Master of Science in Social Studies of Gender

SIMZ21

Major: Political Science

Supervisor: Milka Ivanovska Hadjievska

LUND UNIVERSITY

FACULTY OF SOCIAL SCIENCES

"We are humans, not animals"

Obstetric Violence in Kosovo: An Intersectional Analysis of Women's Responses to Obstetric Violence

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Spring 2022

Word count: 19490

Abstract

This study explores different modalities of agency that birthing women in Kosovo express when met with a high threat of obstetric violence and structural constraints. Specifically, this study identifies the strategies and tactics women employ during pregnancy, childbirth, and postpartum to avoid and minimise the risk of obstetric violence in public and private health settings. Moreover, this study examines the intersections between and across multiple identity markers and backgrounds of the birthing women and how they shape their strategies and tactics. The results emphasize that obstetric violence is present in Kosovo, especially in public sector settings, and it assumes multiple forms. Simultaneously, obstetric violence in this study site is undergirded by broader factors such as patriarchal norms embedded at all levels of society, commodification of healthcare, and informality. This study shows that women employ multiple strategies and tactics to avoid and minimise obstetric violence. The most utilised strategies by women are (a) purchasing obstetric care in the private sector and (b) informal practices, while the most utilised tactics are (a) performance of docility and (b) performance of resistance. In this study, I argue that the intersections of women's identities and backgrounds shape their choices of strategies and tactics and their "*success*." These agentic actions vis-à-vis strategies and tactics that women employ take the form of complicity and resistance, however, they represent a strong expression of agency (Avishai, 2016). While the agentic actions of women might uphold the current oppressive structures, women use the space to bargain with the system and maximize their security, avoid, and minimise obstetric violence (Kandiyoti, 1988). Hence, this study argues that even in such a context characterized by multiple structural constraints, women can think, plan, make choices and re/negotiate their position within the system (Avishai, 2016; Kandiyoti, 1988).

Keywords: Obstetric Violence, Kosovo, Agency, Intersectionality, Commodification, Informality, Strategies, Tactics

Acknowledgements

The biggest and warmest thank you to all the women who opened their hearts to me and shared their stories. I dedicate this thesis to you and all the women in Kosovo and elsewhere that have gone through similar experiences.

To my supervisor, Milka, thank you for your continuous support and constructive feedback. Also, thank you for reminding me that mental health is essential and for making sure that I am doing well.

To the Swedish Institute, thank you for making this journey possible for me. I am proud to be a Swedish Institute Scholarship recipient.

To my parents, thank you for being my inspiration. It is hard to be away from you, but you will always be an endless source of love and inspiration to me. I acknowledge and appreciate your efforts to provide a better life for me, and I can only hope to pay those efforts back someday. I love you.

To my siblings, thank you for always being there. Your unconditional love and support mean the world to me. I am who I am today because of you. Being away from you during this period has not been easy, but you have gone out of your way to make me feel loved and support me.

To my nephews and nieces, I hope the world will be fairer and better for you. I look forward to seeing you go out there and live your dreams. Hearing your voices during the thesis writing period has made everything better.

To my comrades in Kosovo, thank you for being an inspiration with your relentless work and activism.

To all my friends in Kosovo and Sweden, you made my studies and thesis writing period better and happier. Thank you.

To Liridona, my life-long feminist comrade, thank you for reminding me that I sometimes need to acknowledge my achievements. Our hours-long conversations dreaming about the future are becoming a reality for both of us, and I am proud of that.

To my partner, Felix, thank you for listening to me talk about my thesis for hours and your patience. Thank you for being next to me every time I needed you, making me laugh, offering a shoulder when I cried, and assuring me that it will all be fine. You make the world a better place, and you surely make my life amazing.

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1 Introduction

In May 2021, one of my friends back home gave birth to her first child. We had a long phone call the day after she returned from the hospital. Her voice was weak, she sounded exhausted and traumatized. Feelings of bitterness and sadness engulfed feelings of happiness because of the mentally and physically violent childbirth she had to go through. After our phone call, I could not stop but think that this was not the first time I had heard about negative and traumatic experiences during childbirth in hospitals in Kosovo. My sisters, sister-in-law, and many friends and relatives had similar experiences, and I observed and participated in these experiences in many ways. But what is this violence?

Obstetric violence is a specific form of gender violence against birthing people who are subjected to acts of violence during pregnancy, childbirth, and postpartum, *because* they are obstetric patients (Chadwick, 2021; Davis, 2019, p. 561; Cohen Shabot, 2016). Obstetric violence can take the form of (but is not limited to) sexual, physical, or verbal abuse, stigma and discrimination, structural issues related to the healthcare system, failure to uphold medical standards of care (over medicalisation or under medicalisation), and miscommunication between the labouring person and medical staff (Bohren, et al., 2015; Cohen Shabot & Korem, 2018, p. 386). The concept of obstetric violence emerged as an influential activist and legal tool over the last decade, from the broader struggle for "*humanised birth*" in the Latin and Central American countries and has since then travelled across trans-national borders, especially throughout the Global South (Chadwick, 2021, p. 104). However, obstetric violence is not isolated to the Global South and has been documented transnationally in many global contexts, including high-income and middle to low-income countries (Chadwick, 2016; Freedman, et al., 2014). Moreover, the specific forms this violence assumes across these settings differ depending on local cultures and politics, situations, localized inequalities, and stratified strands of discrimination, including class, ethnicity, size, sexuality, age, and other identities (Chadwick, 2021, p. 105).

In 2007, Venezuela became the first country to define and institutionalize obstetric violence. The country codified obstetric violence as one of the nineteen punishable acts of violence against women through the *Organic Law on the Right of Women to a Life Free of Violence*:

> "By obstetric violence we understand the appropriation of women's body and reproductive processes by health personnel, which is expressed by a dehumanizing treatment, an abuse of medicalisation and pathologisation of natural processes, resulting in a loss of autonomy and ability to decide freely about their bodies and sexuality, negatively impacting their quality of life." (Cited in Sadler et al., 2016, p.4).

Following Venezuela, Bolivia and Mexico also adapted laws on obstetric violence. The ongoing struggle of activists and the legal institutionalization of obstetric violence got the ball rolling and led to the international recognition of obstetric violence by global health and intergovernmental agencies. World Health Organization (WHO) officially recognized the issue in 2014 by releasing a consensus statement, considering mistreatment and abuse during childbirth as violations of human rights (Chadwick, 2021; Cohen Shabot & Korem, 2018; Sadler, et al., 2016; Freedman, et al., 2018). Later, in 2019, the United Nations (UN) Rapporteur on Violence Against Women (VAW) also used the term obstetric violence directly to report on violence in reproductive healthcare services (Chadwick, 2021). What has been seen for a long time as a personal tragedy, natural or normal occurrence (maternal death or "suffering in childbirth"), is now rightfully a global public health imperative generating more extensive discussion within the human rights and reproductive justice movement (Freedman, et al., 2018, p. 108).

In response to the legal and public health definitions and studies of obstetric violence, feminist scholars emphasize the need to distinguish it from medical violence and position it as gender violence and a feminist issue. Feminist authors argue that obstetric violence is gender-based violence as it is directed at women simply because they are women and obstetric patients, and it is structural violence

which involves a patriarchal need to tame labouring bodies (Cohen Shabot, 2016; Sadler, et al., 2016; Davis, 2019). Hence, the need to produce knowledge that explores women's agency beyond the static victim vs perpetrator nexus by identifying women's responses/acts of resistance in the face of power and coercion (Chadwick, 2017, p. 491). Furthermore, documentation of obstetric violence from different sites has shown that it is not a homogeneous experience, namely identities other than gender (e.g., race, ethnicity, socioeconomic status) shape the intensity and experiences of obstetric violence, which stresses the need for more studies that look at the intersections of these identities (Davis, 2019; Chadwick, 2016).

Obstetric violence is not included and is not discussed on the institutional level in Western Balkan countries (Mrkić-Radević, 2021). From comprehensive desk research focused on Kosovo specifically, there are no available data on obstetric violence, and women's narratives in that regard are scattered across temporary pop-up news. Smith-Oka, Rubin, & Dixon (2021) argue that obstetric violence is naturalized and normalized in societies where violence against women is prevalent (p. 5). Furthermore, the manifestation of obstetric violence collides with local infrastructures, policies and histories that enable the continuity of violence (Smith-Oka, Rubin, & Dixon, 2021, p. 5). As a study site, Kosovo is characterized by patriarchal norms and rules embedded in institutional and societal practices, thus enabling gender-based violence at all levels of society (Krasniqi E. , 2014; Cernobregu, 2020; Farnsworth & Qosaj-Mustafa, 2018). Moreover, the continuous health reforms expanded over a timespan of over 30 years and throughout different political situations have led to a semi-privatized health system characterized by policies that enable commodification of healthcare and informal practices (Kosovo Women`s Network, 2016; Levizja FOL, 2016; Hashani, Hoxha, & Mati, 2017). Thus, when the underlying context of pervasive and prevalent gender violence collides with a struggling healthcare system, it presents a particularly useful site to examine and explore the occurrence of obstetric violence but also women's responses to it. Considering the characteristics of Kosovo as a study site and the current feminist scholarship on obstetric violence, I want to move beyond identifying and exploring the forms that obstetric violence assumes in Kosovo and

explore women's responses to obstetric violence instead. Furthermore, I want to demonstrate the agency women have in this context and how their responses are shaped by certain constraints instead of assuming that their experiences and responses are homogenous and that they are only victims.

1.1 Aim and research questions

This study aims to explore different modalities of agency expressed by birthing women in Kosovo in the face of an oppressive system characterized by patriarchal norms, commodification, and informality. Specifically, the study aims to identify strategies and tactics that women employ during pregnancy, childbirth and postpartum to avoid and minimise obstetric violence in public and private health settings. Furthermore, the study sets to explore and understand the intersections between and across specific identity markers and backgrounds of the birthing women and how they shape their choices of strategies and tactics. Therefore, this thesis aims to answer the following research questions:

What strategies and tactics do birthing women in Kosovo employ during pregnancy, childbirth, and postpartum to avoid and minimise obstetric violence? How do their identity markers and backgrounds shape their choice of strategies and tactics?

To answer the research questions, this study uses a comprehensive theoretical framework. I adopt feminist theorizations on women's agency that centre peripheral and non-Western experiences and narratives and see women as agentic subjects. These theorizations are complemented by the concept of "patriarchal bargain", which enables me to explore women's agentic actions in relation to certain systematic and structural factors, namely a patriarchal society characterized by commodification of healthcare and informality. Furthermore, I use an intersectional approach to identify how different identity markers and backgrounds shape women's choices of strategies and tactics. Methodologically, the research questions are answered using the personal narratives of thirteen women from different regions

of Kosovo and of diverse backgrounds. This study uses experience-centred narrative analysis as a method of analysis. This study contributes to the sparse feminist scholarship on obstetric violence due to the theoretical and methodological approach that it utilises. Furthermore, the study's findings bring forward empirical, conceptual, and practical contributions to the field.

1.2 Limitations of the study

This study has several limitations. One of the study's main limitations is the ethnic homogeneity of the participants. Due to the inability to be physically in the field, access to women of other ethnic backgrounds such as Roma, Ashkali, Egyptian or Serbian was limited. The reasons varied from lack of access to technology to language. Hence, I could only gain access to participants who spoke Albanian and had access to a mobile phone. However, study participants are heterogenous in socio-economic backgrounds, geographic identity, age, occupation, and education level. Also, the study only includes the narratives of the birthing women and does not include the narratives of medical professionals. Many authors argue that nurses and obstetricians are also intersectional subjects whose actions are shaped by the broader factors that undergird obstetric violence (Chadwick, 2017). Hence, it is essential to investigate their narratives and experiences with the system and how they relate to obstetric violence. Lastly, the study has a limited number of interviews.

2 Context

In this chapter, I briefly provide context on Kosovo as a site, focusing on three systematic issues that are relevant to this study. First, I focus on Kosovo's health system evolution and reform starting in retrospect from former Yugoslavia to date, outlining the main reforms and structural issues. Additionally, I provide context on gender-based violence in Kosovo, and its prevalence and normalisation on all societal levels. Lastly, I focus on informality and informal payments in healthcare in the Western Balkans, an omnipresent practice in Kosovo.

2.1 Kosovo's health system reform over the years

To navigate the reform of the health system, it is crucial to look at Kosovo's history in retrospect, as it has had reformative importance on how the system functions today. Thus, these sub-sections outline the system's evolution from the Semashko model in former Yugoslavia toward a semi-privatized healthcare system characterized by commodification and informality.

2.1.1 Kosovo's health system in the former Yugoslavia

As part of the former Yugoslavia, Kosovo was included in the Semashko health delivery model, a system utilised in the Soviet Union and Eastern Europe (Percival & Sondorp, 2010). The primary principle of the Semashko model of health care is financial accessibility, meaning that all citizens are entitled to free health care while decisions are decentralized on the level of regional hospitals or health centres (Sheiman, Shishkin, & Shevsky, 2018; Percival & Sondorp, 2010). The health improvements that were noticed due to the utilization of the new health care system approach were disrupted by the abolition of the autonomous status of Kosovo in 1989 within the former Yugoslavia. The political turmoil largely impacted the access to healthcare for Albanians, as health care became a battleground. This led to two important events in the regulation and functioning of the health care in Kosovo, a) Belgrade Ministry of Health assumed full control over Kosovo's health system, namely, all stakeholders had to report directly to Belgrade, the University

of Prishtina was closed, and Albanian medical staff was fired and b) a parallel voluntary health system known as “Mother Theresa” was established by Albanians in Kosovo, funded by local people and diaspora community amongst others (Percival & Sondorp, 2010; Mustafa & Hysa, 2016). Additionally, in response to the situation, many Albanian health professionals opened private practices, which continued their function even after the end of the conflict and the political instability (Percival & Sondorp, 2010). The most hard-hit population were women who needed gynaecologic and maternal care, which became impossible due to the circumstances and Albanian women’s position and role in the former Yugoslavia (Percival & Sondorp, 2010, p. 3).

2.1.2 Kosovo’s health system under the administration of UNMIK

In June 1999, the United Nations Security Council approved the resolution 1244, which initiated the establishment of the United Nations Interim Administration (UNMIK) as a mission that would have the power to undertake political, economic and social reforms in Kosovo (Percival & Sondorp, 2010; Mustafa, Berisha, & Lenjani, 2014). As Kosovo's health system heavily deteriorated, and so did the health of citizens, the need for reform and improvement in the sector was significant. The reform, implementation and timeline of the sector were shaped by external actors who flooded Kosovo with funds and assistance as a post-conflict relief tool (Percival & Sondorp, 2010). The major health care reform under the UNMIK administration was the adoption of a comprehensive legal framework for the health system, including the Law on Health, Law on Private Practices on Health, and a Law on Health inspectorate, the establishment of the Health Care Commissioning Agency, and the establishment of three health care levels, namely primary care, secondary and tertiary (Muharremi, 2017).

However, the long deterioration of the health system of Kosovo combined with political instability in the post-conflict period, lack of coordination among stakeholders, lack of trained health staff, minimum funding and mismanagement of funding, corruption and politicisation of appointments, amongst other issues, resulted in a very complex and not successful reform under UNMIK administration

(Percival & Sondorp, 2010; Mustafa & Hysa, 2016). Moreover, similarly to the 1989-1999 period of political turmoil, under the UNMIK administration as well, citizens that had lower socioeconomic status, lived in rural areas, or were women, were mostly affected by the complexity of the situation and suffered the lack of access to public health care or had to pay out of pocket, both in public and private hospitals and clinics (Percival & Sondorp, 2010).

2.1.3 Kosovo's health system after the declaration of independence

After Kosovo's declaration of independence in February 2008, UNMIK transferred full autonomy over the country's political, economic, and social development and decision-making to the current government. One of the primary interventions was the health sector reform which was concretized through the adoption of the Health Sector Strategy, intending to improve the management and increase the quality of services, and reorganizing the existing infrastructure per European standards (Muharremi, 2017, p. 13). While still relying on the Semashko model of health care but with difficulty in providing universal health care, Kosovo's health system utilises a mixed financing system, which is a combination of financing through the state budget and co-payment from patients, except for those who are exempt by law (Muharremi, 2017). As a result, health system does not *de facto* cherish priority from the government as funding trends throughout the years are low and lower than European standards. For instance, in 2012, the total spending of the government on health was 9% which is lower than the European standard of 13%, further lowered to 6.4% of Kosovo's government spending in 2019 (Arenliu Qosaj, Froeschl, Berisha, Bellaqa , & Holle, 2018 ; Kosovo Women`s Network, 2016). Due to low funding for health system from the government, the out-of-pocket (OOP) payments from citizens have increased and did amount to 38% of health funding in 2012 and 40% in 2016 (Arenliu Qosaj, Froeschl, Berisha, Bellaqa , & Holle, 2018 ; Kosovo Women`s Network, 2016). According to Mužik and Uka (2013), the highest rates of OOP are spent on the purchase of supplies and drugs, private healthcare services and informal payments (i.e., money, gifts, or social

network to jump queues, or obtain better quality of care) to health practitioners in the public sector.

Lastly, laws in Kosovo allow medical staff to be employed in both public and private healthcare facilities or own private facilities but do not allow them to use public facilities to refer patients to private practices (Kosovo Women`s Network, 2016). However, the reality shows the contrary as the number of private clinics and hospitals continuously increases. For instance, data from the Kosovo Agency of Statistics (2019) show an increase in private gynaecological clinics and hospitals from 95 in 2017 to 142 in 2019. The fact that the majority of medical practitioners are employed or own private practices has led to high levels of '*competition*' within the health system and continuous referrals to private practices from the public hospital, which in turn reinforce informal payments and directly impact the principle of equal access to healthcare for all citizens (Levizja FOL, 2016; Kosovo Women`s Network, 2016; Hashani, Hoxha, & Mati, 2017). In addition, the failure of governments to implement the Public Health Insurance Fund has led to a particular group of citizens acquiring health insurance from private companies (around 6%), while the others cover health expenses based on the current financing system of health (Kosovo Women`s Network, 2016).

Thus, the evolution of the health system starting from the former Yugoslavia to date has strengthened the presence of commodification and informality as practices, which in combination with other structural issues such as low funding and lack of health insurance, affect the quality of healthcare services and contribute to differentiated access to healthcare for marginalized population groups.

2.2 Gender-based violence in Kosovo

Kosovo is characterized by systematic and institutionalized discrimination and violence against women at all societal levels. Authors such as Krasniqi (2014) argue that if we look at women's position in Kosovo from a legal perspective (*de jure*) after the war, then one can conclude that significant progress has been achieved. However, the author argues that the legal framework, which has been mainly adopted in response to EU requirements, does not represent the reality of women,

whose lives remain socially insecure and are held '*hostage*' to their families, traditions, nation, and the state (Krasniqi, 2014). Some of the relevant laws that have been adopted throughout the last years include Gender Equality Law, the Law Against Discrimination, the Law Against Domestic Violence, the Law on Family, and the Law on Family and Social Security. Yet, laws that address violence and/or discrimination against women lack practical implementation on the institutional level and have not managed to change the social norms and gender dynamics yet (Latifi, 2014; Krasniqi, 2014). The patriarchal culture, which is deeply entrenched at all levels of society, becomes visible through data that shows that women's labour force participation in 2020 was only 14.1%, women's ownership of all properties was 17%, and more than 64% of women have stated that they have experienced sexual harassment in their life (Qosaj-Mustafa, Berisha, Farnsworth, & Banjska, 2016; Cernobregu, 2020; Farnsworth, et al., 2018; Banjska, et al., 2022).

Furthermore, studies on domestic violence in Kosovo show that the vast majority of domestic violence victims are women, while most perpetrators are men (Kosovar Gender Studies Center , 2019; Farnsworth, 2008; Farnsworth & Qosaj-Mustafa, 2018). According to Kosovar Gender Studies Centre (2019), the reported cases of gender-based violence have marked a continuous increase in the last years (after 2018), yet the official numbers do not match the actual extent of gender-based violence. Many authors and organizations argue that the patriarchal culture is entrenched in Kosovo's institutions as well; hence women who report violence face stigmatization and victim-blaming by the Kosovo Police and other relevant institutions, insults, lack of confidentiality, lack of specialized services leading to an overreliance on DNA samples and tests, and a lack of guidelines and coordination mechanisms (Kosovar Gender Studies Center , 2019, p. 8; Tahiraj, 2015). Such barriers limit the safety and access of women to report cases of violence. The failure of public institutions in Kosovo to ensure safe reporting mechanisms and to protect victims of gender-based violence has led to several domestic violence deaths, serious bodily injuries, rape, and sexual assault (Kosovar Gender Studies Center , 2019, p. 9).

Another issue that has sparked discussions and protests from feminist activists is maternal deaths and the lack of reaction from responsible institutions. Gjocaj (2020) reports that Kosovo has no register of maternal deaths, and no relevant health institution claims responsibility for recording this data, which leaves those responsible for women's maternal deaths immune and the victim's family without justice. Furthermore, not acknowledging the existence of maternal deaths makes it nearly impossible to prove the use of violence that might lead to it, the lack of adequate treatment or other causes.

Navigating the pervasiveness of gender-based violence in Kosovo and its normalisation is a complex task. The country is marked by a long history of oppression, international intervention and remains of customary law that together compound the effects of gender inequality. Some authors argue that the construction of masculinities vis-à-vis femininities and gender norms in the context has been highly influenced by the customary law or otherwise known as The Code of Leke Dukagjini that regulated the functioning of all social institutions and served as a punitive apparatus centred mainly around *honour* (Tarifa, 2008; Latifi, 2014; Krasniqi, 2014). For instance, according to the Code, women do not cherish any authority within the family. Their role is confined to biological and social reproduction and protecting the family's honour. Hence, the position of women today and the extent to which gender-based violence is normalized and engrained in all social institutions that oppress women systematically can be connected to the remains of the customary law in the daily practices, intersecting with other structural issues.

2.3 Informality and informal payments in healthcare

Informality is a pattern of social life connected to formal institutions, meaning that informality exists in relation to formal rules, and is temporal and contextual (Krasniqi, Papa-Pandelejmoni, Hysa, & Kera, 2019, p. 137). Informal payments for healthcare are widespread in Central and Eastern European and the former Soviet Union countries (Gaal, Carlo Belli, McKee, & Szócska, 2006). Many authors argue that this is because of the decline in economic production during the transition

period, which led to reduced government spending on health in these countries and hence the development of informal patient payments (Mejsner & Karlsson, 2017, p. 621; Belli & Lewis , 2001 ; Gaal, Carlo Belli, McKee, & Szócska, 2006). Gordy and Efendic (2019) argue that the post-socialist period is also characterized by the adoption of liberal policies which do not respond to actual conditions and therefore have led to a gap between formal and informal practices in everyday experiences including healthcare policies (p.10). Gaal, Carlo Belli, McKee & Szocska (2006) defined informal payments for health care as a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in-kind, by patients or others acting on their behalf, to health care providers for services that the patients are entitled to (p. 276). Informal payments can be cash, in-kind, bought or brought goods or gratuities and can be both paid voluntarily or asked for by the providers, implicitly or explicitly (Belli & Lewis , 2001 ; Mejsner & Karlsson, 2017, p. 622). Additionally, in-kind contributions can include bringing your own sheets, food or even medicine to the hospital (Belli & Lewis , 2001 , p. 2)

In the Western Balkans, including Kosovo, informal practices, especially in the health sector, include giving gifts, providing services or money, and 'having people in places' to get better treatment in healthcare (Cvetičanin, Popovikj, & Jovanović, 2019; Krasniqi, Papa-Pandelejmoni, Hysa, & Kera, 2019, p. 139). For example, in Albania, Bosnia and Herzegovina, Kosovo, North Macedonia, Montenegro and Serbia, between 20% and 30% of citizens admit that they had to use informal practices to make a living or secure health-care services (Krasniqi, Papa-Pandelejmoni, Hysa, & Kera, 2019). Lastly, according to these studies, informality as a practice is widely distributed among all strata of the population, regardless of their social standing (Krasniqi, Papa-Pandelejmoni, Hysa, & Kera, 2019; Williams & Yang, 2017; Cvetičanin, Popovikj, & Jovanović, 2019). Informal payments can be made voluntarily (to show gratitude), or they can be coerced by providers (Belli & Lewis , 2001). However, Gaal et al. (2006) argue that the concept of coercion vis-à-vis voluntary in this context should be looked at more critically. The authors emphasize that even if providers of care do not, subtly, or otherwise, demand

informal payments, the anticipation that you get better healthcare if you do so is coercion in itself (Gaal, Carlo Belli, McKee, & Szócska, 2006, p. 271).

2.3.1 Informality and the private-public healthcare nexus

Another interesting manifestation of informality in healthcare is the interrelation to the private sector vis-à-vis the development of the private sector. Gaal et al. (2006) argue that the collapse of the Communist regime in the region, more specifically the remains of the Semashko health system, has led to the development of the private sector, which is very closely interlinked to the public sector (p. 274). A good example of the 'awkward symbiosis' between the two sectors regarding informality is Poland and the phenomenon of "*advance payments*" (Gaal, Carlo Belli, McKee, & Szócska, 2006; Belli & Lewis , 2001). Belli & Lewis (2001) found that in Poland, many medical practitioners in the public sector also own private practices and use the poor funding and disorganization in the public sector to create a clientele for their private practices. Their findings show that patients who visit doctor's private practices preceding their stay in the public hospital do so not only because of the "better quality" healthcare but because these doctors have influence in the public hospital and will ensure easier access to and better quality healthcare for them in the public hospital (Belli & Lewis , 2001 , p. 10). Greece also shows similar patterns (Kaitelidou, et al., 2012). Healthcare in the private sector is mostly accessible to a particular group of society, meaning that the suffering from the system dysfunction falls on the shoulders of the poorer and marginalized segments of society (Kaitelidou, et al., 2012; Belli & Lewis , 2001).

In sum, the use of informal practices and informal payments in healthcare is a determinant factor in the region, and it applies to Kosovo. Access to quality healthcare services is highly impacted by the intersection of informal practices with formal institutions, and it burdens the most marginalized communities, such as women. The omnipresence of informality characterizes the healthcare system in Kosovo, and in combination with other broader factors such as commodification of healthcare and prevalence of GBV, they represent the structural barriers that constraint women's agency and shape their experiences with healthcare. Lastly, the

above presented issues are also representative of the impact of the current global neoliberal order that has profoundly changed the political climate, including the organization of public health systems and women`s position and role amongst others. As such, the exploration of these structures in this chapter also facilitates the understanding of the study vis-à-vis findings within bigger global political processes and structures.

3 Literature Review

In this chapter, I identify the main arguments and discussions within the literature that are relevant to obstetric violence and this study. In the first section, I investigate the definitions of obstetric violence and its positioning within different fields, which highly impacts our understanding of obstetric violence today. In addition, I look at literature that positions obstetric violence as gender-based violence and a feminist issue and interrogates bigger structural and systematic problems that normalize and institutionalize obstetric violence. These two sections build-up to the section on the occurrence of obstetric violence in non-Western contexts and feminist studies that employ intersectionality and theorizations of agency to investigate women's experiences and responses to obstetric violence.

3.1 Defining obstetric violence: Typologies

Despite the high volume of narratives and data on obstetric violence, they remained scattered, and there was no existent typology of obstetric violence. Bowser and Hill (2010) were the first scholars to conduct a review of evidence and categorize disrespect and abuse directed towards women in facility-based childbirth into seven categories: physical abuse, non-consented clinical care, non-confidential care, non-dignified care (including verbal abuse), discrimination based on specific patient attributes, abandonment of care, and detention in facilities (p. 9). The typology brought forward by Bowser and Hill (2010) served as a building block for other researchers, such as Freedman and colleagues (2014), who argued that this categorization lacked factors such as characteristics of healthcare provider behaviour, facility conditions or other factors that could be considered as disrespectful and abusive (p. 915). The authors proposed a model that assesses the individual, structural and policy level conditions that shape disrespect and abuse against birthing women (*see Figure 1*). They further defined disrespect and abuse in childbirth as interactions or facility conditions that local consensus deems to be humiliating or undignified and those interactions or conditions that are experienced as, or intended to be humiliating or undignified (Freedman, et al., 2014, p. 916).

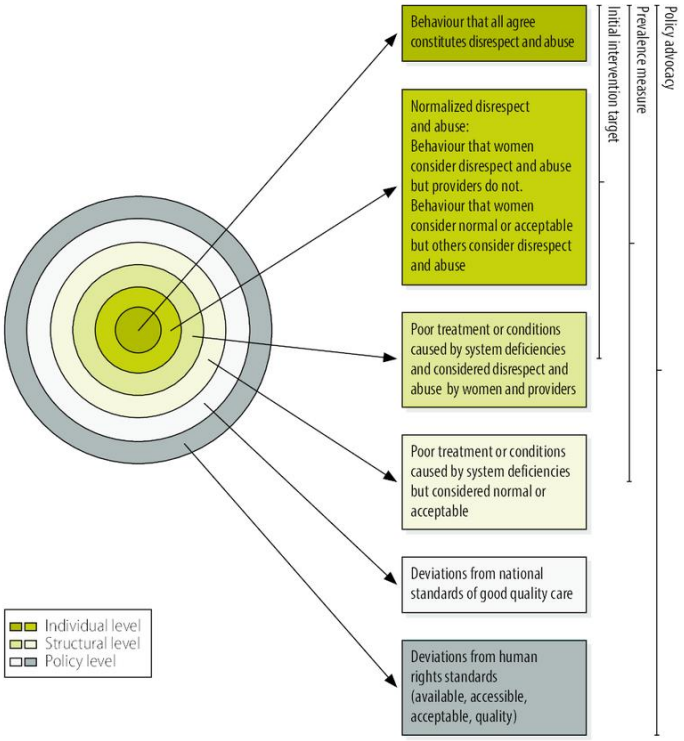

Figure 1: Defining disrespect and abuse of women in childbirth visualization by Freedman and colleagues (2014)

The scale of obstetric violence was further shown by Meghan Bohren and her colleagues (2015) who systematically reviewed studies from more than thirty-four countries on the disrespect and abuse women face in medical facilities during childbirth. Bohren and colleagues (2015) argue that the available data indicates that the occurrence of mistreatment of women[1] does not only happen at the level of interaction between the woman and the provider, but it rather encompasses a complex range of systemic failures at the level of the health facility and health systems, such as insufficient staffing and power dynamics that systematically disempower women, amongst others (Bohren, et al., 2015, p. 21). Hence, the proposed expanded typology by Bohren and colleagues (2015) includes broader structural factors and emphasizes the need to position obstetric violence within a larger discussion.

[1] Many authors use terms such as "mistreatment of women", "dehumanized care", "inhumane birth" or other terms instead of obstetric violence. Chadwick (2021) considers these terminologies as `*softer*` and advocates for the use of the term "obstetric violence" as it positions pregnancy and birth within a larger political and social struggle, embedded in racial, economic and gender relations of power, and it shows the severity of the problem (p. 105). Hence, in my study, I use the term obstetric violence. However, in the literature review, I use the terms that were originally used by authors in their studies.

These robust definitions that capture both individual and structural disrespect and abuse acknowledge the fact that health systems are deeply embedded in the broader political and social dynamics, and that pregnancy and childbirth are complex human experiences that are also embedded in the family, community, institutional power structures and social dynamics, and that very often obstetric violence is normalized by both women and medical practitioners (Freedman, et al., 2018; Freedman, et al., 2014; Bohren, et al., 2015). However, one aspect of these definitions that is not adequately addressed is the gendered nature of violence which reveals why obstetric violence is institutionalized and normalized (Smith-Oka, Rubin, & Dixon, 2021; Sadler, et al., 2016; Chadwick, 2017).

3.2 Obstetric violence as gender violence and a feminist issue

Going beyond the existing literature on obstetric violence or building on their work, many authors argue that obstetric violence is gender violence (Chadwick, 2021; Cohen Shabot, 2016; Davis, 2019; Sadler, et al., 2016; Cohen Shabot & Korem, 2018; Jewkes & Penn-Kekana, 2015; Smith-Oka, Rubin, & Dixon, 2021). Jewkess and Penn-Kekana (2015) argue that there is a clear connection between obstetric violence and gender-based violence. The authors argue that, systematically, women's lives are devalued and thus, low allocation of resources to maternity care or the use of violence against women is enabled and allowed (Jewkes & Penn-Kekana, 2015). Feminist authors also argue that obstetric violence is gender violence and a feminist issue as it is directed at women simply because they are women and obstetric patients, and it is structural violence which involves a patriarchal need to tame labouring bodies that are not properly feminine (Cohen Shabot, 2016; Sadler, et al., 2016; Davis, 2019). Labouring bodies are generally healthy and not pathological, yet there is a systemic need to dominate the female body in labour and restore its inherent feminine submission (Cohen Shabot, 2016). Furthermore, a similar pattern of obstetric violence occurs across various sites and is primarily linked to gender (Smith-Oka, Rubin, & Dixon, 2021, p. 2). However, as seen above, definitions of obstetric violence are found mostly in public health literature or legal definitions, which tend to represent women as passive victims of

obstetric violence, use a softer language and sometimes equate obstetric violence to other forms of medical violence (Chadwick, 2017; Sadler, et al., 2016). Feminist scholarship on obstetric violence, even though sparse, calls for 1. more theorizations that go beyond static victims vs perpetrator positions, 2. more approaches that explore identities other than gender (e.g., race, ethnicity, class and other contextually crucial identities), and 3. exploration of women's responses/acts of resistance in the face of power and coercion (Chadwick, 2017, p. 491). Some of these conceptualizations are further expanded below.

Chadwick (2021) argues that the current typologies of obstetric violence do not adequately explore the ontological contours of the modes of violence they list, namely the logics and harms of it (p. 111). The author theorizes obstetric violence as *a specific form of violation against reproductive subjects* – a concept that entails the intersectional dimension of obstetric violence and acknowledges reproductive subjects more broadly (i.e., trans men, non-binary persons, and those who do not identify as 'mothers' or 'women') (Chadwick, 2021, p. 111). Furthermore, the author argues that the concept of obstetric violence should go beyond the sphere of birthing/labour and include violent, dehumanising, coerced and disrespectful treatment during reproductive care more broadly, including abortion (Chadwick, 2021, p. 107). Such inclusive definitions of obstetric violence would not compartmentalise reproductive events and would allow the space to also look at racialized and classist layers of obstetric violence, such as experiences of black women, poor women, adolescent mothers, and other marginalized groups (Chadwick, 2017).

In this study, I adopt this inclusive definition of obstetric violence brought forward by feminist scholars that entail the intersectional dimensions of obstetric violence. While my participants identify as women, they are not a homogenous group, and nor are their experiences the same, which emphasizes the need for an intersectional analysis. Furthermore, I acknowledge my participants' experiences with reproductive events other than birthing, namely their experiences of miscarriage or abortion.

3.3 Obstetric violence in non-Western contexts, women's experiences and responses

Obstetric violence is manifested transnationally across various settings in both the Global South and North (Chadwick, 2021). However, non-Western women's experiences in childbirth are homogenized, "*othered*", and they are represented as passive victims (Kumar, 2013). Utilising a feminist postcolonial approach, Kumar (2013) argues that the women from other geopolitical spaces (Global South) are represented in the literature only in terms of maternal mortality, childbirth abuse, and victims of Third World conditions, violence, and infrastructure. In this section, I focus on studies that take a more inclusive, agency-centred, and intersectional approach to studies of obstetric violence in non-Western countries to escape the dichotomous view on women's experiences.

Chadwick (2017) uses the term "ambiguous agency" as a decentred view of agency to explore women's responses/acts of resistance in the face of obstetric violence in South Africa (p. 494). Her findings show that obstetric violence is an assemblage of acts that are shaped by racialized, classed, gendered, and medicalized norms about "*good patients*" and "*good birthing bodies*" (Chadwick, 2017, p. 504). Performing docility was a strategy that South African women utilised to avoid violence, but their class, age, race, or other identity markers impacted the ability of some women to fully conform to being "*good*" (Chadwick, 2017, p. 505). This study shows the complexity of obstetric violence, the enactment of agency of women and how their experiences are shaped by the intersections of gender with other identity markers. In Tijuana, Mexico, Espinoza-Reyes & Solis (2020) conducted a study that categorized women's agency into four categories: 1) unawareness or lack of knowledge that you are experiencing violence, 2) passive awareness 3) tactics and 4) strategies (Espinoza-Reyes & Solis, 2020, p. 194). The authors found that women use strategies and tactics linked with their awareness regarding the abuse to avoid violence (Espinoza-Reyes & Solis, 2020, p. 202). Strategies and tactics were utilised by women of different strata in different situations and included verbalization of needs, change of type of healthcare, complaint filing, and therapy or support groups (Espinoza-Reyes & Solis, 2020).

Similarly, data from Rosendal Østergaard (2015) study in Burkina Faso shows that women employ tactics to receive better quality healthcare and minimise abuse. These tactics include getting on good terms with the staff, taking care of the booklet with patients' data, attending prenatal care events, showing late in labour to minimise waiting times and using traditional medicine to minimise the pain (Rosendal Østergaard, 2015). Finally, the study of Smith-Oka, Rubin and Dixon (2021) in Mexico and South Africa shows that women were aware of the potential of becoming victims of obstetric violence, so some of them decided to change the clinic, some "booked late", and others fought against the lack of privacy or the judgemental nature of the staff (p. 9). The authors argue that in their research setting, the synergy between gender and class undergirded obstetric violence (Smith-Oka, Rubin, & Dixon, 2021).

These studies that centre on women's narratives and explore their experiences and responses to obstetric violence through a non-dichotomous agency lens are limited in number but immensely contribute to feminist theorizations of obstetric violence. The studies show that while there is a structural universality to obstetric violence, the specific forms it takes are enacted and enabled by local ways and structures, just as how the responses and strategies that women utilise are unique to local circumstances. Furthermore, as narratives of women in these studies take place in different contexts, the importance of looking at localized understandings of gender, ethnicity, race, and other identity markers and how they impact women's experiences and responses becomes very visible. Taking inspiration from these studies, I situate my study within this body of scholarship and contribute to this line of research. My theoretical and methodological framework centre on non-dichotomous approaches to women's agency and acknowledge their identities and how they shape their experiences.

4 Theoretical Framework

I have identified the following theories and key concepts as relevant and applicable to my study based on literature review. The key concepts and theories presented in this chapter are used to analyse the collected data. As such, they have enabled me to examine and understand the strategies and tactics employed by women to minimise the risk of obstetric violence in Kosovo and how their identity markers and background intersect and shape their experiences and choices. This chapter is divided into two sections. In the first section, I focus on theorizations of agency, connecting them to the concept of patriarchal bargain, tactics, and strategies. Secondly, I focus on intersectionality as a theory and analytical tool, its applicability to the context and how it complements theories and concepts from the first section.

4.1 Theorizations of agency and patriarchal bargain

Agency is one of the key concepts in social thought that has challenged feminist theorists to discern its limits on when and how individuals interact with oppressive social structures (Avishai, 2016; Parker & Dales, 2014). Avishai (2016) argues that an inclusive feminist concept of agency explores the agentic actions, decisions, preferences, and choices that can be expected from subjects who are constrained by their environments (p. 265). Even within the feminist thought, theories of agency have very often assumed universally shared experiences of oppression, based on a Western and liberal definition of agentic action premised on individualism, satisfaction, capacity for rational thought and free will (Mahmood, 2006; Avishai, 2016; Kandiyoti, 1988; Mohanty, 1988). Other mainly postcolonial feminist scholars such as Mahmood (2005) or Kandiyoti (1988) sought to recognize the agency of subjects in sites, practices, and social institutions that could be simultaneously sites of oppression and empowerment, sites of reproduction of gendered regimes and subversion (Avishai, 2016, p. 267). These studies show that agency is not dichotomous, but it is diverse, as it is created and enabled from

historically specific relations of subordination (Willmann Robleda , 2020; Mahmood, 2006).

In aggregate, agency is the capacity to think, strategize, plan, make choices or negotiate with power in different forms and within a certain set of realities, which could take the form of complicity or partial complicity, deviance, compromise, or resistance – and with a variety of motivation, be that intentional or not, self-expression or self-interest, and voluntary or involuntary (Avishai, 2016; Kandiyoti, 1988; Espinoza-Reyes & Solis, 2020; Parker & Dales, 2014). I adapt this conceptualization of agency in my study as it allows me to capture expressions and modalities of agency that go beyond the static depiction of women as either victims or resistants and to consider women as agentic subjects *a priori*. To better capture and analyse the systems within which women's agency is expressed vis-à-vis constrained, I further adopt the concept of 'patriarchal bargain', which was coined by Kandiyoti (1988). Kandiyoti (1988) argues that in different forms of patriarchy, women are presented with different rules and norms and therefore "come up" with different strategies to maximize security and optimize life options, meaning that they can contest, redefine, or renegotiate their position within the system (p. 286). Thus, I combine these two concepts in my study, as I am aware that women's agency is expressed and constrained within and from specific sites, practices and institutions that are complex, local, and historically entrenched. Translated to the case of Kosovo, this concept is suitable to understand women's choices considering constraints by the patriarchal society and a healthcare system characterized by commodification and informality.

4.2 Conceptualizations of strategies and tactics

De Certeau (1984), in his book *"Practices of everyday life"*, attempts to theorize the relationship between the structural elements of culture and the practices that enact and modify them by analysing practices that compose individuals' everyday life. The author argues that ordinary people adopt strategies and tactics that enable them to reclaim autonomy from the all-pervasive forces of economics, politics, and culture in general (de Certeau , 2005, p. 217; Spiegel, 2005). According to de

Certeau (1984, 2005), it is crucial to distinguish between tactics and strategies. In his conceptualization, strategies are defined as a tool of the powerful and are executed over time, while tactics are the domain of the non-powerful who employ tactics to survive, trick the system or diminish the effects of the methods of control from the system (Willmann Robleda , 2020, p. 84; Espinoza-Reyes & Solis, 2020; de Certeau , 2005).

Strategies are a calculus of force-relationships that becomes possible when a subject of power can assume a place, be "isolated from the environment", and take an action (de Certeau, 1984, p. 16). Tactics, on the other hand, do not have a spatial or institutional localization and thus depend on time – meaning that one is on the watch for opportunities that could be seized and ways to manipulate events and turn them into "opportunities" (de Certeau, 1984, p. 16). Hence, everyday acts such as walking, moving about, reading, cooking, are seen as tactical by de Certeau (1984, 2005) and as "ways of operating" of the *weak* over the *strong*. These conceptualizations of tactics and strategies from de Certeau have been adapted to similar studies on obstetric violence to explore how women experience and respond to the phenomenon, as shown in the literature review section. Based on these studies and the context of Kosovo, I consider as strategies the acts that women temporally use before and during the pregnancy, which can show effects during the childbirth as well, while tactics are those acts used in the facility during childbirth and postpartum.

4.3 Intersectionality

As a term and concept, intersectionality was coined by Kimberle Crenshaw to examine the marginalization of Black women because of their intersectional identity as both women and of colour (Crenshaw, 1991, p. 1244). By examining the experiences and struggles of Black women, especially in feminist and anti-racist discourse, the author argues that intersectional subordination is frequently a consequence of the imposition of one burden that interacts with other pre-existing vulnerabilities and creates yet another dimension of disempowerment (Crenshaw, 1991).

Intersectionality has been developed by other scholars, such as Nash (2008), who argues that intersectionality as a theory, method, practice, and politics should expand in approaching other identities and categories outside of race and gender (p. 10). Intersectionality challenges the homogeneous idea that all women's experiences are identical. As such, it highlights the significance and effect of systemic structural inequalities and power dynamics that stem from different identities and orientations, such as gender, race, class, and sexual orientation, which intersect and have a cumulative effect on women's experiences in social practices, institutional arrangements, cultural ideologies, and systems of power (Karmakar, 2022; Davis, 2008, p. 68). Additionally, an intersectional perspective is utilised to demonstrate the multiplicity of identities beyond gender that impact the different forms of agency expression. For instance, concepts such as the patriarchal bargain by Kandiyoti (1988) that I adopt in this study looks exclusively at gender relations, hence the need to complement the concept with an intersectional lens that sheds light on other identities and their intersections in the context.

Thus, drawing on the understandings of intersectionality by Crenshaw (1991) and Nash (2008) and the use of intersectionality in obstetric violence research, I will employ intersectionality both during the data collection and data analysis. Specifically, I aim to examine the intersections of gender, ethnicity, level of education, geographic identity, and socio-economic status as contextually crucial identity markers. This approach is in line with calls by feminist scholars who argue for the need to utilise intersectionality in studies of obstetric violence as the intersection of women's background and identities shape and define their experiences of obstetric violence and their response to it (Espinoza-Reyes & Solis, 2020; Smith-Oka , Rubin, & Dixon , 2021; Chadwick, 2017).

In conclusion, this study adopts an understanding of agency that centres on peripheral and non-Western' experiences and narratives and sees women as agentic subjects capable of thinking, strategizing, planning, making choices or negotiating with power in different forms and within a certain set of realities. This conceptualization is complemented by the concept of patriarchal bargain, which allows me to position the agentic subjects of the study in a larger context and

explore how their agency is constrained by certain systematic and structural factors, namely a patriarchal society characterized by informality and commodification of healthcare. Furthermore, the intersectional perspective facilitates the understanding of how women's identities and backgrounds intersect within the context and shape women's expression of agency and their choice of strategies and tactics to minimise the risk of obstetric violence.

5 Methodology

This chapter outlines the data collection process, research design, ethical considerations, researcher's positionality and the employed method for data analysis. The sections are as follows: research design, semi-structured interviews, sampling, time and place of interviews, coding and data analysis, researcher's positionality, and ethical considerations.

5.1 Research design

This study focuses on women's personal narratives and centres their experiences of obstetric violence during childbirth in public and private hospitals in Kosovo. Hence, this study uses a single case study design which allows me to research a specific phenomenon and a context as inextricably linked, i.e., narratives of obstetric violence in Kosovo (Tetnowski, 2015). Single case study design has allowed me to go beyond confirming vis-à-vis opposing the occurrence of obstetric violence in Kosovo and instead describe the phenomenon by centring the personal narratives of women who experienced it (Tetnowski, 2015, p. 42). Furthermore, case study research design requires the researcher to follow a systematic and intentional process, such as employing data collection methods, theoretical framework/s, and data analysis methods that are linked to and inform one another (Tetnowski, 2015). Method-wise, the study utilises qualitative methods for data collection and analysis. I have used both purposive and snowball sampling to identify the study participants, who have been interviewed through semi-structured interviews with open-ended questions. As the study focuses on the personal narratives of women, I have chosen qualitative methods for data collection, namely interviews, as a more appropriate method that enabled a deeper understanding of women's experiences in comparison to the results that I could have obtained through surveys.

Furthermore, in terms of analysis, I have coded the data in NVivo using a combined coding approach. Lastly, the study employs experience-centred narrative analysis as a data analysis method. The data analysis method has been chosen

considering that it centres on women's narratives in the analysis while allowing for a broader analysis of the context, which I have considered crucial in this study. Hence, I argue that I have been able to answer the research questions by using a qualitative single case study research design in combination with theoretically informed data collection and analysis methods.

5.2 Semi-structured interviews

All interviews were semi-structured with open-ended questions in relation to the research question and aim. I deemed semi-structured interviews as an appropriate method for this study as they provided the space to keep a thematically structured setting while also maintaining a relatively informal exchange with the interviewees without limiting their narratives (Mason, 2002, p. 62). I started the interviews with informal conversations about the study or other topics such as family or school, which allowed us to go into the interview questions in the same style of exchange; informal and open. The interview themes were identified while I was informally talking to women in my family and circle about their experiences with pregnancies and childbirth and later complemented with themes from literature review and context analysis. The main themes included personal questions about their status and identity, number of pregnancies and births, their organization of antenatal care, experiences of receiving obstetric care, and post-partum experiences in the hospital and family (*see appendix A for the interview guide*). Additional questions and themes discussed depended on the flow of the interview, issues brought up by the interviewees or experiences that they deemed as necessary to share.

5.3 Sampling

In this study, I have employed both purposive and snowball sampling. The sampling was purposive because I have looked for women who have monitored their pregnancies and/or have given birth in Kosovo's public or private hospitals in the last 4 to 5 years. Snowball sampling was utilised as the participants were asked if they knew of someone in their family or friends who shared similar experiences (Scheyvens & Donovan, 2003). From September 2021 to March 2022, I

interviewed thirteen women. The number of interviews was set based on the study published by Guest, Bunce & Johnson (2006), who considering the interview structure and content, and participant heterogeneity state that 12 interviews are sufficient to understand the field of interest in qualitative research (p. 17). The participants were found through different channels, such as through existing contacts, through the first interviewees, social media platforms, and journalists who have written pieces on postpartum depression and had contact with many women. I have used Facebook community groups focused on pregnant women and new mothers to reach out to a more heterogenous community and found most of the participants through these groups, such as *Happy Moms and Babies, Pregnancy and Babies,* and *Advises and Recipes for Babies & Children*. I provided a brief description of myself, and the research aim on group posts, along with my contact information, so participants could have the freedom to reach out to me (*see Appendix B for an example of the Facebook post*).

As intersectionality is employed as an analytical tool in the study, I tried to avoid homogenizing women's experiences and look at different social categories and how they intersect and shape women's narratives (Nash, 2008, p. 2). Hence, the social categories that I have looked at and that have impacted the sampling process are age, educational level, occupation, geographic identity, and socio-economic background *(see appendix C for participants list).*

5.4 Place and time of the interviews

Twelve interviews were conducted online as the COVID-19 pandemic restrictions determined the fieldwork course, and I could not safely travel. One interview, however, was conducted in person, as there was a short timespan when travelling between Sweden-Kosovo was deemed safe and allowed. As online interviews were not my primary choice, I became observational of the pros and cons of online interviews versus face-to-face interviews. The perceived superiority of face-to-face interviews over remote interviews has been highly contested since the beginning of the COVID-19 pandemic that forced many scholars to collect data remotely.

Very recent studies show that the length of the interviews or word count is usually lower in remote interviews, but this does not lead to differences in the quality of data or in substantive data codes generated or used from analysis (Gray, Wong-Wylie, Rempel, & Cook, 2020; Johnson, Scheitle , & Howard Ecklund 2021, p. 1143; Zadkowska, Dowgiałło, Gajewska, Herzberg-Kurasz, & Kostecka, 2022). While I acknowledge the limitations on establishing rapport or observing in more detail the body language, I would argue that in my study, I have observed more benefits to online interviews rather than downfalls because a) online interviews allowed me to adapt more to the participants needs so the encounter would be easier, more accessible, and more convenient for them. For instance, I have conducted interviews during all times of day (midnight or early morning) when their kids would sleep, or participants were alone and felt safer, and on platforms of their choice (Zoom, Messenger, Viber, WhatsApp); b) it was time-saving for the participants, and c) enhanced personal interface to discuss personal and emotional topics (Gray et al., 2020). Furthermore, I would argue that the participation of most of the participants was possible because of the mode of the interviews, as many expressed that conducting face-to-face interviews would imply them informing family members about the interview, getting approval, or securing someone to take care of their children.

All interviews have been conducted in Albanian, audio-recorded, and have been transcribed *ad verbatim* as such. The quotes used for the analysis were further translated to English, but I have tried to keep the terms and structure of the sentence as like the original as possible. As Blommaert & Dong (2010) state, the researcher is also part of the interview, so I have transcribed my responses and dialogues as well. Interviews have lasted between 30 minutes to 2 hours, or 188 pages when transcribed into text.

5.5 Coding and data analysis

The transcriptions have been coded using NVivo, which allowed me to look at repetitions and contradictions in the participants' narratives. I have utilised a combination of deductive and inductive coding. Initially, based on the theoretical

framework, I developed a codebook with three main codes, including obstetric violence, strategies, and tactics. After identifying excerpts in the narrative that were assigned to the three main codes, I reread the data. The second coding round was inductive as the types of strategies and tactics derived from the data. The different derived codes were then grouped under strategies and tactics, respectively (*see appendix D for a visualization of the coding*). By identifying the main codes in the narratives of the participants, I was then able to identify the main experience centred narratives as such.

As mentioned in the research design, I have used experience centred narrative analysis to analyse the data. As a basis, the experience-centred narrative approach sees narratives as a) sequential and meaningful; b) human; c) re-present experience, reconstitute it, and express it; d) display transformation or change (Squire, 2013, p. 48). Experience-centred narrative analysis assumes that personal narratives are all meaningful stories of personal experiences that people produce, and they can be narratives about an event specifically, or they may also be more flexible in time and personal experiences (Squire, 2013, p. 42). Another crucial element of the experience-centred narrative is that to understand the meaning, it allows the space to expand the contexts or the materials that are studied, so in addition to the narratives, contextual analysis on Kosovo and obstetric violence are also included. The method as such is not substantially different from thematic analysis but it provides the possibility to expand the analysis beyond the data which in turn allows me to situate women's narratives to a specific site and connect their experiences to bigger contextual factors. Also, Squire (2013) argues that the researchers can also include in the analysis hard-to-transcribe fragments, words themselves, contradictions and gaps within narratives, and paralanguage such as pauses or laughter (p. 43). Furthermore, experience-centred narrative analysis also focuses and reflects on the power relations between the interviewer and interviewee in the process of data collection, transcription, translation and lastly, data interpretation (Squire, 2013; Temple, 2008).

5.6 Researcher's positionality

I am Albanian, born and raised in Kosovo and have moved to Sweden in 2020 to pursue my studies. While being ethnically Albanian and speaking the language facilitated my access and connection to the participants, my other identities played a more crucial role in me being considered an 'insider' or 'outsider' by the participants. Narayan (1993) argues that the positioning of "native" researchers is mostly linked to shifting identities, such as gender, age, marital status, religion, or other contextually important identities. As the study focuses on women who have experienced pregnancy, childbirth and are mothers, my status as 'single' and 'childless' very often played a role in me being considered as someone who cannot fully understand their experiences, hence an 'outsider' or the 'other' at the time being. However, there was an assumption that I will give birth soon and therefore, it is of interest (beyond academic interest) for me to research the issue and be trusted with their narratives. Such examples show the ambiguity of the dichotomous insider/outsider distinction and how they are instead fluid, challenged, shifting, and being negotiated (Labaree, 2002; Narayan, 1993, p. 672).

Lastly, my knowledge of the context and awareness of the culture and norms in Kosovo shape and are shaped by my subjectivity and positionality. Hence, I have not tried to remain objective during the data collection and analysis but rather utilised my knowledge and awareness.

5.7 Ethical considerations

The main ethical considerations of this study are informed consent, anonymity and confidentiality, and the freedom of choice (Scheyvens, Nowak , & Scheyvens, 2003). To assure participants of confidentiality and that I might be entrusted with information, each participant has been given a coded name prior to the interview. I have assigned common Albanian female names to the participants to ensure anonymity while still staying respectful of the local culture. These coded names are used in transcripts, analysis, and participants list.

Per the Ethical Guidelines for Good Research Practice, I have negotiated informed consent and avoided undue intrusion in the participant's life. Most of the participants have initiated the first contact with me, and all participants have voluntarily chosen to be part of the study. The participants have been informed in detail about the research before the interview and the risks associated with the research. They have had the chance to read the interview guide and could also withdraw their participation at any given time. Considering that most of the interviews were conducted online, consent has been taken on record through a more personal and informal form of conversation to make the participants more comfortable and to try to avoid the hierarchical relation between the researcher and the participants. The recording and the transcriptions are saved on my personal computer with a set of copies on a personal USB and will be deleted after completing the thesis.

6 Findings

In this chapter, I provide a descriptive interpretation of the data by focusing on two main elements a) obstetric violence and b) understanding the risk of obstetric violence. The findings demonstrate the existence of obstetric violence in Kosovo and that women are aware of the high possibility of experiencing negative and traumatic childbirth. These sections further outline the forms that obstetric violence takes and how women build a learning trajectory of obstetric violence, namely how they come to understand the risk of obstetric violence. These two sections facilitate the understanding of the analysis and how women come to choose their strategies and tactics.

Warning: Some of the quotes from the participants are graphic and disturbing.

6.1 Obstetric Violence in Kosovo

I interpret obstetric violence as a specific form of gender violence against birthing people who are subjected to acts of violence during pregnancy, childbirth, and postpartum, that can assume the form (but not limited to) sexual, physical, or verbal abuse, stigma and discrimination, structural issues related to the healthcare system, failure to uphold medical standards of care (over medicalisation or under medicalisation), and miscommunication between the labouring person and medical staff (Chadwick, 2021; Davis, 2019, p. 561; Cohen Shabot, 2016; Bohren, et al., 2015). The fear of experiencing obstetric violence was prevalent in the narratives of all interviewed women, but not all of them were subjected to obstetric violence directly. Most of the women that were interviewed reported to have had negative and traumatic birth experiences, which may be interpreted as obstetric violence.

Experiences of obstetric violence are more occurrent in public hospitals. Ariana, a 26-year-old woman, who gave birth for the first time in the University Clinical Centre of Kosovo, narrates the psychological and physical abuse that she endured during childbirth and postpartum. Ariana insisted on a caesarean section after several days of pain because of birth stimulants. She narrates having been

continuously neglected by the medical staff until she was finally promised the procedure (caesarean section), but only "after another patient who was *not* in active labour yet would give birth." She considers this act as a punishment for her requirement:

> *"I was left sitting in a wheelchair, bending backwards, my eyes closed…almost, almost unconscious, in terrible pain…waiting for her (the other patient) to give birth. I do not know how long I was left waiting."*

The experience of physical pain or psychological needs being neglected by medical staff is shared by many other women. Leonora, a 31-year-old woman, also mentioned that she was neglected by the doctor covering the shift from four in the afternoon to four in the morning:

> *"I was in pain…and when the nurses told the doctor covering the shift that I was ready to give birth, she said 'I do not care!! Call her doctor', and so I was just left there".*

The phenomenon of obstetric violence expressed through neglect and physical or psychological abuse, is not limited to public hospitals. While women's narratives show a much higher occurrence and intensity of obstetric violence in public hospitals, some of the negative experiences are located in private hospitals as well. Genta, a 31-year-old, highly educated woman, monitored her pregnancy and planned to give birth in one of Kosovo's most famous private hospitals. However, she experienced negligence, lack of care, and lack of information from the medical staff of the hospital that led to her losing the baby in the last week of pregnancy. Furthermore, she was also asked by the private hospital staff to transfer to the public hospital herself without any support or explanation:

> *"Their negligence brought me to the point that I ended up like this (referring to giving birth to a dead baby)".*

Apart from neglect, obstetric violence in Kosovo also takes the form of non-consensual procedures, abuse of medicalisation, inhuman treatment through use of

jargon or damaging physical acts, refusal of providing treatment, emotional abuse, and lack of access to health services. The most common shared experience of non-consensual procedures performed on women are pelvic examinations. Interviewed women narrate that pelvic examinations are very frequent, often humiliating, and can be violent as well. Ariana shares her experience of pelvic examinations as violent, painful, and non-consensual:

> *"While doing the check-up with fingers, she (the nurse) said that my waters had not broken. At that moment, I felt a much stronger pressure. So, she inserted her hand much deeper and broke my water. She did not tell me about anything, and I did not even know that such a thing could happen."*

Pelvic exams are practised in two different wards, namely in the admission and the gynaecological ward, where women in active labour are placed. Women express that for the first-time giving birth, they were not knowledgeable that pelvic exams are practised in the admission room. Furthermore, they were not informed nor asked for consent. Genta expresses that she initially thought that it was her fault for not knowing about the pelvic examinations during the admission until she later noticed that no one who was there for the first time did:

> *"I could tell for the other women as well when they would come upstairs from the admission room; no one knew that there is going to be a pelvic exam, and they were frustrated".*

The common knowledge is that pelvic examinations are practised in the waiting rooms when women are in active labour. Most of the women, especially those that gave birth in public hospitals, were examined by different staff members that they did not recognize, including students, which they experienced as humiliating and violent. Additionally, the procedure is conducted under non-favourable conditions such as crowded rooms and lack of privacy. Genta further expressed that:

> *"Those exams were my nightmare. You do not only get physically naked, but you are also naked from everything".*

The same sentiment is shared by Shpresa, who remembers pelvic exams as a humiliating procedure in a room full of medical staff and other patients and feels as if these exam rooms are made for "animals" and not people. Similarly, in the labour room, women are generally not informed nor asked for consent for performing procedures such as vaginal cuts or the use of vacuum.

Another common form of obstetric violence experienced by interviewed women was abuse of medicalisation. Some of the participants experienced over medicalisation which, according to them, could have led to severe health issues for themselves or the baby. Rina, a 28-year-old woman, found out that she had to terminate her pregnancy and was admitted to the public hospital. Despite the emotional distress and pain, she managed to look into her medical history sheet and found out that she was given thirty-three pills while the recommended dosage is six. In the upcoming days, she went through two surgeries and many procedures for which she was not informed and did not know what was happening to her:

> *"I was unconscious for many hours, and they (the doctors) did whatever they wanted, you know? I was not told about it. I did not even know if I had all the organs (laughs). I mean, I knew I did but were they damaged? I did not know anything."*

Many other women share her experience of over medicalisation and neglect. Many women report having been under medication for a longer time than recommended without being checked in by any medical staff and forced into specific childbirth methods such as caesarean sections, use of epidural or intense use of stimulants.

Some women also experienced a lack of care that takes the form of inhuman treatment, such as denial of food and water and denial of medication. Women were placed in different postpartum wards depending on the birth-giving method. Those placed in intensive care express that they were fully dependant on the medical staff for food, water, medication, and use of facilities such as the toilet in comparison to those in other wards. The high level of dependency on medical staff made women very vulnerable to their authority which mostly took the form of negligence, lack of care and inhuman treatment. Shpresa, a 38-year-old woman, shares that she was denied water or food throughout the whole night by the medical staff that was

covering the shift, under the pretext that it was not their responsibility to support her. Furthermore, one of the nurses got the food that she had brought with her and gave it to the other nurses while Shpresa was begging for it:

> *"I would ask her (the nurse) to give me something to drink. She would say, "Wait for the other one. It is not my duty". The other one would come, and I would ask again—the same answer. I could not even swallow. I was in great need of some water and still nothing. At some point I said that I was very hungry, and can I have a biscuit? She (the nurse) gave only one to me and gave the rest to the other nurses. They did not give me anything to drink until the next morning".*

Most of the women who gave birth in public hospitals had to buy drinking water, drinks, food (those in intensive care), and medicine for themselves. In addition, many of the women narrate to have been yelled at for not bringing bed sheets, covers and pillowcases with them. While some were forced to go out and buy them or ask their family members to bring some if they lived close by, some had to lay on used and bloodied sheets that had been used by the prior patient. The experiences differ from woman to woman, as some narrate to have had a cleaner room, drinking water, and clean sheets, which might be because of infrastructural changes in some hospitals or inequality in-room distribution.

It is important to emphasize that obstetric violence is complex, and birthing women can have multiple experiences throughout childbirth and postpartum, variating between good and negative, even exercised by the same medical professional. Therefore, this section is concerned with identifying and outlining the forms that obstetric violence assumes in Kosovo, emphasising the most common forms that women have narrated.

6.2 Understanding the risk of obstetric violence

Pregnancy is not experienced in a vacuum. All interviewed women expressed to have actively discussed their pregnancies with other women around them or observed the experiences of other women in their family or friends' circles. The discussions were focused on where to purchase better antenatal care, experiences of giving birth in public and private hospitals, including treatment from medical

staff and conditions of the facilities. Despite the stories and experiences being heterogenous, they tended to be more intense on the spectrum of bad or traumatic stories, especially those in public hospitals. These heard stories or observed experiences indicate to the women that giving birth almost certainly leads to obstetric violence. For example, Valentina, a 34-year-old woman, lost her closest cousin due to the medical staff's continuous negligence after giving birth in a public hospital, which has shaped her perception of obstetric care and strengthened her fear of experiencing obstetric violence herself. She said:

> *"I had a bad experience with the public hospital. My aunt's daughter died there two hours after giving birth, and…we experienced it very badly, I don't even know how to say it…she went in very healthy, and they say that she died because of the negligence of the doctors."*

Another participant, Fatlume, a 33-year-old veiled woman, heard from her friends that veiled women are forced to either accept the care of male doctors or sign a legal document that they have refused treatment. These stories enabled psychological pressure during her first pregnancy as she was afraid of being asked to either go against her core religious principles or 'willingly' put herself and her baby at risk. However, the general fear of receiving bad treatment or having negative experiences with the healthcare system is not new to the participants. Women express that they have had prior experiences with various levels of the healthcare system, so there is a collective agreement that there is a lack of basic conditions and quality treatment from medical staff.

Understanding the forms that obstetric violence takes in Kosovo and the fear of experiencing and/or reexperiencing it becomes much more intense for women who have given birth more than once or had experiences with other reproductive events. Most of the interviewed women had more than one pregnancy or had given birth more than once, so their perceptions and fears were shaped by personal experience of obstetric violence or first-hand observation of obstetric violence to other patients. Genta, who gave birth twice, expresses this, saying:

"I was struck that women who were giving birth for their second time were much more scared, and only now I can understand why."

She did experience different forms of obstetric violence both in private and public hospitals during both her pregnancies and in labour, which shaped her understanding of how the system works and what to expect. This sentiment is shared by many other women, such as Fjolla, a 31-year-old-woman who thinks of her first childbirth as a traumatic event that highly impacted her during the second pregnancy and shaped her decisions:

"For the second pregnancy…I was so scared. So scared because of the first time when I gave birth, the bad experiences that I had."

Other women expressed to have observed obstetric violence in different forms on other patients when they gave birth to their first child. Therefore, they were able to grasp other dimensions of obstetric violence – other than those that they had experienced themselves. Genta had spent many days in the hospital and had observed many events unfolding. She explains:

"While I was getting ready (to go to another room), there was another woman there that they (medical staff) were yelling at her, saying GET UP! Get up because we do not have time to wait for you all day, you must go take care of your baby, get up! I was so scared that they would yell at me too".

Willingly or non-willingly, women collect information from various sources, observe, and experience obstetric violence or lack of it thereof, in both public and private hospitals. However, such exposure shapes the understanding of the phenomenon for women, which in turn shapes their strategies to minimise and avoid the risk of obstetric violence.

7 Experience Centred Narrative Analysis

The narratives further reveal that women utilise their knowledge and understanding of the health system and, more specifically, of obstetric violence to minimise the risk of experiencing and/or reexperiencing it themselves. Based on the narratives and applying the theoretical lenses, two main experiences are identified and thoroughly analysed, namely (a) strategizing to avoid and minimise the risk of obstetric violence and (b) utilised tactics while in the hospital. Due to many intersections that impact women's experiences and choice of strategies and tactics, the analysis has a separate section that looks at how different identities shape women's choices.

7.1 Strategizing to minimise the risk of obstetric violence

Women's narratives indicate that two main strategies are widely utilised as an avenue to minimise and/or escape the risk of obstetric violence. The two identified strategies are a) Purchasing healthcare services in the private sector and b) Utilising informal practices.

7.1.1 Purchasing healthcare services in the private sector

Out of thirteen interviewed women, all report having monitored their pregnancies in private clinics or private hospitals that provide obstetric services. Purchasing obstetric services in private practices of doctors who were also employed in public hospitals shows to be the main strategy that women utilised to minimise the risk of obstetric violence in childbirth. The strategy can take different forms *per se*, as some women resort to *both* the private and public sector while some resort to the *private sector only*. In fact, most of the participants prefer public hospitals as their first choice, as they believe that despite the conditions, there is higher safety since private hospitals might not be equipped sufficiently (human resources or equipment) to respond to serious complications during childbirth.

7.1.2 Combining private care with public care

The high threat of obstetric violence functions as a mode of discipline that shapes women's actions and leads them towards planning and carrying out strategies prior to and during pregnancy (de Certeau, 1984; Chadwick, 2017). Women start searching for doctors who simultaneously have influence in the public hospital and their private practices, as an established *good rapport* in private practices guarantees 'good treatment' during childbirth in the public hospital. Ariana narrates that the only reason she chose a specific private clinic is that the doctor who owns the practice also works in the public hospital:

> *"...I had heard that he is a very good doctor, but he also works in the gynaecologic pathology ward. This means that if you already are his patient and you have a complication before or during childbirth, then they say you will do great with this doctor. Much better. You get much more help."*

Flora also monitored both of her pregnancies with the same doctor in his private clinic, while aware that he works in the public hospital, and even became ward chief:

> *"You went to him (private clinic), so maybe he will take better care of you in the hospital as well, you know?"*

With the increasing number of private practices in Kosovo and the high number of doctors employed both in public and private healthcare facilities, there is a big overlap of obstetricians operating in this way (Levizja FOL, 2016; Kosovo Women`s Network, 2016). Women seem to be aware to some extent of the high commodification of healthcare as they express dissatisfaction with the prices, unjustified tests, or an intense number of recommended visits in private practices. However, in the face of obstetric violence, women choose to utilise the fact that doctors have double jobs and implement strategies to their benefit.

Towards the last weeks of pregnancy, women initiate their negotiations with the doctors. As the time for childbirth in public hospitals approaches, women are

assured that in exchange for their loyalty and financial payments to the private clinics of doctors, they will be supported and taken care of once they are in labour and are admitted to the respective public hospital. Such is the case of Ariana, who spoke to her doctor in the last weeks of pregnancy:

> *"He (the doctor) said that when you go, when you are admitted to the hospital (public), you send me a text message with your name, surname, and the room number. And then I will deal with the rest of it…this meant that he would inform one nurse in the admission ward and another in the labour room that follows his patients…"*

Similarly, Rina, a 28-year-old woman, spoke to her doctor and got the information on when her doctor will be covering shifts at the hospital. She texted the doctor to let her know that she was in labour, and while she was in the delivery room, she heard a phone call from her doctor to one of the nurses, saying, *"I have a patient of mine there, so take care of her"*. The level of authority and influence the doctor has in the public hospital is crucial. Doctors that hold high-level positions such as chief of the ward or shift chief are more likely to have more influence in the hospital and consequently increase the chances that "their patients" do not experience obstetric violence. For instance, for Genta, the fact that her "doctor" was chief of the ward played a crucial role as she gained "privileges" amongst the other patients in the public hospital. She narrates that the medical staff used to refer to her as "*the Doctor Chief's patient*", and she was prioritized for a caesarean section:

> *"So, they brought the list, who to take...the doctor (the chief of the ward) himself asked for me first, and then whoever the nurses wanted.".*

Previous studies from Portugal and Poland show similar findings, as patients who resort to both private and public sectors and establish a good *rapport* with the doctor have higher chances of receiving better care if the doctor has higher authority in the hospital (Belli & Lewis, 2001, Barata, 2022). Still, as Barata (2022) argues, legitimate it is, this strategy often proves faulty and is a source of frustration (p. 172). Some of my respondents narrate that their expectations towards the doctors

proved to be too high, as sometimes they did not show any extra care or support for women who were their patients, or they failed to keep their promises about performing certain procedures. For instance, Valentina and Blerta, had to leave the public hospital while in labour and go to their doctor's private practices again and pay for a visit just to reaffirm that they would be taken care of once they went back to the public hospital. These women were disappointed and frustrated as they felt that the profit they had brought to the doctor's private practice should have resulted in the minimisation of these risks, and not the contrary.

7.1.3 Private care from start to end

Another form that this strategy takes is childbirth in private hospitals. This strategy, however, is rarely used. The data shows that women who attend private hospitals for both pregnancy monitoring and childbirth do it because: (a) they belong to a higher socio-economic background, or (b) they or someone they know has experienced intense obstetric violence in public hospitals.

The first group represents a minority of my participants, as only one of the women reported to have given birth in a private hospital. Arbnora, a 35-year-old economist who holds a high-level position in banking, narrated that she never considered a public hospital as a facility where she could give birth. This is because she heard from other women about their negative and traumatic experiences, so she decided to give birth in private hospitals:

> *"Luckily, my occupation, namely my employer, provides health insurance so of course I attended private hospitals".*

Arbnora is part of the 6% of the population in Kosovo who acquire health insurance from private companies, either paid by the employer or by the person themselves (Kosovo Women`s Network, 2016). However, the second group shares that they were 'forced' to resort to a private hospital for childbirth hoping that their

experiences would differ, even if the financial burden felt completely on their shoulders and was barely covered.

7.2 Informal practices

As extracted from women's narratives, preceding childbirth in a public sector setting by attending private practices is not always a fully successful strategy. Women utilise and carry other strategies that are common within the system, such as informal practices. Due to dysfunctional regulatory environments, Kosovo is characterized by high levels of informality, namely, the phenomenon is omnipresent in society at large (Cvetičanin, Popovikj, & Jovanović, 2019, p. 599; Krasniqi, Papa-Pandelejmoni, Hysa, & Kera, 2019, p. 139). Women's narratives demonstrate that they partake in informal practices as a strategy to avoid and minimise the risk of obstetric violence in public sector settings during childbirth. The two most utilised informal practices are informal payments in the form of goods and gifts and having social connections that help to "*get things done*".

Similarly, to the first strategy, women have previous personal or second-hand experiences with informal practices in healthcare. They understand the strategies that could optimize their options to receive better healthcare and minimise or avoid the risk of obstetric violence. For example, one of my participants, Rina, a 28-year-old woman, had one miscarriage and two childbirths in the public hospital. During her miscarriage, Rina had to be taken in for an emergency intervention for which she did not receive any prior or post-op information. She narrates that the negligence and lack of consent from the medical staff were continuous, and she was struggling to access information or any kind of 'good treatment' for that matter, which led to her utilising informal practices. Rina claims that she went prepared to the hospital with goods and gifts for the nurses, namely make-up products, which she had bought during her pregnancy and had them "*waiting*":

> *"…it is very important that when you go to QKUK (national hospital) you have gifts with you, you know? So, I had prepared lipsticks, make-up, all new and in a bag…I asked my*

aunt to bring them to the hospital for me because I needed to 'get on' with the nurses. I started giving 2-3 lipsticks to the nurses…and then they would tell me."

This strategy was successful as she started receiving timely information on her condition and managed to send indirect messages to the doctors through the nurses to whom she had given the goods. Rina narrates that she utilised the same strategy the following two times during childbirth in public hospitals.

Informal payments in the form of goods and gifts were identified in the narratives of three other women who also used this strategy to ensure that they got better treatment. For instance, directly giving money to nurses for being 'nice' to them or giving money to doctors to perform a specific check-up or to monitor them, and having their families give money to nurses and doctors in the waiting room. While it is not the preferred course of action, the utilization of such strategies comes as a response to an oppressive site that is unresponsive to women's situations and needs (Krasniqi, Papa-Pandelejmoni, Hysa, & Kera, 2019).

When asked about informal practices, many participants were hesitant to share that they had utilised such strategies. This shows that women are aware of the phenomenon and the negative connotations, hence the "guilt" of utilising it as a strategy, but they do, however, plan and carry out such strategies to renegotiate their position in the health system (Kandiyoti, 1988).

While bringing gifts or goods and money was more isolated and limited, having social connections was a widely utilised strategy. Studies from the Western Balkans, including Kosovo, show that not everyone has connections, yet they proactively are in the search for them because personal relationships and connections help people 'get things done' and improve their livelihood (Brkovic, 2016; Krasniqi, Papa-Pandelejmoni, Hysa, & Kera, 2019). Similarly, women narrate that during pregnancy, they identified social connections, family, and friends who work or have influence in the public hospital as a strategy to minimise and avoid obstetric violence. One of the participants, Flora, shares that in addition to attending a private practice preceding her childbirth, she spoke to her cousin, who works in the public hospital, to negotiate:

> *"My aunt's daughter works there, specifically in the labour room and so they took me into consideration, both doctors and nurses. They stayed close to me for everything I needed, checked on me, gave me medication, followed up on my situation."*

Kaltrina also had family members who worked in the hospital and made sure that when they were not at work, their colleagues would take care of her. So, the social connections extended to other medical staff members or third parties. Women's narratives show that this informal practice of "knowing people" might have to be combined with other informal practices (e.g., your "connection" might also ask for money or favours in exchange for help). Many women, however, shared that their social connections "failed" and hence their experience was not improved. Shpresa narrated to me that after her first strategy had been unsuccessful, she utilised social connections, which also failed:

> *"Even though I thought I had some connections, nobody helped me. I had people who I thought had people, connections in that ward."*

In conclusion, women's narratives demonstrate that they strategize to minimise and avoid obstetric violence, and the two main strategies shown here are the most frequent ones. While these strategies might not succeed, women utilise more than one strategy and tactic, as shown in the next section.

7.3 Utilised tactics

Unlike strategies, tactics depend on time and on immediate situations that could be turned into "opportunities" (de Certeau , 2005). I identify as tactics those agentic actions that are utilised while women are in labour, childbirth and postpartum. Women's narratives demonstrate that the utilization of strategies does not exclude the need for immediate tactics. As such, they are complementary. Due to their immediate nature, tactics are multiple, and women's narratives show that they can be contrary to one another. That is, in a certain situation, women might have to

perform docility, while in another, they become loud. In women's narratives, I have identified two main tactics a) performing docility and b) performing resistance.

7.3.1 Performing docility

The embodied performances of women, their actions and subjectivities during labour are highly impacted and shaped by the continuous threat of obstetric violence, which functions as a mode of discipline (Chadwick, 2017). Unlike strategies that are shaped by broader contextual systems, tactics that emerge during labour to avoid and minimise obstetric violence seem to be universal in nature and embedded in patriarchal structures. For example, a tactic that was widely used by women in my study, namely performing docility and being obedient, is a tactic that feminist scholars found common in other sites such as South Africa and Mexico (Smith-Oka , Rubin, & Dixon , 2021; Chadwick, 2017). According to Shabot (2016), medical ideals of the good patient lead women to adopt a "hesitant, docile, and silent body" (p. 246).

My participants' experiences, especially in the public sector settings, show that there was an expectation from the medical staff to behave and be a 'good patient' or the contrary could lead to obstetric violence. Rina describes her docility as:

"I was being very careful not to say what I was thinking, just be there."

Shpresa also shares that she once asked for a painkiller which was met with yelling and verbal abuse by the nurse, which led to her being silent and docile afterwards. According to Shpresa, silence and obedience help labouring women avoid angry nurses. Another participant, Ariana, narrates that after a couple of days under the effect of stimulants, she was exhausted and in pain, but no attention was paid to her needs. As her doctor, whose private clinic she had attended, was not currently in the hospital, she was called in for check-in with another doctor who was hostile to her. The medical questions asked by Ariana were met with yelling and angriness, so she figured that acting silent and obedient was the only tactic to avoid more abuse:

"I just went to my room, started crying silently, and went upstairs (following the orders)."

From this case, we see that being assertive or asking questions is punished. The hanging threat of intensified obstetric violence forced her and other women similarly to "become docile" (Chadwick, 2017).

Another regulatory norm embedded in the logic of obstetric violence is the moral imperatives tied to gendered norms (Chadwick, 2017). Shabot (2016) argues that labouring bodies are expected to comply with notions of "passive femininity" (p. 244). The author further argues that labouring bodies are a threat to that ideal as they are loud, vigorous, sexual bodies who therefore need to be put in their place and reminded of their inherent condition of being passive and silent (Shabot, 2016, p. 244). So, the quieter and the more "sick presenting", the more tolerated you will be in the system, as a weak and feminine body is deserving of attention and help (Shabot, 2016, p. 244). These moral imperatives are present in the women's narratives in Kosovo, which leads them to perform docility further and even reinforce these imperatives in front of the medical staff to "negotiate" their position. For instance, Fatlume, a 33-year-old veiled woman, shares that her experiences in the public hospital were generally good, and she was taken care of by the medical staff. Fatlume narrates that other women around here were "loud and requiring", and they were met with angriness and hostility from the staff (reasonable according to her), but she was silent, and even though she was experiencing a lot of pain, she felt it was not a "motherhood trait" to scream. Her docility and suffering in silence were used as an example by the nurses to discipline the other women:

"While we were waiting, she (the nurse) asked her (the other woman): which childbirth is this? She said second. She then said to her: Ohhhh, mother, you are screaming too much! Look at her (Fatlume), she is much younger than you and not screaming. Be like her."

Similar stories were shared with me by other participants who were on either side of the spectrum. The moral imperatives of "passive femininity" (Shabot, 2016) and "good motherhood" were used to discipline women and to showcase the threat of

obstetric violence if the contrary is to happen. Hence, performing docility as a tool to fulfil the role of the good patient and the good mother were immediate tactics that were utilised by women to avoid obstetric violence. Women complied with the gendered norms to secure a position of safety for themselves, which is an indication of a constrained but still emerging form of agency (Kandiyoti, 1988; Avishai, 2016). It is crucial to note that in the narratives of some women, it became obvious that these gendered norms and ideals of motherhood were internalized and not necessarily performed as a tactic.

7.3.2 Performing resistance

Strategies and tactics are complementary, so more than one tactic has been identified in women's narratives. Shabot (2016) and Chadwick (2017) argue that performing docility to negotiate better treatment and avoid obstetric violence requires a significant effort, and women sometimes break the script as they experience fleshy and painful experiences of labour and birth. It is in this scenario that labouring bodies become "loud" and strongly agentic (Chadwick, 2017).

Women described that their docility and obedience would break in moments of intense pain, continuous negligence and/or mistreatment despite their enactment of good patients. Rina explains that she struggled with the intense pain and was also not knowledgeable about certain procedures. She was called in for a pelvic examination, and while trying to lay down, the doctor noticed that she was wearing shoes and started yelling at her for not being "*a clean patient*" and being disrespectful. Rina was taken aback as she had forgotten about the shoes (which she explained to have had on because of the unclean floors) and felt that she was being treated like an "animal," which led to her talking back:

> *"I told her (the doctor), I said: "pay attention to how you are talking to me because I am a human and an intelligent woman. You are talking to me …like I am a first grader. What is this kind of communication…and to think that you call yourself a doctor?." She (the doctor) froze and wanted to say something, but I kept going. I told her: "look, I am here to give birth, so stop.." I was tired of their treatment, you know?"*

According to Rina, pointing out to the doctor that she is educated, and an intelligent woman led to the doctor not punishing her for her "banter," which she believes would not have been the case if she were to start crying or performing docility at that moment. Rina describes that she used this tactic later as well, as she noticed that it helped her position herself as someone who cannot be abused.

Ariana also narrates that there were certain situations where she used her medical knowledge as a dentist to insist on receiving information and insist on specific procedures. She described that she had been in continuous pain, silent and docile, but that did not seem to get the attention of the medical staff, who were not informing her and were neglecting her cries for help. Hence, she found the space to point out to the medical staff that she is a medical professional, implicitly pointing out that she is aware of rules and procedures. Ariana describes that this was not welcomed and was met with hostility on some occasions but worked on others. Hence, the use of tactics leaves women very vulnerable as their capacity to act is limited due to the process of labour and childbirth. However, some women could express bodily agency, resistance, and power, depending on contextual, subjective, and relational factors (Chadwick, 2017, p. 504).

For other women, the performance of resistant agentic actions was met with hostility or punishment. Shpresa shares that after a few days in the hospital due to pregnancy complications, she was in pain and neglected by the medical staff, who would not visit her for long hours while taking IV medication. During the rare visits, she would receive pelvic examinations (from different medical staff members) that were hurtful for her. One day, she asked not to be examined and to get a painkiller instead, if possible. The doctor said nothing and left. Shpresa describes that after a few minutes, a nurse walked in:

> *"I didn't know anything…a nurse walked in, gave me a paper, and told me to sign it. I asked why? She said that I had to because I had refused the doctor's assistance. I read it, and it said that I take full responsibility for myself if anything happens, and many other bad things about me. I didn't sign it."*

Her resistance to unconsented procedures was met with hostility and punishment. Apart from the silent treatment from the doctor, and the hostility of the nurse, because of her "talking back", she did not receive any medical attention or treatment until the following day when her condition was urgent due to a haemorrhage. The threat "disciplined" Shpresa to be silent and obedient if she wanted to receive treatment.

Thus, the use of tactics that show a stronger bodily agency or stronger agentic forms are experienced very differently and are very relational. Some women experienced hostility and punishment in return, while others were able to find the space to be resistant. Performing resistance was a much more isolated tactic as it went against the expectations of the patriarchal society towards the labouring body. My participants voluntarily or involuntarily performed docility as the most beneficial tactic to negotiate their position and experience within a system that aims to diminish their agency (Kandiyoti, 1988).

7.4 An intersectional understanding of women's choices of strategies and tactics

Women's choices of strategies and tactics are shaped by the intersections of their identity markers and backgrounds, such as socio-economic background, education attainment, geographic location, and occupation. Crenshaw (1991) and Nash (2008) argue for an intersectional approach to understanding different experiences and intersections of oppression and privilege in societies.

Women with high economic capital have unlimited access to the private sector compared to women with lower economic capital. While all women narrated that they attended private practices to precede their stay in the public hospital, women from the low or low-middle class (Shpresa, Fatlume, Flora, Blerta, Rina, Valentina) expressed that they experienced great financial burden due to those visits. Women described that in private practices, in addition to regular check-ups, they were asked to do multiple tests for themselves and the foetus, which in most cases were unaffordable. The inability to do the tests led to high anxiety and stress, even if they

were aware that additional tests are an expected outcome of the private sector as a tool to increase profit. Many women explained that they felt pressured to do the tests and borrow money from family or minimise other elementary expenses to cover those tests. However, none of them resorted to the public hospital as the threat of experiencing obstetric violence both during pregnancy and childbirth was highly associated with the sector. Hence, they felt the absolute need to attend private practices.

Differently, women who belonged to the upper class and some to the middle-upper class (Arbnora, Genta, Leonora) had more alternatives in choosing the private clinic, namely the doctor, and many of them expressed to have attended multiple private clinics during their pregnancy. Furthermore, some of these women were also able to decide between giving birth in public or private hospitals, as the latter was accessible for them as well. The differences in access to the private sector highly affect the carrying of women's strategy. As the findings show, doctors with higher-level positions in the public hospital are one of the best strategies for women to avoid and minimise obstetric violence in the public hospital. The "privileges" that come with being the patient of a doctor who has authority and influence in the hospital ensure a better experience for women. These doctors, however, have a higher demand for appointments in their private clinics and consequently higher prices, according to the narratives of the women. Similarly, informal payments such as goods, gifts, and money completely dependent on women's economic capital.

Furthermore, I argue that their choice of informal practices, such as social connections, is also dependent on the intersections of their socio-economic background and geographic identity. Women from rural areas and working or low-middle class (Nita, Valentina, Ariana, Blerta) reported having fewer social connections that could help them get better quality healthcare and avoid obstetric violence in the hospital. This was not the case for most middle and upper-middle class women, especially those who live in urban areas, as they had more access to social networks and were able to identify social connections that could help them "get things done."

This is a result of liberal policies in contexts such as Kosovo that are going through transitions and mostly impact the marginalized groups, including women of low and low-middle class (Levizja FOL, 2016; Kosovo Women`s Network, 2016). Hence, within a system that enables privatization and informality, women's choice of strategies and 'bargaining' are highly shaped by their socio-economic backgrounds, which are closely related to their occupation as well.

Like the strategies, women of different backgrounds had different experiences with tactics. I argue that their identities and backgrounds shaped this navigation of the situation and the forms that their tactics took, while it also impacted the way their tactics were received from the medical staff. For instance, women with higher education attainment and higher economic capital had more of a haptic knowledge of the birth process and utilised this knowledge to talk back or resist certain procedures. Women with lower education levels did not have the same access to knowledge (i.e., one of the women had no information about what stimulants are, or other women did not know how to ask the "right" medical questions), which led to them internalizing the moral imperatives tied to gender norms such as "passive femininity" and endure the pain. Lastly, women with higher education levels or more "valued" occupations used their social status to negotiate their position while in labour and childbirth, which was not the experience of women with lower education levels.

In conclusion, the findings show that the intersections of different identity markers and socio-economic backgrounds shape women's choice of strategies and tactics and further shape how (from the perspective of these women) they are treated by medical staff. Women with lower economic capital, social capital, and status are more vulnerable to the "failure" of their strategies and tactics, while women with higher economic capital and education levels experience relatively more success.

8 Discussion

The findings from this study show that birthing women in Kosovo experience many, albeit not all, forms of obstetric violence that have been identified in typologies of obstetric violence. Women's narratives demonstrate that obstetric violence in Kosovo assumes the forms of neglect from medical staff, abuse of medicalisation, non-consensual care, verbal abuse, indifference, humiliation, and other forms. Furthermore, these narratives emphasize the lack of decent conditions in public setting facilities, such as lack of clean bedding, drinking water, and clean toilets and rooms. The findings also show that women's perception of and knowledge of the threat of obstetric violence is not an isolated event, detached from previous experiences with the health system. Instead, women build a '*learning trajectory*' through their previous individual experiences with obstetric violence or through the stories that they hear from their relatives and friends. Hence, they are aware of the threat of re/experiencing obstetric violence, especially in public health facilities. Thus, my findings show that the threat of obstetric violence works as a disciplinary mode and a productive force that pushes women to act in certain capacities to minimise and avoid this threat (Chadwick, 2017). Chadwick (2017) further argues that obstetric violence is not a decontextualized event that occurs between an individual perpetrator and the victim, but it is rather an assemblage of disciplinary, bodily, and material relations (p. 504). Similarly, my findings show that women's experiences with obstetric violence vis-à-vis their responses to it are shaped and/or constrained by contextual factors. As I have argued in this study, the broader factors that undergird obstetric violence in Kosovo are patriarchal norms, commodification of healthcare and informality.

Through an experience-centred analysis of women's narratives, I showed that within these constraints, women plan and carry agentic actions prior to and throughout their pregnancies, childbirth, and postpartum to minimise and/or avoid obstetric violence. I defined these agentic actions as strategies and tactics (de Certeau, 2005). Women's narratives demonstrate the use of multiple strategies and tactics, as shown in the figure below (*see Figure 2*).

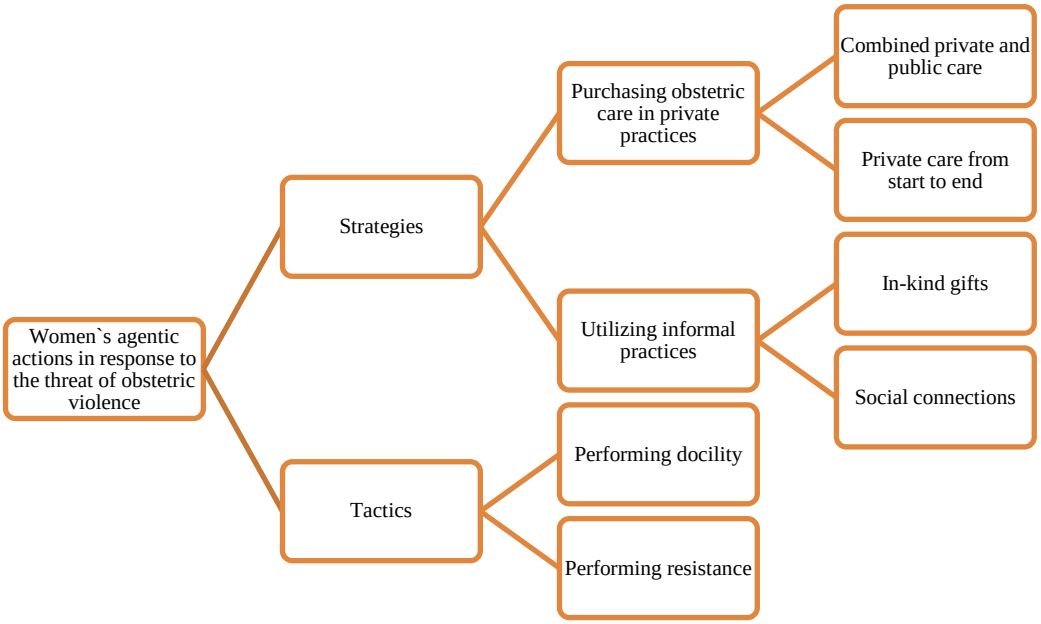

Figure 2: Women's Agentic Actions in Response to the Threat of Obstetric Violence

The first set of agentic actions, strategies, have a spatial and institutional localization, meaning that women plan and carry out these strategies prior to and throughout their pregnancies (de Certeau, 1984). I argue that the capacity to think, strategize and plan based on the previously obtained information on obstetric violence, and carry the strategy is a strong expression of agency (Avishai, 2016; Chadwick, 2017). Situated in a context that enables prominent privatization of healthcare services and informality, women aim to redefine their positions within the existent circumstances (Kandiyoti, 1988). The choice of strategies and carrying is played out within this context of identifiable bargains that define, limit, and inflect women's options (Kandiyoti, 1988). Thus, the identifiable bargains in the study setting are precisely the strategies that women utilise, meaning that their options might be limited as to what they can do, but they do, however, provide a baseline for them to act. Furthermore, I argue that it is clear that broader structures and systems underlined by gender-based violence constraint women's expression of agency, but this does not, however, fully take their ability to act – women

strategize and act, even if their agentic actions uphold precisely the same oppressive structures (Smith-Oka , Rubin, & Dixon , 2021; Avishai, 2016; Kandiyoti, 1988). These agentic acts, however, are used in ways that benefit them and potentially optimize their safety for the future vis-à-vis childbirth (Kandiyoti, 1988). Compliance with the system in these contexts is not equal to passivity and should be recognized as a form of agency instead (Chadwick, 2017; Tanassi, 2004). Women's experiences demonstrate that the primary motivation to precede their childbirth by purchasing obstetric care in private practices is to not only receive better quality healthcare during pregnancy but also to "*set the scene*" for better experiences later.

Similarly, utilising informal practices such as social connections or in-kind gifts and goods is motivated by the same reasons. Women are presented with different rules and norms in society and, therefore, "come up" with different strategies to maximize their security (Kandiyoti, 1988, p. 286). I have shown in the analysis that the combination of strategies is different from one woman to the other, and this proves that women are able to identify the rules and norms that are applicable to them and bargain with these norms and rules (Kandiyoti, 1988).

As seen in the literature review, in countries where the Semashko model was applicable and where reforms and transitions in healthcare were harsh and not well adapted, the symbiosis between the private and public sectors is complex and ambiguous, and so is the presence of informality (Belli & Lewis, 2001). In these contexts, it is common for doctors to use their authority and position to implicitly or explicitly require patients to visit their private practices as a pathway to gaining access to public hospitals, or as Belli & Lewis (2001) call the transaction, as "*advance payments*". While these practices are embedded in transitioning systems, including Kosovo, how this situation is used strategically by women to negotiate their position and optimize their experience during childbirth and postpartum is of crucial importance. By partaking in the current regulation of the system, women uphold the structures in place, but they also find the space to bargain their position and role (Kandiyoti, 1988). My participants' narratives demonstrate that even in contexts where there is a high threat of obstetric violence and their agency is

constrained by broader factors, women still have the ability to think, plan and strategize in a longer time span, voluntarily or in-voluntarily, and express their agentic actions in ways that benefit them (Avishai, 2016). Based on the data, I also argue that women plan their strategies even prior to the pregnancy. I have shown that the first strategy of purchasing obstetric care in private practices dates *prior to* the pregnancy and is common amongst birthing women who aim to become mothers. The strategies that women in Kosovo utilise to avoid and minimise obstetric violence are not present in other studies on obstetric violence, but it could be argued that they could be found in other similar contexts.

Furthermore, in this study, I showed that women also utilise immediate acts – tactics throughout childbirth and postpartum to seize opportunities and avoid violence. In public sector settings, the threat of obstetric violence is fuelled and closely interlinked by moral imperatives that are tied to gender norms, namely notions of "*good mothering*" and "*good feminine patients*" (Smith-Oka , Rubin, & Dixon , 2021; Chadwick, 2017). So, there are wider norms and expectations about the behaviour of good patients; hence, the result of possible violent consequences for misbehaviour leads women to perform the good patient script (p. 498). The good patient script is best enacted when women perform obedience and docility, which is a common tactic used by my participants. Yet again, the performance of obedience, compliance and docility are tactics to minimise or avoid violence, but they do not represent passivity and are rather an expression of a certain form of agency (Chadwick, 2017). Women's narratives demonstrate that they shape their tactics as an immediate response to the hierarchical power relations and gender norms that are embedded in the system. By performing docility and obedience, they increase the chances of having a better experience within an oppressive system. Shabot (2016) argues that obstetric violence aims to diminish women's embodied selves, reduce, repress, and objectify them (p. 232). The constant threat of obstetric violence *per se* is enough to awaken those feelings in women; yet again, they come up with immediate tactics that help them optimize a certain level of safety within the given conditions (Kandiyoti, 1988). Knowing the potential consequences of not partaking and/or internalizing these norms leads women to comply with the rules

to “enact” the good patient and minimise or avoid the risk of obstetric violence (Chadwick, 2017, p. 498). However, I showed in the analysis that women tend to switch their tactics based on the opportunities presented, for instance, from performing docility to resistance. The painful experience of labour and birth or the continuous acts of violence from the medical staff leads to some women breaking the script of the good patient and becoming “*loud*” and agentic (Chadwick, 2017). These specific agentic acts against the patriarchal norms place women in a vulnerable position and at a higher threat of obstetric violence, as the response is unpredictable. In my study, I showed that some women experienced hostility and punishment in return, while others were able to find the space to be ‘resistant’. Thus, women are in a position that requires them to navigate the context and identify immediate tactics while being aware that the response might be precisely the use of violence. Similar tactics have been identified in other contexts where the threat of obstetric violence is present, such as in South Africa, Mexico, and Burkina Faso (Chadwick, 2017; Smith-Oka , Rubin, & Dixon , 2021). This leads to assumptions that moral imperatives tied to gender norms are present in many contexts and assume similar forms, which leads to similar responses as well.

Another key finding of this study is that women’s choice of strategies and tactics are shaped by the multiple intersections of their identity markers and backgrounds. In terms of strategies, women with higher socio-economic status have unlimited access to the private sector and consequently have more choices and relatively higher chances of *success*. Furthermore, geographic identity also impacted women’s access to strategies and shaped their choices. For instance, access to social connections was more limited to women from rural areas and/or of the low-middle class. Similarly, in terms of tactics, the intersections of the education attainment, class, and occupation vis-à-vis social status played a crucial role not only in the choice and performance of tactics but in how they were received by medical staff as well. Studies on obstetric violence from other contexts that have utilised an intersectional approach also show that the entanglement of gender with multiple axes of power, privilege and marginalization shape women’s experiences with obstetric violence and their response to it (Chadwick, 2017; Smith-Oka , Rubin, &

Dixon , 2021; Espinoza-Reyes & Solis, 2020). Chadwick (2017) and Davis (2019), in their respective studies in South Africa and the US, emphasize the role of race as a crucial identity that shapes women's experiences with obstetric violence and their response to it. In other contexts, such as Mexico, age, education attainment, and ethnicity and their intersections were emphasized as determinant identities in women's experiences (Espinoza-Reyes & Solis, 2020). Similarly, in this study, I showed that identity markers and backgrounds such as geographic identity, socio-economic background, and educational attainment that are contextually crucial shape women's experiences with obstetric violence and their choice of strategies and tactics.

9 Conclusions

In this thesis, I wanted to answer two main research questions: *What strategies and tactics do birthing women in Kosovo employ during pregnancy, childbirth, and postpartum to avoid and minimise obstetric violence? How do their identity markers and backgrounds shape their choice of strategies and tactics?*

Women employ both strategies and tactics to avoid and minimise the threat of obstetric violence. While strategies are planned and carried out prior to and throughout pregnancy, tactics are immediate and take place during childbirth and postpartum. Women plan and carry out two main strategies (a) purchase obstetric care in the private sector and (b) utilise informal practices. The two main strategies assume different forms (*see figure 2*). The tactics that women utilise during childbirth and postpartum also consist of two main groups (a) performing docility and (b) performing resistance. Strategies and tactics are complementary, meaning that women might utilise more than one strategy in combination with multiple tactics or other combinations. The *successful* outcomes of the strategies and tactics are affected by the unpredictability and instability of public healthcare (Rosendal Østergaard, 2015) and the intersection of women's identities and backgrounds.

These agentic actions are situated in a context of multiple constraints, namely a health system characterized by commodification and informality in a society that has patriarchal norms entrenched at all levels of society. This study argues that even in such a context that is characterized by multiple constraints vis-à-vis the high threat of obstetric violence, women can think, plan, make choices and re/negotiate their position within the system (Avishai, 2016; Kandiyoti, 1988). In this context, these agentic actions take the form of complicity and/or resistance through the utilised strategies and tactics, however, they represent a strong expression of agency (Avishai, 2016). While the agentic actions of women might uphold the current oppressive structures, women use the space to bargain with the system and maximize their security and avoid and/or minimise obstetric violence (Kandiyoti, 1988).

In response to the second research question, this study has utilised an intersectional approach which reveals that women's identity markers and backgrounds play a crucial role in their choices of strategies and tactics. Identity markers and backgrounds such as socio-economic background, education attainment, geographic location, and occupation shaped not only the choice of tactics but also their success. This study argues that women with lower economic capital, social capital, and status are more vulnerable to the "failure" of their strategies and tactics, while women with higher economic capital and education levels experience relatively more success.

This study contributes to the sparse feminist scholarship on obstetric violence by empirically studying obstetric violence in a new context that has not been studied before. Beyond being a new study site, Kosovo also is a new state, going through multiple transitions, and is characterized by commodification of healthcare, informality, and patriarchal norms. These characteristics make this study empirically relevant to scholarship on obstetric violence as it expands knowledge on women's agency and response to obstetric violence in such constraints. Furthermore, this study contributes conceptually to this body of scholarship as it outlines a new typology of strategies that are not found in other studies and that could be used by other scholars in the field to design similar research. Lastly, the findings of this study can be used to inform women's CSOs and other stakeholders on the state of obstetric violence and women's experiences from an intersectional perspective which could shape further policymaking.

Due to the limitations of the study that have been discussed in the introduction, I suggest further research be conducted with women of other ethnic belonging in Kosovo, such as Roma, Ashkali, Egyptian and Serbian. Moreover, due to the limited number of interviews, I suggest further research with a broader sample. Lastly, further research that includes both women and medical staff as study subjects is necessary.

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Appendices

Appendix A: Interview Guide

1 - General information about age, ethnicity, nationality, residency, socio-economic status.

2 - How many children do you have and in what year/time frame were you pregnant? When were you children born?

3 - Have you monitored your pregnancy regularly?

3.1 - Where did you monitor your pregnancy? How did you feel throughout that time? Can you describe one ordinary check-up visit (based on your memories)?

3.1.1 - Did you pay for these check-ups? Were the payments affordable for you?

3.2 - Reasons for not monitoring the pregnancy on regular basis (if applicable)

Open conversation about the treatment in the hospital. Experiences and feelings during pregnancy and childbirth.

4 - Labour: admission to the hospital process and medical and administrative staff to you.

5 - Childbirth: How long was the process? Were you informed about the performed procedures, and do you remember what procedures were performed?

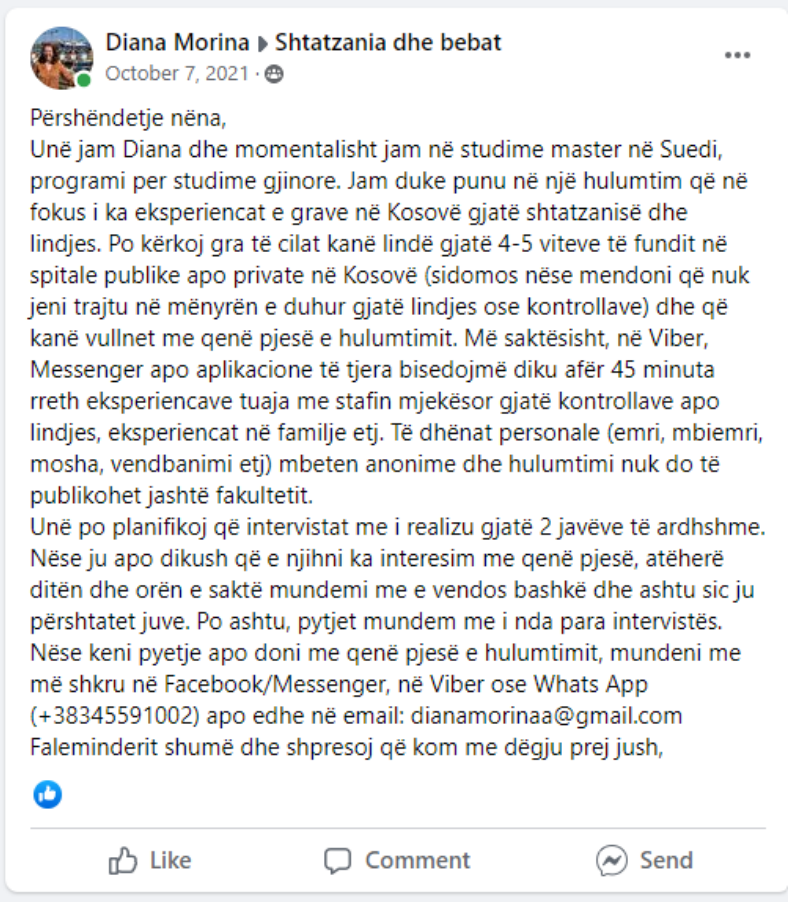
6 - How did you feel during childbirth? (If applicable)

7 - How did you experience the approach/behaviours of the main doctors and nurses that were responsible for you?

8 - What were your experiences postpartum (including the hospital stay)?

9 - Experiences with family and friends during pregnancy, childbirth and postpartum.

Appendix B – Sampling Example



This picture is one of my posts on a Facebook community called *Pregnancy and Babies* that counts thousands of members who are mainly pregnant women or mothers. The post is written in Albanian.

It starts with a short presentation of myself, my studies, and my program. The post continues by shortly describing my research, and its main aims. The post further outlines my sampling, method of interview, place and time of interview, interview guide, and ethical consideration such as anonymity, and publication of the study. At the end of the post, I listed different ways on how interested participant can contact me: Facebook/Messenger, Viber, WhatsApp, and my email. The interested participants reached out to me in all these platforms.

Appendix C – Participants List

Coded Name	Age	Occupation	Employment status	Education level	Socio-economic status	Geographic identity
Ariana	26	Dentist	Employed	University degree	Middle class	Rural/Podujeve
Rina	28	Administrative assistant	Employed	Master`s candidate	Low-Middle class	Urban/Pristina
Kaltrina	29	Administrative assistant	Employed	Bachelor`s degree	Middle class	Urban/Gjilan
Leonora	31	Private hospital general manager	Employed	Master`s degree	Middle-upper class	Urban/Gjakova
Arbnora	35	Economist	Employed	Master`s candidate	Upper class	Urban/Pristina
Genta	31	Civil society worker	Employed	Master`s degree	Middle-upper class	Urban/Pristina
Shpresa	38	N/A	Unemployed	High school degree	Low-class	Urban/Fushe Kosova
Fatlume	33	N/A	Unemployed	Bachelor`s degree	Low-class	Urban/Fushe Kosove
Nita	27	N/A	Unemployed	High school degree	Middle class	Rural/Podujeve
Fjolla	31	N/A	Unemployed	Master`s degree	Middle class	Urban/Drenas
Valentina	34	Teacher	Employed	Bachelor`s degree	Low-Middle class	Rural/Bresalc
Flora	30	Store worker	Employed	High school degree	Low-class	Urban/Gjilan
Blerta	36	Store worker	Employed	High school degree	Low-class	Urban/Gjilan

Appendix D – Coding Example

Codes	Meaning	Example
Obstetric Violence	**Deriving from literature:** sexual, physical, or verbal abuse, stigma and discrimination, structural issues related to the healthcare system, overmedicalisation or under medicalisation, and miscommunication between the labouring person and medical staff.	*"It would happen that they would give me an IV for 11 hours or 12-13 hours, and no one (medical staff) would check on me. I could not even go to the toilet"* Quote from Shpresa
Strategies	**Deriving from literature:** Strategies are acts that are executed over time and have a spatial and institutional localization.	*"Yes yes, I decided to go to a private clinic for the check-ups first. I was so scared because of my first childbirth."* Quote from Fjolla
Combining private and public care	**Deriving from the data:** Agentic actions that based on the theoretical framework are strategies, but the specific strategy derived from the narratives.	*"They say it is better to go (private sector) and then you go to give birth (public hospital) it is different. It is better."* Quote from Flora
Tactics	**Deriving from literature:** Tactics are acts that are dependent on time and are employed with the aim of tricking the system or creating opportunities.	*"For me it was okay. But us mothers need to behave as well, I told you. We need to be very nice with them (the nurses) because if you start screaming (due to the pain) and she (the nurse) starts screaming at you…you are the one who needs her. When you are dependent on someone, be very nice to them"* Quote from Fatlume

Docility	**Deriving from the data:** Agentic actions that based on the theoretical frameworks are tactics, but the specific tactic derived from the narratives.	*"In my first childbirth, I was very docile. I did not say a word…I just stood there and watched and did what I was told to do…"* Quote from Rina