hosting the survey on Online Surveys (Jisc 2023), a secure web platform. We included a participant information sheet and consent form on the questionnaire landing page, requiring all participants to give informed consent before participation. Participants were then asked to view the webcomic prior to completing the 30-minute survey. Open-ended responses were professionally translated into English for analysis. None of the authors had access to information that could identify individual participants during or after data collection.

Analysis

ES analysed data from closed-ended questions descriptively, estimating frequencies and cross-tabulations using Excel. ES imported translated qualitative responses to NVivo v.12 (QSR International 2020) and analysed them as a whole, rather than individually, to develop themes holistically. We used reflexive thematic analysis, as described by Braun and Clarke (2022). This involved re-reading of responses for data familiarisation, initial data coding, searching for and reviewing themes from the codes, and finally refining and naming them. Both responses to questions and the ways the webcomic elicited responses were analysed.

Ethics

Research ethics committees at the London School of Hygiene and Tropical Medicine (reference 22641 - 1) and University of Belgrade in Serbia (reference 1322/II-7) provided ethical approval. Informed consent was obtained from all participants using an online consent form which was embedded into the online questionnaire.

Results

Participant characteristics

Table 1 categorises the 38 individuals who viewed the webcomic and completed the online survey. Most were health professionals (22). Of 10 identifying as 'other', one stated they were a woman's worker, another a mother, and the remainder did not indicate a professional identity. Six participants indicated they were from a woman's CSO.

Table 4 Categorisation of online questionnaire participants

Respondent type	Total
Health professional	22 (58%)
Other	10 (26%)
Woman's CSO member	6 (16%)

Descriptive statistics

Most (27; 71%) described themselves as having no or little awareness of the experiences of Afghan women around the childbearing time, prior to viewing the webcomic, and the majority (31; 82%) said

their awareness had increased quite a lot or a lot. Just over half of the respondents (20; 53%) thought that it is very important that maternal health providers understand the experiences of Afghan women around the childbearing time, with all others except one stating that it is quite important for Serbian maternal health providers to understand these experiences (17; 45%).

All except two respondents ranked all seven aspects of maternity care at 6 of 10, or above, suggesting these participants considered all aspects listed in the questionnaire as important. Respectful maternity care ranked highest overall, with a mean of 8.2 out of 10, with screening for mental health problems and support with breastfeeding were both ranked lowest, with a mean of 6.3. The results are summarised in Table 2.

Table 5 Rankings of importance of aspects of maternity care

Aspect of maternity care	**Mean rank (out of 10)**
Respectful maternity care	8.2
Regular antenatal care	7.4
Provision of interpreters	7.4
Information about how to access maternity care	7.1
Choices about what happens during labour and birth	6.8
Screening for mental health problems	6.3
Support with breastfeeding	6.3

Analytical themes

Thematic analysis identified four inductive themes: (1) maternal healthcare provision as inadequate; (2) Afghan women face difficulties in Serbia; (3) solidarity with Afghan women; and (4) the webcomic raises awareness.

Maternal healthcare provision as inadequate

Overall, respondents across categories described maternal health provision in Serbia for Afghan women as inadequate. The health system itself, language barriers, treatment of women by medical staff and poor postnatal care were commonly cited examples. Several respondents indicated that the Serbian health system was not organised to adequately accommodate the needs of refugee women.

> *"Our healthcare system is not adapted to any foreign women, not just women in this situation*

who are particularly and additionally vulnerable." (Serbian CSO member)

There was also surprise expressed that women were able to access the healthcare system at all. For example, in response to a question, "When you read the webcomic, what surprised you most about the experiences of Afghan women in Serbia during the childbearing time?", one respondent answered, "*That they even have medical care*." (respondent identifying as 'other').

Language barriers were perceived by many as particularly challenge for Afghan women. Being able to communicate with health professionals was considered by respondents as enabling women to understand what was happening to them, as well as a "*surmountable*" challenge, through the routine use of interpreters.

> *"I suppose the language barrier is the biggest challenge. It would be a lot easier for them if they could communicate with the healthcare workers who are helping them."* (health professional)

In the webcomic, the main character, Zohra, describes how she was alone when she gave birth, and her worries and sadness that her baby was removed from her after birth, being brought to her three to four times throughout the day for feeding. An image is shown of a health professional placing the baby in a cot in a nursery, away from Zohra. Several participants commented on the attitudes of health professionals to women and disrespect during childbirth, not only for Afghan women, but for Serbian women as well. A woman's worker commented on the webcomic saying, "*The doctors seemed nice! Apart from a few exceptions, they are never nice.*" (woman's worker). This was illustrated further by another respondent:

> *"Serbian doctors often don't communicate with Serbian pregnant women, new mothers and women who have undergone gynaecological surgery of some sort either. Many of us have some kind of trauma because of that (among other things). We expect information but we don't get it. I cannot imagine what it's like for women who can't even expect information and what trauma they have because of that."* (Serbian CSO member)

Responses such as these were not limited to those outside the health system. Health professionals themselves commented on the attitudes of their colleagues, for example:

> *"I suppose I should've been surprised by the medical staff's behaviour, unfortunately I wasn't."* (health professional)

However, some health professionals acknowledged the inadequacy of the situation and expressed hope that it would change, and a need for greater awareness of the topic. For example:

> "*I'm very sorry about the current situation and I hope it will change soon. Every woman deserves to be treated humanely, both during pregnancy and after childbirth. Anything other than that is a defeat of the entire society and a disgrace for all of us. Thank you for educating me on this subject, I wasn't even aware of how unfamiliar I was with what these women go through*." (health professional)

In terms of maternal health care itself, several respondents said that they thought the care for Afghan women was no different to that of Serbian women, specifically citing a lack of decision-making in childbirth, lack of postnatal care for women, including little breastfeeding support, and insufficient attention paid to maternal mental health. This is exemplified in the following quote:

> *"A big problem is the fact that new mothers have no choice or options during and after labour because others decide for them (in what position they will give birth, whether they will use medicines or some other pain relieving methods, whether they will be with their child and breastfeed it or if they will give it formula, how and when the umbilical cord will be cut, whether the baby will be given a bath immediately or if it will have skin-to-skin contact and first breastfeeding..."* (respondent identifying as 'other').

Afghan women face difficulties in Serbia

Respondents frequently commented on the difficulties for Afghan women in Serbia, notably perceptions of poor living conditions, material hardship, and challenges being in a country away from home. Respondents commented on poor living conditions as being inadequate for pregnant women, or mothers with children, also citing unsanitary conditions and risks of abuse of women.

> *"The conditions in camps are equally bad for a new mother and for raising children."* (health professional)

Connected with poor living conditions was Afghan women's material hardship and poverty, the latter of which one respondent said *"… saddened me the most." (health professional)*. Other respondents highlighted the lack of basic necessities available to Afghan women, such as nappies, clothes, and food, or the money to purchase these items, with suggestions that items like these should be provided for mothers and their infants in the form of "*packages*" or "*funds*".

Being away from home and family was perceived by many as a source of stress for Afghan women in Serbia, with some commenting on the challenges of dealing with pregnancy and motherhood alone.

> *"I believe that pregnancy and birth are much more stressful for them than for women who give birth in their own homeland."* (respondent identifying as 'other')

One respondent compared his experience of becoming a parent in Serbia with women giving birth away from home:

> *"The fact that I'm a father of four means that I know what childbirth means even in ideal conditions, on the one hand, and on the other hand facing the possibility of a pregnant woman finding herself in a foreign environment, without a home, without help, without knowing the language... "* (health professional)

These difficulties and hardships were largely viewed as situations which Afghan women should not have to face and were concerning for many respondents, whilst some also recognised women's agency:

> "*Kudos to them for daring to have children as refugees, without a home and people they know!*" (women's worker)

Solidarity with Afghan women

The theme of solidarity with Afghan was expressed through respondents' personal experiences of interacting with Afghan women during the childbearing time, or through their desire to be able to provide assistance, *"... because they are people, like us*" (respondent identifying as 'other'). Another respondent expressed solidarity as:

> *"...a sense of belonging regardless of different cultures, religions etc. should be nurtured*." (health professional)

In a vivid account of sharing a room with an Afghan woman after giving birth, a respondent described how she helped the woman during her hospital stay:

> *"... I gave her painkiller suppositories, diapers, everything I had. She hugged me when I was leaving, I have a different view of the situation after that experience. I put myself in her shoes, I don't know whether I'd be able to handle it. I remember, when I gave her the suppositories, the nurses pushed her onto the bed and applied the suppository in front of the whole room because they couldn't explain to her how it was applied." (*Serbian CSO member*)*

Shared humanity, a desire for Afghan women to receive their rights in Serbia and expressions of wanting to help were common expressions of solidarity.

The webcomic raises awareness

As mentioned, most respondents had little or no prior awareness of the experiences of Afghan women in Serbia around the childbearing time. However, several commented on how the webcomic increased their awareness of this matter, and its specific value as a mode of communication that enabled them to gain understanding of the key issues:

> *"The comic is attention-grabbing and puts us in a real situation where we empathise with the actors, in this case Afghan women in a difficult position in life. The comic has largely helped to raise my awareness."* (health professional)

Another respondent commented on a particular aspect of the webcomic which made it relatable:

> *"There already was some awareness of the problems of refugees but when a story gets a face, a first and last name, then it's no longer a problem someone somewhere is facing, rather it becomes a tangible thing and makes you think."* (health professional)

For some health professionals, this increased awareness enabled them to have a better understanding of the issues facing Afghan women around the childbearing period, linking this increased understanding with being able to provide improved care. For example:

> *"To help a patient, you must understand and empathise with them. How can you provide empathy and understanding, support, if you don't even know what the patient is going through?"* (health professional).

Discussion

These findings highlight firstly, the value of raising awareness about Afghan refugee women's perinatal experiences and that secondly, a webcomic can be an effective medium to elicit responses to a questionnaire to understand respondents' perceptions, attitudes, and opinions. Among 38 respondents, existing awareness of the situation for Afghan women in Serbia during the perinatal period was explored, along with the extent to which the webcomic altered this awareness, aspects of the webcomic which were surprising and unsurprising, perceived challenges for Afghan women in Serbia, and the importance of various aspects of maternal health care. Overall, the webcomic can be

seen to raise awareness of the childbirth and maternity experiences of Afghan women 'on the move' among its viewers, who also reported their previous awareness to be limited. Respondents particularly commented on the inadequacy of the maternal health care for Afghan women (but also Serbian women), the difficulties faced by Afghan women in Serbia, the lack of material provision for them, but also expressed solidarity with them.

The findings of this study, with respect to quality of maternal health care in Serbia, corresponds with other studies which have explored Serbian women's experiences of utilising maternity care. Lack of communication and informed consent during childbirth, for Serbian women using public maternity services, were identified in several studies, as was being without a companion during birth (Arsenijevic *et al*. 2014, Stankovic 2017). This points to a service in which respectful maternity care is not prioritised. Respectful maternity care is an essential element of quality maternity care and includes the tenets of the individual's right to dignity and respect, information and choice, in addition to evidence-based clinical care (Jolivet *et al*. 2021). To date, there is a dearth of literature pertaining specifically to maternity experiences for refugee women in Serbia. However, the health service overall is an under-funded post-socialist health service which was not set up to respond to the needs of migrants and refugees (Bjegovic-Mikanovic *et al*. 2019, Buch Mejsner *et al*. 2021). Some maternity service users engage with private care providers, enabling them to have a known caregiver and preferential treatment (Pantović 2022a), but this requires sufficient financial means to pay for such a service, restricting this as an option for many refugees.

Breastfeeding is more commonplace among women in Afghanistan than women in Serbia. Data show that women 58% of women in Afghanistan (in 2015) were exclusively breastfeeding their infants by six months of age, compared with 13% of women in Serbia (in 2014) (The World Bank 2022). The World Health Organization guidelines on promoting breastfeeding within maternity facilities recommends rooming-in and demand feeding, in order to aid the establishment of breastfeeding (World Health Organization 2017a). This is further highlighted in the guidance for infant feeding in emergencies (Emergency Nutrition Network 2017) in recognition of the fact that breastfeeding is particularly important in situations where there is lack of access to safe conditions for the preparation of formula milk (Gribble and Berry 2011), as can be the case in refugee camps. However, practices on postnatal wards in Serbia are not universally supportive of breastfeeding (Matejić *et al*. 2014, Pantović 2022b). For example, separating mother and baby during the initial postnatal period is at odds with rooming-in (keeping the mother and baby together to promote breastfeeding), and the common enforcement by health professionals of timed or restrictive breastfeeding, which can hinder a mother's milk supply, are commonplace on postnatal wards (Pantović 2022b).

There is an urgent need for further research exploring the maternity experiences for all women in Serbia, as well as research focussed on the specific needs of refugee women, in order for systems fostering respectful, women-centred high-quality care to be developed. In Serbia, a medical-led, technocratic model of birth is followed (Pantović 2022a). That is, a philosophy of care viewing the birth process as a medicalised production line rather than a holistic process in which women are decision makers in their care (Davis-Floyd 2001). Midwifery care is widely recognised as an essential component of the provision of quality maternal and newborn health care (Renfrew *et al*. 2014, UNFPA 2021). A state-level investment midwifery education and incorporation of midwives into the Serbian health system could therefore play a pivotal role in improving quality of care for women using Serbian maternity services.

Solidarity towards Afghan women on from Serbian women on postnatal wards through the sharing of clothes and nappies was depicted in the webcomic. At a basic level, solidarity can be thought of as "… *an agreement of feeling or action*" (Oxford Languages 2022). Solidarity with Afghan women was invoked by questionnaire respondents in pragmatic terms - actions which can be taken to improve the situation for Afghan women in Serbia around the time of childbirth, and social terms and the shared humanity between refugees and citizens (Siapera 2019). This solidarity is important to recognise in a context when there is an increasing anti-migrant sentiment in Serbia, contrasting with the Serbian state's desire to portray Serbia as welcoming to refugees, during the so-called 'migrant crisis' of 2015-16 (Petrović and Ignjatijević 2022). One of the recommendations of a report which highlights the growth of far-right anti-immigrant sentiment and groups in Serbia, is the media's role in accurate reporting of issues facing refugees and migrants, including talking to the migrants and refugees themselves, as a means of countering disinformation and fear mongering among Serbian citizens (Petrović and Ignjatijević 2022). With this in mind, webcomics may have a role in countering anti-migrant narratives.

As discussed earlier, webcomics, combining the visual with the textual, are well-suited to communicate challenging and traumatic subject matters (de Rothewelle 2019). They can "… offer a window into the subjective realities…" of others' lived experiences, providing an alternative means of relatedness, exploration and connection on an emotional level, with complex topics (Williams 2012, p.5), and are a vehicle to creating an emotional connection between the narrative and viewer. It cannot be assumed that one short webcomic can fully encapsulate the wide-ranging experiences of Afghan refugee women who are pregnant or give birth while on the way through Serbia. Nonetheless, this study suggests that it is an advantageous approach to disseminating and giving visibility to Afghan women's experiences in a format that engages a wider audience – in this case Serbian health professionals and

members of women's CSO's. In this study, many Serbian health professionals recognised a greater need for awareness of the issues facing Afghan refugee women in the perinatal period and noted that the webcomic provided them with a greater understanding of these issues. Webcomics can be valuable in the education of healthcare professionals, acting as a powerful modality for conveying the lived experience of others (de Rothewelle 2019, Williams 2012). Further research could explore the use of webcomics as a tool for training health professionals in providing care to refugees.

Limitations

This study was conducted in a relatively short period, thus limiting the number of responses obtained. The reasons for this were practical and budgetary, but a larger number of respondents would have provided more data and potentially more perspectives for consideration. Due to the questionnaire being self-administered, it is possible that respondents were those interested enough to complete the questionnaire having viewed the webcomic, thus introducing sampling bias. Finally, only six of respondents self-identified as being a member of a woman's organisation versus 22 being health professionals. Engaging with more women's organisations may have increased the proportion of respondents from this group.

Conclusion

Among the respondents of this study, there was little previous awareness of the experiences of Afghan women travelling through Serbia around the childbearing time. The webcomic was a valuable modality in bringing Afghan women's experiences perinatal experiences to light. Whilst webcomics do not address the structural realities that cause refugee women to find themselves in these situations in the first instance, they may play a role in fostering solidary among Serbians and increasing awareness and empathetic care among health professionals.

CHAPTER 8 - DISCUSSION

Introduction

Having presented the findings of this research study in the preceding chapters, this section considers these findings and the study's strengths, limitations, and challenges as a whole, in addition to making recommendations from this research.

Findings related to my research questions

Understanding Afghan women's childbearing experiences from their own perspectives is vital in understanding the factors shaping these experiences, what is important to them, and how best to provide quality maternal and newborn health that ensures their physical and emotional wellbeing. My thesis provides a significant original contribution to the literature on the perinatal experiences of Afghan women in Serbia from multilayered and nuanced perspectives. Although this study's findings are highly context-specific, they are valuable in extending and contributing to firstly, the overall discourse on perinatal experiences of subaltern, forcibly displaced women, including those on the move, and secondly, understandings of maternal and newborn health needs and provision for women in transit contexts. In this section, I consolidate my study findings, and relate them to my research questions.

I started the exploration of my research aim - to explore the lived experiences of Afghan women in Serbia during the perinatal period - with a focus on understanding their interactions with, and the provision of, maternity care, by situating the study in the existing empirical evidence, in Chapter 3. By conducting a scoping review of forced migrant women's perinatal experiences, I showed how intersecting structural factors create multiple liminalities resulting in a loss of control and powerlessness and loss of existing support mechanisms (Sharma *et al*. 2020). I highlighted the important role that maternal health providers could play in vital support for women, also drawing attention to culturally sensitive, compassionate, and respectful maternal health care (including the provision of appropriate interpreters) as being particularly important for forcibly displaced women (Sharma *et al*. 2020).

In Chapter 4 I explored the migratory circumstances experienced by perinatal Afghan women travelling through Serbia. Weaving together multiple methods, I foregrounded how securitarian logics of border enforcement both at, and within, Serbia's territorial boundaries work to reproduce suffering and violence for childbearing Afghan women yet showed Afghan women's resistance to harmful deterrence measures, as they continued journeying to seek international protection in Western Europe.

I then focussed on the narratives of Afghan women in Chapter 5, privileging their accounts to understand their experiences of the perinatal period and maternity care in Serbia. Here, I showed that perinatal experiences are deeply embedded within migratory experiences, and discussed the dual harms to Afghan women in Serbia of structural violence and obstetric violence, and the benefits afforded by motherhood that some women experienced.

In Chapter 6 I examined the perspectives of clinical and non-clinical actors providing perinatal care and support to Afghan women. Here I demonstrated the challenges in providing perinatal care to highly mobile Afghan women and state interference in this provision as an overspill of regional geopolitical influence on Serbia's migration governance, but also the important role that actors beyond clinical maternity care providers played in supporting maternal and newborn health needs (Sharma *et al*. 2024a). Following on, in Chapter 7, I also explored Serbian health professionals' and women's civil society group members' awareness about, and attitudes towards, childbearing Afghan women in Serbia, through eliciting questionnaire responses through a webcomic, showing respondents' perceptions of maternity care for Afghan women as inadequate (Sharma *et al*. 2024b).

Bringing together my study findings reveals ways in which women's perinatal experiences are entangled with, but not entirely constrained by, intersecting structural factors, with colonial origins. Geopolitics, that is, examining "how politics and geography intersect to make the world the way it is" (Flint and Mamadouh 2015, p.2) at a regional EU level trickle down through mechanisms of migration governance to ultimately, through deliberate harm and indirect neglect, marginalise, exclude, and render invisible childbearing Afghan women passing through Serbia. Scholars examining these gendered impacts of geopolitics on mobility have argued that borders reveal ways in which geopolitics acts on the body, and that embodied accounts reveal the harms and strategies experienced and enacted by displaced women (Bagelman and Gitome 2021, Hyndman 2004, 2019, Mountz 2011).

Maintaining 'Europe's way of life' (Foret and Trino 2023) and taking a stance that is 'tough on migration' (Vela 2024) continues to dominate EU political agendas. As such, the EU enacts increasingly stringent measures to deter the arrival of unwanted people from its borders, while simultaneously extending hospitality (albeit bounded) to those deemed desirable, such as certain skilled workers, or deserving, as seen in the Ukraine war response. By taking the position of migration as exceptional, going to great lengths to protect its borders, and reinforcing its superiority in deciding who may or may not traverse its boundaries (Allen *et al*. 2018), the EU overlooks its own histories of colonialism, predicated upon financial gains at the expense of the Global South and forced (im)mobility of colonised peoples (Davies and Isakjee 2019, Lemberg-Pedersen *et al*. 2022). People seeking international protection from the Global South are largely considered to be undesirable and undeserving of safe and legal passage to the

EU and hospitality on arrival - in this way bordering practices extend colonial legacies by functioning on racialised logics (Isakjee *et al*. 2020). The perceived threat of EU immigration has led to securitisation and externalisation of EU borders, in spatially distant geographies, as well as at its peripheries, including in Serbia. Concomitant with Serbia's aims for EU accession is the asymmetric power imbalance between the EU and Serbia. This enables the EU to enact bordering practices at and within Serbia's borders, fuelled also by an internal nationalist sentiment in Serbia. These bordering practices exact harms to Afghan pregnant women and their newborn , directly during pushbacks from EU borders at the hands of border police and indirectly by denying them modes of travel that protects their perinatal physical and mental health. Unable to take safe routes, Afghan women in this study engaged with smugglers to assist them with travel, necessitating risks to themselves or their infants. Furthermore, some were forced to take long, circuitous routes, often on foot, that took a physical toll on their pregnant bodies, as well as an emotional toll from the chronic uncertainty associated with lengthy journeys. This is discussed by Tazzioli (2020) who argues that mobility should not only be thought of as a freedom, but is as much a strategy of migration governance as containment, forcing people to take erratic and convoluted routes to stymie movement. Border violence has been widely evidenced (Lindberg 2024), and this study extends the evidence of border violence to that experienced by pregnant women or women travelling with a newborn. These harms, to which the EU turns a blind eye, reveal how bodies of perinatal Afghan women and their newborns are considered disposable 'collateral damage' resulting from the securitised border regime (Smith *et al*. 2016).

In addition to border violence, exclusionary policies that restricted formal refugee support and access to free routine maternal healthcare (pathways to which are summarised in Figure 10) to women contained within sub-standard camps are also contributory factors that significantly shaped Afghan women's perinatal experiences in Serbia. De-prioritisation and funding cuts led to a reduction in specific NGO programming around reproductive, maternal and newborn health, for women in camps. The Serbian state curtailed access to maternal and newborn healthcare and support for Afghan women staying outside camps to continue their journey, by *de facto* outlawing NGO healthcare provision and limiting access to free public health facilities to emergency care only. Some Afghan women known to participants gave birth with no maternity care at all. This constitutes a failure to provide Afghan women with Universal Health Coverage, as per Sustainable Development Goal 3.8 (United Nations 2016), effectively penalising them for onward mobility by rendering them undeserving of vital maternal healthcare and support. Meanwhile, those without funds to travel rapidly through Serbia had their journeys decelerated by being forced to reside in state-run camps in order to be considered sufficiently 'deserving' by the state of access to public routine maternity care. These camps were largely sub-standard for childbearing women – overcrowding, inadequate nutritional provision,

unsanitary conditions, and a lack of safety for women and girl adversely impacted women's physical and mental health. Moreover, the ostensible closure of mother and baby corners when they were handed over to the state left women deprived of postnatal care, breastfeeding support, and inadequate access to formula milk and its safe preparation. The physicality of pregnancy enmeshed with the policies restricting access to maternal and newborn health care led to most Afghan women in this study self-accommodating in camps, for at least the immediate period around birth, resulting in a temporary 'stuckness': an "immobility within mobility" (Chemlali 2024, p.15). Systems of healthcare provision that render people on the move immobile, when mobility is equated with life (Pallister-Wilkins 2018), and state restrictions enforcing camp-only based refugee support, forms part of a wider discourse in which scholars have revealed how humanitarianism serves to govern mobility, making visible the connections between care and control (Horst and Nur 2016; Pallister-Wilkins 2018; Sahraoui 2020). In this study, congruent with findings from Horst and Nur (2016), it was the state-imposed system of perinatal care and support for Afghan women in Serbia that simultaneously rendered women immobile, rather than individual actors, who in some cases clearly resisted the boundaries enforced upon then by providing care and support during mobility. Indeed, a range of actors played an important role in facilitating Afghan women's access maternity care, although within a constrained environment. The perinatal mental health impacts of both mobility though Serbia and immobility within camps was evident from the accounts of Afghan women and yet specific programming to address this was not identified in informant interviews or observations, revealing a lack of measures addressing perinatal mental health conditions through screening or targeted interventions (although generalised psycho-social support for women was provided by some NGO actors).

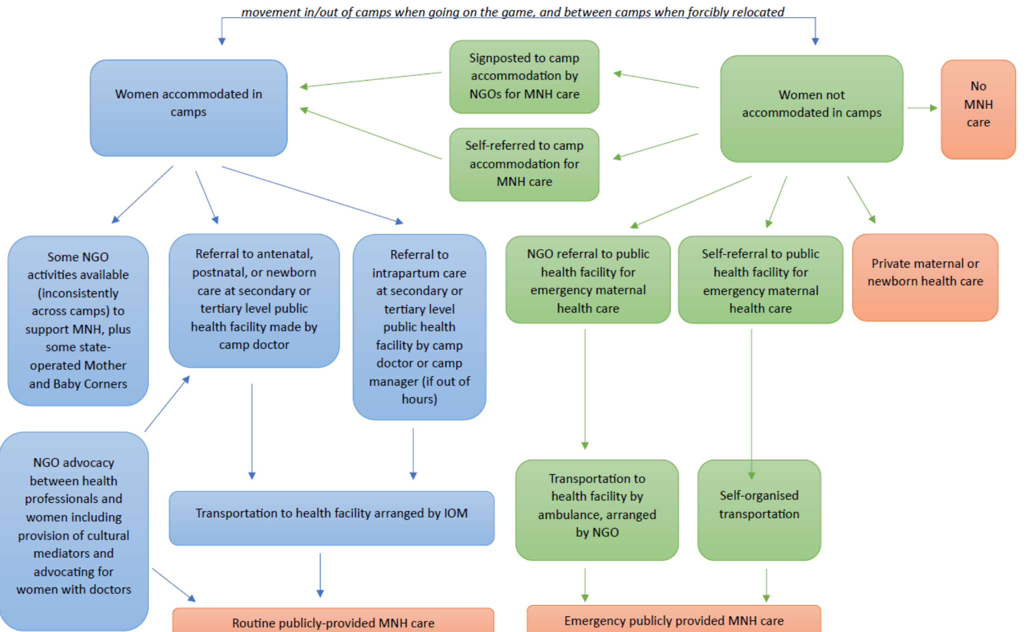
Afghan women who were able to access maternity care commonly experienced intrapartum obstetric violence, specifically in the form of being denied an interpreter (therefore a means to communicate) or a birth companion for labour support. Furthermore, separation from their infants at birth was not only extremely distressing for women in this study, but constituted disrespectful newborn care as the benefits of early skin-to-skin contact and breastfeeding were removed. This continued into facility-based postnatal care for women and newborns who were kept apart, other than for pre-determined feeding times, limiting the opportunities to establish breastfeeding. Models of maternity care such as these experienced by Afghan women understand birthing bodies, "…akin to a perpetually faulty machine that requires continuous maintenance and intervention in order to function smoothly…" (Lokugamage *et al*. 2022, p.267), requiring a conveyor belt approach to care provision (Davis-Floyd 2001). There is a growing scholarship that departs from equating these approaches to birth with the oppression of women, recognising instead Global North women's agency to choose a medicalised birth (Chadwick 2018). However, systems of maternity care that perpetuate views of women as passive

objects (Cohen Shabot 2016), and birth as a process requiring medical management and surveillance, neglecting the socio-cultural aspects of birth, were established by practices of white, male Western European and North American men (Donnison 1988, Lokugamage *et al*. 2022). The power relations inherent in managed, 'top-down' births shaped the experiences of Afghan women in Serbian maternity facilities, often to control and silence, and therefore dehumanise them. Yet the findings from the public engagement project suggest that there is an awareness of the inadequacies of maternity care for refugee (and Serbian) women among some Serbian health professionals.

Some women resisted being rendered passive, visibilising their agency by self-advocating, yet not altogether always escaping obstetric violence by doing so. While this disrespectful care is also experienced by Serbian women and newborns (Arsenijevic *et al*. 2014, Pantović 2022a), the controls exerted on Afghan women's facility-based intrapartum and initial postnatal care adds to the modes of control imposed by the state on access to care in the first instance and (im)mobility of their bodies through the enactment of migration governance, laying bare the multifarious controls that Afghan women negotiated in Serbia.

Despite, or because of these controls, women in this study resisted efforts to halt their entry into EU member states, demonstrating again the ineffectiveness of punitive deterrence mechanisms that fail in their mission yet create much human suffering (Barrigazzi 2024). In line with other scholarly work, I found in this study that women's agency was creative, as it negotiated power and resisted forms of mobility control, enabling women to re-shape their security and future as they prioritised mobility, rather than having a solution pressed upon them (Hyndman 2019, Mainwaring 2019). This agency unsettles stereotypes of forcibly displaced women as 'passive victims' who are essentialised as being vulnerable (Sharma 2020). That some Afghan women in this study longed for pregnancy or found comfort and purpose in having a newborn challenges tropes of fertility during migration as highly undesirable and burdensome. Moreover, women's varied experiences of having a newborn highlights the importance of not flattening experiences but rather giving space for diverging accounts. This speaks to the right of women to control their fertility – both to have access to reproductive health services to avoid unwanted pregnancy but also the right to be pregnant and experience fulfilment, purpose, and a sense of normality in the midst of great uncertainty that upends hegemonic discourses of pregnancy during migration as solely undesirable.

Figure 10 Pathways of access to maternal and newborn health care for Afghan women in Serbia



Considering this study's findings in relation to my scoping literature review (Sharma *et al*. 2020), there are both notable corresponding findings, and points of departure. This is unsurprising given most included studies were conducted in high-income settings where firstly, participants were in the process of, or had already, sought international protection rather than being on the move, and secondly, where health systems were better resourced than those in Serbia. My literature review concurs with this study's findings in so far that the nature of being forcibly displaced is pivotal to perinatal experiences. However, ways in which displacement impacted women in my study varied from the literature review: whilst liminality, being 'betwixt and between' was evident in the literature review, this study brought to the fore the immobility-mobility continuum, showing how perinatal experiences were understood in relation to onward movement. The dehumanising impact in this study of communication barriers when using maternity services was consistent with the literature review, and highlights again how critical it is for appropriate interpreters to be made available for women using maternity services who

do not speak the majority language. Similarly, this study's finding showing the absence of female support in labour is congruous with the literature review's findings. Evidence from the literature review also supports this study's findings that women were required to navigate structural factors, although the nature of these structural factors differed - rather than encountering structural barriers to accessing maternity care, as I found in my literature review, in this study the structural factors Afghan women were required to navigate were controls on their mobility. Concurring with the literature review was the purpose and comfort that having a newborn provided.

Strengths and limitations of the research process

Each of the chapters presenting my empirical findings outline the associated strengths and limitations. This section considers overarching strengths, limitations, and challenges, and limitations of the study as a whole.

Strengths

This study makes a significant original contribution to the corpus of knowledge, and current discourse on perinatal experiences of Afghan women on the move in Serbia, from multiple perspectives – most importantly the perspectives of women themselves, centring and amplifying their voices. To the best of my knowledge, it is the first of its kind to explore aspects of perinatal experiences, or issues of maternal and newborn health for refugee women on the 'Balkan route' or specifically in Serbia, therefore also adding to the broader literature on refugee experiences at the edges of the EU. Although this is a small study due to the nature of it being doctoral research, it adds to the conversation on, and knowledge about, maternal and newborn health and wellbeing for forcibly displaced women in transit contexts, whose voices are under-represented in research. Not only does it add to the academic literature, it also provides important testimonials of harms at EU borders that are sequestered by the EU despite these harms at odds with its human rights paradigm.

Focussing specifically on Afghan women's experiences in this study removed the homogenisation of migrant experiences, by recognising the specific circumstances of migration to the EU for Afghan women.

The study offers methodological insights for other study settings and illustrates the benefits and feasibility of employing a multi-method qualitative study design. Any research involving highly mobile populations in rapidly evolving contexts is a high-risk endeavour. Incorporating various methods from differing perspectives offered a greater degree of flexibility during the research process because I was not reliant on collecting one form of data from a particular group, but rather had a breadth of methods and participants that could even out any difficulties that arose in one strand of data collection. For example, incorporating an online questionnaire in the public engagement project methods enabled

me to engage with health professionals in this study and understand their perceptions of Afghan women's perinatal experiences in Serbia, despite limited engagement with recruiting health professionals for oral interviews. Participating in an online questionnaire that offered complete anonymity may have been viewed as less threatening than a face-to-face interview (whether conducted in-person or remotely).

Whilst I privileged the accounts of those with lived refugee experience in this study, gathering data from a range of perspectives provided not only a rich, nuanced, and diverse understanding of phenomena but also extensive insights into a complex landscape that would not have been captured using only a single method. Including perspectives of both women and service providers facilitated dissemination among both groups, thus engaging a wider audience in the research findings. The value of narrative inquiry as a method when interviewing women who were rendered vulnerable, and the power it ascribed to them in shaping their accounts was starkly apparent on occasions when their account differed from those relayed to me by other actors. This reiterates the importance of employing methods that seek to address researcher-researched power imbalances and demonstrates the agency of participants in shaping their narratives. Furthermore, employing case-based methods of narrative inquiry enabled the diversity within Afghan women's experiences to shine through, rather than flattening this diversity by clumping their experiences into themes.

A further study strength relating to methodology from this study was the importance of relationships I built throughout the study lifespan, that was central to its success, and also provided some ethical guardrails. As an outsider I was fully reliant upon others to assist me in this study, which required me to rapidly build trust with a wide range of actors, often at a senior level, who could authorise access to participants. My ability to be culturally flexible in approaching these actors, in addition to my credibility as a midwife who had lived in Afghanistan, aided initial relationship building, as was also the case when recruiting Afghan women. However, in building these relationships, I was also acutely aware from an ethical standpoint that stepping out of research was as important as stepping into the research. Having forged meaningful connections with a number of Afghan women and several NGO actors, I remained in intermittent contact with them through WhatsApp messaging throughout the research study. Due to the length of the study, some of these relationships naturally fell away. By being able to maintain this contact (only where this was reciprocated – some clearly did not want to remain in contact, which I respected) I was able to shift away from a researcher who swooped into people's lives to extract their deeply intimate stories only to then disappear from their lives (Pittaway *et al*. 2010).

Taking the novel approach of engaging with decolonial feminism and CBS in this study, I was able to centre subaltern women's voices, and show how gender, race, and colonialism intersect to marginalise Afghan women in Serbia during the perinatal period. This approach demonstrated how the effects of the EU border regime with its roots in colonialism, enacted in Serbian migration governance, trickled down to reproduce harms to childbearing Afghan women in Serbia. Using these approaches, which stemmed from the two dominant disciplines from which I drew in this study, provided depth of insights into how relationships at differing levels shape perinatal experiences beyond solely individual- or health system-level thinking. To the best of my knowledge, this was the first study to employ these two theories together, and therefore this study offers an important theoretical contribution.

Engaging with concepts from CBS mitigated some of the problems created by my pragmatic decision to use a nation-state (Serbia) as a unit of analysis: as CBS understands borders as not merely territorial, this approach enabled me to think beyond state boundaries. As Schiller (2007) argues, nationalist-framed research can preclude migration scholars from accounting for power imbalances that shape migrant experiences. CBS provided a lens through which to interrogate these transnational uneven power dynamics in the context of territorial boundaries that are, "… are memories of past and present violences etched into social landscapes" (Parker and Vaughan-Williams 2012, p.731), no less pertinent for research in relatively recently-formed Serbia, with its ongoing violent border dispute with Kosovo (Hoxhaj 2023).

A further advantage of drawing from these two theoretical stances in this study was that neither are highly structured theories with associated frameworks, but rather theoretical lenses that allowed me to use as guiding lenses to inform my research (Braun and Clarke 2022) whilst retaining flexibility and an inductive approach to analysis.

Limitations and challenges

The most significant limitation of this study was the limited time I had in Serbia. This was primarily because of the Covid-19 pandemic and the ensuing lockdowns, which initially limited travel. As these restrictions started to lift, it became apparent that vaccine uptake in Serbia was relatively low, therefore posing a great deal of uncertainty about the medium-term spread of Covid-19 and risks of new restrictions being imposed, making planning for field visits challenging. Despite being able to mitigate these unexpected events by shortening my field visits and switching to remote methods where necessary, there is no doubt that I would have been able to collect richer observation data had I been able to stay in Serbia for a longer time period. A longer time spent in Serbia (as I had initially planned) would have opened possibilities of building greater trust with camp managers enabling me greater access to camps, and deeper 'hanging out' with participants. Spending more time in Serbia (if

I also had greater funds to pay for rapid travel between camps in different parts of the country) would have allowed me greater responsiveness to meet Afghan women who were pregnant or had a newborn but were only staying in camps for one or two nights before continuing their travel. As a result, I potentially could have recruited greater numbers of women who were in the perinatal period during the time of the interview, which may have provided different perspectives from those who were interviewed retrospectively. Additionally, in between my field visits, there were several occasions when I was informed that a pregnant Afghan woman had arrived in one of the camps but by the time my research assistant had been able to visit the camp, the woman had already left. Being in Serbia would have enabled me to be more responsive to such opportunities. It is also possible that I would have been able to build trusting relationships with health providers which may have led to the inclusion of more health professionals in the informant interviews. Moreover, shortened field visits, coupled with a decrease in NGO funding for reproductive health programming meant that I was not able to undertake any real-time observations of Afghan women receiving maternal or newborn health care, or other forms of support, in Serbia, which I had also initially planned in this study. Doing so would have provided insights into dynamics between women and health providers.

NGO teams working with communities in migrant squats were reluctant to have researchers coming and going for short periods of time, which could damage the trust they had with these communities – longer fieldwork would have provided opportunities to spend time with these teams. The Afghan women I recruited to this study were those who were visible – I was not able to access those staying in squats or in smuggler-organised accommodation to include their perspective in this study.

Another complicating factor was the Taliban takeover of Afghanistan in August 2021, which took place during my first field visit. Many Afghan families who were in Serbia at the time, took the opportunity to continue their onwards journey while there was perceived to be increased international support for Afghan refugees and possibly a softening of the EU border regime. The numbers of Afghan families accommodated in Serbian camps decreased dramatically. Through a number of informal conversations I had with NGOs and Afghans, it was expected that the numbers of families entering Serbia would once again increase due to the conditions in Taliban-run Afghanistan. However, this did not occur, possibly due to increase prices being charged by smugglers or the lack of mechanisms to transfer funds from families in Afghanistan to their on the move, to pay for smugglers. This in turn led to a severe drop in funding for NGO's to continue activities with Afghan women and children. Multiple NGO actors with whom I had been in contact over many months lost their jobs or were re-deployed to work on other projects. As a result, when I conducted my second field visit, the access to Afghan women, which NGO actors had provided for me during my first field visit, had dissipated and indeed I was informed that there were very few Afghan families staying in the refugee camps in Serbia.

The retrospective nature of interviews, not only with the majority of Afghan women participants, but also with some service providers, could be construed as a limitation due to recall bias. While there is no doubt that over time, some details would have eclipsed participants' memories, as I have previously argued, all qualitative interviews are temporally situated and constructed.

Recruitment of healthcare professionals proved to be extremely challenging for several reasons. The first reason was access. My visits to the Serbian camps were often controlled either by the camp managers or the NGO actor I was accompanying. At the camp in Serbia which I visited most frequently the camp managers told me that I was not allowed to speak with the camp doctors. On one occasion, I nonetheless did try to speak to the camp doctor but she was extremely busy with many patients to see and although I was very briefly able to speak with her about the research and pass on my contact details, I did not hear back from her. There was only one occasion when I was able to speak freely with a camp doctor during my visit to the camp, and recruit the doctor to the study. Access to doctors working in state-funded hospitals or clinics was equally challenging. With the assistance of the Serbian Research Assistant, I was put in contact with a several gynaecologists (the primary providers of maternity care in Serbia) and paediatricians who were willing to speak with me by video call. However, none of these had direct experience of providing health care to Afghan women or newborns or were able to signpost me to any colleagues who had. Prior to my second field visit to Serbia, I was able to establish the hospital in Belgrade at which most Afghan women in Belgrade was sent to give birth. The Serbian RA was able to set up a meeting with two gynaecologists at that hospital. Physically entering the hospital was a challenge, with the medical student having to negotiate entry with two security guards at the hospital's entrance, for some time. After eventually gaining entry to the hospital, I was told in no uncertain terms by one of the gynaecologists that it was impossible that any of her staff would remember providing health care to an Afghan refugee among the thousands of women who give birth in the hospital each year.

In this study, I occupied a position towards the 'outsider' end of the insider-outsider continuum, and as such my outsider position influenced every aspect of knowledge production, from data collection through to interpretation. One way to mitigate this in qualitative research is to involve participants in data analysis and interpretation. However, in this case of this study, I needed to consider the level to which participants in precarious circumstances, also with caring responsibilities, can be expected to continue to give their time freely (as I did not have funds to pay participants to act as paid experts by experience) to provide feedback on my data analysis and interpretation.

The findings of this study are temporally and spatially context-specific, and I prioritised small sample sizes and rich, thick data, and therefore there are limitations to the extent to which it can be

generalised to other settings. Nevertheless, the findings have relevance beyond the specific context of this study to shed light on some broader issues, for example, the impact of border regimes on people on the move at EU borders, the state-imposed limits on refugee support and health care provision and obstetric violence in Serbia's maternity systems.

Whilst the two theoretical lenses with which I engaged in this study provided a valuable means to inform and guide this study, they are not without their limitations. Both decolonial feminism and CBS have been developed relatively recently and arguably are still undergoing further development and refinement. A limitation of decolonial feminism is that it focuses on exploring oppression and inequalities through the prism of the intersecting categories of gender, race and colonialism, offering little explanation of women's agency or resistance in the face of oppression. CBS has been critiqued along similar line - that it over-emphasises the success of the securitisation of bordering practices, and under-emphasises ways in which these practices are resisted by displaced people (Stierl 2019).

Unending journeys

Completing a doctoral thesis is often compared with giving birth to an academic baby. My own experiences of giving birth tell me that while birth marks the end of pregnancy it simultaneously ushers in a new journey of parenting. Similarly, people who migrate might reach their destination country, but encounter a new kind of journey as they navigate a new way of living, and continue to live across worlds as they maintain transnational ties with home countries and globally scattered kinships networks. In the same (but far less perilous) way, completing this thesis marks both an end and a not-so end.

This doctoral research was first conceived over five years ago. Since then, Covid-19 and a wave of global geopolitical uncertainty have altered the lives of many. Women in Afghanistan have had to adjust their lives in light of the Taliban takeover of 2021 and the ensuing gender apartheid. Relations between Serbia and Kosovo are fragile, and further instability between these states could have far-reaching consequences. But despite these momentous events, women continue to leave Afghanistan and continue to give birth during the journeys to reach safety. Serbia continues to be a transit zone for Afghans travelling without state-authorisation to EU member states. So this thesis remains relevant and important, not only for Afghan women in Serbia, but for other women on the move through Serbia, and for Serbian women giving birth within a technocratic maternity system.

All childbearing women must have access to quality maternity care throughout the childbearing continuum irrespective of their nationality or legal status, and be free from harm inflicted towards them or their newborns as they cross borders in search of international protection. The lives of Afghan

women and their newborns are not dispensable or insignificant - their lives matter and must be treated with dignity and respect.

Conclusion and recommendations

This thesis explored the experiences of Afghan women in Serbia during the perinatal period, with a focus on understanding their interactions with, and the provision of, maternity care. Drawing on the theoretical lenses of decolonial feminism and Critical Border Studies, and using multiple qualitative methods, I have shown that there are two dominant factors that shape Afghan women's perinatal experiences in Serbia. First, regional EU geopolitics and migration governance and local Serbian socio-political and economic factors combine to create local migration governance that restricts access to perinatal care and support, and exposes perinatal Afghan women and infants to unwarranted harms during migration. Secondly, Serbian maternity care can produce obstetric violence through deleterious systems and practices, further subjugating Afghan women. Nevertheless, I have also shown how Afghan women remained active agents in shaping their own perinatal experiences in Serbia, despite the monumental constraints on them, as they resisted controls on their mobility, to seek protection and safety for themselves and their family. It is imperative that more research is conducted on maternity experiences of women on the move in a greater diversity of contexts so that their maternal and newborn health needs are understood and a range of clinical and policy responses can be implemented. Irrespective of migration status, all women are entitled to safe and positive childbearing experiences.

Recommendations

In this section, I propose several recommendations arising from study insights, geared towards various actors: policy-makers, health professionals, state and non-state actors, activists, and researchers. Some recommendations are discussed in earlier chapters and some situations may have changed during my PhD study, so I acknowledge that my recommendations are temporally situated within the period during which this study took place. Firstly, I will make policy recommendations relating to migration governance, secondly, practice recommendations relating to the treatment of Afghan women during the perinatal period in Serbia, provision of clinical maternal and newborn healthcare for Afghan women in Serbia, and finally, recommendations for research.

Policy recommendations relating to migration governance

In the foreseeable future, Afghans who have neither access to passports or travel documents to use legal routes nor funds for regular travel, will continue to take overland journeys to the EU through Serbia. While the asymmetric relationship between the EU and Serbia exists, the EU will continue to exert its influence on Serbia to enact its externalised border regime. A number of smaller-scale

changes to migration governance that could positively impact Afghan women travelling through Serbia during the childbearing time.

First, safe and legal routes to safety must be established by migration policy-makers for Afghan women who are pregnant or who have a newborn must be prioritised for entry. This would omit the need for childbearing women to take dangerous overland journeys, or stay in sub-standard camps, or outside camps without access to free maternal and newborn healthcare. Secondly, there is an urgent need for the EU to remove human rights violations by border guards for all pregnant women, or anyone travelling with an infant, including not only physical violence and intimidation but also illegal pushbacks for those making state-unauthorised journeys. This would remove the risks of women having to run from border guards while pregnant or with a newborn, medicating their infants to avoid them alerting border guards and would reduce the psychological trauma of border crossings. Finally, creating greater access to asylum processes and integration opportunities for those opting to remain can provide a means for Afghan women who no longer wish to travel to settle in Serbia.

Recommendations on the treatment of perinatal Afghan women in Serbia

Greater sex-disaggregated data of people on the move in / through Serbia needs to be collected by UNHCR and IOM. Without this, the scale of women migrating through Serbia remains unclear and justifying the allocation of funds to support the needs of women on the move through Serbia is problematic.

It is critical that all women, irrespective of their registration status with the Serbian state, receive access to routine maternity care. To truly make maternity care available to *all* women in Serbia, in line with SDG 3.8 principles of Universal Health Coverage (United Nations 2016), the Serbian state needs to lift restrictions on the provision of health care to those staying outside camps, with financial support from the EU.

The Serbian state also needs to make improvements to camp accommodation for pregnant women and mothers with newborns to improve physical and psychological wellbeing. Material conditions of camps, including hygienic sanitation, spaces where women can cook, use of heaters and coolers for rooms, and the provision of essential clothing and equipment for newborns, are steps that can be taken to improve living conditions for perinatal women in Serbia. Added to this is the need for spaces for pregnant women and new mothers, with adequate infant feeding support and equipment. But also critical, as this study revealed, is the emotional care and support of camp-based staff. Providing training to all camp-based staff on the practical and psychological needs of perinatal women, to ensure that they are treated with care and dignity, would be a helpful first step in responding to the concerns

raised by women in this study. Again, EU funding would be required to financially support Serbia in implementing these changes.

Recommendations for maternal and newborn health care

The aspects of maternity care that require improvements, highlighted in this study, can be mapped against the WHO (2016) standards for improving quality of maternal and newborn care in health facilities to form clinical practice recommendations for maternity care providers. Additionally, this study's findings demonstrated the need for routine provision of postnatal care for all women and newborns, beyond that provided in health facilities, and perinatal mental health screening and interventions, the need for both of which are laid out in the WHO recommendations on maternal and newborn care for a positive postnatal experience (World Health Organization 2022). The below table (Table 6) maps the relevant WHO recommendations to women's experiences and recommendations for practice (based on recommendations previously discussed in Chapters 5 and 7). Quality measures are given for the purpose of illustrating the specific clinical component(s) of the quality statement.

Table 6 Research recommendations for clinical maternal and newborn healthcare based upon WHO standards/recommendations

WHO standards for improving quality of maternal and newborn care in health facilities (WHO 2016)				
Standard	**Quality statement**	**Quality measure (input or output)**	**Women's / service providers experience(s) based on study findings**	**Recommendations for practice**
Standard 1: Every woman and newborn receives routine, evidence-based care and management of complications during labour, childbirth and the early postnatal period, according to WHO guidelines.	1.1b: Newborns receive routine care* immediately after birth. .	Output 3: The proportion of all newborns who received all four elements of essential newborn care: immediate and thorough drying, immediate skin-to-skin contact, delayed cord clamping and initiation of breastfeeding in the first hour.	Removal of newborns from mothers after birth	All women should receive skin-to-skin contact after birth (unless clinically contra-indicated), and the opportunity to initiate breastfeeding in the first hour after birth.
	1.1c: Mothers and newborns receive routine postnatal care**.	Input 2: The health facility practises and enables rooming-in to allow	Mothers admitted to postnatal ward without any rooming-in or support with breastfeeding	Newborns should remain with mothers on the postnatal ward, with unrestricted access of newborns to mothers.

		mothers and babies to remain together 24 h a day Input 7: The health facility has local arrangement to inform pregnant women and their families about the benefits and management of breastfeeding		Breastfeeding support should be offered to all women.
	1.9: No woman or newborn is subjected to unnecessary or harmful practices during labour, childbirth and the early postnatal period.	None Keeping babies separated from mothers in nurseries was identified as a harmful practice in the quality measure rationale, but no quality or outcome measure has been attributed to this practice. However, in practice, this	Newborns were kept in a nursery away from their mothers.	No newborn should be kept in a nursery – training should be implemented to ensure facilities follow a policy of zero separation of mothers and newborns unless clinically indicated.

		quality statement can be measured from the 1.1c quality measure		
Standard 4: Communication with women and their families is effective and responds to their needs and preferences.	4.1: All women and their families receive information about the care and have effective interactions with staff.	Outcome 2: The proportion of all women who gave birth in the health facility who reported that their needs and preferences were taken into account during labour, childbirth and postnatal care.	Many women reported that they did not have access to interpreters during admission to hospital, and were therefore neither able to communicate with staff nor have their needs and preferences taken into account.	All women should have access to suitable interpreters while in hospital and their needs and preferences should be discussed with healthcare providers and taken into consideration.
Standard 5: Women and newborns receive care with respect and preservation of their dignity.	5.3: All women have informed choices in the services they receive, and the reasons for interventions or outcomes are clearly explained.	Outcome 3: 3. The proportion of women who gave birth in the health facility who felt they had shared decisions about their labour, birth and postnatal care.	Women were not given the opportunity to have a translator present in order to make shared decisions about their care.	All women should be offered an interpreter during labour and birth to enable them to communicate with staff, understand their choices, and rationale for procedures or interventions that occur.
Standard 6: Every woman and her family are provided with	6.1: Every woman is offered the option to experience labour and	Output 1: 1. The proportion of all women who gave birth in the health facility	Labour and birth companions were denied.	All women should have the option to have a labour and birth companion. Where a woman's husband is the

emotional support that is sensitive to their needs and strengthens the woman's capability.	childbirth with the companion of her choice.	who had a companion of their choice during labour and childbirth		birth companion of choice, camp manager must ensure that if the mother has other children, they are safely looked after until a parent returns to the camp.
	6.2: Every woman receives support to strengthens her capability during childbirth.	Outcome 1: The proportion of all women who gave birth in the health facility who expressed satisfaction with the health services. Outcome 3: The proportion of all women who gave birth in the health facility who reported a positive birth experience. (83.23) Outcome 4: The proportion of all women who gave birth in the health facility who were satisfied that their choices and	A number of women expressed the disrespectful care they received during labour and birth, which I describe as obstetric violence. In these situations, they received inadequate support to strengthen their capability during labour and birth or to communicate with healthcare professionals. However, some specifically commented on, and appreciated the kind and caring attitudes of health care professionals.	All women should be able to communicate with health professionals and have the adequate emotional support that they require. Training staff in cultural safety and developing a communication plan for refugee women would assist in meeting women's emotional needs during labour and birth.

		preferences were respected.		
WHO recommendations on maternal and newborn care for a positive postnatal experience				
Care category	**Recommendation**	**Category of recommendation**	**Women's / service providers experience(s) based on study findings**	**Recommendations for practice**
Screening for postpartum depression and anxiety	Screening for postpartum depression and anxiety using a validated instrument is recommended and should be accompanied by diagnostic and management services for women who screen positive.	Recommended	No perinatal screening identified.	Implementation of a culturally-sensitive perinatal mental health service for refugee women in Serbia, to include specific psychological interventions during the antenatal and postnatal period, as well as screening, diagnosis, and management for women with postnatal depression or anxiety.
Prevention of postpartum depression and anxiety	Psychosocial and/or psychological interventions during the antenatal and postnatal period are recommended	Recommended	No specific perinatal psychological interventions identified (although some camp-based psychosocial interventions offered for women in general).	

	to prevent postpartum depression and anxiety.			
Exclusive breastfeeding	All babies should be exclusively breastfed from birth until 6 months of age. Mothers should be counselled and provided with support for exclusive breastfeeding at each postnatal contact.	Recommended	Inconsistent breastfeeding support available camps.	Implementation of the recently updated 'Mother and Baby Corner Operations Manual' (UNICEF 2023) requires auditing to ensure that key recommendations are being followed, particularly with regard to breastfeeding support. Serbian state to lift restrictions on the provision of maternal and newborn care to those residing outside camps, to enable specialist breastfeeding support to be provided by humanitarian actors.
Schedules for postnatal care contacts	A minimum of four postnatal care contacts is recommended. If birth is in a health facility, healthy women and newborns should	Recommended	No postnatal care outside health facilities identified by study participants.	Patronage nurses (providing family-centred postnatal and early years care) to extend their home visits to include visiting all postnatal women. Alternatively, Mother and Baby Corners, which if operating correctly

	receive postnatal care in the facility for at least 24 hours after birth. If birth is at home, the first postnatal contact should be as early as possible within 24 hours of birth. At least three additional postnatal contacts are recommended for healthy women and newborns, between 48 and 72 hours, between 7 and 14 days, and during week six after birth.			should have nurse-led monitoring of the antenatal care received by pregnant women and provision of newborn care, extending to provide postnatal care of mothers, to ensure their physical and emotional wellbeing in the first six weeks after birth.
Home visits for postnatal care contacts	Home visits during the first week after birth by skilled health	Recommended	No postnatal care outside health facilities identified by study participants.	

	personnel or a trained community health worker are recommended for the postnatal care of healthy women and newborns. Where home visits are not feasible or not preferred, outpatient postnatal care contacts are recommended.			

* Routine care of newborns includes skin-to-skin contact and early initiation of breastfeeding (World Health Organization 2017b)

** Routine care of mothers includes rooming in with their newborn for 24hours a day and access to skilled breastfeeding support

In addition to these health facility-based recommendations for improved quality of care, it is important that women receive postnatal care outside health facilities. WHO (2022) recommendations for a positive postnatal experience state that women should have postnatal contacts from health professionals between 7 and 14 days and during six weeks after birth, in addition to earlier contacts that may occur while staying in a health facility. These postnatal contacts are to ensure the mother's and baby's wellbeing, assess maternal mental health, provide support with newborn care and infant feeding, and offer contraceptive information (World Health Organization 2022). Therefore, a further recommendation arising from this study is the implementation of a system of postnatal care for all women, including those outside camps. This postnatal care could be easily incorporated into the function of existing Mother and Baby Corners for women staying in camps. However, considering that access to basic postnatal care is a human right, rather than a humanitarian function, embedding postnatal care for all women regardless of where they are staying, within the existing system of home visits from a patronage nurse (who has a similar function to that of a UK health visitor) would ensure that all women in Serbia receive equitable access to postnatal care.

A further recommendation for maternity care relates to perinatal mental health. Perinatal mental health screening should be embedded in maternity care for refugee women and offered by maternity care providers during pregnancy and the postnatal period, with the provision of appropriate psychological interventions where required.

Providing a suitable interpreter for all women when receiving maternity care is an absolute necessity that enables care to be provided in line with ethical principles of consent. A communication plan for women accommodated in camps that sets out in advance agreed communication flows between women, their husbands, camp staff and maternity care providers, from the intrapartum through to postnatal hospital admission period could be developed. This would be a low-cost measure that addresses some of the enormous anxieties felt by women resulting from communication breakdowns, and would also set out expectations that women are to be informed the care of themselves and their newborns while in hospital.

Recommendations for research

Future research examining perinatal experiences of women on the move should include perspectives of maternal and newborn health professionals, to understand more fully their experiences of providing health care to women on the move, and how bordering processes impacts their routine work. Along similar lines, ethnographic observations of the interactions between childbearing women and health providers in transit contexts would build on this understanding and offer additional insights into the interplay between perinatal women's experiences, including care experiences, and bordering processes. While these formal aspects of care are vital sites of interrogation, it would be equally

important to explore informal sources and networks of maternal and newborn health information used by women and care to provide insights into how these can be leveraged to provide alternative mechanisms for maternal and newborn healthcare for childbearing women on the move through Serbia. Including perinatal experiences of women on the move through Serbia from other home countries in future research would shed light on variances in experiences between groups of women from varied socio-cultural, economic, and educational backgrounds that may intersect to produce divergent experiences from those in this study.

The obstetric violence experienced by women using public maternity care in Serbia highlighted in this study calls for further research to implement and evaluate interventions to increase respectful care and promote breastfeeding-friendly practices. Specifically, such interventions may include training components on respectful intrapartum communication and zero-separation of newborns from mothers.

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APPENDICES

Appendix 1 – Topic guide for narrative interviews with Afghan women

Uninterrupted narrative

- Can you tell me about your pregnancy, (if relevant) birth and having a new baby?
- How does it feel to go through this during migration?
- How would you describe your experiences of maternity care in Serbia?

Further prompts (if not already covered above)

- Pregnancy
  - Can you tell me about the time when you found out when you were pregnant?
  - Can you tell me about your antenatal care?
- Birth (if relevant)
  - How was your birth?
  - Can you tell me about your experience of the maternity care during your birth?
- Postnatal (if relevant)
  - How was it after your baby was born?
  - How does it feel to have a new baby away from home?

Closure

- Do you have anything else you want to say?

Appendix 2 – Topic guide for semi-structured interviews with service providers

Background questions

- Can you describe your involvement with working with or supporting Afghan women in Serbia?
  - And specifically working with or supporting Afghan women during pregnancy, birth or postnatal period?
- How long have you been involved in working with or supporting Afghan women in Serbia?
- How did you come to be involved in working with or supporting Afghan women in Serbia?
  - How do you feel about this role / work / activity (as relevant)?

Service provision

- What are the challenges for providers of maternal health services?
- Can you describe the health care that Afghan women receive during pregnancy?
  - What other forms of support do women receive during pregnancy?
- Can you describe the intrapartum care that Afghan women receive?
  - What other forms of support do women receive during
- Can you describe the health care that Afghan women receive in the first 6 weeks after birth?
  - What other forms of support do women receive during
- What do you think are the challenges for health professionals or NGO's in providing maternity care to Afghan women?

Experiences

- Can you tell me what you think the Afghan women's experiences of maternity care in Serbia are?
- Can you describe what you think Afghan women's experiences of being pregnant are in Serbia?
- Can you describe what you think Afghan women's experiences of giving birth are in Serbia?
- Can you describe what you think Afghan women's experiences are in Serbia, in the first 6 weeks after birth, with a newborn?

Covid-19 (if relevant)

- In what ways do you think that Covid-19 has affected the experiences of Afghan women during the perinatal period, in Serbia?
- Are there any ways in which the maternity care they have received has changed during Covid-19?
- How has your work / role / activities, related to supporting Afghan women during the perinatal period changed since Covid-19?

Conclude

- Is there anything else you would like to add to, or change what you've said during our conversation?

Appendix 3 – Topic guide for follow-up semi-structured interviews with service providers

- Since we last spoke, has your involvement with working with or supporting Afghan women in Serbia changed at all?
  - And if so, can you describe how it has changed?
  - And why do you think it has changed in this way?

- Do you think that Afghan women's experiences of maternity care have changed since we last spoke?
  - And if so, can you describe how it has changed?
  - And why do you think it has changed in this way?

- Do you think that Afghan women's experiences of being pregnant, giving birth or the postnatal period have changed at all since we last spoke?
  - And if so, can you describe how it has changed?
  - And why do you think it has changed in this way?

- How has the ongoing Covid-19 sitation / Ukraine war / Taliban takeover of Afghanistan changed the manner in which you are able to work with or support Afghan women since we last spoke?

- How has the ongoing Covid-19 situation / Ukraine war / Taliban takeover of Afghanistan affected women's experiences of being pregnant, giving birth or having a newborn since we last spoke?

- Is there anything you would like to add to, or change what you've said during our conversation?

Appendix 4 – Online questionnaire

1. Have you viewed the webcomics? [insert link here]

   Yes No

   [if no, ask the participant to view the webcomic before completing the survey]

2. Are you completing this survey as:
   - A health professional?
   - A member of a Serbian women's group?
   - Both?
   - Other? [please state your profession here]

3. How would you describe your awareness of the experiences of Afghan women around the childbearing time?

   None A little Quite a lot A lot

4. To what extent has viewing the webcomics increased your awareness of the experiences of Afghan women around the childbearing time?

   None A little Quite a lot A lot

5. Please explain why this is. [free text]

6. When you read the webcomic, what surprised you the most about Afghan women's experiences around the childbearing time? [free text]

7. When you read the webcomic, what did not surprise you about Afghan women's experiences around the childbearing time?

8. What do you think are some of the biggest challenges for Afghan refugee women who are pregnant, give birth or have a newborn baby while they are in Serbia?

9. How important do you think it is for Serbian maternal health care providers to understand the experiences of Afghan women around the childbearing time?

   Not important Somewhat important Quite important Very important

10. Please explain why this is. [free text]

11. On a scale of 1 to 10, how important do you think the following aspects of maternity care for Afghan refugee women are?

[1 = not at all important; 10 = extremely important]

- Provision of interpreters
- Respectful maternity care
- Information about how to access maternity care
- Regular antenatal checks
- Choices about what happens during labour and birth
- Support with breastfeeding
- Screening for mental health problems
-

12. Is there anything else that you would like to comment on?

Appendix 5 – Webcomic (English language version)

Webcomics available online (best viewed on a computer):

English language version: https://birthingontheway.wixsite.com/project/webcomic-english

Dari language version: https://birthingontheway.wixsite.com/project/webcomic-dari

Serbian language version: https://birthingontheway.wixsite.com/project/webcomic-serbian

5
Shhh Shhh, hush now, time to sleep little one.
Thank god the baby was born easily, but then they took my baby away from me. I thought something was wrong, I was so afraid. I wanted to give her my milk, but I couldn't. I was crying. After a while the nurses brought her to me so I could feed her. I was so happy she was alive! But then they took her away from me again and only brought her to me 3 or 4 times a day.
My little Shukria...
6
Here, take these for you and the baby.
I was so sad being seperated from my baby and being all alone. I didn't have enough clothes or nappies for my baby or food for me. But the Serbian lady in the same room as me gave me some of her food and clothes.
After one week, I returned to the camp with Shukria. Everyone was very happy to see us! Some of the other women in the camp helped me a bit with washing the clothes and looking after my children, but otherwise, I was on my own. I took Shukria to the mother and baby corner to be checked, but nobody made sure I was okay and recovering after the birth. I need to rest a bit longer before we can try crossing the border again.
7
My family and I WILL make it to Germany, safely
The smugglers won't take such a small baby in case she cries and alerts border police
8
Some families I know successfully crossed the border by giving their babies sleeping pills.
Maybe I'll try that too...
Sleeping Pills

Appendix 6 – Article published in *The Practising Midwife*

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Sharma E (2020) Rethinking vulnerability: labelling of the so-called 'vulnerable migrant woman'. *The Practising Midwife* 23(10):14-16

RACISM MATTERS

3. RETHINKING VULNERABILITY:

LABELLING OF THE SO-CALLED 'VULNERABLE MIGRANT WOMAN'

SUMMARY

The ubiquitous labelling of migrant women as 'vulnerable' can be unhelpful and problematic. Vulnerability is often poorly defined and understood in the context of the perinatal period. This article reflects on the implications of labelling women in this way, explores the concept of vulnerability and considers the important role that midwives play in fostering resilience.

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The term 'vulnerable' has become increasingly used by midwives as well as widely across the health sector to describe various groups of the population. It is recognised that midwives play an important role in reducing health inequalities and inequities and there is an emphasis on providing targeted midwifery care to those who are considered to be within vulnerable groups in order to achieve this. One such group is the so-called 'vulnerable migrant woman'.

VULNERABILITY LABELLING AS PROBLEMATIC

In this context the term 'vulnerable migrant women' is often used collectively in the literature to describe any combination of women who are refugees, asylum seekers, undocumented migrants or recent immigrants, ignoring other categories of migrants. Among some categories of migrants (refugees and asylum seekers) there is evidence of poorer perinatal mental health[1-3] and difficulties in accessing maternity care, which can result in late booking and fewer antenatal appointments.[4-6] However, the evidence for the impact on obstetric outcomes is unclear, largely because of the fact that studies include varying categories of migrants and in varying contexts, rendering direct comparison problematic. Nonetheless there can be a tendency to assume that outcomes are worsened. This assumption is confounded by ethnicity sometimes being used as a proxy measure for migrant status.

Vulnerability in relation to pregnancy, childbirth and the postnatal period is poorly defined in the literature.[7] This vagueness not only reinforces 'othering' but can lead to a 'filling in of the blanks' or multiple interpretations of its meaning.[8] Such gaps or interpretations may be filled or informed by the stereotypical portrayal of migrants in the media – migrants stranded in boats eliciting pity or, paradoxically, the angry rhetoric of migrants adding pressure to already-stretched public services – creating unhelpful narratives. Additionally, the hegemonic migrant-trauma discourse often portrays women through a lens of despair and loss; as passive and dependent victims. This, in turn, can result in performative interactions with health professionals, resulting in service users enacting stereotypes of being docile victims rather than resilient individuals, capable of expressing agency[9] (an individual's ability to act on their choices).

UNDERSTANDING AND RESPONDING TO VULNERABILITY

Seeking to address the ambiguity of vulnerability around the time of childbearing, a concept analysis identified two categories from the existing literature that contributes to vulnerability: threats and barriers.[10] The authors found that threats could be physical, such as age or having a pre-existing medical condition; psychological, such as anxiety or confusion; and sociological, including deprivation or forced marriage. Barriers that were identified related to difficulties in accessing maternity care or the barriers created by health professionals when failing to engage appropriately with women. However, barriers that create vulnerability are far wider than this. Structural barriers are those political, economic, social and organisational power relations that can exacerbate vulnerability. Restrictive access to free NHS maternity care; dispersal policies resulting in women being rehoused with their newborns upon discharge from hospital[11]; the organisation of maternity care (access to interpreters[5] or clinic locations that women have difficulties physically getting to[6]); and austerity measures resulting in cuts to specialist services are all structural barriers that affect migrant women's ability to access or use maternity care.

> *Resilience here can be thought of as an adaptive behaviour that enables flourishing under adversity*

The provision of respectful and dignified, individualised and person-centred care is important in addressing some of these threats and barriers, through, for example, the use of interpreters, culturally sensitive and empathetic care, appropriate multi-disciplinary referrals and relevant information. However, it is vital that structural barriers are addressed. Doing so will involve challenging discrimination and racism. Additionally, although working with community-based organisations and those whose activities include national-level advocacy may not be within the remit of most midwives' roles, supporting such organisations through awareness raising on social media, signing campaigns or fundraising can contribute to reshaping the structural barriers in order to reduce inequities for migrant women.

THE ROLE OF RESILIENCE IN SHIFTING AWAY FROM VULNERABILITY

In spite of this, there is a growing body of evidence demonstrating resilience in countering vulnerability. It has been found that women who experienced vulnerability through adversity were able to shift away from this vulnerability using resilience.[10] Rather than the misplaced notion of resilience being the ability to bounce back from difficulties, resilience here can be thought of as an adaptive behaviour that enables flourishing under adversity.[12] Vulnerability and resilience are not dichotomies, but are dynamic and overlapping. Indeed, migrant women may feel vulnerable in some aspects of life, while concurrently being resilient and expressing agency in others.[13]

Social support and networks, religious beliefs and personal characteristics such as optimism have been identified as factors that support resilience for migrant women.[14,15] Social support includes formal support, such as that provided by midwives. The importance of women having a midwife with whom a trusting relationship can be built can play an important part in enabling women to shift towards resilience from vulnerability,[10] as can vital signposting to community support groups and activities, especially if migrant women find themselves separated from family and kinship networks. Specifically, models of midwifery care that provide continuity of carer (CoC) can provide this vital social support, enable cultural understanding and safety and are positively experienced by women.[6,16]

CONCLUSION

By very virtue of being human beings, everyone has the potential to become vulnerable at some point.[17] The labelling of migrant women as vulnerable can be stigmatising and disempowering.[15] That is not to say it should be a term that is abandoned, because it is acknowledged that its use can legitimise additional support that midwives provide for women as well as access to funds and resources.[9] Nonetheless, it must be used with care and caution, recognising that *'these women are not simply victims to be coddled and pitied, but instead they build a framework to exercise their immense agency in meeting needs'*.[18(p.151)] The use of woman-centred language is powerful[19] and midwives have a unique opportunity in recognising the agency that women express and supporting their resilience through individualised care that meets their unique needs in their specific context, as well as challenging structural barriers. Further research is needed to understand the perspectives and lived experiences of those in so-called vulnerable groups on their perceived vulnerability, as well as the specific role that midwives play in increasing reliance through interactions with migrant women. **TPM**

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Appendix 7 - International Maternal and Newborn Health Conference 2023 published abstract

Sharma E (2024) Afghan refugee women's narratives of pregnancy and birth while 'on the move' through Serbia. *BMC Proceedings* https://doi.org/10.1186/s12919-024-00289-y

pre-eclampsia/eclampsia and for all women from populations with low calcium intake. This research aims to improve the understanding of factors (barriers and facilitators) influencing the uptake and use of calcium supplementation during pregnancy to prevent pre-eclampsia.

Methods

We conducted a mixed-method systematic review. We searched MEDLINE, EMBASE, CINAHL, and Global Health databases from the database inception to September 2022. We included qualitative and quantitative studies that explored views of women, health care providers, community members, and other relevant policy-makers about calcium supplementation during pregnancy. We used the Theoretical Domains Framework (TDF) and Capability, Opportunity, and Motivation of Behavior (COM-B) models to identify barriers and facilitators of calcium supplementation implementation to prevent pre-eclampsia/eclampsia. We used the GRADE-CERQual approach to assess the confidence of each qualitative finding and mapped quantitative findings to qualitative themes.

Results

We included 16 studies. There was limited knowledge about calcium-containing supplements and pre-eclampsia. Fears and experiences of side effects, varying tablet preferences, dosing, and challenges due to routine were the barriers to calcium supplement use for women. Information regarding pre-eclampsia and the safety of calcium supplementation from reliable sources, options of daily doses, reminders and support from family and community may help increase women's calcium uptake. Early initiation of antenatal contacts and the provision of calcium supplements at no cost might increase adherence to calcium supplement uptake. Consistent messages, training, and ensuring that an adequate number of human resources and calcium dosage forms could encourage the providers' use of calcium supplements.

Conclusions

When formulating interventions and policies on calcium supplement use, relevant stakeholders should consider the identified barriers and facilitators to optimize benefits. Findings from this study can inform implementation considerations to ensure effective and equitable implementation and scale-up of the provision of calcium-containing supplements in public health.

O297.

Afghan refugee women's narratives of pregnancy and birth while "On the Move" through Serbia

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BMC Proceedings 2024, **18(5)**:O297

Submission ID #: IMNHC126

Background

There is a dearth of research exploring the maternal health needs of women during their migratory journeys. Large numbers of Afghan refugees have passed through Serbia during overland journeys to the European Union (EU), often finding themselves "stuck" for months or years in Serbia as the EU has enacted increasingly restrictive border regimes. This study aims to document the lived perinatal experiences of Afghan women in Serbia and explore the provision of maternity care and support for Afghan women in Serbia during the perinatal period.

Methods

Using a qualitative study design, data was collected between August 2021 and August 2022 both remotely and during visits to Serbia, to understand the context for Afghan women transiting through Serbia. In addition to unstructured field observations, 11 narrative interviews with Afghan women who had given birth in Serbia were conducted. Narrative analysis was employed to analyze the data.

Results

Findings suggest: (1) EU border restrictions are a source of gendered harms and thus have a detrimental effect on Afghan women during the perinatal period; (2) pregnancy and motherhood play a key role in (im)mobility; (3) perinatal mental health and postnatal care, including infant feeding support, are insufficiently addressed among Afghan women in this context; and (4) migratory journeys do not curtail pregnancy and therefore there is a greater need for maternal and newborn health needs to be considered as part of the refugee response in Serbia.

Conclusions

This study highlights the challenges created by the EU border regime for Afghan women who are "on the move" during the perinatal period, pointing to an urgent need to address maternal and newborn health needs, provided in a timely manner and incorporating quality of care, for refugee women during migratory journeys.

O298.

Implementing effective quality improvement plans at health facilities to improve maternal and neonatal services in South Africa: identifying key components for replication in resource-constrained settings

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BMC Proceedings 2024, **18(5)**:O298

Submission ID #: IMNHC110

Background

Maternal and neonatal mortality and stillbirths in South Africa remain relatively high. To address this, South Africa's National Department of Health launched a multi-partner, facility-based, quality improvement (QI) program (2018–2022), called Mphatlalatsane, in 21 resource-constrained facilities across three high-burden provinces. The program's aim was to work with facility staff to establish QI teams. These teams identified key areas to improve maternal and newborn health (MNH) services, then developed and implemented the QI plans (QIPs).

Methods

An evaluation was conducted (2020–2022), assessing Mphatlalatsane's impact on maternal and neonatal mortality, still births, maternal experiences of care, quality of care, and implementation processes to inform the replication of effective QIPs. We report the results from the qualitative evaluation of facility-level implementation processes. We purposively selected 14 of the 21 facilities. Three rounds of interviews were conducted (May 2021–September 2022) with QI team leaders and members (health care workers in the participating facilities); regular debriefings were conducted with QI advisors (technical experts supporting the QI teams); and program documentation was reviewed. All data were thematically analyzed.

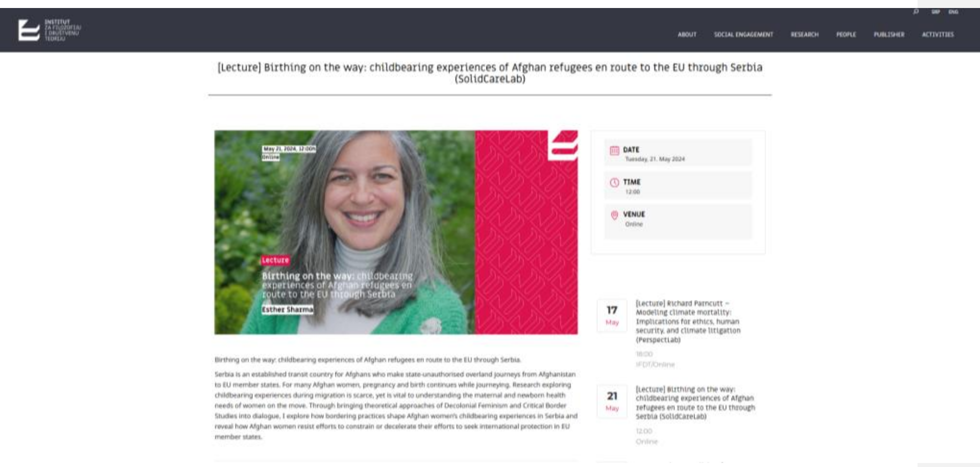
Results

Across the facilities, 28 effective QIPs were developed and sustained, addressing a range of MNH services: promoting early booking of antenatal care visits (five facilities); triaging patients in labor admission and antenatal care high-risk clinics (six facilities); improving completeness of records such as the partogram (five facilities); TB screening of antenatal care patients (three facilities); and QIPs implemented in only one facility (e.g., postpartum family planning). Key components in successful implementation were: involving community health workers and traditional practitioners when needed; upskilling staff to use standard tools and protocols; and developing user-friendly tools to monitor effectiveness. The team leader and QI advisor were key drivers for successful teams. Staff shortages and attrition, and the high-pressured environment of MNH services were barriers to successful implementation.

Conclusions

The Mphatlalatsane QI teams developed an inventory of replicable QIPs to improve MNH services in similar settings. The first steps were recently taken with spreading these QIPs in neighboring facilities. Its outcomes are to be carefully monitored to optimise the potential of these QIPs.

Appendix 8 – Presentation of PhD findings, University of Belgrade webinar



Link to webinar recording: https://www.youtube.com/watch?v=LHxx00Cmtbw