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EU Border Care

EU Border Care is a five-year, anthropological research project on the maternity experience of migrant women on the borderlands of four European states: France, Greece, Italy, and Spain. It examines the relations and processes of care that unfold between health-care personnel on these borderlands and migrant women, pregnant or recent mothers, without a fully regularized legal status (undocumented, with precarious documentation, or in the process of applying for documents or asylum).

EU Border Care is funded by the European Research Council.

The project is hosted at the European University Institute's Robert Schuman Centre for Advanced Studies.

Abstract

This report offers an account of the maternity care pregnant migrants received in the Greek capital between September 2016 and August 2017, and of their living circumstances in relation to their pregnancy and care. Research in Athens was conducted with five Syrian women from November 2016 to July 2017 in the camps, squats, and NGO-run hotels and apartments where the women resided. It was further conducted, during the same time, at three healthcare sites in the center of Athens. The report discusses legal and practical matters related to migrants' access to maternity care; issues of linguistic and cultural communication between migrants and healthcare practitioners; issues of "obstetric violence;" the reproductive agency of migrant women; and their overall surroundings and daily circumstances that conditioned their physical and mental well-being and therefore impacted their maternity experience. The report recommends priorities of intervention in order to respect the autonomy and dignity of pregnant migrants and maximize the quality of social and medical care.

Keywords

Maternity care, migrants, European refugee "crisis," Greece.

This report was written by Cynthia Malakasis, post-doctoral research associate at the EU Border Care research project.

Martha Alycia Patsi and Gianna Vasilaki, midwives who have worked with pregnant migrants in Athens in a variety of settings and capacities, have drafted/reviewed parts of or otherwise contributed to this report. The report was further reviewed by EU Border Care Director and Principal Investigator Vanessa Grotti. The primary author, Cynthia Malakasis, takes full responsibility for errors or omissions.

We would like to extend our gratitude to the medical and administrative personnel at the Athens maternity-care facilities where Cynthia Malakasis conducted research. We are further indebted to Hala Alhouch, who offered her services as interpreter and photographer. Our strongest gratitude belongs to the five Syrian women, who shared their experiences with EU Border Care, knowing they had nothing to gain.

Findings presented in this report apply to the period of Cynthia Malakasis' fieldwork in Athens, September 2016 to August 2017, unless otherwise specifically stated.

Summary

Since August 2015, more than one million people, primarily fleeing conflict in Syria, Afghanistan, and Iraq, have entered Greece (UNHCR 2020). Among these arrivals, the percentage of women has consistently hovered around 21 percent (UNHCR 2015, 2016b, 2020). This report offers a detailed account of the maternity care pregnant migrants received in the Greek capital between September 2016 and August 2017, and of their living circumstances in relation to their pregnancy and care. It discusses the legal framework determining their access to care; the actual access enjoyed; the availability and provision of legal, medical, and other information; issues of "obstetric violence" (UNFPA 2007); issues of linguistic and cultural communication with healthcare practitioners; the reproductive agency migrant women were able, encouraged, or allowed to exert; and their overall surroundings and daily circumstances that conditioned their physical and mental well-being and therefore impacted their maternity experience.

Research in Athens was conducted with five Syrian women from November 2016 to July 2017 in the camps, squats, and NGO-run hotels and apartments where the women resided. It was further conducted, during the same time, at three healthcare sites in the center of Athens: a) the premises of an independent Mother-Baby Center that subscribes to the midwifery model of care and caters exclusively to migrant women; b) the satellite clinic of a major transnational health NGO, funded by the UNHCR and established specifically to offer medical, including maternity, services to refugees enrolled in the EU Emergency Relocation Scheme; and c) the outpatient department, the triage area, and the labor ward of a maternity clinic in a major Athens public hospital.

Our empirical findings indicate the following **priorities of intervention** in order to respect the autonomy and dignity of pregnant migrants and maximize the quality of social and medical care:

- Maintain and enforce the provisions of Law 4368/2016, passed in April 2016, which mandates free prenatal and perinatal care for all women in the jurisdiction of the Greek state, irrespective of legal or political status.
- Increase state funding to provide the public healthcare sector with additional personnel and resources. The maternity clinic where we conducted research consistently suffered from a lack of beds. Obstetrics residents staffing the labor ward worked an average of 71 hours a week – 23 hours more than the 48-hour workweek mandated by EU legislation (see Section I.B.).
- Direct EU funding earmarked for the care of migrants in Greece to the public healthcare sector. The medical humanitarian sector provided prenatal care to migrant women in the form of consultations, basic ultrasounds, and physical examinations. It managed their care and facilitated their access to public hospitals by booking appointments, writing referrals, and overseeing their trajectory of care. All other prenatal examinations, however (non-basic ultrasounds, blood examinations, prenatal screening, etc.), as well as labor took place in public maternity clinics. Funding for the care of pregnant migrants in Greece therefore – such as EU Commission monies through AMIF, ISF, or ECHO – which was directed exclusively to the humanitarian sector, should also be directed to the public healthcare sector.
- Employ interpreters, intercultural mediators, and social workers in public maternity clinics. These professionals are pivotal in communicating the need for consent and dignity to medical professionals overworked and frustrated by the inability to communicate with their patients. Interpreters, intercultural mediators, and social workers are further necessary in order to inform migrant patients of their medical needs, options, and rights.
- Listen to the women themselves, rather than rely exclusively or primarily on the insights of intercultural mediators (or interpreters, who usually "translate" culturally as well). These professionals, especially interpreters, often espouse the stereotype of (mainly Muslim) migrant women as passive, ignorant of issues related to their own reproductive functions and care, and

uninvolved in decisions about their childbearing. Healthcare personnel should think of pregnant migrant women as autonomous adults and aim to establish direct communication with them via the help of interpreters.

- Clarify and simplify the bureaucratic process of access to maternity care, particularly the issuing of the social security or healthcare number that asylum seekers and other categories of migrants without a fully secure status need in order to access public healthcare.
- Foster independent housing, such as the apartment-living scheme financed by the UNHCR, rather than accommodation in open or closed camps, or in hotels administered by NGOs.

I. Introduction

Since August 2015 and through the end of our research in Athens, August 2017, more than one million people, primarily fleeing conflict in Syria, Afghanistan, and Iraq, entered Greece, hoping to make their way to destinations in northern and western Europe (UNHCR 2020). Among these arrivals, the percentage of women consistently hovered around 21 percent (UNHCR 2015, 2016b, 2020). This report offers a detailed account of the maternity care pregnant migrants received in the Greek capital between September 2016 and August 2017, and of their living circumstances in relation to their pregnancy and care. Further, it includes a set of policy recommendations in order to improve the care of migrants who have remained in the country or others who may arrive there in the future. The report also includes an Appendix with sources of information on migrants' maternity and overall health care in Greece and Europe.

Two issues must be addressed before proceeding. First, the report's findings correspond to rules and policies regulating the living circumstances, social care, and mobility of migrants in and through Greece that have changed in crucial ways since the time of our fieldwork. The Syrian women who participated in our research were not subject to the EU-Turkey Statement, which has, since March 2016, confined more than 40,000 people in the Aegean islands of first reception. Further, our fieldwork evolved during the period covered by the legislative framework instituted in April 2016, which offered free prenatal and perinatal care to all women in the territory of the Greek state, regardless of nationality or legal status. The situation changed in July 2019, when the newly elected conservative government issued a directive that banned migrants from acquiring a social security number (AMKA), necessary to receive care in public-health facilities – or, in the case of pregnant women, necessary for the prescription of prenatal examinations in public-health structures. The directive thus restricted the healthcare access of the approximately 53,000 asylum seekers (*I Kathimerini* 2019). A new rule mandating a temporary healthcare number for non-nationals was planned to go into effect in November 2019, but did not materialize until April 2020 (Amnesty International 2019; *Naftemporiki* 2020). Since we did not conduct fieldwork during this period, however, we are not able to discuss how these policy changes have affected pregnant migrants in practice.

The second issue regards terminology. The words we use to describe social phenomena, processes, or groups are almost never neutral. Descriptions shape our understanding of the world, and therefore produce specific social and political outcomes. In this report, we use the term "migrants" (as well as "migration") to denote cross-border mobility in general – not to imply a moral, legal, or any other type of distinction between people with or without claims to international protection. A rigid distinction between people who migrate for economic reasons and people who seek to escape persecution or war is problematic. Scarcity and violence often co-exist, and therefore people's motives for moving are usually mixed (Rodier and Portevin 2018: 13-19). Furthermore, poverty and scarcity may present just as strong challenges to survival as bombs or chemicals (*ibid.*). In this report, the term "migrants" is used interchangeably with "refugees" to capture the diverse circumstances of the people involved: they have crossed international borders, yet have done so in seeking refuge from potentially lethal conditions (on the political stakes of selecting a term, see also Ben-Yehoyada 2018; Holmes and Castañeda 2016; and Kallius *et al.* 2016).

Similarly, we deliberately refrain from using the term "crisis" to describe the episode of migration toward Europe that soared in the summer of 2015. The advent of refugees to Europe in recent years has been represented as a "crisis," firstly in the sense of mass population movements that deviate from the nationalist norm of people remaining in their own states and not migrating, and secondly because the supposed high numbers of arrivals are perceived as a strain to the host countries' already tight resources (Grotti *et al.* 2019). This report subscribes instead to the notion of a crisis of "reception" or of "solidarity" (Christopoulos 2017). This signifies a lack of willingness on the part of Europe to recognize the non-transient and non-exceptional character of these population movements, and to allocate resources toward the reception and integration of newcomers, whose numbers – one million in a continent of half a billion – far from render them an unmanageable challenge (for additional critiques of

the term and of the political work that it does, see also Grotti *et al.* 2019, Holmes and Castañeda 2016, and Kallius *et. al* 2016).

A. Background and Methodology

EU Border Care's ethnographic research has aimed to encompass the range of these migrants' maternity care: the legal framework determining their access to care; the actual access enjoyed; the availability and provision of legal, medical, and other information; issues of "obstetric violence" (UNFPA 2007); issues of communication with health-care practitioners (linguistic and cultural); the reproductive agency migrant women were able, encouraged, or allowed to exert; and their overall surroundings and daily circumstances that conditioned their physical and mental well-being and therefore impacted their maternity experience.

This report provides information on all these aspects of the maternity experience of migrants in Athens, Greece, where EU Border Care's post-doctoral researcher, Dr. Cynthia Malakasis, conducted field research from September 2016 to August 2017. To a lesser degree, the report includes information on care provided in the islands of first reception and refugee camps in the mainland. This information is meant to complement and frame the insights that derive from Athens.

The information in this report is based primarily on pregnant migrants' experience that the researcher and the two Athens-based midwives who contributed to this report had the opportunity to witness firsthand or to hear about directly from the women themselves. The researcher, Dr. Malakasis, conducted long-term ethnographic research with five Syrian women from November 2016 to July 2017 in the camps, squats, and NGO-run hotels and apartments where the women resided. During the same period, Dr. Malakasis witnessed the care provided to migrant women at three health-care sites in the center of Athens: a) the premises of an independent Mother-Baby Center (heretofore "IMBC")[1] that subscribes to the midwifery model of care and caters exclusively to migrant women; b) the satellite clinic of a major transnational health NGO,[2] funded by the UNHCR and established specifically to offer medical, including maternity, services to refugees enrolled in the EU Emergency Relocation Scheme;[3] and c) the outpatient department, the triage area, and the labor ward of a maternity clinic in a major Athens public hospital.[4] All research outlined above subscribed to the EU Border Care ethics protocol, reviewed and approved by the European Research Council Executive Agency (ERCEA) Ethical Assessment Committee. Fieldwork at the hospital, the NGO clinic, and the IMBC was conducted after formal approval was sought by submitting the project's research protocol to medical and administrative personnel. Informed consent was sought from the five Syrian participants at the beginning of and repeatedly throughout the research. Anonymity was pledged to and is maintained for all participants.

Martha Alysia Patsi attended migrant women as a volunteer midwife at the makeshift camp at the Port of Piraeus. She also worked for the IMBC mentioned above, and in the mobile units of two major transnational health NGOs serving refugee camps in the Attica region and other locations in the Greek islands and mainland. Gianna Vasilaki has attended migrant women as a volunteer midwife in the center of Athens, in a makeshift, semi-official camp structure camps and in three squats. Ms. Vasilaki owns a private maternity center, which subscribes to the midwifery model of care. The center's staff and volunteers have provided prenatal and lactation support to several hundred migrant women.

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1 The Center's name is not mentioned in this report, per the research project's ethical commitment to anonymity.

2 The NGO is not named, per the research project's ethical commitment to anonymity.

3 The scheme was adopted by the EU Council in September 2015 to relieve pressure on Greece and Italy by transferring people "in clear need" (EASO n.d.) of international protection to other EU member-states, where they would be able to apply for asylum.

4 The hospital is not named, per the research project's ethnical commitment to anonymity.

The introductory section of this report continues with information that contextualizes the discussion on the maternity care and living circumstances of pregnant migrants in Greece. Section B outlines the Greek health sector, including the effects of austerity since 2010. Section C discusses the models of maternity care practiced in the country. Section D offers information on arrivals and on the management of migration since 2015.

B. The Greek Health Sector

Since the establishment of the Greek National Health System (NHS) in 1983, the country's system has been a mixed-model one, comprising both tax-based financing and social health insurance (Economou *et al.* 2017). In the public sector, the NSH co-exists with social-insurance funds. The NHS offers care to all people who are in the country legally (nationals and non-nationals), whereas the different social security funds purchase services from the NSH as well as from private providers for their subscribers (Economou *et al.* 2017; Kotsioni 2009). Social security funds were unified, in 2011, under one main provider, the National Organization for the Provision of Health Services (EOPYY), which acts as the sole purchaser of NHS services (Economou *et al.* 2017). The private sector includes hospitals, diagnostic centers, and doctors' independent practices; among these entities, many enter into contracts with EOPYY, providing primary or ambulatory care for the NHS (*ibid.*). Social insurance in Greece is mandatory, and covers workers and pensioners, as well as their dependents (Kotsioni 2009).

The regime of austerity that has decimated the Greek welfare state since 2010 has been felt acutely in the health sector. A demand of the country's lenders, implemented by Greek governments, has been to cap health spending at six percent of GDP, plunging the country's health budget below all the pre-2004 EU member states (Economou *et al.* 2017; Kentikelenis *et al.* 2014). Given the sharp reduction in GDP,[5] however, since 2010 (OECD n.d.), health spending has fallen about 20 percent since 2010 (Economou *et al.* 2017). Meanwhile, a large part of the population, nationals as well as documented migrants, lost insurance coverage and therefore access to public health care through prolonged unemployment or other inability to pay contributions (*ibid.*). In 2015, public spending on health accounted for 59 percent of the total; the remaining 41 percent constituted private, mostly out-of-pocket payments (*ibid.*).

The inability to access public and private health structures turned both nationals and migrants toward medical NGOs and grassroots health initiatives (*ibid.*). Indicatively, *Médecins du Monde* report that consultations in Greece made up 68.7 percent of total consultations performed in 13 European countries[6] in 2016 (Aldridge *et al.* 2017), although this number is also due, to a large part, to the migrant arrivals to the country since 2015 (see Section II.D). In 2011, however, one year into the austerity regime and long before migrant arrivals peaked in 2015, the percentage of Greek nationals seeking medical assistance from *Médecins du Monde* more than doubled from the previous year (Chauvin *et al.* 2012).

Grassroots initiatives consist mainly in the network of social clinics established in the country since the beginning of the austerity regime to fill the need for medical care of people – nationals and migrants – without social insurance or the ability to pay for health care (Cabot 2016; Malamidis 2016). Based on donations and the volunteered labor of medical professionals, these clinics have numbered as many as 83 throughout the country (Cabot 2016), offering primary health care and medication (Malamidis 2016). Notably, the first social clinic was established in 2008, prior to the austerity regime, in the island of Crete, in order to offer care to undocumented migrants (*ibid.*), then entitled only to emergency services (Kotsioni 2009; NCHR 2007). With the advent of austerity, the clinic expanded its services to Greeks (Malamidis 2016).

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[5] The country's GDP marked a 7 percent reduction in 2010. By 2016, it had fallen 12 percent from the 2009, pre-austerity levels.

[6] Belgium, France, Germany, Greece, Ireland, Luxembourg, Norway, Romania, Slovenia, Spain, Sweden, Switzerland, and the United Kingdom.

Social clinics, however, began scaling down their operations once the public health sector stepped up to the plate again with a pivotal legislative change, which restored free care to uninsured nationals and legal residents and to certain categories of "vulnerable" undocumented migrants (Malamidis pers. comm.). Law 4368/2016 offers free primary and secondary health care in all public health structures to all uninsured nationals and legal residents (Ministry of Health 2016). Among undocumented migrants, free care extends to "vulnerable" cohorts; the law's text mentions pregnant women, minors, people suffering from mental illness, and people suffering from chronic illnesses. Undocumented migrants not included in a "vulnerable" category have access to emergency care.

The humanitarian sector, however, maintained its increased role even after the 2016 legislative change – a significant part of EU funds meant to assist Greece, as a state of first reception, in the care of refugees, were channeled directly to the humanitarian sector (Howden and Fotiadis 2017; Papastefanou 2018).

As part of the cuts in health spending, the budget for public hospitals was reduced by 26 percent between 2009 and 2011 (Kentikelenis *et al.* 2014). The increase in staff workloads and waiting lists reported in the literature (*ibid.*) and its dire effects on maternity care was witnessed firsthand during the EU Border Care research in the public hospital from March to July 2017. In the labor ward, we observed midwives on duty spending as much as their entire morning on the phone with their counterparts in the maternity wards in order to find beds for women who had just delivered or were about to deliver. In one instance, a frustrated midwife reported that she agonized almost daily about the scarcity of beds. Further, obstetrics residents, who staff the labor ward under the supervision of a senior obstetrician, work overnight shifts seven times per month. Each shift lasts 32 hours (24 hours morning-to-morning followed directly by a regular eight-hour shift). This translates to an average of 71 hours of work per week – therefore considerably higher than the 48-hour workweek mandated by EU legislation (Temple 2014).

C. Norms of Maternity Care in Greece

Maternity care is the care received during pregnancy, childbirth, and the post-partum period. Since at least the 1950s, two broad models of care have vied for prevalence: the biomedical and the midwifery models of care. The biomedical model defines pregnancy and childbirth as "potentially pathological – potentially disease-like" (Barker 1998: 1069), and therefore as processes that should be treated medically, or managed through biomedical intervention and technology-assisted surveillance by formally trained health-care practitioners (*inter alia* Barker 1998; Cosminsky 2016; Georges 2008; Smeenk and ten Have 2003). The midwifery model of care looks at pregnancy and birth as normal physiological processes, emphasizes the ability of women to carry and deliver children without technological intervention, and focuses on individualized care, continuity of care by a midwife through pregnancy and labor, and a holistic approach to well-being (Rowland *et al.* 2012). In most industrialized countries, responsibility for pregnancy and birth moved from midwives to doctors in the 20th century; since the 1950s, however, calls are made for a less biomedical approach and the return of responsibility to midwives (*ibid.*).

A detailed discussion of the medicalization of pregnancy and childbirth is beyond the scope of this report. Briefly, medicalization has resulted in changes in the role of midwives, the location of birth, and the use of intervention techniques in pregnancy and childbirth (Smeenk and ten Have 2003). Indications of the medicalization of pregnancy are the increase of prenatal care, and particularly its diagnostic aspects, to monitor and control the health of the mother and the fetus (*ibid*.). The medicalization of childbirth entails birth in hospital rather than home settings, the technology-assisted monitoring of fetal heart rate and uterine contractions, and the increase and normalization of interventions such as episiotomies, amniotomies, C-sections, and the use of oxytocin to induce labor (Smeenk and ten Have 2003; WHO 2015a). Critiques of this model of care emphasize, among other elements, its negative effects on the autonomy and dignity of pregnant women by discrediting the idea of pregnancy and birth

as physiological processes and women's knowledge of their own body (Barker 1998; Davis-Floyd and Sargent 1997; Smeenk and ten Have 2003). It thus increases the dependency of women on biomedicine, violates the right of women to make informed decisions and express their wishes regarding their care (Lokugamage and Pathberiya 2017), and reduces their options for care (*ibid.*). It is, therefore, strongly implicated in the problem of "obstetric violence" (*ibid.*), defined as the over-medicalization of labor, which wrests control of these processes from women and deprives them autonomy and agency (Lokugamage and Pathberiya 2017; Perez 2010; UNFPA 2007; WHO 2015a). Obstetric violence affects thousands of women around the globe during childbirth (*ibid.*). Additional information on obstetric violence as a series of violations of women's human rights is provided in Section III.C.3, along with an account of instances of obstetric violence we encountered during our research.

The biomedical model of maternity care prevails throughout Europe, with the notable exception of the Netherlands (Rowland *et al.* 2012; Smeenk and ten Have 2003); midwife-led care for low-risk pregnancies is also the norm in the United Kingdom (Rowland *et al.* 2012). In Greece, the biomedical model of care emerged after WWII, and almost fully replaced the midwifery model within a span of two generations (Georges 1996). The paragraphs that follow demonstrate the biomedical approach to pregnancy and birth in the country on the basis of two key indicators: C-sections and episiotomies.[7]

Since 1985, the World Health Organization (WHO) has placed the optimal rate of C-sections between ten and 15 percent (WHO 2015b). C-section rates that exceed ten percent are not associated with reductions in maternal and newborn mortality; conversely, because of the risks associated with the procedure, the organization recommends that C-sections should be undertaken only when medically necessary (*ibid.*).

In Greece, however, a staggering 56.8 percent of births are performed by C-section, according to information released by WHO Country Office in Greece (Kalyviotou 2018). C-sections are dominant in private maternity clinics, where vaginal births without any surgical interventions are as low as two percent, compared to 37 percent in public maternity clinics (*ibid.*). The discrepancy between the public and the private health sectors are attributed to financial incentives and doctors' convenience (Mosialos *et al.* 2005). A senior hospital midwife who participated in our research asserted that at least 25 percent of C-sections performed in Greece are unwarranted. She characterized as unwarranted those C-sections performed on women that did not feature one of the WHO indications. She blamed unwarranted C-sections on the scheduling convenience of doctors (in the case of patients in private and public hospitals who have their personal obstetricians, as opposed to women who go to public facilities to be assisted in their delivery by physicians on duty), on defensive medicine, and on the lack of information given to Greek patients who are led to believe that their post-operative recovery will be as smooth as in the case of vaginal birth.

Similarly, the WHO advises an episiotomy rate between ten and 20 percent (Sleep and Grant 1987). Yet a study based on a questionnaire administered to physicians found that, in Greece, episiotomies are routinely performed in 51 percent of natural births and 89 percent of vacuum-assisted deliveries (Grigoriadis *et al.* 2009).

In the case of migrant women, instances of episiotomies of C-sections increased due to the lack of linguistic communication, particularly as non-medical personnel (including interpreters) are not allowed in Greek labor wards. According to medical professionals interviewed at the public hospital where we conducted research, vaginal delivery without such interventions requires a higher level of cooperation between the midwife or doctor and the patient – cooperation which is not possible, if they are not able to speak to each other. We discuss this in more detail, citing testimonies of our research participant, in the section on "Obstetric Violence," as instances wherein migrant women were deprived of agency and autonomy over their childbirth (Lokugamage and Pathberiya 2017; Perez 2010; UNFPA 2007; WHO

[7] An episiotomy is an incision made in the perineum, the tissue between the vaginal opening and the anus, previously considered to prevent and heal better than spontaneous tears during childbirth (Mayo Clinic 2018).

2015a). We now turn to discussing the circumstances of the migration journey and the context of reception however, particularly living conditions, which made a significant impact on the psychological and physical well-being of pregnant migrants.

D. Arrivals in Greece and Mobility Management since 2015

Since Greece joined the EU's Schengen Zone of control-free internal movement, it has served as the European Union's south-eastern gateway. The most recent episode of migration started and soared in 2015, when sea arrivals in Greece reached an unprecedented 850,000, up from 43,000 in 2014 (UNHCR 2020). Primary source countries included Syria, Afghanistan, and Iraq. Almost in their entirety, 2015 arrivals were successful in transiting through Greece on their way to countries of northern and western Europe. Although Greece was their country of first entry into EU territory, these migrants were able to request international protection in other EU states following the suspension of Dublin[8] transfers to Greece in 2011 (Cabot 2014).

This process changed radically in March 2016. On March 9, 2016, Greece's neighbor to the north, Macedonia, closed its border to refugees, (Squires *et al.* 2016), in response to border closures farther north, which would immobilize refugees on its territory (Al Jazeera 2016). People who did not make it to the border in time were stuck in Greece, applying for asylum there or attempting to transition to other European states via regular or irregular channels. The report draws on the experience of the refugees who passed through the wider Athens metropolitan area – either for a few days on their way to Greece's northern borders or for several months. Some of them are still there, and may remain and settle in the country.

Sea and land arrivals to Greece, 2014-2020 (UNHCR 2020)

	Sea	Land
2014	41,038	2,280
2015	856,723	4,907
2016	173,450	3,874
2017	29,718	6,592
2018	32,497	18,014
2019	59,726	14,887
2020 (March 8)	6,875	1,861

To a lesser degree, the report outlines the conditions of maternity care in the Aegean islands of first reception – again, during the time of our fieldwork, from September 2016 to August 2017.[9] The EU-Turkey Statement, which went into effect on March 20, 2016, stipulated that Turkey would prevent refugees from crossing into Greece or readmit those who did (CoE 2016). Refugees arriving after March 20, 2016, therefore, have been required to remain in the islands, so that they may be returned to Turkey, unless they can prove the latter does not constitute a safe country for them. Only persons deemed vulnerable[10] are allowed to leave the islands, but their transfer to the mainland is fraught with administrative errors and delays, as the next section discusses. Prior to the EU-Turkey Statement, refugees would remain in first-reception structures in the islands for an average of 24 hours, before transitioning to the mainland (GRC 2016). After the Statement, however, open reception structures

[8] The EU's asylum regime is called "Dublin" due to its original establishment in the 1990 Dublin Convention. It stipulates that third-country nationals must request asylum in the member-state of first entry. People who manage to leave the state of first entry via irregular channels and request asylum elsewhere are normally sent back to the country of first arrival.

[9] The main Aegean islands of refugee arrivals in Greece since 2015 are five: Lesvos, Chios, Kos, Leros, and Samos.

[10] This categorization most often includes pregnant women or families with small children.

turned into hotspots overnight, where refugees have been contained for indefinite amounts of time, in living conditions violating most moral, legal, and common-sense standards of safety and dignity, according to reliable NGO and journalistic accounts. The living conditions of refugees in different types of accommodation in the islands and the mainland, focusing on the circumstances of refugees we encountered in Athens in 2016 and 2017, and particularly as they pertain to pregnancy and childbirth, open the next main section on our empirical findings.

II. Empirical Findings

A. Living Conditions of Pregnant Migrants in Greece

This section lays out the living conditions of pregnant migrants who arrived in Greece between 2015 and 2017. Migrants and refugees who arrived in Greece during that time resided in six different types of accommodation, which are outlined below. Most of these arrangements violated the human right to an adequate standard of living, which includes food, clothing, housing and medical care and necessary social services (UDHR 2015: 52 [1948]), recognized in the Universal Declaration of Human Rights (1948) and the International Covenant on Economic, Social, and Cultural Rights (OHCHR n.d. [1976]); the right to housing, recognized in the European Social Charter (CoE 2015: 40); the right to "enjoy the highest possible standard of health attainable," recognized in the European Social Charter (CoE 2015: 10); and the rights "of the family to social, legal and economic protection" and "of mothers and children to social and economic protection" recognized in the European Social Charter (CoE 2015: 16), among others.

Hotspots in the islands of first reception: These are closed structures, where Greek Police, Frontex, the Greek Asylum Service, and the European Asylum Support Office register arrivals and detain them so that they may be returned to Turkey, unless they file a successful appeal (CoE 2016). Prior to the EU-Turkey Statement, which went into effect on March 20, 2016, migrants would reside there for a few days, before transitioning to the mainland. Since the Statement, they remain there indefinitely. Close to four years after the start of this policy, more than 40,000 people are confined in the islands, expecting the adjudication of their asylum claims (*I Kathimerini* 2020a). Hotspots are overcrowded to almost eight times over capacity (*ibid.*), and conditions there are still described by reputable human-rights sources as "squalid," "inhumane" (Naidoo 2018), "awful," and "unsafe" (Tonella 2018), including lack of hygiene and sanitation, insufficient clean drinking water, raw sewage and rodent infestations (Amnesty International 2018; HRW 2018). Food is not always guaranteed, and it is often inedible (Naidoo 2018). Human-rights actors report that no special conditions are in place for pregnant women or infants, who reside, like everyone else, in tents with scarce electricity (Amnesty International 2018) and little protection from the elements (Naidoo 2018), sleeping in mattresses on the floor (Amnesty International 2018). For women, basic activities, such as sleeping or showering, carry the risk of sexual and gender-based violence (Amnesty International 2018; Tonella 2018). Further, while "vulnerable" migrants, including pregnant women, are supposed to be moved to the mainland, delays and errors in the vulnerability-assessment procedure and lack of space in the mainland means that they are never identified as "vulnerable" or that their they remain in the hotspots for months (Amnesty International 2018; HRW 2018), with new arrivals far outnumbering transfers (HRW 2018). Our first-hand account comes from the testimony of Jouthour, one of the Syrian women who took part in EU Border Care's research. Jouthour stayed in the Moria hotspot, in the island of Lesbos, from March until August 2016.

Testimony

"They're afraid we're contagious; that they will catch refugee-ness from us."

Jouthour and her husband arrived in Lesvos at 3 a.m. on March 20, 2016. They were taken to the Moria hotspot. Technically, they should have been subject to the EU-Turkey Statement, but they were exempt because they arrived before dawn. Their registration, however, as people who arrived before the agreement and could therefore apply for asylum in Greece, took three months. They were given this news on June 11, 2016. Despite this decision, the couple was told they had to stay on the island until their October 12, 2016 scheduled interview at the Athens headquarters of Greece's Asylum Service.

Meanwhile, on June 14, 2016, Jouthour found out that she was pregnant. The general practitioner but also the gynecologist who examined her at the camp had limited technology and resources; there was no ultrasound equipment. The camp's male gynecologist gave her supplements, and made her an appointment at the island's public maternity clinic for June 30, 2016. Prior to this, she had tried to go to the hospital by herself, but was turned back at the camp's entrance, and was told to ask the camp gynecologist to book her an appointment.

Jouthour visited the island hospital three times before her October transfer to Athens. Her husband was not allowed to join her, neither was she accompanied by camp social workers or other personnel.

> "The driver takes you to the hospital with the referral paper, and leaves you there, and you're on your own. They're afraid we're contagious; that they will catch refugee-ness from us."

At the hospital, she had to find her way around by herself, helped by the Arabic-speaking doctors. Interpretation was also available. On her first two appointments, in the second and the third months of pregnancy, she was given ultrasounds and blood work. Her third visit, in September 2016, was a walk-in on her own initiative, because she wanted to hear her baby before her transfer to Athens. She was scolded and initially turned away for coming without an appointment, but was given a quick ultrasound and supplements after all the other pregnant women had been seen.

Jouthour's pregnancy made no different to her life circumstances in the hotspot. At the camp, there was no air-conditioning, when daytime temperatures in Greece in the months of July and August hover around 35 °C. NGOs that visited to register "vulnerable" people and transfer them to hotels or apartments worked very slowly. When her turn came, there were no apartment lefts; this is the same answer she was given by the UNHCR. She assumes she was not chosen, because she had a set date for transferring to the mainland, whereas other "vulnerable" residents were subject to the EU-Turkey Statement, and were therefore stuck in the island indefinitely. Her multiple complaints to UNHCR staff in the camp, about substandard nutrition and unhygienic conditions, remained unanswered, despite her pregnancy. The three meals a day they were given were, in Jouthour's words, "inedible." Snacks, such as bananas or biscuits, were hoarded in warehouses and served to camp residents after they had gone bad. Protein such as meat or chicken was served only on Sunday. Jouthour would wash it off and cook it again. Physical fights erupted frequently at the food queues, which camp officials did little to stop, other than shutting down the food distribution. In early August 2016, Jouthour and her husband were finally transferred to the open, municipal structure next to the Moria hotspot, the Kara Tepe camp, meant to house "vulnerable" people from Moria. They were placed in a one-room container with five to seven other families; each family had about two meters of space, just enough to sleep. They left for Athens on October 11, 2016.

State-run camps: As of January 2020, there were almost 25,000 people living in the 30 long-term accommodation sites on the mainland (IOM 2020). EU Border Care conducted research in the camp of Elaionas in the Athens metropolitan area, where our research participant Jouthour, cited above, resided from October 2016 to June 2017. Our observation attests to the fact that life conditions in the camps lack basic necessities – protection from the elements, regular electricity, hot water, toilet and washing facilities, suitable nutrition, privacy and safety. At Elaionas, electricity failed constantly leaving camp residents without heating, while outside temperatures plummeted below the freezing point. Jouthour,

heavily pregnant by the winter of 2017, slept in a mattress less than two-centimeters thick, and subsisted on whatever food she could cook in her tiny container, as the food provided was often expired or inedible. The testimony of another Syrian research participant, who spent several months in a camp in northern Greece, is highly indicative of the adverse conditions in camp and their effects on pregnant women.

Testimony

Being Pregnant in a Camp: "The worst time of my life"

Nidal became pregnant by mistake, because of insufficient contraception, in June 2016. At the time, she was living in the Cherso camp in northern Greece, an official, government camp run by the Greek army. She had arrived in Greece in February 2016 with her husband and four daughters, all under five. The family was residing in the camp while undergoing the bureaucratic process of transferring their asylum claim to another European country.

Her pregnancy caused her significant stress, primarily because of her living conditions. It was summer, it was hot, there was no cold water, and her tent felt like an oven. She used to say, "I hate Greece, how can it be possible that you keep us in such conditions?" She said that the response she received from army officials, NGOs, and the UNHCR was that, if she didn't like it, she could go back to Turkey. She said NGOs would further respond that they were unable to help her, because they were mere NGOs and not the government. She would faint in her tent; she would tell them that, "I'm tired, I'm a mother, I'm pregnant, I'm hand-washing clothes." She was washing clothes by hand, three hours each time, carrying water in buckets, lighting a fire to cook. All her family members were anemic and feeling dizzy because of malnutrition.

Nidal said there were snakes in the camp. Residents would kill two or three snakes daily, and her children were afraid to go to the camp's toilets by themselves. She saw a snake in her tent, and the fear she felt caused her to faint. Subsequently, she started bleeding; she almost miscarried.

> "It was the worst time of my life. I haven't experienced worse moments. I will never forget them. If I stay in Europe – how long will I stay, ten years? – I want to never go by there again."

These living circumstances caused her to lean toward terminating her pregnancy. Yet her husband and the Hellenic Red Cross doctor stationed at the camp persuaded her to keep the baby. The doctor asked her if she wanted another baby anyway, and since Nidal said yes, the doctor told her it would be a pity to terminate. Nidal was strong and healthy, the doctor said, and with a little better nutrition she should be OK. The doctor spoke from a medical perspective, Nidal said, but she could not possibly fathom her daily hardship. Sometimes, she would only have bread to eat for two days in a row. She had four children in her care and a tendency to difficult pregnancies.

Nidal was persuaded to keep her baby. Indeed, her pregnancy was very hard at first. She was bedridden and constantly dizzy. Her red blood cells and her weight were decreasing. When she fainted and started bleeding, she was taken to a hospital in the nearest major city, Kilkis. The doctors wanted to keep her in for a week to monitor the bleeding in her womb, but her husband insisted she return to the children. He told her that the children were neither eating nor sleeping; they were afraid of snakes and were missing their mother. Medical personnel at the hospital cautioned her that returning to the camp would be dangerous for her and her fetus. Yet Nidal was more concerned for her children.

> "I can't stay in the hospital to take care of my own health and leave my children behind crying."

After this incident, the UNHCR in collaboration with a Greek NGO arranged for her and her family to be moved to an apartment in the city of Thessaloniki, something they had been requesting for a long time.

Makeshift camps: (1) The camp of Piraeus, Greece's biggest port, located in Attica, and for most refugees their first stop on Greek mainland, after their initial arrival in the Aegean islands. (2) The camp of Eidomeni, a town in northern Greece, where people camped out in their effort to cross into neighboring Macedonia. Both camps housed hundreds of thousands of people in transit since 2014 until they were dismantled by state authorities in the summer of 2016, and residents were transferred to official, state-run camps throughout the country.

Activist-run structures: These were created primarily by grassroots activists, Greeks as well as nationals of the main source countries (Syria and Afghanistan), who oppose the official, state model of housing refugees in camps usually removed from urban areas. The conservative government that came into power in July 2019 has since forcefully vacated most of these structures. Until then, squats were mostly located in the center of Athens. Some offered basic medical services in situ, provided by organizers who were members of the medical profession. Activists directed these structures' migrant residents to public health structures, mostly public hospitals, or social clinics. Official accounts of living conditions in these structures are not available. Our own observation in two of these structures, from September 2016 to July 2017, attests that living circumstances there were not worse, but were in some ways better than living circumstances in camps. While temperature control was not always available, residents were protected from extreme weather conditions. Further, they often slept in beds instead of mattresses. Crucially, their location in the center of the city placed pregnant migrants much closer to healthcare structures. Most squats in the center of the city were at walking distance from the IMBC and the clinics of three major medical NGOs, and within a ten-minute taxi ride from two major public maternity clinics.

NGO-administered hotels and apartments: Since November 2015, the UNHCR has used EU Commission funds to finance NGOs to offer housing, either in hotels or apartments, to asylum seekers. Refugees eligible for accommodation in these structures were those enrolled in the EU Relocation Scheme, Dublin family-reunification candidates, and, since 2016, "vulnerable" applicants (GCR 2018). Three of our research participants benefited from these housing schemes in 2016 and 2017. The women characterized hotel living as fraught by major loss of agency and autonomy: our participants noted that they were deprived of control over key areas of their lives, such as managing their medical care (allocated to social workers) and their family's nutrition (hotel rooms were not equipped with cooking facilities and even minor appliances, such as microwaves or water boilers, were not allowed). Apartment living was overwhelmingly preferred, but, at least during the time of our research, places were scarce and the duration of stay uncertain. Current data provided by the Ministry of Migration Policy place the number of asylum seekers in apartments at 22,000 and in hotels at 6,600. Among these, however, 6,500 and 3,500 respectively have attained refugee status, and will therefore no longer be eligible for accommodation (*I Kathimerini* 2020c).

The Health Effects of Living Conditions on Health and Well-Being

Healthcare personnel that participated in our research have noted the effects of substandard living conditions on the health of pregnant migrants. A senior midwife argued that the hardship incurred during the war and the migration journey altered the physical as well as psychological profile of Syrian pregnant women to whom she attended at the hospital. She said that common conditions she observed included gestational diabetes and hypertension due to malnutrition, exacerbated by the highly adverse circumstances of camp life in Greece. Ethnographic observation at the IMBC and the medical NGO further confirms that malnutrition among expecting migrants was a regular occurrence. Among the women whose consultations we observed at the NGO and the Mother-Baby Center, most came in, in the morning and early afternoon, without having had a meal.

The following section lays out the empirical information gathered by the researcher and the two midwives on the maternity care of migrants in 2016 and 2017. It outlines the legal framework determining access to health care for citizens and different categories of migrants since 2000, as well as

the obstacles that hinder access in practice. It further discusses the conditions and practices of migrants' prenatal care and childbirth, putting particular emphasis on issues of information and communication, as well as obstetric violence.

B. Access to Maternity Care

a. Legal Framework

The legal framework of access to maternity care for nationals and foreigners, documented as well as undocumented, in Greece underwent a significant change in April 2016, with Law 4368/2016, outlined in section II.B. Until then, only labor was considered an "emergency" procedure and was therefore available at no cost in public healthcare facilities.

The previous law regulating matters of migrants' access to social services, Law 3386/2005, stipulated that adult undocumented migrants were entitled strictly to emergency care and only until their health had stabilized. This prohibition included prenatal care for undocumented migrants, unless they were underage (Kotsioni 2009; NCHR 2007).

Moreover, Law 3386/2005 upheld a previous, 2001 clause that made healthcare workers liable to disciplinary and criminal prosecution, if they offered non-emergency services to undocumented migrants (NCHR 2007), annulling, however, their obligation to report undocumented patients to the police (Kotsioni 2009). In practice, healthcare workers, following medical ethics, seldom observed either of these clauses (*ibid.*).

Further, prior to the April 2016 legislation, nationals and foreigners without insurance were obliged to pay for their care in the NHS; in case of hospitalization, 50 percent of the cost was payable in advance. Provisions for free care were in place only for uninsured nationals who could prove that their income was below a certain threshold (*ibid.*).

Provisions for migrants' access to health care were first instituted in 2000. Since then, access to the Greek NHS has been tied to their employment status in Greece. Employed, legally residing migrants may access the NHS at no cost via their membership in social security funds. Law 2910/2001 granted legally residing migrants the same rights as nationals to social welfare. However, this still impeded the healthcare access of unemployed or informally employed migrants, who would have to pay out of pocket. Further, migrants were not entitled to certain provisions of extra protection, such as hospitalization at reduced or no cost available to uninsured Greeks (*ibid.*).

Recognized refugees, asylum seekers, and beneficiaries of international protection are formally entitled to the same access as nationals, yet not until their documents are issued, a process which may take several months.[11] Further, two presidential decrees, of 1999 and 2005, stipulate free care for these categories, if they are uninsured or cannot afford the cost of medicines and hospitalization (*ibid.*).

Law 4368/2016, passed in April 2016, stipulates free access to maternity care to pregnant women who are uninsured or cannot afford to pay for it, irrespective of legal or political status. Changes effected by the directive that banned the issuing of a social security number (AMKA) to asylum seekers are explained in the introduction to this report.

b. Access in Practice

During the time of our fieldwork, migrant and refugee women in Athens primarily received maternity care in public hospitals, in the premises of medical NGOs, and at the premises of the small Mother-Baby

[11] The same is the case in Austria (Norredam *et al.* 2005).

Center where we conducted research. The latter was staffed by midwives, who offered routine ultrasounds, prenatal vitamins and supplements, and extensive consultations regarding the process of pregnancy and birth. Medical NGOs were staffed by gynecologists and/or midwives, and offered the same services as the IMBC. The administrative staff of medical NGOs, usually people trained in social work, also at times undertook to write referrals for hospitals and to book appointments for migrants there via the centralized phone system. All prenatal testing other than routine ultrasounds was done in public hospitals.

The specifics of prenatal care are discussed in detail in the relevant section. Here it must be noted that whether a pregnancy was monitored by a medical NGO or a public hospital depended, largely, on where migrant women were channeled by the people who manage other aspects of their care – NGO-employed social workers, social workers in refugee camps, or activists in squats – or by the networks they themselves developed in the Greek capital.

Residents in activist-run hospitality structures were at times offered prenatal consultations and routine ultrasounds by doctors or midwives who volunteered their services there. In addition to providing these usually rudimentary examinations in situ, the same medical professionals also directed pregnant migrants to the IMBC, to social clinics, or to public hospitals.

Migrant and refugee women in Athens primarily underwent prenatal testing in public hospitals. NGO doctors might monitor them throughout their pregnancy, but they directed them to public hospitals for prenatal examinations (except for routine ultrasounds) and labor.

A major potential obstacle to receiving care was the lack of access to persons and mechanisms that could act as liaisons between migrants and the health structures and practitioners, or the lack of trust and efficient communication between migrants and such persons and mechanisms. The pivotal matter of linguistic interpretation is discussed in detail farther into this report. The obstacles that the lack of efficient communication may generate are the following:

Physical access to hospitals: This can be particularly challenging for newcomers who are not familiar with the Athens public transportation system or for women in camps or other facilities beyond the range of the city's public transportation system. Women residing within the Athens metropolitan area learn to navigate the city independently and quite quickly. An additional issue is that ambulances transport women to hospitals in case of emergency, but do not return them to their place of residence. A research participant, Hajer, told us of having to wait at the bus stop in an unfamiliar area in the middle of the night with her husband, until the bus service started sometime 5 a.m. (see testimony cited below).

Booking appointments: This constitutes a challenge for migrants and refugees who do not speak Greek or have access to a Greek-speaking person (social worker, friend, activist, etc.). Appointments for prenatal examinations are booked through a centralized, semi-automated phone service of the Greek NHS. This service, therefore, cannot be used by migrants who are not aware of it, or do not speak Greek. Activists, volunteers, and NGOs often undertook the task of booking appointments for migrants, or hospitals' outpatient departments might accept them on a walk-in basis. Yet, as we observed, these practices were not consistent, and therefore could not constitute a permanent solution.

Navigating care spaces: The process of prenatal care often entails navigating the care facilities' internal spaces and mechanisms without help or guidance. A pregnant Syrian research participant reported throwing away vials with her blood and leaving the hospital in frustration, as she struggled and was not able to find the laboratory, where she had been instructed to deliver the samples herself. Bisan had been asked to take the vials from the examination area to the testing laboratory – both within the hospital building – herself. Yet after walking around for a significant amount of time, she could not find the laboratory. Given the lack of linguistic interpretation, Bisan was not given clear instructions on how to find the lab. Further, signs directing patients and visitors to the hospital's different departments and spaces are in Greek. It is, therefore, not surprising, that Bisan was not able to find her way to the laboratory.

Testimony

Access to Health-Care Facilities: "If a person is not dying, they don't call an ambulance."

Hajer got pregnant in late March or early April 2016, when she was staying at the port, in a tent distributed by the Hellenic Red Cross. Hajer and her husband and two sons, aged 10 and 11, arrived in Greece in February 2016. On April 20, 2016, late at night, she fainted. The reason, as doctors told her at the hospital where she taken, was her severe anemia – the result of two months of malnourishment at the port.

At the time, medical care at the port was offered by a mobile unit of a major, transnational, medical NGO. She said her husband called them to their tent, and they examined her while she was unconscious. All the while, she said, her husband was urging them: "What are you examining her for? She needs an ambulance." According to her husband, the NGO's healthcare workers took about half an hour to decide among themselves whether to call an ambulance. After doing so, it took another 45 minutes for the ambulance to arrive at the port and an additional 45 minutes to get to the hospital.
Hajer's husband asked the ambulance crew to allow him to take the two children along, rather than leaving them alone at the port, in the middle of the night, surrounded by some 4,000 strangers. He told Hajer later that the crew refused; they barely allowed him to accompany his wife. "We left them in God's hands," Hajer said about her children,

At the hospital, Hajer regained consciousness, when she was given oxygen and hooked on an IV. She was diagnosed with anemia related to her pregnancy; this is how she found out she was pregnant. To make their way back to the camp, she and her husband asked the hospital for transportation, because they did not know their whereabouts. They were told to find a way to get back by themselves. The hospital personnel told them that the ambulance brought them there, but was not obligated to take them back; they were further told that the ambulance was out of service. To return to the camp, she and her husband asked random people to help them figure out the bus routes. Subsequently, they waited until 5 a.m. for the buses to start running. It took them an hour and two buses to get back to the port. When they arrived, Hajer hugged her children, who had been waiting for their parents in the family's tent. She fell asleep crying.

Barriers to access, then, consist in physically accessing health-care facilities, navigating the bureaucratic processes of booking appointments, and becoming familiar with the spaces, rules, and procedures of maternity care in the Greek public-health system. The next section explicates processes of prenatal and perinatal care.

III. The process of care

A. Prenatal Care

Pregnancies may be monitored, from the beginning until labor, at the outpatient departments of public maternity clinics. Appointments are necessary for prenatal examinations, but we observed that walk-ins were also accepted in the case of bleeding or pain, or for non-stress tests[12] in pregnancies close to term. Prenatal screenings are prescribed at the outpatient department and performed, by appointment booked via the centralized system, at the hospital's relevant department. We did, however, witness instances when the staff at the outpatient department would encourage migrant patients to stop by the screening department and either book their appointment in person or undergo an examination on the spot. This flexibility on the part of public health-care staff and structures was displayed particularly in the case of

[12] The "non-stress test," or NST, evaluates a baby's health before birth. The test determines the baby's oxygen supply by checking her heart rate (Mayo Clinic 2019b).

migrants who were at risk of missing key prenatal examinations, because they had not booked appointments through the centralized system early enough. As we highlight at the end of the report, this constitutes one of the most commendable practices observed throughout our research, evincing the commitment of healthcare personnel to offering care, despite scarcity and overall structural and bureaucratic constraints.

Prenatal tests are done on specific stages of the pregnancy. At the public hospital as well as the medical NGO where EU Border Care conducted research, we encountered pregnant women whose prenatal care did not start in time for certain key tests (e.g., nuchal translucency[13]). Hospital staff further reported that since the beginning of mass arrivals (summer 2015) and throughout 2016, migrant women would come to the hospital's outpatient department mostly without appointments. The situation was streamlined through a coordination between hospitals and the NGOs in charge of migrants' overall care.

Matters of scarcity and coordination between the public and the NGO sector also affected the scheduling of planned C-sections. In the public hospital where EU Border Care conducted research, we witnessed incidents when migrant women came in to schedule C-sections and the hospital had no availability on the necessary dates. In this case, the patient was given a referral to seek another hospital, yet no transfer was arranged for her; she would have to find the new hospital herself. Had she opened a file at an earlier stage in her pregnancy, her C-section would have been scheduled while there were still slots available.

Prenatal care was also provided in the premises of medical NGOs throughout Athens. It should be noted, however, that NGOs were only able to provide consultations, basic ultrasounds, free supplements (iron, calcium, etc.) and, in some cases, non-stress tests to women close to term. Despite the fact that a significant part of monies from the European Commission's Asylum, Migration and Integration Fund (AMIF) and Internal Security Fund (ISF) allocated to the care of refugees in Greece – one of the two main border states of first arrival at the time of the EU Border Care field research,[14] the other being Italy – was given directly to NGOs, and not to the Greek state (Howden and Fotiadis 2017), it was the Greek public healthcare system that provided prenatal examinations and labor. Healthcare staff at NGOs that examined migrant and refugee women would routinely refer them to public hospitals for blood examinations, specialized ultrasounds, prenatal screenings, and labor. However, according to information provided to us by a midwife who participated in our research, since 2017, at least one major transnational NGO performs several prenatal examinations in its own Athens clinic (such as basic bloodwork and doppler ultrasounds).

Birthing classes and breastfeeding counseling are offered in at least two major public maternity clinics in Athens. In practice, however, they are not accessible to migrant women, because the classes are offered in Greek. At least during the period of our research, and there was no interpretation service that would enable migrant women to attend these classes. Breastfeeding counselling was available at the IMBC and at the mobile units and stationary clinics of certain medical NGOs around the country. Midwives and lactation consultants volunteering in activist-run accommodation facilities also offered breastfeeding consultations.

For the prescription of prenatal examinations to take place in public health structures, a social security number (AMKA) is necessary (please see this report's "Introduction" for changes to this policy since the time of our research). At the time of the EU Border Care research, a senior social worker in a major Greek NGO explained that this requirement went into effect in the summer of 2016; until then, migrants had free care in public hospitals with their asylum-seekers' cards. The process of issuing an AMKA was complicated for several months, because the asylum seeker's card had not been included in

[13] This is an ultrasound examination that offers early information about a baby's risk of certain chromosomal conditions, such as Down Syndrome (Mayo Clinic 2019a).

[14] This is true until 2017. In 2018, arrivals in Greece and Italy lag behind Spain, the third state of entry into the European Union via the Mediterranean (please see Section II.D).

the directive listing the identification documents making one eligible for an AMKA. The issue was eventually solved; yet new complications arose in the summer of 2019 (please see "Introduction").

As in all aspects and stages of maternity care, a major hindrance that lowers its quality, efficiency, and potential for compassion and dignity is the lack of linguistic interpretation.

B. Communication and Information

Linguistic interpretation was almost consistently available, at the time of our research, in non-state residence and health-care structures: activist-run accommodation facilities, the IMBC, and NGOs. In activist facilities, migrants and refugees – some of whom have been in Greece for several years – were usually among the organizers, and took on the voluntary, unpaid role of the interpreter for their compatriots in languages such as Arabic or Farsi (or other languages spoken by refugee cohorts, such as the Pakistanis' Urdu, or the Kurdish dialects of Kurmanji or Sorani). The IMBC and NGOs similarly employed migrants and refugees who had been in Greece for several years and were fluent in both Greek and the language of the country of origin. The demand for interpreters, however, was noticeably higher than the supply – or funds might not be available to employ a sufficient number. This was the case even with NGOs that derived their funding for the medical care of refugees directly from the EU Commission via the UNHCR or, in the case of one major transnational NGO, also from private donations. At the IMBC as well as at the major, transnational health NGO included in the EU Border Care research, the interpreters employed were seldom sufficient to cover needs. During our research there, we often witnessed the interpreters dashing between the different examination rooms, trying to cover different consultations going on at the same time.

The major state hospitals featuring maternity clinics, where most migrant women undergo prenatal testing and deliver their babies, do not employ interpreters among their regular personnel. Since March 2018, the hospital where we conducted research and nine other public hospitals in Greece utilize the interpretation services of the Greek NGO *Metadrasi*, funded by the European Commission's Directorate-General for European Civil Protection and Humanitarian Aid Operations (ECHO), offered during specific days and times each week (*Metadrasi* n.d.).

During prenatal examinations in the public hospital included in the EU Border Care research, most migrant patients arrived with their own interpreters. Crucially, the type of interpreter to which they had access depended strongly on their type of residence. Women who resided in NGO-run facilities were accompanied by interpreters, male and female, employed by the NGOs. Residents of activist-run structures were also often, although not always, accompanied by activists or volunteers able to interpret. Women residing in camps, however, were accompanied by interpreters – again male or female – only if they were able to find friends and compatriots who spoke Greek or English.

The lack of linguistic interpretation exacerbated issues of obstetric violence, defined as the lack of autonomy and agency of pregnant women related to childbirth (Lokygamage and Pathberiya 2017).

C. Childbirth and "Obstetric Violence"

In a recent statement, the WHO denounced the "widespread" abusive, disrespectful, or neglectful treatment many women around the globe receive during childbirth (WHO 2015). This treatment includes

> "outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay" (WHO 2015).

Such abusive, disrespectful, or neglectful treatment violates the fundamental right of women to dignified and respectful care, freedom from violence and discrimination (UN 1948, 1976, 1993; WHO 2015). Pregnant women have the right to dignity, to freely seek and receive information, and to the highest attainable standard of physical and mental health (UN 2012; WHO 2015). The term "obstetric violence" emerged in the text of a 2007 Venezuela law (UNFPA 2007). It designates the lack of autonomy and agency of pregnant women over the conditions and decisions related to their delivery, particularly in contexts of excessive medicalization of childbirth (Lokugamage and Pathberiya 2017).

The issues that emerged in Athens related to the conditions of labor and delivery are diverse in character, ranging from migrant women's social needs and cultural preferences to more clinical matters. In the paragraphs that follow, we focus on matters of equal treatment, the violation of cultural norms, and issues of women's autonomy and agency over their childbirth. While the latter constitutes a concern for Greek women as well, the lack of linguistic communication exacerbated matters for migrant women.

Below, we cite the testimony of a Syrian woman who wished to deliver her third child vaginally, but was almost coerced into a C-section. Hajer had delivered her first child via C-section, yet her second child was born vaginally. However, as a senior midwife told us, Greek hospitals rarely undertake VBACs (Vaginal Birth after Cesarean). Unless it is a case of advanced dilation, VBACs are considered dangerous. The senior midwife who participated in our research said she believed VBACs were safe under certain conditions: if the patient had experienced normal dilation before, if there was no pathology, and if there was no need for special maneuvers. Yet she also expressed her doubt that VBAC could prevail in biomedically oriented Greece (see Section II.C). Midwives cannot do much about it, she said, because they risk liability, if something goes wrong in a VBAC that they have performed against hospital policy.

Testimony

Escaping a Coerced C-section: "It was the most beautiful birth."

Hajer was told she should do a C-section in late November 2016, when she was about a month away from giving birth. Doctors at the maternity clinic of a major public hospital recommended a C-section because this is how she had delivered her first child, now aged 11. But Hajer delivered her second son, aged 10, naturally. When she said she did not want a C-section, hospital personnel told her they could not assume the responsibility of performing a VBAC; they declined to be held responsible for the possible risk to her as well as to the fetus. Hajer was asked to sign a disclaimer stating that is was her decision to not deliver at that hospital, since she did not consent to a C-section. She was given a week to think about it, but was told that the hospital would not admit her for vaginal birth.

At the time, Hajer and her family were living in a hotel run by one of the major NGOs operating in Athens. The social worker assigned to her by the NGO booked her an appointment for another Athens major maternity hospital. On December 4, 2016, the social worker took her there supposedly for some tests. Yet, upon arrival, she was placed in a room where she was told she would be given a C-section. Hajer protested vigorously: "Why do you want to put me into surgery? I don't agree, and my husband does not agree." She said the medical personnel retorted that she was in danger because of her previous C-section and that her uterus would not open enough for the baby to emerge. They asked her to sign a disclaimer, and she agreed, but asked if she could first use the bathroom. Instead of using the bathroom, Hajer left the hospital, taking care to not be seen leaving.

In the previous few months, Hajer had been receiving prenatal care by a midwife affiliated neither with a public healthcare facility nor with an NGO. The midwife had encouraged her to ignore the warnings on the necessity of a C-section – this is what gave her the courage to flee the hospital. She made her way directly to the midwife's place of employment, crying. "I just ran away from a surgery they were going to do against my will," she told the people there. The midwife instructed her to go to the hospital only once she was well into labor. Hajer agreed, taking responsibility. On her part, the

midwife pledged to join her once her labor started and to accompany her to the hospital. Indeed, when she went into labor, about three weeks later, the midwife did join her in her hotel room, monitored her, and called an ambulance when her dilation had almost reached six centimeters.

The midwife asked the ambulance crew to take them to the other major public hospital, which had originally recommended the C-section. The day before, she had inquired whether they would accept a patient without an open file there, and had been told the hospital does not turn anyone away. At the hospital, they examined her upon arrival; Hajer's water broke before the examination was over. It took less than half an hour for the baby to crown. Her own, independent midwife was allowed to remain with her in the labor ward, against usual protocol. The baby arrived at the second contraction after its head had crowned. Hajer was not given an episiotomy.

> "I want the world to know, so that other women can deliver naturally, and not just go into surgery without protesting."

The inability to communicate verbally hinders all possible[15] requests for consent: migrant women are not asked before their labor is medically induced or their water manually broken. Neither are they asked whether they would prefer to be assisted or seen by female practitioners. The choice of practitioner usually follows the needs of the medical establishment (i.e., shifts, or the obstetrics residents' labor quotas) rather than the women's potential preference. Healthcare staff further reported that, because the linguistic gap prevents them from getting the medical history of migrant women, they are reluctant to administer epidurals; on their part, women cannot ask for them. A senior midwife told us that, for years, there had been a program wherein information related to epidurals was distributed to migrant women in a pamphlet in many languages. Yet she said that many women were not literate enough to understand the pamphlet, and therefore it did not constitute an adequate solution.

The testimony cited below belongs to one of EU Border Care's five main Syrian research participants. The incident she describes occurred in the maternity of clinic of a public hospital, yet *not* the one where we conducted research. The testimony touches on the majority of issues encompassed by the term obstetric violence: not only the excessive medicalization of pregnancy, but also issues of autonomy, dignity, information, and consent (Lokugamage and Pathberiya 2017).

Testimony

Obstetric Violence: "What are all these people doing in here? Am I giving a performance?'"

At her afternoon visit to the maternity clinic, Bisan was given a non-stress test and subsequently instructed to go home and return to the hospital when her contractions occurred in ten-minute intervals and her waters had broken. These occurred on the same night; she said she left the squat at 11:50 p.m. (via taxi; although they called an ambulance, it never arrived), arrived at 12:15 a.m., and had given birth by 12:30 a.m.

As soon as she arrived, Bisan was put on a gurney and wheeled into the labor ward, from where she reported "horrible behavior" on the part of healthcare staff. She said she was commanded to remove her clothing, a task hard for her during advanced labor pains. En route to the delivery room, she said she tried to hold on to a midwife's hand and started crying. Yet she said the midwife swatted her hand away and told her, "you're giving birth now; stop yelling."

In the delivery room, she was dismayed by the number of healthcare staff present: five male and four female midwives and two doctors; "all of Greece was in there." She said the room looked like a "slaughter house," not a clinical, sterile, quiet environment. Additionally, the number of people present

[15] It is not clear whether Greek-speaking women are asked either.

made her feel like she was "performing in a show," not that she was in a medical environment suitable for delivery.

In the labor room, her legs were raised and tied to the birthing bed's stirrups. Yet she was slipping off the bed, she was frightened, and did not know what was happening. Then the medical personnel adjusted the bed's mechanism, and she could hold on to the handles. The staff present were facing her and laughing encouragingly, she said, telling her in English, "coming baby."

Bisan said that, during her delivery, doctors performed an episiotomy on her, making two incisions on her perineum without asking her. She resented this, and she knew that it was her right to be asked for and to grant consent, because she had been asked to during her previous delivery in Turkey. Further, the local anesthetics did not work, and she felt it when they were suturing her. Although her baby was born at 12:30 a.m., the delivery-room process was completed at 2 a.m., when she was taken to a post-partum room and shortly thereafter to the maternity ward.

The same research participant, as well as another woman we interviewed, narrated incidents that constitute abusive and degrading treatment. As such, they violate the right of migrant women to equality and non-discrimination, reflected in various human-rights instruments : the Universal Declaration of Human Rights (2015[1948]), the International Covenant on Civil and Political Rights (1976a), and the International Covenant on Economic, Social, and Cultural Rights (1976b).

Testimonies

Head Covering During Labor
Incident 1, Jamila: "I told them, 'I want to put something on my head.'"

Jamila experienced intense labor pains in late March 2017, in the squat where she resided with her three-year-old daughter, her husband, and his extended family in the center of Athens. The ambulance her husband called transferred them to a major public maternity clinic (***not*** one where EU Border Care conducted research).

In the labor ward, she was asked to undress and remove her scarf. When health-care staff were getting ready to transfer her from her individual labor room (where women in labor are placed, until they are almost fully dilated and ready to deliver) to the delivery room, she asked for her scarf, but they refused to give it to her, although she insisted and started crying. She said she told healthcare staff that she would like to put something on her head, but she was not given anything. She said a male medical assistant pushed her gurney to the delivery room, where several male doctors were waiting. "I did not know there would be so many men in there."

Incident 2, Bisan: "As soon as I got there, the racism started."

Bisan went into labor in late February 2017, in her residence in the same squat as Jamila. Around 4 p.m. on a Sunday afternoon, an English-speaking Syrian resident of the squat called an ambulance, and Bisan was transferred to the same public maternity clinic as Jamila. She said a midwife told her in Greek to remove her scarf in a very bad way. Subsequently, Bisan said, the following dialogue ensued between herself and another, Arabic-speaking midwife:
Midwife: *"What are you and you're wearing the scarf, ISIS?"*
Bisan: *"You think only ISIS women wear the scarf?"*
Midwife: *"Since they hold signs, 'There is only one God'…"*
Bisan: *"And what does this mean, that we're all the same?"*

Her bitterness in recounting the incident is palpable: "Instead of focusing on the fact that I was giving birth, they focused on my headscarf," she told us.

III. Policy Recommendations

The information provided in Section III demonstrates that, during the time of our research, women in Greece were legally entitled to free access to maternity care, perinatal and prenatal, irrespective of legal or political status. This has been the case since April 2016, instituted by law 4368/2016. Its significance cannot be discounted. In practice, however, a number of issues related to access to care in practice and to the type of care received persist. All patients deserve to receive care, and the health system's role is to ensure the most vulnerable are reached and treated equally and fairly. On the basis of this premise and of the circumstances that we encountered, the report makes the following recommendations, in addition to the **priorities of intervention** listed in the "Summary":

Consent and Dignity

- Consent and dignity refer to the need for pregnant migrants to be adequately informed of their medical needs and possible issues that arise, as well as of the options and procedures available, and to be given the option to select the course of action that fits their medical but also social and cultural needs (UN 2012; WHO 2015). Failure to provide information and respectful, compassionate treatment violates the fundamental right of women to dignified and respectful care (UN 1948, 1976, 1993; WHO 2015).
- The role of the interpreter, the intercultural mediator, and the social worker is pivotal. These professionals should be able to communicate the need for consent and dignity to the often overworked and frustrated medical professionals and advocate for migrants' patients right to such care. They should further be able to inform migrant patients of their rights and support them actively in the demand for these rights.

Linguistic Interpretation and Intercultural Communication

- The Greek state should ensure that adequate linguistic interpretation is provided to all women who do not speak Greek in public facilities of health care.
- Interpreters should be allowed to be present in all spaces where women receive care and at all interactions between them and medical personnel, including the delivery room and the process of labor. Their presence is necessary not only to ensure linguistic communication between medical personnel and maternity patients, but also to help women navigate care spaces.
- Interpreters should further be trained in issues of intercultural communication or, if such interpreters are difficult to find, intercultural mediators should also accompany women to their hospital appointments. They should be able to impart the women's socioculturally mediated beliefs and needs to medical personnel, but also the reverse, explain established patterns, rules, and protocols of medical procedures, behaviors, and interactions to foreign patients.

Extra-Hospital Help (Social Work)

- Pregnant migrants should be paired with state-employed social workers to ensure that a) they are sufficiently able to navigate the Greek health system or that they receive all the help necessary for doing so and b) that their living conditions meet the necessary standard of comfort and dignity.
- Social workers should ensure that a) pregnant migrants receive adequate services of interpretation and cultural mediation in the context of their maternity care and b) that this care is complete and continuous. Particular help is required with a) booking hospital appointments via the centralized phone system and b) ensuring that pregnant migrants enter a schedule of care sufficiently early into their pregnancy and do not miss important examinations or screenings.

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Appendix I

Relevant links and sources

Academic studies of migrants' maternity care in Greece:

This list comprises the academic studies we were able to find on the maternity care of migrants in Greece, published since 2008. Any omissions are not purposeful.

http://www.mednet.gr/archives/2018-1/pdf/74.pdf
http://www.hsj.gr/medicine/refugee-women-in-greece--a-qualitative-study-of-their-attitudes-and-experience-in-antenatal-care.php?aid=3663
http://www.vima-asklipiou.gr/volumes/2007/VOLUME%2001_07/VA_OP_2_06_01_07.pdf
https://www.tandfonline.com/doi/abs/10.1080/14767058.2017.1371131

Academic studies on migrants' maternity care in European countries other than Greece:

This list is not meant to be exhaustive, but rather comprises key studies, published since 2012, that emerged in a bibliographic search. Listed in chronological order, starting with the most recent, articles engage with the maternity care of migrants in the following European countries: Denmark, Finland, Germany, Ireland, the Netherlands, Norway, Spain, Sweden, and the UK. It also includes review articles and cross-country studies. Thematically, it covers the following areas: access to maternity care legally and in practice; social, cultural, and structural barriers to care; migrants' experience of and perspectives on care; health-care workers' experience of and perspectives on care; best practices and health-system interventions; social, structural, and cultural determinants of care; social, structural, and cultural determinants of labor and perinatal outcomes; and provider-patient linguistic and inter-cultural communication in the context of care.

https://www.sciencedirect.com/science/article/pii/S026661381830281X
https://www.sciencedirect.com/science/article/abs/pii/S0277953615302380?via%3Dihub
https://www.tandfonline.com/doi/full/10.1080/13648470.2016.1180579
https://www.sciencedirect.com/science/article/pii/S1521693415001571?via%3Dihub
https://www.sciencedirect.com/science/article/pii/S1521693415001650
https://www.magonlinelibrary.com/doi/abs/10.12968/bjom.2016.24.4.275
https://static1.squarespace.com/static/562e7d33e4b0da14ad6d202f/t/581fa98f03596e90590dba96/1478470243490/SocialistLawyer72.pdf
https://link.springer.com/article/10.1007/s10903-016-0483-2
https://www.magonlinelibrary.com/doi/abs/10.12968/bjom.2016.24.2.130
https://www.sciencedirect.com/science/article/pii/S0266613816300614
https://www.sciencedirect.com/science/article/abs/pii/S187757561400055X
https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0429-z
https://www.hindawi.com/journals/nrp/2015/878040/abs/
https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/tog.12224
https://b.3cdn.net/droftheworld/08303864eb97b2d304_lam6brw4c.pdf
https://www.sciencedirect.com/science/article/pii/S0266613814000709
https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-14-141
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3916638/
https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0091843
https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-13-27
https://link.springer.com/article/10.1007/s10903-012-9587-5
https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-13-196
https://www.tandfonline.com/doi/abs/10.1080/13557858.2013.797567
https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-13-81
https://www.sciencedirect.com/science/article/pii/S026661381200023X
https://www.sciencedirect.com/science/article/abs/pii/S187757561300030X
https://www.sciencedirect.com/science/article/pii/S0020748913001259
https://www.tandfonline.com/doi/abs/10.1080/10810730.2012.665421
https://onlinelibrary.wiley.com/doi/full/10.1111/j.1369-7625.2012.00770.x
https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1365-2834.2011.01364.x
https://www.tandfonline.com/doi/abs/10.1080/07399332.2013.769999
https://www.sciencedirect.com/science/article/pii/S1871519211000199

Policy reports on migrants' reproductive care in Europe:
This list is not meant to be exhaustive. It comprises the main reports found, published from 2017 to 2013, on the sexual and reproductive health care of migrants across Europe, including Greece.
http://picum.org/wp-content/uploads/2017/11/Sexual-and-Reproductive-Health-Rights_EN.pdf
http://www.euro.who.int/__data/assets/pdf_file/0017/330092/6-Migrant-womens-health-issues-irregular-status.pdf?ua=1
https://mdmgreece.gr//app/uploads/2015/05/MdM-Intl-Obs-2015-report-EN.pdf
https://mdmgreece.gr//app/uploads/2014/05/mdmgreece-research-Access-to-Healthcare-en.pdf

Academic studies on migrants' health care in Greece:
http://www.mednet.gr/archives/2017-1/pdf/113.pdf
http://www.inhealthcare.gr/assets/uploads/manuscripts/18c9c0e62fc5b579fdf1ecb370d94060.pdf

Policy reports on migrants' health care in Greece:
This list is not meant to be exhaustive. It comprises the main reports found, published from 2018 to 2009, on the sexual and reproductive health care of migrants across Europe.
https://www.msf.org/greece-overcrowded-dangerous-and-insufficient-access-healthcare-moria
https://www.msf.org/greece-2016-vulnerable-people-left-behind
http://www.mighealth.net/el/images/3/30/%CE%88%CE%BA%CE%B8%CE%B5%CF%83%CE%B7_%CE%B3%CE%B9%CE%B1_%CF%84%CE%B7%CE%BD_%CF%85%CE%B3%CE%B5%CE%AF%CE%B1_%CF%84%CF%89%CE%BD_%CE%BC%CE%B5%CF%84%CE%B1%CE%BD%CE%B1%CF%83%CF%84%CF%8E%CE%BD_%CF%83%CF%84%CE%B7%CE%BD_%CE%95%CE%BB%CE%BB%CE%AC%CE%B4%CE%B1_17%CE%9C%CE%B1%CF%81%CF%84%CE%AF%CE%BF%CF%852009.pdf

Academic studies on migrants' health care in Europe:
This list is not meant to be exhaustive. It comprises broad studies, including two review articles, on the topics of migrants' access to health across the EU, the collaboration of the state and international organizations, and challenges for healthcare providers.
https://publichealthreviews.biomedcentral.com/articles/10.1186/s40985-016-0033-4
https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-015-1065-z
https://academic.oup.com/heapol/article/29/7/818/552418
https://www.ncbi.nlm.nih.gov/pubmed/21659389
https://academic.oup.com/eurpub/article/16/3/285/469874

Policy reports on migrants' health care in Europe:
This list is not meant to be exhaustive. It comprises the main reports found, published from 2017 to 2012, on the access to and state of health care for migrants across Europe.
https://www.medecinsdumonde.org/en/actualites/publications/2017/11/08/falling-through-cracks-failure-universal-healthcare-coverage-europe
https://mdmgreece.gr//app/uploads/2014/05/mdmgreece-research-Access-to-Healthcare-en.pdf
http://fra.europa.eu/en/theme/asylum-migration-borders/overviews/focus-healthcare
http://fra.europa.eu/en/publication/2012/migrants-irregular-situation-access-healthcare-10-european-union-member-states
https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2012_dec_1650_gray_hlt_care_undocumented_migrants_intl_brief.pdf

Resources on health care for migrants in Greece (in several languages):
http://uoa.campaign.com.gr/
https://philosgreece.eu/images/MyMedia/pdfs/informative/parousiasi-koinonikon-upiresion/Parousiasi-Koinonikon-Ypiresion--Ellinika.pdf
https://philosgreece.eu/images/MyMedia/pdfs/informative/parousiasi-koinonikon-upiresion/Parousiasi-Koinonikon-Ypiresion--Aravika.pdf
https://philosgreece.eu/images/MyMedia/pdfs/informative/parousiasi-koinonikon-upiresion/Parousiasi-Koinonikon-Ypiresion--Farsi.pdf

Resources for maternity-care practitioners working with migrants:
https://www.vmw.org.uk/

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