



ARCTIC PASSAGES: MATERNAL TRANSPORT, IÑUPIAT MOTHERS, AND  
NORTHWEST ALASKA COMMUNITIES IN TRANSITION

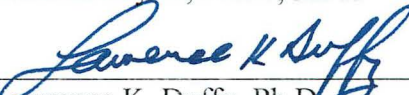
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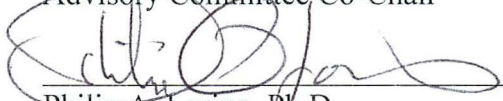
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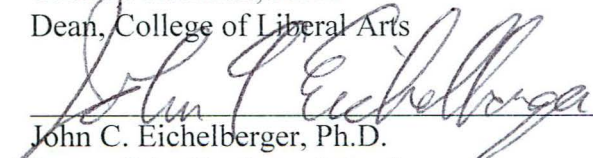
  
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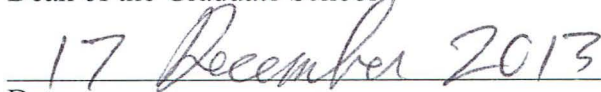
  
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ARCTIC PASSAGES: MATERNAL TRANSPORT, IÑUPIAT MOTHERS AND  
NORTHWEST ALASKA COMMUNITIES IN TRANSITION

A

THESIS

Presented to the Faculty  
of the University of Alaska Fairbanks

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By

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Fairbanks, Alaska

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## Abstract

While the primary goal of the northwest Alaska Native village maternal transport program is safe deliveries for mothers from remote villages, little has been done to examine the impact of transport on the mothers and communities involved. I explore how present values (Western and Iñupiat cultural values) can influence the desire of indigenous women of differing eras and northwest Alaska villages to participate in biomedical birth practices, largely as made available by a tribal health-sponsored patient transport system. The work that follows portrays the varying influences on these women and their communities as they determine the level of importance for mothers to get to the hospital to deliver. I have enlisted viewpoints of Alaska Native families and women of different generations from various Iñupiat villages to help paint a picture of the situation.

With this research, I ask, how do generations of mothers, transport situations, and villages compare in terms of experiences during the processes of these Iñupiat women becoming mothers? What gender, ethnicity, and power interplays exist in this dynamic helix of social and political elements (*embodiment*) during their periods of liminality? What are influences (biomedical and community) that contribute to a woman's transition to motherhood in this community? Moreover, how do women, families, and community members perceive the maternal transport policy today?

I examine how the transport policy figures into stages of liminality, as these mothers and communities produce future generations. With theoretical frameworks provided by medical anthropology and maternal identity work, I track the differences concerning the maternal transport operation for Iñupiat mothers of the area. I compare the influences of cultural value systems present in each of the communities by birth era and location. Using content analysis to determine common themes, I found connections among presence of Iñupiat values, community acceptance of maternal transport, and expressed desire for community autonomy in maternal health care.



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### List of Abbreviations

<b>ANMC</b>	Alaska Native Medical Center (tribal hospital in Anchorage, Alaska)
<b>ANTHC</b>	Alaska Native Tribal Health Consortium (non-profit tribal health organization)
<b>ANVMT</b>	Alaska Native Village Maternal Transport (policy or protocol)
<b>CDC</b>	Centers for Disease Control and Prevention
<b>FAS</b>	Fetal Alcohol Syndrome
<b>FASD</b>	Fetal Alcohol Spectrum Disorders
<b>IHS</b>	Indian Health Service
<b>MHA</b>	Maniilaq Health Association (regional tribal non-profit health corporation serving northwest Alaska)
<b>MHC</b>	Maniilaq Health Center (regional primary care facility in Kotzebue, Alaska)
<b>MIW</b>	Maternal Identity Work (a Social Anthropology framework describing a reciprocal, interactive social process of mothers in effort to identify themselves in their society).
<b>MSA</b>	Maniilaq Service Area (the geographical area serviced by MHA)
<b>NIH</b>	National Institutes of Health
<b>PNC</b>	Prenatal Care
<b>PRAMS</b>	Pregnancy Risk Assessment Monitoring System
<b>SUID</b>	Sudden Unexpected Infant Death
<b>SIDS</b>	Sudden Infant Death Syndrome
<b>UNICEF</b>	United Nations International Children's Fund (originally the United Nations International Children's Emergency Fund)
<b>VBAC</b>	Vaginal birth after Cesarean (in a woman's delivery history, subsequent vaginal delivery occurring after previous cesarean birth)
<b>WHO</b>	World Health Organization



## Glossary

- AI/AN** *American Indian and Alaska Native*: a common racial categorization used by the US Census and other statistical US government agencies (including the CDC), which groups all US indigenous peoples (with the exception of Hawaiian Native Islanders) together. Statistically treating these populations as one can have the impact of masking trends (like problems of typically low birth weight associated with Native Americans in urban areas and living on reservations in the lower US states—while Alaska Natives typically have larger babies) that might be useful to inform health policy that deals with these issues.
- Alaska Native Births** *Mostly meant to mean number of babies born to Alaska Native mothers, unless otherwise specified.* This common treatment of race/ethnicity at birth confounds the proper counting of individuals and size of these groups, but efforts are being made to extract this information from birth certificate data and include in analyses. Unlike Native Americans of the lower contiguous states, whose 'blood percentages,' are considered for statistical (and other) purposes, one is considered Alaska Native with any amount of biological relation to other-identified Alaska Natives.
- Authoritative Knowledge** *A description of the professional medical knowledge system in America, as applied to the transformation of a pluralistic medical system to an allopathic professional knowledge system as the dominant form.* Detailed by anthropologist Bridgette Jordan in the mid-1990s, she describes how all other kinds of healing knowledge were negated in this process and the newly defined medical profession ultimately gained a position of “cultural authority, economic power, and political influence” in American society.
- Biomedical Birth Model** *A framework of birthing knowledge based on Western biomedicine.* What has become first a Western, and now, a worldwide 'standard' in obstetric care—sometimes referred to as 'technocratic birth' for the bureaucratic and technological interventions involved. Credited with saving the lives of mothers and babies with advances in medicine, and offering relief from the difficulties and pain of natural birth, this model has risen in favor to the point of becoming the norm for even the most rural of the world's populations. While this model has been associated with lower risk birth outcomes, and



typically required for women experiencing high risk pregnancy, recent studies have revealed comparable figures for the midwifery model in place for lower risk pregnancies. Some statistics that include risk of infection, and repeated cesarean sections, show that instead of a failsafe measure, biomedical birth might simply be a trade-off of risks for women in lower risk birth situations.

**Infant Mortality**

*The rate of deaths of infants aged 12 months or younger per 1,000 live births.* With larger populations this figure is a reasonable account with which to analyze trends. With smaller populations, such as a statewide figure for Alaska Natives, however, the numbers are so small that statisticians have found it more meaningful to look at "three-year running averages," as reported and used in this study.

**Low Birth weight**

*Based on average birth weights across the US, babies weighing less than 5.5 pounds at birth.*

**Low/ or High Risk Birth**

*Usually refers to the condition of the expectant mother: i.e., the risk of whether she is likely to be able to deliver 'normally' or not.* This is very subjective and based on a number of factors, from what region of the world (or country) one lives in, to age, fitness level, and what the provider considers a "risk." In most of the developed world, many measurements, test results, and ultrasounds of pregnant women's bodies and fetuses are used compare to standardized averages to make this qualified determination to insure that proper measures are taken to mitigate this risk. While it is common for a pregnancy to move from "low" to "high" risk, once interventions are involved, it is very unusual for the pregnancy to reverse to "low" risk level.

**Midwifery Birth Model**

*A women-and family-centered framework of birthing knowledge based more on reliance of a mother's natural abilities to give birth, coupled with less intervening and more homeopathic care for the mother and baby.* Originally, the more common attendant for birthing women, the midwife has fallen out of regular practice in the US mainstream society—although there have been, and continue to be periods and locations associated with heightened interest and movements alongside religious or feminist activism. Use of midwives at birth was supplanted by hospital-birth and use of an OB/GYN as preferred (and now mostly available) provider. There are more alternative birthing models (home birth, birthing centers) in use today which employ mostly midwives, and some

nurse-midwives work in the hospital environment within the biomedical model framework.

**Neonatal Infant  
Mortality**

*The rate of deaths of infants aged 28 days or younger per 1,000 live births.* This figure is used to classify maladies that tend to be more associated with birth and birth defects. This figure is also reported in three-year running averages for Alaska Native populations. Infant deaths resulting from premature births, low birth-weight babies (commonly associated with prematurity), and large-for-gestational age (LGA) or macrosomatic babies (associated with maternal obesity, gestational diabetes—although some LGA birth weights might be from a simple genetic predisposition from certain ethnic groups and larger-framed parent)—fall into this category.

**Postneonatal Infant  
Mortality**

*The rate of deaths of infants aged 29 days to 12 months per 1,000 live births.* This figure is used to classify maladies that tend to be more associated with situations concerning health care and treatment after birth. This figure is also reported in three-year running averages for Alaska Native populations. These figures for US indigenous populations (AI/AN) are higher than for any other racial group in America. Figures accounting for these deaths among Alaska Natives, and northwest Iñupiat are covered in the discussion of this manuscript.

According to WHO, Indigenous populations in countries across the globe reflect the same phenomenon of drastically higher postneonatal death rates in comparison to their fellow citizens. Socioeconomic factors, poor living conditions, lower income and education levels and unequal access to services are cited as possible factors involved in this tragic statistical trend.

**Premature Birth**

*Birth of babies before 37 weeks gestation*



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## Preface

As one of four siblings (with eight aunts on my mother's side); mother of four children; and grandmother of six grandchildren, I am acutely aware of the influence of women's roles as 'mothers' in our society. Having faced logistical difficulties while delivering my third child in the early 1990s in a region of the country where the practice of midwifery and home delivery were at odds with state public health laws—I know what it is to experience the influence of the state on how we women choose to care for our babies and ourselves. When I arrived in Alaska to teach Sociology at the University of Alaska Anchorage, I learned about Alaska Native culture and was surprised to hear about the health care system's unique way of handling maternity care for these families. I wondered what it must be like for these women, and how it affected them and their families. I had no idea at that time that, roughly ten years later, I would be here completing a dissertation on a study that spun off that original thought.

Of course, I could not have even begun and certainly not completed this work without the interest, compassion and generosity of the participants. I was welcomed into people's homes, fed, brought on fishing trips, loaned warm clothes, invited to join in fun and solemn family occasions. They allowed me, on some levels, to become part of their families. It is my intention and hope that my efforts to interpret and inform will in some way honor and respect their input—and perhaps assist them in efforts toward self-determined policy formation, as they deem fit. I tried my best to accurately portray and document the findings derived from the words of peoples described in this work. While indebted and grateful to this group of participants, responsibility for any inadvertent misinterpretations lies solely with me.

I would especially like to acknowledge my committee UAF Professors Dr. Lawrence K. Duffy, Chemistry and Biochemistry; Dr. Phillip Loring, Cross Cultural Studies; UAA Professors Dr. Phyllis Ann Fast, Anthropology, and Dr. Brian Saylor, Policy. Ms. Laura Bender, Mr. Juan Goula, and Faith and Hope (aptly-named Graduate School assistants) from UAF Graduate School have been very patient and helpful. These

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Thanks also to Specialized Neurological Research Program director Ms. Mary van Muelken; the late Dr. Angayuqaq Oscar Kawagley, whom I wish could have been here in person when I completed my work, and Dr. Ray Barnhardt, for giving me a home department that made more sense than Chemistry—and to Chemistry for 'housing' me in the meantime.

The generous funding and support of the National Science Foundation with a Small Grant for Exploratory Research for the preliminary work from 2007 to 2009 made this research possible. A NSF Arctic Social Sciences Program Dissertation Improvement Grant provided continued financing for the larger research project—on which I base this dissertation. I am also grateful to the Arctic Division of the American Association for the Advancement of Sciences and the Specialized Neurological Research Program for enabling my travel to professional conferences.

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Division of Public Health. They were very generous with their time on my behalf. All of my students along the way deserve thanks for their patience with my tardiness or absent-mindedness as I tried to teach after a late night of writing or just returning from the field. Another source to whom I am eternally grateful, Iñupiat mother herself, as well as stalwart young leader, able research assistant, and friend, Ms. Randi Madison. I also extend special thanks to Mr. Andrew Tooyak, Jr., Iñupiat community leader and scholar, and Mr. Sean Topkok, fellow UAF doctoral candidate, Iñupiat leader, dancer and scholar—for their invaluable assistance.

Finally, to my ever-expanding family: starting with my first example of the role of mother: my own mother, Marjorie Llewellyn, a champion of hard work and her brand of motherly love, heartfelt thanks. To her mother before her, a nurse and farm wife who delivered nine children from the 1930s to the 1950s—I hope this work honors her memory and the perseverant (or bullheaded) attitude I inherited from her. My Aunts Eris, Joan, Edith, and Nancy, also impressed on me what the role of mother means in our family. My husband, Jan, has been a supportive presence for me throughout much of my unconventional journey through adult life and graduate school; even acting as attendant at the home birth of our son, over 20 years ago. My adult children: Kelly, Jessi, Alec, and Ilsa; and their children, my grandchildren, Bayla, Isaac, Brielle, Alexa, Orson, and Brennan, also inspire me. It is great to see our offspring becoming adults and parents as they help teach us the depth and meaning of this special relationship we call family. My since-passed Dad, George Llewellyn, taught me "good, better, best, let us have no rest, until our good is better, and our better is best," and other sayings that are not appropriate to share here. My siblings—my older brother, George Llewellyn, Jr., and those who have left this world (but not my thoughts), my brilliant older sister Teresa Anne Shipley and my gracious younger brother Steven David Llewellyn are especially included. To all mentioned here, I dedicate this work. You have helped me prepare this dissertation as you shaped my outlook and me. Thank you all.





## Chapter 1 Maternal Health Care for Iñupiat Mothers of the Northwest

*"In any society the way a woman gives birth and the kind of care given to her and her baby points as sharply as an arrowhead to the key values of a culture."*

-Shelia Kitzinger (1978:115)

### 1.1 Introduction

The Northwest Passage, a sea route in the Arctic Ocean that follows the coastline of North America, was first explored and successfully navigated as a trade route by Edmond Amundsen in 1908. Since, it has been mostly dormant, inaccessible to shipping traffic, until recent climate change and the resulting melting of sea ice have once again renewed commercial interest in the route. The route has now transitioned into an area fraught with political issues over which nations have passage rights there. The terms ‘passage’ and ‘transition’ and the fact that politics and jurisdictions have a role in how things play out for this waterway, offer a ripe analogy to birthing practices among the Alaska Native communities in the same region of the world. The analogy is even more fitting when considering the process that Alaska Native expectant, and then, new mothers must endure as they navigate the sometimes-conflicting bureaucracies of health agencies and programs designed to assist them.

The primary aim of this study is to gain an understanding of influences (biomedical and the community) involved in the transitional process of motherhood for this group of Iñupiaq women and their communities. This work also addresses important questions about how practices and policies—designed to help alleviate disparities in infant mortality rates—are having indirect, unintended repercussions for the women, families and communities of the area. With a medical anthropology stance, I add context to standard epidemiological or policy evaluation perspectives which tend to rely solely on quantitative figures. Previous works dealing with maternal and infant health tended to inappropriately deal with Alaska Native and American Indian groups as one, and concentrate solely on numerical data, without offering a clear understanding of how the maternal health care policies of the area may impact the utilization behavior of the

affected mothers. Some policy evaluations continue to rely on outdated comparisons to mainstream population averages (arbitrary number of visits to evaluate adequacy of prenatal care; birth weight averages for White populations as standard; lack of acknowledgement of benefits of co-sleeping arrangements, and general mainstream bias when dealing with non-middle-class, non-White, non-urban populations). The thesis questions presented add a qualitative, distinctly Alaska Native perspective of maternal and infant care services for these Iñupiat<sup>1</sup> communities.

In the chapters that follow, I explore several issues encountered by Iñupiat mothers from different northwestern Arctic villages of different birth eras (generations) as they contend with the institutionalized structures of biomedical birth as realities of life—as well as the challenges and empowerment that stems from belongingness to family and community. There are different expressed levels of interest in keeping birth in communities across the study village leaders and participants. For example as one village leader explained to me, "Who wants to say they were born in Anchorage?" Yet, in reality, community birth has decreased as local midwifery service has declined and the idea that their mothers need to deliver at the hospital has become the norm. Many Buckland and Point Hope community leaders and mothers I spoke with conveyed an interest in return or bolstering of local midwifery; while some expressed satisfaction with the access to biomedical care afforded by the transport system. For these communities, either they are at a turning point: a position of possible transition, to continue with the current maternal transport system, or they are interested in development of a different combination of care that is "their own."

This thesis details these findings and the possible implications about informing maternal and infant care policy with more attention to self-determination, and shows how Alaska Native families and women of different generations from various areas of mostly-Iñupiat villages of northwest Alaska consider the importance of getting to the urban hospital to birth. Information concerning usage of health care derived directly from the

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<sup>1</sup> The term *Iñupiat* refers to a group of north and northwest Arctic -dwelling Alaska Native Inuit peoples. The term *Iñupiaq* refers to their language or used as a descriptive adjective meaning "of the Iñupiat."

viewpoint and voices of these participants helps inform agencies looking into ethnic and racial health differentials tracking health disparities here. Higher postneonatal infant mortality figures might have more to do with lack of continuity of care brought on by the transport system than mothers' utilization of hospital services, per se. Desires for change in the system expressed by participants and community leaders can also be viewed as a new way to address some of these concerns. Some women desiring change are calling for greater communication with the people in charge of making their health care decisions. As one Point Hope mother of three describes<sup>2</sup>: "...I think it would be better for us [Maniilaq-area Iñupiat mothers] to talk with the people [caregivers in charge of making decisions] ourselves, instead of having the community health aide do it for us."

## 1.2 The Alaska Native Village Maternal Health Transport (ANVMT) policy

The ANVMT program for air transport enables Alaska Native expectant mothers who reside in remote villages to access maternal health care in regional hubs and/or urban Alaska Native hospitals, by flying these women out at about 4-weeks prior to delivery, and returning them to their villages with their babies after delivery. The implementation of the ANVMT system varies from region-to-region, depending on the level of care available in the region's hub at time of expected delivery; the determination and perception of risk involved for the mothers and babies; and type of health care coverage used (private or Medicaid-based insurance or tribal health corporation-funded coverage). This protocol also allows for maternal stay in either a dorm-like facility at the urban hospital—made available for all outside-village hospital patients—or provisions for stay in a nearby hotel. Depending on the situation (age of mother, severity of condition, coincidence of need of care), this system can possibly cover the travel and lodging costs for a second person serving as an escort to the pregnant mother as well.

The risk-assessment basis of the ANVMT protocol is designed to insure access to biomedical care, including specialized personnel and facilities, medications (including

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<sup>2</sup> Anonymous participant, interviewed by Lisa Schwarzburg, December 15, 2011.

anesthetic/analgesic agents and labor-inducing drugs) and, when indicated, emergency interventions such as cesarean sections. The women reside in a hotel or dorm-like prematernal home in or near the hospital and care includes biomedical services throughout this perinatal period. According to ANMC health officials (Schwarzburg 2007b), this process has functioned with a fair amount of consistency for almost 30 years with informal but standardized protocols utilized between each of the individual Alaska Native Health Care Regional units and the Alaska Native Medical Center's Labor and Delivery unit.

The ANVMT policy, in existence since 1982 for the Northwest Alaska area (according to a recent Maniilaq source), provides air transport of expectant mothers at 36-weeks' gestation from outlying villages into a main hub with a staffed clinic or to an urban hospital for delivery. The Maniilaq Service Area (MSA) mothers must travel distances of between 239 kilometers (149 miles from Point Hope Alaska to the Maniilaq Health Center (MHC) in Kotzebue) to 1126 kilometers (or 700 miles from Point Hope to the Alaska Native Medical Center (ANMC) in Anchorage), sometimes in a small bush plane, before delivery. Afterwards, they must make the same one-half hour to five and one-half hour trip with their newborn.

The protocol of air transport for the Alaska Native mothers stems from perceived risks of maternal (from preeclampsia-induced hemorrhage) and (neonatal) infant mortality (Schwarzburg 2007a). Currently, US maternal mortality is rare<sup>3</sup> and maternal morbidity is more of an issue (Centers for Disease Control and Prevention 2009). Historical infant mortality trend analysis, however, shows overall infant mortality rates (death within first year of life per 1,000 live births) have fallen among Alaska Native populations (discussion forthcoming). This is largely a reflection of improved neonatal

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<sup>3</sup> While historical trends from 1987-2009 show an increase in US maternal mortality from 7.2 to 17.8 deaths per 100,000 live births in 2009 among all races, and 3 to 4 times higher rates among Blacks (35.6 deaths per 100,000 births in 2009) and lowest among Whites (11.5 death per 100, 000); some of the increase is explained by differences in cause of death determinations on death certificates over the years, or poor socioeconomic conditions related to poor pre-conception health, to begin with, among higher risk women. See <http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PMSS.html> for further details.

death rates (death in first month of life per 1,000 live births) rates during the early transport policy period. At the same time, however, already higher postneonatal death (during one to 12 months) rates among Alaska Native babies are inexplicably on the rise (Alaska Bureau of Vital Statistics 2009; Centers for Disease Control and Prevention 2012).

Differing worldviews and class divisions among doctors and patients—which sometimes creates barriers to cultural competency, effectively acting as an obstacle to appropriate patient treatment—can ultimately translate to poor access to health care for low-income and minority patients. Maternal care is an area where societal expectations loom large, and this can add to this disconnect between care provider and maternal patient (Arney 1982; Donovan 2006; Jordan and Murphy 2009; Katz-Rothman 1996). Social control of birthing women and instillation of 'birth fear,' are common features of the Western norm and medicalized view of birth (Jordan and Murphy 2009). With perceived superiority of the biomedical model, more and more international maternal health programs are geared toward helping rural and remote women access hospital care.<sup>4</sup> With the idea that access to Western medicine-based maternity care will help combat maternal and infant mortality in these underserved areas, medical intervention is becoming a more common part of birth experiences for mothers throughout the world, in industrialized and non-industrialized nations. This phenomenon, the globalization of biomedical birth<sup>5</sup> can cause difficulties for pregnant women from areas lacking infrastructure to the point that some women and infants can be in a dangerous situation with sometimes lengthy and difficult trips to the hospital. The logistical and bureaucratic structures that the Alaska Native women of Arctic Alaska must navigate place them, at times in similar situations. To help tease out any of these factors enmeshed in the

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<sup>4</sup> Brunson (2010:1725) however, finds that Nepalese women do not have the power to demand biomedical services or emergency care, and men still viewed birth as the domain of women and remained mostly uninvolved in the process, such that, " local acceptance of a biomedical model does not necessarily lead to the utilization of services if neither women nor men are in a culturally-defined position to act."

<sup>5</sup> See Ginsburg and Rapp (1995); Ishida, et al. (2012); McCoy, et al. (2010); Sargent (2004); Say and Raine (2007); Van Hollen (2002); Wagner (2001) for more details on implications of widespread acceptance of biomedical birth.

complex network of service, provider, patient and community expectations in the study population, I ask the various research questions listed in the next section.

### 1.3 Arctic Passages research questions

To address the impact of the ANVMT policy protocol among Iñupiat mothers of northwest Alaska Native villages, my ethnographic fieldwork centered on the following questions:

**QUESTION SET 1:**

How do expectant women, families, and community members perceive the ANVMT Policy? Have ANVMT practices been so accepted that they might be recognized as a new tradition or norm for maternal care?

**QUESTION SET 2:**

How does the ANVMT system enable, constrain, or otherwise influence the *Maternal Identity Work* of predominantly Iñupiat women and their communities in various stages of liminality, throughout the generations? How are elements of the ANVMT system *embodied* in the health and well-being of the mother and her community?

**QUESTION SET 3:**

How do the different generations of mothers, transport situations, and villages compare in terms of experiences and periods of *liminality* (and associated *communitas*) in the processes of these Iñupiat women becoming mothers?

**QUESTION SET 4:**

What are the nature and extent of the influences that contribute to a woman's transition to motherhood (biomedical and family/community) in this community?

I constructed these questions to uncover some of the intricate details that go beyond quantitative or statistical details of the program. In this thesis, I ask the mothers and community leaders how they feel about the ANMVT in their communities and why they feel as they do. That is, how are the women and families of these communities

interpreting and using the policy in their maternal health care as manifested in their communities throughout time?

As I address these questions, I will reveal factors observed and expressed by participants as influential opportunities or barriers to liminal passages as well as conditions present in their respective communities that enable or impede such passages. Instead of a standard health policy evaluation, which is typically used by health agencies to measure the performance of a policy designed to affect desired changes in health statistics (e.g., lowered infant mortality figures)—I will provide a look at the ANVMT system from a different angle. Using participants' perspectives, I analyze how the policy functions for expectant mothers as they care for their families in their communities. With the maternal and community perspectives, I move beyond statistics and provide a look at the policy from within the Iñupiat and biomedical cultures where it is applied.

#### 1.4 Risk assessment and postneonatal mortality statistics

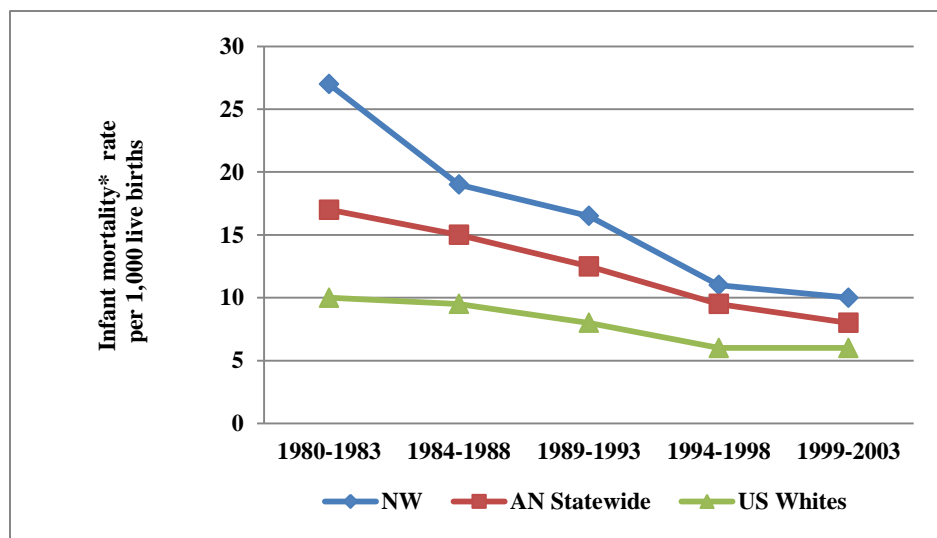
Part of the medical protocol for hospital birth in any US setting involves risk assessment. However, risk assessment approaches and their role in maternal care are being questioned. For example, Jordan and Murphy (2009) state that in the US health care system, all pregnant women are considered 'at risk,' because pregnancy and birth are conceptualized as 'medically problematic.' They show how standardization of risk scoring and surveillance in obstetric care leads to labeling women "high risk," and eventual unnecessary interventions with negative "psychologic sequelae" (Jordan and Murphy 2009). These authors also note that there has been a lack of improvements because of treatments involved in some standard protocols (fetal monitoring, ultrasounds, prenatal testing) to avoid perceived risk factors. Western cultural constructs of risk aversion has led to an exaggerated perception of risk, and the risk surveillance approach to prenatal and birth care in the US and worldwide. Jordan and Murphy (2009) further point out that in the Western medical system, maternal care providers tend to exaggerate perceived risks, outweighing the 'real risk.' These authors' study results show how maternity care protocols based on exaggerated risks lead to unnecessary treatments and



practices, as well as unintended and sometimes harmful consequences for mothers (birth fear and trauma) and babies (lung problems associated with cesareans and premature deliveries, e.g.).

#### 1.4.1 Data used for risk assessment

In Figures 1.1-1.3, I present the types of data that health statisticians commonly use as indicators for medical risk of pregnant mothers. This risk assessment guides the perceived medical needs for groups, and then bases the program development on the outcome of these assessments (Ecker and Frigoletto 2007). Data sources commonly used in the risk assessment of Alaska Native pregnancies includes birth certificates, linked infant death certificates, and datasets from the Centers for Disease Control (CDC) and Indian Health Service.



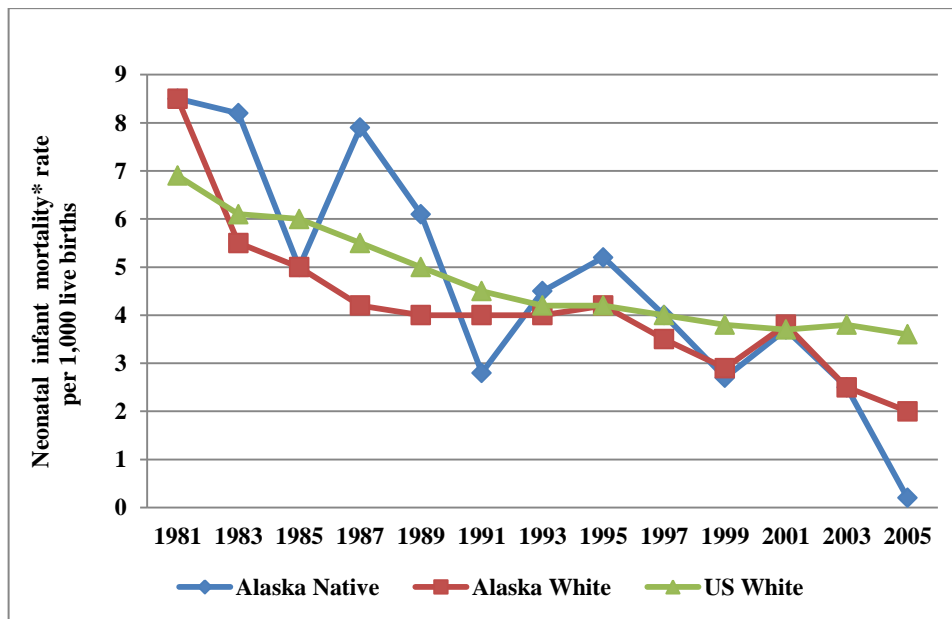
**Figure 1.1** Infant Mortality Trends for Northwest Alaska; Alaska Native, Alaska, and US Whites, 1980-83; 1984-88; 1989-93; and 1999-03

\*Infant Mortality: death of infant less than one-year of age

From: Toffolon-Weiss et al. (2008) presentation, 'The State of Alaska Native Infant Mortality,' available at: <http://www.anthc.org/chs/epicenter/upload/10B-The-State-of-AK-Native-Infant-Mortality-MTW.pdf>

Data sources listed: CDC (2012)-reported data from Alaska Native Tribal Health Consortium (ANTHC) Epidemiology

The CDC (Centers for Disease Control and Prevention 2009) lists Sudden Infant Death Syndrome (SIDS) or Sudden Unexpected Infant Death (SUID) as the most frequent causes for these Alaska Native postneonatal infant deaths, followed by unintentional accidents. Using extensive birth certificate data, Blabey and Gessner (2009) found a connection between these death rates and three major factors associated with respective births to Alaska Native mothers: the mothers' use of tobacco, the mothers' education level, and the absence of a father's name on the certificate. Prevalence of perinatal alcohol abuse had declined for this population during the study period (1989-2009), and became less of a factor while importance of education level rose. This birth certificate study was the first time absence of father's name was entered into the research



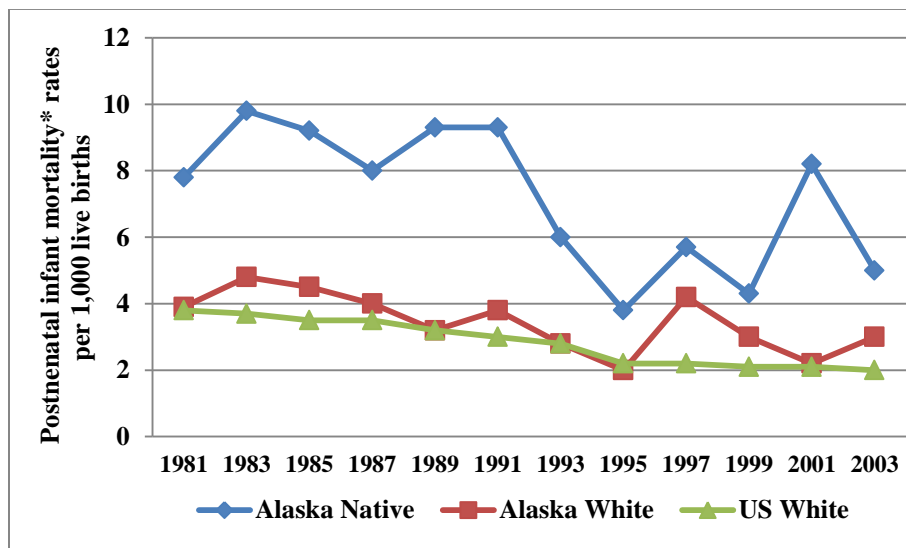
**Figure 1.2** Neonatal Infant Mortality Trends for Alaska Native<sup>a</sup>, Alaska White<sup>a</sup>, and US White<sup>b</sup>, 1981 to 2005, running three-year averages

\*Neonatal infant mortality: death of infant between birth and one-month of age

From: Toffolon-Weiss et al. (2008) presentation, 'The State of Alaska Native Infant Mortality', available at: <http://www.anthc.org/chs/epicenter/upload/10B-The-State-of-AK-Native-Infant-ortality-MTW.pdf>

Data sources listed: (a) Alaska Bureau of Vital Statistics, Division of Public Health, ADHSS and Alaska Native Births and Deaths, 1980-1997. (b) Health, United States, 2007 and Vital Statistics Reports, Volume 57(2), 2008.

model for Alaska Native infant deaths. Blabey and Gessner (2009) speculated as to the possible underlying explanations for this connection between absence of father's name and postneonatal rates for this population: 'the rates of unreported statutory rape among this group;' or 'inability of the mother to discern who the father of her baby was;' or 'mother's feeling that father should not be named if there were no expectations of support.' Authors made these speculations while admitting that there were problems with using the birth certificate data collection method (underreporting, misrepresentation of both race of child and mother), and that more qualitative research was required to get closer to the likely reasons behind their findings.



**Figure 1.3** Postneonatal Infant Mortality Trends for Alaska Native<sup>a</sup>, Alaska White<sup>a</sup>, and US White<sup>b</sup>, 1981 to 2003, three-year running averages

\*Postneonatal infant mortality: death of infant between one month and a year of age

From: Toffolon-Weiss, et al. (2008) 'The State of Alaska Native Infant Mortality,' available at: <http://www.anthc.org/chs/epicenter/upload/10B-The-State-of-AK-Native-Infant-Mortality-MTW.pdf>  
 Data sources listed: (a) Alaska Bureau of Vital Statistics, Division of Public Health, ADHSS and Alaska Native Births and Deaths, 1980-1997. (b) Health, United States, 2007 and Vital Statistics Reports, Volume 57(2), 2008.

Blabey and Gessner (2009) note that Alaska Natives are not the only indigenous groups to show significantly higher postneonatal infant mortality rates when compared to fellow citizens of non-indigenous ethnicities. Indigenous postneonatal mortality figures

are higher than those for non-indigenous Australian, Canadian, and Norwegian groups, to name a few. Most evidence-based research<sup>6</sup>, however, is hard-pressed to address the reasons for this phenomenon (Blabey and Gessner 2009).

#### *1.4.2 'They must simply be asked'*

Anthropological methods that collect 'thick description' via ethnographic fieldwork is effective for attaching meaning to accompanying quantitative research and datasets (Bernard 2006). As I describe later in chapter 2, I interviewed mothers, their families, and village leaders living in these communities in the current treatment of health policy research presented here. I use these data to explore how access to maternity health services in distant locations affects mothers' and community's abilities to participate in the social processes supporting the mothers, as they see fit.

Felton-Busch (2009) mentions the importance of 'birthing on country' to Aboriginal women from remote communities, in which she refers to her role as "...the sole Aboriginal woman member of a 'Birthing on the homelands' steering committee;" however, she resented being cast as a "gatekeeper of community knowledge around birthing." She notes that Aboriginal people are "often represented as one homogeneous group and many policy documents reflect this." Felton-Busch (2009) reminds us that just like mainstream communities, Aboriginal communities are "made up of a diverse range of people, who hold a variety of views and opinions." She calls for the development of maternity care for herself and her clanswomen, then, to "be informed by the many voices" of these women. Succinctly stating the idea of how to accomplish this goal, Felton-Busch (2009:162) concludes: "They must simply be asked."

With an understanding that not all Iñupiat mothers or communities experience the transport identically, I describe the presence and nature of different influences, and the impact of these influences as expressed by the participants; instead of merely categorizing the mothers and communities. I briefly summarize the processes involved in

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<sup>6</sup> One reviewer (Saylor 2013) comments that these infant mortality figures (presented in Figures 1.1 and 1.2) are 'noisy' i.e. lacking in patterns from which to derive significant findings.

the study populations' maternity and mothering processes as mentioned by study mothers in Table 1.1, and those mentioned among Arctic Passages communities in Table 1.2.

After a brief introduction to the processes involved, I provide more in-depth treatment of these processes and worldviews in later chapters.

### 1.5 Liminality, *communitas*, and maternal identity work

In this study, the main theoretical concepts used to explore how mothers, families, and communities navigate the maternal care service system operating in their villages are: 1) liminality, 2) *communitas*; 3) maternal identity work (at times, in tandem with Alaska Native, or specifically Iñupiat identity work). Below, I provide background on these concepts. I also cover my conceptualization of how Western and Iñupiat cultural values are backdrops of the liminal processes experienced in the unique maternal and communal passages of the Alaska Natives of northwest Alaska.

#### 1.5.1 *Liminality*

Liminality is an anthropological concept concerning a state of "in-betweeness," introduced by van Gennep (1960 [1908]) as a state of transition from one social status to another, during what he called 'Rites of Passage.' During such an event, van Gennep (1960 [1908]) explains, one must leave a group at the onset of their transition, and then there is a re-entering period, whereby ritual or rites will welcome the transformed back into the group.

A list of van Gennep's divisions of rites of passage in looking at pregnancy and birth follows in Table 1.1. Grouped as a whole, he terms preliminal, liminal and postliminal rites as 'Rites of Passage.' Van Gennep considers ceremonies of pregnancy and childbirth as a whole, with the first rites often separating the pregnant woman from society, her family group and sometimes, "even her sex." This description follows some of the limited accounts of pre-1950s Iñupiat births (Chance 1991; Fortuine 1992). Both authors describe how birth took place in a special parturition i.e. birth lodge, known as the *aanigutyak*.

**Table 1.1** Van Gennep's Rites of Passage Surrounding Birth

<b>Main Set of Rites</b>	<b>Associated Activity</b>
1) A collection of preliminal rites	Rites of separation
2) Liminal rites	Rites of transition
3) Postliminal rites	Rites of incorporation

**Source:** compiled by author from van Gennep (1960 [1908])

In some circumstances, perhaps out of necessity or desire, women in pre-contact Iñupiat society would birth alone (Chance 1991; Fortune 1992). Burch (2006) also mentioned a parturition<sup>7</sup> hut in his account of historic Iñupiat birth, but referred to it as an *igñivik*. Burch described how a mother would leave her family to enter the nearby hut (sometimes built of snow, sometimes a skin tent) three to four weeks before the baby was due, deliver the baby by herself, and then after several more days of seclusion, she could return to her family. An older woman would sometimes stand outside the hut to give advice, and in the event of a difficult birth, she could be attended by her husband. Dundes (2003) mentions several cultures that observe(d) ceremonial rites that involved women leaving the main group at time of birth or eating certain foods and shunning others during pregnancy.

The Hindu custom of considering a sacred newborn not truly born until he has obtained the "favor of all those present," is an example of social involvement in incorporation phase of mother and baby. Social acceptance and incorporation of newborns has been noted among the Inuit, Iñupiat, and other Alaska Native groups by authors, shown in Table 1.2. The belief that when a relative dies, giving the name of the deceased to a newborn baby will allow the spirit of that relative to live on in the child—is

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<sup>7</sup> Parturition means: 'of or pertaining to birth.'

**Table 1.2** Works on Canadian Inuit and Alaska Native  
Newborn Naming Customs by Group Represented

<b>Reference (year)</b>	<b>Group Represented</b>
Burch (2006)	Iñupiat of US Northwest Alaska
Chance (1990)	Iñupiat of US Arctic Alaska
Fast (2002)	Gwich'in Athabascan of US Interior Alaska
Kirsis (1996)	Koyukon Athabascan of US Northeast Alaska
Langdon (2002)	Alaska Natives US Alaska
VanStone (1962)	Iñupiat of US Northwest Alaska
Winkler-Sprott (Winkler- Sprott 2002)	Iñupiat of US Northwest Alaska

**Source:** Compiled by Author

mentioned in their accounts of birth customs. A young character in *The Fast Runner*, a 2007 Canadian film depicting an Inuit legend, is referred to by her grandmother as *Anaanakulugaas*, "dear little mother:" a common practice among many Inuit and many Alaska Native groups.

### *1.5.2 Related Studies use of liminality as analysis tool*

Côté-Arsenault et al. (2009) use the concept of liminality to explore normative and non-normative pregnancy experiences. These authors center on the role of *communitas* in easing the transition of mothers in the liminal state of passage. Côté-Arsenault et al. actually mention "modern midwifery" as evidence of Turner's definition of *communitas*, since it is out of mainstream (anti-structure), and it is often supportive to expectant mothers. In addition, the pregnancy process is shown to follow rites of passage with tests,

announcement, prenatal exams, baby shower, birth, and return home with baby. Côté-Arsenault et al. present three case studies of pregnancy in their study:

- 1) one typical,
- 2) one complicated, and
- 3) one atypical—in which the mother gives her baby up for adoption.

In the complicated birth, the infant's death makes the rite of incorporation incomplete, for both the mother and the baby. The atypical birth story involved a mother who avoided rituals and *communitas*, as she was not going to keep her baby. The authors concluded this avoidance left the atypical mother with no support, "alone, scared," and traumatized. While some of the assumptions by the nursing school authors were slightly biased toward the unaccepted medical care being offered to this last mother as reassurance, it is questionable if someone in the third case would perceive it as support. They referred to her behavior as dissociative so she could handle having a child that she will immediately be delivering to someone else to parent. The authors used the term 'normal pregnancy' without defining it, which is common in many medical and nursing journal articles. In this context, it is most likely a birth that did not require cesarean section or other extraction devices for delivery.

Côté-Arsenault et al. illustrate how liminality can be used for understanding a woman's experience with maternity care and the process of social transformation from pregnancy to motherhood. The authors offer suggestions for how ritual might be created in some circumstances to actually assist with supporting women in situations that lack established rituals (like pregnancy loss, for instance). There are situations described in this thesis where atypical rituals are in place that resemble some of the supportive nature that is mentioned here.

### 1.5.3 *Communitas*

Many authors use the related concept of *communitas* to describe the camaraderie and closeness that might be felt among fellow liminoids that might effectively move them toward structure and re-entry into their communities. In its strictest sense, as used by Trosset (1988) to describe Welsh ethnic affinity, *communitas* can also be used to describe



communities having experienced common life experiences, that "generate similar habitual dispositions." She proposes that, since *communitas* is an experience of shared identity, "it results from ideological appeals made to that identity, and consists of shared response to those appeals." Trosset describes how *communitas* can be invoked, as in the instance with the Welsh audiences attending the *Mab Darogan* performance, as the actors sing (a typically Welsh activity) in the Welsh language. The history depicted in the performance also speaks to the audience and 'gathers' them with a theme of unity.

This process, identified as 'interpellation' is somewhat similar to that described by Gwynn (2010) in her look at Alaska Native dance. When these are performed, those in the audience who understand the significance, whether in a historic sense, or current day stories, will respond with recognition, and at times, join in the dance. Gwynn does not specifically call this *communitas*, but recognizes these dances as "extending the boundaries of the village" for these urban dance groups.

In this research, I use the concepts of liminality and *communitas*, in reference to both the individuals experiencing the transitions into motherhood, and the communities as they experienced change, particularly with reference to Western- and Iñupiat-based influences. Guar and Patnaik (2011), in their work among the indigenous Korwa community in Central India, found health-generating attributes of forest life and health-threatening miseries of current wage labor economy of life for the Korwa informants moving from hill forests to lowland villages. Using a liminality framework, Guar and Patnaik explored the health experiences of the displaced Korwa as embodiment of their social and material conditions of existence. My work covers similar changes described by Iñupiat women of MSA birthing in earlier eras in comparison to their counterparts' birth accounts from today. And, while Douglas (2010) does not specifically employ the concept of liminality, she found creation of a similar bonding in her treatment of birth among the Inuit of Nunavik.

#### *1.5.4 Communitas and Turner's contribution to liminality*

Turner (2008 [1969,1997]) sheds light on the interstitial areas between one state and the next in social life. Pregnancy is used in both van Gennep and Turner models, but

Turner counts the role of the community into the ideas of the stages, not just the biological processes as biomedical models are apt to.

Ritual is the focus of Turner's (2008 [1969,1997]) liminality with emphasis on the characteristics of the "liminal personae (threshold people)." He describes the ambiguous state of liminal entities using the Ndembu *Isoma* ritual: possessing nothing, having no status, property, or position. Turner (2008 [1969,1997]) posits it is in this humble state that fellow liminoids identify with one another, and "develop an intense comradeship" and powerful egalitarianism. Turner views the ritual as a "matter of giving recognition to an essential and generic human bond, without which there could be *no* society [Turner's emphasis]," instead of the ritual reinforcing the society's structural positions. He also looks at the process as applying to societies and groups, as well as individuals. This continually changing transition from high to low, and from that of structure to *communitas*, and back again; Turner explains, is a process that societies naturally go through to maintain balance and stability.

As this Arctic Passages study centers on community influence on how the mothers are experiencing their process toward motherhood, my use of liminality and *communitas* are more in line with the Turner conceptualization of these constructs. He lists the difference between the use of transitions within a structured status system and the passages involved in liminality as he sees them. Among the most applicable to this study are:

- 1) Transition/state;
- 2) *Communitas*/structure;
- 3) Equality/inequality;
- 4) Total obedience/obedience only to superior rank;
- 5) Simplicity/complexity;
- 6) Acceptance of pain and suffering/avoidance of pain and suffering;
- 7) Sacred instruction/technical knowledge.

These discriminations will be re-visited in discussion of results in later chapters to determine stages of liminality and appearance of *communitas* in each study community.

Turner (2008 [1969,1997]:107) also makes the observation that:

with the increasing specialization of society and culture, with progressive complexity in the social division of labor, what was in tribal society principally set of transitional qualities 'betwixt and between' defined states of culture and society has become itself an institutionalized state.

Transition, in this case, he argues, becomes a permanent condition. He likens this permanent liminality to the monastic life in religious institutions. Turner evokes Irving Goffman's example of total institutions, i.e. prisons, monasteries, as institutionalized, permanent liminality. Another example is the military, where new recruits are initially stripped of their former identity and then re-socialized into a new soldier identity—initiates in the *Mukanda* seclusion lodge ritual and novices in St. Benedict's abbey in St. Joseph, Minnesota undergo a similar process.

For Turner, liminality is not the only cultural manifestation of *communitas*. His discussion of cult associations whose members have gained entry to "therapeutic powers with regard to such common goods of mankind as health, fertility, and climate," is reminiscent of inclusion of Western medicine in the tribal health program. These associations, he continues, "transect such important components of the secular political systems as lineages, villages, subchiefdoms, and chiefdoms." He includes the role of structurally small and insignificant nations within systems of large nations, i.e. tribal groups within America, as upholders of their religions and moral values. Turner suggests that these marginal types or out-groups often come to symbolize *communitas*. The "open society" of *communitas* is contrasted to the "closed society" of structure in its ability to accomplish this "...extensible to the limits of humanity." These movements borrow their symbolism from traditional rites of passage, either from the cultures from which they came, or the culture from which they are in "dramatic contact." As Turner specifies, *communitas* is a collective dimension to be found at "all stages and levels of culture and society."

### *1.5.5 Maternal identity work*

I use the concept of a special kind of liminality from sociological role theory called maternal identity work (MIW) to examine the Iñupiat passage rituals and transition

aspects of birth practices through generations, place, and process. I will provide a view of how the risk assessments—and protocols that go along with the ANVMT system—impact these women as they experience motherhood in their respective northwest Arctic communities.

Howes-Mischel (2009) also studied the relationship between biomedical influences and health of pregnant women in Oaxaca, Mexico. She noted how the conceptualization of risk by the health care institutes become a “guiding troupe for institutional narratives,” yet these institutes tend to focus on what women themselves need to do to avoid risk. In “*Regimes of Responsible Pregnancy Management*,” Howes-Mischel describes how women are socialized as “appropriate pregnant subjects,” that had more to do with their own self-care practices rather than “affective ties to their future children.” Similarly, I develop this concept (maternal identity work) as it functions among the Iñupiat women of the MSA, where women are subjected to expectations of their community and family, along with the western-based health care providers they access through the ANVMT system. I offer more extensive treatment of this primary theoretical concept in a later section on study design. Presently, I provide a brief synopsis of how influences of identity work of mothers of different generations (Table 1.3) and different communities (Table 1.4) are dealt with in this study.

**Table 1.3** Influences Operating on Maternal Identity Work\* process of Arctic Passages mothers

<b>Influence</b>	<b>Nature of Influence</b>	<b>Source of Influence</b>
Western-based construct of birth	Mother's association to influence through policy compliance	ANVMT protocol risk assessment (to enable access to biomedical birth)
Iñupiat culture-based construct of birth	<i>Communitas</i> (solidarity)	Iñupiat features of community

**Source:** Compiled by author

\*Behavior mothers engage in toward establishing identities of themselves in their societal role; explained in further detail in later chapters.

**Table 1.4** Influences Operating on Arctic Passages Communities Involving Features of Iñupiat

<b>Influence</b>	<b>Nature of Influence</b>	<b>Source of Influence</b>
Western-based construct of birth	<ul style="list-style-type: none"> <li>• Strictly applied ANVMT protocol;</li> <li>• Little or no involvement of Iñupiat culture-based maternity care</li> </ul>	<ul style="list-style-type: none"> <li>• ANVMT protocol risk assessment:</li> <li>• to enable access to biomedical birth</li> </ul>
Iñupiat value system based construct of birth	<ul style="list-style-type: none"> <li>• Leniently applied ANVMT protocol;</li> <li>• Some involvement of Iñupiat culture-based maternity care</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of Iñupiat culture-based maternity care (local midwives)</li> <li>• Open, everyday access to features of Iñupiat value system</li> </ul>

**Source:** Compiled by author

The impact of these influences is discussed in greater detail as I answer research questions. At this point, I introduce and detail the communities in which the study focuses the questions.

## 1.6 Iñupiat communities of northwest Alaska

### 1.6.1 Population

Iñupiat mothers (aged 18 and older) residing in the selected Maniilaq Service Area (MSA) villages that gave birth at a regional hub or urban hospital in Anchorage, their families and communities were included in the study. Strategic sampling i.e. selecting candidates for participation based on desired characteristics was used to identify mothers willing to participate.

- Buckland, population: 429 in 2011, was selected as a comparison study village, first, because people I had signed on for involvement in preliminary study lived here. The area also ended up serving as a perfect example of differing expressions of Iñupiat cultural values and. A Maniilaq village clinic serves this area, but it is not continually manned and services are not as extensive as those offered in the medical center in Kotzebue. This village has just recently started making provisions for access to running water beyond the washeteria (community laundry facility) and other public

buildings, including the school.

- Kotzebue, population: slightly over 3,000 in 2011, is the regional hub where the Maniilaq Health Center is located, and is also the location of a Pre-Maternal home that was used during the onset of the study but that closed near the end of the study period. Its location and larger population, made for easier access; both in terms of travel logistics and (originally thought) garnering participation.
- Point Hope, population ca. 680 in 2011, was also selected based on access to willing participants, and its unique identity as a coastal whaling community of northwest Alaska that still engages in pre-contact ceremonies and practices. The only village within the MSA that is not under the Northwest Arctic Borough jurisdiction, a Community Health Aide (CHA) from the North Slope Borough (to which Point Hope belongs) still serves this village.

#### *1.6.2 Geography, climate, and transportation*

The study population resides within the Maniilaq Service Area (MSA), located in northwest Alaska (Figure 1.4). Mostly within Alaska's Northwest Arctic Borough on the Chukchi Sea, Maniilaq<sup>8</sup> Health Association's service area encompasses the Kotzebue Sound, Noatak and Kobuk Rivers, and portions of the Brooks Range and Seward Peninsula, along with North Slope Borough's far-west Village of Point Hope. The MSA experiences temperatures from about -10 degrees F. in February to highs in July about 60 degrees F., with rare low and high extremes of -82 to 86 reached at times. Snowfall averages about 47 inches per year. From June 2 through July 9 every year, the sun does not set, with the area experiencing almost full darkness during the long winters.

With no roads connecting the region to the rest of Alaska, and no roadways connecting any of the villages, transportation can be an issue for residents of the MSA. Residents are limited to air services out of the Ralph Wien Memorial Airport in

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<sup>8</sup> Maniilaq Association is a regional, tribally-operated non-profit health corporation that provides health and social services to residents of the Maniilaq Service Area (MSA), comprised of the Northwest Arctic Borough and the village of Point Hope. This protocol was in use as early as the 1970s in other Alaska Native health regions of the state.

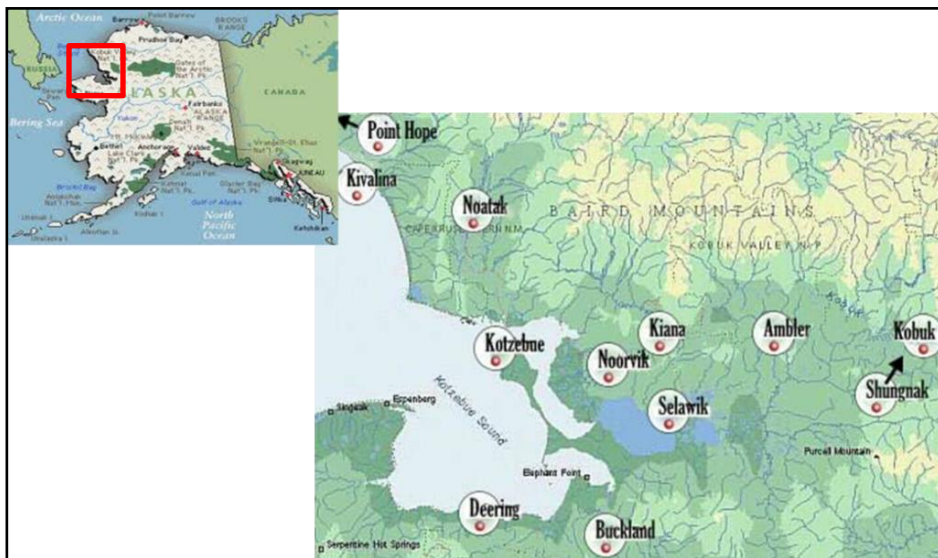
Kotzebue, which supports daily jet service to Anchorage and Nome, as well as smaller prop-driven aircraft to the villages. High winds can also shut down air travel and make any transport—especially for trips to deliver in Kotzebue or Anchorage—difficult.

### 1.6.3 NW Alaska Socio-political maternal health care governing bodies

Responsibility for maternal health care services for this population lies among several multilevel jurisdictions at the state and federal levels I will discuss the features of western-based US and Indian Health Service maternal health care as it pertains to this thesis in depth in later chapters, including the State of Alaska, Native Corporations, and Village level entities concerned with maternity care in this area.

- State of Alaska Public Health and Alaska Native Tribal Health Consortium

The State of Alaska funds a Medicaid-like public assistance program, Denali Kid Care, to provide prenatal and maternity care for expectant low-income mothers, along with infant and child health and medical care for their infant(s) for up to 18 years. Many Iñupiat women from the Maniilaq Service Area (MSA: Figure 1.4) are eligible for these benefits



**Figure 1.4** Map of Alaska (Inset) and Maniilaq Service Area

Sources: Alaska: [www.loneyplanet.com](http://www.loneyplanet.com); Maniilaq: [//www.maniilaq.org/aboutNWAlaska.html](http://www.maniilaq.org/aboutNWAlaska.html)

provided through the State of Alaska Department of Health and Social Services Division of Health Care Services. State of Alaska public health clinics, including, in most cases, maternity clinics, are also available in some regional hub communities. Kotzebue is one such village.

Other mothers are provided similar benefits through their representative Corporation's membership in the Alaska Native Tribal Health Consortium (ANTHC). This collective group pays for much the same health and medical services, transportation and lodging as the Denali Kid Care program. ANTHC is the parent consortium of all Alaska Native health care associations and corporations throughout the state. This administrative body is responsible for use and dispersal of collective funding from Indian Health Service (approximately 30%) and Native Health Corporations (the remaining majority).

Those sick and injured among Alaska Native village residents who require more care than village clinics can offer must travel to regional Alaska Native medical centers or urban native hospitals in Fairbanks or Anchorage. Pregnant women are included in this arrangement. As noted above, pregnant “patients,” will likely remain in the Kotzebue or Anchorage area for longer periods than will other types of patients.

- Northwest Alaska Native Association (and Arctic Slope Regional Corporation)

The participant Inupiat village residents are represented by Northwest Alaska Native Association (Kotzebue, and Buckland residents), and Arctic Slope Regional Corporation (Point Hope residents). These Alaska Native Claims Settlement Act (ANCSA) corporations are more of a business-oriented body than political one. As such, they represent their shareholding members, with a for-profit mandate. Unlike typical business operations, however, these corporations can also form associations and enclaves like the health consortium to provide health care for their clients collectively. In addition, unlike other solely Indian Health Service-funded health care agencies operating among other Native American groups, Alaska Natives have access to Native Corporation supported services and facilities. A unique situation exists in which the NANA region-sponsored



Maniilaq Health Association grants service and facility access to an Arctic Slope Regional Corporation village, Point Hope.

- Northwest Arctic Borough

This political boundary is comprised of the same villages as those represented by the NANA Regional Corporation villages of the MSA: Ambler, Buckland, Deering, Kiana, Kivalina, Kobuk, Kotzebue, Noatak, Noovik, Selawik, and Shungnak.

- Maniilaq Health Association/Health Center

Maniilaq Health Association is the health corporation formed and funded by NANA. Because of the closer proximity of the ASRC Village of Point Hope, however, this Alaska Native village is also included in the Maniilaq Service Area. The Maniilaq Health Center (MHC) is located in the regional hub Village of Kotzebue. The Health Center is "a primary care facility that houses an emergency room, with local and Medevac support for accident/trauma victims, as well as an Ambulatory Care clinic, Dental and Eye Care Clinics, a Pharmacy, a Specialty Clinic, and an Inpatient wing with 24 beds for recovering patients (Maniilaq Health Association 2003)." The present facility was constructed in 1995, replacing a building one-half its 88,000 square-foot size.

Maniilaq Association lists a Tribal Doctor program under their Cultural Services, adding that this holistic approach offers 'traditional medicine and healing techniques.' Maniilaq Association's Tribal Operations unit, under Native Services is able to reallocate funds and 'redesign, plan, conduct, consolidate, and administer programs to enhance the effectiveness and stability of tribal governments (Maniilaq Health Association 2003);' and lists goals to aid tribal government self-sufficiency and self-government.

- Village Clinics and Councils

Maniilaq Health Association oversees the operation of 11 clinics, including 10 NANA village clinics and one clinic in the Village of Point Hope. Each are staffed with two to four aides from their Community Health Aide Program (CHAP). All clinics have connection and access to medical records at the Health Center in Kotzebue, as well as video and audio teleconferencing, and a computer telemedicine unit.

The Maniilaq Association Board of Directors consists of twelve full-time members, each of whom is elected to a three-year term by the Tribal Councils of his/her respective community. This governing body is formed with one representative from the Tribal Council of each of the eleven communities in the Northwest Arctic Borough, and a representative from the village of Point Hope.

### 1.7 Overview of the thesis

In chapter 1, I introduce the Alaska Native Village Maternal Transport system as it operates in Iñupiat communities of northwest Alaska. I list the research questions that guide the thesis—asking how birthing outside one's community, enabled by the risk assessment feature of the ANVMT protocol, impacts these Iñupiat mothers.

I discuss the main concepts liminality and *communitas*, and briefly touch on the concept of identity work in this introductory chapter. I present two tables depicting an overview of the thesis strategy involving mother and community influences, and end the chapter with an introduction of the Arctic Passages communities.

In chapter 2, I describe the development and design of the thesis and analytical techniques used. I explain how I constructed tables for trend analysis of available maternal health data for the study area and compared to results of ethnographic fieldwork involving communities and mother-participants. I also explain how inter-community, inter-generational and birthing transport differences among the Iñupiat mothers are used in an attempt to understand the maternal health experiences of these mothers.

In chapter 3, I provide important historical background describing the US fetish with science, development of US maternal health policy, and emergence of birth models. This review of literature covers some of the underlying issues of gender and cultural discrimination involved in global, US, Indian Health Service, and Alaska Native maternal health care policy. I begin with a description of how health care policies in general, even with cultural competency measures in place, can fall short with institutionalized gender, class, and race discrimination (called social determinants) embedded in the worldwide capitalist-based operating systems. Foucauldian concepts of biopolitics/bio power—along

with Kleinman's and Farmer's take on the power structures involved in medical care—help inform my analysis. After a critical postmodern feminist literature review of global and US medicalization with special attention to Jordan's description of 'authoritative voice' in health care; I trace the development of the biomedical and midwifery birth models. I discuss how the biomedical model has become the most prevalent and accepted birth model worldwide, as the operating knowledge system of Western science tends to "outrank" the holistic midwifery model.

In chapter 4, I outline the main theoretical concepts used this policy analysis of maternal health care services for Iñupiat mothers of northwest Alaska, focusing on a specific transition for women as they become mothers: maternal identity work. After a brief treatment of foundation studies related to this area from the nursing theorists Rubin and Mercer, I include Howes-Mischel and Faircloth discussions of the maternal identity work process as it can operate for women in contemporary mainstream culture.

In chapter 5, I use secondary data sources to describe the MSA trends and historical comparisons of relevant maternal and infant data. This unique gathering of vital statistics data, including utilization of hospitals by the NANA villages and Point Hope, combined; helps shed light on where women from the area have been going to receive their maternity care over the years. I include analytical interpretation of these statistics to create a backdrop of the situations in which MSA women experience transport before concluding the chapter of my ethnographic research results.

In chapter 6, I describe themes of affirmation, resilience or resistance that surface from some study communities; and themes of resentment, guilt, or appreciation that resound for some of the mother-participants. I explain how differing utilization patterns among the mothers vary by association with these themes. My analysis shows that perspectives of women transporting to Anchorage and Kotzebue to birth can contribute to and inform policy.

In chapter 7, I present the overall conclusions of the thesis. I conclude this chapter and the thesis with a discussion of limitations, implications, and recommendations, based on my findings and observations over the 20-month study period. The final "take-away"

message from these results: the voices of the Iñupiat mothers need to become 'authoritative voices' in maternal health care in their northwest Alaska communities utilizing these services, whether biomedical or local. From the voices I have heard, Iñupiat communities, along with a special brand of Iñupiaq feminists, are able and ready to navigate an Arctic Passage toward a more autonomous maternal health care system.



## Chapter 2 Design, Methods and Analytical Techniques

To address important questions about how maternal health practices and policies impact Iñupiat women, families and communities of northwest Alaska, I devised a research plan that includes ethnographic studies and qualitative analysis. Using the postmodern feminist framework of the anthropology of birth, while applying self-identification modules, I constructed holistic ethnographic accounts of the effects of maternal transport on these women and their communities. I also look at how nature of home community and perceived importance of Iñupiat values, and eventual transport situation influence a woman's birth experience.

Mothers' accounts were collected via interviews as well as secondary research and general behavioral observation. Content analysis techniques identified core themes in interview transcripts and field notes. In this chapter, I describe how mothers' accounts were gathered and. I discuss the criteria for selection and inclusion of participants; processing of data, and analysis of results. After a description of sampling, and methods to identify core processes at work (liminality, *communitas*); I discuss the way core concepts maternal identity and embodiment exhibit themselves among Arctic Passages participants. I also describe how expressions of Iñupiat cultural values and Western values in study communities and perspectives of the mothers from these communities can influence and be influenced in their maternal health care strategies. A comparison of responses from mothers of different generations: those delivering before, in early days, and recent years of the ANVMT policy, informs this study.

### 2.1 Selection of topic and study area

Before I knew about the maternity care policy operating in Alaska Native villages, I was interested in US maternal and infant care. I have been exploring the rise of the biomedical model and the place of the midwifery model in US birth, both as a researcher and an advocate for informed birth choices. After moving to Alaska, I learned about the ANVMT policy. I became especially interested to find that not only were the expectant

mothers from Alaska Native villages transported to deliver in Anchorage or regional medical center, but they were usually sent there 4 weeks prior to their delivery date to avoid an emergency trip, "just in case."

I marveled that this maternal transport system had been ongoing since its inception in about 1972 in some areas of the state, and since about 1982 in Maniilaq, with virtually no policy assessment that I could find (Schwarzburg 2007a). I had also followed the development of "birthing on country" in Australia (Felton-Busch 2009) and "bringing birth back to community" among First Nations women in Canada (Epoo and Wagner 2005) I thought it was very interesting that a similar call had not—according to any sources I spoke or checked with—occurred in Alaska among indigenous communities here.

### *2.1.1 ANVMT policy analysis in exploratory phase*

Since there seemed to be a dearth of knowledge surrounding the policy and the reaction of the participants to policy, I wondered if there might be a benefit from looking into these questions. In trying to find out more, I unsuccessfully searched for a formal policy regarding maternal and infant care for ANMC patients. When I first broached the topic with the midwives at ANMC, I was matter-of-factly told that other remote indigenous populations served with similar maternal transport policies did not have the factors of unpredictable weather and lack of a road system that necessitated pre-term air transport in the Alaska Native maternal transport policy. As part of requirements for a UAA graduate policy course, under the direction of Dr. Brian Saylor, I prepared a program evaluation based on root cause and logic modeling analysis for the ANVMT protocol. What I came up with was the main idea behind the protocol: that it was "necessary" to get women to a hospital to deliver. I also found that the policy plays out differently for different regions at different times, depending on the availability of facilities and personnel at the time of the transport, and according to the condition of the delivering mother (Schwarzburg 2007a).

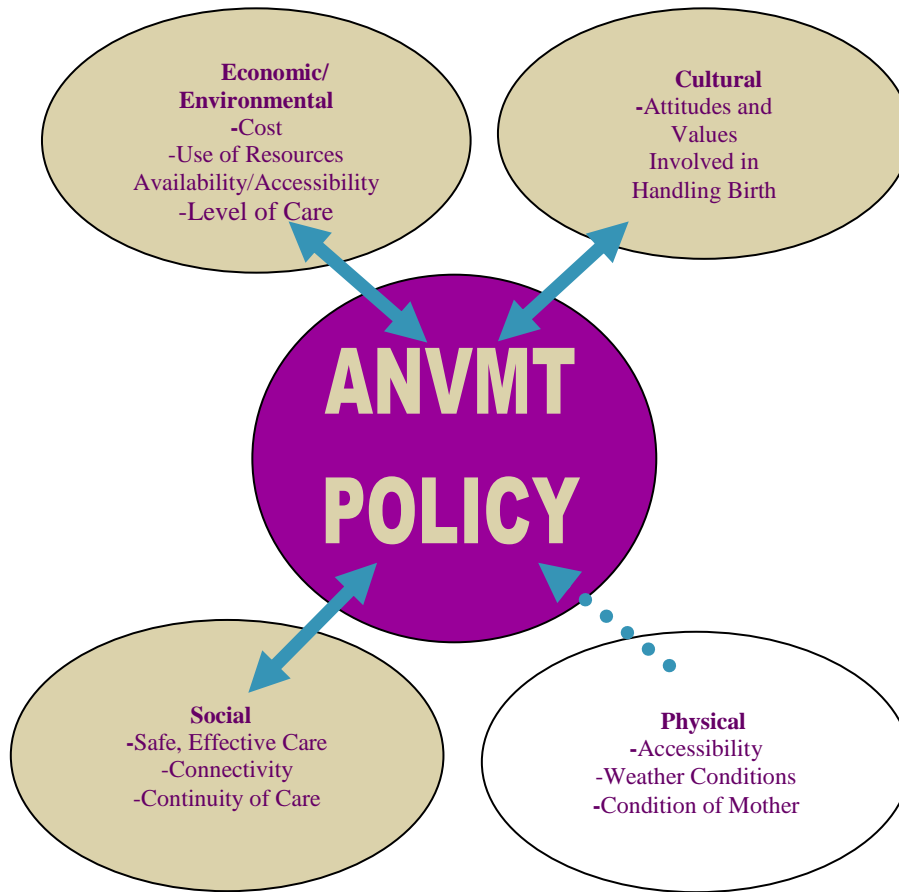
While this policy applies to all ANTHC regions of the state, several factors led to singling out the Maniilaq Service Area for study. First, the fact that the Alaska Native

birth rates from the area is higher than most (Alaska Bureau of Vital Statistics 2009), making for high utilization of the service; and presumably, the abundance of potential participants. Secondly, when exploring the possibility of conducting the research, the majority of my contacts were from the NANA region. During the preliminary phase of the study (Schwarzburg 2007a), community leaders were expressing concerns over the 'costs' of this protocol, both financially and culturally. Medical care providers from Maniilaq and ANMC had begun to express concerns about the safety of mothers not making it to the hospital, or leaving the prematernal facilities prior to delivery to return home. I began, at this point, to realize that the northwest communities and care providers had questions that I could explore as part of this study.

Lastly, the other area under consideration of high Alaska Native births, the Yukon-Kuskokwim service area, had recently been the site of several health and social research investigations. An advisor and Alaska Native health care policy specialist recommended that I take a look at how the policy operated in the northwest. The harsh climate and relative isolation underlining the need for the policy there, the high birth rates, and the dearth of study concerning the impact of the 30-year policy—made Maniilaq an ideal area in which to concentrate my investigation into this unique maternal care transport.

Once I settled on the Maniilaq Service Area for my research site, I developed my original set of questions around the Iñupiaq first-time expectant mothers (primigravida) from the MSA villages. I wanted to capture the impact of the maternity care protocol as it was happening. In 2007, with NSF Exploratory grant funds, I made introductions and was able to speak to some hospital officials at both ANMC in Anchorage and the Maniilaq Health Center in Kotzebue. I learned as much as I could concerning the history, protocols, and functioning of the policy from the caregivers' and administrators' standpoints. At this point, relationships among variables that seemed to influence how the policy was experienced by mothers had begun to surface (Figure 2.1). Arrows in the ANVMT policy operation schematic diagrammed in 2009 represent forces and interactions. The solid, double-headed arrows indicate two-way flow of activity among the manifestation of the policy and economic/environmental; cultural; and social realms in





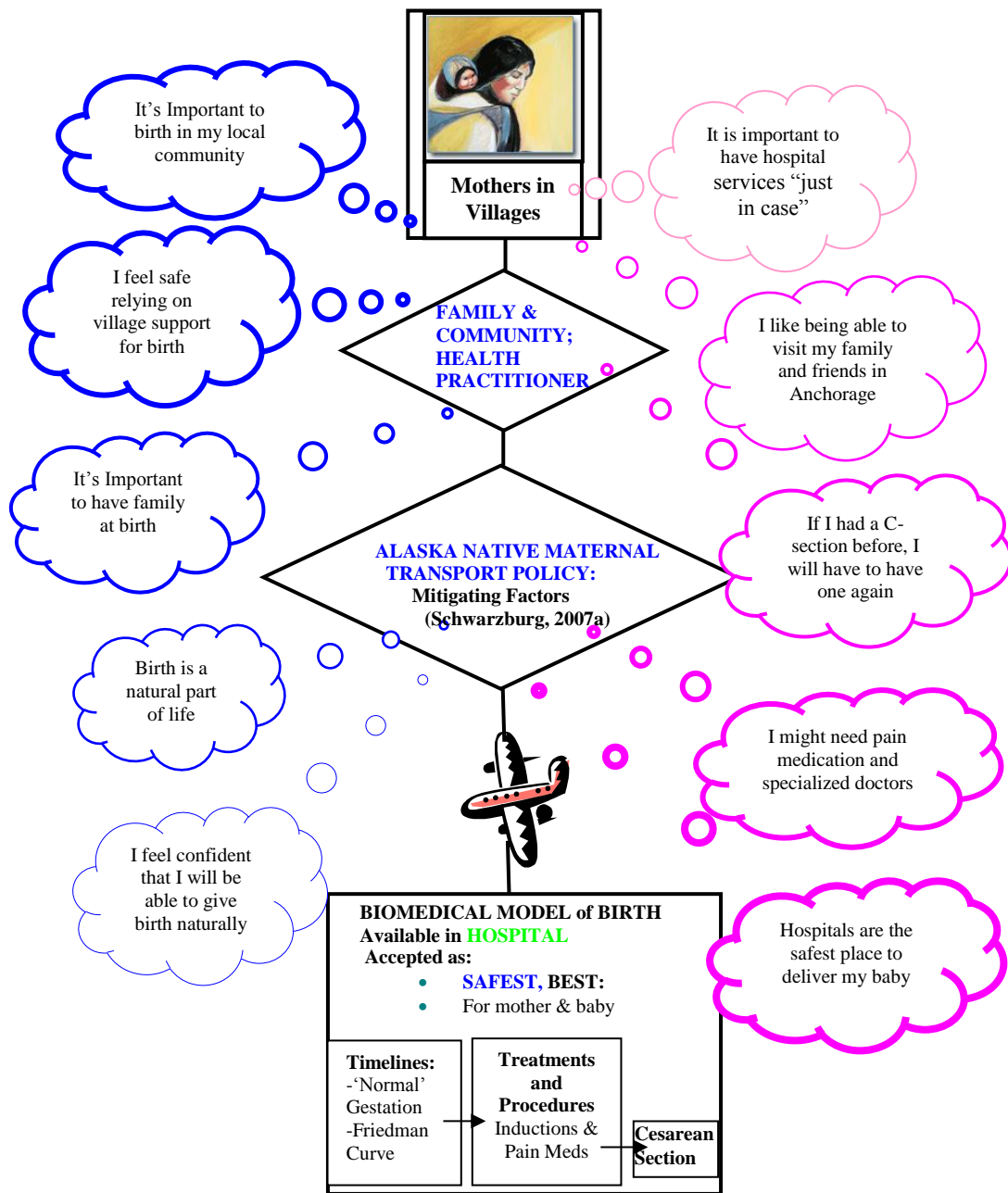
**Figure 2.1** Schematic of ANVMT Policy in NANA region from Preliminary Results of Exploratory Fieldwork, 2008

**Source:** Prepared by author from findings of 2008 exploratory investigation of ANVMT policy

which the mothers of the northwest villages lived. The dotted-line, one-way arrow coming from the physical realm represents those features of life beyond the control of the human efforts to provide immediate needs such as health care and medical services; social or financial support. A preexisting condition of the mother, weather conditions and existing lack of services and roads (lack of access) are examples of these.

### *2.1.2 ANVMT policy analysis and early stage hypothesis development*

This conceptualization quickly became inadequate as I began to hear from Maniilaq personnel and community and family members about how many women were flying out of their communities to have their babies. I also needed to incorporate the viewpoint of the mothers themselves, along with their community-input, for a thorough picture of how the policy operated and impacted them. In Figure 2.2, I show my original attempt to shift



**Figure 2.2** Schematic of Decision-making Process of Mothers Subject to ANVMT Policy in NANA region

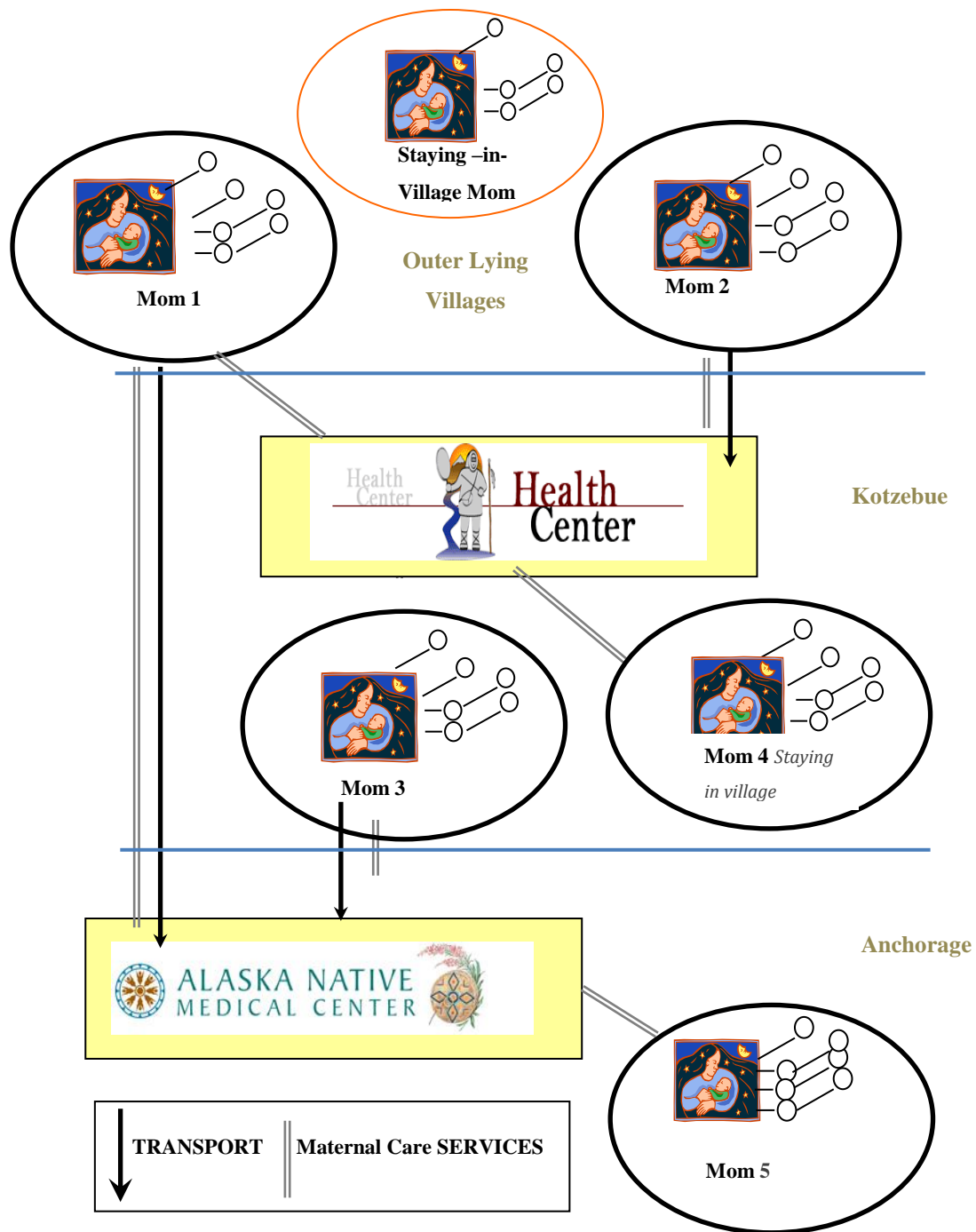
**Source:** Prepared by Author from findings of 2008 exploratory investigation of ANVMT policy

the focus on the person central to the unique transport protocol: the expectant mother. Dealing strictly with Buckland and Kotzebue at this time, I came up with a schema that I thought best described the decision-making process that women in these communities engaged. It turned out, however, that for the most part, expectant mothers are not and have not been the primary decision makers in whether or not they leave their communities to deliver (Schwarzburg 2007b). In the next chapter, I discuss the underlying factors in Arctic maternal health care in detail.

At this point in the development of the Arctic Passages study, I focused on the fact that there were differing transport circumstances for women from different villages, and diagnosed with different risk factors. With this in mind, I originally turned to Social Network Analysis to compare the two main influences on the expectant mothers: family and community (depicted by the blue 'clouds' in Figure 2.2) and biomedicine, accessed through the regional Medical Center in Kotzebue or ANMC in Anchorage (depicted by the pink 'clouds'). I would find out later, however, that while the elements of "thought" shown in Figure 2.2 are relevant, they pretty much remain thoughts for most of the birthing mothers of the area. Contrary to some expressed Maniilaq employee opinions, I found no evidence of a mother's ability to control or influence the level of care prescribed by doctors. Only in cases where local midwifery care existed, could women avail themselves use of alternate care. Even in that situation, however, the use of local maternal care alternatives was greatly discouraged by medical practitioners.

## 2.2 Version One of study scope and parameters

I originally thought to select three different primigravida expectant mothers representing three different transport situations: staying in the village to deliver, transporting to Kotzebue from an outer-lying NANA village, and transporting to Anchorage. Then, I would compare them to mothers who had stayed in Anchorage (from Anchorage), and Kotzebue (from Kotzebue) to deliver, for a total of five mothers and their respective networks. I present the original sampling design in Figure 2.3 to show the different transport possibilities involved. The networks depicted in the diagram are no



**Figure 2.3** Transport Scenarios for Sampling of Maternal Networks, Study Version One

Source: Author devised, 2/22/2012; Maniilaq and ANMC logo from websites.

longer under consideration in my current research strategy, but the different transport scenarios are the same for post-policy deliveries from northwest Alaska Native villages.

I had planned to trace the influences in a social network analysis of each of these case-study mothers. I would then identify the source of influence as either policy-based i.e. medical protocol or community/family-based, and compare the reported results to see which showed greater influence from their transport situation. I had also intended to capture the process of the mothers flying to their birthing destinations and planned on using the footage for coding and analyzing behavior streams later, at my leisure, without continually imposing on participants.

To identify first-time mothers, I had to have research liaison, lest I should look like a very strange stalker preying on young pregnant Alaska Native women. From 2008 to 2009, with the doctoral dissertation improvement grant, I instilled the assistance of key informants, but the process was slow and unproductive. I ran into issues making certain I dealt with adult-only mothers, dealing with medical privacy issues, and ultimately, lack of support from the ANTHC IRB (Schwarzburg 2012) and Maniilaq medical staff to assist with recruitment of participants. It was too difficult to track these specific first time mothers, scheduled to deliver within the study time period, without the assistance of medical personnel. Plus, there was no way for even the medical personnel to know who was going to end up staying in the village to deliver. Hence, after making adjustments to my research proposal with the approval of my funding agency and IRB, I proceeded with a different design.

### *2.2.1 Development of new study scope*

Faced with the challenge of dealing with self-recruitment, I devised a new way to uncover the impact of the transport policy without the assistance of ANTHC or the medical staff. I had contacts in a few Maniilaq villages, so I reset my boundaries to include mothers from those villages: Buckland, Kotzebue, and Point Hope. I adjusted the scope of my study to include all mothers. I found I could uncover the impact of the policy by comparing mother's stories from differing communities and differing transport policy birth eras. Divided up this way, the criteria for participating in the study were simply: an

Alaska Native mother, 18 or older, who had given birth while living in, and presently residing in one of these villages. Another interesting feature of this new sample design was the fact that the most remote village, Point Hope, was also the only non-NANA village in the MSA. This fact adds dimension to the results when considering policy-influence and Iñupiat cultural-influence. I wanted to see if the village that mothers came from in addition to which birth era they delivered in effected the way the policy was applied or utilized for each group.

Since I designed the Arctic Passages study to question the impact of the maternal transport system operating within the Maniilaq area, these communities were obviously the ones on which I would concentrate my efforts. Inclusion of the situation in Selawik had become an option to begin with, but my contact ended up not going at the last minute, and Buckland surfaced as an outlying village comparison. Kotzebue, as the regional hub and site of the health care center and pre-maternal facility for the area medical center, was an obvious choice. Kotzebue mothers delivering in Kotzebue provided an interesting situation of birthing in community, yet somewhat within the biomedical model of birth—sans drugs and intervention strategies involving surgery. As previously mentioned, I had contacts in Point Hope, which led to its inclusion.

### *2.2.2 Development of new study design*

With the communities and new comparisons in place, I focused on how to address the original research questions without the input of the medical community operating in these areas. Originally, the medical staff would recruit and become participants, informing the questions at hand about the specifics of the protocol in certain situations. I was never planning to collect information with regard to an individual's treatment. I had planned to outline what happened when women in certain situations, presented as primigravidae from these communities. Having been cut off from this conversation with the lack of ANTHC support for the study at that stage in development, and loss of a filming element for data collection, I altered the design of collection and analysis. At this point, my data collection efforts excluded direct input from the Maniilaq medical community. Analytical framework no longer involved a comparison of medical

community influence to family and village community influence in a social network analysis. I concentrated on a comparison among villages and birth eras; instead, to flesh out impact of the maternal transport policy as it operates in these northwest Alaska Native villages.

I also observed during this developmental phase of the study that certain features of a community were lining up with patterns of behavior among the participant mothers. This discovery led me to include features of the villages in respect to presence of cultural values. In recursive fashion, I incorporated this cultural value influence into the analytical framework, as presented earlier. This reorientation led to a new focus on how the policy, communities, and mothers were affected by changes in birth practices over time, and to uncover how cultural and political forces are operating in the process. To ask whether there were changes was not as relevant as uncovering how things had changed for expectant mothers over time and what community factors, if any, might be influencing these changes.

By devising a new methodology and adjusting the questions to reflect the new tact, I was able to look at how Western and Iñupait cultural influences of different areas affect how a mother experiences the protocol. In addition, I also explored how the mothers from areas with different aspects of Iñupiat cultural influences affect how the policy operates where they live. I present a breakdown of this picture of cultural features in each community in the final chapter, in which I also cover the outcome of this analysis.

### 2.3 Arctic Passages study scope and parameters

This comparative system of analysis, coupled with the original research questions to guide formulation of theoretical output, set the parameters for the resulting Arctic Passages study design. I used qualitative data collection and analytical techniques. I have described above how the findings from the field helped shape and refine the emerging propositions concerning these mothers' impression of the maternal transport policy as it operated in their respective situations. The unit of analysis changed from relationships branching from three case-study primigravida mothers to multiple birth cases from

mothers of MSA distinct villages. Moreover, the analysis moved from one of deductive hypothesis testing of preliminary work to a framework approach involving advance-set objectives, shaped by inductive comparative testing of results of fieldwork. I continue with a description of how I developed analytical categories and theoretical framework to explain the social phenomenon of birth as it occurs for these women in this area.

#### 2. 4 Sampling and Data collection techniques

I derived the study population from opportunity sampling of mothers from the communities selected, as previously discussed. Besides the assistance of an additional field interviewer in Point Hope, I was the source for all other interviews. There were two Point Hope trips into the field for ethnographic interviewing: one with both the field assistant and myself, and one with just the field assistant. Phone calls and email contacts prior to travel facilitated these interviews. On the multiple Kotzebue sessions—partly because it is a regional hub and partly because there were regional contacts there—I was able to secure fewer interviews than any other location. The larger size of the Village could account for this. There is a decrease the likelihood that one will know as much of a percentage of the other folks living there.

I used ethnographic unstructured interviewing, coupled with observation and field notes to obtain the information needed to conduct this study. A broader approach to the subject was addressed in the exploratory phase of the research, resulting in a basic line of questions (see Appendix A) used for the inductive content analysis toward formation of grounded theory described in Table 2.1.

Each field session was planned with presence of availability of key contacts arranged prior to travel. In Buckland, arrangements were made for home visits and aside from preliminary work there, notes were made, as recordings were impractical. Interviews were recorded in Point Hope, and then transcribed. No recordings occurred in Kotzebue and only preliminary film footage with audio recording during a group interview, occurred in Buckland. For primary interviews in Buckland, notes were taken and transcribed for analysis.



**Table 2.1** Preliminary Deductive Stages of Framework Approach as Applied in Arctic Passages Fieldwork and Analysis

Stage of Research:	Process	Outcome	'Moving Hypothesis Forward'
<p><b>Preliminary</b> (Exploratory)</p> <p>Exploring: If ANVMT policy had an effect on Iñupiat Culture?</p>	<p><b>Deductive:</b></p> <ul style="list-style-type: none"> <li>• Comparative testing techniques</li> <li>• Birth practices "old ways" verses birth practices "new ways," via maternal transport system.</li> <li>• Tested original theory that the transport policy was in part responsible for changing birth practices</li> </ul>	<ul style="list-style-type: none"> <li>• Preliminary medical personal and administrative input</li> <li>• Discussion generated among village leaders, midwives, and a few originally 'non-qualifying' (multiparous) mothers</li> <li>• Acquired preliminary data</li> </ul>	<ul style="list-style-type: none"> <li>• Emphasis on testing hypothesis impact of policy itself changed</li> <li>• Mothers' well-being (assumed by cultural continuity)</li> <li>• Proceeded to develop Version 1 of study design</li> </ul>
<p><b>Original Proposed Research Design (Version 1):</b> (Social Network Analysis)</p> <p>Exploring: Does involvement with ANVMT policy impact level of biomedical and community influences on expectant Iñupiat mothers?</p>	<p><b>Deductive:</b></p> <ul style="list-style-type: none"> <li>• Proposed to use identified personnel and mothers involved in the different transport situations</li> <li>• Designed investigation to determine whether the criteria (ANVMT policy) for transport impacted the social and cultural experiences of mothers</li> </ul>	<ul style="list-style-type: none"> <li>• Abandoned this approach when lack of continued involvement of medical personnel was made apparent</li> <li>• And, themes counter to initially-proposed hypothesis emerged</li> </ul>	<ul style="list-style-type: none"> <li>• Set to analyze types and strengths of differing influences surrounding use of ANVMT policy</li> <li>• Led to development of new scope and strategy in study design, which</li> <li>• Involves transition (liminality) and social (embodiment) and cultural influence during these transitions</li> </ul>

Source: Compiled by author from Pope, et al. (2000).

All participants were given informed consent forms, approved by IRB (see Appendix B), and Wal-Mart gift cards for participation. One-time short interviews were compensated with \$50 gift cards. Those with more in-depth coverage and follow-ups were compensated with \$100 gift cards. With village 'Bush' deliveries offered at the Wal-Mart in Anchorage, this was a way to compensate participants without having to fill out income tax information. They did sign a form (see Appendix C) to acknowledge that they had been informed of the parameters and purpose of the study with the possible risks and benefits spelled out.

#### *2. 4.1. Arctic Passages framework approach*

As mentioned, this research started out with more of a deductive approach and began to follow a more inductive tact as the scope of the study changed and I began to compare results of preliminary fieldwork. Pope, Ziebland, and Mays (2000) explain how this combination of procedures can be typical for "applied or policy relevant qualitative research." When the objectives of the investigation are set in advance and "shaped by the requirements of the funding body [or health authority]," although not the case for the Arctic Passages study, policy analysis of this sort is oftentimes "short and there is often a need to link the analysis with quantitative findings." Pope, Ziebland, and Mays (2000:116) point out that while "...the framework approach reflects the original accounts and observations of the people studies (that is grounded, and inductive), it starts out deductively from pre-set aims and objectives."

This approach enabled the results to be "viewed and assessed by people other than the primary analyst." The framework approach can be used to 'move the hypothesis forward' with analytical induction.

#### *2. 4.2. Arctic Passages grounded theory*

After preliminary fieldwork and analysis, and devising and revising methodology, I ultimately gathered, prepared, and analyzed findings from the Arctic Passages study presented in this thesis (Table 2.2). I used collection and analysis strategies described in the following Methods section. This process allowed me to develop a theoretical-based proposition that evolved from careful analysis of my concentrated findings, observations and participant input. This part of the analysis, an anthropological-based process called grounded theory (Bernard 2006; Pope, et al. 2000) allows the findings from the field to guide the researcher toward the propositions, rather than the standard scientific method of testing a pre-existing hypothesis. As I was not certain what to expect concerning the relationships among pregnant mothers, their communities and their use of maternal health

**Table 2.2** Final Stages of Framework Approach as Applied in Arctic Passages Fieldwork and Analysis

Stage of Research:	Process	Outcome	'Moving Hypothesis Forward'
<b>Final Methodology:</b> (Framework Approach)	<b>Inductive:</b> <ul style="list-style-type: none"> <li>• Take preliminary results, to</li> <li>• Recursively develop grounded theory, with</li> <li>• Emergent themes from content analysis</li> </ul>	<ul style="list-style-type: none"> <li>• New Design, conceptually and logistically more appropriate for available population,</li> </ul>	<ul style="list-style-type: none"> <li>• Uses what had been done up to this point to inform rest of analysis</li> </ul>
Grounded Theory	<b>Inductive:</b> <ul style="list-style-type: none"> <li>• Identifying analytical categories as they emerge from data</li> <li>• Developing hypotheses from the ground or research field upwards</li> </ul>	<ul style="list-style-type: none"> <li>• Identification of analytical categories</li> </ul>	<ul style="list-style-type: none"> <li>• Discovery of emergent themes is based on responses to descriptions of NW Inupiat mothers' birth experiences : <ul style="list-style-type: none"> <li>• By home community</li> <li>• By generation</li> <li>• By birth location</li> </ul> </li> </ul>
Emergent Themes	<b>Inductive:</b> <ul style="list-style-type: none"> <li>• Constant comparison, in which items are checked and compared to rest of data</li> <li>• Centered on like phrases or incidents or types of behavior</li> </ul>	<ul style="list-style-type: none"> <li>• Sections of the data are placed together in matrices</li> <li>• Categories are added to reflect as many of the nuances as possible</li> </ul>	<ul style="list-style-type: none"> <li>• Discrete incidents with many themes</li> <li>• Available for cross-indexing</li> </ul>

**Source:** Compiled by author from Pope, et al. (2000).

services in this area—the grounded theory process evolved with this thesis as layers of information were acquired throughout the data collection stages of analyses.

The resulting findings from this process, along with a look at publicly available statistics concerning birth and infant mortality in the area are presented in chapter 5. I continue at this point with a description of procedures followed to supply and analyze the required information.

## 2.5 Methodological and analytical techniques

As mentioned, I used a framework approach, described in the following list of stages of data analysis as outlined in (Pope, et al. 2000)

### 1) Familiarization

- 2) Identifying thematic framework
- 3) Indexing
- 4) Charting
- 5) Mapping and interpretation

I used this framework approach for determining cultural influences and manifestation as risk assessment was applied through the ANMVT policy for each birth situation described by study participants.

### *2.5.1 Familiarization*

While in the field, on each occasion i.e. preliminary and multiple fieldwork sessions in each community, I took notes regarding my observations as to what was happening and referred to the notes as I continued interviewing. During the preliminary phase, the videographer and I videotaped a conversation with a group of Buckland mothers and in the last phase of data collection, the research assistant and I recorded some of our unstructured interviews with participants in Point Hope.

As I originally began working on Version 1 data collection and analysis, I was preparing my first field notes and interview transcripts for entry into UCINET 6<sup>9</sup>, a Social Network Analysis (SNA) software program. Since the nature and parameters of the research changed, however, I abandoned the SNA portion of the design, and simply transcribed the interviews into Microsoft Word<sup>10</sup> for later sorting, indexing and interpretation, as described in sections below. I had acquired and loaded Atlas.ti 6.2<sup>11</sup> for sorting, labeling and managing the data, but after a few attempts, and some further background investigation, I discovered that the software was more applicable for larger datasets. I could accomplish the same routines with Microsoft Word's search and compare functions and manually placing like-items in files together.

Before beginning these analytical processes, however, I played and replayed recordings, viewed and reviewed the videotape, and read and re-read field notes. I looked

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<sup>9</sup> Ucinet 6 for Windows: Software for Social Network Analysis. 2002. Analytic Technologies. Harvard, MA.

<sup>10</sup> Microsoft Office Professional Plus 2010 Microsoft Word 2010. October 26, 2010. Microsoft. Redmond, Washington

<sup>11</sup> Atlas.ti 6, 2012.October 30, 2012. Atlas.ti. Berlin, Germany.

over the secondary data like ANTHC and community and village descriptive reports; and statistics from the Alaska Bureau of Vital Statistics and the State's Alaska Native Epidemiology Center. Immersion in the background material and especially in data collected from the field, led to discovery of certain themes. Certain words, ideas, or elements began to surface during the familiarization process of constant comparison that provided a sorting scheme from which I could begin to analyze the data.

### *2.5.2 Identifying thematic framework*

With the list of discovered themes, I was able to construct a filing system of sorts, beyond the characteristics of age or community, that would become the framework with which the data to be examined and referenced. Using the issues and questions that were originally derived from the aims and objectives of the study, along with topics raised by the participants themselves and views and experiences that recur in the data, I was able to identify the key issues, concepts, and themes present. With these thematic headings I was able to categorize segments of conversations that stressed these different constructs and create an index of the data, labeling the data into manageable pieces for subsequent retrieval and exploration.

I used constant comparison techniques (Pope, et al. 2000) to accomplish identification of these themes until I reached a saturation point, i.e. until further iterations began to reveal identical themes.

### *2.5.3 Indexing*

Once I identified the thematic framework, I annotated the transcripts with numerical codes from the index. Some of the passages had numerous themes, and would therefore, be cross-referenced under several thematic headings. These cross-references were noted in the margins of each transcript.

### *2.5.4 Charting*

According to Pope, Ziebland, and Mays (2000:116), charting is "the act of arranging the data according to the appropriate part of the thematic framework to which they relate, and forming charts." This basically means making tables or diagrams from the results of the indexing process. Done properly, there should be a chart for each key subject area or

theme with entries for several respondents. These charts will not contain simple cut and pasted verbatim text, but rather distilled summaries of views and experiences. Therefore, this step of analysis involves a great deal of "abstraction and synthesis (Pope, et al. 2000)."

#### *2.5.5 Mapping and interpretation*

With the chart I constructed to define concepts, I then created typologies and found associations between and among themes—concerning the range and nature of feelings surrounding the experiences of the participants as they delivered under different situations. In this way, I provide explanations for the findings of the research. The original research objectives, then, have guided the process of mapping and interpretation, along with the themes that emerged from the data themselves.

#### 2. 6 Summary

I have described the development and design and the framework approach used to analyze results for this thesis. Through a recursive process of first deductive, then inductive analyses, along with the development of grounded theory, I was able to code, compile, and analyze data gathered from the Arctic Passages ethnographic fieldwork.

I present the Anthropology of Birth as a theoretical framework in chapter 3 and include an extensive literature review i.e. Jordan (1996), Kitzinger (1991) , Davis-Floyd (1997), that covers the medicalization and surveillance involved in birth. Jordan's explanation of how 'authoritative voice' operates in a maternal care delivery system is particularly useful to my analysis. Furthermore, I look at the network of individual birthing practices, culture, community, and in some cases, nationalism or factionalism.



### **Chapter 3 Biomedicine, Maternal Health Policy, and Birth Models**

#### 3.1 Introduction: US maternal health care policy and biomedicine

Women in the predominantly Iñupiat villages of northwest Alaska have gone (much like their colonial counterparts) from a social-based, women-centered birthing system to biomedical model of birth. Unlike their counterparts, this process was aided with the development of a protocol involving air travel. This policy was originally put into effect to help address some troubling infant mortality rates of the period (Schwarzburg 2007a). An historical comparison of these rates appears in a later section. In recent history, overall infant mortality rates (death within first year of life per 1,000 live births) have fallen among Alaska Native populations, neonatal deaths (in first 28 days of life) are improving, but postneonatal death (during 1 to 12 months) figures are on the rise. While the rate of FAS (Fetal Alcohol Syndrome) among Alaska Native populations is lowering in the state (Shinohara 2010), the actual numbers are still high (Indian Health Service 2007) and maternal behaviors are associated with such postneonatal outcomes (Alaska Department of Health and Social Services 2010; Shinohara 2010).

It makes sense, then, that throughout the world and the US, Prenatal Care (PNC) is seen as an important feature to programs aimed at affecting healthy birth outcomes. Normally, studies use the Kessner Index number-of-visits standard to assess effective PNC. More studies (Alexander and Koltelchuck 2001; Fiscella 1995; Novick 2009) are finding that this index is not as important as how involved women perceive their care and caregivers. Especially among low-income and non-white women in the US, these groups were found to experience discrimination or stereotyping as well as external barriers to care. Others (Weir, et al. 2010; World Health Organization 2011b) are finding that this systematic use of number of prenatal visits is not the only telling factor of adequacy of prenatal care, and certainly not a factor of healthy outcomes or what makes a “good” mother as defined in one’s community.



‘Safe Motherhood’<sup>12</sup> (as defined by WHO) might seem like a universally understood concept, then, yet there are actually cultural variations to the idea of safe or “good” mother, or even when official “mothering” begins (Bryant, et al. 2007; Howes-Mischel 2009; Kitzinger 2005). In the National Institutes of Health study (Novick 2009), further research is called for to “understand women’s experiences and to develop and implement evidence-based, women-centered approaches.” The connection between the physical, socio-emotional wellbeing of mothers and the health of their infants has been well documented (Bryant, et al. 2007; Wejnert, et al. 2008). Maternal health has also been linked to the infant’s health in later life (Maggi, et al. 2006).

The Western ideals associated with a biological (and now, biomedical) process is on a different continuum of importance for most of the study population. When bureaucracies of US Medicine, Public Health, and even Alaska Native Health get involved, the biomedical model, with the Western-based definitions of proper and safe birth, mothering, and health care, of course, prevails. Risk assessments, as mentioned in chapter 1, are the main drivers for these bureaucracies.

Yet, aside from linear comparisons of annual maternal and infant morbidity and mortality, and rates of C-sections among IHS hospitals (Murphy 2008), the ANVMT policy has gone relatively un-reviewed for roughly 30 years. Little has been gathered or published on the intended and unintended impacts of the policy in a holistic, culturally inclusive manner. Processes of maternal identity work in this population should be investigated—especially since maternal behavior seems to be (at least to some degree) implicated in causes of these infancy and early childhood maladies. This information, derived from the mothers themselves, will better inform programs designed to tackle the postnatal mortality problems exhibited among this northwest Alaska Native population.

When exploring any health policy, however, analysts still need to take relevant health care statistics into consideration. Policy research analysts Patton and Sawicki (1993) point out that most policy analysis approaches resemble ideal, rational decision-

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<sup>12</sup> See [http://www.cpc.unc.edu/measure/prh/rh\\_indicators/specific/sm\\_for](http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/sm_for) for details on this initiative, including a description of the difficulties involved with universal measurement of such a concept.

making processes found in many fields, for example, economic development; design; urban and regional planning; and public administration. These authors also uphold that following steps in such a rational approach (on which biomedicine tends to be based) is not a realistic expectation, yet policy analysis frequently suffers from unrealistic demands and overstated claim.

Thus, I will not be offering a standard policy analysis, as such. My study is meant as more of a holistic perspective on the maternal transport policy as it operates in northwest Alaska i.e. beyond statistics, incorporating participant input while exploring policy impact. As previously mentioned, however, the statistics are still an important part of the analysis. In the next section, I discuss these statistics and some of the relevant issues surrounding their use in health care analysis.

### 3.2 Use of Alaska Native maternal and infant health data to inform policy

Many individuals and agencies have gathered relevant data pertaining to health care issues present in Alaska Native communities, but few of them include an approach that incorporates input from actual village utilizers of the care. Data gathered usually applies to US population as a whole (PRAMS), combines American Indians with Alaska Natives i.e. CDC as one group, or comes from state birth certificates that is limited by: 1) questions asked on the certificate application and, 2) how the questions are interpreted by the parents filling out the application. The lack of information, ethnographic or otherwise, which separates data on American Indian populations from that of Alaska Native groups, can lead to misplaced application in policy efforts concerning maternal and infant health<sup>13</sup>.

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<sup>13</sup> For instance, a US government website on minority maternal and infant health, <http://www.womenshealth.gov/index.html>, lists 'low birth weight' as a major factor in higher infant mortality rates among AI/AN populations. In reality, this factor is more prominent among indigenous groups of the lower 48, and is mostly related to infant deaths of the neonatal period; while postneonatal deaths are more of a problem among Alaska Native groups.

The Alaska Native Tribal Health Consortium has an epidemiological division that supplies data without disclosing identifiable features surrounding birth data. If ANTHC were to publish data for the fewer births in smaller villages, they may potentially disclose births or infant deaths of individuals. Therefore, they present this data in three-year increments, and combine regional data to handle the non-disclosure issue. Still, only questions listed on the birth certificate, PRAMS,<sup>14</sup> or *Kids Count*<sup>15</sup> are gathered; therefore, those in the position of using the data are limited by what is available for program planning based on what was asked on the birth certificate, disclosed, how, and by whom. Programs such as PRAMS and Kids Count are effective for planning policy for most groups in our larger US society, but some specific topics such as drinking behavior of mothers and co-sleeping, can be of questionable reliability. As discussed in the Safe Motherhood initiative (Islam 2007), these figures are difficult for health statisticians to pin down in general, let alone relate them in a causal fashion to prevalent maladies.

Health care professionals trying to combat risks that are associated with the main causes of SIDS, FAS, and FASD are also in a tough position of deciding what statistics are relevant to determine underlying causes and target areas on which to focus their efforts. Internationally, the overuse of medical care, brought on by maternal mortality risk data (Say and Raine 2007) is associated with this issue. These difficulties are currently being discussed at the first international FASD conference held in Canada in August 2013. In the meantime, for lack of a better gauge, target populations exhibiting

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<sup>14</sup> PRAMS stands for Pregnancy Risk Assessment Monitoring System, which is a survey of mothers who have recently had a baby. The Centers for Disease Control and Prevention (CDC) started PRAMS in 1987 to help reduce infant mortality and morbidity, in the United States. PRAMS provides information about a woman's experiences before, during and just after a pregnancy that resulted in a live birth."-from PRAMS website: [www.cdc.gov/prams/](http://www.cdc.gov/prams/)

<sup>15</sup> "KIDS COUNT, a project of the Annie E. Casey Foundation, is a national and state-by-state effort to track the well-being of children in the United States. By providing high-quality data and trend analysis, KIDS COUNT seeks to enrich local, state and national discussions concerning ways to secure better futures for all children — and to raise the visibility of children's issues through a nonpartisan, evidence-based lens."-from *Kids Count* website: [www.aecf.org](http://www.aecf.org).

high 'risk' factors (high SIDS, infant mortality rates, and FASD rates) are offered testing and technology through access to more biomedical care.

Another aside to increased use of technology and surveillance<sup>16</sup> (testing) in birth, the trend became a special interest to some birthing women, counterculture groups, health care providers, and social scientists. A group of medical anthropologists particularly interested in the medicalization of childbirth began to specialize in an area termed "anthropology of birth."

### 3.3 Anthropology of birth: medical anthropology and cultural competency

The term "medical anthropology" has been used since 1963 as a label for empirical research and theory production by anthropologists on the social processes and cultural presentations of health, illness and the nursing/care practices. Medical anthropology is the study of human health and disease, health care systems; and applied medical anthropology deals with intervention, prevention, and policy issues (McElroy 1996). Originally started as a group of doctors interested in meeting the needs of their patients by conducting informal interviews, like ethnographies, the formal sub-discipline of anthropologists later emerged. Today, many health professionals are medical anthropologists, and medical anthropology has evolved into a section of American anthropology (since 1960s) with goals of helping to bridge the gap between medicine and patient; investigating the influence of culture on medicine; and studying how the institution of medicine itself, functions as a culture in society. Researchers and doctors alike have come to the realization that culture does matter in the clinic. Kleinman and Benson (2006) point out that, even though there are connections made between attention to cultural factors and effective diagnosis, treatment, and care, the research has failed to "routinely assess" the cost-effectiveness of culturally informed treatments. This failure, they hold, is not from a lack of trying to introduce "culturally informed strategies" into clinical settings (cultural competency efforts). Kleinman and Benson (2006) suggest that

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<sup>16</sup> Birth surveillance refers to a standardized regiment of testing for birth defects along with periodic ultrasounds during pregnancy and electron fetal monitoring (EFM) during labor.

the issues with cultural competency stem from how culture is defined in medicine, which is very different than its definition in anthropology. Medicine has tended to make culture synonymous with ethnicity, nationality, and language (Kleinman and Benson 2006).

### *3.3.1 Physician-patient cultural divide and cultural competency*

A forerunner in medical anthropology, Dr. Arthur Kleinman, with Benson (2006) helps place the importance of a cross-cultural perspective in this field, as he covers "*Anthropology in the Clinic: The Problem of Cultural Competency and how to Fix it.*" Kleinman's (2006) work had centered on cultural competency model to open respectful dialogue between a clinician and patient, but he noted that clinicians were more likely to use the guidelines "...to end a conversation rather than start a conversation." These authors suggest that this happens because doctors tend not to see cross-cultural communication as a valid clinical concern (Kleinman and Benson 2006). The original goal with the explanatory model approach was to help the clinicians communicate and set their expert knowledge beside (not above) the patient's own explanation and viewpoint, with questions like:

What do you call this problem?

What do you believe is the cause of this problem?

What course do you expect it to take?

In the more recent working of this model, Kleinman and Benson (2006) help the clinician perform what they call "mini-ethnography," using an explanatory model approach. The process was designed to replace the cultural formulation model, frequently used by health care practitioners, as put forward in the Diagnostic and Statistical Manual. Outlined in a series of six steps (Table 3.1), the newer procedure is presented to assist physicians with the ability to more effectively treat their patients, and avoid stereotyping, despite any cultural differences that might exist. This process is also recommended by the authors to take place for improvement of any doctor-patient relationship, as it is designed to help make certain that the divide between caregiver and those cared for does not impact the practitioner's ability to give proper care, or the

**Table 3.1 Kleinman and Benson's Physician Explanatory Model Approach**

<b>Step:</b>	<b>Area to be addressed</b>	<b>Physician (clinician)/ Patient dialogue</b>	<b>Results of Communication</b>
<b>Step 1:</b>	Ethnic Identity	<ul style="list-style-type: none"> <li>• Ask patient about ethnic identity and its salience to them</li> <li>• Acknowledge and affirm experience of ethnicity and illness</li> </ul>	<ul style="list-style-type: none"> <li>• Recognize that people live ethnicity differently</li> <li>• Ethnicity is not viewed as an abstract identity; it is a vital aspect of how life is lived</li> <li>• Leads away from assuming knowledge of a person; and toward a useful determination of a patient's salience of ethnicity in the situation at hand</li> </ul>
<b>Step 2:</b>	What is at Stake?	<ul style="list-style-type: none"> <li>• Asking "What is at stake?"</li> <li>• Responses can include discussion of close relationships, material resources, religious commitments, and even life itself</li> </ul>	<ul style="list-style-type: none"> <li>• Sheds light on the moral lives of the patients and their families</li> </ul>
<b>Step 3:</b>	The illness as narrative	<ul style="list-style-type: none"> <li>• <u>Explanatory Models Approach</u> Questions (about the patient's understanding of their illness):</li> <li>• What do you call this problem? What do you believe is the cause of the problem? What course so you expect it to take? How serious is it? What do you think this problem does inside of your body? How does it affect your body and your mind? What do you fear most about this condition? What do you fear most about the treatment?</li> </ul>	<ul style="list-style-type: none"> <li>• A reconstruction of the patient's illness narrative</li> <li>• Patient and family's explanatory models can be used to understand cultural meanings that have implications for care and treatment</li> <li>• Conversation opens the physician to cultural differences in local worlds; and helps patient recognize that doctors don't fit a stereotype, either.</li> </ul>
<b>Step 4:</b>	Psychosocial Stresses	<ul style="list-style-type: none"> <li>• Clinicians record the chief psychosocial problems associated with the illness and its treatments</li> <li>• For example, family tensions, work problems, financial difficulties, personal anxiety</li> </ul>	<ul style="list-style-type: none"> <li>• Avoid misunderstandings</li> <li>• Consider the ongoing stresses and social supports that characterize people's lives</li> <li>• Can List interventions to improve any of difficulties such as professional therapy, self-treatment, family assistance, and alternative complementary medicine</li> </ul>
<b>Step 5:</b>	Influence of culture on clinical relationships	<ul style="list-style-type: none"> <li>• Self-reflection of being between social worlds: grounded in the world of the patient, in own personal network, and in the professional world of biomedicine and institutions.</li> <li>• Check the formative effect of biomedical culture on clinical practice, including: bias, inappropriate and excessive use of advanced technology interventions, stereotyping</li> </ul>	<ul style="list-style-type: none"> <li>• Teaches practitioners to consider the effects of the culture of biomedicine (which is contrary to the view of the expert as authority)</li> <li>• And, the media's view that that technical expertise is always the best answer</li> </ul>
<b>Step 6:</b>	The problems of cultural competency approaches	<ul style="list-style-type: none"> <li>• Question efficacy: "Does this intervention actually work in particular cases?"</li> <li>• Look for side effects of cultural competency (attention to cultural differences can be interpreted as intrusive, singled out, or stigmatized)</li> <li>• Overemphasis on cultural differences can also lead to mistaken idea that if we can only identify the cultural root of the problem it can be resolved</li> </ul>	<ul style="list-style-type: none"> <li>• Realization that inattention to cultural factors can cause problems</li> <li>• But once those cultural issues are addressed, there could still be the situation where no easy resolution exists</li> </ul>

Source: Compiled by author, from Kleinman and Benson (2006:2)

patient's ability to help determine what that might be. Kleinman and Benson submit that a major problem with cultural competency is that it suggests that culture can be a "technical skill for which clinicians can be trained to develop expertise."

As cultural competency models tend to represent patients and families as if theirs are the only culture entering into the discussion, Kleinman and Benson (2006:3) urge doctors to realize that the culture of the professional caregiver needs to be included in the conversation of culture in medicine:

including the cultural background of the doctor, nurse, or social worker, and the culture of biomedicine itself—especially as expressed in institutions such as hospitals, clinics and medical schools.

Kleinman and Benson (2006) also cite several studies that have linked the culture of biomedicine with "...transmission of stigma, the incorporation and maintenance of racial bias in institutions, and the development of health across minority groups."

### 3.3.2. *Cultural competency efforts in Alaska Native health care*

- Some cultural competency efforts have been underway in Alaska Native health care programs. Many such experimental programs translated into requirements of all new employees with agencies like Maniilaq Health Association to undergo cultural awareness training (Schwarzburg 2007b). Dixon and Roubideaux (2001) outlined the history, disparities, and need for this type of activity in their edited manual on Indian health in the US under a 'Summary of Guiding Principles.' They recommended that policy makers and planners should ask certain questions to enable consistent criteria for evaluation (Dixon, et al. 2001:239):
  1. Is this policy or approach consistent with the basic tenants of federal Indian policy, tribal sovereignty, government-to-government relationships, and federal trust responsibility?
  2. Were tribes consulted in the process of developing this policy and do they endorse it? Does the approach protect and enhance Indian health facilities and services?
  3. Does the policy protect the rights of AI/AN individuals to choose whether they receive their health services from an Indian health system, or another type of provider, or both?

4. Do payment rates cover the cost of delivering services and are they sufficient to assure access to care for AI/AN consumers?

5.

Have steps been taken to identify and eliminate barriers to AI/AN participation?

Dixon, et al. (2001) also mention Alaska Native maternity care delivery as a success, because it "keeps unattended village deliveries from occurring." At the same time, in the historical section of their Guiding Principles, they acknowledge that Indian health care "predates the history of the United States by centuries." The American Indian and Alaska Native peoples were their own first health care systems with an extensive knowledge of traditional and herbal medicines. There is an implied context of the automatic discounting of any births attended by traditional birth attendants as being "non-attended."

The main focus in Dixon and Roubideaux's (2001) treatment of AI/AN history and health policy development centers on the shortcomings of effective services and how the tribes and US government can work together with a public health approach to improve the situation for the future. This work points out lack of financial backing from the US Congress—to honor treaties with the Indian Nations (Alaska Natives comprising nearly half of the recognized tribes) to provide for their health care in exchange for land—as the main causes the shortages in care. Including tribal input in policy formulation and utilization of traditional healers were mentioned as part of a strategy to improve health policy. Incorporating or bolstering any existing midwifery practice, however, is not mentioned in their assessment. Kirsis (1996) notes that during this period the Tanana Chiefs Conference was mandating that Interior Native women had to deliver in urban hospitals to receive Bureau of Indian Affairs insurance coverage .

### *3.3.3. History and cross-cultural treatment of birth*

This implicit undervaluation of midwives as viable birth attendants is not limited to the AI/AN health care system. There was a prevailing theme of equating only medically trained personnel with skilled birth attendant in maternal policy, even though WHO studies, especially those concerning rural and indigenous populations show otherwise. In the US, as the prioritization of a medical scientific authority became the prevailing schema with rise of medical obstetrics, the practices of homeopathy and midwifery fell



out of favor. Table 3.2 outlines some of the historical and comparative works centering US, worldwide and indigenous birth situations and cultures.

**Table 3.2** References of Historical and Comparative Birth Studies

<b>Topic</b>	<b>Suggested Reference</b>
<b>History of Birth</b> In Mainstream U.S.	<ul style="list-style-type: none"> <li>• <i>Birth as an American Rite of Passage</i> Davis-Floyd (1992)</li> <li>• <i>Lying In: A History of Childbirth in America</i> Wertz and Wertz (1989)</li> </ul>
<b>Cross-cultural Birth</b> Worldwide	<ul style="list-style-type: none"> <li>• <i>Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives</i> Davis-Floyd and Sargent (1997)</li> <li>• <i>Conceiving the New World Order: The Global Politics of Reproduction</i> Ginsburg and Rapp (1995)</li> <li>• <i>Childbirth Across Cultures: Ideas and Practices of Pregnancy, Childbirth, and the Postpartum</i> Selin and Stone (2009)</li> </ul>
<b>Indigenous Birth</b> In Canada, U.S., and Australia	<ul style="list-style-type: none"> <li>• <i>"Until Our Hearts Are On the Ground:" Aboriginal Mothering, Oppression, Resistance, and Rebirth</i> Lavell-Harvard and Lavell (2006)</li> </ul>

**Source:** Compiled by author.

While medical interventions and biomedical birth practices came into vogue among the American elite in the 1930s, and then spread to the rural areas as a nationwide practice by the 1950s (Wertz and Wertz 1989); it is ironic that today, participation in midwifery is actually easier to accomplish in the urban areas.

#### 3.3.4 Jordan's Midwife construct

Jordan's (1996) argument is that decision-making power and authoritative knowledge is legitimized by the US health care system, as technical procedures and artifacts necessary to manage labor define and display who is in charge. This thesis uses the concept of authoritative knowledge (detailed in later section) to ascertain where mothers of different generations and villages stand in regard to the prevailing systems at Maniilaq Health Center and ANMC. The constructs of birth derived from the

communities these mothers identify with, help these women inform what they deem an appropriate and proper care and birthing practices. Instead of the stark hegemony of power Jordan found attached to the technology in her study of the late 1990s, alternate birth ecologies<sup>17</sup> with horizontally, rather than hierarchically, distributed knowledge is evident in some communities.

While the Biomedical (or Hospital) and Midwifery (or Holistic) Models are often construed as dichotomous; there are situations in which the two systems overlap. This occurs when the participants are actively incorporating sub-themes and practices of the other model into their system and practice, as the overlap can encompass more than platitudes or superficial acts. All practitioners, however, whether WHO officials in the global community as described by Wagner (1986; 2001), or a doctor operating in a local community, are obligated by the mandates of their profession to function within community standards in which they find themselves.

Included in among the main points Davis-Floyd, et al. (2009:22-23) summarize as characteristics of midwifery birth models that work (in hospitals, clinics, birth centers, and villages around the world), are:

- A woman-centered ideology known as midwifery model of care
- Midwives, practitioners of midwifery model of care, as primary practitioners for normal births (which constitute the vast majority of births)
- Midwifery care based in community
- Continuity of care (caseload midwifery, one-to-one care)
- Cultural appropriateness and sensitivity
- Physicians providing appropriate services for high-risk and emergency births
- Mutually respectful and collaborative relationships among all types of providers
- "Referring back," meaning that if a woman with a previous risk condition improves and becomes low risk, she can be reclassified as "normal" and referred back to a midwife
- Reflective practice, in which practitioners continually reflect on what they are doing and make efforts at improvement on an ongoing basis

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<sup>17</sup> I use this term to refer to the interrelated services and treatments involved in a process of caring for pregnant and birthing women and their babies. Two main birth ecologies to emerge, biomedical and midwifery models; arose from the differing philosophies of birth of the respective practitioners.

- Viable systems of transport to hospitals for out-of-hospital practices
- Regional and national organizations and communication networks that support this work, which include major consumer components that can generate political support and facilitate practitioners in their ability to humanize care.

The purpose behind this list of recommendations is not to attain uniformity of practice, Davis-Floyd states, "but to provide functional maternity care." Davis-Floyd's and others' (Davis-Floyd, et al. 2009) edited collection of *Birth Models that Work* are presented as goals to "shoot for," with the understanding that some models have obstacles or limitations that keep policymakers and planners striving for improved models like them throughout the world.

An understanding of which models are considered adequate and by who, with an outline of their components, is requisite to any evaluation of the impacts of the ANVTM transports policy on mothers. This list of desired birth model characteristics is presented to show that "birth models that work" are first, closely tied to the midwifery model itself, and secondly, to the nature of the Arctic Passages framework, in which women and their families become the authoritative knowledge.

As presented, there is not a universal understanding of "skilled" childbirth assistance: Certified Nurse Midwife? Doctor? What kind of Doctor? Anesthesiologists? Surgeons? What care is necessary for birth? What constitutes the need for testing or the need for a cesarean section? The answers to these questions vary from state to state (and community to community). Women find themselves in the middle of these political and economic issues while in the process of making decisions about their own childbirth experiences hand the power over to the doctor. Erikson (2012) pointed out that mothers and families are being guided to acquiesce to tests and procedures of which they are not knowledgeable as an example of the dynamics behind decision-making in pregnancy. Many tests are agreed to because the expectant mothers are socialized into being a good patient, as Howes-Mischel (2009) notes in her discussion on the making of "proper" pregnancy patients in Mexico.

The issue of power in these decisions is alluded to in doctors' Ecker and Frigoletto (2007) article. As instances of successful lawsuits concerning cesarean sections rise, they contend, medical practice costs rise. There was no recursive connection, however, of the cesarean sections bringing on more lawsuits. Ecker and Frigoletto (2007) acknowledged that this connection had an impact on OB/GYN behavior and patient assessments. The result of this physician behavior attached to ideas about legal ramifications instead of patient condition, in turn, gives the physicians additional impetus to place their own needs ahead of the patients. The history of medicine and economic and political power of the biomedical construct of birth practice in the West come together to form pressure on women giving birth, to comply with “recommendations.” Other researchers found that this hegemonic relationship between provider and patient is intensified when ethnicity is involved (Fast 2002).

I have provided an outline of material addressing hegemony in indigenous health and maternal care in Table 3.3. These works concerning indigenous health care, midwifery; and women, children and family care in different settings collectively point to the universality of the topic.

Jordan uses the term "Authoritative Knowledge," while Daviss (1997) uses the term “logic” to describe classification systems that people use to manage birth. Daviss explains that the assumptions in these logic systems affect the person’s perception of risks and normalcy. She identifies the following types of logic: Scientific, Clinical, Personal, Cultural, Intuitive, Political, Legal, and Economic. Daviss (1997) has traditional midwifery training from Guatemala, and she developed this classification system to better understand the dichotomies existing between and within systems. Working with the Inuit in Canada, she developed and presented a deeper understanding of how different perceptions, or overlaps of perceptions, affect health care systems, especially where birth is involved. She contends that the way in which birth is handled by a society, speaks to the strength of community in that society. When management of birth slips from the community, she hypothesizes, the community is in danger of disintegration (Daviss 1997).

**Table 3.3** References of Hegemony in Indigenous Maternal Health Care

<b>Topic</b>	<b>Suggested Reference</b>
<b>Athabascan Health Care</b> Alaska Native	<ul style="list-style-type: none"> <li>• <i>Northern Athabascan Survival Women Community and the Future</i> Fast (2002: 41-46; 232-270)</li> </ul>
<b>Cross-cultural Maternal and Infant care</b> Indigenous Worldwide	<ul style="list-style-type: none"> <li>• <i>Childbirth in Cross-Cultural Perspective: In The Manner Born Birth Rites in Cross-Cultural Perspective</i> (Newton and Newton 2003:7-30)</li> </ul>
<b>Midwives</b> In Canada, U.S., and Australia  Alaska Native (Koyukan Athabascan)	<ul style="list-style-type: none"> <li>• <i>Cross-Cultural Perspectives on Midwives In The Manner Born Birth Rites in Cross-Cultural Perspective</i> (Cosminsky 2003:69-84)</li> <li>• <i>"She taught us How to Be": The Cultural Construction of Birth and Midwifery Among the Koyukon Athabaskans of Interior Alaska.</i> Kirsis (1996)</li> </ul>
<b>Indigenous Childbirth</b> Canadian (Inuit)  India	<ul style="list-style-type: none"> <li>• <i>Heeding Warnings from the Canary, the Whale, and the Inuit. In Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives</i> Daviss (1997)</li> <li>• <i>Irniktakpunga! Sex Determination and the Inuit Struggle for Birthing Rights in Northern Canada In Conceiving the New World Order: The Global Politics of Reproduction</i> O'Neil and Kaufert (1995)</li> <li>• <i>Birth on the Threshold: Childbirth and Modernity in South India</i> Van Hollen (2002)</li> </ul>
<b>Aboriginal mothering/ Indigenous families</b> Worldwide  Native American (Mohawk)	<ul style="list-style-type: none"> <li>• <i>"Until Our Hearts Are On the Ground:" Aboriginal Mothering, Oppression, Resistance, and Rebirth</i> Lavell-Harvard and Lavell (2006)</li> <li>• <i>Kahnawà:ke Factionalism, Traditionalism, and Nationalism in a Mohawk Community</i> Reid (2004)</li> </ul>

**Source:** Compiled by author.

### 3.4 Emergence of birth models

This section compares the power and authoritative knowledge systems in operation in birthing in the study area (Begay 2004; Browner and Press 1996; Jordan 1996) and also the level to which birth is viewed as a medical condition that needs to be treated

(Davis-Floyd 1994; Wagner 2006; Wertz 1998). Non-hospital birth practices are usually based more on traditional knowledge systems of healing and naturalness of birth. Caregivers practicing in non-hospital sites tend to conceptualize birth with mother-centered power as an entity of nature to be relied on in the situation (Coronado 2005; Jordan 1996; Kirsis 1996; Wagner 2006).

Davis-Floyd (1992), in *Birth as an American Rite of Passage*, explains how analysts can look at obstetrical procedures as rituals, and analyzes the American medical system as a microcosm for our society, which “seeks through these rituals to socialize birthing women into the collective core value system of the technocracy.” Other authors propose that interventions, such as cesarean sections, are linked “...to doctor control and protection,” rather than an actual “lifesaving measure” for mothers and babies (Dietch, et al. 2011; Walsh 2005). Did birth change from an expression of culture as described by Mead (1955) or Geertz (1973) to a medical process mainstreaming reproduction for these women and their societies to the dominant culture?

In the early 1970s, Dr. Warren Hern (1971), a medical doctor and epidemiologist, stated in a family planning journal that since women weren't doctors, they really could not speak for themselves, so he was "doing it for them." With the title of his article: "Is Pregnancy Really Normal?" he answered at the 1970 American Anthropological Association meetings in San Diego, that no, indeed, it is not. He goes on to define pregnancy as a disease, best monitored by medical specialists. Hern discusses how, for tribal women, from populations experiencing high fertility rates, that pregnancy might be 'normal' state; but, for women in the US, where the number of actual births could be limited with family planning and abortion, that there were alternatives to them spending the majority of their fertile years pregnant. This doctor subsequently wrote a book on abortion, and set up an abortion clinic in Boulder, Colorado. He views his services as a health care measure that will release women from the harm of giving birth. Some women's rights activists of the 1970s were behind this philosophy, until the "earth mother" element of natural birth came on the scene (Hern 1971).

WHO (2002) documents and other researchers (Amankwaa 2003; Begay 2004; Cairns 2005; Douglas 2009) are beginning to cite situations where the traditional ways of birthing, could have merits that were overlooked. Exploring the value of local knowledge to mothers and communities in prenatal and birthing assistance care in indigenous communities, can respond to this element often missing from western-based evaluations.

Many anthropology-based studies (Kitzinger 2005; O'Neil and Kaufert 1995) and health care research (Douglas 2009; Webb, et al. 2008) report a connection between positive birth outcomes and less intervention than that involved in standard hospital birth. Additionally, the well-being of mother is shown to improve if she is involved in birth practices that observe her cultural background (Acharya and Rimal 2009; Dietch, et al. 2011; Kildea and Wardaguga 2009) . Davis-Floyd (2000:34), while cautioning against romanticizing indigenous midwives, also speaks out against the loss of values in the biomedicalization of birth and asks the question: "Must we lose the viable indigenous birthways that still exist before we rediscover how valuable many of them were?"

### 3.5 Midwifery and biomedical birth models

In some European countries, particularly Denmark, the midwifery model is the norm, with home births very common. In France, hospital births are normal, but extended postpartum care is also provided at home by the state. House calls by doctors are also common in France (Cherfils 2010). This is one of the only industrialized countries that compare to US infant mortality rates, as well. Epidemiologists are not quite sure what to make of the phenomenon in which excellent access to biomedical birth is associated with the highest infant mortality rates among highly industrialized societies.

It is rare that for any biomedical attendant other than a CNM to attend home births in the US. All CNMs are required to have a "doctor back-up," an agreement of a physician, usually an obstetrician, to act as the next level of care for the midwives' clients in the event the next level of care was required. The CNMs must also carry malpractice insurance. Some CMs or DPMs are also required to have back-up support from a physician in the event the midwives are permitted by the hospital to act as an attendant.

DEMs rarely have hospital privileges, and are not usually required to have the same insurance or doctor support. Indeed, DEMs, which are similar to traditional birthing attendants (TBAs), are typically the least respected among maternal caregivers, especially by the medical profession, but even by other midwives, in some situations. Nevertheless DEMs are most commonly used for home births. In the US, the DEMs tend to have informal arrangements with CNMs or other doctors for unexpected emergencies (Janssen, et al. 2009). Some areas of the US have family practice doctors delivering in the clinics (the rural West), with a midwifery-type model, but typically not home births (Topping, et al. 2003). For some such doctors, this is in part due to the limits placed on them by malpractice insurance policies. Midwives of varying levels of certification and types of training can attend women in hospitals, clinics, and at home. Sometimes the licensed, non-nurse midwives are not welcome in hospitals, so that in the event their clients must transfer from home (or birthing center) to hospital, they are not permitted to accompany them (as a professional caregiver).

Say and Raine (2007), in a Bulletin of the WHO, show how less interventive care or too much interventive maternal health care can actually stem from lack of cultural barriers between patient and caregivers. For some situations in which mothers live in remote, difficult to access areas, yet are serviced by a larger health agency, the context of access to medical services becomes more complicated than similar situations in urban areas. McCoy et al. (2010) describe how features of rural and remote health care in general i.e. lack of staffing, equipment, supplies, infrastructure, are exacerbated when dealing with providing maternal and infant health care in these remote situations.

In regard to international maternal and infant health, McCoy, et al. (2010) describe eight tensions underlying a lack of clarity, consistency, and agreement on how policy makers and planners should expand maternal, neonatal, and child health (MNCH) services and interventions. McCoy, et al. (2010) attempt to "promote greater alignment between the policy agendas of MNCH and health systems development, and draw attention away from discussions about what should be done to how it should be done." Eight areas of tensions are described among/between:



- 1) needs of mothers, infants and children;
- 2) balancing investments across continuum of care;
- 3) community and facility-based scale-up;
- 4) the selective-comprehensive divide;
- 5) using evidence, but recognizing its limitations;
- 6) managing the public-private mix;
- 7) improving supply and strengthening demand;
- 8) acting urgently and building slowly.

McCoy et al. (2010) also discuss "cross-cutting" messages that can be drawn from the challenges and questions for MNCH policymakers, planners and advocates. The authors point out; there is "no universal recipe for scaling-up MNCH interventions and improving the health of mothers, newborns, and children." Contextual factors from the 'social, economic and cultural determinants of health seeking behavior and home based care' to 'the epidemiology of maternal, neonatal, and child deaths and the incidents and prevalence of disease' are listed as impacting the affordability, effectiveness, feasibility, and appropriateness of strategies of interventions to improve worldwide MNCH health.

While McCoy, et al. are really speaking to international agencies and policymakers, their message can be applied to national and state program developers, as well. The discussion of inefficiency and impotence of health policymaking and "global approaches" is especially relevant to agencies dealing with such a varied client base as in Alaska (from urban to rural; homogeneous to cross-cultural). These international health specialists propose that lack of successful research and pilot projects is in part due to "lack of sensitivity to context and socio-political nature of health care systems." For instance, in the 'bridging the selective-comprehensive' divide mentioned, "bottom-up and integrated" is listed for the comprehensive primary health care delivery system. I contend that these situations could be alleviated somewhat in remote areas with endorsement by health agencies involved in a model more akin to the midwifery model, described next.

### 3.5.1 The Midwifery birth model

The midwives model of care (Table 3.4) is based on the belief that pregnancy and birth are normal life processes. Midwives provide an array of health care services for

**Table 3.4** Midwifery (Holistic) Model of Birth

Practice in:	Types of Midwives	Services	Level of Interventions
Hospitals	CNMs Sometimes CPMs or CMs (depending on hospital)	Low risk delivery for hospital, which can include application of <ul style="list-style-type: none"> <li>• labor inducing drugs,</li> <li>• fetal monitoring</li> </ul> epidural ("saddle block anesthetics) Also: <ul style="list-style-type: none"> <li>• education, lactation consultation</li> <li>• annual gynecological exams, family planning preconception care</li> <li>• menopausal management</li> </ul>	Low level technology in clinic: showers, hot tubs, massage Along with: <ul style="list-style-type: none"> <li>• Access to more technology in the hospital;</li> <li>• Referral abilities to items beyond scope of CNM services</li> </ul>
Clinics	CPMs CMs	Low-risk delivery including: <ul style="list-style-type: none"> <li>• herbal/mechanical labor induction</li> <li>• herbal/mechanical pain management</li> <li>• education, lactation consultation</li> <li>• prenatal care, labor and delivery support, postpartum and newborn care</li> </ul>	Access to low level technology in clinic: herbal pain remedies, showers, hot tubs, massage <ul style="list-style-type: none"> <li>• Less access to smooth referral process in case of transport</li> </ul>
Birth centers	Some CNMs (with home births 3%) CPMs CMs DEMs	Low-risk delivery including: <ul style="list-style-type: none"> <li>• herbal/mechanical labor induction</li> <li>• herbal/mechanical pain management</li> <li>• education, lactation consultation</li> <li>• prenatal care, labor and delivery support, postpartum and newborn care</li> <li>• (In rare cases of CNM here, addition items associated with this practitioner)</li> </ul>	Low level technology in clinic: showers, hot tubs, massage <ul style="list-style-type: none"> <li>• Less access to smooth referral process in case of transport</li> </ul>
Village (or home birth)	Some CNMs (with birth centers only 3%) CPM CM DEMs Lay Midwives	Low-risk delivery including: <ul style="list-style-type: none"> <li>• herbal/mechanical labor induction</li> <li>• herbal/mechanical pain management</li> <li>• education, lactation consultation (in some cases) or socialization</li> <li>• prenatal care, labor and delivery support, postpartum and newborn care</li> <li>• (In rare cases of CNM)</li> </ul>	<ul style="list-style-type: none"> <li>• Low level technology in clinic herbal pain remedies, showers, hot tubs, massage</li> <li>• Less access to smooth referral process in case of transport</li> </ul>

**Source:** compiled by author, as adapted from information available at:  
<http://americanpregnancy.org/labornbirth/midwives.html>

women that can include medical histories and gynecological examinations, contraceptive counseling, prescriptions, and labor and delivery care. Providing care during labor, delivery, and after birth is a specialty of midwives. The services of a midwife depend on the certification and licensing credentials obtained and the practice restrictions of each state. Because of the additional licensure in nursing, a nurse-midwife can offer very comprehensive health care services to women (American Pregnancy Association 2013) .

The midwives model of care includes:

- 1) Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle
- 2) Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support
- 3) Minimizing technological interventions
- 4) Identifying and referring women who require obstetrical attention

Midwives are qualified health care providers who go through comprehensive training and examinations for certification. Certification is offered by the American College of Nurse Midwives (ACNM) and the North American Registry of Midwives (NARM). The practice and credentials related to midwifery differ by state throughout the United States. Below is a brief description of each of type of midwife:

- 1) *Certified Nurse-Midwife (CNM)*: an individual trained and licensed in both nursing and midwifery. Nurse-midwives possess at least a bachelor's degree from an accredited institution of higher education and are certified by the American College of Nurse Midwives.
- 2) *Certified Professional Midwife (CPM)*: an individual trained in midwifery who meets practice standards of the North American Registry of Midwives.
- 3) *Direct-Entry Midwife (DEM)*: an independent individual trained in midwifery through a variety of sources that can include: self-study, apprenticeship, a midwifery school, or a college/university program.

- 4) . *Certified Midwife (CM)*: an individual trained and certified in midwifery. Certified midwives possess at least a bachelor's degree from an accredited institution of higher education and are certified by the American College of Nurse Midwives
- 5) *Lay Midwife*: an individual who is not certified or licensed as a midwife but has been trained informally through self-study or apprenticeship.

Most caregivers, biostatisticians, and public health epidemiologists will agree that low risk pregnancies make up about 80% of all pregnancies (American Pregnancy Association 2013). This means that up to 20% of pregnancies could have potential complications. These are times when either the mother or the baby will require medical interventions that are outside the scope of services offered by a midwife. Nurse-midwives (and sometimes other midwives) routinely consult with obstetricians, perinatologists, and other healthcare professionals and will refer women to appropriate medical professionals if complications arise. If complications are anticipated, caregivers usually recommend that women elect a hospital setting with more convenient access to obstetricians, perinatologists, and other professionals trained to deal with complications affecting either the mother or baby.

According to American Pregnancy Association (2013), a "non-profit organization that promotes pregnancy wellness," most midwives (and some obstetricians) prefer to facilitate a natural childbirth as much as possible. Therefore, it is common to receive care from a midwife in a privacy and comfort of a birthing center or in the mother's own home. Some midwives (certified nurse-midwives, especially) have special nursing training and certification; and are part of a labor and delivery team associated with the local hospital. Expectant mothers in urban areas can often choose to use the services of a midwife whether electing to give birth at home, a birthing center, or at a hospital. Women in more remote areas, or those with cultural or religious preferences, however, are more limited in their access—as are women living in rural Alaska Native villages—to birthing practitioner choices made available to them through health care channels at their disposal. Some very remote areas of India, for instance, have trouble getting to a hospital, if

needed, because of remoteness of her village or lack access to standardized care because of her status or social class. While efforts are being made to avail expectant mothers to safe maternal health care, getting them to the hospital is often seen as the best way to accomplish this. Staffing hospitals with qualified personnel, though, is a problem in some of these areas, and even when there are 'physician extenders,' like midwives, a divide can exist among the different types.

According to the research conducted by Peter Schlenzka (1999), the choice of using a nurse-midwife and natural delivery can result in the following benefits:

- 1) Lower maternity care costs
- 2) Reduced mortality and morbidity related to cesarean and other interventions
- 3) Lower intervention rates; Fewer recovery complications
- 4) Electing to use a nurse-midwife is generally viewed as appropriate for low risk pregnancies, which constitute about 80% of all pregnancies.

In Schlenzka's (1999) review of over 800,000 births, he reports there are no advantages of a standard obstetric hospital approach over a nurse-midwife setting inside or outside of the hospital. Schlenzka's study only applies to the use of nurse-midwives, however, and was conducted before the WHO came out with similar findings in regard to traditional birthing attendants in less industrialized areas of the world (World Health Organization 2002).

While midwifery has become associated with the term 'traditional,' it is important to note here, however, that the terms traditional and modern, applied to birth models reflect different ideas than those in the latter discussion of traditionalism and modernization as discussed in reference to communities. While, the midwifery birth model is associated with 'traditional' as in 'natural,' the term 'normal,' however, in regard to birth models, depends on time and place, and worldview (as discussed in chapter 1).

Prior to the late 1930s, home birth was normal for most everyone, then just for the rural, minority, and underprivileged. Poor sanitation, lack of access to handle emergencies occasionally arising in homebirth, and superiority of gaining a foothold in the market, all contributed to the replacement of midwives with the biomedical model

(see Wertz and Wertz (1989) for details on US history of childbirth). Post World War II, hospital birth and bottle-feeding associated with modernity and safety became the US norm nationwide. At that time, Alaska was an official part of the nation, as a territory.

Because of the hospital location, environment, and regional policies involved in access to a biomedical birth, the ANMC birth practices (even with CNMs involved), can be more viewed as closely aligned with the biomedical model of birth, and described next.

### *3.5.2 The Biomedical birth model*

The prevailing protocol in the United States for hospital birth is referred to in this thesis as the biomedical birth model (Table 3.5). The idea of ‘normal’ birth changed throughout the country from settings of home to hospital and common practitioners of midwives to specialty physicians called obstetricians within the course of a generation. Industrialized countries, particularly capitalist countries where efficiency was a value to offer in all services, including health care, embraced a progressive rationalization of maternity services. Practices that offered women freedom from pain and what were viewed as safer outcomes became part of normal deliveries. By the 1950s in the US, most births, even in rural areas were "performed" in hospital settings, by doctors. Forceps, twilight sleep,<sup>18</sup> strapping women into positions suited for a doctor's convenience, were all common features of this era. Modern US mothers were producing the baby-boomer generation with everything science had to offer: drugs, sterile operating rooms; and modern infant and childcare advice. Mothers were feeding their babies bottles as only the affluent (with wet nurses) had in the pre-war generations.

Pregnancy and birth moved from the realm of women and families to the institutions of health and hospital. Instead of families and other women giving advice and offering

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<sup>18</sup> Twilight sleep birth: a commonly used pain remedy for childbirth in the late 1950s and early 1960s; induced by an injection of morphine and scopolamine, causing an amnesic condition characterized by insensibility to pain without loss of consciousness.

**Table 3.5** Biomedical (Western) Model of Birth

<b>Practice in:</b>	<b>Types of Practitioners</b>	<b>Services</b>	<b>Level of Interventions</b>
Hospitals	<ul style="list-style-type: none"> <li>• CNMs</li> <li>• General Practitioner or Family Practitioner (GPs or FPs)</li> <li>• Obstetrician/Gynecologists (OB/GYN)</li> </ul>	<p>Low risk delivery for hospital, which can include application of</p> <ul style="list-style-type: none"> <li>• Extensive testing, monitoring</li> <li>• labor inducing drugs,</li> <li>• fetal monitoring</li> <li>• epidural and episiotomy</li> </ul> <p>High Risk prenatal care and delivery including:</p> <ul style="list-style-type: none"> <li>• in addition to above:</li> <li>• access to cesarean section</li> <li>• education, lactation consultation</li> <li>• annual gynecological exams, family planning</li> <li>• preconception care</li> <li>• menopausal management</li> </ul>	<p>In some cases</p> <p>Access to low level technology in clinic: showers, hot tubs, massage, birthing ball</p> <p>Along with:</p> <ul style="list-style-type: none"> <li>• Access to more technology in the hospital;</li> <li>• Referral abilities for access to items beyond scope of CNM services</li> </ul>
Clinics (usually restricted to Prenatal care; delivery occurs in hospital or medical center)	<ul style="list-style-type: none"> <li>• CNMs</li> <li>• FPs and GPs</li> <li>• (rarely) OB/GYNs</li> </ul>	<p>Low-risk delivery including:</p> <ul style="list-style-type: none"> <li>• education, lactation consultation</li> <li>• prenatal care, labor and delivery support, postpartum and newborn care</li> </ul>	<ul style="list-style-type: none"> <li>• Access to low level technology in clinic: herbal pain remedies, showers, hot tubs, massage</li> <li>• Smooth referral to higher level care in case of transport</li> </ul>
Birthing Centers	<ul style="list-style-type: none"> <li>• CNMs</li> <li>• (rarely) FPs and GPs</li> </ul>	<p>Low-risk delivery including:</p> <ul style="list-style-type: none"> <li>• education, lactation consultation</li> <li>• prenatal care, labor and delivery support, postpartum and newborn care</li> </ul>	<ul style="list-style-type: none"> <li>• Access to low level technology in clinic: herbal pain remedies, showers, hot tubs, massage</li> <li>• Smoother referral to higher level care in case of transport</li> </ul>
Village (or home) births	<ul style="list-style-type: none"> <li>• CNMs</li> <li>• (rarely) FPs and GPs</li> </ul>	<p>Low-risk delivery including:</p> <ul style="list-style-type: none"> <li>• education, lactation consultation</li> <li>• prenatal care, labor and delivery support, postpartum and newborn care</li> </ul>	<ul style="list-style-type: none"> <li>• Access to low level technology in clinic: herbal pain remedies, showers, hot tubs, massage</li> <li>• Smoother referral to higher level care in case of transport</li> </ul>

**Source:** compiled by author from information on <http://americanpregnancy.org/labornbirth/midwives.html>; and Janssen, et al. (2009).

assistance, birth was best advised by professional doctors. By the 1960s, hospital births and bottle-feeding were very much norms, and midwives were relegated to minorities, the poor, or very remote. Doctors and hospitals eventually noted the problems associated with twilight sleep, and effects of some medications given during childbirth, but the biomedical model had a strong foothold in US maternity care.

Standardization and efficiency for what were determined to be 'good' birth outcomes provided rationalization for control by the medical profession in this arena of women's health care by this time. Walsh notes that women's bodies were objectified in this process (Arney 1982; Foucault 1973; Fox 1993; Kirkham 1989) along with disconnection from the baby, as a separate patient. Fetal monitoring devices and adherence to timetables were considered part of "normal" birth. Policy measures were taken to make certain that births were safe, and under control. In birth events, the unexpected is worrisome. Speeding things up became a value, preferable to waiting through the pain of a long labor that might endanger the baby. Technological advances including the fetal monitor allowed doctors to monitor the women in labor. Time wise, the doctor received progress reports until nurses indicated it was time for the baby to be born.

During this era, treatments and procedures were developed that improved infants chance of live birth at earlier weeks-gestational ages. This was seen as progress, as infant mortality rates lowered from 20 per 1,000 US births in 1950 to 7.5 in 2003 (Maniilaq Health Association 2003), but levels were twice for Blacks as Whites. On the other hand, the number of low birth weight, premature babies simultaneously increased during this time (Behrman and Butler 2007).

Husbands, children, and family members were also removed from the process. The hospital staff was employed to care for birthing women and delivered the baby. "Who delivered you?" was a common question among young mothers of this era. At birth, babies were separated from mothers, and placed in a separate wing of the hospital (the nursery), after genetic testing and physical examination.

Later, as the women's rights, birth control, and back-to-nature movements grew, pockets of counterculture groups became interested in returning to "natural birth." By the



1970s, the merits of breastfeeding were being re-introduced, while simultaneously handing out formula samples to new mothers. Lamaze classes and LaLeche League membership became popular, and spurred some hospitals to allow husbands in the delivery room, keep babies with their mothers, and forego extensive medications or interventions. Breastfeeding began to move back into popularity as more educated mothers were convinced that it was a better practice for infant, and their own health (Wright and Schanler 2001).

Some of the indirect outcome from the "back-to-nature" era has remained an influence like breastfeeding, and awareness of influence of drugs on the fetus (Murray, et al. 1981). Other changes are regarded as more superficial (Davis-Floyd 1997) like flowered wallpaper or a rocking chair in the room. Some (Ross 2006) still maintain that these are good features to make the institutionalized birth setting homier, while still having access to all the tests and procedures a complicated birth could require. The functioning body of authoritative knowledge in this model is the medical-based science and technology available to obstetricians, and the doctors, themselves. The level of technology involved in the prenatal care and birth—numerous tests, and surveillance procedures (routine ultrasounds, fetal monitoring)—have led some to refer to this model as "technocratic birth," as coined by Robbie Davis-Floyd (1997).

Opponents of the normalcy of medicalized birth, dispute the risk level they feel is unfairly associated with non-hospital birth (Janssen, et al. 2009; Warwick 2010). Conversely, many doctor and hospital-birth advocates voice concern over the health of the mother and baby that might be at risk for the sake of a "birth experience." These arguments are not going to be resolved in this thesis. Different "camps" of philosophical leanings exist in US society, but the biomedical model remains the most common and prevailing dictate in maternal health care and Alaska policy follows the biomedical model, as well. Even so, there are some situations in which hospitals are setting up birthing centers that employ nurse-midwives, and feature elements of the midwifery models as more studies are coming out reinforcing claims of the merits of the model.

For example, Australian aboriginal women are going to great lengths to participate in a biomedical model (that includes CNMs). Kildea (2006) questions if the perceived risks that compel program designers to get these indigenous women out of their community and into the medical center are indirectly counting ethnicity as a risk in and of itself. She also looks at how local aboriginal knowledge is discounted and insists that the term 'safety' should include a woman's ability to 'feel safe' in this assessment. Kildea (2006) calls for holistic maternity services, in which a social, or community model (midwifery model) is in effect with all stages of pregnancy, birth, and postpartum treated equally. Kildea emphasizes that authoritative knowledge is a social construct. When aboriginal voices are suppressed in that process, they are not participating in the formation of their own maternity services. Kildea and Wardaguga (2009) also use the Canadian experience with First Nations maternity services, where women are given this opportunity, as an example of how incorporation of aboriginal women's local experiences can mean a more holistic maternity services program in these remote areas, with improved success in mothers well-being.

'Western' became associated with the biomedical model of birth because of its alignment with medicine as the proper arena for childbirth. US medicine's roots in bureaucratic standardization and comparative outcome rationalization of health care, was based in tackling the uncertainty of birth, by revealing the previously unknown. Part of this rationalization involves gathering statistics on the birthing mother and baby to become as knowledgeable as possible so as to react appropriately to any irregularities.

Contrary to the extreme rationalization and 'efficiency' values built into this model, however, there is still uncertainty in birth. Knowing' via surveillance using the dominant authoritative knowledge system, appealed to the US viewpoint of maternal and infant safety assurance with more tests and more intervention, giving a perception of more control over the process (Table 3.5). Interpretation of fetal monitoring and adherence to guidelines became accepted customs in maternal health care and can lead to unnecessary and sometimes dangerous overtreatment and side effects associated with this birth model.

### 3.5.3 *Authoritative knowledge in birth constructs*

Jordan (1996) looks at maternal healthcare and birthing from an authoritative knowledge standpoint. She identifies a specific document the Flexner Report of 1910<sup>19</sup>, as illustrating a turning point in the professional medical knowledge system in America, from that of a pluralistic medical system to an allopathic professional knowledge system as the dominant form. She explains that as a result of this transformation, “delegitimizing all other kinds of healing knowledge (Jordan 1996:57)” occurred. With this transformation, the newly defined medical profession gained a position of “cultural authority, economic power, and political influence” in American society. She cites noted Pulitzer-prize winning sociologist of medicine Starr (1984) and offers his description of how doctors came to be “in charge of the facts, that is to have the authority to define when somebody is dead or alive, sick or well, competent or not.”

This medical profession authority of health is so embedded in our culture that it seems natural, legitimate and in the best interest of all parties. So much so, Jordan points out, that this position of superior authority among Western medical professionals appears impossible to change. Authoritative knowledge is persuasive because it is consensually constructed, and carries the possibility of powerful sanctions, from social exclusion to physical coercion, such as funding or licensing. This way, people of the group not only accept the authority, they actually take part, either consciously or subconsciously, in its “routine production and reproduction (Jordan 1996).” I hypothesize that the Maniilaq Health Association, as part of the ANTHC, has become that legitimate authority for some, but not all, of the MSA villages.<sup>20</sup>

In her work on authoritative knowledge and its construction, Jordan reminds us that analysts of this knowledge are by no means attesting to the correctness of the knowledge.

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<sup>19</sup> The Flexner Report of 1910 was a Carnegie-supported study of the state of the medical profession in the United States that revealed a wide array of unregulated and competing schools of medicine. The report led to enforcement of standards, plus substantial funding for allopathic medicine, closing other “irregular schools” that frequently admitted women and blacks. Thus, the report became instrumental in cementing the cultural dominance of “regular” medicine and ensuring that American physicians would be White, middle-and upper class, and male (from Jordan, 1997).

<sup>20</sup> I provide more details of this concept in chapter 7 conclusions.

Rather, they are attesting to the status of that knowledge within a particular group, and “...the work it does to maintain a particular group’s definition of morality and rationality. *The power of authoritative knowledge is not that it is correct, but that it counts* [original emphasis] (Jordan 1996:58).” Jordan continues:

By authoritative knowledge I mean, then, the knowledge that participants agree counts in a particular situation that they see as consequential, on the basis of which they make decisions and provide justifications for courses of action. It is the knowledge that within a community is considered legitimate, consequential, official, worthy of discussion, and appropriate for justifying particular actions by people engaged in accomplishing the tasks at hand.

Her study was based on work in a feminist health clinic where some women came in insisting that they were pregnant before a test was administered, before the days of in-home pregnancy testing. It turned out that, whether the doctor disagreed with them or not, the women were always right. She discovered that the social interpretation allowed knowledge to be displayed in one situation and did not allow it to emerge in another. Later, she began to study court-appointed cesarean sections. Of all the cases she studied, none were found to be necessary. What struck her the most about these situations was that women’s knowledge did not count, medical knowledge did.

Interestingly, Jordan (1996) found that the women who were court-ordered to undergo cesarean sections who eventually escaped having the section, had a couple of things in common: 1) they had powerful social networks within which “their version of reality was upheld and supported,” and 2) they were removed from the hospital. Those women who actually got the cesarean sections, she reports, were not accompanied by a partner and remained in the hospital. She also mentions that the women who ended up with the operation were “poor, foreign, and illiterate.”

Jordan (1996) found this pattern of oppression of non-Western medical values repeated when studying midwives receiving hospital-based training. At the hospital, these midwives appeared “stupid, inarticulate, and illiterate;” but when placed in their community, where their skills and knowledge were respected, they took on a whole other persona. With this framework of viewing knowledge as a socially based entity operating in birth, Jordan studied Yucatan birth practices. She found, in sharp contrast to Western-

based birth practices, that there was no one person in control, not even the Yucatan mother. The store of knowledge came from all participants, with experiences from previous births brought forth and this particular birth added to that body of knowledge, “being created and re-created as they jointly do the work of birthing.” She notes that it is interesting that, in 1992, she and her colleagues came across the same kind of knowledge sharing work when studying the control center for an airline’s ground operation.

Jordan contrasts the Yucatan practices with a description of American hospital birth practices, where multiple kinds of knowledge do not come together. All participants in American birth of the late 1990s, Jordan says, devalue non-medical knowledge, “usually including the woman herself, who comes to believe that the course charted on the basis of medical knowledge is best for her (Jordan 1996:61).” Walsh (2005) summarizes situations in American hospitals where, for the very large part, this is still the case. He does cite unique examples in which team efforts between midwives and obstetricians, however, are creating more sound results, with less costly (physically and emotionally) results. Over the decade and a half that Jordan's work came out with these findings, some hospitals have incorporated more midwifery care into their procedures. While the timelines, routines, and hospital regulations still exist; alternate birthing positions, showers, and other measures to use the natural processes involved in birth (counterposed to chemical and medical interventions) are also likely to be made available and encouraged by midwives and nurses in today's hospitals.

### 3.6 Summary

I have conducted a specific literature review in this chapter to describe some of the underlying issues of gender and cultural discrimination involved in global, US, Indian Health Service, and Alaska Native maternal health care policy. After a description of social determinants in health care, I describe how even cultural competency applications are not always effective when these tendencies of institutionalized gender, class, and race discrimination are embedded in the worldwide capitalist-based operating systems. Using Kleinman's take on Foucauldian biopolitics/biopower, Kleinman's work on physician's

Explanatory Model, and Farmer's discussion of 'structural violence' concepts—I describe works that help inform my analysis. I presented this critical postmodern feminist literature review of global and US medicalization as I traced the development of the biomedical and midwifery birth models. I discussed the worldwide prevalence of the biomedical birth model, with the associated bias toward ethnocentric policies, as the operating knowledge system of Western science.

In the next chapter, I discuss the theoretical concepts of: maternal identity, from its nursing theory roots to present feminist stance; embodiment, in terms of the presence of illness based on the treatment and interpretation of groups of peoples and relation to social determinants of health; and Iñupiat cultural value system, formally called Iñupiat *Iitqusi*.



## **Chapter 4 Maternal Identity, Embodiment and Iñupiat Cultural Values**

### 4.1 Introduction

Not since Freud and Mead, had there been substantial work done on anything other than a physiological, medical view of pregnancy and birth when nursing theorists began to take on the subject in such a way. Rubin (1967) , and later, Mercer (1995; 2004) offered a look at how a mother becomes a mother in American society, prior to and including birth. Even after addressing some of the problems such as limited time frame and population, of Rubin's initial discussion of the concept of defining the process a woman goes through to fully acquire and master the role of mother, Mercer's eventual "Becoming a Mother" theory is considered value-laden and paternalistic. Given that these approaches come from a nursing stance, it is reasonable that their central themes involve helping a woman reach her maternal goals. However, they also decided what those goals should be. Even so, looking at birth and parenthood through a social lens and a potentially maternal point of view provided a foundation for the more sociological and anthropological studies and influence Arctic Passages.

### 4.2 Nursing theories and maternal identity

Ramona Mercer (1995) a nursing theorist, capitalized on the work of her mentor, Dr. Reva Rubin, in the context of women's transition to motherhood and the "acquisition of a maternal identity." In the 1960s, Dr. Rubin first described the process of maternal behavior in achieving a maternal role identity, called Maternal Role Attainment (MRA), beginning during pregnancy and extending through puerperium. The outcome of Rubin's work (Mercer 1995:viii) "elevated maternity nursing from a mechanistic level of routine to a creative, professional level of care focused on helping the childbearing woman achieve her mothering goals." Mercer then describes how she veers from Rubin's MRA construct, and develops her own construct of "Becoming a Mother (BAM)" which is more role-theory and ecological-based (Bronfenbrenner 2005). This construct extends



beyond the one-month puerperium period to twelve months. Mercer believes the additional focal change of roles of US women over the three-decade period shows the transition between Rubin and her ideas.

The differences between MRA and BAM are more pronounced in a later Mercer (2004) article in which she again stresses the time frame differences between the two. Mercer also divided maternal identity into stages using age of child and gives new names to the processes in each (Table 4.1).

**Table 4.1** Mercer's Stages of 'Becoming a Mother'

<b>Stage of Motherhood/ Age of Child</b>	<b>Associated with:</b>
Pregnancy	Attachment and Preparation
First 2-6 weeks following birth	Acquaintance, learning, and physical restoration
2 weeks to 4 months	Moving toward a new normal
Around 4 months	Achievement

**Source:** Compiled by Author from Mercer (2004)

While Ruben and Mercer were certainly not the first ever to explore the social aspects of motherhood and pregnancy, i.e. the Freuds and others from Psychology; Mead and Newtons and others from Cultural Anthropology; the Wertzes from Sociology, but they were the first nursing theorists to do so. The culture of their helping professions, I contend, accounts for the moral and paternalist tone of sanctioning of what it is to be a proper mother in our society, based on the health of the baby. While these theorists might be accused of ethnocentrism, these same tones can be found in some of the public health measures in maternal and infant care today.

Douglas (2009), and later nursing theorists built on this concept, yet leaving it to the women and their community to speak to the idea of what makes a safe and proper

mother. The processes themselves are different as the newer theories show. Women inevitably go through a process when they become a mother, in whatever environment, i.e. hospital, birthing center, home. Facing maternal and infant mortality and morbidity, the WHO (2002) proposed measures reduce mortality. Once the connection between "good" mothering and healthy infant survival and maintenance was made, WHO and other agencies began to focus on programs designed to facilitate survival. Robbie Davis-Floyd (2011) actually considers the connection between nurses and anthropologists who focus on birth, saying "Not all nurses are anthropologists, but most anthropologists who concentrate on birth, are also nurses."

In a sense, then, the Rubin and Mercer models are on the nursing side of the social sciences treatment of birth, and a valuable (albeit, incomplete) facet of looking into how a woman transitions into the important role of mother in her society. It is important to understand this background. This study draws more heavily, however, on the more recent and applicable works of Faircloth (2009) and Howes-Mischel (2009), and adopts their terminology referring the process of working toward one's identity of mother. I explain below how the behaviors and use of knowledge simply becomes a part of overall identity work: in this case, Maternal Identity Work (MIW).

#### *4.2.1 Maternal identity and ethnic identity*

Rubin and Mercer accounts are more biosocial in nature, discussing the impact of hormones, from conception to pregnancy and birth, on through breastfeeding—with special attention paid to what nurses can do to instill proper behavior toward good mothering skills in their patients, as they become mothers.

There have been criticisms of the paternalistic attitudes of this outlook impressed on mothers-to-be, and assimilation into acceptance of a biomedical birth model and future life of the mothers to social mainstreaming of new mothers in the US (Parratt and Fahy 2011:447-8):

Transition to motherhood theory is baby-centred and this undermines midwifery as a woman-centred discipline. The theory positions the midwife as knowing more about a woman's transition than the woman does herself. When midwives, consciously or

unconsciously, use the transition to motherhood metanarrative to understand women's self change during childbearing, each woman's embodied and contextual experience becomes invisible. Likewise, her inner power and inner knowledge are over-ridden and silenced. The woman is thought of as a passive recipient of social forces and caregiver actions; in practice, this translates into caregivers surveilling and policing women's behaviours. Under this metanarrative, the most disadvantaged women in society are the ones who are likely to be the subject of caregiver reporting to child protection agencies

From early 1950s mothers to current day working mom with a scheduled cesarean sections all point to how responsive mothers can be to the day and times of their respective (Vanderberg-Daves 2002) situations. What is largely left out of the Western nursing academic discussion on motherhood, however, is how all women view motherhood. Where do non-EuroAmerican mothers and their babies fit into these scenarios as they bring new life to their own communities, in addition to the 21<sup>st</sup> century world in which they live? Multi-faceted identities potentially at stake include those of: 'cultural' mother, 'working' mother, 'good' mother. Add daughter, sister, worker, caregiver, head of household, head of tribal household, member of community, to these sometimes-conflicting roles that are underway during pregnancy. Mothers face more decisions than whether to breastfeed or not. How identity is played out is not just about decisions, or even the appearance of decisions. Sometimes the mere "finding one's self" in a particular situation is how something plays out, as support is offered to lure one into activity or deterrence comes from obstacles placed in the way of finding other paths.

Faircloth (2009:17) states:

[A]ccountability strategies...justifying choices ... (implementing both scientific and affective arguments)...at once putting their decisions beyond debate, cementing their authority in congruence with wider social trends and bolstering their sense of identity as mothers.

#### *4.2.2 Maternal identity and group membership*

Faircloth (2009:15) , arguing for an anthropological treatment of parenting as "identity work," calls for exploration into how "relatedness is enacted in conjunction with construction of self." In her look at attachment parenting (particularly in regard to long-term breastfeeding) in the United Kingdom, she cites the work of Sharon Hays ( 1996)

which notes how the construction of "ideal" mothers as an occupation in which mothers are expected to be completely absorbed and reach fulfillment in life through parenting. The identity work described in Faircloth's (2010) discussion of women in a study on La Leche League members, refers to them 'finding their tribe.' "To describe collective expectations for the proper behavior of actors with a given identity is to describe norms," Faircloth (2010:363) offers. In a sense, these attachment mothers were not only 'allowed to be normal' around one another as they were breastfeeding toddlers up to 5 years of age. They were also learning 'what was normal.'

Faircloth makes a connection between norms and rules, which, she quotes Katzenstein (1996:5) as saying, "[have]... 'constitutive effects' that specify which actions will cause relevant others to recognize a particular identity." The La Leche League is then used as an example of social control (Andrews 1991; Faircloth 2010) as it validates long-term breastfeeding. Faircloth maintains that some of her participant mothers had also expressed that they felt pressure to breastfeed 'as long as they were physically capable (Faircloth 2010).' For these mothers, then, engendering a sense of belonging to a group meant differentiating themselves from other mothers. A typical trope in identity work for these mothers was 'externalization of discourses' surrounding maternal identity, diligence, and risk. One informant spoke of "educated" people whom still did not breastfeed as 'willfully ignorant.'

Faircloth points to sociology's concept of group endurance for an understanding of why this member might talk of informed, yet non-breastfeeding mothers this way. She explains that through 'commitment mechanisms,' these women acknowledge their excluded choices, and validate the ones they have made. She quotes sociologist (Kanter 1972) work on group endurance to describe how a person can become more and more committed. This provides internal satisfaction through 'dependen[ce] on the group,' and opportunities to make other choices or go after other options declines. Group coherence is strengthened (Kanter 1972:70): "... through other commitment mechanisms like sharing food, having ceremonies, and the "idea of sacrifice and/or renunciation." Faircloth also noted that for some of the mothers in her study, there was a translation from information

and self-awareness to prescription to other mothers in the form of advocacy of long-term breastfeeding." This tended to make 'other mothers' feel uncomfortable, citing the remarks of a one-year breastfeeding mother as feeling "excluded" by her local La Leche League's more militant and righteous members. For this woman, Faircloth concluded, full-term breastfeeding was not the central element of her identity work as a mother. For the long-term breastfeeding mums, however, their feeding behavior is certainly central to their identity work, as they "actively create culture through their accountability." She shows how this group relies on language of risk and health of infants, in line with the current 'politicization of parenting,' they "oscillate between...affirmation and marginality, reifying a gulf with wider society."

#### *4.2.3 Public health policy, nationalism, and tribalism and maternal identity*

Howes-Mischel (2009) focuses on the area of maternal identity work as it relates to the place where it occurs: international, and national, socioeconomic and local. She noted how ultrasounds were not used Oaxaca, Mexico, while they are often used in the US to "provoke or encourage personification or social bonding." Instead of doctors personifying the infant to facilitate mothering behavior, the women in Howes-Mischel's study are found to have been socialized into proper 'pregnant subjects' in ways that identifies their own self-care rather than "medical interventions or larger structural and intercultural issues that might dissuade women from seeking biomedical care."

Howes-Mischel describes how medical care personnel in Oaxaca tend to focus more on the individual practices that women and local communities should implement to improve their health outcomes. Howes-Mischel (2009:15) told of walking around an Oaxacan community with a nurse from the hospital (looking for patients who had missed prenatal appointments) "because, if they don't come into the clinic, we don't know what they have been doing, and then bad things happen." The important point here is that the groups that are often admonished when statistics are 'bad,' such as maternal mortality rate in Oaxaca, Mexico or postneonatal infant mortality rates among NW Alaska Natives are the mothers and their communities. Howes-Mischel (2009:16) finds that genetic and biological risks are not considered, that: "...women are encouraged to look at their

individual lives as the site of risk production and alleviation, and implicitly draw on long-standing narratives about the women as irresponsible reproducers."

The first prenatal examine for women described by her study, occurs with the OB/GYN at the hospital, sometimes up to six hours away (even though family doctors are available at the local regional health center for routine prenatal care). Howes-Mischel (2009) argues that the "risk sheet" filled out by the doctor at this visit acts as "a form of reproductive technology that encourages women to conceptualize themselves as pregnant subjects in the particular terms of their socio-medical histories." Much like the risk assessment used in the ANVMT policy, the risk sheet is filled out by asking questions that are largely addressing the number of years of education the woman has completed, her birth spacing, family planning preferences, and marital status, and then a "reproductive risk score" is assigned. The last two questions, Howes-Mischel points out, do not appear on the risk sheet. The centralized top-down public health system in Mexico has become increasingly privatized since the 1980s. With this change comes a change in perspective from the state taking an interest, to emphasizing individual responsibility for production of good health (Howes-Mischel 2009). She adds that national campaigns were advocating this same sensibility of self-care, with 'large standardized murals.'

Howes-Mischel relays an incident concerning a community social worker being chastised by state health workers for an outbreak of dengue fever in her community. The social worker was frustrated because she had told the state to sweep the streets more often and take more responsibility for the community's health. The state supervisors blamed her for inadequacy in teaching community members to keep a clean community.

Howes-Mischel (2009) contends that both the individual and the community are held to self-care by the government policy for being 'responsibly socialized subjects' in the face of health risk. While there is a certain amount of internalization that takes place for these Oaxacan mothers in this facet of their maternal identity work, they also incorporate local idioms into the biomedical frameworks. Overall, among indigenous populations of Oaxaca., Mexico that the federal-, state-, and tribal-sponsored socialization process impacts the maternal identity work of these women.

Van Hollen (2002) speaks of the influence of the government and local TBAs on how mother deliver in South India. There is a myriad of care levels from central hospitals in large cities, to smaller town hospitals, with teams of varying level midwife. The more remote areas use fewer attendants other than low-caste midwives (*dai*) who deal with "pollution" and waste associated with childbirth. Van Hollen's thesis does not use the state's pathologizing of childbirth as central issue or cross-cultural comparative, but rather as a backdrop of difference. She explains her usage of important terms "medicalization" as healing assistance of all types. Citing the work of Scheper-Hughes and Lock (1987), Van Hollen insists that medicalization of birth is at the heart of the matter. Instead of transforming the social structure and the causes that give rise to such problems as hunger, alcoholism, and attention deficit disorder, these ailments tend to be viewed as purely biological disorders treated with biomedical interventions on individual bodies. Viewed in this context, medicalization of childbirth can be seen as an "extension of the power of professionalized medical institutions."

The difference in Van Hollen's (2002) account in rural Tamil, India, and most anthropological research on childbirth up to that point is that she claims the hegemony and related power plays are not coming from global biomedicalization of birth, as in India. Van Hollen (2002:28) argues that because:

- 1) from its inception OB/GYN care is a female profession in India, and
- 2) hospital birth did not become the norm in India

This is compared to the 99% hospital birth rate in the city of Madras (now Chennai). So, the inequality that is normally referred to by anthropologist as causing the globalization of biomedicalized birth is inappropriate in India. The struggle in India involves the rural women of lower castes trying to get hospital treatment in their communities and homes. This is not, Van Hollen finds, because of the women's lack of desire to access biomedical treatments. Women in rural India, she reports, want to bring the biomedical practices into their homes. This way, they are not subjected to discriminatory treatment at the hospital, but have access to the biomedical care.

Van Hollen (2002) describes the example of what happened to one woman, who resisted going to the hospital as long as she could, until she gave birth right in her doorway, "at the threshold." Indeed, Van Hollen uses this analogy in the title of her book, *Birth on the Threshold: Childbirth and Modernity in South India*. Explaining that the threshold of their home is actually the last place Tamili women would typically want to have a child, because this place is thought to a source of evil, as well as a place of protection from the outside. Van Hollen says that they will risk letting things get this far before going to the hospital, as a form of resistance. Women in these areas are not against biomedicine, she says, they just want the biomedicine in their communities, and they have found their own ways to activate for that. Gender and class figure prominently in her analysis.

Finally, Van Hollen contributes to future studies dealing with issues surrounding biomedical models of birth. She advises against treating biomedicine in birth as a monolithic structure, as it has not processed, she contends, across or within national boundaries, in a uniform way. Instead, Van Hollen (2002:13) argues for researchers to look at the "stratification of reproduction on a global scale," as recommended by such authors as Jordan (1996), Faye Ginsburg and Rayna Rapp (1995). At the same time, she cautions, as these authors, against unidirectional models of the relationship between power and knowledge in the context of globalization. Ginsburg and Rapp (1995:1) write:

People everywhere actively use their local cultural logics and social relations to incorporate, revise, or resist the influence of seemingly distant political and economic forces.

Jordan (1993), Ginsburg and Rapp (1995) ; and Kitzinger (1997) also deal with these issues as they relate to maternal identity. Kirsis (1996); O'Neil and Kaufert (1995); Coronado (2005); and Begay (2004) research rural indigenous peoples birth practices in terms of work among Canadian First Nations peoples, Mexican indigenous and American Indian groups, respectively. The themes of discrimination, attempted assimilation, cultural annihilation, and marginalization are evident in these stories. Embodiment is a common element and a name for the results of this long-term singled-out treatment amongst certain peoples of a larger population.



### 4.3 Embodiment and birthing practice

Embodiment is not a new concept. In the disciplines of medical sociology and political anthropology the phenomenon of poor health, lifestyle, and lack of ability to thrive was referred to as 'social determinants of health.' The WHO (2011a), for instance, lists determinants of health as follows: "the social and economic environment; the physical environment, and the person's individual characteristics and behaviors." As WHO (2011a:1) Report points out:

The context of people's lives, they explain, determines their health, and so blaming individuals for having poor health or crediting them for good health is inappropriate. Individuals are unlikely to be able to directly control many of the determinants of health. These determinants—or things that make people healthy or not—include the above factors [below] and many others.

The WHO report lists income and social status; physical environment; social support networks; genetics; health services; and gender as other factors influencing one's health.

Michael Marmot (2006:2082) describes the social determinants of health as: "The circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness." These circumstances, he explains, are in turn, shaped by a wider set of forces: economics, social policies, and politics. The WHO report is not referring solely to non-industrialized nations; but also to the inequities of health across the most industrialized countries. For indigenous populations in countries like Canada, Mexico, and the US, where disparities exist between the indigenous and non-indigenous populations, disparities are not due to racial genetic differences, but are more indicative of the lower socio-economic conditions of the areas where indigenous populations live. This phenomenon is referred to by medical anthropologists as *embodiment*. In Table 4.2, I present the 'three bodies' as described by Scheper-Hughes and Lock (1987). These authors use these perspectives of "the body" to explain how society, science, and medicine conceptualize and categorize the human body. The individual body is understood through the "lived experiences of the body-self." The social body is representative of "a natural symbol with which to think about nature, society, and

culture." The body politic refers to the "regulation, surveillance, and control of bodies (individual and collective) in reproduction and sexuality, in work and leisure, in sickness and other forms of deviance and human difference."

#### *4.3.1 Embodiment and the body politic*

Scheper-Hughes and Lock (1987) highlight that bodies are more than biological entities, but carry social meaning as well. For example, the Iñupiat mothers of NW Alaska have experienced a type of embodiment described by O'Neil and Kaufert (1995) present among the Inuit of Canada: "the embodiment of statistical norms." In addition, Scheper-Hughes and Locke (1987:10) point out: "Medicalization inevitably entails a missed identification between the individual and the social bodies, and a tendency to transform the social into the biological."

Many authors believe the treatment of indigenous women is driven by typically non-indigenous practitioners' thinking of their patients as superstitious. Like the Inuit women in O'Neil and Kaufert (1995), they are typically treated as children lulled into naivety with their "superstitious" Native beliefs. First Nations women were stereotyped as knowing "relatively painless birth" but have in the last 50 years moved to being stereotyped as needing greater assistance from the medical community (Janssen 1997). This concept is central to Hennessy (2013) and his work on influenza mortality where he questioned whether Alaska Native race could be looked at as a health risk. In the Arctic Passages study, I also indirectly ask if Alaska Native mothers' race is being viewed as a pregnancy risk. The US government assignment of responsibility to individual's characteristics rather than historical and unfair socioeconomic conditions is an example of political embodiment. It is easier to let the group's race remain the "problem" and public health appears attentive by prioritizing the group. Emphasizing the nature of embodied identity work (Gimlin 2010) discusses 'narrative identity,' in which identity is "...discursively constructed and, hence, culturally and historically variable.' The telling of self, especially for social legitimacy as Gimlin (2010:61) points out is the retelling that

"... may be driven primarily by the desire to reassert the familiar," or "...reinforce an irreflexive unity of self."

#### *4.3.2 Embodiment among maternal Third and Fourth World identities*

Embodiment of this 'third world' identity among patients, in general, is seen globally (Farmer 2005). The very definition of "less-industrialized" comes from the lifestyles of poverty and deprivation, which can lead to poor nutrition, poor health, and lack of access to necessary health and supportive services. Farmer (2005:308) describes how what he terms 'structural violence' has a hand in this phenomenon by "erasing history." In his work in Haiti, where he was a medical doctor and anthropologist, he learned that those in power tend to gloss over the histories that placed them in their positions (in this case, the French elite), and continue to oppress those that helped them stay on top (the Haitians). Similar to Wallerstein's (1974) World Systems Analysis, Farmer shows how history, biology and social life are linked in a hierarchal network throughout time and throughout the globe. Continuing with the Haiti example of structural violence, Farmer describes the component of 'erasing biology,' as well. For example, AIDS is attributed to the living conditions and "free" lifestyle of the Haitians, when the actual source of the AIDS epidemic lies with ties to the United States, not Africa. These features can hold true for populations within more industrialized nations. Because of unequal access, remoteness, or socioeconomic inequality, racial and class discrimination, populations in certain areas of developed nations, i.e. inner city, remote and rural or "reservations," can experience the same type of embodiment—as a result of colonization and discursive power, termed 'Fourth World.' Sometimes, the common denominator of underprivileged, after gender and age, is indigeneity. Maternity patients in these areas have a greater chance of facing difficulties. Institutionalized embodiments exist among maternity patients in many industrialized nations (Australia, Canada, US). Table 4.2 shows the works of authors who include discussions of the importance of where their participants live, what groups they belong to, how they identify themselves. This relates to perception of different treatment that ultimately impacts the behavior and interactions with the policies.

Table 4.2 Works on Indigenous Mothers and Importance of Cultural Identity by Group Represented

Reference (year)	Group Represented
Begay (2004)	Tohono O'odham Nation US Arizona Desert
Douglas (2011)	Inuit of Canada Nunavik
Epoo and Wagner (2005)	Inuit of Canada Nunavik
Kildea and Wardagugua (2009)	Aboriginal and Torres Strait Islander Women of Australia
Kirsis (1996)	Koyukon Athabaskan of US Interior Alaska
Mason (2004)	Aleut of US Alaska Islands
O'Neil and Kaufert (1995)	Inuit of Canada Keewatan NWT
Winkler-Sprott (2002)	Iñupiat of US Alaska

Source: Compiled by Author

#### 4.4 Iñupiat *Iitqusait*: backdrop to everyday changing realities

##### 4.4.1 Maternal and medical cultural influences

Mothers delivering babies in the US are subject to judgment from their cultural communities, regardless of where they live or what class or social group they belong to. The health care provided to individuals in American society can actually be a reflection of our social class (Larson and Halfon 2010). How we behave in regard to that care is also a reflection of where we fit in our social system (Henry 2001). The association between health and time perspective is one of the relationships between class and health that Henry examines. In reference to lower-class associations with poor health behaviors and present-orientations, Henry (2001) notes: "one reason for this lower-class present-orientation is that they hold a relatively pessimistic view regarding improvement of their material position in the future."

Changes like telemedicine have been documented and critiqued (Sherry 2004). The pre-state, pre-World War II, pre-boarding school Alaska Native groups have been compared to the current trends in Alaska Native villages as revitalization occurs. The influence of previous attempted assimilation measures and unfair treatment of Native Americans are a part of the historical background of a nation and Alaska. While these patterns of discrimination and oppression toward US indigenous peoples had an impact on attitudes toward government entities, health care in Alaska may have been a unique exception. In *Must we all die?* Fortuine (2005:216) even suggests that Alaska Native acceptance of Western medicine in their health care today was greatly influenced by the improvement of TB patients during that era:

The very success of the tuberculosis control program in Alaska, especially after effective drugs became available, fostered a certain level of confidence in the value of modern health care among Alaska Natives. Many of those who initially distrusted or avoided the government's health care program were thankful to see those with tuberculosis coming home from the hospital alive and well. It is reasonable to suggest that the confidence engendered by the tuberculosis program spilled over into other health programs.

With Western medicine, came Western lifestyles and a different authoritative knowledge system. Hand in hand with education, medical intervention and poor infant mortality rates paved the way for the biomedical model in childbirth in rural Alaska. In the early 1980s funding from the Indian Health Service, Medicaid, and ANTHC helped usher in the early era of the transport system in northwest Alaska.

Prior to the common use of ANVMT policy, many northwest Arctic mothers, married to military husbands, were birthing in military hospitals (Schwarzburg 2007b). By the early 1980s in northwest Alaska, however, flying mothers out of their communities to access biomedical birth became a common occurrence. With the input of this feature of maternal care, came the lessening of reliance on existing local midwifery (Schwarzburg 2007b). Consequently, fewer births were being attended by local midwives (Alaska Bureau of Vital Statistics 2009), and this part of Iñupiat culture began to die out.

The influence of Iñupiat culture in the everyday lives of the Arctic Passages participants can be viewed as in Reid's (2004) historical account of the Mohawk and ties

to Iroquois of Kahnawà:ke, in Canada in a political factionalism. He described a Traditionalist movement to restore the Council of Chiefs in 1890. What Reid found was that as he was addressing traditionalism and nationalism in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries, that there were elements of factionalism.

In *Making Modern Mothers: Ethics and Family Planning in Urban Greece*, Heather Paxson (2004:25) explains Greek modernity as: "...not that [Greeks] cannot live up to [Enlightenment ideals] not because they are too traditional, but "Enlightenment ideals are *themselves* [her emphasis] too contradictory and therefore, unrealizable." Paxson insists on the alternative modernity, much the way Douglas (2009) identifies the Inuit call for birth back into the community in Canada with a stance of 'non-modernity.' The difference in urban Greece, and First Nations Canada, however, was that—as with the Mohawk community described by Reid—there are strains of nationalism in the alternate Greek modernity, that seems to be absent for the indigenous groups. Paxson focuses on the particular brand of Greek modernity under which women becoming mothers there function, and claims it "is no less confusing for the women in America," operating under a "normative standard set by liberal political ideals," of which the Greek women fail to conform.

The complexity of birthing can be seen in the context of embodiment and its individual, sociocultural and political elements of identity. For the Arctic Passages study, I focus on cultural elements described by the participants themselves, and those in the Iñupiat *Iitqusait*.

#### 4.4.2 Iñupiat *Iitqusait* definition for Arctic Passages

During the Spirit Movement of the early 1980s, Iñupiat Elders responded to what they deemed youth exposure to unhealthy lifestyles. Many people turned to alcohol, drugs, and suicide as a "way out," they felt. Iñupiaq Values were defined by the Spirit Movement in the early 1980s (Alaskool 1998-2004; McNabb 1991) . The Iñupiat *Iitqusait* program got started at that time because, as one participant described:

there was a lot of concern that our young people were being exposed to unhealthy lifestyles as a result of poor role modeling. A lot of our young people were turning to alcohol, drugs and suicide as a way out.

There was a historical perspective given, to remind people of the transition that took place over the last 100 years. This "brought things to the present [late 1990s]" and got people at those meetings "to start looking at how they could do things differently to address these issues (Alaskool 1998-2004) .

The region's leaders, working with, and for, the Elders, began the process of traveling to the villages to hold town meetings so each community could discuss their problems and try to figure out a way to solve them. Iñupiat means "the Real People," and *Iitqusait* means, "Those things that make us who we are." Iñupiat Values are just basic human values, but they also help understand, Jules continues, "what they mean...we see that they reflect the culture because that is what defines us as a people. These values have helped us [these peoples] survive the test of time."

#### *4.4.3 Iñupiat Iitqusait expressions in Arctic Passages*

In Alaska, the value in looking at indigenous cultural influence can be seen in many revitalization programs and movements, with beneficial outcomes reported in Alaska Native communities throughout the state. Other areas in the developed world where internal colonialism has caused a phenomenon called 'transgenerational shame' (Atkinson 2002), indigenous groups are effectively looking to the past to guide them through the future, autonomy, and self-determination. Krupnik and Jolly (2002), Barnhardt and Kawagley (2005) and others give examples of how Traditional Knowledge systems are coming to be seen as valuable resources addressing indigenous and global issues.

For some First Nations peoples in Canada and Aboriginal peoples in Australia and New Zealand, the process of re-incorporation of local knowledge is especially meaningful when bringing birth back to the community (Douglas 2011; Epoo and Wagner 2005; Kildea and Wardaguga 2009) .

**Preamble:**<sup>21</sup>

"Every Iñupiat is responsible to all other Iñupiat for the survival of our cultural spirit, and the values and traditions through which it survives.

Through our extended family, we retain, teach and live our Iñupiat way"



**Figure 4.1** Iñupiat *Iitqusait* as appears on Alaskool website, from 1994

Source: <http://www.alaskool.org/images/IñupiatIitqusait.gif>

The values listed in the Iñupiat *Iitqusait* shown above are not the only set of values that are expressed as Iñupiat among the study participants. Neither was there any specific mention of this formalized set of values. The specific features, however, are evident through the speaking, sharing, and activities that go on in the villages. Some of these features temper how a woman might engage and participate in the maternal care and transport she is offered through the protocol.

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<sup>21</sup> This preamble appears with most listings, but on the NANA regional corporation website <http://nana.com/regional/about-us/mission/values/>, additional lines are added to the end as follows: "... With guidance and support from our Elders, we teach our children our Iñupiat Iitqusait values. Our understanding of the universe and our place in it is a belief in God and a respect for all of His creation."



Features of Iñupiat Identification are described in this research in similar manner used by Coe, et al. (2004) in their work on 'traditionalism' as a factor in disease risk and protective behaviors among Hopi women living on the reservation. I used three dimensions of indigenous culture to develop a description of Iñupiat Identification in each study village: language usage; cultural participation; and village involvement with Alaska Native-based activities.

#### 4.5 Summary

In chapter 2, I discussed the terms liminality and *communitas*. In this chapter, I covered the concepts and theoretical background of: Maternal Identity work, with its roots in nursing theory; Embodiment, and how social and political inequality toward colonized racial and ethnic groups can impact this process. I also presented the importance of discussing authoritative voice within anthropology of birth framework. Finally, I discuss Iñupiat *Iitqusait*, the guiding statement of values professed by Elders in the Arctic Passages communities. I will continue with the next chapter describing the methods incorporating theoretical frameworks from this chapter, along with concepts liminality and *communitas*, to paint a picture of the processes involved with Iñupiat mothers' navigation of the maternal transport system in the Arctic communities of Alaska.

## Chapter 5 Iñupiat Birthways in Northwest Alaska and ANVMT Policy

Before delving into the sampling of secondary statistics concerning the ANVMT policy as it operates in the Maniilaq region, I will revisit the definition of the maternal transport policy. As mentioned in chapter one, I have named the Alaska Native tribal health medical protocol for access to maternal care: the Alaska Native Village Maternal Transport (ANVMT) policy<sup>22</sup> or protocol. Collectively, these are criteria for decisions concerning what level of care is needed for an expectant Alaska Native mother from one of the outer-lying villages in Alaska. A 'travel triage' of sorts, this maternal care protocol and its application will vary from season to season and region to region, depending on weather and services and expertise available at regional hubs from time to time.

The way that the policy is used by practitioners may also fluctuate, just as two cardiac surgeons can look at the same patient and decide on different approaches. Not so typical, however, is when practitioners must take current or expected weather conditions into account along with the condition of their patients. This policy, criteria, or protocol includes a host of measures from flights and extended lodging and local ground transportation to easy access to timely prenatal appointments and testing, and if necessary, birth interventions and neonatal intensive care for the newborn. These measures are not "one size fits all"; the distance of the patient from the facility, her condition and anticipated needs, her fetus or neonate, the availability of equipment and service features of proposed facility, weather, flight schedules, and the presence or absence of roads and accommodations all enter into the decision-making process for healthcare givers when caring for rural Alaska Native maternity patients.

With this renewed understanding of the policy, we will now take a comparative look at how the policy has impacted Maniilaq's Iñupiat mothers over the years in the current chapter.

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<sup>22</sup> As a reminder, I use the terms policy, protocol, and transport system interchangeably in this thesis when referring to the Alaska Native Village Maternal Transport system.

### 5.1 Sampling results and scope

Twenty one (21) mothers were interviewed (Table 5.1). Of these, data are included from conversations with three mothers from the preliminary stage of the study, whom I interviewed in 2008. For the rest of the interviews, my research assistant and I participated in several lengthy one- to three-week visits.

**Table 5.1** Arctic Passages Population by ANVMT Policy (Birth) Era and Village

Birth Era <sup>a</sup>	Buckland	Kotzebue	Point Hope	Total
Pre-policy (<1983)	2	1	2	5
Early Policy (1983-1990)	2	2	3	7
Recent (1991-2011)	3	2	4	9
Total	7	5	9	21

**Source:** Compiled by author

<sup>a</sup> defined by year mother experienced first birth

We conducted the interviews between March 2009 and December 2011, with the research assistant involvement concentrated in Point Hope in the last several months of this time period. Mothers agreeing to participate were asked the year they first experienced birth to determine which policy era she would have experienced. There were a couple of mentions of twins, in which discussion was treated as one birth experience. Any cases where mothers' total birth experiences spanned more than one birth era are listed in their first experience category above, but all birth stories were included in results, with each particular birth categorized by year, where possible.<sup>23</sup> Only one instance of a pregnancy loss (first-trimester tubal pregnancy) was relayed in the course of the study. The reported care and experience was included for this case; all other

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<sup>23</sup> Some older mothers, in particular, became frustrated trying to remember all the years of their many children's delivery dates; in which case, the research assistant and I would attempt to calculate and get "as close" estimates as possible relative to reported years for other offspring.

experiences were live births with children living into childhood. There were a couple of special circumstances that involved loss of offspring as adult in an accident; and another with a cultural adoption mother describing the experience of being selected by a birth mother, along with relaying that mother's birth experience. This last case was included as a special example, but not in the participant population descriptions above. Unless demise of offspring was a part of infant mortality, it was not addressed in this study.

I visited during both summer and winter seasons; sometimes right as fish camp was ending outside of Buckland; during Fourth of July celebrations in Kotzebue, or just in time to join in some ice fishing on the Kotzebue Sound of the Chuckchi Sea. When in Buckland and Point Hope where there were no formal lodgings to stay in, the research assistant and I relied on community members to provide us shelter. The research assistant's extended family contacts were especially helpful for establishing rapport in the Point Hope community; and my key contacts in mostly Buckland and somewhat in Kotzebue enabled some success in those areas. I reciprocated their hospitality with honoraria, and helped with chores, cooking or cleaning when and where possible and appropriate. I also compensated with rides from the airport or to stores when some of the key contacts would arrive in Anchorage. My Kotzebue stays involved a combination of bed and breakfast lodging with stays as a guest at key contacts' homes.

## 5.2 Secondary birth and transport figures

Terms for inclusion in the study, as previously mentioned, include adult-aged mothers who had given birth and currently reside in one of the study MSA villages. Some of the items discussed with the Iñupiat mothers included: how many deliveries a woman had experienced, where, and under what circumstances? In other words, had she been transported to deliver? And if she had been transported, to where? More detail was shared as our discussion moved further into the informal interview process, but these were mostly the questions to begin with. To get an idea of where these stories fit into the community experiences for the different generations of women, and how the protocol is

involved in the birth practices and pathways (or 'birthways'), I consulted the available historic and current statistics on number and types i.e. transport situations for the area.

Dealing with northwest Alaska Maternal transport includes the following scenarios for Iñupiat women from the study villages (including some shown in Figure 2.3):

- 1) stay in their village to deliver (for Kotzebue, this option includes direct access to the MHC, without transport);
- 2) leave outlying village to deliver in Kotzebue;
- 3) leave outlying village or Kotzebue to deliver at ANMC in Anchorage;
- 4) occasionally, women will be directed to Providence Hospital in Anchorage if specialist care is needed; or the mother and family might have provisions or desire to deliver elsewhere;
- 5) on occasion, Point Hope mothers have also been known to deliver in Barrow, because of stronger connections to the Arctic Slope community;
- 6) and finally, outside state in other private or military hospitals, more common among older generation mothers.<sup>24</sup>

Scenarios one-three are the more common and the main focus of this study, with some attention paid to fourth and fifth options. Option 6 was only briefly mentioned among select few of the older generation participants. One should bear in mind that the mothers from these areas rarely have complete discretion as to where they will deliver. Rather, health practitioners make this determination based on perception of risk. The findings from this study uncover some intricate nuances involved in how women from different generations and communities express their feelings about being transported—and how their reactions can potentially have an influence in the way the policy is applied and services are utilized.

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<sup>24</sup> There were also reports of women returning to their home village in Alaska from out of state for the delivery services of a midwife in the village at the time. These accounts were mostly from pre-policy and early generation (older) women.

### 5.2.1 Arctic Passages statistical data sources

Secondary birth and infant mortality data for the MSA provided by the Alaska Bureau of Vital Statistics was broken down into categories based on mothers village of residence: (Kotzebue, Other Maniilaq region village, and Non-Maniilaq resident) and facility of birth:

- MHC in Kotzebue,
- ANMC in Anchorage,
- Providence Hospital in Anchorage, and
- Other (out-of-hospital births, other in- and out-of-state facilities)

The Bureau collects these data from birth certificates for public health planning and evaluation and to furnish the Centers for Disease Control relevant data on Alaskan maternal and infant health, for inclusion in nationwide statistics. Details such as mother's race, residence, and facility where delivery took place are gathered. Alaska State Vital Statistics use raw databases to compile and tabulate this information by combining a common borough analysis category with data for Point Hope, Alaska to create a unique Maniilaq region geographic category for use in the Arctic Passages study. When the data was tabulated on 03/02/2011, it was based on historical and 2009 figures, the very latest information available.

**Table 5.2** Maniilaq Service Area<sup>a</sup> Births to Alaska Native Mothers, Facility of Birth, and Northwest Village of Residence, 2009

Village of Residence	Maniilaq Health Center	Alaska Native Medical Center	Providence Hospital (Anchorage)	Other	Total
<b>Kotzebue</b>	20	53	1	3	77
<b>Other MSA</b>	56	92	8	5	161
<b>Non-MSA</b>	0	0	0	0	1
<b>Total</b>	77	145	9	8	239

**Source:** Data provided by Alaska Bureau of Vital Statistics; last updated 03/02/2011.

<sup>a</sup> The Maniilaq region includes all villages within the Northwest Arctic Borough, plus Point Hope.

This information provides background for the contextual information gathered from the ethnographic field interviews that appear later.

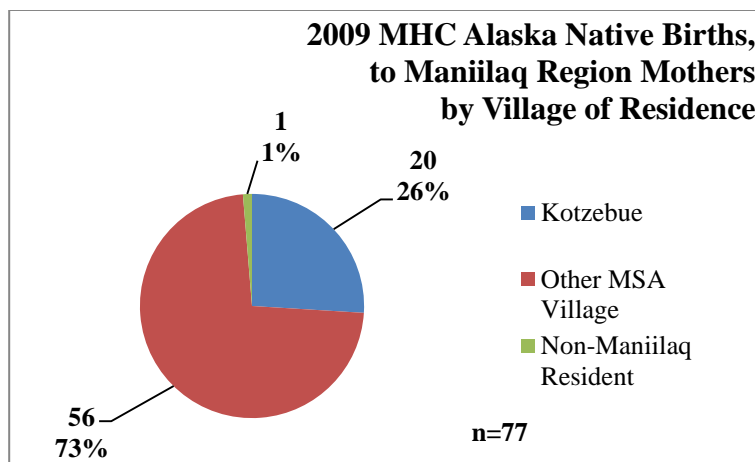
With the most recent data available, this snapshot of 2009 births occurring among MSA Alaska Native mothers helps paint a picture of where and how many births are currently taking place in the Maniilaq region. The *Alaska Maternal and Child Health Data Book 2011: Alaska Native Edition* uses this data, along with PRAMS<sup>25</sup> and Childhood Understanding Behaviors Survey (CUBS, conducted in Alaska) to present a profile of the situation of Alaska Native Maternal and Child Health. The separation of the Northwest Arctic region from the Arctic region in this report, however, makes it problematic to use the data in this thesis as Point Hope is an Arctic Slope community under a NANA region health care program. Also, because of the limitations of PRAMS i.e. data limited by what was asked on the birth certificate, the data from the Vital Statistics is presented in this thesis, as it pertains solely to the MSA area. Births by Non-MSA mothers rarely occur at MHC, and are, at any rate, not part of the study population. Hence, this data is included in historical data presented, but not discussed.

### *5.2.2 Maternal and infant health statistical records on Maniilaq region births*

Figures 5.1 and 5.2 represent 2009 data, graphically depicting the overall make-up of Maniilaq Service Area's most current birth records. I present these to show the utilization rates of the facilities and a breakdown of facility usage by Maniilaq area Alaska Native mothers. Figure 5.1 shows that the majority of Alaska Native births at MHC in Kotzebue that year were of Alaska Native mothers from MSA villages outside Kotzebue, i.e. one of the remaining 11 villages of the service area. These women would have had to transport to Kotzebue from the other villages to deliver there. Only 26% of the births that occurred at MHC in 2009 were to Alaska Native mothers from Kotzebue. Figure 5.2 shows the facilities utilized for 2009 Maniilaq region births for Alaska Native mothers from

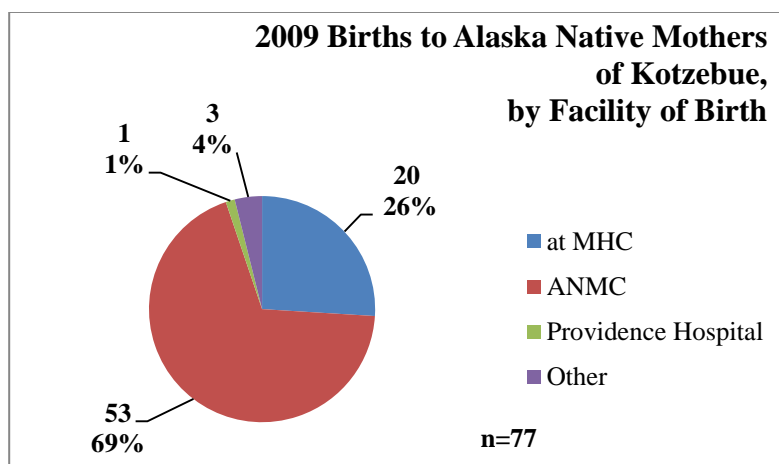
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<sup>25</sup> Pregnancy Risk Assessment Monitoring System



**Figure 5.1** Alaska Native Births to Maniilaq Region Mothers, at MHC, by Village, 2009

**Source:** Created by author. Data provided by Alaska Bureau of Vital Statistics, 03/02/2011.



**Figure 5.2** Births to Alaska Native Mothers of Kotzebue, by Facility, 2009

**Source:** Created by author. Data provided by Alaska Bureau of Vital Statistics, 03/02/2011.

Kotzebue. The majority of Kotzebue mothers (69%) were transported to ANMC in Anchorage to deliver that year. The 'Other' category shown in these figures represents births to Alaska Native mothers from the MSA occurring elsewhere besides MHC, ANMC, or Providence. This category could include out-of-hospital births in home community; another facility in the state, such as Samuel Simmonds Memorial Hospital



(SSMH) in Barrow; Alaska Regional Hospital in Anchorage; or an out of state location. The resources available to an expectant mother whether through self-pay, private, or public insurance; or tribal health coverage can often influence the ability of mothers to access services at these alternative delivery sites. The availability of alternative care such as local midwifery services can also make a difference in care sought. These differences surface in the ethnographic sketches discussed in chapter 6.

The 77 Alaska Native deliveries recorded for Kotzebue mothers account for about 32% of the total births (239) for the Maniilaq region births for 2009. The total MSA Alaska Native births for that year are above the average for the area given previous decade-long trends (Table 5.3). After a brief discussion of the part flight service might play in this trend, I will return to a more detailed description of utilization rates.

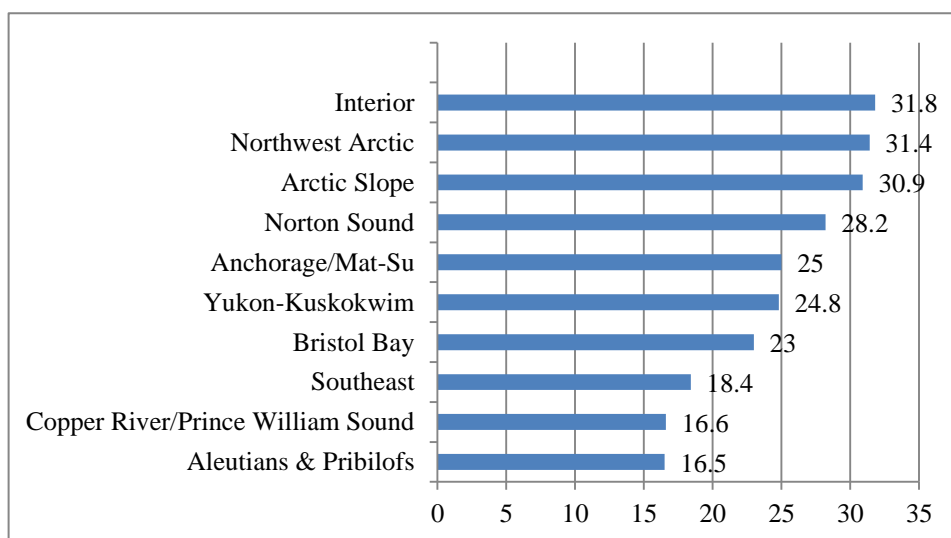
### *5.2.3 Maniilaq region flight services impact on ANVMT policy*

The flight arrangements of the commercial and bush airlines also factor into available options for delivering MSA mothers. For instance, Alaska Airlines serves the area with flights from Anchorage to Kotzebue with a stop in Nome. Flight service between Fairbanks and Kotzebue, however, is not available with this airline. Bush plane service is available on a frequent, but sporadic basis between and among the MSA villages, however Kotzebue, as the regional hub, is the only MSA village to have commercial airline service from the major airline. A mother from any of the MSA villages outside Kotzebue set to deliver in Anchorage must first board a bush plane and then catch an Alaska Airline flight to her destination. She will make the return legs of travel with her baby after the birth. Since the Anchorage flight is the only one to an urban area, it makes sense that most expectant MSA mothers not delivering in the MSA go to Anchorage to deliver as opposed to Fairbanks. As of June 2013, costs of the round trip bush flights from smaller villages to Kotzebue ran anywhere from \$260 to \$540 in the summer months; and even more in the winter months. As with any other airline ticket, the closer to travel date tickets are purchased, the more expensive. Roundtrip flights from Anchorage are typically around \$300 in the summer, but flights can get booked quickly and costs go up during periods of high-travel which include: before school season and in

October because so many from total villages travel to attend the Alaska Federation of Natives when it is held in Anchorage, or for Christmas shopping and travel. Finally, as mentioned in the introductory remarks of the thesis, fog; wind; and ice or snow storms can have a great bearing on whether a flight arrives or leaves as scheduled. All told, these flight parameters can be a determining factor in whether mothers (or any other patients) get to the care they need in a timely manner. These obstacles to timely travel obviously enter into the planned early departure date as part of the policy—sometimes as early as four to six weeks prior to due date for the mothers.

#### 5.2.4 Maniilaq region facility usage trends, historical and current data

In Table 5.3, I present the data that shows trends of MSA maternal care utilization statistics over the past decades, looking at the periods: 1977-79; 1980-89; 1990-99; and 2000-09. These period categories reflect a natural decade-long period that helps deal with disclosure issues that would be otherwise present and statistically irrelevant for shorter periods. I have also included some data which first became available from the



**Figure 5.3** Crude Birth Rate<sup>a</sup> by Tribal Health Region Alaska, 2006-2010

<sup>a</sup> per 1,000 population

**Source:** Statewide Data Crude Birthrate, Alaska Native Epidemiology Center  
<http://www.anthctoday.org/epicenter/>

birth certificates in the early years: e.g. residence of mother, though these data were not available at the beginning of the 1970s, and as such are listed only for 1977-79. Similar eras are used in later management of ethnographic data, as policy or birth eras for the different generations of participating mothers surrounding these phases. Row and column percentages by decade or year grouping are included in this table for comparison. The comparisons presented figured within each corresponding decade category.

- Alaska Native birth trends for MSA residents at MHC in Kotzebue

From late 1970s to the 1980s decade there was an overall 65% birth rate drop from an average of about 568 MSA births per year to about 194 MSA births per year; followed by a steady rate for the next two decades. After the 1970s, Maniilaq region mothers showed increasing ANMC utilization rates as the Native hospital became their main delivery alternative.

- Alaska Native birth trends for MSA residents at ANMC in Anchorage

ANMC went from being the location of about 16% of all MSA births, to the site of 54.5% of MSA births from the late 1970s to the 2000-09 decade. While over two-thirds (68.3%) of MSA births in the late 1970s took place at MHC; this proportion dropped to about two-fifths (39.6%) of the MSA births at MCH in the 2000-09 decade.

Deliveries by mothers in Kotzebue accounted for about one-third of these ANMC deliveries the first decade of the 2000s; and deliveries by mothers from Other MSA Villages accounted for the remaining majority with 68.2% of births at the tribal health facility. Kotzebue mothers delivering in Kotzebue has steadily decreased over the last several decades from 42.4% in the late 1970s, to 41.7%, then 40.7%, and finally 33.0% from the 1980s, 1990s, and 2000-09 periods, respectively.

ANMC records indicate that the number one reason for a hospital stay at their facility is for deliveries (Indian Health Service 2007). With some non-Native mothers delivering babies with Alaska Native fathers included in this assessment, there are also other areas of the state (Yukon-Kuskokwim, e.g.) that account for large numbers of deliveries at ANMC. Still, the NANA region is known for one of the highest birth rates

among the state tribal regions (Figure 5.3). It should also be noted that Interior, Norton Sound, and Arctic Slope expectant mothers are transported to either urban Interior Alaska Native hospital or their own regional hub facility. These area maternal health care protocols are not as likely to use ANMC for deliveries as those from Northwest Arctic. Alaska Native Health Associations and their employee coverage can afford the expectant mothers among their staff the choice of going to a non-tribal facility to birth. Another possible scenario not reflected in these statistics is the case in which a mother delivered at ANMC from non-Kotzebue MSA villages.

Table 5.3 shows that while the portion of MSA deliveries by mothers from other MSA villages had gradually risen from 56% during the 1977-79 periods to 56.8% in the 1980s, and then 57.8% in the 1990s—a final seven percentage point rise to 65% was shown for the 2000-09 decade. These births represent mothers from the remaining 11 MSA villages outside of Kotzebue, including Point Hope.

- Alaska Native birth trends for MSA deliveries at Providence in Anchorage

No immediately notable trends emerge from the inspection of the historical figures on Providence births for the MSA Alaska Native Mothers in Table 5.3. There is, however, a consistently larger portion of Kotzebue mothers delivering at Providence than Other MSA Village mothers, and this figure doubled for Kotzebue mothers from the 1980s decade to the 1990s decade, and then dropped back to almost 1980 levels (23 deliveries at Providence Hospital in Anchorage) during the 2000-09 decade. I speculate that this might be a reflection of the increased abilities of the ANMC to handle neonatal intensive care over the years. Previously, when practitioners would suspect a woman might experience birth-related difficulties beyond what ANMC could handle, they would transfer her to Providence for delivery. The capabilities of ANMC to handle these situations, as mentioned, have increased, and so presumably, there might be less of a need to transfer. Some mothers with private insurance could also be among these numbers. Kotzebue mothers are more likely, with the larger number of employers there offering company-supplied health coverage. Ironically, Maniilaq is one of the largest employers in the area

**Table 5.3** Historical Alaska Native Maternal Care Facility Usage, Maniilaq Region<sup>a</sup> Village Mothers by Policy Decade or Years

Decade or Years↓	Village of Mother	% of tot↓	MCH	% of tot →	% of tot↓	ANMC	% of tot →	Providence Hospital	% of tot →	OTHER	% of tot →	TOT
2000-2009	OTZ	33.0	54	40.4	31.8	336	53.5	23	3.7	15	2.4	628
	O MSA V	65.1	501	38.6	68.2	722	55.6	30	2.3	46	3.5	1,299
	N-M	1.8	14	100.	0	0	0	0	0	0	0	14
	<b>Total</b>		<b>769</b>	<b>39.6</b>		<b>1,058</b>	<b>54.5</b>	<b>53</b>	<b>2.7</b>	<b>61</b>	<b>3.1</b>	<b>1,943</b>
1990-1999	OTZ	40.7	435	62.8	32.4	199	28.7	38	5.5	21	3.0	693
	O MSA V	57.8	618	53.3	67.6	415	35.8	36	3.1	91	7.8	1,160
	N-M	1.5	16	88.9	0	0	0	0	0	2	11.1	18
	<b>Total</b>		<b>1,069</b>	<b>57.1</b>		<b>614</b>	<b>32.8</b>	<b>74</b>	<b>4.0</b>	<b>114</b>	<b>6.1</b>	<b>1,871</b>
1980-1989	OTZ	41.7	533	71.2	39.4	163	21.8	19	2.5	34	4.5	729
	O MSA V	56.8	726	60.0	60.6	251	20.7	13	1.1	220	18.2	1,210
	N-M	1.5	19	67.9	0.0	0	0	0	0	9	32.1	28
	<b>Total</b>		<b>1,278</b>	<b>64.3</b>		<b>414</b>	<b>20.8</b>	<b>32</b>	<b>1.6</b>	<b>263</b>	<b>13.2</b>	<b>1,987</b>
1977-1979*	OTZ	42.4	494	73.6	44.0	122	18.9	8	1.2	20	3.1	644
	O MSA V	56.0	653	63.2	56.0	155	15.0	3	0.3	223	21.6	1034
	N-M	1.6	19	67.9	0	0	0	0	0	9	32.1	28
	<b>Total</b>		<b>1,166</b>	<b>68.3</b>		<b>277</b>	<b>16.2</b>	<b>11</b>	<b>0.6</b>	<b>252</b>	<b>14.8</b>	<b>1,706</b>

OTZ: Village of Kotzebue resident; O MSA V: Other MSA Village resident; N-M: Non-Maniilaq region village resident

**Source:** Data provided by Alaska Bureau of Vital Statistics; last updated 03/02/2011.

<sup>a</sup>The Maniilaq region includes all villages within the Northwest Arctic Borough, plus Point Hope.

\*only 3-year data available for pre-policy era

(Maniilaq Health Association 2003), and their employee benefits enable their staff to seek outside-MSA community maternal care, if desired.<sup>26</sup>

Providence hospital reports, by far, the largest number overall births (all races) in the state (Figures 5.4). The breakdown of deliveries by practitioner in 2006 is very similar to today's figures (Alaska Bureau of Vital Statistics 2009). CNMs assist most all deliveries at ANMC (59.3% in 2006), while mostly medical doctors attend Providence deliveries (91.2% in 2006). Non-nurse midwives accounted for an extremely small percentage (2.3%) of total births at Providence in 2006. This last noted statistic is likely a reflection of the presence of a nearby freestanding birthing center staffed with midwives with hospital privileges. That same year, Maniilaq reported no CNM-assisted deliveries, and 20 out of 75 births attended by non-nurse midwives. The Alaska Bureau of Vital Statistics lists the 'Other' category as practitioners such as family physicians and osteopaths. Providence had only one such practitioner delivering babies that year, while ANMC reported 10 births assisted by these 'other' practitioners.

- Practitioners and caesarean-section rates

The statistics in Figure 5.4 reflect the outcomes for Maniilaq Health Center and two Anchorage Hospitals for the latest available details on total births. Providence Hospital dominates as the state's top birthing site, yet only 3.8% of total Maniilaq Area Alaska Native births occurred there in 2009. While ANMC figures presented alongside the Providence are for total births, as well, because of the nature of the requirements to access care at this facility, they reflect births to Alaska Native mothers, non-Native mothers delivering babies with Alaska Native fathers, or births to other Native American parents.

ANMC, as previously mentioned, reports the lowest caesarean-section rates of all Indian Health Service Hospitals (Indian Health Service 2007) nationwide on a regular basis, recording 13.7% in 2006. The maternity care staff at ANMC, mostly nurse-

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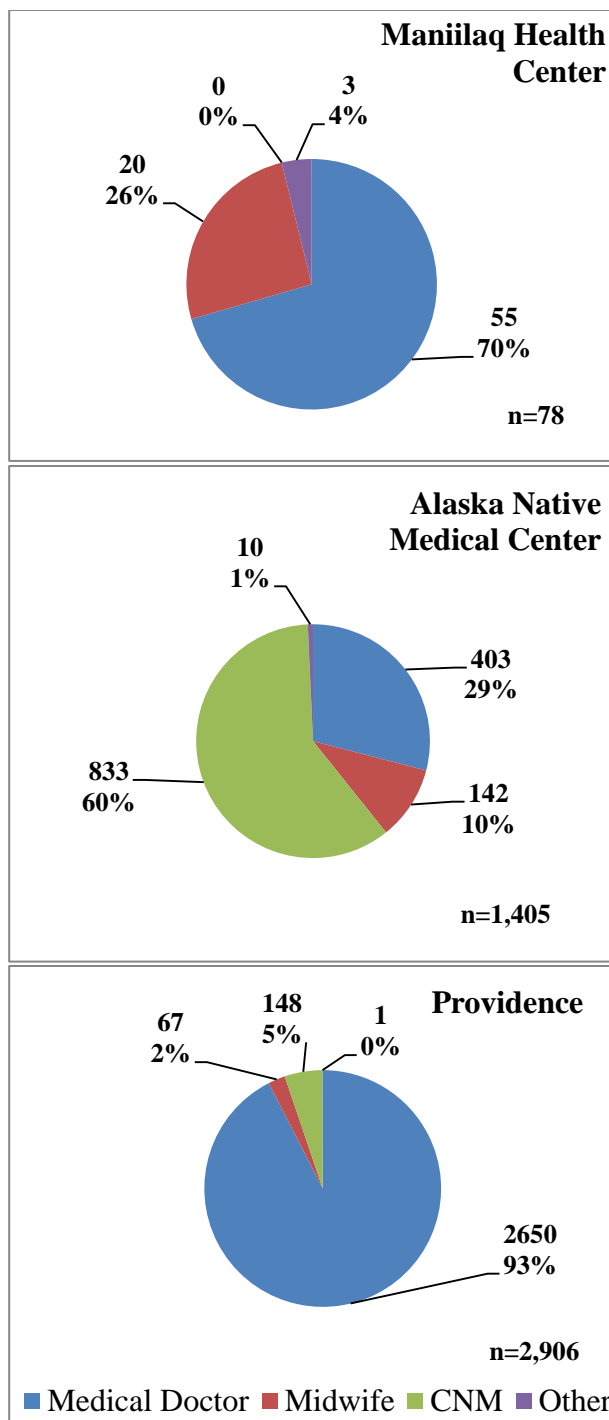
<sup>26</sup> While in Kotzebue, an insurance representative struck up a conversation with me in regard to how costly it was for his company and the employers to transport women to deliver. He made it sound as if it was a consumer-driven trend, but he had only hearsay to offer for evidence. Similar notions were expressed by a Maniilaq social worker.

midwives, is not qualified to perform cesareans, and the features of their care tends to fall more along the lines of the midwifery model of care—which emphasizes less intervention. Providence Hospital, with a higher percentage of medical doctors on staff, does not represent the highest caesarean-section rate in the state, reporting only slightly above national averages (32%) for 2006, at 33.1%. With no such services available at Maniilaq Health Center, caesarean-section rates are not reported. For comparison, Bartlett Regional Hospital in Juneau reported the highest caesarean-section rate (40%) in the state in 2006. The percentage of midwives employed there is also lower, at 3%. According to the literature, a logical relationship exists between number and type of maternity care staff and rates of cesarean deliveries at the respective facilities.

I graphically present the statistics for Alaska Native births from Kotzebue and the remainder of the MSA villages in Figure 5.4. This figure readily shows that the northwest mothers from outside Kotzebue flew to ANMC in 2000-09 to deliver more frequently than any other period on record; and comparatively more so than Kotzebue mothers. Kotzebue mothers' usage of ANMC for deliveries, however, is also on the rise.

- Alaska Native birth trends for MSA deliveries at 'Other' facilities or places

Table 5.3 shows that the proportion of births taking place at 'Other' facilities by Other MSA Village mothers went from 21.6% (223 of 1,034 births) in the late 1970s to 3.5% (46 out of 1,299) in the 2000-09 decade. Overall deliveries by MSA village mothers at 'Other' locations went from about 1 in 6 births to nearly 1 in 17 births from the late 1970s to the 2000-09 decade. MSA mothers from villages other than Kotzebue delivered the overwhelming majority of the births at these 'Other' locations for each time period from the 1970s (88.5%) to the 2000-09 period (75.4%), even though the last decade births at 'Other' locations by the non-Kotzebue MSA mothers only accounts for 46 births.



**Figure 5.4** Total Births (All Races), by Practitioner, MHC and Anchorage Facilities, 2006

**Source:** Coalition for Improving Maternity Services website from Alaska Bureau of Vital Statistics, last updated 90/22/2008.

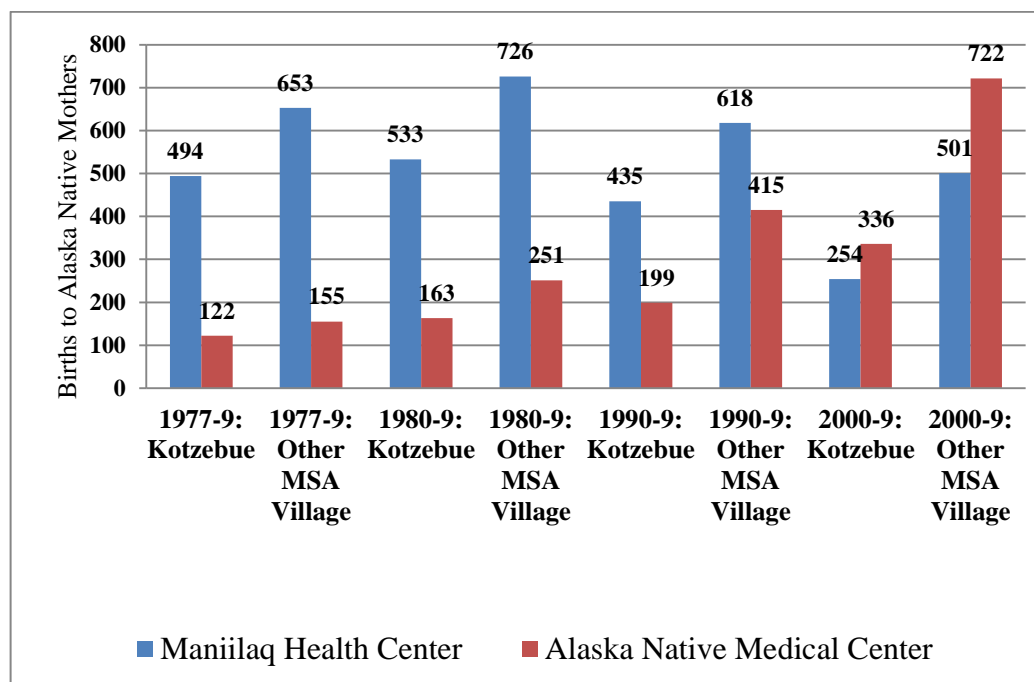


These 'Other' locations could be representative of births occurring in outside villages. While the Arctic Passages data does not comprehensively cover the entire Maniilaq Service Area's 12 villages to acquire such data, there was talk of births taking place in homes and in clinics. The "off-the-grid" fashion of these births makes it difficult to determine how many of these situations exist and where they are occurring. Looking at the 'Other' category of facilities for the northwest villages, however, as it shows a pattern of sharp decline in this category from the late 1970s to 2000-09 decade—could be a view of loss of local midwifery services in the area. I cover this aspect of practitioner availability on the Arctic Passages communities in the final discussion (chapter 6).

One can also see that local mothers used Kotzebue's own Maniilaq Health Center for deliveries far more frequently in earlier periods, dropping to almost one-third of original usage between the 1970s and more current 2000-09 period. While the 'Other MSA Villages' category comprises 11 villages, Kotzebue's much larger population offsets any possible "weighting" of the data. Analysts should bear in mind, as well, that mothers from these outside villages actually travel to Kotzebue to deliver and receive prenatal care; whereas the Kotzebue mothers, obviously do not. In a meeting with medical staff at MHC, a family practitioner who delivered babies wondered why the local women did not utilize the local facility, and I am not certain why that is, either. I do not intend to answer that question with this study, per se. Again, I strongly question the insinuation by this practitioner and others that a mother is the ultimate authority—even in the situation of the delivery of her own baby—where she will deliver. In chapter 6, I discuss some surrounding utilization issues that came up during conversations with participants.

### 5.3 Delivery and infant mortality figures

Intervention rates during birth i.e. inductions and cesarean sections, have become the 'gold standard' of biomedical maternal care. In previous chapters, I have discussed how this is more of a function of changes in practices and attitudes towards risks rather than changes in women's abilities to birth naturally. Earlier in history among non-indigenous groups, and more recently among indigenous groups, the biomedical model of birth has



**Figure 5.5** Alaska Native Births by Facility, Village Residence, Years or Decade

**Source:** Compiled by author with data provided by Alaska Bureau of Vital Statistics; last updated 03/02/2011.

<sup>a</sup>The Maniilaq region includes all villages within the Northwest Arctic Borough, plus Point Hope.

\*only 3-year data available for pre-policy era

become the norm. Health professionals usually present rates of intervention and cesarean sections as a reflection of what level of risks encountered among certain populations and areas of the country and world; yet, these figures are truly more of a reflection of prevailing practices (see DeClercq et al. (2006) and Wagner (2006)). I will not dwell on the various explanations offered for this upward trend, which may include women's desire for a scheduled delivery, doctor and hospital greed, or more obese and diabetic women delivering babies. I will simply state that the high level of this birth intervention is a harbinger of stressed maternal care situations.

### 5.3.1 Maniilaq Service Area 'type of delivery' statistics

The Alaska Native Medical Center in Anchorage has the services, equipment and personnel needed to perform cesarean sections. They also house a neonatal intensive care

unit. Some higher level care and more beds are available at nearby non-Native Providence Hospital<sup>27</sup> in Anchorage, so some of the maternal patients are transferred or directly sent there for more intensive maternal or neonatal care. Among Indian Health Service hospitals across the state and country, ANMC reports the lowest cesarean section rates. Regional facilities like MHC in Kotzebue cannot typically offer such services, as they lack personnel and equipment i.e. anesthesiologists and operating rooms. Therefore, MHC's cesarean rate is always zero. With ANMC's flank of Certified Nurse Midwives attending almost 60% of all deliveries in 2006 (Alaska Bureau of Vital Statistics 2009), they are able to keep their cesarean sections well below Indian Health, National, and state averages. Despite all the high-risk transports, fewer actual births necessitated cesarean delivery at ANMC. There are other interventions such as forceps, episiotomies, rupture of membranes (see Appendix D). The physicians at MHC can perform some of these less intensive practices, but Pitocin-drip induction and the common companion epidural are not available.

Table 5.4 shows the 2009 number of cesarean deliveries to Iñupiat Maniilaq women transported for birth, by facility. That same year, 'Other' facilities reported no cesarean sections for Alaska Native women from the Arctic Passages communities. I present the

**Table 5.4** Maniilaq Region<sup>a</sup> Births by Village, Facility, and Delivery By Cesarean Section to Alaska Native Mothers, 2009

Village of Residence	Alaska Native Medical Center	Providence Hospital (Anchorage)	Total C-sections	Total Births	C-sections/ Births (%)
Kotzebue	6	1	7	77	9.0
Other MSA	12	1	13	161	8.1
<b>Total</b>	18	2	20	—	—

Source: Data provided by Alaska Bureau of Vital Statistics; last updated 03/02/2011.

<sup>a</sup>The Maniilaq region includes all villages within the Northwest Arctic Borough, plus Point Hope.

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<sup>27</sup> Alaska Regional is another private non-Native hospital that services Anchorage. Statistics are not available for Alaska Natives' use of these facilities, except for inclusion in the 'Other' facilities category.

same cesarean section statistics for the 2000-2009 and 1990-1999 decades for the area in Table 5.5. I have already described the tendency for most Maniilaq region mothers to deliver at ANMC, even by cesarean section. This explains the lower figures from

**Table 5.5** Maniilaq Region<sup>a</sup> Births to Alaska Native Mothers by Village Residence, Facility, and Method, Cesarean Section, By Decade

Decade	Village of Mother	ANMC	Providence Hospital	OTHER	TOTAL C-sections	Total Births	C-section/total births (%)*
2000-09	Kotzebue	32	7	2	41	628	6.5
	Other MSA Village	58	14	2	74	1,299	5.7
	<b>Total</b>	90	21	4	115	–	–
1990-99	Kotzebue	22	11	0	33	693	4.7
	Other MSA Village	33	13	4	50	1,160	3.8
	<b>Total</b>	55	24	4	83	–	–

**Source:** Compiled by Author with data from the Alaska Bureau of Vital Statistics; last updated 03/02/2011.

<sup>a</sup>The Maniilaq region includes all villages within the Northwest Arctic Borough, plus Point Hope.

\*only 3-year data available for pre-policy era

Providence Hospital. The percentage of MSA overall births involving Providence transfers from ANMC or directly from the villages were also comparatively small; therefore, it is not surprising the number of cesareans performed at Providence on mothers from the MSA villages was also comparatively small. The 'Other' facilities category listed here most likely represents another Alaska private hospital within the state, or elsewhere besides Providence in the Anchorage vicinity. In this instance therefore, it is safe to assume that the 'Other' category of facilities does not include births in MSA communities.

### 5.3.2 *Maniilaq Service Area infant mortality statistics*

Infant mortality figures are another group of statistics that health professionals frequently refer to when gauging maternity and infant care. Saving mother and infant lives is a primary goal behind transporting expectant mothers to hospitals to deliver. The small populations in the villages, coupled with relatively small number of babies born each year in each village cause disclosure issues when reporting the small number of infant deaths per year. Therefore, reporting agencies use a three-year-average to report these rare instances by regions.

Alaska Native infant mortality rates, per se, as mentioned in introductory chapters, do not cause alarm for this area. Compared to other ethnic/racial groups, the overall infant mortality rates are similar. However, when broken down into separate categories of neonatal mortality, i.e. mortality within first 28 days of life, and post neonatal mortality, i.e., within 28 days to 1 year of life, the figures for Alaska Natives compare as somewhat higher than other ethnic/racial groups in average periodic trend analysis. The *State of the World's Indigenous Peoples'* chapter on health (Cunningham 2009) lists many possible reasons for this disparity, including racism. Racism has been identified as a key issue in health care disparity experience by Indigenous Australians (Durey and Thompson 2012). These authors recommend anti-racism policies aimed at reducing the power inequalities between privileged and oppressed groups, along with a critical analysis of those in power. This relates to the authoritative power of the biomedical system of care over a more autonomous system that could include local knowledge and practitioners in maternal health care in the study villages.

In the Arctic Passages study, I do not take this task on; rather I offer a look at issues experienced by Alaska Native mothers from these communities in a later discussion. I present infant mortality figures as available through the Alaska Bureau of Vital Statistics. A breakdown of infant death type i.e. neonatal and postneonatal to Maniilaq regions mothers appears in Table 5.6. I present also total infant deaths by village residence and facility of birth reported by birth era periods used by Arctic Passages (Table 5.7). These figures reflect infant deaths to Native and Non-Native mothers.

Table 5.6 shows that infant deaths in the MSA peaked during the 1980-1989 decade, with higher numbers in both neonatal and postneonatal categories. Since the "flying-out" policy began, according to Maniilaq staff, in 1983, some of these neonatal deaths during this period occurred after the policy began operation in the area. These statistics must be interpreted with care, however, as they represent All mothers, not just Alaska Native mothers, and the 10-year period does not allow for annual comparisons. That is, we do not know if these deaths were concentrated in one particular year or another during the 10-year span.

**Table 5.6** Infant Deaths by Type and Era, to Maniilaq Region Mothers

	1977-1979	1980-1989	1990-1999	2000-2009
<b>Neonatal</b>	16	19	13	6
<b>Postneonatal</b>	23	24	13	13
<b>Total</b>	39	43	26	19

**Source:** Data provided by Alaska Bureau of Vital Statistics; last updated 03/02/2011.

<sup>a</sup>The Maniilaq region includes all villages within the Northwest Arctic Borough , plus Point Hope.

In addition, the 1977-79 figures represent a three-year period, where other periods represent a 10-year span. When looking at the number of total infant deaths in this late 1970s era, it is very telling that only four less occurred in that period than the following 10-year period. The large portion of Alaska Native population and the usual practice of combining years when looking at small-number statistics make these the "best available" to look at this figure for the MSA area.

This breakdown is also useful to compare neonatal to postneonatal figures, as the postneonatal deaths appear to be the "stubborn" statistic among Alaska Native results. When comparing overall infant mortality rates for the areas by decades, we see lower numbers from the 1980s to first decade of the 2000s. Comparing the components of that dip in overall numbers, we can also see that change comes from a drop in neonatal deaths, while postneonatal figures remained the same. Health care officials are hard-

pressed to determine what these statistics mean, yet the involved agencies continue to design programs that attempt to forestall any increases.

Table 5.7 shows Native and Non-Native infant deaths, comparing figures across eras, reflecting relatively little change between the late 1970s and 1980-89 decade. Again, keeping in mind that the late 1970s era only encompasses a 3- year period, we can actually interpret this identical figure shown for Maniilaq and ANMC infant-death figures for the 1980-89 period, as a decline of sorts. ANMC figures for MSA infant deaths, at zero in the 1990-99 decade, are consistently lower than Providence Hospital

**Table 5.7** Number of Maniilaq Infant Deaths, Village Residence, Facility of Birth to Alaska Native and Non-Native Mothers, by Era

1977-1979	Kotzebue	2	1	2	3	8
	Other MSA Village	7	3	6	15	31
	Total	9	4	8	18	39
1980-1989	Kotzebue	2	2	3	3	10
	Other MSA Village	7	3	7	16	33
	Total	9	5	10	19	43
1990-1999	Kotzebue	2	0	3	3	8
	Other MSA Village	1	0	7	10	18
	Total	3	0	10	13	26
2000-2009	Kotzebue	2	0	1	3	6
	Other MSA Village	3	2	2	9	16
	Total	5	2	3	12	22

**Source:** Data provided by Alaska Bureau of Vital Statistics; last updated 03/02/2011.

<sup>a</sup>The Maniilaq region includes all villages within the Northwest Arctic Borough , plus Point Hope.

\*only 3-year data available for pre-policy era

figures. MHC infant deaths lowered substantially during the 1990-99 era, but then climbed slightly to five during the 2000-2009 decade. Providence Hospital reported identical MSA infant death figures from the 1980s to the 1990s, and then their lowest figures during 2000-2009. While these variations in infant deaths recorded for MSA births at these hospitals are somewhat helpful in evaluating maternal and infant care, one must be careful when inferring causal or even direct relationships. For instance, births requiring care that was originally only available at Providence tended to be very high-risk births to begin with. By very definition, high-risk involves a greater the likelihood of problems leading to death. Health officials can understand, then, why larger numbers of infant deaths may be reported at the hospital most likely to have problem patients on their rosters.

One could also look at these statistics and surmise that the reduction in Maniilaq infant deaths from late 1970s to 1990s stemmed from transporting problem births out of the area to higher-care facilities. When taking this stance, however, it would be difficult to explain the increase from the 1990s to 2000-10 periods. Analysts should also take into account that these deaths are not broken down by age of infant. Figures in Table 5.8 reflect neonatal and postneonatal figures combined, so we cannot discern from this table

**Table 5.8** Number of Maniilaq Infant Deaths to ANVMT Mothers, by Village, and Era

<b>Village of Residence</b>	<b>1977-1979</b>	<b>1980-1989</b>	<b>1990-1999</b>	<b>2000-2009</b>
<b>Kotzebue</b>	7	9	8	5
<b>Other Maniilaq Region Village</b>	30	32	18	16
<b>Total</b>	37	41	26	21

**Source:** Data provided by Alaska Bureau of Vital Statistics; last updated 03/02/2011.

<sup>a</sup>The Maniilaq region includes all villages within the Northwest Arctic Borough , plus Point Hope.

\*only 3-year data available for pre-policy era

whether deaths occurred closer to birth or after the infants were aged 28-days. It is difficult, then, to associate a common factor as a cause for the differences in hospital resulting deaths, as the baby could have just as likely gone home and later died, or stayed



in a neonatal intensive care unit before expiring before or after 28 days of life. Table 5.9 shows the leading causes of infant deaths for the Maniilaq Region Births by era. With 'Other' as the overwhelmingly most common reason, we cannot draw many conclusions from this information at first glance. Still, if we concentrate on the definitive birth-related cause of death i.e. birth asphyxia, the table does show a steady decline across decades in those numbers. It is unclear at what age infant death like pneumonia and cardiomyopathy occurred. Sudden infant death syndrome (SIDS), however, is most likely to have occurred during the postneonatal period of the infants lives. Many programs, studies, and agencies focus on improving this figure among US indigenous populations, as SIDS is widely held as the most common reason for postneonatal infant

**Table 5.9** Leading Causes of Neonatal Infant Death of Maniilaq Region<sup>a</sup> Births, by Era

<b>Leading Cause of Death</b>	<b>1977-1979</b>	<b>1980-1989</b>	<b>1990-1999</b>	<b>2000-2009</b>
<b>Pneumonia</b>	5	7	3	**
<b>Sudden Infant Death Syndrome</b>	5	7	6	**
<b>Congenital Malformations, deformations, and chromosomal abnormalities</b>	4	5	3	**
<b>Birth Asphyxia</b>	**	3	**	**
<b>Cardiomyopathy</b>	**	3	**	**
<b>Accidents (unintentional injuries)</b>	**	**	**	6
<b>Other</b>	20	17	12	10
<b>Total</b>	39	43	26	22

\*\* Numbers of Leading Causes of Death with fewer than 3 are not reported

**Source:** Data provided by Alaska Bureau of Vital Statistics; last updated 03/02/2011.

<sup>a</sup>The Maniilaq region includes all villages within the Northwest Arctic Borough , plus Point Hope.

death. In Non-Native populations, public health officials have gained some success with the "Back to sleep"<sup>28</sup> program. Similar efforts are underway within the Indian Health agencies, including ANTHC regional hospitals and clinics. The 2000-09 statistics showing trace (less than 3) deaths would indicate that MSA families have also experienced progress in lowering SIDS during last decade on record. I will discuss more on this possible connection, following a presentation of the ethnographic results and implications.

I conclude this coverage of relevant MSA maternal and infant vital statistics, as I begin chapter 6, presenting the results of the ethnographic fieldwork and discuss implications of the results.

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<sup>28</sup> 'Back to sleep' programs are public health campaigns geared toward educating parents of newborns about the research findings that link SIDS rates to sleep– positioning of babies; in which lower SIDS rates are associated with babies being consistently laid down to sleep on their backs.



## Chapter 6 Iñupiat Mothers Navigating the ANVMT System: Today and Yesterday

I begin this final chapter by revisiting the definition of the ANVMT transport policy and a brief comparison of evolution of the ANVMT policy across two tribal health service areas. Then, using the four sets of question sets from the introduction, I outline the results of the ethnographic findings from this study. I discuss the Iñupiat mothers' overall experiences with the maternal transport policy, detail the themes that resulted from my ethnographic analysis, and then cover the main points of maternal identity work that the mothers themselves expressed as I answer the second set of questions raised at the onset of the thesis. I explain how these mothers perceive risk assessment in application to their maternal care, as they worked their way through the process of delivering under these circumstances.

Finally, I conclude with a discussion of the communities and presence of liminal *communitas* as it operates differently for women from each of these villages. Resulting matrices reveal an interconnectedness of the experiences of these women, of all ages, to the nature of their communities—and how they influence and are influenced by the prevailing epistemologies concerning maternal care in their area.

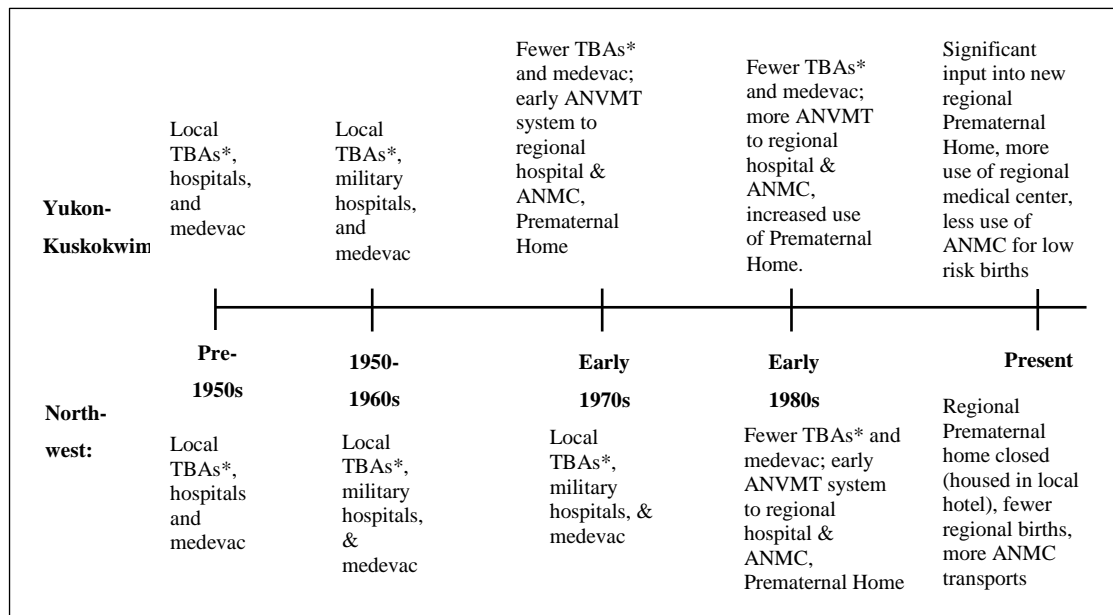
While only the MSA is addressed here, the ANMVT protocol applies to the tribal health service areas of the entire state of Alaska<sup>29</sup>. As discussed, varying weather conditions, availability of flight services, number and level of medical services and equipment, all factor in to how the policy plays out in any given area. As an example of

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<sup>29</sup> From <http://www.ihs.gov/alaska/> website:

The Alaska Area Indian Health Service (IHS) works in conjunction with Alaska Native Tribes and Tribal Organizations (T/TO) to provide comprehensive health services to 141,921 Alaska Natives (Eskimos, Aleuts, and Indians). Approximately 99% of the Alaska Area budget is allocated to T/TOs who operate under the authority of Indian Self-Determination and Education Assistance Act, Public Law 93-638, as amended. The Alaska Area maintains 14 Title I contracts with Alaska tribes and tribal organizations, and negotiates one Title V compact with 25 separate tribal funding agreements each year. The Alaska Tribal Health Compact is a comprehensive system of health care that serves all 228 federally recognized tribes in Alaska. IHS-funded, tribally-managed hospitals are located in Anchorage, Barrow, Bethel, Dillingham, Kotzebue, Nome and Sitka. The Indian Health Service still holds title to six tribally operated hospitals and three tribally operated health centers in Alaska, and is responsible for their maintenance.

how these scenarios might differ from area to area, I show a comparative timeline of ANVMT policy evolution in Kotzebue and Bethel in Figure 6.1.



**Figure 6.1** Timeline Comparing Maternal Care Policy Features in Yukon-Kuskokwim Service Area (Bethel, AK) and MSA (Kotzebue, AK), Decades and Present.

\*TBAs: Traditional Birthing Attendants: locally-trained attendants operating within the community

**Source:** Information from various Maniilaq hospital and management personnel 2008-2011, literature review and Yukon-Kuskokwim newsletter, by author.

Note: Accurate as possible given lack of published information concerning appearance of certain features.

While weather and flight availability are certainly factors beyond control of parameters addressed by the policy, as shown previously in chapter 2's Figure 2.1; investment in prematernal arrangements stands out as a discernible difference in how the policy evolved in Bethel's Yukon-Kuskokwim versus Kotzebue's Maniilaq Service Area. Thus, while the operation of authoritative entities, i.e. IHS, ANTHC, applies equally across Alaska Native tribal health areas; geography, weather, and the priorities of investment into maternal services and facilities may differ from area to area and therefore have caused differences in implementation among healthcare initiatives.

We should also bear in mind that all mothers from distant Alaska Native villages are subject to their village's own brand of application of a maternal transport protocol. Each

village has a varying childbearing population and level of resources. How the ANVMT protocol performs in these villages depends on structural features i.e. the presence of a health care facility, like in Kotzebue, along with the number and level of practitioners. Community features impacting the operation of the protocol also include presence of strong community leadership able and committed to participating in their local health care. Availability of alternative care like local midwifery for maternity care patients in their community desiring it, also ultimately depends on the presence of such practitioners.

Certified Nurse Midwives, like those employed at ANMC, have had appointments at Maniilaq, and there have been obstetricians employed there, as well. However, I have not found evidence of local midwives ever having been officially hired by any of the communities. To protect the identity of these "off the grid" caregivers, I present any mention of local midwifery care in the following passages in the most general sense. With this understanding, I continue with a look into how mothers of three MSA communities described their own experiences navigating the transport system as it operated in their respective villages of residence.

#### 6.1 Arctic Passage mothers and the ANVMT policy

One of the main goals of this study is to find out how the mothers most affected by the maternal transport felt about the policy as it operated in their village. In answer to the first question I begin with a description of how some mothers from each of the Arctic Passages communities felt about the special mode of delivery in their area. A description of Buckland, Kotzebue, and Point Hope mothers' impressions from their experiences with the maternal transport policy is followed by community leaders' reactions to the operation of the ANVMT policy in their communities. As all mothers from the ages of 19 to 75 years old were included, one could hardly expect that they were all expecting at the same time. Once revisions were made to the study, a more accurate beginning to the first question would have been: "How *did* expectant women...." For the sake of conformity, however, I have listed the question as originally posed:

**QUESTION SET 1:** How do expectant women, families, and community members perceive the ANVMT Policy today? Has the ANVMT become a new tradition?

Maniilaq area women interviewed for this study, overall, associated the involvement with the medical care system as they experienced it during their deliveries, as necessary. The variation occurred in the thoughts about how applicable were the measures planned for their deliveries, as they experienced them. First generation mothers' (G1s) correctly pointed out that they were not subject to the transport system as it has operated in their community only since the early 1980s. Birth place histories as recounted by second (G2) and third (G3) generation mothers are shown in Table 6.1. The 'Other' category for Buckland included a local birth, as the four births in this category for Point Hope. The additional 'Other' for Point Hope reflects a hospital birth in Barrow. Interestingly, with the most number of G2 and G3 participants, Point Hope reported the second fewest number of Anchorage births, and Maniilaq births. Two of the Point Hope Anchorage births required medevac. The Kotzebue village deliveries, as mentioned, were actually hospital deliveries, with family practitioners, OBs, or other medical, non-'local' attendants. There was a greater likelihood, however, that there would be family present at these hospital deliveries for support for the Kotzebue women.

**Table 6.1** Birth Experiences Described by ANVMT Mothers, Facility of Birth and Northwest Village of Residence

<b>Village of Residence (G1 + G2 mothers)</b>	<b>Maniilaq Health Center</b>	<b>Alaska Native Medical Center</b>	<b>Other</b>	<b>Total</b>
<b>Buckland (5)</b>	3	10	1	14
<b>Kotzebue (4)</b>	6	4	0	10
<b>Point Hope (7)</b>	4	5	4 (1)	14
<b>Total</b>	13	19	5 Village (1) Barrow	38

**Source:** Compiled by Author with information 'Arctic Passages' Participant Interviews

Note: Figures presented for context, not based on statistically significant or representative sample

Even though Kotzebue represents the MSA location of the most 'local' births, I was able to involve the fewest number of participants from there. Out of this small number (5), three had given birth in Kotzebue. Unlike the other villages, however, birthing in their home community is slightly different in that they are birthing in a medical facility. MHC offers less equipment, drugs, or specialized personnel than ANMC, nevertheless it is still a medical care facility, and does afford Kotzebue mothers the ability to labor at home for as long as they are able or prefer. In relation to the answer to question set one, I refer to the content analysis for G2s and G3s in Tables 6.2, 6.3, and 6.4, for these constructs, respectively.

I asked the mothers how they felt about transporting to deliver. In the analysis phase of looking for "common denominators" within these village groups, I noted repeated:

- 1) verbs of actions and feelings;
- 2) identification of places and times; and
- 3) names of constructs and concepts.

#### *6.1.1 Themes*

- A theme of "resignation" emerged from the Buckland mothers, "had to" or necessity was a prevalent theme voiced by the Kotzebue mothers, as well as Point Hope mothers in this group, who additionally spoke of "desire" for change. Verbs associated with the past indicative of 'be' i.e. 'was,' for instance, 'born,' instead of 'I had a baby,' or I 'delivered a baby' can reflect a person's sense of being acted upon, instead of themselves doing the acting.

The 'was' verb occurred most commonly in the Kotzebue transcripts for this group (Table 6.2), which makes sense if we take into consideration, as mentioned, that the Maniilaq Health Center is a powerful presence in this community. This can translate into a feeling of paternalist control among employees who also live in housing provided by the largest



**Table 6.2** Thematic Analysis of Action and Feelings, ANVMT Mothers, by Northwest Village of Residence

Village of Residence (G1 + G2 mothers)	Prevalent Verbs	Associated Theme (s)	Dominant Theme(s)
<b>Buckland (5)</b>	Went (with) Stayed (with) Came (with) End-up Go or Went-through	Followed Complied Accompanied Resigned Tolerated	Acquiescence Resignation Provision Treatment
<b>Kotzebue (4)</b>	Had to (be or go) Did not know Medevac'd Was (born, sick, all bloody, RH-) Saw Wanted	Forced Uninformed Taken Afflicted Observed Desired	Necessity 'Subject to' Provision Assessment
<b>Point Hope (7)</b>	Delivered/Had baby Chose to Had to go Take (took) care of Had to pay Changed	Produced Determined Forced Handled/Cared Encumbered Altered	Resistance Reluctance Reformation

**Source:** Ethnographic sketches created by author from participant interviews

employer in town, and have health care based on their job. Like any other resident of a 'company town,' one can feel stress from making certain not to 'bite the hand that feeds [you].' There are certainly other large employers of those in the areas, e.g. Red Dog Mine, The NANA School District, or NANA Corporation. Still, the Maniilaq presence as a medical, employment, and housing institution in Kotzebue, naturally permeates the lives of the residents with Western-based values prevalent in biomedicine.

There were a couple of "outlying" comments in the Kotzebue group, from semi-professional women employed outside of Maniilaq. These women tended to use verbs with 'made,' like example; they 'had' or 'delivered' babies, and one insisted she was 'not going to' do something that had been requested of her. Point Hope women of this G1 and G2 eras were more likely to mention action verbs, and were actually voicing complaints about some of the situations in which they felt they were being dealt with unfairly. These women also had the "had to go" situations," but they also offered advice for others when those instances occurred. One G3 Point Hope mother said she advises other young

mothers: "Call them [travel] yourself, that way you know what is going on. Make the arrangements yourself." She noted that this was also helpful for any other health-related travel from her community. Explaining that all residents with ailments requiring more care besides that available at the health clinic, the Point Hope mom was reminding the research assistant and me that pregnant women were not the only ones from Alaska Native villages to have occasional problems getting to their health care when needed.

- Location and time indicators (Table 6.3) frequently mentioned by all the second- and third-generation participants included: Anchorage, Kotzebue, here, there, and when. Special places and times to Buckland included here, the Prematernal Home, actual naming of Anchorage more than any other Village in this group, with Kotzebue second, and Buckland third.

**Table 6.3** Thematic Analysis of Places and Times, ANVMT Mothers, by Northwest Village of Residence

Village of Residence (G1 + G2 mothers)	Prevalent Places and Times	Associated Theme (s)	Dominant Theme(s)
<b>Buckland (5)</b>	Anchorage Here/ Buckland Kotzebue There Hotel Prematernal Home	Known Unfamiliar Travel Away	Safe Home  Move to Accommodate
<b>Kotzebue (4)</b>	Anchorage Here/Kotzebue Home There Hospital When	Known Comfort Care-MCH Time	Safe Home-Hospital  Stay/Move to Accommodate As Needed
<b>Point Hope (7)</b>	Anchorage Kotzebue There Hospital Home/Here When On the Ice	Unfamiliar Travel Away Care-Home Time	Safe Home  Stay to Resist As Needed Environmental Provider

**Source:** Ethnographic sketches created by author from participant interviews

All mothers mostly referred to the Maniilaq Health Center, as "Kotzebue" or "here" (for those from Kotzebue); and refer to ANMC, as "Anchorage," no matter their village

of residence. It became obvious during transcribing that place terms "here" referred to their home, and was preferable, and "there" was the transport location and was necessary. Aside from one mother who described "turning her own baby"—a painful process of getting a breech baby to turn head-down for proper presentation shortly before birth—to avoid going to Kotzebue or Anchorage; most Buckland mothers were compliant. For the most part, these mothers were happy with the travel and care and pretty much happy with the accommodations. Most Kotzebue moms did not mind staying at home to birth. To be fair to the Point Hope mothers having traveled to Kotzebue before, the biggest complaint was the Senior Center accommodations, where mothers got "called in to sit down to dinner every night with Elders" they didn't know. Point Hope women are more likely to feel more comfortable up in Barrow, another Arctic Slope whaling community, than the regional hub of NANA. This small flicker of factionalism will be discussed in Maternal Identity work, as well.

I show the analysis of constructs and concepts from the ethnographic sketches in the Table 6.4. The dominant themes that surfaced from the analysis of the G2 and G3 responses to items centering around question set one, deal with community in most aspects.

These women, for the most part, seem to look at being transported not so much as a tradition, but as a necessity and normal part of life, their reactions can be expressed as:

- 1) Appreciative for the care it provides, and be made the best of, as in Buckland (for now; their leaders, however, are calling for a resurgence local of midwives);
- 2) Enduring, as they handle tough situations in exchange for benefits that come (jobs, housing) with residing with the strong presence of Maniilaq, along with the downsides that might come along with it (less self-determination in health care, even though it is a tribal-based entity) and inevitable exposure to institutional colonialism entrenched in biomedical healthcare;
- 3) Questioning. While understanding the need for some women to transport, and certainly as appreciative as Buckland mothers, the more remote group of Point Hope mothers are questioning their lack of involvement in maternal care decisions, and calling

**Table 6.4** Thematic Analysis of Constructs and Concepts, ANVMT Mothers, by Northwest Village of Residence

Village of Residence (G1 + G2 mothers)	Prevalent Places and Times	Associated Theme (s)	Dominant Theme(s)
<b>Buckland (5)</b>	Placenta Good/Better OK/Fine Safe Good Hunter (Husband) Intensive Care	Mothering Caring Comfort Provider/Providing	Protection/Care Sustenance through women and Community caring  Iñupiat-based institutions providing community-mindedness and family strength (including strong Male role) Elders figure prominently Teaching Youth
<b>Kotzebue (4)</b>	What it took (Birth)/ Placenta Financial Stability Respect Iñupiat Boy 'Raise'/Pass Values on Emergency Tubal Pregnancy Split-up (Relationship)	Economics Status Important Conduct/Acting Mothering/Life Support Rearing/Raising Going Wrong/Awry Pain and Suffering	Social Strength Through women's Economic Resilience and Stability Endurance  Western-based Institutions as Economic Providers
<b>Point Hope (7)</b>	Choice Go through/went through Step Up Expectant Mother (16 year old) Too much Alcohol Length of Time Good/Better Labor Pains/Go into Labor Pregnancy	Iñupiat brand of Feminism Younger generations  Tackling Issues Dealing with Hardships Making Decisions  Taking on Roles Taking on Leadership	Political and Cultural Strength through Understanding and Involvement of Women and Community Leaders  Iñupiat based Institutions Used to Provide Cultural Backbone, Economic and Social Security

**Source:** Ethnographic sketches created by author from participant interviews

for birth in their community in order to strengthen their community. As many anthropology of birth scholars connect birthing in community to resurgence community connectedness and solidarity (Kornelsen, et al. 2010) so do many G2 and G3 Point Hope women. I will discuss this brand of feminism in further detail while talking about MIW and embodiment.

Kotzebue and Buckland mothers expressed sentiments that most closely represent individual, not community-minded interests with mentions of their own 'financial

stability' and 'intensive care.' Contextual drifts of security and comfort are at play in Buckland comments. While 'placenta' was mentioned concerning a possibility of a problem, it was also very interesting a first-time young mother would talk of such things, as if she were knowledgeable. In an abstract way, this mention of the concern for the life-support of her infant was telling of the concern for her community.

Some of these younger Point Hope mothers expressed their part in providing the support needed for strengthening their communities. Buckland younger mothers tended to support their Elders and mention their husband's prowess as hunters. Others are either too young or too involved with their own domestic troubles and worries to step forward right now. Even these mothers, however, are engaging in Eskimo dance, community activities, and caring for their families as they can. When 'off the wagon,' however, there are bouts of forgetfulness of family duties that can cause this small-town population some grief. The reliance on Elders, both women and men, in Buckland will be addressed further in the community section.

#### *6.1.2 Buckland mothers' views of the ANVMT policy*

I interviewed Buckland mothers on two separate trips. The first trip was when the study was in earlier stages during the week of March 24, 2009. We discussed differences in yesterday and today, and how things had changed in the policy and in the community. Here, I present a few comments that exhibit a feeling that leaving their community was viewed as and they in some instances, not welcomed, but seen at least to some extent, as the provision of care that is provided for them by their community. Indeed, Maniilaq is a tribal-based health care body charged with meeting their health care needs, of which their maternity care is part.

- Lidia<sup>30</sup>, 26-year-old Iñupiat mother of six, was reared in a US northwest city by a White adoptive mother.

She quietly described having delivered all of her children in Anchorage, the last five by cesarean-section.

I was young with my first baby, so I *had to* [emphasis mine] go to Anchorage with him, and then my second I *had to* [emphasis mine] go to have a C-section. And then, every baby after that I have to go, too, to have another C-section.

My mom went with me for [the first baby], and then I was by myself, because she couldn't go and my husband had to stay to hunt. He's a good provider. He came with me for one of them, though.

Lidia's story of "having" to go to Anchorage at first because she was young was common throughout the Arctic Passages communities. She described a deeper resignation when expressing how hard it was to leave the other children when staying the extra time in Anchorage for her multiple cesarean-sections. Besides age factors i.e. too young or too old, preeclampsia, related high blood pressure, occurrence of a previous cesarean-section, and even evidence of macrosomatic babies are common reasons practitioners can label women as 'high risk.'<sup>31</sup>

The later participants in Buckland were 19, 29, and 34 years old. Delilah answered with shy remarks of a 19-year old. Her transport was originally planned for Buckland, and later changed to ANMC as her condition indicated. She told of how the policy allowed for her mother's travel as an escort when her destination changed. The transportation costs for both of her trips were also covered. It was not clear whether she was accessing this care through Denali Kid Care, as provided to many low-income

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<sup>30</sup> A pseudonym. Only first names are used in study results, and all names are fictitious to protect identity of participants.

<sup>31</sup> Once designated, many American women with these conditions will eventually undergo a cesarean-section. Practices at IHS hospitals, in general, and ANMC, in particular, result in lower cesarean rates even with some of the risk situations. VBACs are also practiced at higher rates, as possible, in IHS hospitals and somewhat at ANMC. The explanation lies in the maternity care largely taken on by CNMs, and the fact that these IHS facilities are covered by federal insurance, not private malpractice insurance. This keeps the mandates and costs associated with private practice from entering into the maternal health care decisions guiding cesarean sections.

Alaska Native and Non-Native and mothers of Alaska—or whether she was funded by IHS and ANTHC provisions for Maniilaq mothers.

- Beth, 29-year old from Buckland

This mother of three was able to speak with me during a later Buckland fieldtrip. Her thick black hair knotted on top of her head added height to her diminutive stature. She spoke lovingly of the births of her three children and made approving comments about the lodgings that conflicted with some others in the study.

Yeah, I went to Anchorage, one-month before the babies were born.

They were born in 2004, 2005, and 2007. I stayed one month with the first one, in the PreMaternal Home [not Quayana House at hospital] and about 3 weeks with the last two, in a hotel.

When asked about why she went: "*I had to* [emphasis mine], because of my heart condition." Asked what she thought of the PreMaternal Home, Beth responded:

It was good, nice and clean.

Good people.

Good food.

She said there was a "nice woman that ran the place, who always kept fruit on the table" and there were other expectant mothers in the residence while she was there. When it came time for Beth to deliver, she reported that her mom was able to come and be with her at ANMC. I was not clear on whether that trip was provided for by the policy. Even though Beth liked the Anchorage PreMaternal Home from the 2004 visit, she did not show either favoritism toward that experience or disappointment with the hotel situation. A third generation (G3) mother, Beth was familiar enough with Anchorage to get around and cited no issues with the length of her stays, the treatment at the hospital, nor the accommodations. If there were any, she did not share them with me. Her reference to her ability to access the health care that she understood as necessary for her condition seemed to give her certain "matter-of-factness" about the situation. This Buckland mother expressed appreciation of the good food, and clean accommodations during her stays in Anchorage to deliver.

- Eleanor, a tall, friendly mother of three was 34-years-old

Eleanor had two children at MHC and one at Providence hospital in Anchorage because of complications. Her last baby stayed in Providence NICU for a year. Her first was born in 2002, second in 2005, and last baby in 2008. Eleanor described the first pregnancy:

It was unexpected. At four months, I started to gain weight and get sick, so I went to Kotzebue to get a test and a sonogram. I didn't tell anybody at first, but then, after I found out, I told people.

She came home to Buckland for "a while," she said, and then later stayed with her mom and sister in Kotzebue. They were with Eleanor when she had her first baby, a nine lb. girl. Eleanor recalled how two nurses at MHC had helped her, as she walked the stairs to speed up her labor. With her second child at MHC, her husband and sister were with her, as she delivered another almost-nine-pound girl.

Eleanor's third pregnancy was determined to be high risk, so after a brief stay in Kotzebue, she was transported to ANMC, and then Providence for intensive care. Her husband stayed in a hotel during this time, as they were not certain how things would turn out, but Eleanor said they were "scared."

I got there at 25 weeks, and he was born seven weeks later, at just 32 weeks.  
I had to have a C-section because it was an emergency.  
[The baby] stayed in the hospital for almost a year in intensive care, but me and my husband stayed in Anchorage about six or seven months.

Now, I turn to Kotzebue for Ester's story, an example of how these many threads of experiences can weave together as scenarios that are not necessarily a direct result of the transport policy. What started out as a happy event for Ester, also ended up in a life-threatening experience. Resilience and resignation are evident in Ester's tone as she relayed her troubled birth story to me.

### *6.1.3 Kotzebue mothers' views of the ANVMT policy*

- Ester, from Kotzebue, transported to ANMC for delivery

Ester, at the time of the study, was a 33-year-old mother of two from Kotzebue who actually experienced two pregnancies, with one loss. Ester's oldest son, currently 13-



years-old, was born at ANMC, and she described his birth as normal, but admitted to drinking a "six-pack, that one time" while she was pregnant with him. She did not go into detail about how that information may have influenced decisions about her care, however stated it as though it *was* the explanation for her transport.

Ester explained her second pregnancy, which resulted in loss, in quite, calm terms. She talked about having gone to her prenatal appointment early into this pregnancy, describing some symptoms to a practitioner she described as a doctor:

The doctor gave me a stool softener and sent me home. After that [later that night], I was getting bloody and called 911 and I blacked out. I was medevac'd to Anchorage but I was 'too foggy' to remember. They [ANMC medical personnel] said I had a tubal pregnancy and they *had to* [my emphasis] take out one of my tubes.

The doctors performed a laparotomy, removing her effected fallopian tube. She described that when she woke up alone in the hospital, she had no knowledge of the events, or her condition. "One night, I was having a baby, and the next day I had no baby, and only one tube. Now it's even harder to get pregnant again," she said. Ester had on many previous occasions expressed her desire to have a child with her new boyfriend.

Ester's further experiences in mothering will be detailed in the sections on community. In this section on the experiences with transport, I am focusing on the mother's sentiments toward transporting for birth. Ester's situation offers a unique glimpse at one mother who has birthed a child she does not live with, experienced a pregnancy loss, and became the selected adoptive mother of another baby. The ANVMT system is not responsible for any of the outcomes for this mother, but her situation might prove to health care providers that more services and stepped up training might be in order for Kotzebue's sole health care center. Ester said a FAX to the Emergency Room at Anchorage's ANMC eventually led to a proper diagnosis for her, and the decision to medevac her likely saved her life, as there are no surgical procedures available at MHC.<sup>32</sup>

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<sup>32</sup> A September/October 2003 Mukluk Telegraph article describes how a woman presented at MHC with a ruptured fallopian tube. A medical doctor, not a surgeon, was forced to perform a laparotomy with only local anesthetics and the aid of an ANMC surgeon via telemedicine. In this instance, because of white-out conditions, no air traffic was able to make it in or out of the Kotzebue airport at the time.

Contrary to the almost ambivalent feelings about MHC or transport from other study areas, two Kotzebue mothers Beulah and Charlotte felt the services in Kotzebue were more than adequate.

- Beulah, Kotzebue mother of first child

This young mother, aged 22 years and set to deliver her first child when briefly interviewed at work, said she originally wanted to go to Anchorage.

I was afraid that there would be a problem with the placenta, you know, of it not coming out right, and I thought I would *have to* [my emphasis] go to Anchorage, at first. But then I had a friend who had that and they [the staff at MHC] took care of it and she was OK, so I decided it would be OK to stay here.

Beulah describes not only her original fear, but also being swayed away from the fear by her friend's experience. This camaraderie among pregnant women and other mothers is common, but the idea that the mother felt she had any control over where she would deliver was interesting. I wondered at this point how much sway women actually had in the process, but without medical care provider input; this would be difficult to say. She did deliver a healthy baby boy in her home community of Kotzebue during the course of the study.

- Charlotte, a Kotzebue outlier

Charlotte was a semi-professional administrative assistant who had given birth to four children, and was an adoptive mother to an additional 15-year-old child. At 34-years-old, this Iñupiaq mom of five had the appearance and lifestyle of a typical suburban mom, complete with Sports Utility Vehicle. Still, the importance of cultural heritage was reflected in her discussion on the importance she and her husband placed on instilling Iñupiat values in their children. She was the only mother in the study who talked to me about how one of the ways she thought to do this was to have her other children present during her births, and to film her births—so that her children "would know what it took to get them here," and feel a naturalness about the birth process.

I stayed in Kotzebue for all my births, and I thought the services were just fine. I went in when it was time to deliver, I had my baby with some or all of my family there, and then I went home. Of course, I didn't have any problems or anything, so I didn't need to go to Anchorage.

- Talia, Kotzebue mother twice transported to ANMC to deliver

Another Kotzebue mother who was 26-years-old at the time of her first interview while awaiting the birth of her second child in Anchorage, detailed how her first child was living with the child's father:

Because he had more financial stability, and I didn't really object at the time because I was young and thought it best, too; I let her go with her dad. We talk and I see her some, and she knows me. But, with this one [her new baby], I want to make all the decisions and keep him [she knew the sex of the baby] and raise him as an Iñupiaq boy.

Talia explained that with the birth of her daughter years earlier, doctors found a medical condition which requires her to have medication during pregnancy.

She described her first transport situation as one in which she "had to" go to Anchorage because she was so young (aged 16 at the time of her daughter's birth). She did not mention any problems with the transport or the earlier prematernal home situation. Talia did mention a different experience, however, for this planned stay.

Someone I knew in Anchorage was just planning on picking me up at the airport when I came in, and taking me to the prematernal home. She [the person giving her the ride] picked me up and took me to the place I was supposed to stay. When I got out and she helped me with my bags, she [the person giving her the ride] took one look at the place and said 'there's no way you're staying here, you're staying with me.' She put my bags back in her car and took me back to her place and that is where I've been staying ever since. She loaned me a car, I have washer and dryer, and I can cook and eat what I want and get myself a cup of tea anytime I want.

Talia later entered the hospital about one-and-one-half weeks prior to delivery date, and ended up having a healthy, full-term baby. She explained that she was sent to ANMC from Kotzebue especially early; as her condition required her to take medication that caused a severe rash. She "had to" take additional medication to control the itching of the rash, she said. Talia's doctors said she "needed" to head to Anchorage at about 28 weeks gestation, when most mothers are sent at about 36 weeks gestation. Her sister and a pastor's wife flew in at their own expense when time for delivery actually arrived.

In this case, Talia felt fortunate to have such accommodating alternative lodgings made available to her during her extensive stay. Talia's benefactor was in a position to

help, as she had extra room and a vehicle while her husband was deployed. This would not have been the case for everyone in Talia's situation. Again, the ANVMT protocol got Talia to Anchorage and her baby and her back home to Kotzebue, but the system's provisions for this apparent longer-term lodging were described as less than desirable.

As far as I can tell from women describing the "outside-hospital" Prematernal Home arrangements besides a hotel, they are referring to an undisclosed residence which serves women who are staying longer than usual before their expected delivery. This is not, however, explicitly stated in policy documents; much the same as the case of the ANVMT policy appearing unavailable.

For those Kotzebue mothers, like Talia, with complications, early travel to access the more involved treatment is deemed necessary to keep the higher risk mothers near emergency care, just in case. Given her condition, Talia did exhibit resilience and patience, with the understandable exception of irritation with the side effects of her medication toward the end of her pregnancy. I am not certain how much of her steadfastness was because of unusual support system in Anchorage, or because she was a second time mother. Whatever the case, she acknowledged the ANVMT system as a necessity that provided her access to the care she needed. Again, none of the mothers have mentioned that they "desired to" go to Kotzebue or Anchorage to deliver. Although one young Point Hope mother mentioned that she chose to go to the hospital in Anchorage, because that is where she wanted to have her baby, Point Hope mothers, in general, were the most vocal about feeling somewhat at odds about leaving their communities to have their babies. Similar to their Buckland and Kotzebue counterparts with a mindset of being more involved in the decision about their care, some of these Point Hope second and third generation mothers felt that they should be more informed about their situation.

#### *6.1.4 Point Hope mothers' views of the ANVMT policy*

Point Hope had more participants than any other village, with two first-generation (G1s), three second-generation (G2s) and four third-generation (G3s) mothers. Again, since the oldest mothers did not take part in the maternal transportation under study, the

G2s and G3s experiences will be relayed here. We should take note that, aside from being a non-NANA village and the most remote of all the Maniilaq villages, compared to the other study villages, Point Hope has a long and recent history with the use of local midwifery care. Alternatives available in the form of birthing in their home village, means the option of a local caregiver, whereas that same option for Kotzebue means dealing with Maniilaq Health Center regulations. Women in Buckland used to have the local birth option, but that has, officially anyway, long since stopped.

I spoke with some of the Point Hope women on my first visit there fall of 2011.

- Jezebel mentioned that she had preeclampsia with her second child, so she was medevac'd to Anchorage.

She was housed in the Prematernal Home, she said and, coincidentally, her husband had fallen ill at the same time:

I was medevac'd and so was he, but they [Maniilaq travel] wouldn't let us stay in the same room (with our daughter).

Jezebel was very confused about why they would not let them room together, but I would imagine that even though the rooms are similar to dorm rooms, that it is still a hospital and there were precautions to be taken concerning pregnant women and appendicitis patients together in close quarters, even if they are married. Still, Jezebel did not feel like she had gotten an explanation and it made her feel frustrated and insulted.

My parents had to pay for a hotel for a month. I could stay in Quayna House if I wanted to, but why would I want to stay away from my husband?

November 19, 2011 the research assistant interviewed the second group.

Later, when talking about a social worker's comments that women were choosing to go to Anchorage, Jezebel spoke up: "When we go, it is NOT [her emphasis] by choice. [You] are forced." This sentiment was echoed by many mothers in all the communities.

She and another young mother began to talk about changing the transport policy:

When I was there [at the ANMC hospital with her sister], they [medical staff] told us we had to leave"

Asked if the policy needs to change?

Umm-hmm

That's what I dreaded about being pregnant here

It was far from better [than staying home to have babies].

Jezebel also spoke of the important role insurance coverage plays on how the policy works out for the mothers:

I wasn't eligible for Medicaid then,  
So it was harder for getting a hotel [Medicaid usually covers this for deliveries].

Jezebel contrasts this experience to her earlier 2005 birth in Point Hope: "My water broke, and I drove myself to the clinic. I had her three hours later, and I went home."

Jezebel was staying with one of her nieces while the research assistant and I were at her house. She recalled her sister's experience in flying out to Anchorage to have the baby:

That's my sister's [sister's name] daughter, she [her sister] was there [Anchorage] two months. And, she lost so much blood, and she was there all alone.

My dad had to pay his own way to be there with her, and a place to stay. When he got there she was scared out of her mind. Her first child.

When the conversation turned back to her experience in Kotzebue, Jezebel said:

That Senior Center [where the former Prematernal Home in Kotzebue was housed],  
that is so uncomfortable

Yeah, they [the staff at Senior Center] go, 'its dinner time.' You go out there and eat  
with a lot of Elders that you don't even know  
And it was my first pregnancy, and I was there alone.

We asked Jezebel what she thought would be a better situation. She replied:

Direct contact with the doctor  
It is not 'just about the mothers' [implying that it should be]; it is all 'medical' [to the  
practitioners]  
They didn't even tell me I was going to the hospital  
Organizations get mad at the patients.

Here, Jezebel is talking about all the agencies that have a part in getting women out to the hospitals to have their babies: the Medicaid, if applicable, the ANTHC-IHS funding, the travel office, the clinics, and all involved. When there is a communication breakdown among these offices, it is usually blamed on the mother, she said.

Another Point Hope G3 mother had more of an issue with the doctors not knowing their patients.

- Josephine talks about her experiences with the medical staff in Kotzebue:

Some of those doctors don't really get to know you.

They only see you once or twice

She had other children in Anchorage and Barrow (at Wainwright). Asked if she chose to go to Anchorage, Josephine said:

I had to go, Just stayed there like one week.

They [health care providers] said I had diabetes with it [that pregnancy]

When asked about what she liked about it: "It was alright. I never thought about staying at home, I *choose* [her emphasis] to have them at a hospital." For Josephine, accessing this care was something she felt was her choice. She said that at first: "You [mothers from the villages] don't realize you have a choice "Josephine then talked about the importance of family and how happy her mom was to be there when her grandchild was first born in 2000:

I had my mom when I had [child's name]

'One more push,' the doctor said, and the my mom was jumping around 'it's a girl, I'm a nana'

When you have your baby and you don't have family, it's hard

It's a big event and to have someone there is better

The boyfriend I had, we broke up before, so for me to have mom and dad [to help] was better

When asked about advice she would give to new moms, Josephine said to 'have help.' With her third child, she said her husband and auntie had helped her during labor. She said they were able to come because it was "dividends time." Out of all her deliveries, Josephine felt Barrow was best, but when asked why, we found it had not as much to do with the facilities or services: "Barrow was better because my husband was not with me." Her sister was with her, the entire time, and she felt more comfortable with that situation. Josephine also talked about the postpartum aftercare. She felt it was better to "go out" to the hospital:

Like two weeks after the baby is born, two weeks, six weeks.

Denali Kid Care [Medicaid] pays.

Check-ups are done in Kotzebue

The G2 mother in Point Hope included two women who had experienced everything from transport to Anchorage to one, who actually had a baby at home by herself.

- Deborah, a woman with six children, had two in Kotzebue, two in Point Hope, and two in Anchorage, she reported.

For her first birth, went to Kotzebue because she was "told to go."

The old place [Prematernal Home] was clean, nice, and well-run with good people. I thought my auntie was going to adopt the first one, but my husband changed his mind, so I came back [to Point Hope] with her.

It was more common, she pointed out, to have babies in the community when she was first having children. When she did have to go, she said it difficult, because of the number of children at home. One time, Deborah said, "I didn't go, because I had too many kids at home." With her fifth child, Deborah explained, she had to go to Anchorage, but she had family there.

It's harder today. I tell my daughters, it's OK, but communication is bad

About the transport system, Deborah said:

No one liked it  
Marriages broke up, relationships get rocky

Deborah added comments about what she saw as the root of difficulties inherent in the maternal transport system:

The politics of Maniilaq and the borough [Arctic Slope] needs to change  
Choice is better  
Now, there is a lack of stability  
We need more good people like [a long-time nurse at Maniilaq], too, to provide better support and back-up. Maybe more midwife training for Health Aids

I noticed more of this kind of "call to action" in this community from all generations.

Regina, a G2 mother, included her account of an unattended birth in Point Hope in her birth stories:

All except [daughter's name], my last baby—all of them [her children] born at home Asked about who attended the deliveries at home, she mentioned the name of a local midwife and an assistance. In response to a question about how many babies she had, she answered, "eight," but then had trouble listing them. Her husband had to tell her: "That's seven."

Ah, I miss [name of son she had already mentioned]



"No, you didn't, you already said him, and you miss [other son's name]." he said.

Unconcerned with the accounting of this list, Regina continued with her birth stories:

I had [third child] all by myself

Ah-di, I sure want to push, and then I have the two of them [contractions], and then I said to myself,

'I wonder how they have a baby a long time ago? '

I put a sheet like this and I got like this [she demonstrates how she squatted next to the couch] and I go like this and then I said to myself 'just let the baby not come from the water' [?]

And then, I push one time only, and I push the baby and it was a boy

And, I cut the cord with a pair of scissors, and I had my baby, and then I get up and pull up, and put my pants on—and just like that and then I had my baby.

I was a real mother

[Before] I tell my brother to go get a midwife, they were slow and I couldn't hold it anymore

[When he returned with the midwife:]

He say he gonna make breakfast

I said 'I already have the baby before you guys come.'

[midwife and brother said] 'Alright! I didn't know you do that, you're a brave lady'

They [midwives] check his eyes and everything and placenta, nothing wrong

I heard them say 'you did a good job, you're gonna be a midwife'

I held the cord for a while and thought 'I wonder how long?' And hold the placenta, and let it go out, and I clean it and it seemed good. I clean it.

She ended her story with well-known Iñupiat humor:

My uncle came and said 'where's your stomach?'

I said, 'up here in the bed.'

'What kind of baby you got? [the uncle asked]'

I said, 'I got a boy.'

- Dalia, a G3 mother of three recalls a distressing experience with her treatment at ANMC after emergency transport to the hospital to deliver.

Dalia was expecting her second child and planning on staying in her community to birth while monitored by a community health aide. She was not planning on delivering outside of Point Hope, so early pre-transport was not talked about since all her 'vitals' (blood pressure, blood sugar, baby's heart rate, etc.) were fine. As she began early labor and reported to clinic personnel, however, it was determined that she was experiencing

preeclampsia, and she was immediately medevac'd to Anchorage. Once at ANMC, right after she successfully delivered her baby, she reported:

A nurse yelled at me for not coming to Anchorage earlier, even told me that I would get sued for not going there earlier I didn't know I had preeclampsia. I was never told. If they [community health aide] had told me, I would have gone...but it [this experience] was really bad when that nurse started yelling at me right after my baby was born.

Later, one of the G2 mothers indicated that the nurses at ANMC had "stopped doing that," but there had been other instances, according to others, that women had been threatened with having to foot the bill if they ended up being medevac'd after passing up or cutting their regularly scheduled transport short. Point Hope is the only community where I heard about this.

## 6.2 Arctic Passages community and family members and the ANVMT policy

Having answered the first part of the first of four main research questions on women's sentiments in regard to the maternal transport policy as it functions in the Maniilaq area, I will briefly address the comments of family and community leaders.

### 6.2.1 *Buckland*

Buckland mothers in the Arctic Passages study did not mention any problems, per se, with how their community handled birth. Comments were made, however, by community leaders concerning how unfortunate it was that community birth was not as much of a possibility as it had been before i.e. when midwives were present, as quoted earlier, "Who wants to say they were born in Anchorage?"

Older female leaders in Buckland voiced an understanding that the ANVMT policy was necessary today because of the prevalence of young mothers "smoking and drinking." The medical monitoring made possible by the transport was viewed as a safety precaution against something going wrong with a delivery to mothers from their area who engaged in such behavior. Still, Buckland stands out as the only village in the study to have included a call for midwives back into the community (in their five-year economic development plan). This is evidence of how the holistic perspective prevalent

among indigenous cultures can be used to address problems and solutions in their communities within an interconnected framework. Subsistence issues, for example can be about community health, environment, politics, economics, as well as social and cultural strength<sup>33</sup>. Similarly, bringing local birth attendants back into use in their community can be just as much about jobs, and community building as improved health. During a 2009 fieldtrip, I heard one Buckland leader referring to how much the Maniilaq Association spends on transport for births. A representative from Buckland, like all Maniilaq villages, sits on the Maniilaq Association board, so they are fully aware of the financial costs of this most frequent reason for medical travel and ANMC inpatient hospitalization.

### 6.2.2 Kotzebue

With respect to costs for transporting medical and maternal patients, Kotzebue leaders are at somewhat of an advantage. Their citizens live in the same town with one of the health care facilities where birthing women are sent. Kotzebue is also a regional hub, has a larger population, and operates in an area more directly influenced by a Western value system (see section 6.5). I did not glean a great deal of direct information from Kotzebue leaders concerning their feelings on the transport situation, but I do recall a village official referring to the Maniilaq Health Center facility as "a Band-Aid Clinic." With the limited services and staff turnover, it is possible that his remarks were directed at these features of the local hospital. I had limited conversations with the medical staff at Maniilaq on a couple of occasions, but I do not consider them to represent the families or communities, so this input is not included here.

I was able to establish rapport with members of the Kotzebue community, and the council was responsive and gracious enough on both occasions of my study (during preliminary fieldtrip and multiple final study trips), to make my involvement possible. As one council member said in a preliminary meeting,

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<sup>33</sup> See Loring (2010), Dissertation, *Ways to Help and Ways to Hinder*, for more on interconnected elements of community health

I am not going to say whether or not village members can participate; they are adults, they can decide for themselves. But it will be a good thing for us to see what they [the mothers] think.

### *6.2.3 Point Hope*

When considering whether to participate, Point Hope community leaders requested a presentation concerning my work. These leaders expressed concern for women from their whaling community they called 'our mothers.' As one council member put it: "It is sometimes hard for our mothers to leave." They deliberated after my presentation and signed the research protocol (Appendix E). They are interested in and already thinking about what they can do to help 'their' mothers. I will be sharing with them, as with other communities, the resulting documents I produce from the study. They liked the fact that the study focuses on the words of the participants, and I appreciated the fact they might be using my work to help inform policy. They seemed to look forward to seeing how it might help them in their efforts to improve maternal health care service in their area. One council member actually said to me, "Thank you for opening our eyes." Nothing could make a community research scientist feel more validated. I did stress to the council that I could not tailor any of the study of findings specifically for them, and they understood.

The fathers, uncles, brothers, aunties, sister, and mothers of the Point Hope participants were also keenly aware of what it meant to get women to the hospital to deliver. Many times, they had to take off work to stay with children, or leave to be with daughters, as mentioned in some of the interviews. These are the realities of those left behind for weeks, and sometimes months at a time. We all have family difficulties when facing medical crises in our families; however these families and communities face these difficulties even for delivery of their children.

Until recently when local midwives 'retired' Buckland and Point Hope had local midwifery services that operated in a somewhat underground fashion, as far as I can tell. Instead of bolstering this practice to include this care as a viable alternative to leaving the community, the practice of lay midwifery in these communities has headed the direction of the blacksmith: a dying occupation. I argue that it is not just because of the lack of necessity for these services, but rather, in combination with the infiltration of a

biomedical system that values the appearance of control, efficiency, and standardization. The perception of the superiority of medicalized childbirth that prevails in the rest of the US has long since reached Alaska Native villages. Buckland and Point Hope, it would seem, are now beginning to question—just as the Point Hope mothers are—if this is truly what they want.

### 6.3 Maternal transport: a new tradition in the Arctic Passages communities?

The last sub-question from Question set one of this study concerns the applicability of the maternal transport as a 'new tradition.' Given the number of responses describing the transport as simply 'necessary' in some cases and an unnecessary venture of the utmost inconvenience to others, there is no evidence to indicate that the transport has become integrated into an Iñupiat value system as a tradition.

While there might be some camaraderie among women who had gone through similar circumstances, there was not the type that one hears from Western women who, say, are talking about their baby shower experiences (a Western tradition). With a few exceptions, these women talking about their transport experiences sounded more like soldiers who had been to war, recounting their experiences in battle. Similar impressions can be derived from listening to all women when they are recounting their birth stories, as labor and delivery are intensive experiences. Nevertheless, few Western women outside of the village environments will include the ordeals and trials of simply getting to the hospital in their accounts of the difficulties of labor and delivery.

The thing that stands out for me as I listened to these women generously share their birth stories, was that with very few exceptions, there was very little mention of joy or happiness at having just had a baby. One woman even used the word "dreaded" when talking about the thought of being transported. Transport in these communities—which a Maniilaq social worker says women look at as a "honeymoon"—is a hardship. Sometimes a necessary hardship, but a hardship, nonetheless. Whether with resignation, resilience; or with a questioning attitude—these women have adapted coping mechanisms

that suit them best. Labeling these attitudes as if they had adopted the transport as a tradition would be drastically incorrect.

In the next section, I cover the processes that women and communities go through as the women become mothers. I turn attention to answering the second set of questions posted in this work in this discussion.

#### 6.4 Maternal identity work, liminality, *communitas* and the ANVMT System

As mentioned in an introductory section of the thesis, as women become mothers, they frequently go through a process of associating themselves with people or groups that reflect an ideal of their identity as mothers. This process, called maternal identity work, is similar to what Goffman termed image or impression management in forming one's self-image.

Many social, cultural, and physical factors enter into the process of forming a self-image, and this is the case for mothers, in general, and indigenous mothers in particular. The focus in this section on identity work also includes a look at liminality and *communitas*, as group association is part of the role ideation involved in identity construction. While realizing that not all mothers are the same and certainly not all indigenous mothers nor Iñupiat mothers are alike, I will just cover mentions of importance of community and Iñupiat identity expressed by mothers in this study.

To this end, I present the second set of questions to be answered in this thesis:

**QUESTION SET 2:** How does the ANVMT system factor into the *Maternal Identity Work* of the predominantly Iñupiat women and their communities in stages of liminality as they produce future generations? Are there elements of embodiment present during the maternal care period?

##### 6.4.1 *Self-identification and embodiment as Iñupiat mothers*

"I was a 'real' mother:" this expression was used by Regina, after describing how she had delivered her baby, by herself, "like they did a long time ago." It was a profound statement for an Iñupiaq woman, as the literal meaning of Iñupiat is 'real' people.

Even G3 mothers associated themselves with belonging to the community as they were outside of their village. Talia, from Kotzebue, who delivered in Anchorage, spoke of wanting to raise her son "as an Iñupiaq boy." Affiliating herself and her half-White son with their Iñupiat cultural heritage was important to this young, working single mother.

When asking the study participants about what a mother did, one young mother replied with comments concerning the physical side of childrearing. Josephine, for instance, said, "cooking, cleaning," and "changing diapers." She seemed to take the question literally, as indeed, this is a list of what mothers 'do.' When asked what a mother teaches her children, Josephine added that one should "talk to your children in Iñupiaq," and "teach them their 'ABCs and colors.'" She basically juxtaposed Western culture values of the importance of "reading and writing" with the Iñupiat values of carrying on the language and culture. There were many examples of this intermixing of value systems in women's responses when they talked about what it means to be a mother, and an Iñupiaq mother.

The G3 mothers tended to recite more of the Iñupiat lessons, like Adeline, referring to "memories" as guides for living the "right way." This Elder had taught Iñupiaq in her earlier years, yet she had also been heavily influenced by missionaries in her upbringing, as had many in her generation. Some of the G1s' comments tended to reflect Iñupiat values intermixed with old-time Christian overtones of "walking the right path," and "patiently waiting [for relatives waiting on the 'other side']." Sometimes the value systems are so intermeshed; however, it is difficult to say whether the sentiment expressed is based on Iñupiat spirituality or fundamentalist Christianity.

Mothers also engage in identity work as they incorporate cultural customs into aspects of pregnancy and childrearing. One tradition that is decidedly Iñupiat is the blanket toss. This cultural tradition is still practiced at celebrations in the whaling community of Point Hope on a regular basis. The community gathers during the whaling ceremonies and places gifts on the large circular sealskin "blanket," as they "toss" gifts up in the air to be caught by mothers of the newborn baby boys from that year. Imogene,

another G1 Elder from Point Hope told of a custom that is no longer practiced as far as she knew: having the baby suck seal oil when first born. Even though mothers no longer follow this custom, there are signs of Iñupiat values incorporated into women's identity work among young Arctic Passages mothers.

Nadia, a young Point Hope mother of two talked about how when she was first pregnant with her second child, she had not told her mom. Yet, according to custom, she was not to go out onto the ice during whaling time. When it came time to go, and Nadia stayed away: "Then my mom knew I was pregnant, because I stayed off the ice." This adherence to custom in the younger generation is more prevalent in this active whaling community than other study villages. I was admiring a "parky" Nadia's mother had made for Nadia's young son. It was white, like that worn by whaling crews, with fur on the inside. Her son is three years old, and she is already looking forward to the day when he can hunt. "Yeah, he will learn to hunt soon, he will be a good hunter." This is this mother's wish for her son, to be a contributing member of his community, and she sees it as her part to prepare him for that.

Nadia talked earlier of how she and her boyfriend used to "party." When she found out she was pregnant with her son, though, she stopped, and threatened to leave her boyfriend if he did not stop, as well. She said sometimes she misses partying, but her "boy came first." Parts of this mother's identity, then, is passing on the custom of male provider to her son, and taking on the role of responsible parent. She identifies as a responsible Iñupiat mother, committed to her children and her community.

These mothers are, in essence, combining what they see as good mother with their identification of themselves as members of an Iñupiat community. In other words, being an Iñupiat mother *means* being a good mother. Where the transport system fits into this scenario of passage into the role of motherhood, as women are "creating" their new identities, has to do with how they were either housed (previously) in the Senior Center in Kotzebue, the Quayna House or Prematernal Home in Anchorage, or a Hotel the month before delivery. During this time, I argue, these women are in the process of being socialized into becoming good patients, just like all mothers involved in US prenatal care.



Through the system of risk assessment, these mothers become exposed to the system of standardization that is decidedly Western and tends to not involve Iñupiat ways or values. This exclusion can have an impact on how a woman first identifies herself as an Iñupiat mother, if she so chooses. Choices about what to incorporate into her care are limited to what is offered by the biomedical care system. What Jordan (2009) refers to as "informed compliance" instead of informed choice is at odds with any women trying to decide what to incorporate into their identities as mothers.

One Kotzebue mother, Ester, had a story of becoming a mother that did not involve transport or medical care, or even birth. The child currently living with her and her live-in boyfriend is actually her nephew. She spoke proudly of the fact that her sister-in-law, the baby's biological mother, had selected her to be her baby's adoptive mother. Ester was even in charge of naming the baby the minute he was born. After describing the process that the mother of the baby had gone through to find a suitable mother, asking questions and observing, Ester relayed with a smile:

She [the baby's mother] called me up and ask me would I be the baby's mom, and I said yeah. Then, when they [Ester's brother and the baby's mother] were at the hospital having the baby, my brother said he's here, what you want to name him?

Ester's sister-in-law later died from exposure, and the family was devastated. They had also lost a brother to a snow machine accident. For this Kotzebue family, incorporating resilience into her identity as a mother was important.

- Embodiment and closeness to Maniilaq

Risk assessment and protocol, as much as possible, helps practitioners decide where these women should give birth, and how early they should try to leave. It is not an exact science. Practitioners temper these decisions, as discussed, with pre-formulated notions regarding the "types" of mothers and their characteristics. I have seen many mothers in general, and Alaska Native mothers in particular treated differently if they reflect an image contrary to what some in the Western medicine field see as the norm. The push for safety and risk avoidance has been the justification for stereotyping and discourteous behavior in some instances to the point where Alaska Native mothers can feel as though

they embody FASD and SIDS cases. There were no reports of this among the study participants, but I have heard this from other Alaska Native participants.

The primary complaint among Arctic Passages mothers had to do with paternalistic treatment that they felt was built into the system. For this group, their embodiment was that of non-compliant, ill-informed children having babies. To some practitioners, remote, Native, and pregnancy in general, equals risk. In this case, Alaska Native mothers would embody risk.

With these examples of Iñupiat mothers' identity work and how it is influenced by their involvement in the transport system, along with a brief treatment of embodiment among this group of mothers, I now move to a discussion of liminality and *communitas* in relation to Alaska Native mothers of the Arctic.

#### *6.4.2 Iñupiat mothers, liminality, and communitas*

In Table 6.5, I show the differences in the Arctic Passages communities and delivery sites as concerns structure and liminality. In Kotzebue, more Western-based institutions occur, along with an environment of structural states. The active whaling community of Point Hope, however, is an example of a place where spaces of liminality create opportunities for *communitas* to occur. Buckland is less structural in nature than Kotzebue, but I have no basis other than the fact that their leaders openly expressed a desire for revitalization of local midwifery. Ironically, this was done within the body of a very structural document.

I posit that the strong presence of the biomedical model in Kotzebue has brought with it the Western values ranking consumerism and materialism over Iñupiat values of community and family. I am not suggesting nor recommending that the ANVMT system halt service to these communities. I simply offer this interpretation to view the communities' strengths and possible influences on the mother's from these areas. In an environment of structure, inequality, and values that can be counter to that of one's cultural heritage, the development and advantage of a support system can be made that much more difficult. This list also bears an uncanny similarity to what it might look like if a list of features of the midwifery model of birth were placed side-by-side to a list of

**Table 6.5** Liminal and Structural Features in Arctic Passages Communities and Delivery Sites

<b>Liminal</b>	<b>Structural</b>
<p><b>Transition:</b>            -A place where the cycle of the seasons prevails,            -even running of business or village, the 'authoritative voice' here is that of nature—            -Leaving spaces of change open for opportunity</p>	<p><b>State</b>            -Bureaucratic schedules and rules prevail,            -causing change to take place only in a methodical, planned fashion</p>
<p><b>Communitas:</b>            -Camaraderie among those going through a common experience (liminals)            -Membership based on experience, not on a structured timetable or predefined schedule, or predefined labels</p>	<p><b>Structure</b>            -In formal institutions, structure, not experience,            -organizes peoples into groups.</p>
<p><b>Equality</b>            -All who are members have access to the camaraderie and support</p>	<p><b>Inequality</b>            -There is an inherent hierarchical system in the structural system, with            -those with power (doctors, nurses, city officials, administrators) on top and            -citizens, patients on bottom</p>
<p><b>Total obedience</b>            -Obey your instincts, and Elders, not just doctors, laws of nature, tribal protocol</p>	<p><b>Obedience only to superior rank</b>            -Obey policy, doctors, government regulations, etc.</p>
<p><b>Simplicity</b>            "I had my baby, just like that"            "My water broke and I drove myself to the clinic and had my baby, three hours later I drove home"</p>	<p><b>Complexity</b>            Coordination among many entities (travel, medical,. Lodging) oftentimes causes confusion and distress</p>
<p><b>Acceptance of pain and suffering</b>            -As in the midwifery model of care, there is to be pain expected, but it is part of life (and birth)</p>	<p><b>Avoidance of pain and suffering</b>            -There have been mentions made of the main reason to access care at ANMC is to procure an epidural for pain relief during delivery.            -This was mentioned by a Kotzebue caregiver.</p>
<p><b>Sacred instruction</b>            -Local midwives have expressed having a calling, like a minister, and            -many references have been made to the "intuition" of a midwife.            -whaling and hunting are not taught in school, and these activities are practiced with reverence</p>	<p><b>Technical knowledge</b>            -Nurses, doctors, pharmacists have Western medical backgrounds.            -While 'tribal doctors' are employed by both Maniilaq and ANMC, they are not on staff for deliveries; and even if they were called in for care of a mother, their services are limited by hospital protocol.</p>

**Source:** Compiled by author, based list from Turner (2008 [1969, 1997])

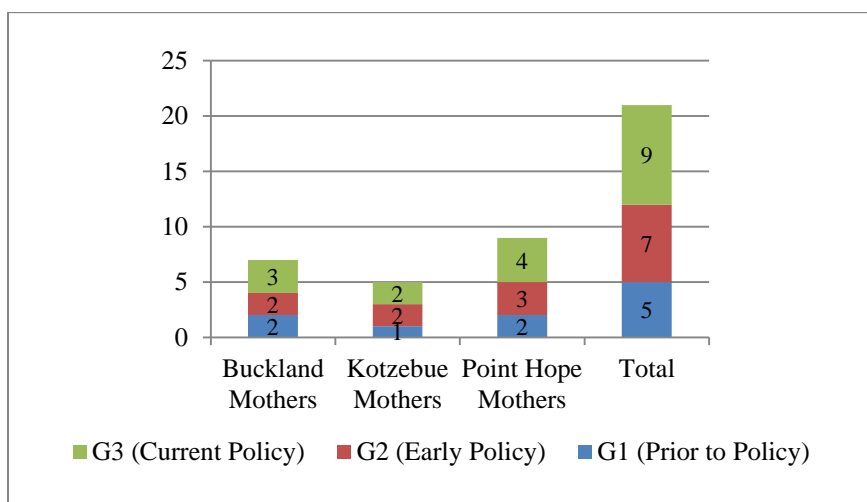
features of the biomedical model of birth. Simply stated, women are able to form support systems of *communitas* more easily in areas with features of the liminal sort, as opposed to areas with features of the structured sort. Dietsch, et al (2011) speaks of this link between community connectedness and maternal well-being among Australian Aboriginal mothers. Kornelsen, et al. (2011) and Miewald et al. (2011) connect the role of community-based maternity care to community sustainability along with healthy Canadian First Nations mothers. Mason (2004) found that first-time Aleut mothers still benefited from strong family support systems in their communities.

With this coverage of the structural and liminal spaces present in the communities and delivery sites, I continue with attitudes among the generations of Arctic Passages moms, as I answer question set three.

### 6.5 Different Generations of Arctic Passages Iñupiat Mothers as Participants

**QUESTION SET 3:** How do the different generations of mothers, transport situations, and villages compare in terms of experiences and periods of liminality (and associated *communitas*) in the processes of these Iñupiat women becoming mothers?

Figure 6.2 shows the generations of the mothers G1, G2, and G3, representing the birth



**Figure 6.2** Number of Arctic Passages Mothers by Birth Era Generation, by Village

**Source:** Compiled by author with data reported by participants

eras pre-1983, 1983-1990, and 1991-2011, respectively. The mothers participating in the Arctic Passages study ranged in age from 19 to 75 years old. As previously mentioned, their birth era was figured according to reported age at their first delivery. The younger mothers were in greater number in the Point Hope group. Point Hope and Buckland samples generated equal number of G1 (first generation) mothers, having delivered prior to the transport policy. The Early Policy, G2 (second generation) mothers, ranging between 33 and 45 years old during the fieldwork period, participated proportionately across the study villages. Overall, the non-representative sample was somewhat laden with current policy, G3 (third generation) participants. Since this is not a quantitative, predictive study, probability sampling was not necessary. I also thought that given the importance of memory recall to the participants' ability to relay their birth stories as accurately as possible, younger mothers with more recent births might have an easier time of it.

As G2s and G3s responses were extensively covered in answer to question set one, I will devote this coverage to the G1 responses, and pointing out differences between the younger and older groups. In the earlier days medical services were not as readily available as they are today, and mostly just military wives seemed to be going to the hospital in Barrow in the earlier years (Interview January 11, 2011: Marjorie, G1 mother from Point Hope). This is corroborated with the findings of Chance (1990).

Birth era reflects how transport protocol was handled during a particular era because of staff available at the Maniilaq area hospital at that time, or what alternative care was present in the village. In the early era flights used to be available (like Kotzebue to Fairbanks), that are no longer available through Alaska Airlines. The main differences between these the older G1 mothers and the G2 and G3 mothers, is obviously the presence of the transport system.

- Anastasia and Ruth, both G1s from Buckland, mentioned the mothers clubs of the past.

They explained that a group of women from the community would go around to the homes where babies were expected, and check everything out to make certain the

mothers had everything they needed. Anastasia said that she felt that in her day, women didn't really need to transport, because they didn't "smoke or drink or anything." She said they [mothers of her day] ate right and exercised, and no one had to "tell us to do that, "we just did."

Anastasia and Ruth reminisced about being in grade school and making sewing kits and postcards to sell to raise money for the mothers clubs<sup>34</sup>. "We used caribou sinew for the thread and antlers for the thimbles," Anastasia described. When asked when the mothers clubs stopped, Ruth and Anastasia said almost simultaneously, "When the teachers came." I imagine that is when the missionaries came to their community, but I am not certain. Anastasia thought out loud, "we should have those again, we could use that now."

This thought of how to help the community was not restricted to the older women. But the younger women of Buckland tended to be more reserved in their commitment to telling anyone else how to handle things. The element of experiential learning inherent in most indigenous childrearing strategies was a pervasive theme among these communities. If one was an Elder, however, it was alright to offer opinions, in fact, expected, and many defer to these opinions. It is customary for these Elders to be knowledgeable on social matters of protocol, which involve practical ways for life in the community.

- Norma, the oldest of the Kotzebue mothers

Norma, a short, stout Iñupiat woman, aged 65 years at the time of the study, birthed six children in Kotzebue from 1964 to 1980. She has lived in Selawik, Buckland, and Kotzebue intermittently during these times, but she had been living in Kotzebue for the longest period, and currently lives there, so she is included as a participant from that community.

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<sup>34</sup> Dr. Brian Saylor was reminded of mothers clubs in Barrow, an Iñupiat village of Arctic Slope: "their activities went far beyond the welfare of individual mothers and babies, but addressed any community issues that might influence the raising of children. They were a power to be reckoned with (comments)."

Norma had lost a son in his early adult years in a snow machine accident. I did not want to bring up anything that would cause her to be upset, and I had seen her cry when remembering him on his birthday. During a trip to the Wal-Mart while in Anchorage, Norma sat in the passenger seat of my car while I was driving and began telling me about her first born. She was still in [high] school, she said, when she became pregnant and went to Kotzebue alone to have her first baby.

I had [eldest son's name] while I was still in school. I go<sup>35</sup> to Kotzebue, and after I have him...I send a telegraph to my mom, and she say, send him home and we'll teach him to herd reindeer. So I did. That's why [her eldest son] is so good<sup>36</sup> now.

She did not talk of the other births, only to say that they were all in Kotzebue. Given that the transport system did not start on a regular basis until the early 1980s, after the birth of her last child, this makes sense. She mentioned no troubles or hardships during pregnancy or birth, but indicated that she was a hard worker and that kept her healthy. It is also interesting to note her mention of the telegraph to announce the 1964 birth of her first child. There were not many details on differences in attendants over the course of her other five births. Since nurses and doctors were flying in to the regional hospitals from Anchorage during that era, she was most likely attended by such practitioners of that time, as available.

- Point Hope Elders Marjorie and Adeline

Marjorie had a family member who was a midwife while she was growing up, so she described what it was like for women in "the old days" to deliver there. She described blanket tosses releasing gifts for newborn boys and pegs that would be pounded into the ground for birthing women to hold as they pushed against a footboard situated at their feet. While she witnessed births like this, she delivered her own children in a Western style home in the village, and her second child at an Indian Health Service (IHS) hospital.

In an interesting twist, many older generation mothers who had moved out of the

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<sup>35</sup> In "Village English" the tense of going is used interchangeably for past, present, and future tenses. In this case, it stands for the past tense, went.

<sup>36</sup> Referring, perhaps, to her son's current leadership role in his community, of which she is very proud.

village, even out of state, came home to deliver so they could use the midwife they knew. Their transport system was self-imposed to access local care.

Adeline mentioned much the same situation, yet she had stayed in the village and not moved out. She had just returned from the Senior Center from poor health, but was presently staying with her son. Her comments about the past centered on the community, and the 'camping house.' She also reminded us, "If you obey your Elders or your parents, you will live long."

In comparison, the generations are each active in shaping their communities in their own ways, but each seem to have motives of guidance for others and preservation of a sense of what their communities stood for. One difference I heard from a younger Point Hope mother, concerned dealing with domestic violence. She felt that older women advised young girlfriends to stay with the boyfriends if they were expecting, even if they were "beating them [their girlfriends]," for the sake of financial support.

Her advice differed as she exhibited an Iñupiat brand of feminism stating, "they don't know they can do it [survive on their own], but they can." She said she never actually had that happen to her, but she was a single, working mother, and stated that she "would never put up with that [beating]." Overall, Point Hope mothers, and some community leaders were women who "spoke out" and "stood up."

"I'm not going to be this Iñupiat woman who just cooks and cleans and takes care of the kids all day. I work and I share my kids with a good man, or not at all," this G3 Point Hope mother professed. This woman is from a whaling community known for its strong Iñupiat values. I deal with this aspect of influence, as I answer question four, the final exploration covered in this thesis.

## 6.6 Influences and the ANVMT System

The maternal transport system allows women to access health care services unavailable in their communities. At the same time, they are increasingly exposed to more of the Western value system, even in Kotzebue, than they are of their indigenous culture. As Paxson (2004) looks at Greek mothers, she discovers a type of nationalism in



their identification as mothers. Western ideals of motherhood to which most global women are measured, she found, were too unrealistic for these mothers. I find a similar reaction among Iñupiat mothers, mostly from the outer lying communities of Buckland and Point Hope that contribute to their ability to resist this unrealistic prolegomenon of motherhood, as I answer question set four.

**QUESTION SET 4:** What are the nature and extent of the influences that contribute to a woman's transition to motherhood (biomedical and family/community) in this community?

#### *6.6.1 Biomedical Influences*

The way the biomedical system influences these women as they deliver their babies is both direct and indirect. Directly, the system provides them with access to medical services as their health care providers prescribe. Indirectly, the expectations, treatments, and occurrences can also involve subjugation of Iñuipatness to the dominant Western model. When asked if doctors or health care practitioners gave any advice, the women sometimes mentioned their dealings with the protocol or transport, about "having to go." Or, "they told me to."

Direct advice from midwives in their community or family and friends were mentioned more frequently than that coming from doctors or CNMs. Any influence of the biomedical sort for these women was indirectly impacting them through the transport. For those not transporting, the G1s before the policy, or the G2s and G3s that stayed in their community to deliver, the impact, and influence was not as prominent as those undergoing transport.

#### *6.6.2 Family and Community Influences:*

At this point, I present a descriptive chart of observations of identifiable Iñupiat cultural expressions present in each study village. There are no assessments associated with each description, these are merely features of openly expressed Iñupiat values as noted by participants, and as I observed. I am not presenting any claims of the 'worth' of Iñupiat nor Western value systems in this thesis. None of the Alaska Native villages in this study (nor likely any in the state), are considered either fully Western at their core, or

paying full homage to strictly indigenous cultural values. Many Alaska Native communities and organizations, along with their leaders and members, will express a desire for a healthy balance of attention to their cultural heritage while engaging in Western-based socioeconomic activities. Since the factor of analysis in this study concerns Iñupiat villages, identified as such based on Iñupiat heritage of their residents, the features exhibiting Iñupiat cultural values for each study village are separately listed in Tables 6.6, 6.7, and 6.8. Appendix E contains the Native Village Council protocols for

**Table 6.6** Noted Features of Iñupiat Values, Village of Buckland, Arctic Passages Study Period

Village	Language Usage throughout village	Cultural Participation	Level of Involvement with Alaska-Native based village activities
<b>Buckland</b>	<ul style="list-style-type: none"> <li>-Signs in schools and buildings in English and Iñupiaq</li> <li>- Iñupiaq used intermittently by village officials</li> <li>-Songs dances in schools reflect youth knowledge of language</li> <li>-Iñupiaq used intermittently by youth and Elders in everyday language</li> </ul>	<ul style="list-style-type: none"> <li>-Very evident importance of Iñupiat-based celebrations from dancing and feasts to</li> <li>-Funerals Western-religious based, yet</li> <li>-Still carry on traditions of Iñupiat meaning</li> <li>-No mention, however, of blanket tosses</li> <li>-Naming of babies still include traditional naming practices and role expectations</li> <li>-Uncles are still very much a part of a young man's hunting and fishing tutelage</li> </ul>	<ul style="list-style-type: none"> <li>-Basketball seems to loom large in terms of carrying on a community-wide healthy competition and identity</li> <li>-Fish Camps are very important here</li> <li>-Many subsistence-based families</li> <li>-An active village council with older members.</li> <li>-Little evidence of younger community member involvement in continuation of Iñupiat value system, aside from</li> <li>-Native dancing at school, occasional Fish or Cultural Camp participation</li> </ul>

Source: Compiled by author for use in study analysis (derived from Coe, et al., 2004)

each of the three communities.<sup>37</sup> I present these as composites of type of influence likely gained from living in each of these areas. The respective community leaders' comments

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<sup>37</sup> The dates of the signatures are different because the last village to officially enter the study was Point Hope. During the latter part of data collection and analysis they requested a presentation and a revised version of the protocol. Therefore, the current name under which the study was conducted also appears on the Point Hope protocol.

**Table 6.7** Noted Features of Iñupiat Values, Village of Kotzebue, Arctic Passages Study Period

Village	Language Usage throughout village	Cultural Participation	Level of Involvement with Alaska-Native based village activities
<b>Kotzebue</b>	<ul style="list-style-type: none"> <li>-Signs in schools, Maniilaq Health Center and office buildings appear in English and Iñupiaq</li> <li>-Colloquial Iñupiaq-based terms heard in casual conversation, especially among Elders</li> <li>-Local crafts sold in village office</li> <li>-Church services in Iñupiaq and English</li> <li>-Gatherings of Elders tend to 'break out' in Iñupiaq ; some grandparents teaching grandchildren</li> <li>-Iñupiaq materials available at library on request</li> <li>- Iñupiaq course taught as on-site and Distance Education through UAF Chuckchi Campus in Kotzebue</li> </ul>	<ul style="list-style-type: none"> <li>-Parades with Iñupiaq themes,</li> <li>-Some ceremonies with Iñupiaq terms,</li> <li>-Subsistence hunting fishing evident in village</li> <li>-While clothing worn by adolescents appear more Abercrombie and Fitch than pre-colonization, there are</li> <li>-Still kuspiks and whaling parkas worn by older community members and infants and children are still occasionally dressed in the more pre-colonization style garments</li> <li>-Women frequently hold children in <i>amaaqtuq</i> style (carrying infant on back inside parka hood), even with Western-style jacket</li> <li>-Participation in Fish Camps, Fishing, Caribou and Seal hunting</li> <li>-Whaling is more of an outer-village activity</li> <li>-Modern village hotels reflect local culture (<i>umiak</i> covers entry way)</li> <li>-Fishing and Seal-hunting still actively practiced by many in the village with young people encouraged to participate</li> <li>-trips to outer-villages are deemed as important to trips to Anchorage or Fairbanks</li> <li>-Recent National Park Service museum presents cultural relics, uncertain impact on Alaska Native participation</li> </ul>	<ul style="list-style-type: none"> <li>-Gathering/Iñupiat Community-building:</li> <li>-Loss of important gathering place (Senior Center in late 2010) that had invited informal congregation of youth and Elders</li> <li>-Changing open hours of MHC</li> <li>-Bingo and radio station are gathering places for select groups</li> <li>-Occasional formal gatherings in churches around Western Christian religious</li> <li>-based holidays sometimes take on distinctly Iñupiaq features</li> <li>-Iñupiat <i>Ilitqusiak</i> (statement of values) posted in Village office, schools, and in Social Service areas</li> <li>-Airports (1 major airline airport, 2 bush plane facilities) have evidence of Iñupiat-based community, as a very social gathering place and virtual hub of activity.</li> <li>-Village Stores (A/C in particular) are common meeting places for village community members</li> <li>-Take-out food from increasing number of restaurants (and use of taxi service instead of walking)</li> <li>-Shuttle bus service provided for Elders and those associated with Maniilaq</li> </ul>

Source: Compiled by author for use in study analysis (derived from Coe, et al., 2004)

have already been addressed. I now call attention to another type of leader that I collectively call 'midwives.'

Collectively, I found the midwives from these communities to be special types of leaders in their own right. AA<sup>38</sup>, an elderly midwife, long-since retired, mentioned it was

**Table 6.8** Noted Features of Iñupiat Values, Village of Point Hope, Arctic Passages Study Period

Village	Language Usage throughout village	Cultural Participation	Level of Involvement with Alaska-Native based village activities
<b>Point Hope</b>	<ul style="list-style-type: none"> <li>-Village leaders and most community members of all ages possess working knowledge (speaking, reading, and writing) of Iñupiaq language</li> <li>-Not as many public buildings in this small village, so not as many signs outright noticeable</li> <li>- Tikigiq school (PK-12), part of the North Slope Borough School District has signs in and English and</li> <li>-NS School district has Iñupiaq language lessons and word search on their website</li> </ul>	<ul style="list-style-type: none"> <li>-Village leaders take on more of an active role in the daily lives of the community residents</li> <li>-Continue to practice whaling ceremonies, rites and rituals passed down from generation to generation</li> <li>-Whaling captain burial evidenced by landmark whalebones protruding from gravesites</li> <li>-Remains of whalebone-constructed houses (which were lived in in this lifetime) still evident near shore</li> <li>-Active carving, collection and use of pre-colonial and ceremonial gear</li> <li>-Strong affiliation exhibited between Christianity and Alaska Native spiritualism in this community</li> <li>-Young people exhibit reverence for and are mindful of cultural taboos and expectations</li> <li>-children of all ages wearing hand-made "parkies" complete with animal fur inside and white outer <i>atikjuk</i>-</li> <li>-Entire community aware of a small child representing Point Hope in the Baby contest of the World Eskimo-Indian Olympics in Fairbanks. Auntie made a miniature parka for occasion</li> </ul>	<ul style="list-style-type: none"> <li>-Community activities continue to revolve around subsistence practices</li> <li>-Everyday meals tend to include more subsistence food</li> <li>-Social activities and caring responsibilities continue to adhere to traditional-based protocols</li> <li>-Iñupiat value system protocols still followed, even with presence of western-based conveniences and institutional structures (village clinic, fire dept., etc.)</li> <li>-Village leaders and Elders more directly involved in daily lives of community members, young and old.</li> <li>-Senior shuttle takes Elders throughout village with a call on VHF radio at any time, provided by Native Village</li> </ul>

Compiled by author for use in study analysis (derived from Coe, et al., 2004)

good to "have doctors" because sometimes it was hard "doing it all by yourself." She also reminisced about how many babies, even twins, she delivered.

<sup>38</sup> I am using a different naming protocol (double capital letters) to protect the anonymity of midwives.

Another midwife, BB, talked about how it was good that "they [ANMC] have those machines,"(while motioning with her hands around an imaginary "belly" on herself) "that strap on, that they hear the babies' heart beat." This woman also continued to describe an experience where she kept her own daughter from having to be medevac'd to Anchorage, by helping with the delivery of her grandchild. She also talked about knowledge and use of medicinal plants and how that skill was being passed down, but not midwifery. BB then relayed an instance during a town meeting in which she "stood up" and chastised visiting state representatives for not following through with their promises.

Midwife CC is not as old as the other two, but she has quit practicing for health reasons. Her experiences as a health care provider in her community went beyond maternity care, but she is most known for deliveries. She thinks that when the transport is necessary that it is a good thing they have it—but when it is not needed women should get the kind of care they prefer. "If they [expectant mothers] are kept informed," she said, "they [expectant mothers] will make the right decision." To this midwife, then, sharing information was imperative to good care for her community.

She also envisioned a more active role for her generation (G2) in tackling some of the issues at hand in their village. "I spoke out loud at the [place], and said 'it is up to us to do something about babies having babies.'" She talked of going to school to set an example to the young people that if she could do it, so could they. She saw the school district in her area as the venue to reach the youth, and had plans for guiding them toward what she saw as paths to healthier futures. This sort of activism resounds across generations and throughout the Village of Point Hope. I include this theme in my recap of the findings, as I conclude this thesis.

## Chapter 7 Conclusion

Overall, this work opens an avenue for further exploration from within the community. When discussing health disparities like postneonatal mortality rates, the findings from this study help change the conversation from how to fix a problem currently framed around routinely transporting Alaska Native expectant mothers for hospital birth; to what might be done to develop a policy from within the community, where called for.

### 7.1 Conclusions

In chapter 6, I outlined dominant themes of Iñupiat-based community-mindedness discovered in Buckland, where Elders figure prominently and teaching youth is important. Buckland mothers expressed appreciation of the Maniilaq and ANMC services, as accessed through the transport system. I find that the importance of social strength that surfaced among the small Kotzebue group was based on resilience and somewhat on the Western-based institutions operating as economic providers in the area. Point Hope's political and cultural strengths were expressed through a deep involvement of women and community leaders, with Iñupiat-based institutions used to provide cultural backbone, as well as economic and social security.

I determined that there is no evidence among this group of the maternal transport system being treated as a new tradition. Quite the contrary, the transport system is mostly viewed as a necessity at best, and a hardship, overall. I found nothing to suggest that the Iñupiat women and their families from northwest Alaska looked at leaving their communities to have their babies for the celebratory, good time that was indicated by some case workers and practitioners. Many mothers mentioned the likelihood that stress from being away for so long even led to family and marriage break-ups. Any mentions of celebration surrounding childbirth tended to come either from the G1 mothers, as they spoke of traditions followed during their early years as new mothers, or on arrival home

in Point Hope, where prevalent Iñupiat values have most recently involved local midwives and blanket tosses.

Investigation into factors at play in the maternal identity work among these mothers led to a discovery of extreme pride in most cases, as these women incorporated Iñupiat values into their parenting, and views of themselves. While exploring how the presence of liminal spaces is more conducive for these women to incorporate Iñupiat values into their identity work— I uncovered a similarity between liminal community and delivery site features and features of midwifery models. That is, the more features of Iñupiat value systems present, the more closely aligned with a midwifery, and holistic model of birth for that community.

Group generational attitude differences concerning maternal care, and women's roles in general, were: mainly along lines of religion in Buckland, not readily discernible in Kotzebue; and somewhat stark in Point Hope. The G2s and G3s expressed an Iñupiat feminism that looks like the makings of new leadership in that community, or perhaps the reemergence of old leadership of the mothers club. As this community is also showing signs of liminal spaces for such revolution in maternal care, Point Hope is a likely candidate for bring birth back to the community.

Finally, in their work on reducing health disparities of indigenous Australians, Durey and Thompson (2012) call for health care providers to "critically reflect on whether policies or practices promote or compromise Indigenous health and wellbeing." The Arctic Passages study can stand as a new way to look at the logic of cookie-cutter application of strictly biomedical solutions for maternity care in this area. It also stands as a call, on behalf of the participants, for local-based solutions and truly intercultural health care.

I opened this dissertation with a quote from an anthropologist concerned with birth. I close with the words of indigenous mother and author LeAnn Simpson, talking about indigenous women and mothers (Simpson 2006:27):

*The way we mother is the way we inoculate our children against consumerist throwaway culture, the fear and self-doubt of colonialism, and provide them with skills, knowledge, and courage to bring about this transformation. Mothering is the way we nurture our children with indigenous interpretations of our teachings, and this transformation begins with birth.*

For Simpson and the Anishinaabeg Nation, a Lake Superior Band of Chippewa she belongs and refers to, pregnancy became a way of linking self-determination with self-determination of the Nation, and responsibilities of women in re-building indigenous nations, as life-givers, transformers, and vitalizers, "whether or not we give birth." Reclamation of this responsibility, she says, has an impact for other occupied indigenous nations in "our collective indigenous visions of sovereignty, freedom, and justice."

This theme of reclamation can be heard loudest among the Arctic Passages feminist of Point Hope, but it also reverberates in the comments of the Point Hope leaders, Buckland leaders and caregivers. They are not calling for more technology as much as they are calling for a more sovereign voice in the care of their own people from this generation forward.

The current passages described in this dissertation are just a glimpse at how some of the mothers from the Buckland, Kotzebue and Point Hope areas of MSA have navigated the maternal health care system as it exists. Like the Northwest Passage mentioned in the introduction, negotiation of the maternal policy involves more than overcoming physical obstacles. Political and cultural strengths as exhibited in the views of the few, retiring local midwives of the area are examples to young leaders. Young women of Point Hope, especially, are beginning to let their voices be heard as they speak to each other, and to their community leaders. They can assist others in navigation of health care issues, as these mothers speak out, acting as example to others in steps toward sovereignty and re-building, spoken of by Simpson. At the threshold of a journey toward possibilities of self-determined intercultural health care, these Iñupiat communities and their future generations born by them are relying on them.

From Kotzebue, an area verily phased into a decidedly biomedical and Western system of care, especially influenced by the omnipresence of Maniilaq, the small number



of participants voiced resigned compliance with a system like no other area. Ultimately, it is up to these communities' members and leaders to decide how much to invest toward making sure assets of an area, including the values of the peoples inhabiting it, are still there to assist in navigation.

In a state of losing its last midwives, Buckland's Native Village Council has called for a resurgence of this presence as a component of in their latest Economic Development Plan (Northwest Arctic Borough 2012). This call is not shunning the much-needed access to medical care provided by the Alaska Native Village Maternal Transport system. This call shows a realization that these Alaska Native villages, with their Iñupiat strengths are viable examples today of how not to buy into the Western and biomedical idea that one in three women need surgical intervention to have a baby. This call shows a realization that risk can be re-evaluated and local care can be re-established under Iñupiat ideals, with thoughtful, careful attention, as it has been done in the past. A new protocol might be developed in areas where women and communities are calling for it, with the indigenous communities steering the direction.

## 7.2 Arctic Passages Limitations and Questions for Further Research

### 7.2.1 *Limitations*

This study is not representative of Alaska Native communities, or even the villages in which the study took place. I do offer a qualitative approach adding context to statistics, but I do not present a simple descriptive, anecdotal analysis. Most standardized, market-based driven comparisons are based on White statistics as being the norm, and any difficulty with health disparities among non-White populations becomes racial-based. There tends to be a medical explanation and proposed solution for the "problem," as defined by medicine (Durey and Thompson 2012; Farmer 2005; Kleinman 2006).

With this approach, which is very common in allopathic health care that is market-driven, it is difficult to see how VBACs could be a good idea, or how self-determined indigenous maternal care might make sense for those interested. It is easier to keep things status quo. Just as it is difficult to view maternal health disparities as indicators of

problems with marginalized racial groups, instead of inherent problems with policy that is ethnocentric and based on Western views of normalcy.

I did not attempt with this study, however, to answer to evidence-based approaches; therefore, any results will apply only to those participating in the study. Also, none of the findings can be applied to the communities as a whole. Buckland, Kotzebue and Point Hope are all made up of caring capable peoples interested in seeing their communities thrive. I in no way intend this work to propose that I know what is best for any of them. I do hope that if they were to venture into addressing their maternal health care situations, that they would feel this work useful toward informing their decision-making processes. There is enough ethnographic data to show that, in these Arctic Passage communities:

- A strong presence of Iñupiat values offers mothers and families the liminal space and opportunity to revitalize community birth in their area if they choose.
- Buckland's Elders are positioned to carry their plans to reintroduce midwives through economic development. The political and social will for such action, however, is most prominent in Point Hope where even younger generation mothers are expressing desires to keep Iñupiat values and birth in their community, and least likely in Kotzebue, where strong ties to Western value systems exist through the large biomedical and economic presence of Maniilaq.
- Programs should be adjusted with community, and most importantly, mothers' input.

### *7.2.2 Questions for further Research*

The largest limitation to most studies beside time and money is space. There is not enough of any of these to fully capture what is going on with the workings of the ANVMT policy in these communities. There are always other questions that arise after one set of research questions has been answered. I think, for instance, that it would be useful to see how Alaska Native communities feel about more self-determined maternal care in their areas.

Have midwives died out in areas where Western influence has overridden Alaska Native value expression, and hung on in areas with strong Iñupiat values? Or, have

individuals who practiced as midwives in these Arctic communities added to the revitalization and continuance of cultural values of an area? It is almost like the old question of "which came first, the chicken or the egg?" The value in exploring this question would be to inform interested communities about existing situations of communities based on cultural values. Uncovering the dynamics operating in a community might help in efforts toward self-determined health care in ways that standard Western-based epidemiological policy studies are lacking. While I cannot address such a question with the information gathered for the Arctic Passages study, it would be a valuable and logical component to a holistic outlook on assessing maternal health care in these communities.

A comparison of Maniilaq Region to other areas where the maternal transport system has been in operation would help uncover some of the ways features of both biomedical and midwifery models impact maternal care in these areas. The Yukon-Kuskokwim area, for example, where the maternal transport policy has been in operation for a longer period of time, has recently built a new PreMaternal Home in Bethel for incorporation into their transport system. Maniilaq has also made changes in arrangements for incoming expectant mothers. The women set to deliver at MHC are no longer housed in the Senior Center that was shut down in 2011, and now they are staying in the newer hotel in Kotzebue. These MHC mothers also receive travel vouchers for cab rides to the clinic for their prenatal visits, and to get to and from the MHC cafeteria for meals, which are also available paid for with vouchers.

### 7.3 Maniilaq ANVMT policy: availability versus accessibility

#### 7.3.1. *Trust and communication between worldviews in Maniilaq maternal care*

While this transport system provides access to MHC and ANMC maternal care services to MSA patients, I found barriers to care experienced by Arctic Passages participants that cannot be handled with vouchers or plane tickets. As mentioned in my discussion of American prenatal care in chapter 3, Novick (2009) stresses the difficulties experienced by minority American women who veer away from the mainstream

biomedical care. Novick finds that minority women tend not to feel at ease enough with the medical community to be open and trusting, as discussed in section 3.3 of this thesis.

The ANVMT policy has features in place to make certain women access doctor care (or CNM care at ANMC, as the case may be) at medical facilities. As this dissertation has shown, however, accessibility may still be an issue, because of disconnect between the caregivers and the expectant mothers in how they are communicating with each other, and what they are trying to communicate. This lack of communication does not solely stem from the biomedical nature in the operation of Maniilaq's ANVMT policy. I am simply pointing out the lack of communication exists, and that making medical care available to someone, does not necessarily mean automatic 'access.'

This is an overall issue in maternal care, in general, as mentioned elsewhere in this dissertation (women undergoing 'informed compliance' rather than 'informed consent' during prenatal care). This disconnect is more pronounced in the rural Alaska Native villages where women come from homes and communities where their cultural influences are stronger. This disconnect may also occur in indigenous or ethnic cultures when the mothers of these backgrounds encounter the pervasive, standardized maternal care offered from a biomedical framework. There is an even greater divide between what these mothers think is "right" for their baby and themselves, and what the biomedical community might be saying is "right." These mothers might feel more under scrutiny—as many women, particularly indigenous women, do—than actually 'cared for' with all the tests involved.

### *7.32. Alignment of like-minded communities and health care philosophies*

My findings, revealed through thematic content analysis as shown in chapter 6, indicate that: participants from study communities identified as having stronger ties to Iñupiat system of values are less likely to find trouble with themselves (internalizing) when there was a problem with maternal transport. That is, the more firmly enmeshed a community in an Iñupiat value system, the more participating women are at ease with their abilities to make decisions regarding their care, with or without the inclusion of biomedical options. If any troubles in their situations do arise, Arctic Passages study

mothers from communities with strong stronger the ties to Iñupiat value system are more likely to find that the difficulties lie with the maternal transport system, and less likely to feel personally responsible. Conversely, when participants were from study communities that I have identified as exhibiting stronger Western influences (primarily through the access to biomedical birth), they were more likely to find personal reasons for any difficulties encountered with the transport system.

Maniilaq acts as the authoritative broker of healthcare expertise in Kotzebue, with standard operating procedures that are rooted in biomedical health practices (large percentage of deliveries involving doctors). By comparison, community leaders and young mothers in Point Hope and Buckland are working to influence change to maternal healthcare that is influenced by their Iñupiat values. Younger Inupiat women of Point Hope, in particular, appear not as ready to internalize problems surrounding maternal health care and transport in their area, as is more the norm for women from a community immersed in Western value systems (and older generations of missionary-influenced women, according to some young Point Hope women).

Similarly, I argue that the village leaders and young mothers of Point Hope and leaders of Buckland are operating from a distinctly feminist paradigm, promoting an alternative (feminist) model of authority and expertise, i.e., one that includes local midwifery. It is noteworthy that it is the communities that are still transitioning to a wholly westernized system of care that have the social space to experiment in this way. In other words, study communities where local traditional midwives have most recently been practicing are those with the best advantage in affording positive change toward their stated desires in maternal care i.e. self-determination in their communities. I would hypothesize that any changes in maternal care practices made in Kotzebue, however, are more likely to come from a paternalistic and 'top-down' bureaucratic fashion.

Just as Daviss (1997), who worked among the Canadian Inuit, hypothesized that a community is in danger of disintegration when birth slips from that community, I attribute the contrast of the heavily biomedical (and Western influenced) study village to those with stronger ties with an Iñupiat value system—to the importance of the local

management of birth in each area. While some communities are navigating the future birthways with a primarily Western-based biomedical mindset; other communities have thrived on their abilities to pay homage to their rich and knowledgeable Iñupiat heritage as it applies to setting a course for the future. As such, there are likely merits with respect to cultural protection and self-determination for these villages as they continue to navigate the emerging and changing social spaces in the Arctic for the next century and beyond. It is likely they will continue to rely on themselves and their communities first, to chart the course for their maternal care to come.



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## Appendix A

### 'Arctic Passages' Line of Questions for Interviewing

#### Line of Questions for Interviewing Questions Regarding:

##### **Motherhood:**

*Answers to these questions are part of the description of the mothers' ideation of 'motherhood' and their tendency to incorporate (or not incorporate) their Alaska Native identity into their process of constructing their own respective maternal identities. These questions are pivotal to the 'Maternal Identity Work' of mothers. What does a Mother do?*

- Who are people you feel are “good” mothers? “Good” Iñupiat” mothers?
- Are there qualities of Iñupiat mothers that you feel give them special meaning? What are those qualities?
- Is there (or has there been) someone in your life like that? Do you know someone like that?
- Are there people you will try to be like? Not be like?

##### **Advice/Assistance on childbirth:**

*One of the main study aims is to determine which sources of knowledge are most influential for the mothers, so this set of questions is necessary to determine this.*

The following questions will be asked to determine where mother-to-be goes to seek advice on childbirth:

- Did you consult anyone for advice concerning your pregnancy?
- Who? Professional? Was this a family or community member? Friend? Age?
- Did anyone accompany you to the hospital? When? (During PreMaternal Home Visit? Just Before Birth?)
- Are there others that you counted on to help you before you left for the hospital?
- What kind of assistance did you feel like you needed?
- Were you able to get that assistance? From whom?
- Did you assume you were going to the hospital? If so, Why?
- Or, was that advised by someone else? Whom?
- Did you taken part in any birthing classes? With whom? If so, did anyone attend these with you?

##### **Practitioner:**

*Family and Community sources will be compared to Biomedical sources to determine strength of each for mothers in different transport situations.*

*Note: Specific caregiver names are not asked for here, just 'types' (midwife, CHA, or doctor, for instance)*

- Which caregiver did you see before birth? During birth? After birth?
- Did you have a special caregiver for the baby after it was born?
- Why were you seeking this type of care?
- Is it the care you preferred?

**Birth:**

*These questions help determine expectations as they compare to advice that was derived from different sources as they apply to each mother's situation. These questions lead to a deeper understanding of elements of each mother's idea of how connected her concept of her identity as a mother is to her anticipated birth experience*

- What did you expect to happen when it was time for you to deliver your baby?
- Did you have any plans for types of treatment you would like? Or, that you would NOT like to have had?
- Did any caregivers or advisors discuss these options with you?
- Did you have a partner or someone else with you (birthing coach)?
- Did you meet any of the caregivers at the hospital before delivery?

**Post-Partum:**

*Likewise, these questions help determine expectations after the baby is born. These questions will also lead to a deeper understanding of each mother's idea of how close her concept of her identity as a mother is to the outcome in her actual role as a mother*

- Did you have any special plans for bringing the baby home?
- Did the baby stay with you for a period of time? How long do you anticipate?
- Was there be someone to help you with the baby while you are caring for your child? Were there plans of adoption? Were you comfortable with those plans?
- If you work, did you plan to return to work? When?
- What are (were) your hopes for your future? Your baby's future?

## Appendix B

### UAF Institutional Review Board Approval Letter



#### Institutional Review Board

909 N Koyukuk Dr. Suite 212, P.O. Box 757270, Fairbanks, Alaska 99775-7270

(907) 474-7800  
(907) 474-5444 fax  
fyirb@uaf.edu  
www.uaf.edu/irb

September 16, 2011

To: Lawrence Duffy, PhD  
Principal Investigator

From: University of Alaska Fairbanks IRB

Re: [260239-1] Special Delivery: Transporting Ifupiat Mothers and Babies in Northwest Alaska

Thank you for submitting the Continuing Review/Progress Report referenced below. The submission was handled by Expedited Review under the requirements of 45 CFR 46.110, which identifies the categories of research eligible for expedited review.

Title:	Special Delivery: Transporting Ifupiat Mothers and Babies in Northwest Alaska
Received:	July 28, 2011
Expedited Category:	7
Action:	APPROVED
Effective Date:	September 15, 2011
Expiration Date:	August 25, 2012

This action is included on the September 15, 2011 IRB Agenda.

*No changes may be made to this project without the prior review and approval of the IRB. This includes, but is not limited to, changes in research scope, research tools, consent documents, personnel, or record storage location.*



## Appendix C

### Mothers' Informed Consent Form

**UAF IRB # 09-12 Date Approved 5 May 10; extended: 17 Oct 11**

#### **Description of the Study:**

We are asking you to be part of a study. It's about mothers leaving their villages to have their babies. We want to learn about how leaving the village affects the mothers and their families and communities. We asked you because you are a village mother. Please read this form and ask any questions you may have before you agree to be in the study.

If you decide to take part in the study, we ask your permission to be with you:  
While we're here, we'd like to:

Learn how you leaving to have your baby affect your family, friends and community members

Personal moments are respected. We will always honor you and your family. We'll get out of the way whenever you ask.

We are also asking you to help us learn what to ask mothers in your community. We think questions are better when they come from someone else going through the same thing. We hope that this study is useful to your community who help Alaska Native mothers who fly in from the villages to have their babies.

We would be around:  
A few hours a day (or night)

#### **Risks of Being in the Study:**

The risks to you if you take part in this study are small. There is the possibility that you could feel uncomfortable with strangers around. We will do everything we can to keep that from happening. We are very respectful of your space. We will never be there when you don't want us to be there. We will always check with you to sure that what we are doing is OK with you.

#### **Benefits of Being in the Study:**

By listening to words and seeing the experiences of mothers like you, we hope to get a better idea of how flying to the hospitals to have babies affects mothers and families in your village. You can help us to show a picture of what it is like. You can also help us learn what to ask other mothers from your village. We might be able to see if mothers like you are getting what you need. This type of study

where we ask the mothers has never been done here before. We think it will be useful to your community, and we are offering to assist you in return for your help. We can help as you feel like letting us. We can help by carrying bags, sharing transportation, cooking, and things like that. We can't promise that you will gain anything from being in this study. And, besides the things mentioned above, there would be not be a direct benefit to you.

**Compensation:** We are offering \$50 when your part of the study is completed. We will also offer our help with things like those mentioned above.

**Confidentiality:**

We will not identify you personally. Any private or sensitive information you provide will be stored in journals and computers used only by researchers. Information you share will be collected with others' information and only shared with the research team (including National Science Foundation), as general findings from case studies. We will not use your real name to answer these research questions and collect NO identifying information from you. Information about you that is collected by the research will be kept strictly confidential. We will protect your confidentiality by giving you a number that no one can trace to your name. We will then destroy any papers that have this information on them. Research records will be stored in locked cabinets. The information from this study could be used in reports, presentations, and publications, but you will not be individually identified.

**Voluntary Nature of the Study:**

Your decision to take part in the study is voluntary. You are free to choose not to take part in the study or to stop taking part at any time without any penalty to you.

**Contacts and Questions:**

If you have questions now, feel free to ask us. If you have questions later, you may contact:

Lisa Schwarzburg, UAF Indigenous and Rural Health PhD Candidate  
PO Box 870573  
Wasilla, AK 99687  
phone: 907.373.5503  
e-mail: [aflls3@uaa](mailto:aflls3@uaa)

Dr. Larry Duffy, Interim Dean of the Graduate School, UAF Graduate School  
PO Box 757560  
Fairbanks, AK 99775-7560;  
phone: 907.474.7525  
or e-mail: [fflkd@uaf.edu](mailto:fflkd@uaf.edu).

If you have questions or concerns about your rights as a research subject, please contact the Research Coordinator in the Office of Research Integrity at 474-7800 (Fairbanks area) or 1-866-876-7800 (outside the Fairbanks area) or [fyirb@uaf.edu](mailto:fyirb@uaf.edu).

**Statement of Consent:**

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been provided a copy of this form.

---

Signature of Subject & Date

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Signature of Person Obtaining Consent & Date





## Appendix D

### List of Terms Associated with Maternity Care

#### Attendants:

Obstetrician/Gynecologist: surgical birth attendant  
 Family Practice Physician: general physician specializing in Family Medicine  
 Physician Assistant: physicians' assistant  
 Certified Nurse Midwife: Midwife with Nurse's degree and training  
 Licensed Lay Midwife: midwife with apprenticeship and state license  
 Direct Entry, Lay Midwife: midwife with apprenticeship  
 Traditional Birth Assistant (TBA): Specially designated attendant, mostly in non-industrialized settings, training varies

#### Guidelines/Procedures:

Gestational Period  
 Friedman Curve  
 Genetic Counseling  
 Ultrasound  
 Amniocentesis  
 Electronic Fetal Monitoring (External and Internal)  
 Rupture of Membranes (Spontaneous/Manual)  
 Forceps  
 Vacuum  
 Epidural Block  
 Oxytocin  
 Pitocin Drip  
 Episiotomy  
 C-section

#### Types of Birth/Place of Birth

Hospital Birth (Planned and Emergency/Transport)  
 Hospital Birthing Center

Hospital  
 Non-hospital Birth (Planned/Unplanned)  
 Free Standing Birthing Center  
 Home  
 In Transit (vehicles, planes, public places)

#### Pregnancy Terms/Conditions

##### Maternal:

Primigravida (first pregnancy)  
 Multigravida (Gravida-2 or more)  
 Pre-eclampsia (Hypertension)  
 Gestational Diabetes  
 Placenta accreta: Placenta that attaches to muscle of uterus.  
 Placenta increta: Placenta that grows into muscle of uterus.  
 Placenta percreta: Placenta that penetrates muscle of uterus.  
 Placenta previa: Low attachment of the placenta, covering or very close to the cervix.  
 Placental abruption: Premature separation of the placenta from the uterus.  
 Placentomegaly: Abnormally large growth of the placenta during pregnancy.

##### Infant(s):

Preterm (prior to 37 weeks)  
 LBW (Low Birth Weight: less than 5 lbs.)  
 Macrosomia (baby too large: either over 8lbs. 13 oz. or 9 lbs. 14 oz., depending on study)  
 Shoulder Dyslocasia  
 Breech  
 Singling/Multiple



## Appendix E

### 'Arctic Passages' Native Village Council Signed Protocols

#### NATIVE VILLAGE OF BUCKLAND RESEARCH PROTOCOL

Name: (PI): Lisa Schwarzburg  
 Institution: UAF PhD Interdisciplinary Studies Program  
 Contact: Phone: (907) 373-5503  
 E-mail(s): [alaskalisas@gmail.com](mailto:alaskalisas@gmail.com) or [ljschwarzburg@alaska.edu](mailto:ljschwarzburg@alaska.edu)

**Title of Project:** Learning To Mother: A Look at How Time and Place Impact Maternal Socialization in Northwest Arctic Alaska

**Summary of Project (brief):** I would like to look at the experiences of mothers who gave birth in the villages (before the transport system) and compare those to the experiences of mothers delivering at Maniilaq Medical Center or other locations (Anchorage) outside their home village.

Other similar studies have found mothers have a sense of well-being and less need for C-sections and drugs when their local support system is available. I will try to explore those possible connections here in these communities using input from mothers from different generations. I'll ask them about who their influences are, whom they seek knowledge about pregnancy, birthing, and mothering; and how they define motherhood and what advice they (gave or) would give to others.

**Funding Sources:** National Science Foundation Office of Polar Programs Arctic Social Sciences Grant # 08-597 has funded this doctoral dissertation study.

**Dates of Project/ Duration:** Initial Data Collection (interviewing of participants) in Buckland should occur during the weekend of the 20<sup>th</sup> of November 2011 (with possible follow-up with telephone or e-mails). Final analysis and written results are anticipated to follow, outside the community.

Two field researchers expect to complete the data collection phase by 31<sup>st</sup> of December 2011. Nothing from this trip will be included in our analysis until Buckland Village Council has signed this protocol.

**Other Personnel and Affiliations:** Field Research Assistant is currently associated with some in the community, and will be helpful in facilitating introductions, etc. Aside from the community's willingness to participate, we will not need any sort of direct assistance. Guidelines and protocols from the Village Council will be followed, and include participation results only from those given UAF Institutional Review Board-approved informed consent.

**Relevance to Tribe/Members:** Decision-making bodies could use this information to make policy decisions concerning Maternal and Infant Health Care and Traditional Healing in this community.

**Role of Tribal/Members:** I am trying to make these findings, from the voices of the women themselves, become part of the information agencies might use to make patient-driven decisions. Since mothers and families that I hope to be speaking with are members—their input would be direct—in their words, from their own viewpoints, but completely anonymous.

**Benefits to Tribe/Members:** This information could be used to make informed policy decisions concerning Maternal and Infant Health Care and Traditional Healing in this area. Hopefully, this study will provide the Tribal Council with a unique, self-directed guide about health care in their community.

**Potential Risks:** I would hope that there would be none. But, if some people relayed an experience that caused them emotional distress, there is an off chance that this could somehow cause grief or shame. Every effort will be made to put participants at ease by honoring their willingness to participate and respecting their feelings.

**Need for Local Involvement:** I would need for these women to be willing to share their stories with me.

**Compensation Rates for Local Involvement:** Young mothers who participate will receive a \$50 Wal-Mart gift card. Secondary participants (identified as maternal knowledge sources by mothers) will receive \$25 Wal-Mart gift cards.

**Expected Results/Publications/Final Product(s):** Case Studies representing different generations and birthing situations (locations) will be used to determine the impact of where and when women of Northwest Arctic Villages become mothers, and compare their sources of knowledge as they become mothers in these communities.

We are currently working on a review article, describing the research aims and design, to submit to an international electronic journal: Rural and Remote Health. Once study is complete there are also plans to present findings in the journal, as well as at the upcoming 15<sup>th</sup> International Congress for Circumpolar Health in Fairbanks in August 2012. Of course, since this is a dissertation study, the results will also take the form of Ms. Schwarzburg's doctoral thesis for graduation.

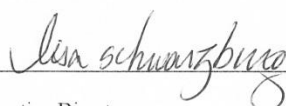
**Plans for Returning Results to Community:** I will present final copy of dissertation to Village Council. And, the Village Council and community might gain unique insight from study results.

**How will intellectual Property Rights be protected (if relevant):** Not relevant.

**How Anonymity/Confidentiality be Protected (if relevant):** No real names will be used,

**Other considerations (eg. Use of Artifacts, Identification of Sacred Sites, etc.):** I will not likely be dealing with this.

  
\_\_\_\_\_  
EXECUTIVE DIRECTOR  
Signature of Principal Investigator  
9/21/12  
\_\_\_\_\_  
Date

  
\_\_\_\_\_  
Executive Director  
21 SEPT 2012  
\_\_\_\_\_  
Date

**NATIVE VILLAGE OF BUCKLAND**

**NATIVE VILLAGE OF KOTZEBUE  
RESEARCH PROTOCOL**

Name: (PI): Lisa Schwarzburg  
 Institution: UAF PhD Interdisciplinary Studies Program  
 Contact: Phone: (907) 373-5503  
 E-mail: [lisa@schwarzburg.org](mailto:lisa@schwarzburg.org)

**Title of Project:** Learning To Mother: A Look At How Time and Place Impact Maternal Socialization in Northwest Arctic Alaska

**Summary of Project (brief):** I would like to look at the experiences of mothers who gave birth in the villages (before the transport system) and compare those to the experiences of mothers delivering at Maniilaq Medical Center or other locations (Anchorage) outside their home village.

Other similar studies have found mothers have a sense of well-being and less need for C-sections and drugs when their local support system is available. I will try to explore those possible connections here in these communities using input from mothers from different generations. I'll ask them about who their influences are, whom they seek knowledge about pregnancy, birthing, and mothering; and how they define motherhood.

**Funding Sources:** National Science Foundation Office of Polar Programs Arctic Social Sciences Grant # 08-597 has funded this doctoral dissertation study.

**Dates of Project/ Duration:** Initial Data Collection (interviewing of participants) in Kotzebue should occur during the weekend of the 8<sup>th</sup> December 2011 (with possible follow-up with telephone or e-mails). Final analysis and written results are anticipated to follow, outside the community.

Two field researchers expect to complete the data collection phase by 31<sup>st</sup> of December 2011. Nothing from this trip will be included in our analysis until Kotzebue Village Council has signed this protocol.

**Other Personnel and Affiliations:** Field Research Assistant is currently associated with some in the community, and will be helpful in facilitating introductions, etc. Aside from the community's willingness to participate, we will not need any sort of direct assistance. Guidelines and protocols from the Village Council will be followed, and include participation results only from those given UAF Institutional Review Board-approved informed consent.

**Relevance to Tribe/Members:** Decision-making bodies could use this information to make policy decisions concerning Maternal and Infant Health Care and Traditional Healing in this community.

**Role of Tribal/Members:** I am presently trying to establish and maintain a working relationship with ANTHC and Maniilaq such that these findings, from the voices of the women themselves, become part of the information they use to make patient-driven decisions. Since mothers and families that I hope to be speaking with are members—  
 Their input would be direct—in their words, from their own viewpoints.

**Benefits to Tribe/Members:** This information could be used to make informed policy decisions concerning Maternal and Infant Health Care and Traditional Healing in this area. Hopefully, this study will provide the Tribal Council with a unique, self-directed guide about health care in their community.

**Potential Risks:** I would hope that there would be none. But, if some people relayed an experience that caused them emotional distress, there is and off chance that this could somehow cause grief or shame. Every effort will be made to put participants at ease by honoring their willingness to participate and respecting their feelings.

**Need for Local Involvement:** I would need for these women to be willing to share their stories with me.

**Compensation Rates for Local Involvement:** Young mothers who participate will receive a \$50 Wal-Mart gift card. Secondary participants (identified as maternal knowledge sources by mothers) will receive \$25 Wal-Mart gift cards.

**Expected Results/Publications/Final Product(s):** Case Studies representing different generations and birthing situations (locations) will be used to determine the impact of where and when women of Northwest Arctic Villages become mothers, and compare their sources of knowledge as they become mothers in these communities.

We are currently working on a review article, describing the research aims and design, to submit to an international electronic journal: Rural and Remote Health. Once study is complete there are also plans to present findings in the journal, as well as at the upcoming 15<sup>th</sup> International Congress for Circumpolar Health in Fairbanks in March 2012. Of course, since this is a dissertation study, the results will also take the form of Ms. Schwarzburg's doctoral thesis for graduation.

**Plans for Returning Results to Community:** I will present final copy of dissertation to Village Council. And, the community might gain indirect returns from the unique insight the Village Council may derive from study results.

**How will Intellectual Property Rights be protected (if relevant):** I will use the guidance of the Native Village on how this should be handled. Any techniques described by tribal doctors, for example, will be done in general terms.

**How Anonymity/Confidentiality be Protected (if relevant):** No full names will be used, and where necessary, names will be changed. Even village names will be withheld when necessary.

**Other considerations (eg. Use of Artifacts, Identification of Sacred Sites, etc.):** I will not likely be dealing with this. If I do happen to be in town when there is a ceremony going on, however, I would seek guidance and approval of Native Village in dealing with any sort of disclosure, if necessary.

Lisa Schwarzburg      16 Dec 2011  
Signature of Principal Investigator      Date

Jeffery J. Hadley      12/21/11  
Executive Director      Date

**NATIVE VILLAGE OF KOTZEBUE**

**NATIVE VILLAGE OF POINT HOPE  
RESEARCH PROTOCOL  
RE-SUBMISSION: 10 July 2013**

Name (PI): Lisa Schwarzburg  
Institution: UAF Cross-cultural Studies Program  
Contact: Phone: (907) 373-5503  
E-mail: [lisa@schwarzburg.org](mailto:lisa@schwarzburg.org)

**Title of Project:** Arctic Passages: Maternal Transport, Iñupiat Mothers, and Northwest Alaska Communities in Transition

**Summary of Project:**

- 1) Studies\* have shown that mothers have a sense of well-being and less need for cesarean sections and drugs when local support systems are available. (\*references available for council on request)
  
  - 2) I wanted to see how flying out to give birth affected the birth experiences of mothers from the Maniilaq Service Area with different transport situations:
    - staying home to give birth,
    - traveling out to Kotzebue, to give birth, or
    - traveling to Anchorage, to give birth,
  
  - 3) So, I asked mothers of the Maniilaq Service Area about their experiences when having babies. I looked at:
    - different generations of mothers
    - from different villages.
- I asked them:
- about how they felt about their experiences with:
- staying in the village,
  - or travelling to Kotzebue
  - or Anchorage Hospitals.



We also talked about:

- what advice they would give to new mothers and
- suggestions they would make to improve the policy to fly mothers out of their communities
- who influenced them as mothers,
- who they went to for advice on pregnancy, birthing, and mothering.

**Funding Sources:** The National Science Foundation Office of Polar Programs Arctic Social Sciences Grant #09-09635 funded the study taking place in Point Hope, Alaska.

**Dates of Project/Duration:****The research (What has already occurred):**

On the weekend of November 20, 2011:

- A research assistant brought Lisa Schwarzburg to the Village of Point Hope.
- They met with the mayor and introduced the project to him.
- They left an original research protocol with him to pass on to the Native Village of Point Hope Council at that time.
- The research assistant then explained the project to women she knew in the village.
- She and Lisa asked the women if they would like to participate in the study.
- These women from the village said yes, and signed informed consent.
- The village women got Wal-Mart gift cards for their participation in the study.

The research assistant returned to Point Hope for a second visit in December, 2011:

- The research assistant explained the study to more Point Hope women.
- The women on second visit also agreed to participate, and they signed consent forms, and received Wal-Mart gift cards, too.

**Other Personnel and Affiliations:** The Iñupiat field research assistant has family ties to many in the community.

She helped with:

- Introductions,
- Explaining the study,
- Getting permissions, and
- Interviewing the participants

We visited the mayor, and attempted to contact the Village Council. We proceeded with participants only after they signed informed consent forms.

**The Protocol (What is needed, please see bottom of page):**

- Lisa's findings also show that Point Hope is a shining example of how communities with such strong ties to cultural values, heritage, and each other can use these strengths for future direction.
- We began in February 2013, by directly approaching the Native Village of Point Hope to ask for their approval of the study.
- Carrie instructed Lisa to FAX a copy of the protocol to Peggy Frankson, the Native Village of Point Hope Executive Director. A personal presentation of the protocol will be done at the request of the Native Village of Point Hope.
- Lisa is again, presenting an explanation and firm commitment to share any findings with the Native Village of Point Hope.
- Lisa wants to inform Point Hope decision makers about maternity care policies in a way that comes from their own peoples' voices.

**Relevance to Tribe/Members:** Native Village Council representatives who make decisions about health care and maternity care in Point Hope might be able to use the information from this study.

- The findings will be shared with them as a courtesy.
- And, Lisa will be happy to give a presentation to the council, at her expense.

**Role of the tribal members:**

- Lisa has only anonymous input of the Iñupiat mothers and families of the Village of Point Hope.
- The effect on mothers flying out to have babies is shown through their own words and their input.

**Benefits to tribal members:**

This information could be used to make decisions about maternity health care for tribal members.

- The results are from anonymous voices of the Point Hope women and families, themselves.
- The Council will have a special self-directed guide about health in their own community.
- Which might benefit women in the community deciding to have children in the future (What follows here?)

**Potential Risks:** All researchers hope that there will be no risks.

- There was the risk of people talking about any bad experiences making them sad
- But we did not really experience any of that with the Point Hope mothers we spoke with.

**Need for local involvement:**

- Lisa and the research assistant were fortunate to have women from Point Hope willing to participate.
- And special thanks to the Village and family members who were kind enough to welcome Lisa and research assistant into their homes.

**Compensation Rates for Local Involvement:**

- Point Hope mothers who agreed to participate received \$50 Wal-Mart gift cards for about an hour of conversation.
- Other family members or people who contributed to the conversation also received \$25 Wal-Mart gift cards.

**Expected Results/Publications/Final Products:**

**Results:**

- This study uses the stories by mothers of different generations and places of birth
- To show how different times and places can impact how women in Northwest Arctic Villages become mothers.
- This study tells a story about birth in Point Hope of yesterday and today. The women also talk of hopes for tomorrow's health care.
- The study compares the sources of their information, and the different experiences the mothers talked about.

**Publications:**

- Researchers have not yet published anything on these findings.
- The Point Hope research assistant and Lisa have plans, on approval, to submit an article about the findings to Rural and Remote Health. This online health journal requires all articles to have at least one author with indigenous background.

- Lisa has also submitted an article to the International Journal for Circumpolar Health. Many indigenous authors publish in this journal, as well. (Lisa is including a link to International Journal for Circumpolar Health for your information: <http://www.circumpolarhealthjournal.net/index.php/ijch>)
- Since this is a dissertation study, Lisa will also want to use the results in her thesis for graduation for a PhD, Summer 2013.

**Plans for returning to the community:**

- Lisa will give a final copy (and/or drafts) of dissertation to Village Council
- Lisa will also make a presentation to council or any other interested parties in the Village of Point Hope, at her expense if the council wants to invite Lisa to give a presentation.

**How will intellectual Property Rights be Protected (if relevant):**

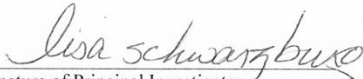

- Does not apply to this study

**How will Anonymity/Confidentiality be Protected:**

- No names are used, names are changed in any quotes from participants
- Where necessary, even village names will be withheld.

**Other Considerations (e.g. Use of Artifacts)**

- Does not apply to this study


  
 Signature of Principal Investigator \_\_\_\_\_ Date \_\_\_\_\_  
 LISA SCHWARZBURG


  
 Executive Director, Peggy Frankson \_\_\_\_\_ Date \_\_\_\_\_