

# Narratives of Slow Violence Fear by Greek-speaking Pregnant Women during the COVID-19 Period

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## ABSTRACT

*During the COVID-19 pandemic pregnant women had to cope with the unknown and unprecedented challenges the coronavirus health crisis created. The Greek state and the biomedical discourse classified pregnant women as vulnerable due to the increased risk of severe illness and mortality rate of pregnant women infected by the coronavirus, depriving them of any kind of agency. However, the fear of slow violence of potential COVID-19 infection to the fetus's health and the health of pregnant women led them, and particularly, the participants in this research, to act agentively as self risk-managers and to proceed to the adoption of several measures in order to alleviate this fear and to safeguard their own and their fetus's health. These measures consisted of self-regulated preventive measures, mitigation strategies, and the COVID-19 vaccine uptake or refusal. These findings constituted the voice of the interviewees and their experience of being pregnant during the COVID-19 pandemic. They were the outcome of the conduct of eighteen online formal semi-structured in-depth online interviews and netnography. The research lasted three months, from 10 February 2022 to 10 May 2022, and was conducted in framework of the thesis: The experience of pregnancy in the COVID-19 period in Greece at the Master Course: Cultural Anthropology-Sustainable Citizenship of Utrecht University.*

## KEYWORDS

*Covid-19; slow violence; pregnancy; self-regulated measures; vaccination anxieties*

## INTRODUCTION

“PANDEMIC! It is a PANDEMIC”. A young doctor rushed out the door of the haematological ward overtaking and ignoring us, screaming in despair, “It is a pandemic!” For a moment, we kept staring at each other, wondering what was happening. And then we were petrified when hearing, “We are shutting up everything. We cease every protocol”.

That was the first day of the formal announcement that the country officially declared a public health emergency, as Barbara colourfully narrated. The narrative above describes how a pregnant woman experienced the first day of curfew measures imposed by the Greek state due to the COVID-19 pandemic in 2020. The COVID-19 outbreak started officially in Greece in March 2020, following the diagnosis of the first COVID-19 case on February 26. On March 22, the government proceeded in establishing a state of exception operation, enforcing serious limitations on free movement as well as suspension of the normal functioning of social life and working conditions (Silva & Higuera, 2021, p.501). Consequently, the fear and horror of SARS-CoV-2 coronavirus contagion (Silva & Higuera,

2021, p.504) were promoted in the name of “biosecurity” (Reader, 2021) in order to control and regulate the population. In particular, Law 4682/2020 on “Urgent measures to prevent and limit the spread of coronavirus” identified pregnant women as vulnerable groups and consequently the National Public Health Organisation (NPHO) issued guidelines relevant to the management of infected or likely of being infected pregnant women by the SARS-CoV-2 coronavirus in March 2020. According to these guidelines pregnant women with confirmed SARS-CoV-2 infection should have been treated exclusively at designated reference. The decision about the time and type of childbirth was individualised depending on the clinical condition of the pregnant woman, gestational age, and the fetus’s condition.

In December 2020 the Hellenic Society of Obstetricians and Gynecologists (HSOG), followed the same rationale, in guideline no 43 on the obstetric provision of care during the COVID-19 pandemic, as the healthcare management algorithm recommended that if a COVID-19 symptomatic pregnant woman were in labour, she would be transferred to a designated reference COVID-19 hospital to give birth in.

Regarding the vaccination uptake against COVID-19 during pregnancy, guideline no 57 issued by the HSOG recommended the COVID-19 vaccination to pregnant women, especially to the ones with comorbidities, as the most effective protective biomedical measure against hospitalisation and severe illness, as well as the transfer of SARS-CoV-2 antibodies to breast milk, following mothers’ vaccination.

The COVID-19 biopolitics described above demonstrate the state response to the pandemic without any reference to the counterdiscourse of pregnant women regarding their experience during the pandemic. This gap of information was the starting point of this research leading to its objective which was to give voice to the experiences of pregnant women during the coronavirus period. Consequently, the main research question was, “**How do pregnant women experience pregnancy during the coronavirus period?**”.

The research lasted three months, from 10 February 2022 to 10 May 2022, and was conducted in the framework of the thesis: The experience of pregnancy in the COVID-19 period in Greece, at the Master Course: Cultural Anthropology-Sustainable Citizenship of Utrecht University. The narratives of slow violence constitute part of the findings.

## RESEARCH METHODS

### *Population*

The target group consisted of women who identified as women and were pregnant when the WHO declared SARS-CoV-2 a global pandemic on 11 March 2020 (WHO) and women who got pregnant during the first and second pandemic periods. As the first coronavirus period, I defined the one that started when WHO declared the COVID-19 outbreak a global pandemic on 11 March 2020, and the second one, after the HSOG issued a COVID-19 vaccination recommendation to pregnant women according to no 57 guideline in May 2021 in Greece.

The total number of interviews was eighteen. Seventeen of these interviews were from the following administrative regions of Greece: Attica, Crete, Eastern Macedonia and Thrace, Central Macedonia, Western Macedonia, Peloponnese and South Aegean Greece, and one from Cyprus. Fifteen interviews from urban centres and three from the countryside. Two women were pregnant during the research and sixteen during the two defined coronavirus periods. All participants graduated from tertiary education; twelve holding a master’s degree and one a PhD. Only one of them lost her work during her pregnancy during the coronavirus. The age group had a broad range from 28 to 42 years old. Six of them already had a child and twelve of them were first-time mothers. Fourteen participants were vaccinated. From those fourteen, five were vaccinated during pregnancy (one during the first

COVID-19 period) and the rest of them in the second coronavirus period. The type of selected vaccine was predominantly a mRNA vaccine, except for one who got vaccinated with a viral vector vaccine. Four participants remained vaccinated even during the lactation period. Three participants decided to deliver their baby at home, six to deliver in a public hospital with a specialised maternity ward, while the rest at a private maternity hospital. Six participants underwent a caesarean section, agreeing with their obstetricians and not due to coronavirus infection. Luckily none of them were tested positive for COVID-19 during labour. Regarding their marital status, only one of them was in a civil partnership, while the rest were married.

### **Ethics**

To ensure potential interviewees' health safety, I contacted them virtually and conducted the interviews remotely online. The potential participants received an extensive and analytical informational letter via email or social media. The informational letter included information about my identity, my contact details and my supervisor's contact details, the topic and objective of the research, the duration of the interviews, the voluntary basis of their participation, and the participants' eligibility to choose the means of conducting the interview. Those who decided to participate in the research received an informed consent document before each interview, requesting them to return it signed before each interview started. The informed consent document included additional information on the potential duration of the interview, the participants' right to stop the discussion whenever they wanted to, the participants' right to refuse response to any questions they feel uncomfortable with and their right to withdraw their consent at any time, during and after the interview, the confidentiality and the protection of personal data, as well as the management, assessment, and storage of data, the duration of the research, and the reference protocol number of approval by the ethics committee of Utrecht University. Additionally, before the onset of any interview, the participants were asked if they were willing to be recorded during the interviews and were informed about their right to request for the recording to stop at any time. Those who gave their consent for their interviews to be recorded were informed about the exact starting and ending time of the recording. Each interview was anonymised and coded according to the numerical consequence. To ensure the anonymity of the participants, no demographic data were used in any part of the analysis.

### **Positionality**

In terms of positionality, I considered and approached the target group as agentive subjects that have to formulate and perform their role within a social framework that might perceive them as docile and vulnerable individuals, excluding the biomedicine discourse which regards pregnant women as a vulnerable group and the birthing body as inherently problematic and potentially dangerous to the fetus (Macdonald, 2006, p. 235). I examine them as subjects in a continuum of renegotiating their personhood and reclaiming their motherhood through their practices and acts of mothering, trying to balance their priorities in a supplementary way, namely themselves and their fetuses, instead of the explementary position of the fetus towards them.

### **Data Collection**

To approach the target group, I follow Marcus's (1995) multi-sited fieldwork imperative on "follow:" the People; the Thing; the Metaphor; the Plot, Story, or Allegory; the Life or Biography; the Conflict (Airoldi, 2018). Consequently, I employed an online ethnography approach which included the conduct of formal semi-structured interviews and netnography.

In order to follow the people, namely to find potential participants, I used three different strategies. First, I addressed four Greek online Facebook mothers' groups that my social network recommended me, namely "momslife"<sup>1</sup>, "Woman-embryo-child lactation" (Greek: "Γυναίκα-έμβρυο-γέννα-βρέφος-παιδί-θηλασμός")<sup>2</sup>, "Volunteers Supporting Lactating Group-Athens" (Greek: "Εθελοντική Ομάδα Υποστήριξης Θηλασμού Αττικής")<sup>3</sup>, and "Birth without violence" (Greek: "Γέννηση χωρίς βία")<sup>4</sup>. Three of these groups accepted me as a member and allowed me to upload the informational letter. In the first two above-mentioned groups, I posted the informational letter with a specific reference to the vaccine discourse of pregnant women regarding COVID-19 and the response was fruitless. In the last group, I followed a different strategy. I sent the informational letter first to the group administrators for approval. Their counterproposal was to delete any reference regarding the vaccination against COVID-19 during pregnancy in the informational letter in order to receive any responses, since the COVID-19 vaccination topic had provoked heated discussion following the initial recommendation of COVID-19 vaccination by the HSBG a year earlier. I followed their advice posting the informational letter with no reference to the vaccination and nine persons responded to my request. The group "Volunteers Supporting Lactating Group-Athens" never accepted me in their group.

The second strategy I deployed was to search for participants through the interlocutors' network. In this case, interlocutors were friends and family members. Snowballing was the third strategy, and it came as an initiative from participants whom I had already interviewed and volunteered to suggest other women who had experienced pregnancy during the coronavirus period.

I conducted eighteen formal in-depth, open-ended semi-structured interviews since this type focuses on the interactively produced meanings and emotional dynamics of the interview itself, and though the focus is on the participants' story, the researcher's words, thoughts, and feelings are also been taken into account (Ellis et al., 2010). I developed an interview guide based on semi-structured questions to conduct the formal interviews and adjusted them to each interview's needs. All interviews started with the general question, "**How is it to be pregnant during the coronavirus period?**" and whenever necessary I navigated the participants by asking them the semi-structured questions prepared. Following the recommendation by Alexia Maddox in "Doing fieldwork in a Pandemic" (Lupton, 2020), before the completion of each interview, I asked the participants if they would like to add something more that I might have overlooked as a way to further engage the discussion.

In order to adapt to the digitally mediated social relations in the COVID-19 era (Hammersley & Atkinson, 2019, p. 139) requirements, to comply with social distancing state regulations to safeguard participants' health and the health of their fetuses and/or infant, I deployed Voice over Internet Protocol (VoIP) technologies, namely the Zoom conference platform, Skype software, Viber, WhatsApp, and Messenger instant messaging apps, following the interviewees' preferences. Voice over Internet Protocol (VoIP) technologies enable the replication features of face-to-face interviews (Iacono et al., 2016) by allowing for real-time interaction involving sound and video (Archibald et al., 2019, p. 2). According to the participants' request, seventeen interviews were conducted online and one over the phone.

<sup>1</sup> "Momslife:" <https://www.facebook.com/groups/1014566959035092>

<sup>2</sup> "Γυναίκα-έμβρυο-γέννα-βρέφος-παιδί-θηλασμός:" <https://www.facebook.com/groups/208881252997061>

<sup>3</sup> "Εθελοντική Ομάδα Υποστήριξης Θηλασμού Αττικής:" <https://www.facebook.com/AttikiThilasmos/>

<sup>4</sup> "Γέννηση χωρίς βία:" <https://www.facebook.com/groups/320870168492073>

To follow Marcus's Metaphor and Conflict, I conducted netnography<sup>5</sup> via online observation of the four selected Facebook mothers' group posts, YouTube platforms, and social media profiles of the policymaking bodies regarding pregnancy and COVID-19.

To triangulate the data and follow the "Thing", I also conducted archival analysis on biomedical guidelines published by international, European, and local biomedical bodies, such as the WHO, the CDC, the ECDC, the Greek Ministry of Health, the Greek National Public Health Organization, and the Greek Hellenic Gynaecological and Obstetrician Society.

### **Data Analysis**

For the data analysis I used the theoretical framework of Foucault's theory on biopolitics and how biopolitics is understood in the Foucauldian sense, namely how biocitizenship disciplines and controls subjects even as it affords them certain rights (Shapiro, 2019, p. 358), being in a COVID-19 state of exception, as Agamben demarcated it. "Biopolitics" as a system of constant surveillance and discipline in governmental control pertains directly to the physical existence of citizens (Berge, 2020). The biopolitics of COVID-19 have been based on the promotion of horror and fear of contagion (Silva & Huguera 201, p.504). Being in a state of exception means the suspension of rules and conventions; creating a conceptual and ethical zero-point from where the law, the norms, and the political order can be constituted (Hansen & Stepputat 2006, p. 301). In this neoliberal state of exception scenery, I deployed the slow violence concept to analyse the data. Slow violence, defined by Nixon (2011), is the violence that occurs gradually and out of sight; a violence of delayed destruction that is dispersed across time and space, an attritional violence that is typically not viewed as violence at all. In this case, it was the fear of potential harm to the fetus's development and the health of pregnant women by COVID-19 complications either by an infection or anti-coronavirus vaccination.

I also used the constructivist grounded theory approach (CGT) as developed by Charmaz, which enables the field to speak, namely to uncover and explain patterns and variations through the constant comparison of data (Bitsch, 2005). This approach allowed me to consider and assess all possible theoretical understandings of the collected data, including my new theoretical constructions (Charmaz, 2017) and my positionality by developing tentative interpretations of the data through constructing codes (Charmaz, 2017). For the creation of the codes, I used NVivo to data, taking into account the theoretical framework and the new data from the field, following Charmaz's constructivist grounded theory. NVivo software package allows detailed analysis of specific topics within other broader issues. Once all the information are encoded, it provides a systematic process in research, increasing the validity and reliability of the study (Zapata-Sepúlveda et al., 2011, p.382).

## **RESULTS AND DISCUSSION**

### **Name it: Slow violence!**

All participants' narratives implicated the fear of slow violence to the fetus's and interviewees' health status as a complication to a potential COVID-19 infection, even if participants did not define it as a concept. In other words, the interviewees were conceptualised-according to the risk discourse-as doubly at risk since they were responsible for more than their own bodies (Wilson, 2019, p.500). To deal with the coronavirus

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<sup>5</sup> Netnography is regarded as one of the most important research tools (Bartl & Stockinger, 2014). It enables researchers to access the community members' knowledge online which in turn helps to provide in-depth insights about the consumers (Kozinets, 2015 p.2).

uncertainty caused by the emergency health risk, to alleviate the fear and anxiety emotions provoked by potential implications on their own and their fetus's health, as well as to safeguard and enhance their well-being and the well-being of their fetus, the participants proceeded in adopting in both COVID-19 periods much harsher self-regulated preventive measures compared to the ones imposed by the state, as well as coping strategies expressing their agency towards the unknown of a potential COVID-19 infection. I interpreted their strategies as agentive ones deriving from docile bodies in a predetermined COVID-19 biopolitical framework. Docility does not necessarily mean passivity; instead, docility refers to creating bodies that are capable of policing themselves (Sawicki, 1999), like in this case in the coronavirus biopolitics scene.

The self-regulated preventive measures were distinguished into those relevant to self-regulation and those applied for regulating their immediate social environment. These measures were multiple and depended on the coronavirus period, the age of pregnant women, and whether women were pregnant and/or first-time mothers. Emotions of fear and anxiety (Molgora & Accordini, 2020; Draganovic, Bosankic & Ramic, 2021; Parlapani et al., 2020) were more prominent during the first period of COVID-19, while stress and feelings of despair, anger, and alienation were experienced as well in both periods and were the driving force of self-policing measures. As a result, self-regulated measures were stricter on most occasions, especially in first-time mothers between the ages of 35-42, since they were more in anticipation of a child. Their self-regulated practices included home confinement with the sole companion of their partner, rare movements—almost exclusively to perform prenatal care appointments—seldom interactions with family members outside their close family circle and implementation of additional hygiene measures, for instance, purchasing specialised equipment. As Zoe recalled:

“I communicated via video and telephone, but I had no help. I did not allow anyone to enter the house. There was a breakdown in the geyser and I told them (the technician) they would have to repair it outside of the house; otherwise, they should wear a mask, take off their shoes, and wash their hands thoroughly”.

If Zoe was highly cautious before the childbirth, Dioni became utterly cautious right after the birth of her baby, from the newborn's arrival at the house until it turned one month old. Following the recommendations given to her and her spouse by the medical staff of the maternal hospital about the risk of COVID-19 infection to infant health, Dioni transformed the house into an almost fully sterilised environment. Disinfection became a prerequisite for going in and out of the house, and the grandmothers were obliged to wear disposable robes. As for her husband, he had to take a shower in a different place before entering their house every time he came back from work. After the shower, he had to put on a disposable robe too. Any social interaction apart from the three above-mentioned members was forbidden. Even the groceries were purchased entirely online.

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

Exceptions to the measures mentioned above were implemented. Few couples were cautious, but they took no additional preventive measures other than the ones imposed by the state of exception and allowed visits to their houses even during the first coronavirus period. Tina and her partner were one of those few couples.

“We were not from these families that got afraid. So, some people were visiting us”.

Regarding the dimension of work in relation to self-regulated measures, there were variations based on estimating the precarity of potential infection in a working environment. Some participants used Law 4682/2020: “Urgent measures to prevent and limit the spread of coronavirus”, which identified them as vulnerable groups. Those who continued to work were working remotely using online Voice over Internet Protocol (VoIP) technologies, namely the Zoom conference platform, Skype, and any other online remote working environment. In cases in which the type of participants’ work necessitated meeting with clients physically, the interviewees took all the preventive measures to ensure safe contact. The measures included mandatory wearing of high efficacy masks, open windows, distancing, prohibition of physical contact, well-ventilated spaces, and occasionally face shield masks and equipment for air sanitation.

Another preventive measure that interviewees implemented voluntarily was associated to school attendance. The participants who had another child in preschool age decided either to not send their child to the nursery school or to limit the child’s attendance in order to avoid exposure to COVID-19 and other viruses, mainly during autumn and winter months in both lockdown periods.

### *I did not cut off from mister “psy!”*

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

This part of Barbara’s narrative describes only one way that pregnant women chose to perform self-care strategies; and it indicates the application of coping strategies to deal with the double complex situation, aka pregnant in a pandemic. WHO (2022) defines self-care as “the ability of individuals, families and communities to promote their own health, prevent disease, maintain health, and to cope with illness with or without the support of a health worker. It recognizes individuals as active agents in managing their own health care in areas including health promotion; disease prevention and control; self-medication; providing care to dependent persons; and rehabilitation. It does not replace the health care system, but instead provides additional choices and options for healthcare.” Consequently, the term was employed in the context of mitigation strategies during the coronavirus period as proactive steps to enhance resilience and overall well-being, and was not strictly connected to work-related settings (Butler et al., 2019, p. 107-108).

For this research and in regard to the findings, three types of self-care individual practices/strategies were examined: physical, emotional, and psychological coping strategies. Starting from the physical mitigation strategies, namely actions to promote one’s physical well-being (Bloomquist, 2016, p. 293), some interviewees referred to their attempts to undertake mild physical activity, like walking, since it was the only thing that was allowed during the imposition of harsh coronavirus measures regarding the restriction of free movement. During the period of general and mini lockdowns, especially during autumn, winter and early spring months of two years, the interviewees could only walk outside and not participate in any other form of physical activity as any other form of physical exercise in athletic indoors centres were not permitted as those premises were closed. Particularly during mini lockdowns, they walked outdoors by themselves or accompanied by friends. As Nicky said:

“Walking with friends was some kind of a way out from the coronavirus situation.”

Regarding the emotional coping strategies, interviewees mentioned meeting up with friends, attending social events, going on vacation, and biosocialising in cyberspace. Meeting up with friends usually took place in open spaces, keeping distances and occasionally wearing masks, and under the prerequisite, the lift of free movement restrictions.

Decompressive was also the decision of some interviewees to go on vacation during summertime, especially in 2020. The motivation, therefore, was the same, but the subjectivities varied due to how pregnant couples<sup>6</sup> had decided to experience pregnancy during the COVID-19 period. Those who had internalised the governmental discourse to a larger degree and, due to previous misfortunes regarding miscarriages, had adopted additional self-regulated measures and consequently decided to go on vacation, but in an isolated and protective way. Rebecca mentioned:

“The only thing we did was go from our room to the beach and back. In the restaurant, we were sitting away and at a certain distance from other clients so we would be able to take our masks off. We tried to make our vacation as safe as possible due to COVID-19.”

On the contrary, other couples were more relaxed in regard to the infectiousness of the virus and decided to visit an island but avoided mingling with other people in small spaces, following the recommendations of their health professionals.

Biosociality<sup>7</sup> as an alternative emotional strategy was applied by the majority of the interviewees, and it was supported as finding by the netnography on the Facebook mothers’ groups, via digital means of communication in their attempt to reinvent socialisation in the pandemic period. The common practice followed was participating in online groups sharing their experiences, concerns, and general knowledge on pregnancy and motherhood. As Friedman explains in her book “Mommy blogs and the Changing Face of Motherhood”, moms’ blogs and groups, give mothers a voice and foster conversation and participation in a community (Friedman, 2013, p. 11), allowing them to perform new forms of maternal subjectivity. It was like an answer to the quest of belonging to the social group of pregnant women in confinement. Ismini’s narrative is indicative of this need:

“I found one group which prepared women for the pregnancy experience and I became a member. It helped me a lot, even if it was once per week; it gave the opportunity to share my pregnancy experience and talk about it.”

Hence online moms’ groups operated as a substitute to relationality in physical space fostering the need of pregnant women to belong in a group in which they could share their feelings, emotions, anxieties, questions, and being empathised. Hence, belonging in this case was constituted by and through emotional attachments and was considered as emotion mediating in creating subjectivities, collectivities, and places (Halse, 2018). Shared emotions connect people to objects and places and shared sentiments bring people together to create social solidarities, groups, and collectivities (Halse, 2018); similar to the case of online groups of pregnant women during the coronavirus period.

Two participants mentioned work as a copying emotional measure to deal with confinement during their pregnancy. In one case, the interviewee despite the fact that she could use the Law 4682/2020 provision that excluded working pregnant women in

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<sup>6</sup> In pregnant couples, the partner is expected to participate in the choice of medical specialists, attend appointments and exams, birth preparation courses, and labour and delivery (Rezende, 2011, p. 535).

<sup>7</sup> Biosociality is the notion that people with shared biological conditions come together to form social networks. The concept was introduced by Rabinow (1996), who considered the implications of new genetics on society (Bradley, 2021).

healthcare-as no vaccination was developed until the beginning of 2021-refused to employ it and continued going to work. It was her way to cope with confinement. Another interviewee chose to self-isolate and started working remotely. Work was a way out for her so she could cope with self-isolation.

Communication with their social networks, namely relatives and friends, also moved online or over the phone, particularly during the first period of the coronavirus. It was the indicated way to keep all parts safe and at the same time provide emotional support despite the fact that it was digitally mediated. Another type of emotional copying strategy was taking foreign language lessons as a way to communicate with the rest of the world, according to Pauline.

As to psychological mitigation strategies, some participants found support in therapy. Three of the interviewees were already in psychotherapy prior to the COVID-19 outbreak. And they continued the sessions with their therapists during the COVID-19 pandemic via digitally mediated means, like Skype, in order to cope with the challenging situation of being pregnant during the coronavirus period.

Other psychological coping strategies related to mothering practice, as it allowed them to experience personhood<sup>8</sup>, included lots of book reading. A participant argued that personal time would have been very limited after her baby's arrival, so reading books was an expression of her present personhood as a pregnant woman who was not a mother yet and therefore prioritised her needs first.

### ***Vaccine anxieties***

Another element from the field related to the fear of slow violence was COVID-19 vaccination and any potential complications to fetuses' development in the third semester.

“I wanted to get vaccinated with the third dose ten days before my appointment. I told them I was pregnant, but they told me (in the vaccination centre) that this was not a reason to get vaccinated sooner until an employee addressed the director, informing him about my frequent contact with people due to my profession. Hence, it was urgent to get vaccinated before the onset of my clients' appointments. So, they accepted it.”

Participants expressed this fear by articulating their discourse through vaccination anxieties—a term employed by Leach & Fairhead (2008)—independently whether they proceeded to get vaccinated. According to Leach & Fairhead (2008), vaccine anxieties can take negative forms, such as worry, concern, or fear—but also positive forms, as a desire or striving (Leach & Fairhead, 2008, p. 39)—and are related to vaccine hesitancy. Under a positive frame, vaccine anxieties imply striving for something and recognising the cruciality of ensuring well-being (Leach & Fairhead, 2008, p. 39). There have been multiple determinants regarding vaccine anxieties, which influenced the vaccine uptake or refusal by the participants.

Professional hesitancy and its causes, as they were described by Chervenak (2022), constituted risk or protective factors regarding COVID-19 vaccination by the participants. This is indicative in Dioni's narrative:

“I remember he (her physician) told me there was uncertainty regarding the vaccine safety during pregnancy at that period, and suggested I should wait a little bit as I

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<sup>8</sup> I refer to the aspect of personhood related to practice, namely what people actually do and how they negotiate interactions in their lives (Strathern & Steward 2011, ed. Mascia-Lees 2011, p. 389).

was in the last month of the pregnancy and the vaccination recommendation had started; just two months ago.”

Her narrative is an example of articulated therapeutic nihilism<sup>9</sup>, one of the causes of professional nihilism. It was prominent during the pandemic outbreak and until the period that international health organisations, such as the WHO, commenced the recommendation of COVID-19 vaccination to pregnant women due to the lack of data regarding any complications to pregnant women and their fetuses. In the case of Greece, some physicians recommended to pregnant women who were in the last month or last trimester—when the COVID-19 vaccination was recommended to pregnant women, namely after May 2021—to wait and get vaccinated during lactation in order to have more data and avoid any harm.

The issue of respect of pregnant women’ autonomy by health professionals was another component of the professional hesitancy that the participants articulated. Following the interviewees’ narratives, there were physicians, primarily until and shortly after the issue of the no 57 guideline of the HSOG, who recommended the vaccination but did not insist on it; like in the case of Marcella:

“My doctor did not ask me if I have been vaccinated. I asked him about getting vaccinated while being in the seventh month of pregnancy, and he told me that it would be good to get vaccinated before the eight month in order to create antibodies and have them passed on to the fetus. However, he did not pressure me to get vaccinated because he knew that we were (her family and herself) confined at home. Instead, he was discreet and replied, 'This is the data. It is up to you to decide what you want to do'. I was relieved by his answer.”

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

“When we saw (her obstetrician and herself) that I was pregnant, she told me that she wanted me to take care of two things immediately; first to get vaccinated with the flu vaccine and second to get vaccinated against the coronavirus. Before I got pregnant, I had done my research on which vaccine was the most suitable for those who wanted to have a child, so when my physician told me about it, I trusted her.”

Trust, as stated in the above-mentioned narrative constituted a protective factor regarding the vaccination uptake in this particular research. Most interviewees, who decided to proceed with getting the vaccine trusted their healthcare professionals. Likewise, in Brownlie and Howson’s research on trust and MMR vaccination, confidence was not only based on knowledge but also on a “leap of faith” that could only be possible because the target group of this research had a relationship with professionals on familiarity (Dube, 2013, p.1769). However, they had no trust or expressed their doubts—regardless if they got the vaccine or not—about the government and the pharmaceutical industry. This lack of trust was strictly connected to the subjective perception of risk stemming from the cultural specificity of the lack of confidence in the current right-wing government. The current government declared its support for the COVID-19 vaccine patents during a meeting of the European Parliament.

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<sup>9</sup> Therapeutic nihilism directs the obstetrician to avoid any clinical interventions during pregnancy to avoid teratogenic effects that might be unknown (Chervenak, 2022, p. 1).

Participants also distrusted the pharmaceutical industry over their profiteering due to the COVID-19 vaccination patents. As one participant stressed out:

“If vaccines were a solution, there would have been a lift of patents, so that everyone globally would have the right to get vaccinated.”

The disenchantment of science echoing in the interviewee’s narrative is indicative of a process of demonopolisation/feudalisation of scientific knowledge with conflictual equalisation tendencies in the gradient of rationality between experts and lay people. And this is related to the increasing issue of conflicts of interest, i.e., situations in which scientists or experts are perceived as untrustworthy because of their financial association to industries (Peretti-Watel et al., 2015, p.6). Due to this economic association to industries-as it is developed by Peretti-Watel et al. (2015)-untrustworthiness in science led to a deficit of trust in the pharmaceutical industry. The limited distribution of data about the side effects for vaccinated pregnant women further nurtured this distrust, which was perceived as a lack of transparency by the participants. As one interviewee described:

“My healthcare professionals listened respectfully to my doubts without directing me to one or another direction. This decision was based on the lack of data based on clinical studies regarding vaccine complications for pregnant women and their fetus. Pharmaceutical companies did not publish this data. It was only after a court case in Texas that the pharmaceutical companies were obligated to disclose their data; otherwise, they would have not informed us about anything.”

Body ownership and protection of its boundaries by the invasion of a regulatory state was another determinant primarily expressed by people who were anti-vaccine, like in Ioli’s case. In her narrative without realizing it, she disputed the core element of biopower and its agents’ attempts to police bodies through the imposition of COVID-19 biopolitics strategies:

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

Another pregnant woman, Nicky, who got vaccinated, shared the same thoughts with someone who refused to get vaccinated against COVID-19 during pregnancy. However, she complied with the coronavirus biopolitics strategies; in particular, to mitigate the restrictions in free movement applied to non-vaccinated people. According to Nicky:

“In general, I was anti-vaccine. I did not want to get vaccinated, but from September (2021), it was a one-way street. You could not move around freely, so I did it because I had no other choice.”

Other determinants that affected the positive aspect of COVID-19 vaccination to pregnant women were their age, potential comorbidity, the trimester of the pregnancy in interrelation to the period of the coronavirus, and the pressure from family members and work environment. A participant with comorbidities mentioned that despite her doubts about being vaccinated during pregnancy, she trusted her physicians since she was at risk of being hospitalised in a designated COVID-19 reference infrastructure if she got infected. She did not want to experience that. She described the vaccination as “a light at the end of the tunnel”. In addition to that, she already had a traumatic experience in the past and yearned

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

Regarding the pressure from family members, their main concerns were related to pregnant women's health and the fetus's well-being and the perception of the protection stemming from the COVID-19 vaccination uptake. Relevant to the pressure from the work environment, there was only one case, the case of Martha, in which there was an attempt to impose a vaccination uptake against the coronavirus after childbirth when she got back to work. According to Martha:

“I work in a kindergarten, and the employer informed the staff in the summertime (summer 2021) that whoever was not vaccinated to consider herself fired. I was the only unvaccinated, and each time I returned to work, they recommended I should get vaccinated.”

## CONCLUSIONS

Being pregnant during the COVID-19 pandemic was challenging for pregnant women as they had to cope with the unknown and the unprecedented coronavirus health crisis. In the context of COVID-19 biopolitics, their bodies and behaviours have been attempted to be regulated through targeted guidelines issued by the NPHO and the HSOG. Experiencing this situation, the participants of this research in fear of coronavirus slow violence, exerted agency acting as self/individual risk managers in the sense of docile biocitizens; capable of policing themselves (Sawicki, 1999) by adopting even harsher self-monitored preventive measures, as well as coping strategies in both COVID-19 periods in order to safeguard their health and well-being, expressing their agency towards the unknown situation of a potential COVID-19 infection.

Both self-preventive measures and mitigation strategies indicated how interviewees performed and experienced their personhood as pregnant women, namely how they managed and negotiated interactions in their lives (Strathern & Steward, 2011, ed. Mascia-Lees, 2011, p. 389) during both COVID-19 periods. In particular, self-regulated measures were related to anticipating a healthy infant during the coronavirus period. Therefore, the discourse of selflessness as central to ideal motherhood affected women's perceptions of their optimal choices (Shabot & Korem, 2018, p. 392) in safeguarding the health of the fetus and the baby. The types of implemented self-regulated measures were multiple and depended on the coronavirus period, the age of pregnant women and whether women were pregnant and/or first-time mothers. Those practices included home confinement with the sole companion of their partner, rare movements-almost exclusively to perform prenatal care appointments-seldom interactions with family members outside their close family circle, and implementation of additional hygiene measures.

Vaccination uptake or refusal as a preventive measure to the COVID-19 fear of slow violence was another strategy of coping with the fear of slow violence. This measure was related to the trust or distrust towards the governmental vaccination discourse and health professionals. Under its positive frame and recognising the cruciality of ensuring the well-being (Leach & Fairhead, 2008, p.39) of their own and their fetus's health in alignment with their health professional recommendations, the majority of participants proceeded to vaccine uptake. However, there were variations concerning the uptake period. The pregnant participants in the first period of coronavirus got vaccinated in the lactation period, except

for one who trusted the biomedical discourse of international organisations. When more data were available to the public, those who were pregnant during the second COVID-19 period were vaccinated during pregnancy following the advice of their health professionals as docile bodies. Biocitizenship practices were also exerted by those who did not proceed to get vaccinated against COVID-19. Refusing both state and scientific discourse, they did not get vaccinated in their attempt to ensure the well-being of the fetus and themselves.

Copying strategies as the representation of the agentive practices of the interviewees' aspect of motherhood, included physical, emotional, and psychological measures. Mild exercise was the primary physical activity during the coronavirus period, whereas biosociality in cyberspace as an emotional coping strategy was the primary one practised by the interviewees. Cyber-biosociality operated as a substitute for relationality in physical space, fostering the need of pregnant women to belong to a peer group where they could share their feelings, emotions, anxieties, questions, and empathise. Other copying strategies involved communication with their social network through cyberspace and going on vacation when coronavirus measures were lifted. Psychotherapy constituted the most frequent psychological mitigation practice.

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**Annex- Table 1. Example of coding**

Text- Initial coding	Focused coding	Theoretical coding	Thematic areas and subareas
...“From the moment I do not take paracetamol during pregnancy and lactation period, I refuse to accept such an intrusion into my body. I ponder that all these have a negative impact on the child, so until I stop breastfeeding, I will not do it”...	Body ownership	Distrust in governmental and scientific discourse	Vaccine anxieties
...“My healthcare professionals listened to my misgivings with respect without directing me in one or another decision regarding the vaccination”...	Autonomy of the patient	Distrust in scientific discourse	
...“The platform has just opened for my age group, but I did not get the dose before the delivery because the physician told me that the shot should have a time distance of twenty days from the caesarian section to ensure that any side effects would be from the caesarean sections and not from the vaccine”...	Therapeutic nihilism	Trust in health professionals	

<p>... ‘My doctor didn’t ask me if I was vaccinated. I asked him about getting vaccinated when I ran the seventh month of pregnancy, and he told me that it would be good to get vaccinated before the eight-month to create antibodies and have them passed on to the fetus. But he didn’t pressure me to get vaccinated’ ...</p>	<p>Autonomy of the patient</p>		
<p>... ‘I did not stop my psychotherapy. I kept going, and I think that if I was not already in therapy, I would have started it during the coronavirus period’.</p>	<p>Alleviation of anxiety</p>	<p>Psychological coping strategy</p>	<p>Self-care strategies</p>
<p>‘I found one group for the preparation of pregnant women, and I joined it. It helped me a lot, even if it was once per week, it helped me to be able to share my experience of pregnancy and to talk about it’</p>	<p>Biosociality</p>	<p>Emotional coping strategy</p>	
<p>... ‘I communicated only through video and telephone calls. I didn’t allow anyone to enter the house. There was a breakdown in the geyser, and I told them you would repair it outside the house’ ...</p>	<p>Sanitation measures</p>	<p>Policing the body</p>	<p>Self-regulated measures</p>