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Temporalities of emergency: Migrant pregnancy and healthcare networks in Southern European borderlands

Grotti Vanessa[a,*], Malakasis Cynthia[a], Quagliariello Chiara[b], Sahraoui Nina[a]

[a] European University Institute, Robert Schuman Centre for Advanced Studies, Via Boccaccio 121, 50133 Firenze (FI), Italy
[b] École des Hautes Études en Sciences Sociales, Centre d'études des mouvements sociaux, 54-56 Boulevard Raspail, 75006, Paris, France

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ABSTRACT

In Greece, Italy, and Spain, austerity policies combined with the structural density of migration flows have had concrete social and material manifestations in the delivery of public health care. Through our ethnographic case studies in Lampedusa and southeastern Sicily, Melilla, and Athens, we examine the maternity care offered to migrant patients in the midst and the aftermath of the so-called "migration crisis" in state and non-state structures. Research was conducted in Athens and southeastern Sicily from August 2016 to August 2017; in Melilla from August 2016 to October 2016 and in January 2017; and in Lampedusa from August 2016 to January 2017. Data collected consist in semi-structured interviews and long-term ethnographic observations. The article explores whether and how the understanding or the labeling of the maternity care of migrants as an emergency within a context of professed crisis generates new norms of care within health-care delivery. Our findings suggest a) the adoption of solutions or practices that in the past might have been considered urgent, ad hoc, or creative; b) their normalization, deeply connected to the wider social landscape of these European peripheries and c) the institutionalization of humanitarianism in the context of these practices. Our research points out temporalities of emergency against the background of a professed migration crisis. In the context of austerity-driven underfunding, temporary solutions become entrenched, producing a lasting emergency. Yet, we argue that "emergency" can, at some point, generate practices of resistance that undermine, subtly yet significantly, its own normalization.

1. Introduction

> *Having to cope with emergencies is one thing, but the situation has been the same every day for a long time already …*
>
> *… Working like this is anarchism! There should be more personnel; we have to focus not only on solving emergencies, but on preventing them.*
>
> (*Midwife and social worker, southern Spain, August 2016, both quoted in Arias [2016, 5]*).

Understaffing and limited resources are complaints which regularly emerge from ethnographic studies of the health-care sector in southern European welfare states, especially in socially deprived areas, or in states affected by austerity and privatizations (Karanikolos et al., 2013; Zavras et al., 2016). The Spanish, Greek, and Italian maternity care services operating in the midst of the so-called "refugee crisis" are situated in a wider social landscape characterized by structural underinvestment partly resulting from austerity policies implemented across southern Europe. Consequences include the slashing of the welfare state, increased unemployment, and lower living standards. These shared challenges arguably render the Mediterranean a unified area of study, no longer on the basis of shared cultural forms, but on the basis of the ways people cope with these new exigencies (Knight and Stewart, 2016).

The combination of chronic regional poverty, austerity, and the advent of migrant populations with specific needs have generated a situation largely perceived as an emergency by the health-care personnel working in Mediterranean borderlands (Grotti et al., 2018). Emergency denotes a situation of urgent need that requires immediate and often exceptional relief measures, which may circumvent usual rules and procedures (see also Beckett, 2013). A recurring observation of health-care staff in these social and geographic peripheries – which also constitute Europe's external borders – is indeed the tightening grip of emergency in their daily practice. This widespread assertion falls into a broader discursive context, which represents the advent of refugees to

* Corresponding author.
E-mail addresses: Vanessa.Grotti@eui.eu (G. Vanessa), Cynthia.Malakasis@eui.eu (M. Cynthia), chiara.quagliariello@ehess.fr (Q. Chiara), Nina.Sahraoui@eui.eu (S. Nina).

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Europe in recent years as a "crisis," firstly in the sense of mass population movements that deviate from the normal, "national order of things" (Malkki, 1995, 495) and secondly because their alleged high numbers are perceived as straining the host countries' already tight resources.

Discourses of crisis represent specific events or processes as deviations from a "normal" social order expected to be restored (Calhoun, 2004). Yet conceptualizing or managing events as crises rests upon hegemonic notions of normality. Labeling an event as "crisis" situates it within a specific field of understanding, and circumscribes the responses to it (Roitman, 2013, 2016) – in the case of our research topic, it prompts specific configurations of care. Further, the "crisis" label marks a before and an after, a rift between supposedly distinct social circumstances and historical periods (Roitman, 2013, 2016). As such, however, it obscures the fact that "crises" may in fact constitute gradual, organic socio-historical change (Calhoun, 2004). Against this hegemonic representation of migrant arrivals as a crisis, some have put forward the notion of a crisis of "reception" or of "solidarity", representing 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 (Christopoulos, 2017).

Within a context of professed crisis, situations that arise – such as the need to provide medical care to a body of newcomers – may be conceptualized as emergencies, distinct and more urgent than the usual order of things. Much like in the case of crisis, anthropological research into "emergency" has emphasized its discursive function as rhetoric, which builds onto and selectively highlights actual need in order to justify exceptional responses (Fassin and Pandolfi, 2010; cf. Beckett, 2013). Like "crisis," "emergency" is a performative category. It shapes our understanding of situations that may well be structural or represent broader societal shifts as short-term phenomena in need of urgent remedial response (Calhoun, 2004). Yet responses to emergencies are seldom uniform, and they often generate new norms of social perception and practice that are not necessarily reactionary or socially oppressive. Indeed, the measures taken in response to emergencies, notably in cases where the emergency comes in the form of the advent of new populations with different needs, may result in the expansion of rights (Honig, 2009) or the display of new forms of solidarity. Our theoretical as well as empirical perspective on this pluralism of responses to situations of urgent need positions our inquiry within an anthropological approach recently outlined by Sherry Ortner (2016), who calls for combined attention to a) the structural factors and processes of violence, inequality, and the exercise of power and b) the ways people grapple with moral dilemmas, display empathy, and conceptualize and try to do good within the context of their socio-cultural meanings and relations (Robbins, 2013).

In this article, we examine the maternity care of migrant patients in state and non-state structures. In previous work (Grotti et al., 2018), we focused on the experiences of pregnant migrants, examining them through the lens of vulnerability and the agency it generated. In this article, we shift our attention to configurations of care, in order to understand changes and continuities in the provision of maternity care to migrants before and after the so called "refugee crisis." We investigate whether and how the understanding or the labeling of the maternity care of migrants as an emergency within a context of professed crisis generates new norms of care within health-care delivery. In the southern European borderlands where we conducted research, austerity policies combined with the structural density of migration flows have indeed affected the way public health care is delivered in practice (Carney, 2017), including the gradual adoption and normalization of solutions or measures that in the past might have been considered urgent, ad hoc, or creative. Yet rather than a recent phenomenon due to the advent of migrants, such normalization reflects the wider social landscape of these European peripheries. The multiplication of local and non-local actors in the health-care sector, especially the growing infiltration of humanitarian organizations, evinces that the so-called "crisis" and the perception of migrants' medical needs as "emergencies" produce structures and relations of care that may persist beyond the current historical conjuncture. Conceptually, therefore, and in terms of its social effects, the temporality of emergency extends beyond the specific social and historical setting where "emergency" is deployed to lend selective urgency and legitimize dubious responses. Emergency has a past as well as an afterlife, and it both echoes and reproduces entrenched structures, perceptions, and relations. Enmeshed and socialized within these processes, health-care actors engage in strategies that reflect these constraints, but may also attempt to challenge them.

2. Maternity care in southern Europe: legal and medical background

Greece, Italy, and Spain are welfare states, which, sharing a broader, European trend, have gradually granted health-care access only to specific categories of undocumented patients (Grotti et al. 2018; Ticktin, 2011a). In Spain, the decree-law 16/2012 terminates universal access to undocumented migrants, unless they fall into a specific category, such as pregnant women and minors, or face a vital emergency. The application of the decree-law varies across autonomous regions. In Italy, Law 189/2002, following previous legislation, grants migrants access to maternity care; if they are undocumented, they may request a temporary-residence visa that covers pregnancy and six months post partum. In Greece, undocumented migrants do not have cost-free access to non-emergency health care. Undocumented pregnant women and other vulnerable categories (minors, etc.) were granted access to free, non-emergency health care in 2016, with Law 4368/2016. Free care is therefore available throughout the pregnancy, regardless of legal or political status. Until 2016, however, only labor was considered an emergency and was available free of charge. The irruption of health-care universalism in the political arena has been accompanied by special provisions for "victims" and particularly vulnerable people, such as migrants and refugees with life-threatening diseases, and victims of sexual abuse or trafficking (Fassin, 2010, 2011; Feldman and Ticktin, 2010). As the state became more protective toward specific categories, however, it turned its back on political subjects, establishing a hierarchy of deservingness based on empathy and suffering at the expense of solidarity and economic opportunities. In recent years, and due to the austerity measures introduced in Greece, Italy, and Spain, health-care provisions to migrants and citizens alike have experienced targeted cuts, apart from the special areas dedicated to protecting and treating vulnerable patients (FRA, 2011; Kentikelenis et al., 2014; MdM, 2016). Whilst pregnancy and childbirth are classified as essential in global health and public health initiatives, free universal maternity care is not a given in most European member states. Childbirth in Greece, Italy, and Spain qualify as urgent care under specific emergency clauses, regardless of the patients' legal status, being saved from cuts, if not extended and adapted to the special needs of undocumented mothers in some cases. However, the translation of these protective policies into the everyday of clinical work and doctor-patient interaction constitutes a complex challenge – as Bayla Ostrach (2013) has also observed in her work on the reproductive care of migrant women in Spain, nominal access to care does not do away with sociocultural or other barriers. The lived experience of maternity patients, especially undocumented ones, illustrates the treacherously multifarious fragmentations of medical care into the everyday of distant, under-resourced borderlands.

There is no unitary norm in the experience of pregnancy, birth, and maternity care in the countries we examine, yet we may identify some common trends. Pregnancy and childbirth are normal physiological processes traditionally confined to the domestic sphere, yet gradually medicalized, and devolved to hospitals. The medicalization of

pregnancy and birth became an object of scientific study in the 1970s and the 1980s among health-care professionals and feminist academics (Rothman, 1977; Martin, 1987; Oakley, 1980). Since then, critical approaches to the management of pregnancy and birth have led to policy reform and changes in hospital practice. Feminist activists and academics have been seeking greater autonomy for women outside but also within the hospital space (Rothman, 2016; Négrié and Cascales, 2016; Castenada and Johnson Searcy, 2015). Yet the biomedical approach to pregnancy and birth continues to prevail (Davis-Floyd and Sargent, 1997; Maffi, 2013; Cosminsky, 2016; Sharma et al., 2013). The three countries we consider feature a growing control by doctors on the female body from the beginning of pregnancy. This includes the systematic use of ultrasound and other screening tests to ensure the well-being of the fetus and increasing interventionism during childbirth, with the normalization of C-sections, episiotomies, and the use of oxytocin (WHO, 2015). Whereas in some northern European countries, such as the Netherlands, the "physiological model" of assistance without obstetric intervention is on the rise (Akrich, 1996), the medicalization of childbirth and women's preference for the assistance of doctors rather than midwives remains prevalent (Barker, 1998). Therefore, because so much of antenatal and perinatal care focuses on mitigating risk, there is less room for physiological processes. Any potential risk factor entails medical procedures presented as morally necessary to "protect" the life of the fetus and to pathologize pregnant women who refuse medical interventionism (Carricaburu, 2007; Charrier and Clavandier, 2013). Southern European norms further designate that birth should take place in a maternity ward – not at home or in a midwife-led unit. Maternity wards in Greece, Spain, and Italy must be in hospitals equipped with intensive care units. The three countries feature state-funded hospitals well-suited for medical emergencies, as well as private clinics expensive yet often less well equipped to manage complications.

Against this background of maternity-care norms in the three countries, we examine how antenatal and perinatal care for undocumented women is delivered under different conditions, which stand to challenge doctors and patients alike (Bridges, 2011; Sauvegrain, 2012). On the basis of the findings collected in Italy, Greece, and Spain, we will explore the daily experiences of health-care professionals in maternity wards characterized as facing "lasting emergencies."

3. Methodology

Over more than a year (August 2016 to August 2017), four researchers conducted ethnographic fieldwork in three European borderlands: Lampedusa and Siracusa in Italy; Athens, Greece; and the autonomous Spanish enclave of Melilla in Northern Africa, on the border with Morocco. Our sites included the spaces where our participants – migrant women positioned along the documented-undocumented continuum – resided and received medical care: the premises of health centers, public hospitals, and medical NGOs; and refugee camps and accommodation centers, hotels, apartments, and urban squats. We focused on the provision of maternity care, but also on the conditions of daily life that shaped our participants' experience of motherhood on the move. We conducted long-term participant observation with migrant women and health-care professionals in the public and NGO sectors. This included health-care assistants, nurses, midwives, and gynecologists. Participants further included volunteers, social workers, bureaucrats, and local authorities. All data were anonymized, and we use pseudonyms for the selected quotations. All methods used to collect data presented in this article were approved by two institutional review boards: The European Research Council Executive Agency (ERCEA) Ethical Assessment Committee and an independent ethics advisory board headed by University of Oxford bioethicist Maureen Kelley, who specializes in women's and children's health. In all research sites, administrators of the health structures where we conducted research were apprised of the research protocol and given the contact information of the P.I. as well as members of the project's independent ethics advisor. Individuals who participated in the research, either health-care professionals or migrant women, were asked for their consent prior to our observation of medical interactions or consultations and ensured that they could pull out of the research or withdraw their consent at any point. Oral consent was sought from participants; they were further provided with written information about the project and the contact details of the Principal Investigator and the ethics review board. Further, migrant women were apprised of the fact that the researchers were not affiliated to the health structures and that refusal to participate in the research would have no repercussions on their care. Moreover, pseudonyms are used for participants whose voices appear in this article and in other published work in order to protect their privacy and anonymity.

The researcher working in Athens conducted ethnographic fieldwork in a) the premises an independent Mother-Baby Centre (IMBC) providing maternity care to migrant women from Syria, Afghanistan, and a number of Middle Eastern and African countries since it opened in September 2016; b) a satellite clinic of a major transnational health NGO, funded by the UNHCR and established specifically to offer medical, including maternity, services to refugees who had applied to relocate and request asylum in other European countries and; c) the outpatient department and the labor ward of a major public maternity clinic. Health-care professionals who participated in the research included midwives, obstetricians, social workers, interpreters, lactation consultants, volunteers, and administrators. The researcher further conducted ethnographic fieldwork with five Syrian refugees over a period of nine months (November 2016 to July 2017). The decision to focus on Syrians reflected the fact that the circumstances (travel, asylum process, transition to Europe, linguistic interpretation, gender norms, etc.) diverge significantly – the Athens-based researcher, therefore, decided to focus on one group in order to produce more in-depth insights.

In Sicily and Lampedusa, researchers worked primarily in maternity health services, where they observed reproductive health consultations of local as well as migrant women. Additional sites included Lampedusa's public spaces, and particularly the harbor where migrants disembarked. The researcher working in Lampedusa further processed medical records from 2013 to 2017, on the nationality, age, family and medical situation, and needs of both migrant and local women, and conducted fifteen interviews with migrant women. In both sites, interviews were conducted with health-care practitioners and social workers.

In Melilla, the researcher worked in two sites: a) the Centre for the Temporary Stay of Immigrants (CETI) and b) the public hospital. Data presented here are based on fieldwork inside the Centre; interviews and observation of daily life. Ten interviews were conducted with health-care professionals employed by an international NGO providing primary care inside the Centre. Interviews were also conducted with 17 migrant residents, pregnant or recent mothers.

The medical encounters between health-care personnel and migrant patients were examined via a) ethnographic observation and b) semi-structured interviews with health-care participants and migrant patients to acquire all parties' subjective representations of these encounters and the ways in which they experienced them. To wit, out data came in the form of a) fieldnotes and b) interview transcripts. This diversity of methods and sources, therefore, ensured our comprehensive understanding of the phenomena under study (Carter et al. 2014; Patton, 1999). Given the reflexive and intersubjective nature of the research, each of the four researchers analyzed and coded her own data separately, but these individual processes of analysis were the subject of regular and systematic conversations among the research team, particularly in order to detect common themes and patterns as well as the variation which is to be expected between the different field sites, but also to determine the centrality or exceptionality of categories yielded.

Data analysis was not computer-assisted. Themes and categories were generated for the most part inductively, given the highly ethnographic nature of the research; however, pre-existing concepts (such as sexual and gender-based violence, care, control, (dis)continuity of care) were also used.

Our analysis and arguments derive from the empirical reality that we encountered from the late summer of 2016 to the late summer of 2017. This clarification is necessary, as the situation on the ground – particularly in terms of the growing role of the humanitarian sector – is subject to change, although it may well follow the trends we have observed and documented here. In Greece for example, the humanitarian sector swelled almost overnight to fill the medical needs of over one million people, who have transited through the country since the late summer of 2015. As geopolitical developments since February and March 2016 have significantly reduced the flows of newcomers and their stock remains stable at some 60,000, the Greek state is currently (May–June 2018) taking over medical care in refugee camps, the humanitarian sector's near-absolute domain since the beginning of the so-called "crisis." For the Italian case, the analysis covers the period before the agreement between Italy and Libya in the summer of 2017. Since then, arrivals in Italy through the Mediterranean have diminished significantly. Our empirical findings and theoretical conclusions, therefore, do not reflect developments after the end of our fieldwork. Yet we argue that our findings' temporal specificity intensifies their theoretical and social relevance. The norms of care generated in response to "urgent" circumstances build onto and illuminate pre-existing tendencies; further, they often entrench ostensibly provisional structures, relations, and practices.

Recognizing and disclosing the partiality of our perspective (Haraway, 1988) and the hierarchies inherent in field research is crucial before proceeding to the discussion. Our positionality was constituted by elements of nationality, gender, but also our ethical imperatives vis-à-vis the populations and the issue we studied. The influence of the researcher's presence on the interactions observed is a methodological matter well known to anthropologists (Althabe and Hernandez, 2004). The attempt to occupy a halfway position (for example choosing to sit at the side of the table during doctor-patient interactions) may not have sufficed in ensuring migrant participants that researchers were not affiliated to the medical establishment. A further challenge faced was to render it clear to migrant participants that we were not in a position to improve their circumstances in any significant way, even though we derived a clear benefit from having them participate in the research. We opted to be clear and explicit, but also try to be helpful to the extent of our ability (the Athens-based researcher, for example, attempted to aid two of her participants with their asylum process, by mediating between them and officials or engaging legal professionals to explain the specificities of the process). An additional issue arises regarding the health-care professionals who took part in the research: as researchers, we were outsiders disrupting their interactions with patients, but also potentially perceived as being there to judge or expose their practices. Again, we chose to be clear and explicit, ensure them that they could withdraw their consent at any point, and face them with the same amount of empathy we faced our more vulnerable research participants.

4. Findings

4.1. Being pregnant on the move: continuities and disruptions

In this section, we provide an overview of the social profile and particular needs and circumstances of pregnant migrants, which may indeed require, but also very often legitimize emergency measures or processes of care.

As the research participants in the Italian field site reported, sexual and gender-based violence constitutes a major factor that characterized the maternity experience of the pregnant migrants we encountered in Sicily and Lampedusa, where pregnant patients were seen and treated after being rescued at sea, at the receiving end of the deadliest international crossing in the world, the Central Mediterranean route (IOM, 2017). Obstetric and reproductive care was either provided in the emergency outpatient clinic of Lampedusa, in the form of initial assessments and tests prior to transfer to Sicily and the mainland, or in the specialized outpatient clinics and larger hospitals in Sicily, where most migrants rescued at sea are transferred by the Italian Navy and NGOs involved in rescue operations. Because of the high rate of violence suffered along the Central Mediterranean route, pregnancies were often unplanned and had occurred on the trail, mostly in Libya. Consequently, health professionals were faced with a high number of abortion requests. Joy, a 29-year-old, Nigerian woman we met in Lampedusa, defined her pregnancy as unwanted: "Getting pregnant is part of the price you pay to get to Europe." Hope, a 19-year-old Nigerian we encountered in Sicily in a sanctuary for female victims of trafficking, relayed how uninformed and unprepared she had been to the dangers and the lengths of the migration trail, when she decided to set off for Mali for work from her hometown in Nigeria. Upon arrival in Mali, she was sucked into a trafficking network, which first sent her to Libya, and from there Italy. Hope had a chance to terminate her pregnancy resulting from rape in the migration trail and build a new life, training as a cultural mediator in Sicily.

Insights from Greece derive from the experience of Syrian refugees. Our research took place in Athens rather than the islands of first reception, and the women we encountered in maternity-care structures were accompanied, in their vast majority, by partners and extended families. They were therefore less vulnerable to sexual and gender-based violence along the way than women travelling by themselves along the Central Mediterranean route, which features different forms of trafficking and gate-keeping (Grotti et al., 2018).

The dangers, hardship, and uncertainty women faced by the Syrian women we encountered in Athens did not interfere with the trajectory of life normative in their socio-cultural world: married women of childbearing age have babies. These migrants' mobility included a physically dangerous yet equally determined journey from Syria into Turkey and from Turkey into Greece; an administratively convoluted passage from the islands of first reception into the mainland; and an indefinite stay in the mainland, until they were either able to leave via formal or informal channels, or temporarily gave up on the goal of moving northwest and applied for asylum in Greece. Pregnancies that occurred during the journey seemed to have done so either because of insufficient contraception, or because these women and their husbands wanted to bear a child even while on the road. Couples who did not terminate accidental pregnancies did so despite living conditions that involved malnourishment and exposure to the elements. Other pregnancies were welcome or even planned, particularly in the case of previous miscarriages, and health professionals often encountered women seeking help to become pregnant.

The experience of Nidal is telling. Nidal and her husband and four children, all under five, arrived in Greece from their Syrian hometown in February 2016, after a journey through ISIS-infested Syrian territory, walking over mountains to cross into Turkey in the middle of the night. The family made their way to northern Greece to cross into neighboring Macedonia and from there slowly to Germany, but, by the time they got there, the Greek-Macedonian border had closed. For almost five months, they stayed in the "Cherso" government-run camp, enduring living circumstances that she says will haunt her for life. In the winter, they had to wash themselves with cold water, light fires to get warm, and boil water to wash. In the summer, her tent felt like an oven, and the camp was infested with snakes.

Nidal became pregnant by mistake. She wanted an abortion, because she had four children to mind and a history of difficult pregnancies. But her husband and the Hellenic Red Cross doctor stationed in the camp persuaded her to keep it. Her pregnancy caused her almost constant dizziness and an episode of heavy bleeding, after which she

was hospitalized. After this incident, the UNHCR in cooperation with a Greek NGO arranged for her and her family to be moved to an apartment, as they underwent the administrative process of transferring their asylum claim to another European country.

Similarly, pregnancy in Melilla combined continuity and disruption for the Syrian, Algerian, and Moroccan women that we met in the CETI. Melilla stands out insofar as it features local mobility by neighboring Moroccan women who return to Morocco after short visits as well as the migration of women from Syria, Algeria, and Morocco, who stay in the enclave. The latter mostly undertook the migratory journey along with family members, although by the time they reached Melilla many had relatives who had stayed behind; this was notably the case for Syrian families arriving in Melilla several years after leaving Syria. Wives and husbands often managed to make most of the journey together, but women were often able to cross the Melilla border before their husbands, due to complex gendered workings at the border. Once in Melilla, the circumstances of life in the Centre for migrants were disruptive due to a lack of intimacy as well as the material hardship they encountered, as related by Mounia, a 36-year-old woman of Algerian origin:

> You're with people, each person has an attitude, a way of life … they leave things all over the floor, I'm very tidy, I'm not used to that, the toilets … eight persons per room, everybody with their personality, it's very difficult. That's the big problem, the room, because for everyone a room is intimacy, stability, when you're tired you go back to your room to rest, but here you go back to your room to fight, to become demoralized, to get angry.

Remarkably, the pregnancy itself was not framed by the women as yet another extraordinary circumstance; on the contrary, they narrated the experience of being pregnant while on the move as an expected element of their lives, ensuring the continuity of their family lives in spite of other hardships that characterized their trajectories.

Contrary to the kinship ties which support and accompany Syrian refugees in Greece or Spain, in Sicily and Lampedusa, a significant number of research participants, mostly from West Africa and the Horn of Africa, experienced pregnancy and childbirth alone: they had left their partner behind, either in their country of departure, or along the trail, often following forced separation because of trafficking, bonded labor, or loss. Data from the Lampedusa immigration office and the European Border and Coast Guard Agency (Frontex) show, for instance, that among the Nigerian migrants who arrived in the island in 2016, among 558 women, less than 200 left Libya with their own partners or travelling companions. Among these, more than 150 said they did not know where their partners were or whether they were still alive. Further, of the 558 total, 79 were pregnant (14 percent). Among these 79 women, 43 stated that they did not know the identity of their child's father and requested an abortion. Physicians, then, were faced with assisting women who rarely had a partner or another supporting figure with them (e.g., sisters or mothers) during medical consultations and delivery. Another regular occurrence health-care staff faced in emergency settings, such as first-reception centers in Lampedusa and Sicily, were patients caring for children who were not their own. Fatoumata, a 34-year-old woman from Ivory Coast, arrived in Lampedusa together with her three-year-old daughter and a five-year-old boy who had lost his mother during the boat travel across the Mediterranean. Amy, a 31-year-old woman, traveled from Mali to Italy along with two children, a seven-year-old boy and a nine-year-old girl, both entrusted to her for the trip to Europe by one of her cousins, who choose not to leave Mali to take care of her third-year-old daughter. As evidenced by these stories, migrant women can travel and arrive with children whose mothers had either died or handed them over to other women before or during the journey. In both cases, physicians had trouble identifying the family relationships between the women and children they were treating and for whom they were creating medical records.

In Athens, we observed that partners and older children usually accompany pregnant migrants. Male partners, Syrians and Afghans alike, often request to be present in the examination room. Yet pregnant migrants in Greece also miss their extended families and the usual support network that underlies their frequent childbearing, although many extended families may indeed travel together.

This section outlined the circumstances of pregnancy on the move in our three Mediterranean field sites. Spain and Greece present similar cases. Research participants there became pregnant within the condition of the migration. Yet their pregnancies largely followed their pre-migration plans. In Italy, however, pregnancies resulted from the migration journey and its most adverse conditions. We now turn to the perceptions and practices of medical professionals. We demonstrate their daily difficulties and their responses to situations of "crisis" and "emergency." We further discuss whether and how these professionals normalize aspects of migrants' maternity experience which would be considered unacceptable in the case of local patients.

4.2. The permanence of emergency care

A recurring observation by health professionals is that pregnant migrants often present health conditions unusual during pregnancy in Europe. Infectious diseases, STDs, and severe malnutrition complicate migrants' care at clinical level. These health conditions stem from poverty and the adverse living circumstances of the journey to Europe and first reception in border-area camps and other "hospitality" structures. In Melilla, many pregnant women residing in the CETI suffered from anemia. Public health studies (Hunt and Macintre, 2000) demonstrated that, if the overall living conditions (diet, etc.) of pregnant women improve, the probability of a healthy birth and newborn dramatically increases as well.

In Athens, medical professionals told us that, particularly in the case of Syrians, their epidemiological profile did not differ much from the profile of locals. Hospital personnel were more on their guard for STDs with women who had come from Africa and whose journey rendered them more vulnerable to sexual violence; at the time of our research, however, these women formed a minority within the migrant population. Malnutrition, however, and anemia were almost omnipresent among the vast majority of Syrian, Afghan, and Iraqi migrants, who lived in different types of "hospitality" structures. To bring in Nidal again, malnutrition caused her milk to dry up, when she arrived in the camp and was still breastfeeding her fourth, seven-month-old child. She despised the fact that her children were given pre-packaged snacks or boiled potatoes to eat.

In Southern Italy, many pregnant migrants present with malnutrition, but also severe burns caused by spilled fuel during their boat travel. Such situations require medical personnel to transcend their regular practices, by offering assistance more extensive than what they usually provide to local women. Eleonora, a gynecologist at the Lampedusa maternity service since 2015, emphasized: "To take care of migrant women, our skills related to pregnancy are not enough, you must have a good knowledge also in general medicine, internal medicine, dermatology, and infectious diseases. The clinical problems these women present are not only gynecological, so you have to know a little of everything." Thus medical personnel develop a considerably localized expertise, which becomes extremely valuable *if* there is no high staff turnover. Yet such turnover constitutes another established practice we have found in our field sites in Lampedusa, Sicily, and Melilla.

Most migrant newcomers had either no or few medical examinations – ultrasounds, blood tests, etc. – or records thereof before arriving in Europe. Most often, the first ultrasound takes place upon entry into the host country's health system. In Melilla, 60 percent of women who gave birth at the hospital in 2015 had not had their pregnancies monitored as indicated in the maternity care scheme outlined in the Spanish "Pregnancy Health Notebook" (Embarazada Cartilla de Salud); though some had accessed private healthcare, they were carrying documents illegible to Spanish healthcare professionals. Consequently,

midwives have grown used to working in a context not seen anywhere else in Spain (except, to a lesser extent, in Ceuta): “This morning, out of 13 persons, one had her medical file. This complicates our work very much. You find things that are surprising at times, and why? Because of a lack of monitoring.” Attending women who had had no care or record thereof, or whose documents are unreadable or unreliable, increases their risk but also the anxiety of health-care workers. Midwives have consequently developed specific skills, and the hospital mostly employs midwives that have trained in Melilla and are familiar with this form of “lasting emergency.”

Related to this is a strong lack of continuity of care within the host country's health system. Continuity of care refers to pregnant women being monitored throughout their pregnancy and assisted in the labor by the same health professionals. For local women, this continuity is largely a matter of class, geography, personal relations, or preference. In Greece, women are often monitored by privately practicing professionals throughout the pregnancy but may opt to give birth for a much lower cost in the maternity clinics of public hospitals, where their labor is assisted by residents on duty. Or, specialized prenatal examinations may be performed by practitioners other than the woman's own doctor. Both processes often involve travelling within the country to access diagnostic centers or maternity clinics in major urban centers. In Italy, women face a similar discontinuity. Within the public health domain, a woman would typically interact with various gynecologists and midwives across her several pregnancy consultations. The gynecologist performing ultrasounds may not be the same who performs consultations or who assists the woman during childbirth. This fragmentation is explained by the bureaucratic functioning of the medical organization, notably doctors' shifts, and the relationship between patient and gynecologist. Research in southern Italy revealed that if a patient is followed by a doctor in a private practice – an arrangement between public and private service called *extra-moenia* – the patient is more likely to enjoy continuity of care (Papa and Arsieri, 2003).

Yet even in the case of multiple health-care professionals, continuity is ensured through verbal and documentary communication via referrals or brokered by the woman herself, who is in her native linguistic and cultural environment. Yet migrant women's medical files from the country of origin are rarely available to physicians. In Athens, we observed migrant women carrying with them a file including all the documents – exams, referrals, prescriptions, etc. – they acquired during their care in Greece. Health workers sort through the papers and attempt to understand the care that has been provided and what the next step should be. To our knowledge, there was little direct communication between doctors in the different health structures in Greece and Southern Italy, a circumstance that differentiates the maternity care of pregnant migrants from local norms. For instance, the impossibility of accessing any hospital in Libya means that the ultrasound examination performed in Lampedusa or Sicily usually constitutes the first diagnostic test migrant women have undergone since the beginning of their pregnancy. However, the collaboration between the hospital and the first reception center located on the island is extremely weak, failing to build an effective network of care.

In Melilla, a certain continuity of care is facilitated by the fact that an international NGO has a permanent station in the CETI. Therefore, the doctor and the team of nurses (several of whom have worked in the CETI for years) know many of the residents, and particularly pregnant women, by name. Therefore, migrant women establish relationships with some of these workers and “pop in” to check on different things, ask for appointment reminders, etc. This NGO provides primary care, but also refers migrants to specialists, arranges their appointments, and follows up on their medical files. Continuity of care is achieved, therefore, through the collaboration of the NGO and public health institutions since these contacts have been functioning for several years. On the other hand, this continuity of care is hampered by the fact that the hospital administrative system in place works imperfectly. When women from the CETI go to the hospital, they are assigned a number that should ensure the continuity of medical information. Yet names and surnames are often misspelled or differ among identity documents, and this breaks the continuity, as different medical histories are created. The lack of linguistic communication aggravates this, as patients cannot relate their medical history, and thus the lack of continuity remains easily unnoticed. A midwife in the maternity ward of Melilla explained: “We do what we can. You try with gestures, words, a mix of languages. You tell her to draw with her hands … and things come out in a way or another because they have to.” If the language barrier constitutes a major challenge in the women's experience of care, it also severely affects the continuity of that care.

The lack of services catering to pregnant migrants' specific needs constitutes an additional challenge. The case of Lampedusa, as a small island community poorly connected to the rest of Sicily, stands out. Lampedusa's health facility offers limited care to local inhabitants as well. Specialized prenatal examinations (e.g. morphological ultrasounds) are not available; further, gynecologists come to Lampedusa from mainland Sicily only once a week. If patients need urgent care on other days, they must be transported to Sicily, or ask for the assistance of the gynecologists “dedicated” to migrants. Specialist services for migrant care suffer equivalent problems. Limited prenatal examinations mean that problems (e.g., breech position) may not be discovered early enough. Or migrant women are assisted in unorthodox ways (e.g., assistance to premature births that occur in Lampedusa within a health facility with no operating room or intensive care unit). As health professionals pointed out, not only are women exposed to greater risks, but doctors are exposed to charges of malpractice – a stark contrast to the prevalence of defensive medicine in Italy. Further, there is no psychologist to assist female patients in overcoming the trauma suffered during the journey; moreover, the translation and cultural mediation services available are insufficient. In Athens as well, public hospitals do not have interpreters. They usually rely on the interpreters the women bring with them; either people employed by the NGOs who manage the women's living structures, or fellow nationals who speak some English or Greek. Interpreters (and outsiders in general) are normally not allowed in the labor room; this means the women must give birth without being able to communicate with the health personnel. The large health NGO and the small midwifery center where we conducted research – both hubs for pregnant migrants' medical care in downtown Athens – employ interpreters who provide their services physically or over the phone; yet interpreters in Athens are scarce, and different practitioners within these centers often must vie for them or wait for their turn.

In sum, the challenges to health professionals relate to the specific circumstances of migrant women, who a) differ from local patients due to the material conditions of the journey, b) lack medical files, and c) require more comprehensive care. Yet the acceptance that migrant patients present with particular circumstances did not seem to generate processes of thinking or planning how to change or adapt medical assistance. The daily climate of underfunding and emergency, followed by long shifts and overextended personnel, often entrenches a status quo which would require time, energy, and institutional support to be changed. Migrants present health systems with the paradox of a *lasting emergency*. The emergency is lasting, because new people keep coming in, because older arrivals maintain the characteristics (e.g., linguistic gap or adverse living conditions) that create specific needs, but primarily because these needs did not seem, during the period of our research, to result in the allocation of additional resources, and in the creation of structures and procedures that would address them systematically.

Yet positing a normalization of urgent circumstances, particularly on the part of medical professionals, may only be telling one side of the story. These countries' health resources have been diminishing for years. Therefore, positing the acceptance of “emergency” must be qualified to account for preexisting challenges. In their vast majority, medical professionals recognize that changes need to be made to serve the needs of these patients, but also the needs of the health system

generated by these women's continuing presence. Yet most lack the confidence that the resources or institutional support necessary to make changes will be available. Lampedusa physicians argue that their desire to offer specialized care is hampered by their lack of resources. They describe public hospitals as "victims" of austerity. These hospitals, in fact, are forced to operate on the same budget and personnel as before the migrants' advent and the additional expenses it generated. In Melilla, health-care personnel argued that non-affiliated patients were not taken into account in the hospital's financial allowances, while they represented a significant share of the hospital's activities (the majority in the case of the maternity ward). In the Athens public hospital where we conducted research, midwives on duty in the labor ward were almost constantly scrambling to figure out whether there were enough beds in the maternity wards. Health spending in Greece has taken several plunges since 2010 as part of the wider austerity regime. What may have been normalized even prior to these women's arrival, therefore, is a general feeling of resignation and acceptance of subpar services. Equally critical are the strategies – ad hoc, or more widespread and systemic, or ad hoc that evolve into systemic – that health professionals devise to meet the needs of migrants; strategies that may not be readily visible. In Greece, for example, interpreters employed by NGOs and accompanying migrants to the Alexandra hospital have come to be seen and treated almost as regular hospital employees to cover the dire need for interpretation. Indeed, the increasing involvement of non-public practitioners and particularly the NGO sector in the medical care of pregnant migrants is a significant part of the normalization of temporary measures in these states' welfare and health-care regimes.

4.3. An afterlife of emergency? The institutionalization of humanitarianism

In Sicily and Lampedusa at the time of our research, the humanitarian field was composed of Catholic and lay associations (all Italian, except for Save the Children and Terre des Hommes). In most cases, health professionals from the public sector collaborated with them, arguing that such collaboration stood to improve the assistance offered to women; these providers recognized the limits of the hospital care system, and interpreted the role of NGOs as complementary, rather than competitive.

In Athens, the humanitarian field consists of numerous local and international NGOs – at the completion of one year of fieldwork, we still heard names of organizations for the first time. Their services are designed to cover the range of pregnant migrants' needs: medical care, housing, and help with acquiring social insurance. NGOs that provide housing to migrants with EU and UNHCR funding are also in charge of getting them social insurance, booking them appointments to public hospitals, and accompanying them there along with an interpreter. Social workers assigned to migrants who reside in these NGOs' structures keep their medical files. A pregnant woman interviewed felt such trust and gratitude toward her social worker for the help during hospital visits that she had planned to name her unborn baby girl after her. Another one, residing in a structure of the same NGO, was convinced her social worker was trying to wrest control of the process from her, by arranging visits and procedures with which the woman did not agree. In refugee camps throughout the country, medical NGOs moved in, with permanent stations or with mobile units. As of June 2018, the Greek state has begun the process of taking over medical care in the camps – yet in many cases, large medical NGOs continue to offer services in premises located closely outside camps.

Health NGOs perform a significant part of women's antenatal care in their clinics located in downtown Athens as well. Their doctors and midwives perform basic ultrasounds, provide women with supplements, prescribe diagnostic exams, and encourage the women to come back on a regular basis, so that they may monitor the progression of the pregnancy almost up until labor. Along with the exam prescriptions, they write referral notes for the hospital health personnel. This NGO's administrative personnel often take on the task of making the women's exam appointments in public hospitals. Many NGO doctors have also worked, or still do, in the public sector, are familiar with its challenges, feel a sense of allegiance rather than competition, and try to facilitate its work. These complex and multi-layered relations, allegiances, and interactions elide ideal-typical distinctions between the medical humanitarian sector and state health services. This boundary becomes more blurred the more layered these humanitarian actors' positionality: they are natives of the country (Greece) whose failings they try to correct with ad hoc solutions, they have worked in (and depend on, as potential patients) its public sector, and therefore are arguably more strongly invested in longer-term outcomes.

In Melilla, both humanitarian and public institutions play a role in migrants' and refugees' access to care. Amongst the humanitarian actors, some have assumed a more permanent role, fully acknowledged by the public health system; notably, an international NGO, whose presence in the CETI is permanent. As explained in the previous section, this NGO's role in linking, by providing referrals, care within the CETI with outside specialists subsumes, in a way, the whole network of care under humanitarian action. The right to access health care is granted, therefore, through the status of CETI resident and the NGO's mandate to attend all residents. This system of humanitarian health care theoretically covers every resident of the CETI in the same way, ensuring that care is provided to undocumented migrants as well, who would otherwise not be able to access health care. Some categories of migrants do however have the right to access regular health care and to be issued a health card (*tarjeta sanitaria*). While asylum seekers residing in the CETI can access care through these humanitarian channels, they are technically entitled to regular social security, and can have a *tarjeta sanitaria*; yet many do not, and the CETI does not process these cards for them. Therefore, this humanitarian system whose presence is supposedly a provisional measure in response to "emergency" circumstances, creates, in practice, an established network of care in the context of Melilla. The fact that this network has taken over situations that are in theory covered by the mainstream public system of health care (such as asylum seekers and minors residing in the CETI) became the accepted response to migrants' arrival over the years. Pregnant women in the CETI also have access to health care on humanitarian grounds. Pregnancy constitutes a specific status that guarantees access to health care, but given that all residents have access to health care on humanitarian grounds, pregnant women do not represent an exception in the CETI context.

The picture painted so far suggests a growing role of the humanitarian sector in the care of pregnant migrants in the countries under study – in Melilla, this role extends as far as an established collaboration with the public sector. NGOs and smaller associations increasingly seek to enter the hospital system to provide "global assistance" to women, as illustrated by a proposal to open a counseling center in the Lampedusa hospital to compensate for the absence of psychological support for women and to create a "network of care" dealing with the different forms of violence experienced by migrant women and combatting the trafficking of women. Apart from health services, the humanitarian sector in all three countries provides a number of additional services (distribution of goods, legal assistance, or housing). The humanitarian sector, therefore, has assumed a dual role: to fill the gaps of the health system and to manage the extra-hospital "care industry" traditionally managed by the state's social workers. Humanitarian actors increasingly enter into play, all the more so in view of the fact that gender has gradually become a central axis of humanitarianism in recent decades (Ticktin, 2011b). The work of humanitarian organizations in the peripheries of the European Union develops alongside state or regional health-care facilities and against the backdrop of changing medical and social norms.

5. Conclusion

In this article, we have examined the circumstances of maternity

care in Mediterranean borderlands that became sites of humanitarian interventions, not least in the wake of what in the summer 2015 has been labeled a "migration crisis" in public and political discourse. Yet the processes which led to the escalation of the so-called crisis and its multiple mismanagements were related to policies and bilateral agreements introduced at national and EU level rather than to the scale of the flows (e.g., Christopoulos, 2017; Holmes and Castañeda, 2016; Kallius et al., 2016). The rampant representation of the arrivals since 2015 as a "crisis" threatening the resources available to local populations obscures chronic and structural underinvestment, but also the fact that a mere two million people arrived in a continent of 500 million.

Notions of "crisis" in the specific arena of health care translated into the understanding or the labeling of the care of migrants as an "emergency." Our focus on the delivery of maternity care to migrant patients in state and non-state structures aimed not only to problematize the rhetoric of "emergency" but also to shed light on its multiple temporalities. Our findings reinforce the anthropological consensus on the performative character of "emergency" as a discursive device that selectively highlights needs in order to legitimize specific responses (Fassin and Pandolfi, 2010). Our case studies nevertheless demonstrate that the discursive manifestation of emergency arises from long-term, entrenched structures that condition the subjectivities of actors delivering care.

But emergency does not only have a past; its past and present also give rise to a future. In the arena of migrant maternity care, past structures and present practices and discourses of emergency generate long-lasting norms at a multiplicity of levels, which may persist well beyond the current historical conjuncture. The institutionalization of humanitarianism in the three countries under study constitutes a significant outcome in this regard. On a broader level, understanding that "emergency" has temporalities that extend well beyond a specific, intense moment carries significant theoretical as well as social import. Notably, it allows the normalization of mechanisms of "urgent" response; further, it discourages plans of structural change. Yet the creative practices and informal socialities we noticed carry their own potentialities. Plans for systematic, structural overhauling were not observed during our research – yet further ethnographic work examining the afterlife of the "emergency" we have outlined may reveal that "emergency" can, at some point, generate practices of resistance that undermine, subtly yet significantly, its own normalization.

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