

# Faces of Childbirth

The Culture of Birth  
and the Health of the  
Greenlandic Perinatal Family



Ruth A. Montgomery-Andersen

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## **The Culture of Birth and the Health of the Greenlandic Perinatal Family**

**Doctoral thesis at the Nordic School of Public Health NHV  
Gothenburg, Sweden 2013**



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**Nordic School of Public Health NHV**

**P O Box 12133**

**SE-402 42 Gothenburg**

**Sweden**

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**The author took all photos used in the dissertation during fieldwork. The author would like to thank the families for their permission to use the pictures in this dissertation.**

## ENGLISH ABSTRACT

**INTRODUCTION.** This dissertation concerns childbirth and its position within the Greenlandic society. It takes a world relational view to health promotion during, focusing on the perinatal family and the importance of the mothers, the child, their families and the local community as equal pieces of a whole.

**AIM.** The aim of the dissertation is to present new concepts and knowledge concerning the health of the perinatal family in Greenland. It looks holistically at the place of birth with focus on the issue of support of the perinatal family. It seeks to present the perinatal family and its position within the Greenlandic society. It links the changes in health policy with the concepts of family, attitude and community structure. It draws on statistical, historical, anthropological and cultural data within the context of the Greenlandic perinatal family.

**METHOD AND MATERIAL.** The dissertation is comprised of four studies and uses multidisciplinary methods. Over an eight-year period from 2003 to 2011, narrative interviews and focus groups were collected at four sites in Greenland: Nuuk, Ilulissat, Sisimiut and Tasiilaq. Data included seven focus groups with 35 participants, supplemented with 18 individual interviews of mothers, fathers and Culture Bearers, as well as two literature studies. The mode of conducting focus groups and interviews was based on the principles in the Helsinki Declaration.

**RESULTS.** The perinatal family's concepts of safety are often connected directly to access to family and community. Family is perceived as security, and lack of family support and network as insecurity. The concept of family and community is culturally specific and connected to the immediate family, extended family and kin. There is a cultural room for birth in Greenland, where the health of the perinatal family lies in their ability to strengthen the bonds within family, kinship and community networks. The mothers of the study perceived themselves as the bearers of their children; the fathers considered themselves to be the artisans and caregivers for their family; the community, including the extended family, deemed an important support network for the families.

**CONCLUSION.** It is important to understand the link that exists between traditional and cultural properties and the health of the child within the family. These are elements of the eco cultural pathways that are already integrated within the family interactions and could be a way to strengthen family interaction and health. Families and community support these traditions and in healthy eco cultural exchanges it enhances the child's role as a health-promoting agent within the family. Greenlandic public health, health promotion programs and the national perinatal guidelines have a physical health focus, but do not address the mental, social and spiritual dimensions of perinatal health. This fragmented way of perceiving and implementing health does not support the relational worldview that is an integral part of the culture of Greenland, and thus many families struggle to exercise choice within the system.

*Keywords:* Greenlandic family, childbirth, perinatal family, health promotion, family support networks

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## DANSK ABSTRAKT (DANISH ABSTRACT)

**INDLEDNING.** Afhandlingen omhandler fødselen og dets betydning i det grønlandske samfund, idet der anlægges et holistisk sundhedsfremmende syn på den perinatale periode og der fokuseres på vigtigheden af kvinder, børn, deres familier og lokalsamfundet som ligeværdige dele af helheden.

**MÅL.** Målet med afhandlingen er, at præsentere nye begreber og viden om sundheden om den perinatale familie i Grønland. Der ses holistisk på fødested og dens indflydelse på familiestøtte i den perinatale periode. Afhandlingen tilstræber at præsentere den perinatale familie og dens placering i det grønlandske samfund. Den forbinder ændringerne i sundhedspolitikken med begreberne familie, holdninger og samfundsstruktur. Den bygger på statistisk, historisk, medicinsk-antropologisk og kulturel data inden for rammerne af den perinatale sundhed i Grønland.

**METODER OG MATERIALER.** Afhandlingen indeholder fire studier som benytter sig af tværfaglige metoder. Der er i en otteårig periode fra 2003 til 2011 gennemført fokusgrupper og individuelle interviews, ligesom der er gennemført to litteraturstudier i samme periode. Det empiriske data er indsamlet fire steder i Grønland: Nuuk, Ilulissat, Sisimiut og Tasiilaq. Syv fokusgrupper med i alt 35 deltagere, er suppleret med 18 individuelle interview med kvinder, fædre og Kulturbærere. De anvendte metoder til gennemførelse af afhandlingens interviews og fokusgrupper er i overensstemmelse med Helsinki-Erklæringen

**RESULTATER.** For de perinatale familier er begrebet sikkerhed ofte knyttet direkte til familie og samfund. Familien opfattes som sikkerhed, og manglende mulighed for familie støtte og netværk opfattes omvendt som usikkerhed. Begrebet ansvar er for familien og samfundet kulturelt specifikt og er knyttet til den nærmeste familie, udvidede familie og slægtninge. Der findes et 'kulturelt rum' for fødsel i Grønland, hvor den perinatale families evne til at styrke båndene indenfor familien, slægtskabet og det lokale netværk er medvirkende til familiens sundhed. Lokalsamfundene, familierne og kvinderne i studierne opfatter sig selv som bærer af deres børn, fædrene opfatter sig som støtteskabende omsorgsgiverer for deres familie, og lokalsamfundet, herunder den udvidede familie, opfatter sig som et vigtigt støttenetværk for familierne.

**KONKLUSION.** Det er vigtigt at forstå det sammenhæng, der eksisterer mellem traditionelle og kulturelle egenskaber og barnets sundhed i familien. Disse er elementer af de øko-kulturelle stier, der allerede er integreret i familiens samspil og kan være måder hvorved familiens samspil og dens sundhed styrkes. Familierne og samfundet støtter disse traditioner og i en sund øko-kulturudveksling styrker det barnets rolle som sundhedsfremmende agent inden for familien. Grønlandsk folkesundhed, sundhedsfremmende programmer og de nationale perinatale retningslinjer har et fysisk sundhedsfokus, men der tages ikke højde for de mentale, sociale og åndelige dimensioner indenfor perinatal sundhed. Denne opsplittede måde at opfatte og gennemføre sundhed på, understøtter ikke det relationelle verdenssyn der udgør en integrerende del af kulturen i Grønland, hvorfor mange familier kæmper for at udøve selvbestemmelse inden for systemet.

*Nøgleord:* Grønlandsk familie, fødsel, den perinatale familie, sundhedsfremme, netværk hos småbørns familier



## KALAALLISUT EQIKKAGAQ (GREENLANDIC ABSTRACT)

**AALLARNIINEQ.** Ilisimatuutut allaatigisap ernineq pillugu imarisaqarpoq, erninerullu kalaallit inuiaqatigiinni pingaaruteqassusia aamma sammineqarluni, erninerup nalaani ataatsimut isiginninnittaaseqarluni aammalu arnat, meeqqat, ilaquutaasa najukkamilu innuttaasut ataatsimoornermi naligiittut isigalugit.

**ANGUNIAGAQ.** Ilisimatuutut allaatigisami anguniagaavoq, isummat nutaat ilisaritissallugit kalaallillu ilaqutariit meeraalu erninerup nalaani peqqissutsimut ilisimasariaqartut sammineqassallutik. Ilisimatuutut allaatigisap anguniarpaa ilaqutariit erninerup nalaani ilisaritissallugit aammalu erninerup kalaallit inuiaqatigiinni inissisimanera takutissallugu. Peqqinnissaqarnermi allannguutit eqqarsaatigalugit ilaqutariissuseq, isummersortarneq inuiaqatigiinnilu aqqissuusaaneq sammineqarput. Sumi inunngorsimaneq ataatsimut isiginninnittaaseqarluni sammineqassaaq aammalu erninerup nalaanni sumi inunngorsimaneq ilaqutariinnut tunaartaanersoq. Allaaserisami paasissutissat Kalaallit Nunaanni erninerup iluani peqqinnissaqarnikkut tunngasutigut aamma statistikkikkut, oqaluttuarisaanikkut, antropologiskimik, biofysiskimik, kulturikkullu tunngavilersuutit atorineqassapput.

**ILISIMATUSARNERMI NAJOQQUTASSANIK KATERSUINEQ.** Atuagarsornikkut misissuinerit ukiuni arfineq pingasuni ingerlanneqarput ukioq 2003-miit ukioq 2011 ilanngullugu, soorlulusooq alaatsinaanneqartunik apersuinerit inunillu ataasiakkaanik apersuinerit ingerlanneqarsimallutik. Atuagassiaqarnikkut misissuinerit marluk ingerlanneqarsimapput, ilisimatusarnikkut paasissutissanik misissuinerit Kalaallit Nunaanni piffinni sisamaasuni ingerlanneqarsimalluni: Nuuk, Ilulissat, Sisimiut Tasiilarlu. Alaatsinaanneqartunik apersuinerit arfineq marluk, taakku katillutik 33-nik peqataasullit ingerlanneqarsimapput, tassungalu ilanngullugu inunnik ataasiakkaanik 18-iusunik arnanik, ataataasunik, kulturikkullu ersuttunik apersuinerit. Ilisimatusarnikkut sakkugineqartut ilisimatuutut allaatigisami apersuineri alaatsinaanneqartunillu apersuinerit Helsinki-Erklæring naaportorlugu ingerlanneqarput

**ILISIMATUSARNIKKUT INERNERI.** Nunasiaajunnaarnermi ernineq arnanut namminerminut tunngatinneqarpoq taamaasilluni ernineq pillugu paasissutissat amerlagisassaangitsutut oqaatigisariaqarlutik. Erninermit naalakkersuinnikkut anguniakkat malittarisassallu sumiiffinni ataasiakkaani qinikkanit allaffimmilu aqutsisunit saqqummiunneqartarsimapput, qaqutiginnartumillu arnanut ernilersunut aammalu najukkami inuiaqatigiinnut isumaqatiginninniutaasarsimallutik. Ilaqutariinnut erneqqajaasunut isumannaallisaaneq isummap imarisaatut isigalugu ilaqtutariinnut inuiaqatigiinnullu tunngatinneqarput. Ilaqtutariit toqqaannartumik isumannaallisaasutut isigineqarput, ilaqutariinnilu qanigisanilu tapersersuisoqarsinnaanngikkangat nalornineq pilersarluni. Akisussaaneq ilaqutariinnut inuiaqatigiinnullu isummap imarisaatut isigalugu kulturikkut immikkut isigineqarpoq qaniginerpaasanullu tunngatinneqarluni, ilaqtutanut qanigisanullu allanut. Kalaallit Nunaanni erninermit tunngasut "kulturikkut immikkut inissaqartinneqarput", tamatumani erninerup nalaani ilaqutariit imminut qanilleqqajaallaqqissisarlutik, ilaqutariissuseq najukkamilu inuiaqatigiit ataqtatigiinnerat peqqissutsimut tapertaalluarterlutik.

**ILISIMATUSARNERUP NAAMMASSILERNERANI ISUMMIUSSAQ.** Kalaallit ilaqutariit unamminartunik naapitsineri naapertuulluartermuk aqqiisinnaasimapput, tamatumani nunarsuarmioqatigiinni aningaasaqarnikkut ineriartornermi inuiaqatigiillu malinnaataasumik ineriatorfiata kingunerisaannik pisimasut anigorluarsimallugit. Najukkami inuiaqatigiit, ilaqutariit arnallu misissuineri meeqqanik nammattutut imminut paasinnipput, ataataasullu ilaqutariinni meeqqanut tapersersuisutut inuttullu isumaginittutut imminut paasinnipput, aammalu najukkami inuiaqatigiit ilaqutariillu tamarmiusut ilaqutariinnut pineqartunut ataqtatigiiaattut pingaarutilittut imminut paasillutik.

*Oqaaseq paasinnissutissaq:* Kalaallit ilaqutariit, ernineq, ilaqutariit erninerup nalaanni, ilaqutariit meeraarartallit ataqtatigiiaanik tapersersuisoqarnerat.

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## LIST OF PAPERS INCLUDED IN THE DISSERTATION

### PAPER I - Literature study

Montgomery–Andersen, R., Borup, I., Douglas, V. (Submitted 2012). Literature Review: The 'Logics' of Choice and Birth Settings in Arctic Greenland. (Revised February 2013 *Midwifery*).

### PAPER II - Literature study

Montgomery–Andersen, R., Borup, I. (2012). Family support and the child as health promoting agents in the Arctic –The Inuit Way. *Rural and Remote Health* 12; 1977: 1–10.  
(Online):<http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=1977>.

### PAPER III - Original research

Montgomery–Andersen, R., Willen, H., Borup, I. (2010). “There is no other way it could have been.”–Greenlandic women’s experiences of referral and transfer during pregnancy. *Journal of Anthropology and Medicine* 17; 3: 302–313.

### PAPER IV - Original research

Montgomery–Andersen, R., Borup, I. (2013). Songlines and Touchstones: A Study of Perinatal Health And Culture In Greenland. *AlterNative–Journal of Indigenous Research* 9; 1: 88–102.

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## LISTS OF DEFINITIONS AND KEY CONCEPTS

Anaana: Mother

Angaju/aleqa: Older sister

Angaju/ani: Older brother

Ataata: Father

Ateq: Name or “soul name”.

Chief Medical Officer (CMO): Annual medical review published the first time in 1953, first as GMR since called *Annual Medical Review*. It is the official health statistics published online by the Office of the Chief Medical Officer. In this paper it is called GMR from 1953-2000 and CMO from 2001-dd.

Greenlander/Greenlandic: Defined in this paper as a person fulfilling one of the following criteria: 1) considers herself Greenlandic, irrelevant of heritage, 2) speaks Greenlandic fluently, 3) is born in Greenland or 4) is of Greenlandic descent.

Greenland Medical Review (GMR): Annual medical review published the first time in 1953 and annually in one form or another since. It offers the only official health statistics from the period between 1953 until 1989. It is now called *Annual Medical Review* and is published by the Office of the Chief Medical Officer. In this paper it is called GMR from 1953-2000 and CMO from 2001- dd.

Health Department of Greenland (HDG): Official name as of 2009.

Ilisimmarpoq: The moment where a child acknowledges his/her own consciousness.

Inuk (sing.)/Inuit (pl.): A person of Inuk heritage from Greenland, Canada, Alaska or the Russian Federation. In this paper Inuit refers mainly to the Greenlandic Inuit.

Inuk naallugu: Greenlandic word for twenty and literally means a whole human and is the basis for a counting system based on sets of twenty; ten fingers and ten toes.

Inuuneritta: Greenlandic national public health program, the word meaning let us have a good life together.

Ittangavoq: Old fashion

Isumassuineq: To protect/take care of

Juumooq: Is either a midwife/lay-midwife working at the hospital delivering babies, or a health worker in the settlements and smaller health stations that does all health related work. This should not be confused with a *paaliorti* who can be anyone who is at or assists in the birth.

Ningiu: The Greenlandic word for *grandmother*, but it can also mean the woman in charge or a female supervisor.

Paaliorti: In the North-Greenlandic dialect, the first person to touch the newborn, the midwife, the birth assistant.

Pagga: Is the Greenlandic tradition of giving of gifts, which is connected with giving thanks and showing generosity in good fortune.

Perinatal Family: Concept that acknowledges change and development in family dynamics during pregnancy and it also effects on each individual member of the family. It acknowledges the family as an entity, including the unborn child and individual family members.

Perinatal room: In this paper is the concept used to describe the period that includes pregnancy, birth and from 0-28 days after birth, for both mother and infant.

Perinatal Status Report (PSR): From 2001- 2007 the National Obstetrics Department produced this report for the Department of Health in Greenland. This report included information about perinatal mortality and morbidity and also provided a comprehensive account of antenatal and postnatal care.

Qallunaat: Someone from the outside/Outsider

Silattorsarpoq: The ability to use reason.

Transfer: The right for a woman to be referred and transferred to National Hospital (DIH) or one of the five regional hospitals for birth.

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## PROLOGUE

*I arrived in Greenland during the summer of 1995, a place that had been a part of my childhood consciousness. As a child I had heard stories about Greenland from my father, an African-American military officer, who had spent six months in Greenland after the Korean War. My father's story of Greenland was very simple: it teks leest a munt tuh thawr yah owt aftah yah git hoam<sup>1</sup>. It was therefore I knew nothing of the culture, the people, the geography, or the language of Greenland. Still, my arrival in Greenland was a feeling of coming home; a meeting with a people that let me into their lives. Within the first weeks of my arrival in Greenland, I went from being a stay-at-home mother, to the midwife of the city with responsibility for 100 births a year. This was the beginning of my life in Greenland and with its people. As the only midwife in Ilulissat<sup>2</sup>, it became my responsibility to do all prenatal check-ups, most of the deliveries, all maternity care at the hospital and the well-woman/baby services for the women of the city. This gave me a door into the culture, a culture that I was not only fascinated by, but was completely foreign to me. As I attempted to learn the Greenlandic language, I developed a deep respect for the people and I met gratefulness and an openness that allowed me access to the homes, the lives and the stories of the women that I served. I discovered that many women had experiences of traumatic births and many families had small graves in the graveyard. I also discovered that for the past decade, pregnant women from settlements and villages were referred to the larger towns for births. I came to realize that women from these settlements and villages were separated from their immediate families for the last two to four weeks of their pregnancy and during childbirth. As a woman living outside of her own country and culture, I felt I understood how hard it could be for them to leave their family at one of the most important times in life. From 1995 until 2007, I delivered babies and supported women from all over Greenland, first as a district midwife, next as a midwife at the referral hospital in Nuuk and then as a supervisor of the labor wards at the national hospital's Department of Obstetrics. Since my arrival to Greenland in 1995, I have supported and serviced over 2000 Greenlandic families and delivered over 1000 Greenlandic babies.*

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<sup>1</sup> "It takes at least a month to thaw you out after you get home". My father was from Texas and spoke the African-American dialect from that region.

<sup>2</sup> Please Figure 1.

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## MAP of GREENLAND

Figure 1. Map of Greenland with major cities and towns

# CHAPTER ONE

## INTRODUCTION

The title of this dissertation “Faces of Childbirth – The culture of birth and the health of the Greenlandic perinatal family,” is inspired by the Greenlandic phrase *inuk naallugu*. This is the Greenlandic word for twenty and literally means a whole human and is the basis for a counting system based on sets of twenty. A whole human has ten toes and ten fingers and each *inuak*<sup>3</sup>, each finger and toe is an important piece of the whole. This Greenlandic concept is a holistic way of looking at a person and indicates the importance of each link as a piece of the whole. This dissertation seeks to study childbirth and its position within the Greenlandic society; the *faces* that together, comprise the whole face of childbirth within the Greenlandic context. The face of history, the face of community, the face of family, the faces of men, women and children that create the whole face of Greenlandic childbirth, each one a part of a whole within society, each one having a face. As the faces of childbirth change within the Greenlandic community, there is a change in the scales of power within the family; it changes the place of motherhood in the community as well as the place of the family in the society (Handwerker 1990). The dissertation strives to link the faces of childbirth post colonially, exploring attitudes, concepts of family, safety and community structure surrounding the perinatal family. The focus is on relatedness, kinship, and use of culture and traditions in promoting health.

### *Conceptualization of "Faces of Childbirth"*

In Cross’s article from 1998, she posits the concept of a “linear worldview” as the basis for European and North American resiliency and health promotion theories. She also presents the concept of “relational worldview”, as the concept of health among many indigenous groups and peoples (Cross 1998). The relational world presents itself in many indigenous and tribal cultures and focuses on balance, intuitiveness and multifaceted relationships. This includes the four equal quadrants of context, mind, spirit and body as seen in Figure 2 (Cross 1998, p. 147).

---

<sup>3</sup> The etymology of *inuak* comes from the word *inuk* meaning person. The fingers and toes of the human are important for survival and in the belief and mythology of the Inuit, the individual parts of the body are comprised of resident spirits that should be protected. The word itself could be understood as “someone or something that can be perceived as a human being”.



Figure 2. Relational Worldview as perceived by Cross 1998, p.147

Health in this context is seen as the harmonious balance between the four attributes that influence each other and are irrelevant to place and time (Cross 1998). The definition of health is not only the level of physical, mental and social well-being, but also includes the cultural understanding of mind, spirit, body and context (Inuuneritta 2007, WHO 1986). Ladd-Yelk (2001, p.17) describes health as a fluid process that is under constant change and that “elements such as hunger, physical exhaustion, intellectual gains and environment change throughout the day—which in turn, makes us different people at different times of the day.” It is in the space between these two worldviews that the Greenland concept of perinatal health can be said to lie. By ‘unpacking’ concepts of Greenlandic perinatal care within a health promotion framework, it also looks at the tensions between the public policy and local perception, whereas the linear and the relational worldviews are often seen to be in opposition to one another. Figure 3 reflects a visualization of the *inuk naallugu* concept, where the ‘worldview’ is that of each piece being a part of the whole.

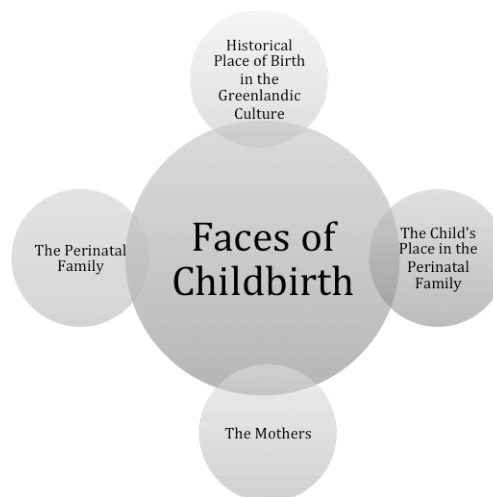


Figure 3. Conceptualization of "Faces of Childbirth"

Møller (2011) states that there is a philosophical and metaphysical tension between a health care system built on the non-Greenlandic (Danish) traditions of healthcare and wellbeing, when placed in a culture based on the Inuit concepts of family, kinship and security. Often health promotion theory take a linear

world-view, and looks at the individual components of health as a cause effect/relationship that can be assessed and evaluated, and used as the only marker for the health of families (Lindenbaum & Lock 1993). The metaphysical tension spoken of involves the understanding of “*structural features and empirical realities*”(Kaufert & O’Neil 1993, p.37). These features and realities include climate, distances and weather, community/family involvement, language and network support, all influence and create the cultural setting for birth in Greenland (Kaufert & O’Neil 1993).

## BACKGROUND

### *Kalaallit Nunaat – Greenland*

Greenland is two point two (2.2) million square kilometers large and has little or no infrastructure. Every city, town, village and settlement in Greenland is isolated, relying on planes, helicopters and boats for transport of goods, post and people, between the 23 larger localities (localities with population over 1000 people). The BNP per capita is \$37,500 dollars per year in (GS 2012). The Greenlandic language is a part of the Eskimo-Aleut languages spoken in Alaska, Northern Canada, Greenland, and Chukotka. Danish is the second language of Greenland, but is not linguistically related (Louis-Jacques 2010). Over 80% of Greenlanders speak Greenlandic as a first language, approximately 40% state that they are bilingual Greenlandic and Danish, and 11% are either monolingual Danish or have another mother tongue such as English, French, Filipino, or Thai (Bjerregaard & Dahl-Petersen 2008, Eliassen et al. 2012). The Greenlandic population in 2009 was 56,194 inhabitants, 29,809 males and 26,385 females. It is a homogeneous society, where 87 % of the population is of Greenlandic Inuit heritage (ICC 2011). There are over 80 active localities in Greenland, including 17 towns and cities, 62 settlements, 4 isolated farms and 6 stations. Although the migration from the outer areas of Greenland to Nuuk is increasing, 71% of the population still lives outside of the capital city of which 15% live in isolated villages (Eliassen et al. 2012). Greenland, *Kalaallit Nunaat* in Greenlandic, often translated as *land of the people*, is an autonomous, constitutional constituency, under the Danish Monarchy. Greenland, a Danish colony until 1953, gained Home Rule status in 1979, and constituency in 2009. Greenland is a part of the Indigenous Arctic, which includes the Inuit of Greenland, Canada, Alaska and Russia and also includes Sapmí, other indigenous areas and peoples of Norway, Sweden, Finland and Russia. Colonization of Indigenous peoples in the Arctic has resulted in new cultural constellations that include elements from North American, European and Nordic cultures. Although the Inuit are the original inhabitants of Greenland, the Danish and European influence in Greenland has resulted in social, cultural and genetic mixing between persons of Inuit and of Danish ancestry (Rink et al. 2009).

### *Family and Kinship as a Part of the Perinatal ‘Room’*

In the Nordic country family is often defined as the nucleus of mother, father and children and the extended family includes grandparents, cousins, aunts and uncles. The perinatal ‘room’ is a metaphor that describes the constellation of family and community that surround the child; and it is defined in this paper as the period that includes pregnancy, birth up to 28 days after birth. It includes all family members, fathers, mothers, siblings and infants, but not exclusively. This makes it possible to include those persons or groups that make up the individual family’s perinatal room, taking into account all possible constellations. The concepts of the *perinatal room* and the *perinatal family* acknowledge change and development in family dynamics during pregnancy and its effects on each individual member of the family. It acknowledges the family as an entity, including the unborn child and individual members of the family. Trondheim (2011) defines the Greenlandic family by describing the invisible lines that are created. These include family constellation and kinship practices unique to each *perinatal family* (Trondheim 2011). Trondheim (2011) explains that kinship either exists or can be created through genealogy, consanguinity, affinity, adoption, naming, friendship or colleagues. Bodenhorn (2000) supports this and adds that local community is a part of the kinship system and as such and often there is no distinct lines separating family and community. Such terms as ‘nuclear family, extended family, relatives’, do not fully uncover the concept of Greenlandic family and Trondheim describes the Greenland family as a “complex system, that do not only describe biological and genealogical aspects of family life” (Trondheim 2012, p. 2). It can also be described as a... “*memoryscape of persons . . . ensure continuity, thus negating finality*” (Nuttall 1992, p. 79).

*“The kinship system rests on the social cornerstone of cooperation, wherein participation in a social forum is an important principle. The participants in the system have to be an active participate in order to support the close social links. Active participation within the family is especially important in order to support and sustain the close relation to the created family (Trondheim 2011, p.63).”*

Trondheim (2010) posits that rapid urbanization and modern civilization has not destroyed the culture of Greenland. Instead traditional relationships such as kinship have just taken on a new form, created within the society around the traditional concepts, but have changed outwardly (Trondheim 2010). Navne (2008) states that the reasoning behind the reproductive choices is a metaphysical process that is deeply imbedded in the Greenlandic understanding of pregnancy and motherhood. Family in Greenland includes mothers, fathers, cousins and grandparents, but also fictive kin and community members (Ladd–Yelk 2001). Fogel–Chance (1993) presents the rationale that in many Inuit societies motherhood and family ties are not only biological ties, but ties established to ensure that children have several parents and thus receive even more care and love (Fogel–Chance 1993). The family is thus defined by through the

invisible lines created by kinship practices within the each perinatal family (Trondheim 2010). Name giving and soul names create kinship and increase the size and strength of kinship or social relations (Trondheim 2010). There is a concept of the soul within the traditional Greenlandic cultural wisdom that there are three types of souls (Hansen 2002). One of these embodiments of the soul is called *ateq*, which is also known as “soul name”. This soul connection usually is between a deceased and a newborn and through naming the newborn child and the deceased are connected (Trondheim 2011). Name-sharing relationships create an enormous range of possible relationships. The families themselves decide how far each person wishes to develop kinship based on kin terms applied to a name-sharer (Nuttall 1992).

Another important aspect in the concept of Greenlandic family is personhood. Nuttall (1992) presents the argument that personhood in the Greenlandic context focuses on the individual as the core of society. He argues that the individual exists as a part of society, both physically and metaphysically. Personhood can be described as a state that is achieved through living and the physical states of pregnancy can be seen as: being pregnant (*naartuneq*), giving birth (*ernivoq*) and becoming a person (*inuungorpoq*). The traits of the metaphysical person include both the individuals “unique identity; but also soul names (also called ‘name souls’) and the relationship to both the living and deceased members of the community (Nuttall, 1992 pp. 59-60).

The child is seen as the family’s center and children are given a large amount of freedom during their upbringing. Punishment and chastisement are seldom used and children are free to explore and experiment only curtailed when something is considered dangerous for the health or welfare of the child (Hansen 2007, Nuttall 1992). The metaphysical processes include the process of gaining personal consciousness (*silattorsarpoq*) and the ability to use reason (*ilisimmarpoq*) (Nuttall 1992). It is common for parents to celebrate the day where children acknowledge their own consciousness (*silattorsarpoq*) in the same manner as people in the United States or Denmark acknowledge the day that their children take their first step or get their first tooth.

## PUBLIC HEALTH AND HEALTH PROMOTION IN GREENLAND

### *Public and Perinatal Health*

Perinatal health is often used as a reference to assess the health of a nation (WHO 2005). Health is also often defined as an improved quality of life, the elimination of communicable diseases, increase in life expectancy and the reduction of mother/infant mortality (UNICEF 2009, UNICEF 2012). These definitions focus on the importance of disease prevention, but also on health promotion and quality of life. Public health is described as “the science and art of preventing disease, prolonging life and

promoting health through organized efforts of society” (<http://www.who.int/healthpromotion>, Acheson 1998). Public health is linked to the concept of health promotion and in 2001 the World Health Organization's (WHO) European Working Group on Health Promotion Evaluation set down a framework that describes principles essential for health promotion and thus the success criteria for health promotion related projects as described in the Ottawa Charter (WHO 1986). The Ottawa Charter for Health Promotion (WHO 1986) presents five pillars that lead to the establishment of healthy individuals and communities. Building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills, and reorienting health services are the keys to a healthy society (Rootman et al. 2001). Health promotion is not only public policy, but also builds and supports the involvement of the community and the individual. Greenland's national policy takes a health promotion view with strong community health programs, clear goals, and success indicators for evaluation of the programs (WHO 1986, Bjerregaard 2004; Kern & Persson 2007; [www.peqqik.gl](http://www.peqqik.gl)). The Ottawa Charter also states that in order to have a healthy society, that society must be able to fulfill the fundamental conditions and resources for health: These prerequisites are: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. Health promotion looks at health on several levels; it takes into account resources, methods, setting, strategic tools and national policy (Povlsen & Borup 2011). Povlsen & Borup (2011) present the rationale that a holistic view is linked with the individual's ability to balance its physical, mental, social and spiritual health and argues that it is a central concept in the Nordic concept of health promotion.

### *Public Health and Children*

The Greenlandic national public health policy and perinatal guidelines are inspired by World Health Organization's (WHO) policy on public health and health promotion (WHO 1986). The WHO's visions and health promotion policies inspired and challenged Greenlandic healthcare pioneers and were the catalyst for development the national public health policy and national perinatal guidelines (Kern & Persson 2001, Government of Greenland 2012). *Inuuneritta*, the Greenlandic national public health program focuses on health promotion with clear goals and success indicators that follow the goals set down by the WHO and include policy and health promotion goals on alcohol use, violence, nutrition, physical activity, smoking and sexual and reproductive health (Inuuneritta 2007).

According to Cassidy (2006) children in a community are often the objects of health promotion, have had limited control over own health, seldom are involved in defining, developing or evaluating programs and projects that they are the focus of. Cassidy (2006) also presents the viewpoint that adults form these limitations through many of their empowerment efforts. Further she describes a lack of choice and that children are educated to fulfill the wishes of adults and that children's health is measured by how well

children fulfill the expectations of the adult population (Cassidy 2006). Schor & Menaghan (1995) describe the concept of eco cultural pathways as method of conceptualizing ways in which families engage with and utilize the resources at their disposal. It incorporates family strengths, including the strength of the individual child, with the family's health practices (Schor & Menaghan 1995). Eco cultural pathways focus on cultural traditions and the 'pathways' families follow to create and support a healthy family life, with special focus on the children in a family (Schor & Menaghan 1995).

## A HISTORICAL PERSPECTIVE OF PERINATAL CARE IN THE ARCTIC

### *Definitions of Perinatal, Neonatal and Infant Health*

The WHO (2006, p. 6) defined the perinatal period as from week 22 (154 days) until seven completed days after birth, while the definition differs for example in the United Kingdom, Australia and the United States. In these countries the perinatal period encompasses from week 20 (140 days) and up to 28 days after birth (MacDorman et al. 2003; Nguyen & Wilcox 2005; <http://www.perinatal.nhs.uk>; <http://meteor.aihw.gov.au>). The neonatal period is from birth to 28 days and encompasses solely the health of the child. WHO's (WHO 2006, p. 6) definition of perinatal mortality/morbidity is fetal deaths after week 22 and death of a live born within the first seven days of life (0-6 days), while neonatal mortality encompasses the time before day 28 (7-27 days), and infant mortality is defined as death within the first year following live birth (<http://www.unicef.org>; <http://www.perinatal.nhs.uk>). In 2001, Greenland initiated use of the definition for perinatal mortality: "the number of stillbirths and deaths in the first 0-6 days of life per 1000 births" (CMO 2010). Greenland still uses live births when doing comparisons with previous outcome and mortality rates. In this paper the concept of the 'perinatal room' will be used to describe the perinatal family's health in the period from conception until 28 days after birth. This includes the period from acknowledged pregnancy, birth and from 0-28 days after birth, for both mother and infant. The concept of the perinatal room seeks to honor how Greenlandic families look at pregnancy and childbirth and does not seek to be a biomedical definition of the perinatal period.

### *Perinatal and Infant Mortality – A Nordic Perspective*

Figures 4, 5, 6 and 7 used in this chapter are reprinted with permission from Dr. Peter Bjerregaard and presents overviews of perinatal and infant mortality (Bjerregaard 2011, pp.15-19). In Greenland, there was a fall perinatal mortality in the 5-year period from 1996-2000 to 19.7/1000 births (Figure 4). Figure 4 also shows that between 2001-2005 perinatal mortality was 3.6/1000 births in Iceland, 4.0/1000 in the Faroe Islands, and 14.2/1000 in Greenland (Bjerregaard 2011, pp. 15-19). The perinatal mortality in Denmark during the same period was 6.5/1000 births (<http://whqlibdoc.who.int/publications/2007>; <http://nomesco-eng.nom-nos.dk>; <http://www.si-folkesundhed.dk>). There were 835 completed pregnancies

and 839 children born in 2008, with a perinatal mortality of 20.3/1000. In 2009 there were 889 women who gave birth to 899 children and the perinatal mortality for that year was 15.6/ 1000. The number of women who gave birth in 2010 was 856 with a perinatal mortality was 11.5/1000 with 866 registered live births (CMO 2010). There is no current published health statistics from the office of the Chief Medical Officer concerning cesarean section rates, delivery complications, morbidity or APGAR scores at birth, but these can be found in the database of the CMO of Greenland (Bjerregaard et al. 2012). Although Greenland's perinatal mortality in 2010 is still far above infant mortality registered in Denmark and compares to perinatal mortality in Iceland during the late 70's and the Faroe Islands before 1990, there can be seen a fall in the perinatal mortality over the past ten years.

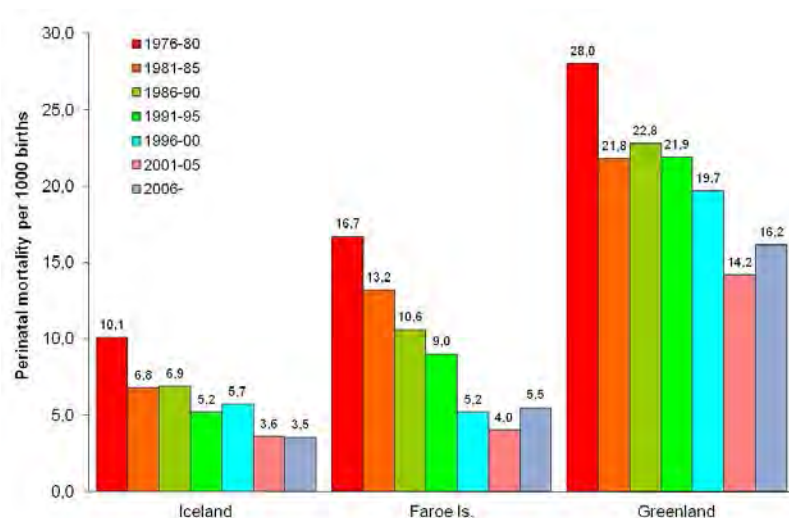


Figure 4. Perinatal mortality Iceland, Faroe Islands & Greenland 1976-2006. Reprinted by permission from (Bjerregaard 2011, p.19)

### *Reproductive Health In Greenland*

The perinatal health of a country is concomitant with the reproductive health of the country, and the Greenland's history of reproductive health presents several paradoxes. First, sexually transmitted disease (STI) rates in Greenland are one of the highest in the Arctic, ten times higher than Denmark, and twice that of northern Canada. Secondly, fertility is low, which is mainly a result of having one of the world's highest rates of legal abortion (Johnston, 2011). Abortion was legalized in 1967 and 1976 was the first year where first trimester abortion became accessible to all Greenlandic women (GMR 1972; Arnfjord, Kristensen & Skifte 2001). The abortion rate has risen steadily, and Table 1 presents the total number of abortions and births from 2001-2009. Between 2001 and 2009 there are registered approximately the same number of live births and number of first trimester legal abortions (CMO 2010).

Table 1.Total number of abortions and births in Greenland 2001-2009

| Year             | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
|------------------|------|------|------|------|------|------|------|------|------|
| <b>Abortions</b> | 812  | 821  | 869  | 905  | 899  | 867  | 887  | 904  | 799  |
| <b>Birth</b>     | 939  | 941  | 891  | 901  | 890  | 845  | 857  | 839  | 899  |

A Greenlandic woman will have an average of 2.13 births, within her lifetime; 2.2 children for women in towns, and 2.9 children for those from settlements. In 2009 five per cent of all live births in Greenland were to mothers under 17 years of age, 11.5% of the mothers were between 17 and 18 years of age, and 16.5% of all mothers were under the age of 20 years old. In 2010 adolescent mothers accounted for 13.9 % of all births<sup>4</sup> (CMO 2009, CMO 2010). Comparatively in 2010 adolescent mothers accounted for 4.6% of all births in the Faroe Islands and 3% in Icelandic (<http://www.landlaeknir.is/english/statistics/births>; SBF 2009; SBF 2010).

### *Perinatal and Infant Health in Greenland*

By 1953, with changes in the childbearing patterns and better health of the Greenlandic population, focus was turned to the high perinatal mortality. Birth rates increased between 1954 and 1970, but fell continuously from 1970 to 2001 (Appendix 1). The hospitals now had space and capacity to receive the women for birth. Because of the long distances between cities and towns, it was necessary for the hospitals to have housing available for the women at or near the hospital (GMR 1956). In Greenland's postcolonial era from 1953-1987, there was a lack of reliable data concerning neonatal and perinatal mortality in Greenland and categories were not clearly defined before 2001 (Aaen-Larsen 2001). There were several reasons for the lack of quality and consistency in data registration in Greenland up until the 21<sup>st</sup> century. These included lack of infrastructure, lack of personnel trained to collect statistical data, and lack of manpower in the individual health districts and hospitals to document and register. In 1992, when the Home Rule Government took over the health system from the Danish state, there was already a well-developed infrastructure of health care facilities with hospitals and health centers in all major towns and settlements (Niclasen & Mulvad 2010).

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<sup>4</sup> In Greenland here are no statistics for the adolescent pregnancy per 1000 adolescents, as found in the rest of the Nordic Countries. Adolescent pregnancy rates are calculated in number of live births to women less than 20 years of age/ per year.

### *Infant Mortality In Greenland*

As shown in Figure 5, infant mortality fell drastically from 1955 until 1985 while in the period from 1985 until 2000 infant mortality stagnated at a level between eighteen and twenty per 1000 live births.

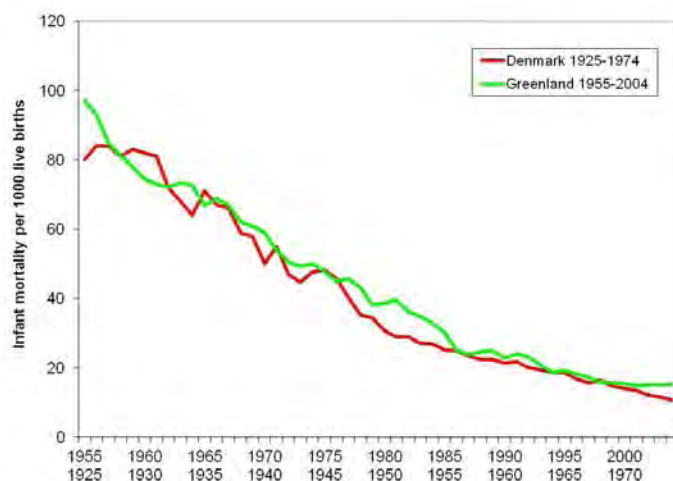


Figure 5. Infant mortality in Greenland 1955-2004 & Denmark 1925-1974. Reprinted by permission (Bjerregaard 2011, p. 15)

During different periods there have been divisions of districts and areas in Greenland; and one common division has been to divide Greenland in Nuuk, Northwest, Southwest, East and Avanersuaq regions as shown in Figures 6 and 7. One of the reasons for the differences was the regional differences in living conditions and the disparities of health service availability between the regions (Aaen-Larsen & Bjerregaard 2003). There was a disparity in health care that was a result of a lack of stable workforce including physicians, lay-midwives and educated midwives, although it was still uncommon for women to leave their communities for birth. This impacted the quality of perinatal care in the local communities and was compounded by extremes of weather and distances, which affected the ability to transfer women out of their communities in the event of an emergency (Aaen-Larsen & Bjerregaard 2003). This affected the regional infant mortality, with high infant mortality in the Northwest and Southwest of Greenland (Figure 6). There has been a significant fall in infant mortality during that period in communities, such as East Greenland in the periods where there have been midwives employed (Figures 6 and 7).

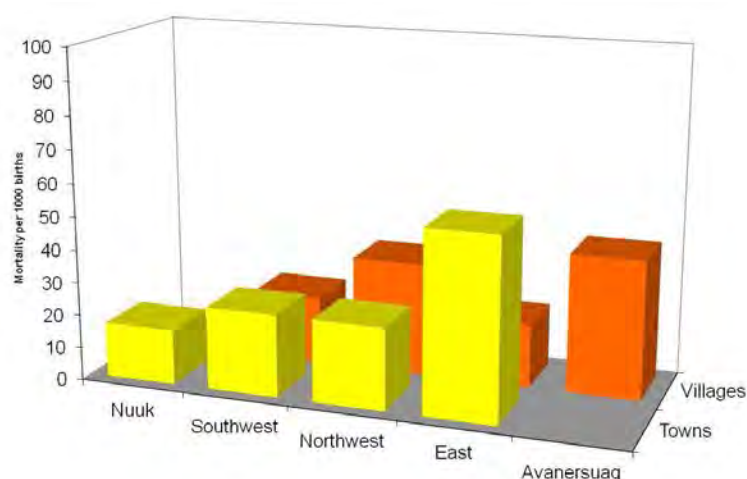


Figure 6. Regional variation in infant mortality 1992-1999. Reprinted by permission (Bjerregaard 2011, p.17)

It was in the period between 1992- 1999 that the Directorate of Health in Greenland (now the Department of Health) initiated systematic activities to reduce child mortality. These activities included 1) the establishment of a perinatal audit board, 2) lay-midwife education courses, 3) upgrade of resuscitation equipment at all hospitals and health centers, and 4) the establishment of a combined birth and child registry (Aaen-Larsen & Bjerregaard 2003).

#### *Establishment of the National Department of Obstetrics*

By 2001, a perinatal mortality of 19.2 per 1000 live births, a lack of certified midwives and the economic burden of transferring women during labor and childbirth, the perinatal audit board was established and then a working group on perinatal health in Greenland (Kern & Persson 2001). Greenland chose to use a Nordic model with the Norwegian *Lofot Project*<sup>5</sup> serving as an inspiration and subsequently approved the establishment of the national perinatal program for referral (Montgomery-Andersen 2005, Vold et al. 2001, Kern & Persson 2001). A universal standard of perinatal care was designed with a simple, effective and transparent guidelines (Appendix 2) that gave Greenlandic women the right to be referred and transferred to the Dronning Ingrid's Hospital<sup>6</sup> (DIH) in the case of potentially complicated delivery (Persson & Kern 2003). The National Department of Obstetrics also ensured that midwifery positions were filled in all districts with midwifery positions (Kern & Persson 2007). From 2001 until 2009, all midwives were hired by the National Department of Obstetrics and in some areas such as Tasiilaq, in East Greenland; the Department of Obstetrics ensured that the district had continuous midwifery service,

<sup>5</sup> Lofot Project” was a public health initiative in Lofot, Norway, focusing on finding alternative operating procedures for health services in the area. The goal was to organize economical, safe and viable perinatal care for the women and families in the isolated Lofot area in Northern Norway (Lofot Municipality 1999).

<sup>6</sup> Dronning Ingrid's Hospital - DIH, Nuuk, the national referral hospital of Greenland.

which might have had an influence on the perinatal mortality during the period from 2000-2004 (Figure 7). Five health regions were established in 2009; the Regional Health Administrations hired thereafter midwives locally.

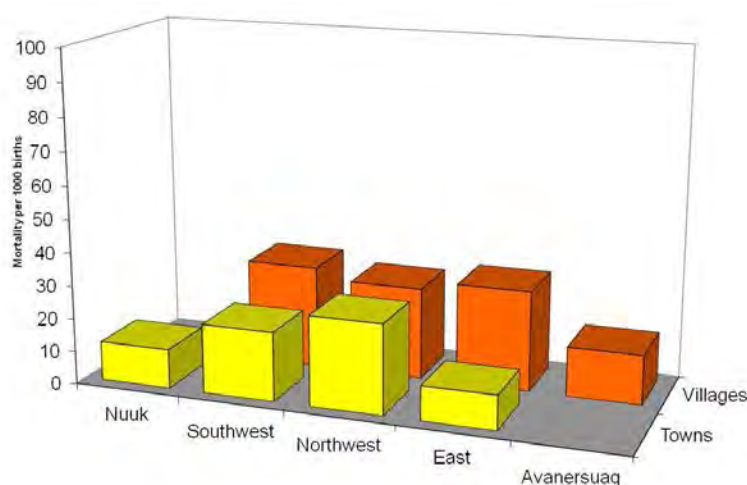


Figure 7. Regional variation infant mortality 2000-2004. Reprinted by permission (Bjerregaard 2011, p. 18)

In the period between 2009-2012 the Government of Greenland established: 1) a new municipal system, with four larger municipalities instead of the former seventeen smaller municipalities, 2) the Agency for Health and Prevention, and 3) five health regions<sup>7</sup> instead of 23 health districts. In 2009 the Department of Health instated new universal referral guidelines that consolidated low-risk pregnancies at obstetric services in clusters at regional hospitals. It is estimated that between 40–50% of the pregnant women in Greenland will be transferred out of their communities during the last two to four weeks of pregnancy and then return home one to two weeks after birth<sup>8</sup>. The Health Department has also formed a perinatal evaluation group to 1) assess the national perinatal guidelines from 2002, and 2) audit perinatal mortality for the period<sup>9</sup>. The group presented an overall assessment of the guidelines to the Department of Health by the end of 2012, where the perinatal mortality was 16.1 per 1000 (Bjerregaard, Kristensen, Olesen & Secher 2012).

<sup>7</sup> In Qaqortoq (Kujataa), Nuuk (Sermersooq), Sisimiut (Qeqqa), Ilulissat (Avannaq), and Aasiaat (Qeqertarsuup tunua).

<sup>8</sup> Signe Kaack (Head of Labor Ward, Dronning Ingrid's Hospital) Personal correspondence May 2012.

<sup>9</sup> Peter Bjerregaard (Perinatal evaluation group Agency for Health and Prevention) Personal correspondence May 2012.

## PERINATAL CARE – IN PERSPECTIVE

### *Nordic Perinatal Care*

Perinatal mortality rates, including maternal and infant mortality in the Nordic countries, are some of the lowest in the world. Common for all of the Nordic countries is that antenatal, during birth and neonatal care systems are standardized in each country and are free of cost for the legal residents of these countries (Hiilamo 2008). Antenatal care in Greenland is carried out locally, following the national guidelines and both hospital and perinatal journals are electronically accessible (Table 2). In all Nordic countries, as well as Greenland midwifery care is the golden standard for perinatal care, along with planned check-ups with either a general or family practitioner, or through strategic check-ups with an obstetrician (Bjerregaard et al. 2012; Kringeland & Möller 2006). The Nordic countries provide a screening program for pregnant mothers, which include testing for sexually transmitted diseases, hepatitis and anemia. This is supplemented with screening for cholestasis familiaris groenlandica<sup>10</sup> (Nielsen & Eiberg 2004). There are prenatal check-ups with health education programs for pregnancy care, films and information pamphlets published in the language of the country, as well as in the languages of the larger minority groups (Hiilamo 2008). In Denmark and Norway—as in Sweden, Finland and Island—parenting classes are offered, but are not universally available and in some cases are paid for by the parents themselves. High-risk patients are centralized at designated hospitals in each country and there is also standardized perinatal policy for each country for women suffering from problems or diseases such as preeclampsia, hypertension, and gestational diabetes. Women in Greenland are followed locally during pregnancy and are referred to DIH in Nuuk between four and eight weeks before planned birth, depending on the risk (Bjerregaard et al. 2012). These referral policies also include women suffering from alcohol and drug dependency, medical or mental disorders (Hiilamo 2008).

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<sup>10</sup> A hereditary liver disease found in the Greenlandic Inuit and is autosomal recessive (Nielsen & Eiberg 2004).

Table 2. Births, Place of Birth, Examinations, Gestational Age and Birth Weight in Greenland (Adapted from the Office of Chief Medical Officer, birth and perinatal care statistics)

| Birth Statistics in Greenland                                     |  | 2009  | 2010  |
|-------------------------------------------------------------------|--|-------|-------|
| <b>Number of Births</b>                                           |  | 889   | 856   |
| Rate per 1000 females 15-49 year                                  |  | 62,3  | 60,5  |
| <b>Place of Birth</b>                                             |  |       |       |
| Total hospital births attended by midwives                        |  | 882   | 855   |
| Total born in Healthcare Centers attended by nurses/lay-midwives* |  | 4     | 5     |
| Total of home deliveries (unplanned)                              |  | 2     | 2     |
| Unknown                                                           |  | 1     | 4     |
| <b>Examinations During Pregnancy</b>                              |  |       |       |
| 1-5 examinations by physicians                                    |  | 90,8% | 84,1% |
| No examinations by physicians                                     |  | 4,0%  | 11,4% |
| 5 or more examinations by midwives                                |  | 72,3% | 73,8% |
| No examinations by midwives                                       |  | 6,8%  | 4,6%  |
| Examinations by auxiliary nurses/lay-midwives*                    |  | 49,5% | 49,6% |
| <b>Gestational Age at Birth</b>                                   |  |       |       |
| Born after week 42                                                |  | 3,7%  | 2,5%  |
| Born in week 37- 41                                               |  | 85,7% | 87,5% |
| Born before week 37                                               |  | 9,0%  | 8,5%  |
| Due date undetermined                                             |  | 2,0%  | 1,4%  |
| Born before week 28                                               |  | 1,0%  | 0,3%  |
| <b>Birth length</b>                                               |  |       |       |
| Below 46 cm.                                                      |  | 2,7%  | 3,0%  |
| Above 56 cm.                                                      |  | 1,1%  | 3,7%  |
| <b>Birth Weight</b>                                               |  |       |       |
| Below 2500 grams                                                  |  | 5,4%  | 6,0%  |
| Above 4000 grams                                                  |  | 17,1% | 18,5% |

\*auxiliary nurses are referred to as lay-midwives in this dissertation

### *Midwifery Care in Greenland*

Maternal well-being and healthy newborns are the goals for perinatal healthcare regulative policies; globally perinatal mortality and morbidity is seen as one of the most important indicators when evaluating the health status of a nation and the effectiveness of their public health system (SOWMR 2011). One of the means of heightening the quality of perinatal care and lessening perinatal mortality and morbidity of a nation is perinatal care that includes antenatal care, referral practices and skilled attendants at birth (WHO 2005, UNICEF 2009, UNICEF 2012). According to WHO (2005) midwifery care is seen as “*one of the most important interventions to ensuring safe births and healthy infants,*” and has been official policy in Greenland for over 150 years. The first Greenlandic midwife were educated in Denmark in the 1820’s, while other young Greenlanders were educated in their own communities as birth assistants by the local physicians (Bertelsen 1927). Greenlandic women were thus ensured the possibility to give birth in close proximity of their own homes, families and communities (Bertelsen 1927). Midwives ensured safe births, and functioned also as the bridge between the people of the communities and doctors—who usually were

Danes (Rønsager 2006). They were not only expected to do deliveries, but were considered “*cultural translators*”. They influenced women and their families’ concept of health to conform to Danish standards and were messengers and translators of Greenlandic cultural understanding for Danish officials, living in Greenland (Rønsager 2006).

During the late 20<sup>th</sup> century, most women in North America and the Nordic countries gave birth in hospitals, in North America serviced by doctors and in the Nordic countries serviced by midwives (TFJ 2010; Montgomery–Andersen, Willén & Borup 2010). The discourse focused often on hospital vs. homebirths, the rights of the father of the child to participate in the birth of his child, or maternity leave for both parents. During the same timeframe Greenlandic discourse focused on local births (within the local city, town or settlement) versus transfer to larger towns, the referral hospital in Nuuk or even transfer to Denmark for special care (Appendix 1). Current health policies in Greenland support medical transfer to Nuuk for perinatal and prenatal care. Approximately 45 % of all Greenlandic women give birth in Nuuk, where 50 % are from other communities (Montgomery–Andersen, Willén & Borup 2010). The health reform of 2009 has also initiated a push for policy that transfers pregnant women to regional centers for birth in the case of normal pregnancy, even though the majority of families express the desire to give birth locally, whenever possible (Government of Greenland 2012; Bjerregaard & Olesen 2010).

#### *Remote and Rural Perinatal Care – Transfer During Pregnancy and Childbirth*

Birth and birth culture is different in each society, each having its own value sets, cultural norms and concepts of security (Kruske, Kildea & Barclay 2006; Abed Saeedi et al. 2011; Kildea 2005). Cultural theories of reproduction and childbirth are contextual and contingent upon the society that the families live in. These value sets and norms define the ‘culture of birth’ within the individual populations and cultures. For example cultural safety among the Baloch women in rural Iran has a different implication than in Australia or Greenland (Abed Saeedi et al. 2011; Ireland, WuliliNarjic, Belton & Kildea 2011). In Greenland the centralization of births, as known in Scandinavia, Europe and North America, has not been the norm (Rønsager 2006). Until the middle of the 20<sup>th</sup> century Greenlandic birth practices were protected and shaped by the women, men, the midwives, and the communities themselves (Rønsager 2006). The traditions surrounding pregnancy, childbirth, and care of mother and child, are protected and passed on by women and their family members (Montgomery–Andersen 2005, Rønsager 2006). Greenlandic women from the villages and settlements were encouraged to leave the settlement and could choose to give birth in the nearest city’s hospital since 1971 (Appendix 1). A study conducted on pregnancy in Greenland in the 1990’s by Bjerregaard and Young (1998) found that 99 per cent of Greenlanders prefer giving birth at the community’s own facilities to transferring out to larger medical centers. While women in Greenland are still in favor of local care in home communities in cases of normal pregnancy and birth, their

preference for transfer in the event of potentially complicated deliveries dropped to 80% by 2010 (Bjerregaard & Olesen 2010).

Transfer during pregnancy is not a Greenlandic phenomenon. Women in remote areas of the globe leave home during late pregnancy to deliver in larger birth settings (Patterson, Foureur & Skinner 2011). Women in Greenland transferred during pregnancy accept referral, but often prefer birth in their own communities (Bjerregaard & Olesen 2010). In the Inuit arctic area of Canada and Alaska birth is linked to traditional Inuit cultural concepts and there has been a resistance to medical evacuation for birth. Douglas (2011) states, that the place of birth is important to the Inuit sense of self-identity and to the individual's place within Inuit society. She posits that there is an "*epistemological Inuit discourse*" surrounding birth, its place in the community and the integration of cultural beliefs and traditions with modern obstetric and medical policy. In the Keewatin community of Canada the subject of transferring of women during pregnancy and its implications for the stability and health of the Inuit families was discussed (Tedford Gold, O'Neil & Van Wagner 2005; Tedford Gold, O'Neil & Van Wagner 2007). In the series of consultations with the elders and the members of the community, several concerns were addressed. The first subject of concern was the transfer of women during pregnancy and its implications for the stability and health of the Inuit families. Secondly, there was concern for the kinship relationships to those children born outside of the home community. Thirdly, there was the worry that family stability would suffer when women were transferred out weeks before their due date and especially the mothers worried that the children left at home would suffer, under these conditions. Finally, since land rights in the Canadian North are connected to place of birth, the community worried whether the rights of the children, their descendants would be jeopardized (O'Neil et al. 1987, Douglas 2011).

In other remote areas with larger Indigenous populations, such as in Australia and the Torres Straits, it has become more and more common that mothers are flown out of their villages and settlements to larger towns and cities with better medical capacity (Kildea 2005). Hoang, Le & Kilpatrick (2012) describe how in rural Australia, there is a schism between choice of birth settings between the aboriginal, indigenous population and the women from the non-indigenous populations and ethnic groups (Hoang, Le & Kilpatrick 2012). While non-indigenous women prefer birth in their own rural communities when at all possible, they choose transfer to larger units if the rural clinics do not meet their expectations of safety. On the other hand women in the indigenous populations are often reluctant to accept transfer under any condition, if it is at all possible to give birth in the home communities (Kildea, Kruske, Barclay & Tracy 2010). In many of the Indigenous communities families and communities follow guidelines, but are not always in agreement with the policy makers on the concept of risk (Kaufert & O'Neil 1993). Care

providers in Australia, New Zealand and the Torres Islands conclude that in the event of transfer during pregnancy the single most important issue is support:

*“In labour and childbirth, women should have support people of their choice. Ideally the person who escorts the woman to town would also support them in labour. Women should be offered, encouraged and supported to utilise their own cultural practices, and serviced by a facility that is warm and welcoming, where each and every woman feels safe.” (Kruske, Kildea & Barclay 2006, p. 77).*



## CHAPTER TWO

### AIM

The aim of the dissertation is to present new concepts and knowledge concerning the health of the perinatal family in Greenland. It looks holistically at the place of birth with focus on the issue of support during the perinatal period. It seeks to present the perinatal family and its position within the Greenlandic society. It links the changes in health policy with the concepts of family, attitude and community structure. It draws on statistical, historical, anthropological and cultural data within the context of the Greenlandic perinatal family.

### SPECIFIC AIMS

- To review literature on the physical place of childbirth in Greenland between 1953 and 2001 and to describe and analyze the change in perinatal health care structure in Greenland (Study I).
- To describe and analyze how Inuit family support networks are conceived and present themselves in these perinatal families. The child's place within the family sphere is explored, as well as the concomitant qualities, within the individual, the family, the community and culture that are the basis for strength and support and resiliency factors as a base for family support network and the child as a health-promoting agent. The child is addressed as an integral part of the family, and the unborn child, its siblings and the social construction of the perinatal family are examined. In addition the concept of the child as a health-promoting agent within families is explored (Study II).
- To document how women referred to Nuuk because of at-risk pregnancies narratively constructed self-understanding and defined meaning during their period of separation from family and community, and how they dealt with the challenges they were presented with (Study III).
- To focus on how family and community in Greenland perceive support-giving during the perinatal period. It explores Greenlanders' use of storytelling during the perinatal period and how it is used to present the thoughts of the families, mothers and community (Study IV).

### ETHICAL CONSIDERATIONS

Greenland is a very small, interconnected society where people know and know of each other, therefore special attention was paid to informed consent, the importance of confidentiality, protection of the integrity of the participants, the protection of data and the ownership of data (Barbash & Taylor 1997, pp. 48-56). Ethical approval was attained from the Commission for Scientific Research in Greenland

(KVUG<sup>11</sup>). Separate permission was granted for use of medical journals for selecting participants and was granted by the Office of the Chief Medical Officer as well as the individual hospitals involved. It was possible for participants to withdraw from the project at any time during the research process. One person asked not to participate or be contacted by the research project, when initially contacted, and one participant withdrew from the project, approximately six months after being interviewed; these files were destroyed, as requested. Culture Bearers were also included in discussions concerning concepts during the analysis, thus supporting the ethical process during fieldwork in an indigenous population (Barbash & Taylor, 1997 pp. 52-53).

Participant protection was one of the greatest challenges to research ethics, when researching in small communities. Information material was developed in the language of the participants, written in an easily understandable language and each participant was given information, both orally and written (Appendix 3). After the KVUG gave their approval, members of the panel reviewed the forms and information materials. Each participant was given information both oral and written and the mode of conducting interviews, storing data and disseminating results is in correlation to the Declaration of Helsinki (DOH 2008). All data and analysis materials are stored in a secure fireproof safe at the University of Greenland.

Ethics and ethical considerations are contingent on the research population. In indigenous cultures there has been a move to translate and develop ethical codes that can be understood in “*cultural terms*” (Smith 2002, p. 120). This is not only linked to the way that researchers meet the community and participants, but also the concepts of intellectual property ownership (Elliot 2005). The concept of intellectual property and ownership has been debated in Greenland, with special focus on the ownership of intellectual data (Rink et. al 2009, Loppie 2007). The discussion is interconnected with the Indigenous rights discourse and subsequent ethical principles concerning research within aboriginal or indigenous groups, cultures and nations (Elliot 2005). The Canadian National Aboriginal Health Organization established the OCAP principles, as the golden standard for research with and within indigenous peoples in Canada (Schnarch 2004). It is only within the last four to five years that ownership of data has been discussed in the research community of Greenland. Until recently, the Greenlandic community seldom had access to research materials collected in Greenland. Scientist and researchers from outside of Greenland, carrying out research and studies among and concerning the Greenlandic people have owned and stored the data that they have collected, in their own countries (Rink et al. 2013, *in press*). This has had both ethical and political implications for the people of Greenland, and the future of Greenland as a sovereign state. Few

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<sup>11</sup> Commission for Scientific Research in Greenland is an advisory body to the Danish Minister for Science, Innovation and Technology and the Greenlandic Government. It focuses on collaborative projects involving Danish and Greenlandic partners.

of the researchers have followed the Greenlandic regulations concerning sharing of intellectual knowledge with the local communities and laws regarding delivering results to the Greenlandic Archives and Groenlandica<sup>12</sup>. Excerpts of the dissertation will be translated to both Greenlandic and Danish and all published papers articles and the dissertation itself will be presented to Groenlandica.

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<sup>12</sup> Groenlandica is a national institution that collects, collates and stores all material that has been published in Greenland, about Greenland or of Greenlanders.



## CHAPTER THREE

### METHODOLOGICAL FRAMEWORK

#### *An Interdisciplinary Design*

An array of different methods was necessary to answer the research questions, and the interdisciplinary design emerged and evolved simultaneously with the studies (Newton Suter 2012). It became apparent that the design could not be static, but had to use a method “that relies on inductive reasoning and a continual interplay between data and developing interpretation” and a comprehensive and flexible design to answer the research questions, and fulfill the specific aims of the dissertation (Newton Suter 2012, p. 362). Public health and health promotion goals can be quantified and measured, but the thoughts, decisions and experiences of the women and their families cannot. I wanted to know the why and how these decisions were made and if they influenced the Greenlandic family structure. When starting the study I wondered if the fact that women were leaving their homes could influence the help and support the perinatal families received from their support networks. I also began to wonder if there was any change in the way that the women and families perceived family support. I believed that by taking into account and researching perinatal mortality and morbidity, comparing it to the decision and outcomes of the women, it might be possible to explore Greenlandic perinatal guidelines and policy influence on the health of the family. What I discovered was that much of the data needed to start the studies—including such materials as comparative literature reviews and the collation of historical birth statistics—was not accessible in current peer-reviewed literature, which meant that I first needed to research the historical background. This information was not easily accessible and it required a systematic literature search of all the available material (Altheide 1987). In order to answer the research questions it was important to use several disciplines: public health, epidemiology, health promotion, as well as historical, anthropologic and ethnographic disciplines (Creswell 2013, pp. 42-65).

#### *Methods of the Study*

The methods used were literature studies, narratives, storytelling, qualitative individual interviews and focus groups. The design of this dissertation was guided by the research questions and the design of the studies emerged as the need for more knowledge arose (Bryman 2004). It was not possible to access birth and death registers, but it was possible to access public information from the Office of the Chief Medical Officer and Greenland’s Bureau of Statistics. Greenland is now a constitutional constituency (June 2009) and has had several changes in government throughout the research period; this has also influenced the decisions regarding and the development of perinatal health care. Statistical data, annual reports, vital statistics and birth records were used to give a historical perspective of perinatal care in Greenland.

### *Implicit Knowledge and Prolonged Fieldwork*

When I started data collection in July 2003, I had already lived and worked as a midwife in Greenland for over eight years. This meant that I had met women and delivered children from as far north as Qaanaaq, and as far south as Nanortalik, as well as from Tasiilaq and Ittoqqortoormiit on the east coast (Figure 1). I was known to many of the women who participated in the study because of the fact that I do speak a somewhat limited but usable Greenlandic. Although I am grateful for my new country and I have become a part of the community, I am often reminded that this is not the country of my birth, nor is it the culture in which I grew up. In many ways it could be said that my fieldwork in Greenland did not start in July 2003 with my research, but at my arrival eight years before and that it is still ongoing.

### *The Ethics and Language of Intercultural Research*

In Greenland, the official and most spoken language is Greenlandic, thus the language of the interviews was Greenlandic, although transcripts were written in Danish and the published articles are in English. Although the researcher and research assistants both spoke Greenlandic, the researcher's limited command of the written Greenlandic made it necessary for all transcripts to be written in Danish, which was the second language of the research assistants (Kvale 1996). It was evident even before starting the research that all interviews needed to be done in the language of the participants, without the use of an interpreter. This was important for positioning of the researcher within the Greenlandic context and gave easier access to the participants of the study. In this process the use of translation and retranslation had an important influence on the research process and an ethical implication (Smith 2002). In all societies language and identity are in some way intertwined, and when working in cultures other than one's own the use and understanding of language is of the utmost importance, even more so in indigenous societies, where language is also a part of the struggle for international acknowledgement of the rights to one's culture and lands. And, the use of language is connected with historical, political, and social issues<sup>13</sup> (Smith 2002, Møller 2011). This historical and political environment influences us as researchers and as human beings (<http://wikis.la.utexas.edu/theory/page/situatedness>). Intercultural research always poses challenges for the participants and for the researcher. One of the challenges for the researcher within an indigenous population, when collecting, analyzing and presenting the data, is to remember that she is analyzing text outside of her own context, a context which might not be the correct discourse for understanding (Jasen 1997, Smith 2002).

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<sup>13</sup> Culture Bearer Nuka Møller Personal correspondence intermittently between 2003-2006.

Haraway (1988, p. 586) takes the standpoint that “*Identity, including self-identity does not produce science; critical positioning does, that is, objectivity.*” Schmaus (2008) states that there is an incongruity on one hand of being an outsider in the cultural and social realm, and on the other being an insider within a professional situatedness. By understanding the cultural, political and social situatedness, it is possible for the researcher to touch some of the important elements of research: 1) the need to examine these forms of interaction, and 2) to establish points of location and situation (Schmaus 2008). The concepts of location and situation not only apply to the social relationship in respect to other scientist, but in the realm of research within indigenous communities, it also is reflected in the relationship to the people, the families, the communities, the Elders and in the case of these studies, Culture Bearers. It is the opportunity for critical interaction that requires cultural humility, respect for language and local access and ownership of data (Loppie 2007, Smith 2002, Medicine 1987).

## METHODS OF DATA COLLECTION

### **Literature Study (Paper I and II)**

Materials were gathered through a general library search, archive materials from the Office of the Chief Medical Officer, Annual Reports, Greenland Medical Reviews (GMR) from 1953-2000 and written policy on place of birth also from 1953 to 2001. Greenland Medical Reviews, the National Library, Groenlandica's archives, the libraries at the Office of the Chief Medical Officer and the primary health clinic in Nuuk, Health Department reports were accessed. Journals and essays written by doctors, nurses, anthropologists and visitors to Greenland were also taken into account. Keywords were Indigenous people, Inuit, Greenland, the Arctic, Safe Motherhood, Perinatal Policy, Birth Policy, and Birth Settings. Search engines included PubMed, CINAHL, CSA, Popline and AnthropologyPlus. Individual journals such as the International Journal of Circumpolar Health, Journal of Anthropology and Medicine, Journal of Arctic Anthropology, Alaska Medicine Journal, and, Inuussuk—the Arctic Research Journal of Greenland were accessed as well. During the last year of the study, information concerning perinatal mortality and morbidity was supplemented by personal correspondence with Secher<sup>14</sup> and Bjerregaard<sup>15</sup>. Study II involved an initial and secondary literature search focusing on the keywords: healthy families, health promoting families, resiliency, Arctic, Inuit, and family support. During the literature search that was executed in PubMed, Popline, CSA and CINAHL, an article of Christensen (2004) that focused on

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<sup>14</sup> Niels Jørgen Secher (Perinatal evaluation group Agency for Health and Prevention) Personal correspondence June-September 2012.

<sup>15</sup> Peter Bjerregaard (Perinatal evaluation group Agency for Health and Prevention) Personal correspondence June- September 2012.

the child as health promoting agent was found. The tertiary literature search was conducted by combining literature gleaned from literature lists and suggested articles<sup>16</sup>, together with other relevant articles from the literature search.

## Empirical Data Collection (Paper III and IV)

### *Participants*

Participants in the dissertation are both women and men. In the statistical data, or empirical descriptions the female participants are presented as “women” and the male as “men”. Otherwise female participants are either referred to as mothers, expectant mothers or mothers-to-be and men as fathers. Data collection was started in 2003 as empirical data for my Master of Public Health study in several communities in Greenland and the result of that fieldwork gave more questions than answers and thus inspiration to continue. Between 2003 and 2011, individual interviews and focus groups were carried out with mothers, fathers and Culture Bearers. In the original study design, three focus groups and ten individual interviews were planned. The three focus groups were to be conducted in three localities in Greenland: Ilulissat, Tasiilaq and Sisimiut, while the individual interviews were conducted at DIH.

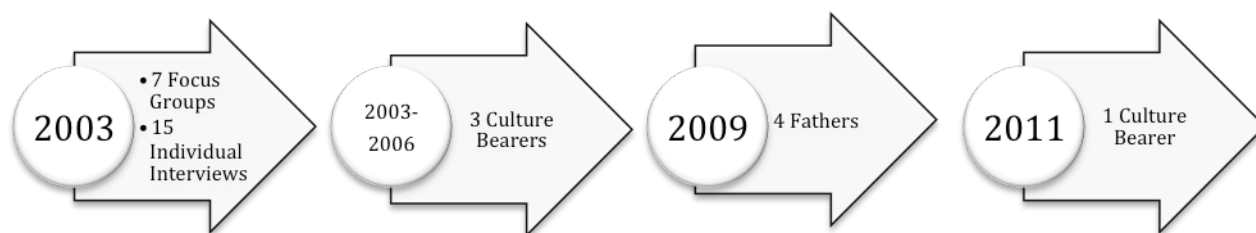


Figure 8. Flowchart of empirical data 2003-2011

During the course of the research period, some changes were made. Nine of the individual interviews were conducted during the women’s stay in Nuuk in their quarters at the Patient Hotel<sup>17</sup>, while six individual interviews were carried out in the women’s home communities, during fieldwork. Of the fifteen individual interviews conducted with mothers, five were not included in the data. The shortest interview was seven minutes, the next one lasted twelve minutes and all others lasted approximately 45-minutes. Two interviews were not used, because the communication between the interviewer and the participant was not optimal, one was not on the subject of the project, one interview has been accidentally erased and one participant asked to be removed from the project. Thus the analysis of the interviews is

<sup>16</sup> Pia Christensen (Professor University of Warwick, England) Personal correspondence December-January 2010.

<sup>17</sup> Both the Patient Hotel, connected to the referral hospital in Nuuk, and Patient Homes, connected to local hospitals along the coast, provide accommodations for the expectant mothers that are transferred during pregnancy, but not requiring bed rest.

based on 10 of the 15 interviews with mothers.

It was expensive to carry out fieldwork in three localities and required travel over a distance of more than 4000 kilometers within a four-week period, so it was decided to plan at least three focus groups in each locality. All seven focus groups were held during this four-week period from June to July of 2003, in which 35 mothers participated.

The stories and storytelling style of the women in the focus groups will be described in depth in the next sections. Three Culture Bearers were initially interviewed in 2003 and were contacted for clarification of concepts and language when needed between 2003 and 2011, and again during the writing of this dissertation. In 2009 four fathers were interviewed and the fourth and last Culture Bearer was interviewed in 2011. The empirical data presented in the dissertation was comprised of: seven focus groups with 35 participants, the eighteen individual interviews included ten individual interviews with mothers, four interviews with fathers and interviews with one male and three female Culture Bearers.

### *Mothers*

Greenland's five largest health districts—Upernavik, Ilulissat, Sisimiut, Qaqortoq and Tasiilaq—were chosen as the research arenas for the study (Figure 1). All women transferred to the referral hospital between 1999 and 2003 were included in the initial sample. Three districts—Sisimiut, Ilulissat and Tasiilaq—responded and gave consent to conduct focus groups in their district. Ninety-two women from these three cities fulfilled the inclusion criteria. Inclusion criteria were developed for interview and focus groups. Careful consideration was taken in determining whether or not the women were suitable for participation in the study (Lunde & Ramhøj 1996). Women in acute crisis were not interviewed, nor were women who had given birth to children that had died during or after the mother's referral. Using these criteria, three women were excluded from the original sample, leaving 92 potential participants.

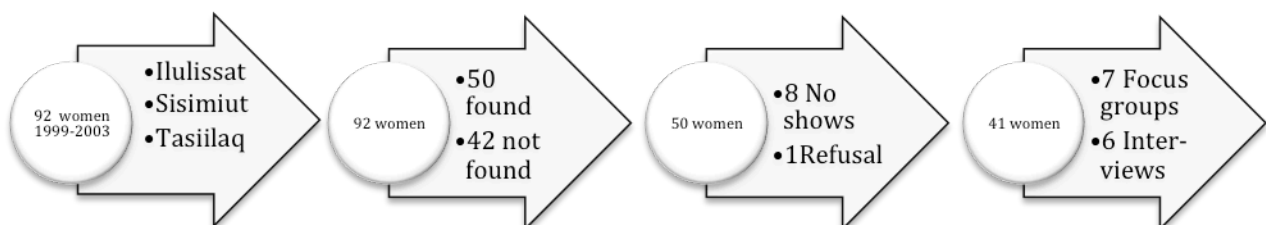


Figure 9. Flow chart of inclusion process for focus groups and individual interviews during fieldwork

Of the 92 women, 50 were found and asked to participate in focus groups. Forty-two women were not asked because 1) they could not be found, 2) had moved, or 3) were on the land<sup>18</sup>. Forty-one of the 50 participated in either focus groups or individual interviews; one requested not to be contacted by the project and eight said that they would participate but did not attend. Seven focus groups were conducted with between three to five participants. All focus group lasted approximately two to two and a half hours. Six individual interviews were conducted during fieldwork and participants were not included in both focus groups and individual interviews. In the instances that only one woman came to the focus group, an individual interview was carried out instead.

### *Fathers*

Interviews were conducted with fathers during 2009. These interviews were seen as a means for focusing questions on the specific topic of family support and to deepen the understanding of the cultural aspects of the birth within the Greenlandic family and community context. Four participants were selected through purposeful sampling. The father's ranged from 27-55 years of age. They were from different walks of life: one skilled worker, office worker, one musician and one engineer/politician. Inclusion criteria for fathers were 1) one child or more living at home 2) interested in expressing thoughts about fatherhood, care and nurturing. The researcher, the Culture Bearers and the research assistant gave suggestions of possible participants and these were followed up. Purposeful sampling was used to reach participants from different ages, walks of life and economic circumstances.

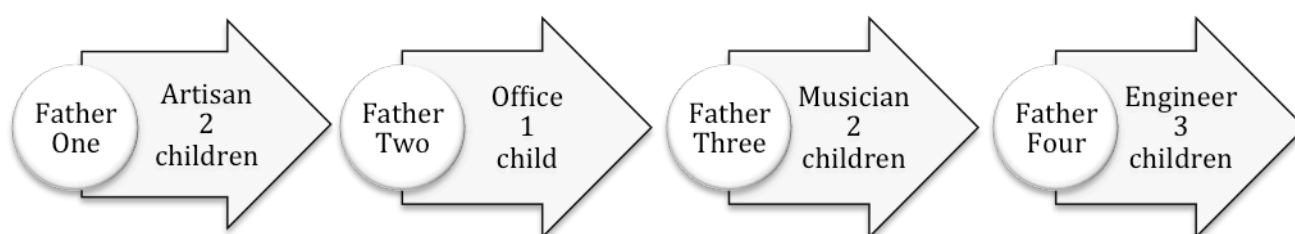


Figure 10. Purposeful sampling fathers

### *Culture Bearers*

Cultural knowledge is passed from one generation to another by word of mouth in most cultures, it is the expression of thoughts, the writing of literature and poems, and the telling of stories which each are important ways to develop and keep culture alive (Banks–Wallace 2002). In Greenland, as in most close-knit communities there are individuals, families or groups that have a voiced or an unvoiced influence and an official or unofficial station within the community (Loppie 2007, Pe–Pua 2006). The term Culture Bearer was used when referring to 1) elders or *people of capacity* respected for their knowledge within

<sup>18</sup> Not in the cities or towns, but were out fishing, hunting or berry picking with their family members.

the Greenlandic culture, or 2) community members who were catalysts for knowledge transfer from one generation to another. As childbirth changes within society, both mothers' and fathers' roles are changing (Handwerker 1990). Medicine (1987) explains that women are often seen as the guardians and Culture Bearers of childbearing traditions in society. They often exercise influence over which traditions and rituals continue within the culture and which disappear from a society's consciousness (Medicine 1987, pp. 159-166). It is important to remember that the Culture Bearers of the research projects were selected through purposeful sampling and that it is members of the community itself who decide who is a Culture Bearer (Loppie 2007, Pe-Pua 2006). Smith (2002) expresses the importance of listening to stories and the knowledge transferred through stories and tales. Skifte (2005, pp. 58-65) voiced the opinion that it is not normal for Greenlandic people to voice opinions unless asked (Montgomery-Andersen 2005, pp. 58-65). Over the past decades, Culture Bearers in Northern communities have been a part of the evaluation process in research projects, as members of committees, in focus groups and as respondents (Csonka & Schweitzer 2004, Tedford Gold, O'Neil & Van Wagner 2005; Tedford Gold, O'Neil & Van Wagner 2007). Use of Culture Bearers can be seen as a part of the process of going back to the informant and develops the use of the importance of intuitive knowledge and the use of elders and Culture Bearers as a important part of empirical data to be employed in research within Indigenous populations (Daviss 1997, O'Neil & Kaufert 1990, Medicine 1987). By asking questions and listening to the answers, new ways of understanding the answers were uncovered and it made it possible to ask questions in another way during the 2011 interviews with the last Culture Bearer (Banks-Wallace 2002). The Culture Bearer concept has been discussed in Aboriginal research communities and is acknowledged and Strickland and colleagues (1999) stated that it is possible to heighten validity by respecting and "*honoring patterns of community communication*" (Strickland, Dick Squeoch & Chrisman 1999, p. 196). As Patton says in his story the *King of Monkeys*:

*"It is a grave responsibility to ask, it is a privilege to listen" (Patton 2002 p. 417)*

Culture Bearers in this dissertation were elders within the community or people of capacity, both male and female. This was also taken into account when choosing Culture Bearers. Culture Bearers were known to the researcher and were referred to us by other members of the community (Loppie 2007). They were all asked several times before they acquiesced. One Culture Bearer was knowledgeable within the health field, one within the use of the Greenlandic language, one on the history of Greenland and Greenlanders, and one has served families as a lay midwife for over 40 years. Culture Bearers were selected through purposeful sampling and had been suggested by several people within the community, as a resource person. Three were between 45-55 when interviewed and one was 65 when interviewed. All were well respected within their fields and in their communities.

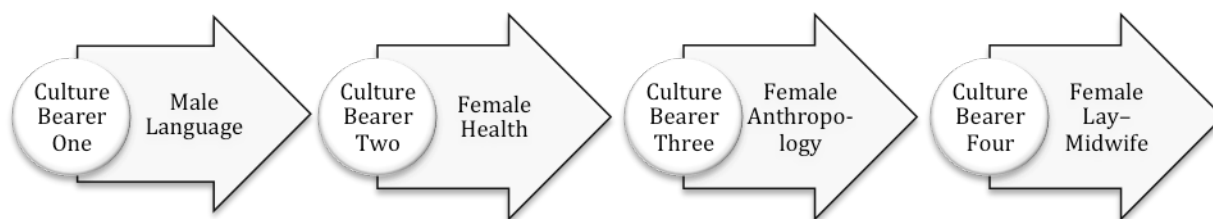


Figure 11. Purposeful sampling Culture Bearers

### *Interview Guides, Interviews and Focus Groups*

Separate theme guides were developed for the individual interviews and focus groups with mothers/mothers-to-be, focus groups, fathers and Culture Bearers. The themes centered on childbirth, transfer, separation, family and community, and included questions about family and community support. The follow-up interviews<sup>19</sup> in 2009 and 2011 focused especially on the role of the family, support network, care giving and changes in traditions around childbirth. See Appendices 4 & 5 for interview guides and themes. The focus group materials were very detailed and the Greenlandic tradition of letting the other speak out, respecting the words of others and connecting stories without judgment was an integral part of the interviews (Jasen 1997). The individual interviews lasted between seven and 45 minutes, and the focus group discussions lasted between two and two and a-half hours. Each session was recorded and the participants were once again informed that they could withdraw their consent at any time and that their tapes would either be destroyed or sent back to them.

Focus groups took place in the participants' home community at the hospital in a room that was set aside for meetings. This room was usually a room that was not an office but a conference room. Individual interviews were conducted either at the women's room at the patient hotel in Nuuk or in the midwives' office at the hospital. Interviews with the fathers were conducted in their own homes, while interviews for Culture Bearers were conducted either in their homes or at the researcher's home.

### *Research Assistants and Transcribers*

Although I conducted the majority of the individual interviews, two research assistants were engaged, one to conduct interviews with fathers and one as a moderator for focus groups. During focus groups the research assistant conducted and moderated while I did conversation mapping, took notes, took care of unruly children, poured juice and served cookies. Only the male research assistant was present at the interviews with fathers and only the researcher was present at Culture Bearer interviews. Both research assistants were hired six to nine months before data collection started. Several meetings were held and

<sup>19</sup> Please look at flow charts (Figure 9) for overview of inclusion process for focus groups and individual interviews.

they were introduced to interview theory, ethics, field notes, and research theory; they also signed an agreement of confidentiality. The theme guides were designed by the researcher and discussed in depth with each research assistants, who then carried out the interviews and focus groups and recorded the transcriptions. During fieldwork and after data collection results and themes were discussed by the research assistants and the researcher.

### *Purposeful Sampling and Gatekeeping*

Purposive sampling was used in collection of interviews with fathers and Culture Bearers. Purposive sampling selects participants that fulfill criteria relevant to subject matter, for example, in this case fathers who live with their children and people of capacity in the local communities (Patton 1990). Sample sizes were not fixed, but were dependent upon the saturation of subject matter and it was determined in a continuous process during the transcription of data (Patton 1990).

Gatekeeping refers to the process of mediating access to the participants a researcher desires to enroll in the study (Bryman 2004). In this work gatekeeping was both a practical and an ethical consideration. I worked as a midwife in several districts between 1995 and 2006, and many of the possible participants in the study were women I had seen or serviced during their pregnancies. Because of this, gatekeeping was especially important and the use of a gatekeeper gave the women the possibility to accept or refuse participation without feelings of guilt or embarrassment (Miller 1998). The Coordinator for the Patient Hotel at DIH agreed to be gatekeeper and distributed information to the women about the individual interviews. For the interviews conducted during fieldwork in the other localities, the personnel served as gatekeepers at the local hospitals, in the kindergartens and at day care centers. Upon arrival in the selected communities we found that telephone numbers were often obsolete, people had moved and that it often was difficult to find the women in order to invite them to the information meetings about the focus groups. Therefore, upon arrival I asked permission to speak with the hospital personnel to whom I gave information about the research and asked them if they would spread the word. We also visited all day care centers and kindergartens in the cities, informing them about the research and then asking permission to post information on their bulletin boards about the information meetings.



## CHAPTER FOUR

### THEORETICAL FRAMEWORK

The history of women in a society is often difficult to research, because research has been a male dominated arena. Saïd (1978, p.207) argues that since literature and text during colonization were developed through “a male concept of the world”, gender was not considered to be an issue, and therefore childbearing and pregnancy were not an important part of the research discourse<sup>20</sup> of the last century. Greenlandic was not a written language before the middle of the 1700’s and men and women who ventured to the arctic focused on the adventure of Greenland and not the women of the country (Mills 1997). Some narratives and travel writing might have been done by women of the time, but were not found by the author during the research process. In order to reflect upon the historical and cultural complexity, a literature review was done to summarize and present all available literature on birth and birth’s place in the post-colonial period (Csonka & Schweitzer 2004, Smith 2002). An ethnographic content analysis approach was chosen, common themes identified from each text and the coding of text done in stages: 1) a topical indexing 2) content coding to frame the content and themes, and 3) chronological indexation of the material (Aveyard 2010). This approach was supplemented with a systematic process to uncover the meaning of the texts, using a transparent and stringent process of setting material in its chronological and historical context (Bryman 2004, Banks–Wallace 2002, Altheide 1987).

Qualitative interviews conversations are encounters between informant and researcher. The researcher explores, and attempts to uncover the informant’s views while giving space to the individual’s right to structure and frame the concepts of the interviews (Creswell 1998). O’Neil & Kaufert (1990), Sennett & Dougherty (1990), and Chamberlain & Barclay (2000) all describe the challenges in conducting interviews and focus groups with the Inuit peoples of northern Canada. Bjerregaard & Dahl–Petersen (2008), also note that it is difficult to get people in the larger cities in Greenland to participate in research. This has not been the case for data collection in studies III and IV of the dissertation. If allowed to, participants will answer questions, as seen through their eyes, within the first moments of their interviews<sup>21</sup>. An example of this can be seen in Sara’s narrative (Appendix 6). Sara’s<sup>22</sup> narrative was typical of the individual interviews conducted during data collection, although its duration was less than 12 minutes. Although Sara’s narrative was one of the shortest of the interviews, it includes elements of storytelling that are specific and recognizable for the Greenlandic community (Kleist Pedersen 2006).

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<sup>20</sup> The term *discourse* is used in this paper to indicate discussions of a subject in both the spoken and written word.

<sup>21</sup> Ruth Montgomery–Andersen. Fieldnotes 2003.

<sup>22</sup> All participants were given pseudonyms.

While she tells her story, she smiles and laughs but does not change intonation throughout the entire interview<sup>23</sup>. She presents her story in a way that the rhythm and intonation of the text creates a space in which all of the details are presented intact (Kleist Pedersen 2006).

## **Analysis Theories**

### *Ethnographic Content Analysis*

Ethnographic content analysis is a reflexive method that makes it possible to take into account a complex data set. Although it is a systematic approach, it is flexible and gives space for exploration and analysis of different types of data (Altheide 1987). It makes it possible to employ several methods of data collection, not only individual interviews and focus groups, but also interpretive interviews with Culture Bearers. Newspaper articles, television media, reports and field notes, which support and gives richness to the understanding of the research question, and add depth (Bryman 2004, Banks–Wallace 2002, Altheide 1987). By structuring the analysis chronologically, it is possible to incorporate different forms of data into the analysis and gain a holistic view of the findings (Bryman 2004). Banks–Wallace (2002 p. 415) supports this by describing how current social and political phenomena can have a direct effect on the stories that are presented to us as researchers. She states:

*“Participants were not directly questioned regarding historical factors relevant to a particular phenomenon... further insight about historical factors that might have influenced women’s stories was gained in various ways, including such things as examining local, national, or global media; talk shows; and e-mail correspondence . . .” (Banks–Wallace 2002 p. 415).*

Although Banks–Wallace’s (2002) research is done within the African–American community of the United States, the observation and the analysis structure that she has developed is relevant to this study, first, because focusing on the historical, cultural or ethnical milieu of the stories is important to the analysis and second, because different cultures have different ways of defining a story. It is important to any research process to understand and include historical changes and developments; this can be honored when the historical and cultural context of the data are kept in sight and used as a way to refine categories during the analysis process (Csonka & Schweitzer 2004, Banks–Wallace 2002). When recording, structuring, analyzing, and interpreting text, one of the research goals is to recreate and reproduce meanings and cultural understandings, as the *participants* have understood it. It is in this process the

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<sup>23</sup> Arnaq Grove (Assistent.Professor at the University of Copenhagen and Researcher at the Institute for Eskimology and Arctic Studies) Personal correspondence 2004.

researcher uncovers the choices of the participants, both the conscious and the subconscious (Chamberlain & Barclay 2000).

### *Ethnographic Content Analysis Process*

Data was collated from database searches, historical materials from national archives, public and private libraries; it also incorporated reports, journals, travel narratives and university theses. Findings were supported through the use of newspaper articles, television programs and Culture Bearer interviews (Altheide 1987). The empirical data of the studies was extracted from the transcribed focus group proceedings, interviews and field notes (Bryman 2004). The texts were read and as recurring themes in the texts became evident, they were categorized and then subcategorized, drawing on both likenesses and differences (Bal 2004, Graneheim & Lundman 2004, Weber 1990). As the themes and final categories emerged, the tapes from interviews were listened to, the transcripts read and re-read, paying special attention to context and meaning (Bal 2004, Riessman 2003). Field notes were reviewed as well as the dialogue/conversation mapping notes. Dialogue mapping is a tool used to map dialogue within a focus group and an example can be seen in Figure 12. It is done in intervals throughout a focus group, and can be used to support findings and to uncover, dynamics within a group. The dialogue/conversation maps were used as support during the analysis process to see the dynamics of the discussions or conversations (Rink et al., 2012). Important newspaper articles, policy papers or press releases were also noted in field notes (Banks–Wallace 2002). Anthropological and cultural documents were used together with interviews with Culture Bearers to validate the development of categories (Bryman 2004, Altheide 1987).

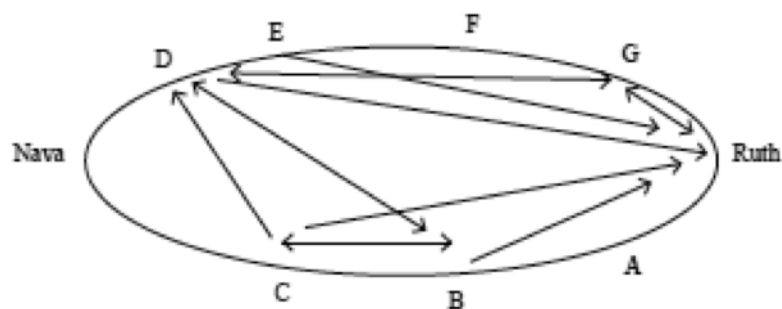


Figure 12. Example of dialogue mapping during a focus group

### *Daviss' Logic*

In her article *Heeding Warnings from the Canary, the Whale and the Inuit*, Daviss (1997) describes the tension and contradictions that exist between the Inuit community's and the medical community's definition of normal and risk in the perinatal period. The article looks at the process of decision-making regarding pregnancy and birth; birth being defined as the process in which families increase their numbers, not only the act of birth. She goes on to argue that each person or institution involved in the

decision-making process around birth has its own understanding of the truths and ‘logics’ around the decisions that need to be made. Daviss (1997) identifies and introduces eight types of logic. In the schematic overview presented in Table 3 the logics are classified and described as: 1) scientific logic, 2) clinical logic, 3) personal logic, 4) cultural logic, 5) intuitive logic, 6) political logic, 7) legal logic and 8) economic logic (Daviss 1997, pp. 442-445). Daviss (1997) states: “Each player in the health care system creates and articulates his or her own system of logics and assumes that it is logical (p. 443)”. It is the schism between the logics and the ability of the individual player to see and acknowledge the other forms of logic that influences collaboration and understanding between the players (Daviss 1997).

Table 3. Schematic overview of Daviss’ Logics<sup>24</sup>

### *Storytelling as a Theory-Building Tool*

The empirical materials for this dissertation are complex and varied, and required analysis methods that take complexity into account (Banks–Wallace 2002). Storytelling as a theory building activity made it

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<sup>24</sup> The text is not identical with the original data source, the complete text can be found in: R.E. Davis-Floyd, C. Sargent (Eds.), *Childbirth and Authoritative Knowledge* (pp. 441-473). Berkeley: University of California Press. Daviss, BA (1997). *Heeding Warnings from the Canary, the Whale and the Inuit. Is a framework for analyzing competing types of knowledge within childbirth* (pp.443 & 444).

possible to glean experience from stories and retold by mothers, families and communities (Ochs, Taylor, Rudolf & Smith.1992). Ochs and colleagues present storytelling as a tool that can be used to build and support analytical/critical thinking and the participant's possibility to build theory. It is within this framework the roles change. Culture Bearers, mothers and fathers, children and researchers change between the role of storyteller, audience, and from the framework, it could be said that these authors take on the role of the child and the Culture Bearers, mothers and fathers, take on the role of the parents in the storytelling process (Ochs et al. 1992).

When stories are told to an audience the audience becomes an actor in the recreation of the story and a relationship is established between those who tell the story and those who listen (Huisman 2008). Within the storytelling process, stories are developed as an act between the storyteller and the audience, and the story is used to create meaning and describe thoughts (Huisman 2008, Banks–Wallace 2002). Ochs et al. (1992, p. 37) also posits, that “each story is potentially a theory of a set of events, that contains an explanation which may be overtly challenged and reworked by co-narrators”. The co-narrators can be children within a family, community, focus groups or the researcher herself (Ochs et al. 1992).

Storytelling can also give space to the historical and cultural context of the stories, by looking at details in the stories: which details are added, and which are left out (Bird et al. 2009). As the story is developed the choices of the participants, both the conscious and the subconscious become something real, something touchable, “touchstones”<sup>25</sup>.

### *Narrative and Storytelling Theory*

In Greenland storytelling has been a gathering point for the family at weddings, funerals, and at births. It has also, as in many cultures, been a means to protect and propagate traditions (Kleist Pedersen 2006, Dulumunmun Harrison 2009). As a deeper understanding of the data surfaced, it became apparent that materials should be analyzed using theories that were based on methods that took Indigenous cultural understanding or cultures other than the European and North American into account (Banks–Wallace 2002). When looking at stories within a cultural context there are three important ingredients for the creation of a story: 1) cultural values and norms, 2) immediate story environment, and 3) historical context (Banks–Wallace 2002). All three ingredients must be present before a deeper understanding can emerge. Denzin (1997 pp. 32-33) describes the qualitative text as a “cultural representation, a genre in its

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<sup>25</sup> The concept of space or room that is created between the storyteller and the audience in which the story becomes something real, something touchable; “touchstones” (Banks–Wallace 2002).

own right” while Lieblich, Tuval-Mashiach & Zilber (1998) describe the process of giving stories space and letting a global impression emerge from the text.

### *Cultural Framework–Cultural Resiliency*

Gesink and colleagues (2009) point out that there have been extensive changes in environment, in infrastructure, healthcare and in cultural traditions in Greenland over the past generation and this requires that the individuals in society find ways to adapt to these changes and yet protect and develop their society from within (Gesink et al. 2009). The understanding of cultural resiliency is often linked with the traditions and cultural concepts that individuals often credit the community’s influence on supporting his or her ability to stay healthy (Ladd–Yelk 2001). The term is also linked with coping and describes the individual’s 1) ability to understand the situations of life, *comprehensibility*; 2) to manage demands, *manageability*; and 3) to find meaning and deal with each challenge as it presents itself, *meaningfulness* (Antonovsky 1998, Lazarus & Folkman 1984). Cultural resiliency theories used in this dissertation hypothesize that health is contingent on several factors 1) the extent to which an individual or group is able to change or manage their environment, and 2) the concept that personal efficacy and competencies have a positive effect on the individual and can be seen as sources of individual and communal strength (McCubbins 1998a, McCubbins 1998b, Ladd–Yelk 2001, SLiCA 2004).

According to Ladd–Yelk (2001 p. 8) culturally specific resiliency mechanisms such as “supportive social networks, flexible relationships within the family, religiosity, extensive use of extended family helping arrangements, adoption of fictive kin who becomes family, and a strong identification with “racial group” can support and protect the society from within (Ladd–Yelk 2001). O’Neil et al. (1987) argue that the strength of the Inuit families comes from the community and the family itself. Both Ladd–Yelk (2001) and McAdoo (1998), state that the ecological framework in which the families live, are affected by the historical and cultural context of their life.

## CHAPTER FIVE

### SUMMARY OF FINDINGS

The findings of this dissertation are divided into four independent studies each reflecting a face of the perinatal room in Greenland. Study I focused on unique culture and cultural norms of the women, families and communities in Greenland and the importance of their involvement in dialogue and changes in perinatal policy. Study II explored the importance of the social construction of the perinatal family and presented the possibility of the child as health-promoting agent within Greenlandic families. Study III emphasizes the aspects that families and communities were the support that “enabled” at-risk perinatal families, during pregnancy, childbirth and the initial bonding period. The psychological and social experiences the women had when they left their community during the perinatal period were an important influence on the quality of life of the mothers and their families. And, Study IV presented the Greenlandic understanding of support and responsibility. Protection of tradition, culture, and perseverance were understood as protective measures for the family’s and the child’s existence and health. Table 4 presents an overview of the study designs, data collection methods, and participants of the studies that comprise the *Faces of Childbirth*.

Table 4. Overview of study designs, data collection methods and participants

| PAPERS | STUDY                                                                                                | DATA COLLECTION                                                                                                                                                            | PARTICIPANTS/SAMPLE                                                                                                           |
|--------|------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| I      | Literature study using Daviss’ Logics as analysis instrument                                         | National Archives,<br>Historical data: Office of the Chief Medical Officer,<br>Groenlandica Archives.<br>Search engines: Popline, CSA, CINAHL, AnthropologyPlus and PubMed | Annual Medical Reviews from 1953-2001,<br>22 notes and articles from between 1861-2001,<br>4 peer-reviewed articles<br>1 book |
| II     | Literature study using content analysis and analyzed with theories of eco-cultural pathways          | Primary and secondary and tertiary literary search.<br>Search engines: Popline, CSA, CINAHL, AnthropologyPlus and PubMed                                                   | 13 peer-reviewed articles<br>Snowball effect<br>Secondary search                                                              |
| III    | Qualitative study using narrative methods                                                            | 13 Individual interviews:<br><br>Field notes                                                                                                                               | 10 women<br>1 male Culture Bearer<br>2 female Culture Bearers                                                                 |
| IV     | Qualitative study using ethnographic content analysis. Storytelling explored as theory building tool | 7 Focus groups:<br><br>5 Individual interviews:                                                                                                                            | 35 women<br><br>4 fathers<br>1 Culture Bearer                                                                                 |

## THE HISTORY OF BIRTH SETTINGS IN GREENLAND (PAPER I)

The purpose of the study was to review literature on the physical place of childbirth in Greenland between 1953 and 2001 and to describe and analyze the change in perinatal health care structure in Greenland. The findings were categorized according to Daviss' logics (Table 3). At the cessation of colonialism in 1953 there were stringent policy guidelines concerning place of birth that took the form of information delivered to the public concerning political decisions. Focusing on the categories presented in Daviss' Logics, the following findings will be highlighted: 1) scientific and clinical logic, 2) personal and cultural decision-making logic, and 3) economic policy.

### *Scientific and Clinical Logic*

Pregnancy and childbirth were considered a physiological phenomenon in the postcolonial period and women were encouraged to have their children at home either in the towns or in the settlements that they lived in. By 1971 all births in Greenland were in hospitals or local health centers and attended by midwives or lay-midwives. By 1995 policy was in place ensuring that women in acute perinatal peril were transferred either to DIH<sup>26</sup> or to Denmark<sup>27</sup>. During this period all other births, which accounted for 90% of the births, were at hospitals in the women's own communities and were attended by midwives or lay-midwives. As the health status of the people improved and the cases of tuberculosis declined the women were encouraged to travel from their settlements and give birth in the larger towns where doctors and midwives were employed. By the late 1980's when the HIV epidemic in Europe and North America raged, although HIV was not yet a problem in Greenland, there was a great concern that it could become an epidemic within the heterosexual community because of the high incidence of unprotected sex in Greenland. The overall concern for health changed the focus of perinatal care from a matter for personal choice for women and their families to scientific, clinical logic. Moving from being considered a natural process it became an integrated part of the health care system, along with tuberculosis and HIV treatment. By the 1990's there were no homebirths and all women were encouraged to give birth in the hospitals serviced by lay-midwives, midwives and doctors. Women from smaller towns and settlements were asked to travel to larger cities and not to give birth in their local health centers. Place of birth was chosen with regard to level of competency of health personnel within the women's community. The place of birth varied and was decided by the clinicians. In the case where there was a possibility for liability for the system, the choice was that of the practitioners and not the women.

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<sup>26</sup> Dronning Ingrid's Hospital in Nuuk, Greenland.

<sup>27</sup> Rigshospitalet (National Referral Hospital in Copenhagen, Denmark).

### *Personal and Cultural Decision-Making Logic*

Extremes of isolation and limited infrastructure between communities influenced the women and their families' possibility to support traditions and to keep logics intact within the individual communities. Childbirth was moved from the private arena to the public arena where decisions were not negotiated with the women. Women, families and communities still developed the personal, cultural and intuitive logics through support networks, and extended family relations. Cultural decision-making logic was dependent upon the instincts and feelings of the women and her families; these feelings may or may not have been tangible and understandable for others outside of family. An important part of the birthing experience was the cultural logic creating and supporting the networks that existed in the women's local communities which played an important role in which family members supported the women during childbirth and labor. Thusly, the women were still able to create a room where their culture, beliefs and traditions could be preserved and recreated. Within the personal logical framework the place of birth would be chosen and agreed upon by the women, their family and/or community. Traditions and cultural preferences would influence this choice. Cultural decisions were influenced by the family's situation and could change several times during the perinatal period. Birth within the community was important for the individual women and for the community. Exercising choice gave the individual women and families greater or lesser power over their own health during the perinatal period.

### *Economic and Political Logic*

Changes in perinatal policy in Greenland came about because of the global focus on the high perinatal mortality and Greenland's falling birth rates. At the same time the fall in prevalence in tuberculosis and subsequent lightened burden on the health system made it possible for women to give birth at the hospitals. Because of the long distances between the cities and the restricted transportation infrastructure in Greenland it was necessary for the hospitals to provide housing for the women at or near the hospital at which birth was to take place. Change in the childbearing patterns and the better overall health of the Greenlandic population influenced the hospitals capacity to receive these women. The goal of changed policy is twofold: to lower perinatal mortality and in addition reduce the economic burden on the medical system. Although there are several models of perinatal care in the arctic that have had a local and institutional success, Greenland chooses to look to Nordic and Danish models. Birth setting were evaluated and developed by policy makers, health and government officials, but the women and families themselves were often not a part of the dialogue. Authority for establishing these policies lie in the hands of the policymakers and it is the duty of the health professionals to execute these policies. Choice was possible if it was within the guidelines set down by the political system. Place of birth was reflected by the policies and the economic framework of the government at any given time, with the economical framework as the deciding factor for birth setting. Where and with whom women give birth was

influenced by the economical choices of the policymakers and government. Choice was only possible if it coincided with the economical preferences set out by the government.

## CHILD AS THE HEALTH-PROMOTING ACTOR IN THE PERINATAL FAMILY (PAPER II)

Study II aimed to describe and analyze how Inuit family support networks were conceived and present in the perinatal families. It focused on the social construction of the perinatal family, the concept of the child as health-promoting agent within families, as well as to explore and discuss the role of family in Greenland during the perinatal period. The results of Study II focused on family support and networks and explored the child as the health-promoting agent. In this thesis the all children of the family are included in the definition of the perinatal family<sup>28</sup>. And, the child as the health-promoting agent is understood as the individual child's ability to affect the health of the family. This part will highlight these concepts and the results of the literature study will be presented in two following main content areas: 1) the child and 2) the perinatal family.

### *The Child*

It can be said that children have an innate understanding of philosophical topics such as family, beauty and truth; and, that it is possible for children to contribute to the development of the health-promoting family. Traditionally, children in the Greenlandic community were perceived as having their own consciousness from a very young age (*silattorsarpoq*<sup>29</sup>). Spiritual connectedness, soul names and kinship with the child as the center of these relationships were seen as important in many Greenlandic families. This and other cultural concepts supported the concept of the child as the health-promoting actor, shifting the view of the child from the object of health care initiatives to the subject of health initiatives, and performing its role as a social being in his/her own right. This can be conceptualized in the ways families engaged and utilized the resources at their disposal and how this supported the development of a healthy perinatal family.

Sharing of names and of history was used to connect the newborn child to the community. Children in Greenland are involved in the development of their own futures, not only as the receiver of health, but by actively participating in forming their own concepts of beauty, responsibility and truth. Children presented with the same philosophical topics as grown-ups often had the same questions and aspirations

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<sup>28</sup> See lists of definitions and key concepts.

<sup>29</sup> See lists of definitions and key concepts.

as adults, even while lacking the same life experiences. The perinatal family supported both the unborn child and other members of the Greenlandic family, including the family nucleus and kinship relationships. Siblings were an important part of the perinatal family unit, and not only contributed to their own health, but to the perinatal families' health. Traditions and kinship practices such as soul names, although initiated by adults, were often an instrument for the children to participate in their own health.

### *The Perinatal Family*

In Greenland the invisible lines that were created by kinship practices and family constellation within the individual perinatal family define the family. The concept of a "perinatal family" acknowledges change and development in family dynamics during pregnancy and how these dynamics affect members of the family. The birth of a new family member influences not only the well-being of the parents and the newborn, but also the life of the other children and family members. The family's decision to support and strengthen kinship relations had an influence on the health of the children and their families. This included both the health of the unborn child and their siblings.

Kinship existed or was created in Inuit Greenlandic families through flexibility in family relationships supportive and cemented social ties, and included adoptive kin and people who "become" family. This was often done through kinship bonds that were strengthened through name giving and soul names<sup>30</sup>. The practice of name giving and the use of soul names increased and strengthened kinship and social relations.

### THE CULTURAL CONTEXT – CREATING A CULTURAL ROOM FOR BIRTH (PAPER III & IV)

Study III and IV are intertwined, as they should be. Culture, language, family and traditions are parts of a whole and must therefore be looked at simultaneously. Within a relational worldview the results will be presented not only using the concepts and content areas from the published articles; other categories and content areas will also be presented.

### THE CULTURAL CONTEXT – CREATING A CULTURAL ROOM FOR BIRTH (PAPER III)

The aim of Study III was to present how women transferred during pregnancy narratively constructed self-understanding and defined meaning during their period of separation from family and home community, and how they dealt with the challenges with which they were presented in this connection.

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<sup>30</sup> Please see the background concerning name giving and soul names.

The concept of family and motherhood as perceived by women and families who have experienced being away from their families and communities during pregnancy and childbirth is analyzed. Through analysis of the stories of Greenlandic women and the dialogue with Culture Bearers, the women's subjective experiences of motherhood, experiences of separation from family and home community and their own understanding of how to deal with these challenges, were analyzed. A semi-structured qualitative interview form was employed and findings were analyzed using narrative theory. The major categories that will be presented in this section are those of 1) identity and 2) sources of strength within a Greenlandic cultural context.

### *Identity*

The women of the study positioned themselves as the carrier of the unborn and the mother of the newborn. In many cases the identity of the women was connected to their place of birth. They identified themselves with and felt connected to their settlement, towns or cities. Instead of pregnancy being a time of joy, it became a time of loneliness, and the women often felt isolated and alone. This connectedness was a defining factor of their position within the community and their own self-understanding. By leaving the community during pregnancy, they were cut off from the traditions surrounding childbirth and motherhood, and many felt invisible. They expressed feelings of not having a "home", family nor loved ones near, and described how it not only influenced them personally, but also affected their partners, the older children and other family members as well. The use of language was also a defining factor in the identities of the women. Hospital personnel often did not speak Greenlandic, but spoke Danish, and the women spoke of how communication problems led to cultural, social and spiritual isolation. Their identity as good mothers and community members was connected to rights and responsibilities, not only to the unborn child, but also to any of their older children, family and community. The women described how difficult it was to protect and nurture from afar.

The tension between their identity as mother to their unborn child and their identity as a part of their local community first manifested itself when they were separated from their other children, husband and community. There was conflict between focusing on the pregnancy as an isolated event contra her identity as a wife, a mother, a member of the community.

*"I wanted to share my newborn with them...it was hard...when you are alone you think a lot about how it would be if your family came in...? ... They couldn't just come by...it was painful."*

Greenland is a small, close-knit society and for some of the women it was a relief to be able to be anonymous for a short time, and thus avoiding bearing the usual responsibility to community and the

extended family. However, even the women who felt a relief in distancing themselves from their community agreed that having family nearby during pregnancy was not only important, but also necessary.

### *Sources of Strength*

The women of the study described and focused on several characteristics of strength, including individual strengths and cultural strengths. During the perinatal period, women transformed from being *just* a mother, wife, and daughter, to include being the bearer of the unborn child. Most women felt capable of taking care of all of these roles. Still, they were worried that the price of safety might include loss of family; there was anxiety that family, especially the children, would suffer when they were away for several weeks before their due date.

“To accept one’s situation gives strength” in Greenlandic “*Nalaataq akuerigaanni nukittunarnerusarpoq*,” explained how many Greenlandic women perceived their acceptance of transfer. The individual women considered their decision to leave their families a sign of strength. Not a passive non-decision, but an active accept of something unwanted. Although they were not sure whether they thought it was necessary, some women accepted transfer from their home community to DIH. Often there was an acceptance of transfer, although there was still conflict between the women’s own view of perinatal safety and that of the medical community. In their concepts of safety the women also included their ability to keep their other children safe while away from their communities. For some women concepts of safety were connected to their access to family and community. Family was perceived as security; lack of family support and network as insecurity. Their encounters with the personnel that did not understand Greenlandic and did not outwardly understand their culture was difficult, and required that the women accept the situation in order to stay strong. Cultural strengths were thus perceived as the connection between the personnel they met and themselves.

*“And you never have been away from home before and you have to go to Nuuk to give birth, and then you are on a ward where almost everyone speaks Danish...there were communication problems...and you’re alone...yeah. And you come to a ward where there are people you can’t even talk to...”*

### THE CULTURAL CONTEXT – CREATING A CULTURAL ROOM FOR BIRTH (PAPER IV)

Study IV researched the changing culture of birth and the role of family in Greenland. The paper focuses on how family and community in Greenland perceived support–giving during the perinatal period. It explored Greenlanders' use of storytelling in the perinatal period and how it was used to present the thoughts of the families, women and community. Stories were constructed around the following

questions: 1) how do family and community in Greenland perceive their roles during pregnancy and childbirth, 2) how do family and community perceive their changing roles, and 3) how do family and community cope with these changes? The participants used metaphors such as: my family ... a safe harbour, 2) the child as the centre of the family, and 3) the equal sharing of burden and joy. The touchstones of these narratives and stories will be presented under two titles, namely: 1) family network, and 2) a cultural *room* for birth.

### *Family Network.*

The concept of responsibility to family and community was an important concept and was one of the culturally specific concepts that reappeared in several of the interviews. The fathers of the study were men that recognized in themselves, their friends and kin, '*a consciousness of care*'. The story of the fathers revolved around responsibility, not only connected to the immediate family, but also to the *extended family*, and was underlined in several of the interviews, stating that family included not only siblings and extended family, but close friends as well. Through their narratives, the family faces included: mothers, children and community members. The *consciousness of care* was reciprocal; the mothers and fathers of the study took the feelings and thoughts of their families into consideration when making health decisions. This included not only partners and grandparents, but other family members as well. The health of the families was intertwined with the health of the community, of their family members and kin. They saw themselves as the "ice floe" of the community, pointing out that a community can only thrive if its families are well taken care of:

*"I don't only think of the children as family . . . maybe I am the one that is 'ittangavoq' [old fashioned] . . . I really feel that one should have a responsibility for his family, partner, kids, but also for other family members such as siblings . . . but I feel this also extends to the care of my closest friends."*

### *A Cultural Room for Birth*

The Culture Bearers believed that the ability to support and strengthen the bonds in the perinatal room was important. This responsibility was not only borne by the immediate family, but was lifted also by members of the community that were close to the family. Fathers created touchstones by describing the family as a secure center within the community, and birth and the creation of family was described as one of the events that created intimate relationships: "*. . . it's like the bedrock of life, small ice floes, that when put together are as big as an iceberg.*" Culture Bearers spoke of the traditions that supported the family and family values. They believed that the perinatal families' strength rested in the ability to continually support and to strengthen the bonds within the families and kinships networks. Name giving

was also included as an important tradition, one that the families protected; one that often gave the *ningiu*<sup>31</sup> an important role in helping to decide which names were given, and this in turn supported and preserved the stories of the community. As one of the Culture Bearers explained that the giving of soul names was often either embraced by the families or decidedly rejected, as a cultural custom. When soul names were not given it was directly related to a conscious decision *not* to follow the tradition.

Communities and kin supported women by continuing practices and traditions such as support during labor, acknowledgment of fictive kin by name giving, and continued respect from an understanding that each new child was of importance for the whole community. They described community as an important link to supporting and continuing such practices, practices which connect the women and the newborns to the social network. Fathers felt that they contributed to family and they described that a new development within the families was connected to openness about their “*consciousness of care*”, which they also felt was very important. This was supported by Culture Bearers who spoke of the changes in dynamics in the Greenlandic perinatal families.

*“There is a consciousness of caring and things like that . . . there is a consciousness about the things – about caring . . .”*

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<sup>31</sup> A Greenlandic term used for *grandmother*, but it can also mean the woman in charge or a female supervisor.



## CHAPTER SIX

### DISCUSSION OF FINDINGS

#### *Policy and Self-Determination*

Health promotion and public health initiatives reiterate the importance of taking responsibility for one's own health (Rootman et al. 2001). In Greenland the intention is to create public and national health policies that support the concepts of health promotion; regarding perinatal policy, the women and their networks are asked to take control of their own health and well-being (Inuuneritta 2007). Families are encouraged to safeguard their health, but policy often does not support the individual's ability to exercise a measure of control over the individual's own well-being (Montgomery-Andersen et al. 2010). While the official policy in Canada moves towards allowing women to give birth in their communities, Greenland moves towards centralization of births in regional hospitals (Tedford Gold, O'Neil & Van Wagner 2007; Government of Greenland 2012).

New policies and guidelines for pregnancy and childbearing are presented to the communities by policy makers and health and government officials, but have seldom been negotiated with the women and communities before they are implemented. There is always a presentation of policy, but not always a dialogue around policy and implementation of policy (HDG 2012). In an open letter to the Minister of Health, midwives as the caretakers and the '*cultural translators*' for the perinatal family in Greenland pointed out the lack of dialogue around perinatal policy (Ernisussiortuunerit Kattuffiat 2010). There is a schism between the perinatal families' experiences and that of the policy makers, where political, scientific, and economical logics take precedence over personal and cultural logics (Daviss 1997). Informed choice and consent, which is the cornerstone of the perinatal guidelines, become abstract concepts that are difficult to glean in practical terms, making it difficult for the families to exercise self-determination around perinatal health issues (Bjerregaard et al. 2012). It is possible to see this in a discourse of power, whereas this dissertation chooses to look at the schism between the policymakers' linear worldview and the relational worldview and faces in the perinatal room that are a part of Greenlandic concept of family (Reimer 1996).

The political and legal arenas have one set of logics, while families and communities work from another set. Greenlanders presented the understanding or belief that the family itself was a health-promoting factor, which is an individual and cultural logic; that is not the same logic that is practiced by the policy

and scientific arenas in Greenland<sup>32</sup> (Daviss 1997). In order for there to be dialogue, there must be a minimal of understanding between the parties and the key to understanding one another is in the acceptance by all actors that all sets of logic do exist and are important (Daviss 1997). This form of acceptance gives validity to other knowledge and seeks to respect the “epistemological Greenlandic discourse,” which incorporates cultural knowledge and culturally specific traditions within the perinatal room (Douglas 2011). This challenge is not solely an Inuit challenge, but is experienced in many Indigenous and Aboriginal communities, both small and large (Kruske, Kildea & Barclay 2006). By reflecting on the importance of using these logics and understandings as a basis for policy, women and their families are given the tools to make choices and decisions concerning their own perinatal health (Bird 2006). Especially tools that could be a support to the perinatal family’s need to be nearby their support-systems, during the perinatal period (Kildea et al. 2010). They presented viable alternatives to transfer of all women, the importance of midwifery care, and the importance of efficient transfer policies (Kildea et al. 2010).

#### *Metaphysical Place of Birth within the Greenlandic Context*

The metaphysical place of birth is linked to the understanding that family can be created and that family and intimate relationships are culturally specific (Trondheim 2010). Families strive to ensure that their children are “born with a home” (Houd 2005). Greenlandic newborns, no matter where they are born physically, have a place within the local community, that they are remembered and that they are given their place and a “face” (Montgomery–Andersen 2005). In their storytelling Culture Bearers supported the collective memory of the family and carried the stories, the touchstones and the song lines of the community (Dulumunmun Harrison 2009). The Greenlandic family can include kin and fictive kin and this means that not only parents are congratulated when a child is born; aunts, uncles and close family friends are also included as parts of the family (Montgomery–Andersen et al. 2010, Trondheim 2010). The concepts of family held by the participants in these studies were not limited to the parents-to-be and the newborn, but also included other concepts of kinship and family that seem to be important aspects in the identities of the Greenlanders. These relational concepts had an influence on the ability to thrive (Trondheim 2010, Nuttall 1992). Rapid urbanization has changed the traditional family and kinship relationships; in this process it might seem as if the communities and families are passive in their reaction to changes in policy, which are developed centrally without citizen participation (Csonka & Schweitzer 2004). Douglas (2011) argues that families and communities use an “epistemological Inuit discourse,” as an Inuit approach to both childbirth and to health in general, while still maintaining the clinical outcomes

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<sup>32</sup> See Table 3.

of “southern healthcare” (Douglas 2011 p.184), which coincides with the results of this study. By protecting traditions, Greenlandic families have been able to support and develop their roles as caregivers and protectors of the unborn child. Culturally specific traditions and kinship practices protect the relationships between community and the unborn child, between the fathers and their role as caregivers, and between the other women of the study and the extended family and kin (Trondheim 2011, Nuttall 1992, Csonka & Sweitzer 2004). It was not only habits and cultural traditions that have a healthy influence on the family, but the process of deciding specifically which ones promoted the health of children within a family (Simon 2012). The process of carrying on traditions and culture required active participation from families and Culture Bearers. They used stories, soul names and other traditions as ways to “feed each other’s spirit” and to re-create the culture of birth (Banks–Wallace 2002). This way of understanding, supporting and placing oneself within the community is a part of the Inuit tradition that has survived for more than a thousand years (Simon 2012, Tundra Dialogues 2012, Montgomery–Andersen & Borup 2012).

Pregnancy and childbirth are milestone events in the life of all families, and in the Greenlandic family, even when the child does not come to full term and does not survive, there is still a place for him/her within the family and each pregnancy is embraced with the consciousness that life is a possibility (Navne 2008). Traditionally, birth in Greenland is a community event and already at conception the child is given a place in the family and the community, and although it does not have a ‘consciousness,’ the child already is considered a living part of the community (Hansen 2002, Nuttall 1992). This understanding of the child is an integral part of the culture of Greenland and makes the unborn child the center of attention within the family. Even the decision such as abortion becomes a family matter (Navne 2008, Sennett & Dougherty 1990).

There is interconnectedness within family and the communities in which the families live; each face of a mother, father, child or kin was a part of the whole (Reimer 1996). The concepts of faces and that of *inuk naallugu*<sup>33</sup> could be linked together. Just as each member of the family was important as an individual, they were even more important as a relational part of the unit. The unit only exists through the individual faces, the individual *inuak*<sup>34</sup>. This connectedness is both a blessing and a burden. Mothers felt the support of family members, but also the reciprocal responsibility that followed with the support network. This responsibility followed them even when giving birth in another community (Bjerregaard & Dahl–Petersen 2008).

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<sup>33</sup> See lists of definitions and key concepts.

<sup>34</sup> See lists of definitions and key concepts.

Cultural safety is not necessarily the opposite of perinatal safety. Nor is cultural safety the only matter of importance when looking at childbirth (Bjerregaard et al. 2012). Satisfaction with safety at birth is often divided into medical/clinical logics of safety and personal/cultural logics of safety (Hoang, Le & Kilpatrick 2012). Safety was discussed in one manner in the press, while a linear worldview was discussed within the health care system (Bjerregaard et al. 2012). Finally, a relational worldview was uncovered when the discussion was within the perinatal family (Qanuqtuurniq 2009). Often the discourse around cultural safety is viewed in terms of the changes that are instituted in society by people outside of the culture (*qallunaat*), those who do not understand the culture or do not know how to meet traditions with cultural humility (Tervalon & Murray–Garcia 1998). However, changes instituted from within a culture can be just as confusing and leave people with the feeling that they are unable to recognize their own country and culture (Montgomery–Andersen et al. 2010, Loomba 1998). Policy in Greenland is developed and instituted by Greenlandic policymakers and health officials, not by outside forces. The National Health program and the obstetric and perinatal guidelines have been developed by the government and have been initiated in order to save lives and to save money (<http://www.peqqik.gl>; Inuuneritta 2007; Bjerregaard et al. 2012).

Greenland is a constitutional constituency and as such, creates its own policies in internal matters including health policies (ICC 2011). Members of the Greenlandic parliament are not only Greenlandic speaking nationals, but in the majority of the cases, also of Inuit descent. As it stands in Greenland the women and their families believe that their personal, intuitive and cultural logics coincide with those of the policy makers and government officials, because they themselves (the policy makers) are Greenlanders with the same traditions and cultural norms, even though this may not actually be the case. Culturally, Greenlandic policymakers look to the west and to the other Inuit communities especially in regard to health, culture and language (ICC 2010). When making health and social policy, it is the Nordic countries and especially Denmark that influences policy and here the Inuit areas are not a part of the scientific spectrum that Greenlandic health policy looks toward (Bjerregaard et al. 2012, Bjerregaard & Olesen 2010). Best practices and scientific results from areas that have a geographical and infrastructural likeness to Greenland, such as northern Arctic Canada or rural Australia, present viable alternatives to transferring of the majority of women, stress the importance of midwifery care, the importance of efficient transfer policies, and have shown that it is possible to support women in their desire to give birth within their own community and culture (Kildea et al. 2010, Bird 2006).

### *Creating Reality: the Health–Promoting Perinatal Family and Community*

Birth influences the well–being of the whole family and includes the lives of the other children in the family, The participants in studies III and IV provided a *snapshot* of women and families from different

communities, different levels of social economic wealth, different strengths, and different relational worldviews (Cross 1998). They have culture and language in common, but different life circumstances. For these women the risk of perinatal mortality and morbidity as a possible outcome was very much a part of the families' realities (Montgomery–Andersen 2005, p. 4). Most of the women expressed relief and gratitude for transfer to the national hospital to give birth, and felt that they and their unborn were well taken care of. Common for most of the women preferring transfer during pregnancy was that, often, they either had family in the city that they transferred to, or they had the economic ability to have their husband and children nearby. Women still expressed that being together with family, especially husbands and children were important for their ability to cope with isolation. Reimer (1996) describes a female consciousness that is an integral part of Inuit women's world relational view. She explains that the women not only experience interconnectedness with their family members, but also with the communities in which they live (Reimer 1996). This connectedness was both a blessing and a burden (Bjerregaard & Dahl–Petersen 2008). Mothers felt the support of family members, but also the responsibility that followed with the support network. They struggled with not being "at home" in their communities and the fact that Greenlandic health policy did not give help to family members to enable them to be in close proximity (Bjerregaard et al. 2012, p. 18).

In Greenland, divorce, social challenges, child neglect and substance abuse also affect the lives and futures of its citizens. Social challenges such as these are even more evident and debilitating for a small and vulnerable society such as Greenland (Gregersen 2010). The mothers participating in the study presented a "kaleidoscope" of the Greenlandic society; the fathers and Culture Bearers came from families with emotional and cultural stamina (Figures 10 & 11). The same close-knit family that supports and engages the individual member can also suppress the health of the family, when the family has dysfunctional or destructive socio-ecological dynamics (Andreassen & Huchtin 2007). On the whole the families and community were interactive and engaged in and exercised influence over their own health and attempted to find meaningfulness and cultural logic in perinatal policy (Douglas 2006, Douglas 2010). When mothers-to-be travelled to the larger cities, female relatives often provided the support networks for the families. Some women left their own families in the settlements or villages to support the pregnant women during childbirth; others took care of the siblings left in the home communities. Reimer (1996) describes this as a "female consciousness", where the responsibility to one's self is interconnected to one's place in the family and in the community (Reimer 1996, pp.84-85). It is important for the individual mothers, families and communities to actively decide which traditions can and should be preserved and which traditions are allowed to die (Trondheim 2010). The decision is often based upon which options are most important and/or easily accessible to the communities and families (Csonka & Sweitzer 2004).

The family's local communities play an important role as well as family members support for the mothers during childbirth and labor, and the results of the dissertation did not reveal a great change in the traditions and family support for the mothers and their families, because of policy changes (Montgomery–Andersen & Borup 2013). The mothers of the study had family support and this support was important, whether they gave birth in their own community or were transferred during the perinatal period. Often, the important aspect was their own feelings of responsibility for families that was interconnected with their “female consciousness” (Reimer 1996). Mothers described the feeling of being an important link to their community (Medicine 1987). They often felt the weight of their roles as mothers (Reimer 1996, Jasen 1997). Fathers focused on their responsibility and the “consciousness of care”. In Douglas (2011) the role of women and access to the perinatal room was predominately female: in this dissertation the importance of both male and female family/kin support in Greenland was underlined (Montgomery–Andersen & Borup 2013, Montgomery–Andersen et al. 2010).

Culture Bearers believed that families and kin rose to the occasion and were active in supporting the perinatal family, not only within the community, but also when it was not possible for mothers to give birth in their local communities. It was important for the families to tell stories about soul names, kinship and *pagga*<sup>35</sup>, and it was through their eyes and their stories that these topics emerged. The participants did not see the changes in society and community as the most important issues or main influence; the participants simply continued to create and recreate the themes of family and community through their narratives (Riessman 2003). One recurring theme was that of the family as “a safe harbor”, as “the bedrock of life”, as “the iceberg”. Other metaphorical themes that arose was that of the women as the bearers of their children, the fathers as the artisans and caregivers to their family, and the community – including the extended family – as the most important support network for the families; this could also be described as ‘the perinatal room’ (Figure 13). The concept of *faces* a multifaceted perinatal room harmonizes with Kildea’s (2005) that argues the importance of acknowledging and supporting the perinatal family. She underlines that cultural safety is one of the most important issues when focusing on the social, cultural and spiritual aspects of the care of the perinatal family (Kildea 2005).

There were several major dilemmas and challenges in the families’ ability to take responsibility for their own health. One was the use of the Danish language in the health care system in Greenland (ICC 2011). Often, there are communication problems between the health care professionals and the families being served by them that lead to cultural, social and spiritual isolation. Although there are translators and

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<sup>35</sup> See lists of definitions and key concepts

interpreters connected to the health care system, there is a cultural and linguistic challenge that is connected to information and informed choice that can impede the families' ability to take responsibility for their own health (Bjerregaard et al. 2012). Rønsager (2006) presented the hypothesis that changes in practices and traditions around childbirth and the perinatal family were brought about through midwives. Midwives are described as *cultural translators*, and emphasized in their roles of supporting and strengthening perinatal health (Van Wagner, Epoo, Nastapoka & Harney 2007; Rønsager 2006). Midwives still inhabit this space between the “doctors and the countrymen,” between the community and the policy makers, and functioned as *cultural translators* for the perinatal families. Midwives interpreted the culture surrounding childbirth and the perinatal period, not only ensuring a minimum of understanding between the doctors and the perinatal family, but also the metaphysical space that traditions inhabit (Ernisussiortuunerit Kattuffiat 2010).

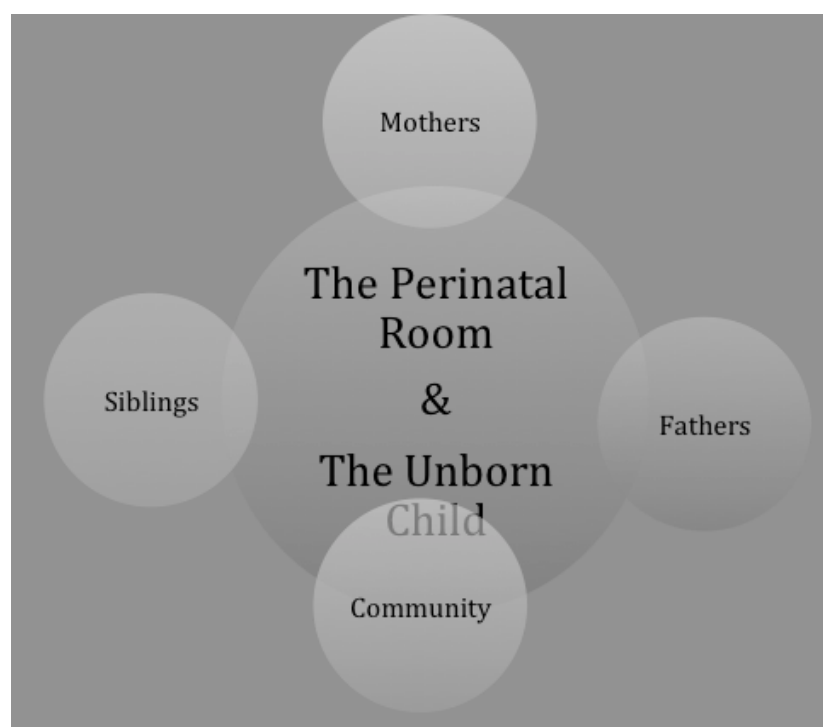


Figure 13. The Perinatal Room & The Unborn Child

### *The Health-promoting Child*

Because the concept of family in the Greenlandic community is often more intricate and interwoven than in Nordic countries and North America, it makes it difficult to use Nordic or North American parameters for assessment. “The child” in the Greenlandic perinatal room pertained to children already a part of the family or to the unborn child. Cassidy (2006) states that it is common that health research often focuses on the unborn child and its vulnerability, and the child is seen as the receiver of health promotion initiatives (Cassidy 2006). There is a framework within the Greenlandic consciousness where it is

possible to see the child as a catalyst for health and children in Greenland are often the health promoting actors in families and the catalyst to healthy habits within the family (Christensen 2004). Hansen (2007) describes the Greenlandic concept that respects and nurtures the individual child's personal integrity (Hansen 2007, Hansen 2002). This revolves around the understanding of traditions that already exist within the Greenlandic community which support families in acknowledgment of the child as an individual, and as such, support the child's autonomy and personhood (Nuttall 1992, Hansen 2002). It also revolves around the understanding that not only parents can support and nurture, but that the health and security of the individual child can be strengthened through a caring community (Fogel–Chance 1993).

Both the mothers and the fathers of the study expressed that children are “*the reason that we carry on*” not only in difficult situations, but also as a means of reciprocal cultural support. The child is an active part of protecting the health of the family and is regarded as such (Schor & Menaghan 1995). Researchers agree that both external factors (such as community) and internal factors (such as name giving practices) influence the lives and health of Greenlandic children and their families (Trondheim 2011, Montgomery–Andersen et al. 2010, Nuttall 1992). Often the discussion focuses on whether the interconnectedness has a positive or negative influence on the health of the communities (Richmond & Ross 2008). For some families this interconnectedness will be a support; for others a burden: both are influenced by the strengths and weaknesses of the individual families. It is the eco cultural structure of the family and the ability of the child and the individual family members to communicate with each other that influences the health of the family, not alone the individual's behavior (Berkman 1995). When children are viewed as an equally important part of the family, this enhances the health of the family (Cassidy 2006). Nuttall (1992) theorizes the importance of the child for the family and its direct influence on the family's well-being in the Greenlandic setting. Christensen (2004) supports the child's influence on the families' well-being and goes on to stress the importance of the shift from viewing the child as the object of health initiatives to the subject of health initiatives, to seeing them as social beings in their own right who are able to voice the questions and opinions on an equal footing with their grown-up counterparts, even though they do not have the same life experience (Stevenson 1991). Greenlandic traditional concepts such as accepting the child's right to say “no”, or the understanding that also infants have their own individual consciousness (*silattorsarpoq*), can support this framework of understanding (Hansen 2002, Nuttall 1992). Both of these traditional concepts may have a health promoting effect on the child and its family (Montgomery–Andersen & Borup 2012).

Hansen (2007) and Berliner (1992) present that the child has a unique place in the Greenlandic family that supports the individual child's self-reliability, and views the child as an equal member of the family,

spiritually and emotionally. An eco cultural pathway for an inclusive family life in which the child is an actor was found in Greenland. The eco cultural pathway is comprised of the families' abilities to use extended family, to acknowledge the importance of family support during childbirth, and to continue to include the child in the community and community activities, even when children are born outside of the local community (Montgomery–Andersen & Borup 2012). It is the families' "eco cultural pathway," the utilization of the families' resources and the acknowledgement of the child's resources that influences not only the health of the individual child, but the health of the family as a whole (Schor & Menaghan 1995). It is important to understand and recognize the fact that the ecological framework of the family has a direct effect on the child through the development and change in culture and society (Jessen Williamson 1992).

## DISCUSSION OF METHODS

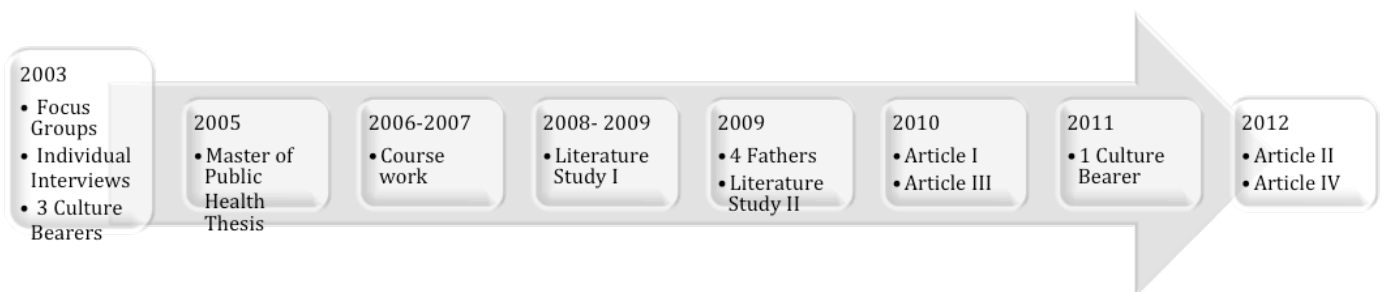


Figure 14. Timeline and Emerging Design

### *Choice of Methods*

This dissertation used an array of methods: literature review, ethnographic content analysis, storytelling and narrative methods and this supported the process of the design emerging concurrently with the data collection (Bryman 2004, Banks–Wallace 2002, Riessman 1993, Weber 1990, Altheide 1987). Each study incorporated a single analysis theory, but new theories have been incorporated over the course of the research to accommodate the specific data (Bryman 2004). The dissertation includes a reflexive development of categories; follow-up data collection to hone the categories and analysis, and “a constant discovery and constant comparison of relevant situations, settings, styles, images, meanings, and nuances” (Altheide 1996, p. 16).

The data for Studies I and II needed methods that could systematize, analyze and encompass the materials that were collected. The articles and statistical materials about birth in Greenland were limited; only a few focused on the women and their families. This created challenges: to include, systematize and analyze the available data within the study itself, and to use this as a basis for the understanding and analysis of the empirical studies in the dissertation. This challenge was compounded by the lack of reliable data from the period between 1953-2001. During the research period; several articles were written by other researchers,

these have been incorporated into the dissertation. Studies III and IV included policy statements, focus groups and interviews with Culture Bearers and individuals (Bryman 2004). Dialogue with Culture Bearers, and related literature reinforced the hypothesis that storytelling traditions are still important to the community and this in turn supported the decision that storytelling be incorporated into the methodology of the project and the subsequent analysis of data (Kleist Pedersen 2006). Ethnographic content analysis creates the possibility to incorporate news clips, newspaper articles, statements from healthcare professionals, field notes and Culture Bearer interviews into the data thus, supporting the complexity of the subject (Altheide 1987).

### *Focus Groups and Individual Interviews*

Participants in the focus groups each gave space to the others' thoughts, opinions and comments, and were supported in this process by the moderator (Montgomery–Andersen 2005, Smith 2002). The focus groups of the study look very different from those described by Maunsbach & Delholm–Lambertsen (1997) or those of Kvale (1996). Inuit have voiced, that when talking to *qallunaat*, it can be difficult to find “the space” to tell their stories. Often, instead of letting the participants speak in their own rhythm, silences are filled up by intrusive talk (Strickland 1999). One of the first steps in the process of conducting successful focus groups in Greenland is the tacit acceptance of several facts: 1) the focus groups are going to run their term, 2) the focus groups have their own processes that do not follow those of Nordic, European or North American traditions, and 3) the role of the moderator is less active yet more supportive of the process. Generally, there was no need for the moderator to stop discussions to bring them back on course; the group did this themselves (Rink et al. 2012; Christensen, Schmidt & Dyhr 2008; Kvale 1996, Kvale 1989, Spradley 1980). The individual interviews helped to give new understanding to the research questions (Bryman 2004). As the individual interviews progressed, the women and men composed and assembled a story that he or she shared with the researcher (Banks–Wallace 2002 ). By the interviewer respecting the Greenlandic concept of letting each participant speak out and by giving the women and men of the studies space to tell their stories, the process of creating meaning and developing thoughts unfolded and the stories were formed as a part of the interview process (Huisman 2008, Riessman 2003). This creates a room in which the identity of the storyteller (the participant), the audience (the researcher) and the environment where the story is told, provided equally important elements (Banks–Wallace 2002).

Focus groups were especially important in the development of the study. The transcripts were rich in data and helped to situate the voices of the women and their families. Although participants were initially asked about referral, through discussion with research assistants and Culture Bearers, it became evident that the interrelated understanding of family, kin, culture and language was as important as place of birth.

Some of the stories presented during the interviews also included elements that were not within the scope of the study, and therefore have not been discussed or brought forth in the dissertation.

### *Validity, Trustworthiness, Transferability and Credibility*

Qualitative research revolves around the contextualization of subjective data, giving the reader space to assess the analysis and the interpretation of the researcher (Graneheim & Lundman 2004). The use of definitions such as validity, trustworthiness, transferability, generalizability, credibility and dependability, are all used in describing the process to ensure a high standard of scientific knowledge in qualitative studies. The use of personal narratives and storytelling can be scientific. Therefore, an integral part of the design of the dissertation was testing for validity during all stages of the research which included descriptive, interpretive, theoretical, generalizability and evaluative validity (Thomson 2011, Kvale 1989). Credibility was heightened by the use of several modes of gathering data, each approach seeking to reflect the focus of the studies (Graneheim & Lundman 2004). This included snowballing, the use of gatekeepers, purposeful sampling and going back to the source. To ensure trustworthiness several methods were used throughout the data collection process that helped to support awareness of objectivity, subjectivity and to uncover strengths and weaknesses in the data collection and methods (Altheide 1996). Quotations used in the dissertation and papers are translated back to the original language to ensure the correctness of the translations from Greenlandic to both Danish and English. Data was also discussed during the writing of articles with the research assistants and with co-authors to the test generalizability. The research arena in Europe, and the Nordic countries' approach to qualitative analysis with its attendant understanding of "knowledge", was set in relation to hierarchical structures and educational level. The knowledge of elders and community were looked upon as documentation for findings but not empirical knowledge, thus having no scientific rigor. On the other hand, in the indigenous research discourse, inclusion of community members, elders and people of capacity are included in the understanding of trustworthiness (Smith 2002, Castellano 2004, Schnarch 2004, Elliot 2005, Baydala et al. 2006, Loppie 2007). The analysis process was also supported by interviews and discussions of concepts, interpretation and language with Culture Bearers. This process supported and developed protocol for discussion and analysis of the focus groups and Culture Bearer interviews within the Greenlandic public health research context (Snarch 2004, Bird 2009). The Culture Bearers were instrumental throughout all phases as a means of understanding the experiences of participants (Loppie 2007). Culture Bearers took part in an ongoing validation process that was conducted while collecting, analyzing and describing data (Thomson 2011). Interviews and discussions with Culture Bearers were not anonymous and thus the use of Culture Bearers was also a counterweight to the challenged posed by intercultural research, not only for the participants but also for the researcher (Loppie 2007).

Throughout the analysis process, transcripts of interviews were used in combination with listening to the original tapes from the interviews and from reading notes from research diaries. There were ongoing discussions with research assistants concerning the analysis and understanding of the translated transcripts to strengthen reliability (Newton Suter 2012). Time codes<sup>36</sup> were placed in the transcripts so that the original text could be used and checked during analysis or when selecting quotations (Denzin 1997). Dialogue or conversation mapping was carried out during focus groups. An observer carried out dialogue and conversation mapping during focus group sessions. Dialogue interchange and discussion dynamics were recorded at five to ten-minute intervals several times during each focus group (Rink et al. 2012). The diagrams depicted in Figure 12, together with field notes were used as support during the transcription and the analysis process (Spradley 1979).

In the final stages of analysis a last Culture Bearer was interviewed, this time to discuss findings and to seek to clarify concepts. This supported the theoretical framework of cultural awareness and humility, and gave the researcher a chance to step back from her data and analyze the text from outside of her own understanding (Jasen 1997, Smith 2002).

## STRENGTHS AND LIMITATIONS OF THE STUDY

### *Design*

One of the goals of this dissertation was to present a multifaceted view of birth in the Greenlandic context, drawing on both quantitative and qualitative data to complete the dissertation. The original dissertation plan included a quantitative study of perinatal morbidity and mortality in which the specific aims were to 1) look at child mortality in Greenland in the years after the implementation of the National Perinatal Guidelines in 2001, 2) describe changes in the causes of death and mortality rates, and 3) propose national indicators for perinatal health in Greenland. During the initial stages of the project several meetings were conducted with the heads of the obstetrics department of DIH and with the Office of the Chief Medical Officer. The Office of the Chief Medical Officer was kept abreast of progress, and a research assistant was hired to help complete the research. Unfortunately, a change in the Danish law had not led to a comparable change in Greenlandic law and it was therefore not clear what procedure was to be followed in order to acquire permission for use of register data; registry accessibility became a gray area, and no agreement could be made for access to the death and birth registries within the time frame set out. This made it unfeasible to complete the quantitative study. This lack of qualitative data and thus the limited data for reflection can be seen as a limitation of the dissertation. During the concluding months of

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<sup>36</sup> Time codes are points on a tape that tell how long the tape is and how far into the tape the transcriber has come in his/her transcription of the interview.

my dissertation in 2012, I was able to talk with members of the new national perinatal evaluation group and with their permission have gained access to an official report and have included some personal correspondence in the data<sup>37</sup>. This was extremely helpful in adding trustworthiness to the data employed in the study.

The interviews and focus groups were conducted over an eight-year period; this was both a strength and weakness for the dissertation. When a study is done over such a long time frame, the validity of the results might be questioned: on the other hand the time frame of the study made it possible to see the transitions experienced by the mothers, fathers, families and communities. It also made it possible to step back from the data and look at it through more critical eyes. It was also possible to incorporate the knowledge gained by Greenlandic National Health Surveys 2005-2007 (NHS), the 2012 evaluation of the perinatal guidelines (Bjerregaard et al. 2012), and to follow the development of the *Inuuneritta* national health initiatives (Bjerregaard & Dahl-Petersen 2008, Inuuneritta 2007).

### *Choice of Participants*

The population of Greenland and the limited number of possible research participants has had an influence on the choice of participants in the studies. The participants were in no way homogeneous. They came from towns, settlements, north, east; they were housewives, musicians, fishermen and officer workers. These details had an influence on the stories of the mothers and fathers. Another consideration was the question of anonymity. Although anonymity was the goal it was often difficult to decide which details were important to keep anonymous and which details were confidential. The process of selection was supported by the interviews of Culture Bearers, and discussions with research assistants. All individual interviews were anonymous. In the case of focus groups, participant members of the focus group and the research team discussed and agreed upon the importance of keeping the details disclosed in the groups confidential.

Regarding the group of mothers that fulfilled the inclusion criteria of the study, the fact that many families in Greenland move quite often made it difficult to find possible participants. Only 50% of the women that could have been included in the focus groups were found. Among those who were not found, many had moved because of family or because of work. What these women and their families would have said, if they had the possibility could not be ascertained, and is a weakness of the study. Of the 41 women

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<sup>37</sup> Peter Bjerregaard & Niels Jørgen Secher (Perinatal evaluation group Agency for Health and Prevention) Personal correspondence June- September 2012.

contacted 35 accepted and participated, and this is a high percentage, which adds strength in the study. The women who came for focus groups, wanted to share their stories. In the event that the other participants to a focus group did not show, the women were offered the possibility to participate in an individual interview. They had a story that they wanted to tell, so they took the chance when it presented itself. It was also important for the research team to acknowledge that each woman's story was important and the women readily accepted the opportunity to share their stories with the researchers. At the same time they were not prepared for the individual interviews and this fact possibly influenced the individual interviews done outside of the Patient Hotel.

Only nine mothers-to-be were interviewed before they gave birth. They were included in the individual interviews. Six mothers were given the possibility to be interviewed individually, because the other focus group participants did not show up at the assigned time and they were there alone. Some women were employed, others not. Transfer was not dependent on their social status. The fact that mothers in the studies came from different walks of life, socio-economic groups and educational levels, strengthened the credibility of the findings.

The fathers of the studies were "present" fathers and partners who were actively involved in the upbringing of their children. All were employed, were either educated or autodidact professionals and willing to talk about their feelings. Culture Bearers were also chosen through purposeful sampling and were not official leaders or representatives. The participants in this study provided a subjective 'face' for the perinatal room, but were not representative of the Greenlandic population.

### *Choice of Language*

The choice of using Greenlandic during interviews without an interpreter present has ethical, practical, and political implications. Ethically because there is power in language, the better you speak a language the more power you have in a conversation. Greenland is a post-colonial country, and as such, the Danish language has a dual inference. Danish is the language of the privileged, and even Greenlanders who speak Danish would often rather speak Greenlandic, because it is both the language of the country and often their mother tongue. The practical implication is that it is the language most people speak in Greenland. Politically, its use signalizes respect for the country and its people whenever a non-Greenlander communicates in Greenlandic with Greenlanders. Culturally, it is important for the women and men to use their mother tongue when describing and talking about feelings and family. Greenlandic was the language of choice during most interviews and focus groups, and this influenced the flow of the interviews and the focus groups resulting in fewer interruptions because of translation. Because Greenlandic is not my native tongue and my understanding very basic, details were lost to me whenever

the dialogue transpired too quickly. This may have influenced follow-up questions during individual interviews and focus groups. This is compensated for by the richness of data that was collected and the strength it gave to the participants.

### *Choice of Literature*

The range and quality of literature on perinatal care, perinatal period and the perinatal family in Greenland, from a public health perspective, are very limited. Studies that directly relate to Greenland are few and often the studies are small. This also applies to many of the studies from Canada, whereas studies from Australia are more comprehensive with larger participant bases. Literature on kinship, family and support– networks directly related to Greenland is also limited. One study by Nuttall (1992) and one by Trondheim (2011) formed the basis for the studies. Although small studies, they are well documented and draw on international kinship theories. These references are supplemented with epistemological literature from Greenland (Hansen 2007, Hansen 2002, Berliner 1994), Alaska (Bodenhorn 2000), and international literature on kinship and relatedness (Carsten 2000). It is an important aspect not only to use literature about indigenous peoples, but also literature and methods created by indigenous researchers. Studies by Native Americans (Schanche Hodge, Pasqua, Marquez, & Geishirt–Cantrell 2002; Strickland, Dick Squeoch & Chrisman 1999; Medicine 1987), Inuit (Trondheim 2011; Kleist Pedersen 2006; Houd, Qiunuaajuak & Epoo 2004), indigenous peoples in Iran (Abed Saeedi et al. 2011), the African continent (Goss & Goss, 1995, p.135), and the Aboriginal peoples of Australia (Dulumunmun Harrison 2009; Ireland et al. 2011) were also incorporated to strengthen the analysis.

### *The Midwife, the Mother and Implicit Knowledge*

The participants of the study accepted that the researcher and research assistants were also a part of the Greenlandic culture. Although they could hear that I spoke Greenlandic incorrectly, there were other parameters such as body language and the ability to let silences linger, not filling silences with unimportant chatter, that created an acceptance of me as a "Greenlander". There was also the implicit understanding that I was a part of the culture, in regards to motherhood and childbirth. As a midwife I am a *paaliorti*<sup>38</sup> and I understand the concept of *pagga*; I had cared for their children and feel kinship with them. I understand the concept of the child as an individual within the Greenlandic context (Berliner 1992, Hansen 2002). There was an unspoken expectation connected to my role during focus groups and interviews. If a child cried during a focus group there was the silent expectation that if I was not the interviewer or moderator I would console and look after the child. This expectation was not a demand

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<sup>38</sup> See list of definitions and key concepts.

from anyone, no one said it, no one asked, but was understood by all. If I had not taken the child, the mothers would have merely gone home, not angry, nor disappointed, but just in a state of “accepting” (Hansen 2002). This was connected to my role as *juumooq*<sup>39</sup>; their participating in the interviews also gave me the responsibility to help them, within that space of time, but only if I chose to do so. Research participants brought their children with them to interviews, not because they could not find a babysitter, but often because – again in the Greenlandic context – children are considered to be individuals with own worth and right to have an opinion and to participate (Berliner 1992, Hansen 2002). Since the research was centered on pregnancy and childbirth, therefore the children were seen as a natural element of the interviews. Finally, per definition there is always *room* for children in the Greenlandic community, and both the women and men therefore felt it quite natural to bring their children with them to the interviews, which were, after all, conducted in their own home communities.

### *Conducting Research in Own Arena*

When researching within ones own arena there is always the risk that the passion that drives the research, transfigures from subjectivity to impartiality. It was inevitable that a large percentage of the women interviewed and participating in focus groups knew the researcher. For some of these women I had been their caregiver (*juumooq*) during pregnancy; in some cases had delivered one or more of the women’s children (*paaliorti*). In a country as small as Greenland this will always be the case that either you know or are known by the participants. This is an ethical dilemma that cannot be solved except by ensuring that there are gatekeepers involved and that the participants understand that they have the possibility to withdraw or decline participation at any time during the course of the study. Another hurdle in researching within one’s own arena is social “situatedness”; both as an insider, and as an outsider. This goes beyond the mechanics of informed consent and ethical validity of research data. It reaches into the realm of understanding of the researcher’s place within the society, in the locality of the research, and the researcher’s place within the scientific hierarchy (Costley 2010, Schmaus 2008, Haraway 1988). The ethical validity can be seen in the researcher’s understanding of his or her “situatedness” in regards to the research participants’ and their social environs. The ethical validity in the studies concerned the concepts of informed consent, voluntary participation, confidentiality, and in some cases anonymity for participants. It also encompassed which research ethics were incorporated in the study (DOH 2008). Within an indigenous context it is the community itself, through dialogue within the community and with the researchers that defines what type of data needs to be shared anonymously (Schnarch 2004).

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<sup>39</sup> See list of definitions and key concepts.

### *Conducting Research in Another Culture – My Voice in the Research*

My own cultural background and my upbringing and life experiences are all inextricably intertwined with the data that is presented (Goss & Goss 1995, p.135). Some may find research done by a non-native researcher with basic language skills, researching Greenlandic women's personal experiences, a bit questionable. Others will look critically at a researcher who as a midwife had serviced many of the women and delivered several of the children for the women who participated in the study. I believe that both of these points of conflict have an influence on the narratives of the women. The researcher knew the women's stories before the interviews and this may have influenced their desire to participate in the interviews. I believe that data collected under such circumstances needs to be analyzed carefully. Both Collins (1997) and Miller (1998) conclude that awareness of *positioning* with regard to status, language, profession and cultural humility is important. They express the opinion that body language, conduct, speech and a true desire to understand can give access to both the private and the personal spheres of experiences and thus strengthen the validation process (Collins 1997, Miller 1998). Although the interviews were done in the Greenlandic context, still it was analyzed and deciphered through the eyes of another culture. Each time a researcher touches interview data she risks returning to her preconceived hypothesis, but it is through the stringent use of analysis theories that meaning is drawn forth and assessed for validity (Collins 2002, Banks–Wallace 2002, Denzin 1997, Kvale 1996, Kvale 1989). It is the combination of social "situatedness", positioning and cultural humility, that ensures and supports processes of validity and trustworthiness (Graneheim & Lundman 2004, Tervalon & Murray–Garcia 1998, Anderson Juarez et al. 2006).

### CONCLUSION

The aim of this dissertation was to link the changes in choice, in birth and in 'the perinatal room' in Greenland, exploring, analyzing and describing the concepts of family, attitude and community. It presents aspects of the perinatal family that are seldom presented in the research arena and links history, culture and the perinatal family.

The Greenlandic Health care system is modeled after the Danish healthcare systems and its perinatal care is inspired by the Norwegian perinatal guidelines. Greenlandic policy and guidelines give the families of Greenland access to quality care in the hospitals and health centers. Greenlandic health care is free of cost, and irrelevant of the individual families' social economic status, the families are given the same choices in regard to where and how they give birth. The foundation for the health system is built on the Ottawa Charter's five pillars and is in place with a healthy public policy.

One of the main conclusions of the studies is the understanding of the link that exists between traditional and cultural properties such as soul names, the concept of *Silattorsarpoq*<sup>40</sup> and fictive kin, and the health of the child within the family. These are elements of the eco cultural pathways that are already integrated within the family interactions and could be a way to strengthen family interaction and health. Families and community support these traditions and in healthy eco cultural exchanges it enhances the child's role as a health-promoting agent within the family. Greenlandic public health, health promotion programs and the national perinatal guidelines have a physical health focus, but do not address the mental, social and spiritual dimensions of perinatal health. This fragmented way of perceiving and implementing health does not support the relational worldview that is an integral part of the culture of Greenland, and thus many families struggle to find a way to exercise choice within the system.

The dissertation shows a schism between the historical, philosophical, and cultural foundations of the Greenlandic perinatal health policies, and the choices that the women and their families are given. It is not visible that Greenland has taken into account the best practices and scientific results from areas that have a geographical and infrastructural likeness to Greenland, such as northern Arctic Canada or rural Australia.

The schism arises because the choices that the perinatal family has access to in regard to new policies and guidelines for pregnancy and childbearing are seldom negotiated with the women and communities before they are put into action. There is a need to ensure that the individual gains skills that empowers and gives ownership of these health policies. It is important that families are not only are informed of changes, but are also made part of the dialogue before changes are effectuated, not only regarding the knowledge about health policy that is in place, but also regarding discussion and dialog. Families need to be able to recognize their own logics in the programs that are initiated. It is when the families hear their own voices and can see their own "faces" that they can take responsibility for their own health. The Greenlandic perinatal family needs culturally relevant knowledge, discussion and dialogue with their policy makers regarding perinatal policy.

There is a true disparity in the health of the study participants, in that those who have economic and social resources are also those who have the possibility to draw on network and community during the perinatal period. The involvement and empowerment of families in the decision making process is an incumbent measure in order for them to take control of their own health and well-being.

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<sup>40</sup> See list of definitions and key concepts.

## RECOMMENDATIONS FOR FUTURE RESEARCH

Further study is needed that includes a quantitative study of morbidity rates in the perinatal period as well as the development of perinatal morbidity indicators that measure mother and infant morbidity in the perinatal period and APGAR scores at birth are also required. A study should also include quality of life indicators that could identify the effect of the revised guidelines for perinatal care, provide indicators as a basis for future research in perinatal care and give a cost–effect analysis of Greenlandic perinatal care. Knowledge acquired from the studies of this dissertation can support policy makers and those working with families and communities to reevaluate how Greenland develops their health promotion programs. The findings might also be useful and important for the Greenlandic families and communities themselves, and could be used as a foundation for dialogue when defining needs and expectations during pregnancy and childbirth. . It could be beneficial for the Greenlandic healthcare system to reassess policy around transfer of Greenlandic mothers, especially in relation to transfer in cases of low-risk pregnancies.

While looking to solve the problem of a high perinatal mortality, new problems have been created. Women, both those with an at–risk pregnancy and those that live in smaller towns, have to leave their community and stay alone in other communities over a longer period of time. There is an acute need to look at and assess the health models employed if the development of different models is to be made possible. This should be the focus of future research.

And finally, these findings lead to the recommendation that policy makers and government ensure that families and communities are provided with comprehensive information about choices and policy regarding childbirth. This information should be disseminated to two groups: 1) to the health workers, lay–midwives, midwives, and doctors, and 2) to the community and families. It is important to ensure the education of midwives in Greenland to address and acknowledge the eco cultural customs that support the strengths within the Greenlandic family. This could be incorporated in the family schools that already are supporting a program being conducted in several communities in Greenland. Such a comprehensive program would include written materials, but should also include film and voice stories that encourage families and communities to continue to create and *recreate* culture that meet the needs of the Greenlandic community as a whole.

The prize for such health promotion actions is not just to be found in lower mortality and morbidity statistics, but in the enhanced quality of life for mothers, fathers, siblings and include the whole Greenlandic perinatal family as defined by the Greenlandic perception of family.



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*“No man is an island, entire of itself; every man is a piece of the continent, a part of the main.”  
(John Donne 1572- 1631)*

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QUJAVUNGA–TAK–THANK YOU!

## ENGLISH SUMMARY

### INTRODUCTION

This dissertation concerns childbirth and its position within the Greenlandic society. It takes a world relational view to health promotion during, focusing on the perinatal family and the importance of the mothers, the child, their families and the local community as equal pieces of a whole.

### AIM

The aim of the dissertation is to present new concepts and knowledge concerning the health of the perinatal family in Greenland. It looks holistically at the place of birth with focus on the issue of support of the perinatal family. It seeks to present the perinatal family and its position within the Greenlandic society. It links the changes in health policy with the concepts of family, attitude and community structure. It draws on statistical, historical, anthropological and cultural data within the context of the Greenlandic perinatal family.

### *Overview of study designs, data collection methods and participants*

| PAPERS | STUDY                                                                                                | DATA COLLECTION                                                                                                                                                            | PARTICIPANTS/SAMPLE                                                                                                           |
|--------|------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| I      | Literature study using Daviss' Logics as analysis instrument                                         | National Archives,<br>Historical data: Office of the Chief Medical Officer,<br>Groenlandica Archives.<br>Search engines: Popline, CSA, CINAHL, AnthropologyPlus and PubMed | Annual Medical Reviews from 1953-2001,<br>22 notes and articles from between 1861-2001,<br>4 peer-reviewed articles<br>1 book |
| II     | Literature study using content analysis and analyzed with theories of eco cultural pathways          | Primary and secondary and tertiary literary search.<br>Search engines: Popline, CSA, CINAHL, AnthropologyPlus and PubMed                                                   | 13 peer-reviewed articles<br>Snowball effect<br>Secondary search                                                              |
| III    | Qualitative study using narrative methods                                                            | 13 Individual interviews:<br><br>Field notes                                                                                                                               | 10 women<br>1 male Culture Bearer<br>2 female Culture Bearers                                                                 |
| IV     | Qualitative study using ethnographic content analysis. Storytelling explored as theory building tool | 7 Focus groups:<br><br>5 Individual interviews:                                                                                                                            | 35 women<br><br>4 fathers<br>1 Culture Bearer                                                                                 |

### MATERIALS AND PARTICIPANTS OF THE DISSERTATION

Over an eight-year period two literature studies were carried out and empirical data was collected at four sites in Greenland: Nuuk, Ilulissat, Sisimiut and Tasiilaq. Data included seven focus groups with 35 participants, supplemented with 18 individual interviews of mothers, fathers and Culture Bearers. The results of these studies are presented in four papers: 1) literature study on the place of birth in Greenland in the post-colonial period, 2) a literature study on the child as a health-promoting agent in the family, 3) a narrative study on women's subjective experience of transfer during pregnancy, and 4) a study that uses storytelling as the basis for research on support networks in Greenlandic families during the perinatal period.

## RESULTS

The perinatal family's concepts of safety were connected to access to family and community. Family was perceived as security, and lack of family support and network as insecurity. The concept of family and community was culturally specific and connected to the immediate family, extended family and kin. There was a cultural room for birth in Greenland, where the health of the perinatal family lies in their ability to strengthen the bonds within family, kinship and community networks. The mothers of the study perceived themselves as the bearers of their children; the fathers considered themselves to be the artisans and caregivers for their family; the community, including the extended family, deemed an important support network for the families.

## CONCLUSIONS

- The Greenlandic Health care system is modeled after the Danish healthcare systems and its perinatal care is inspired by the Norwegian perinatal guidelines. Greenlandic policy and guidelines give the families of Greenland access to quality care in the hospitals and health centers. Greenlandic health care is free of cost, irrelevant of the individual families' social economic status and the families are given the same choices, in regard to where and how they give birth. The foundation for the health system built on the Ottawa charter's five pillars is in place with a healthy public policy.
- One of the main conclusions of the studies is the understanding of the link that exists between traditional and cultural properties such as soul names, the concept of *Silattorsarpoq*<sup>41</sup>, fictive kin and the health of the child within the family. These are elements of the eco cultural pathways that are already integrated within the family interactions and could be a way to strengthen family interaction and health. Families and community support these traditions and in healthy eco cultural exchanges it enhances the child's role as a health-promoting agent within the family. Greenlandic public health, health promotion programs and the national perinatal guidelines have a physical health focus, but do not address the mental, social and spiritual dimensions of perinatal health. This fragmented way of perceiving and implementing health does not support the relational worldview that is an integral part of the culture of Greenland, and thus many families struggle to find to exercise choice within the system.
- The dissertation shows a schism between the historical, philosophical, and cultural foundations of the Greenlandic perinatal health policies, and the choices that the women and their families are given. It is not visible that Greenland has taken into account the best practices and scientific results from areas that have a geographical and infrastructural likeness to Greenland, such as northern arctic Canada or rural Australia.
- The schism arises because the choices that the perinatal family has in regard to new policies/guidelines for pregnancy and childbearing seldom are negotiated with the women and communities before they are put into action. There is a need to ensure that the individual gains skills that empowers and gives ownership of these health policies. It is important that families not only are informed of changes, but also are part of the dialogue before changes are effectuated. Not only knowledge about health policy that is in place, but also discussion and dialog. Families need to be able to recognize their own logics in the programs that are initiated. It is when the families hear their own voices and can see their own "faces" that they can take responsibility for their own health. The

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<sup>41</sup> See list of definitions and key concepts.

Greenlandic perinatal family needs culturally relevant knowledge, discussion and dialogue with their policy makers around perinatal policy.

- There is a true disparity in the health of the study participants, in that those who have economic and social resources are also those who have the possibility to draw on network and community during the perinatal period. The involvement and empowerment of families in the decision making process is an incumbent measure in order for them to take control of their own health and well-being.

## RECOMMENDATIONS FOR FUTURE RESEARCH

Further study is needed that include a quantitative study of morbidity rates in the perinatal period as well as the development of perinatal morbidity indicators that measure mother and infant morbidity in the perinatal period and APGAR scores at birth. A study should also include quality of life indicators that could identify the effect of the revised guidelines for perinatal care, provide indicators as a basis for future research in perinatal care and give a cost and effect analysis of Greenlandic perinatal care.

Knowledge acquired from the studies of this dissertation can support policy makers and those working with families and communities to reevaluate how Greenland develops their health promotion programs. The findings might also be useful and important for the Greenlandic families and communities themselves, and could be used as a foundation for dialogue when defining needs and expectations during pregnancy and childbirth. . It could be beneficial for the Greenlandic healthcare system to reassess policy around transfer of Greenlandic mothers, especially in relation to transfer of low-risk pregnancy.

While looking to solve the problem of a high perinatal mortality, new problems have been created. Women, both those with an at-risk pregnancy and those that live in smaller towns, have to leave their community and stay alone in other communities over a longer period of time. There is a acute need to look at the health models employed and assess if development of different models, is possible. This should be the focus of future research.

And finally, these findings lead to the recommendation that policy makers and government ensure that families and communities are provided with comprehensive information about choices and policy regarding childbirth. This information should be disseminated to two groups: 1) to the health workers, lay midwives, midwives, and doctors, and 2) to the community and families. It is important to ensure the education of midwives in Greenland to address and acknowledges the eco cultural customs that support the strengths within the Greenlandic family. This could be incorporated in the family schools that already are being conducted in several communities in Greenland. Such a comprehensive program would include written materials, but should also include film and voice stories that encourage families and communities to continue to create and *recreate* culture that meet the needs of the Greenlandic community as a whole. The prize for such health promotion actions is not just to be found in lower mortality and morbidity statistics, but in the enhanced quality of life for mothers, fathers, siblings and including the whole Greenlandic perinatal family.

## DANSK RESUME

### INDLEDNING

Afhandlingen omhandler fødselen og dets betydning i det grønlandske samfund, idet der anlægges et holistisk sundhedsfremmende syn på den perinatale periode og der fokuseres på vigtigheden af kvinder, børn, deres familier og lokalsamfundet som ligeværdige dele af helheden.

### MÅL

Målet med afhandlingen er, at præsentere nye begreber og viden om sundheden om den perinatale familie i Grønland. Der ses holistisk på fødested og dens indflydelse på støtte til familien i den perinatale periode. Afhandlingen tilstræber at præsentere den perinatale familie og dens placering i det grønlandske samfund. Den forbinder ændringerne i sundhedspolitikken med begreberne familie, holdninger og samfundsstruktur. Den bygger på statistisk, historisk, medicinsk-antropologisk og kulturel data inden for rammerne af den perinatale sundhed i Grønland.

### *Oversigt af undersøgelsens design, data indsamlingsmetoder og deltagere*

| STUDIER | TYPE                                                                                             | DATA INDSAMLING                                                                                                                                                | DELTAGERE/ MATERIALER                                                                                                    |
|---------|--------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| I       | Literaturstudie som benytter "Daviss' Logics" som analyse-redskab                                | Nationalarkiv,<br>Historisk data:<br>Embedslægeinstitution,<br>Groenlandica Archives.<br>Søgemaskiner: Popline, CSA,<br>CINAHL, AnthropologyPlus and<br>PubMed | Medicinske årsrapporter fra<br>1953-2001. 22 noter og artikler<br>fra 1861 til 2004<br>4 peer-reviewed artikler<br>1 bog |
| II      | Literaturstudie som benytter indholdsanalyse og "eco cultural pathway" teorier i analyse arbejde | Primær, sekundær og tertiær<br>litteratur søgninger.<br>Søgemaskiner: Popline, CSA,<br>CINAHL, AnthropologyPlus and<br>PubMed                                  | 13 peer-reviewed artikler<br>Snowball-effekten<br>Sekundær søgning                                                       |
| III     | Kvalitativ undersøgelse med benyttelse af narrativ metode                                        | 13 Individuelle interview<br><br>Feltnotater                                                                                                                   | 10 kvinder<br>1 mandlig Kulturbærer<br>2 kvindelige Kulturbærer                                                          |
| IV      | Kvalitativ undersøgelse med etnografisk indholdsanalyse "Storytelling" som teoriskabende redskab | 7 Fokusgrupper<br><br>5 Individuelle interview                                                                                                                 | 35 kvinder<br><br>4 fædre<br>1 Kulturbærer                                                                               |

### METODER OG DELTAGERE I STUDIET

Over en otteårig periode fra 2003 til 2011, er to litteraturstudier blev gennemført, og empiriske data blev indsamlet fire steder i Grønland: Nuuk, Ilulissat, Sisimiut og Tasiilaq. Syv fokusgrupper med i alt 35 deltagere, er suppleret med 18 individuelle interviews med kvinder, fædre og Kulturbærer. Resultaterne af disse studier er fremlagt i fire artikler: 1) et litteraturstudie om fødestedet i Grønland i den postkoloniale periode, 2) et litteraturstudie om barnet som den sundhedsfremmede element i familien, 3) et narrativt studie om kvinders subjektive oplevelses af at være overflyttet i forbindelse fødslen, og 4) et studiet som benytter sig af "storytelling" som fundament i forskning om netværksstøtte i grønlandske

familie i den perinatale periode. De anvendte metoder til gennemførsel af afhandlingens interviews og fokusgrupper er i overensstemmelse med Helsinki-Erklæringen.

## RESULTATER

For de perinatale familier er begrebet sikkerhed ofte knyttet direkte til familie og samfund. Familien opfattes som sikkerhed, og manglende mulighed for familie støtte og netværk opfattes omvendt som usikkerhed. Begrebet ansvar er for familien og samfundet kulturelt specifikt og er knyttet til den nærmeste familie, udvidede familie og slægtninge. Der findes et 'kulturelt rum' for fødsel i Grønland, hvor den perinatale families evne til at styrke båndene indenfor familien, slægtskabet og det lokale netværk er medvirkende til familiens sundhed. Lokalsamfundene, familierne og kvinderne i studierne opfatter sig selv som bærer af deres børn, fædrene opfatter sig som støtteskabende omsorgsgiverer for deres familie, og lokalsamfundet herunder den udvidede familie, opfatter sig som et vigtigt støtte netværk for familierne.

## KONKLUSIONER

- Det grønlandske sundhedsvæsen er udviklet efter det danske sundhedssystem og dens perinatale omsorg er inspireret af de norske perinatale retningslinjer. Grønlandsk sundhedspolitik og retningslinjer giver familierne i Grønland adgang til sundhedsydelser af høj kvalitet i hospitaler og sundhedscentre. Grønland tilbyder gratis sundhedsydelser og uafhængigt af de enkelte familiers socioøkonomiske status får de samme valg, med hensyn til, hvor og hvordan de føder. Grundlaget for sundhedssystemet bygger på Ottawa Charterets fem søjler, hvilket etablerer en sund offentlig politik.
- En af afhandlingens centrale konklusioner er forståelsen af de sammenhæng, der eksisterer mellem traditionelle og kulturelle egenskaber, såsom sjæle navne begrebet Silattorsarpoq<sup>42</sup>, og fiktive pårørende; og de sundhedsmæssige forhold omkring barnet i familien. Disse sammenhæng er elementer af de øko-kulturelle stier, der allerede er integreret inden for familiens samspil og kan være måder til at styrke familiens samspil og sundhed. Familierne og samfundet støtter disse traditioner og i en sund øko-kulturudveksling styrker det barnets rolle som sundhedsfremmende agent inden for familien. Grønlandsk folkesundhed, sundhedsfremmende programmer og de nationale perinatale retningslinjer har et fysisk sundhedsfokus, men disse tager ikke højde for de mentale, sociale og åndelige dimensioner indenfor perinatal sundhed. Denne opsplittede måde at opfatte og gennemføre sundhed på understøtter ikke det relationelle verdenssyn, der udgør en integrerende del af kulturen i Grønland, og dermed kæmper mange familier for at finde en måde at udøve deres selvbestemmelse inden for systemet.
- Afhandlingen viser et skisma imellem det historiske, filosofiske og kulturelle grundlag for den grønlandske perinatale sundhedspolitik, og de valg som kvinderne og deres familier får. Det er ikke synligt, at Grønland har taget hensyn til den bedste praksis og de videnskabelige resultater fra områder, der har en geografisk og infrastrukturel lighed med Grønland, såsom det arktiske Canada eller landdistrikter i Australien.
- Skismaet opstår, fordi de valg, den perinatale familie har i forbindelse med de nye retningslinjer for graviditet og børnefødsler sjældent forhandles med kvinderne og samfundet, før de sættes i værk. Der er et behov for at sikre at de enkelte tilegner sig egenskaber og færdigheder, der giver bemyndigelse og ejerskab til denne sundhedspolitik. Det er vigtigt, at familierne ikke alene er underrettet om

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<sup>42</sup> Silattorsarpoq: Det at kunne bruge ræsonnement.

ændringer, men også er en del af dialogen før ændringerne iværksættes. Det er ikke alene viden om sundhedspolitik der bør være på plads, men der bør også være plads til diskussion og dialog. Familierne skal være i stand til at erkende deres egen logik i de programmer der iværksættes. Det er når familierne hører deres egne stemmer og kan se deres egne "ansigter", at de kan tage ansvar for deres egen sundhed. Den grønlandske perinatale familie har brug for kulturelt relevant viden, diskussion og dialog med deres politiske beslutningstagere omkring den perinatale politik.

- Der er blandt undersøgelsens deltagere en sand forskel indenfor sundhedssektoren, hvor det ses, at de der har økonomiske og sociale ressourcer, også er dem, der har mulighed for at trække på netværk og samfundet i den perinatale periode. Inddragelse og bemyndigelse af familier i beslutningsprocessen, som en etableret foranstaltning for denne forskel, er nødvendigt for at familierne tager magten i relation til deres egen sundhed og trivsel.

## ANBEFALINGER TIL FREMTIDIGE FORSKNINGS TILTAG

Yderligere forskning bør omfatte en kvantitativ undersøgelse af sygeligheden i den perinatale periode, samt udvikling af perinatale sygeligheds indikatorer, der måler mor- og spædbarnssygelighed i den perinatale periode og APGAR score ved fødslen. En undersøgelse bør også omfatte livskvalitetsmålinger, der kan identificere effekten af de reviderede retningslinjer for perinatal omsorg, give indikatorer som grundlag for fremtidig forskning i perinatale omsorg og give en pris og effekt analyse af grønlandsk perinatal pleje. Viden erhvervet fra undersøgelserne i denne afhandling kan støtte de politiske beslutningstagere og dem der arbejder i familier og lokalsamfund til, at revurdere hvordan Grønland udvikler deres sundhedsfremmende programmer. Resultaterne kan også være nyttige og vigtige for de grønlandske familier og samfundet selv, og kan anvendes som grundlag for dialog ved fastlæggelsen af behov og forventninger under graviditet og fødsel. Det kan være til gavn for det grønlandske sundhedsvæsen at revurdere politikken omkring overførsel af grønlandske mødre, især i relation til overførsel ved lav risiko graviditet.

Mens man søger at løse problemet med en høj perinatal dødelighed, er der skabt nye problemer. Kvinder, både dem med en risikograviditet og dem der bor i mindre byer, er nødt til at forlade deres samfund og bo alene i andre samfund gennem længere perioder. Der er et akut behov for at se på de sundhedsmæssige forhold omkring barnet og de anvendte modeller, for at vurdere om det er muligt at udvikle andre modeller. Dette bør være fokus for den fremtidige forskning.

Endeligt, førerresultater disse til, at de politiske beslutningstagere og Naalakkersuisut anbefales at sikre at vedrørende fødsel familien og samfundet er forsynet med omfattende information om valg og sundhedspolitik. Disse oplysninger bør formidles til to grupper: 1) til sundhedspersonale, sundhedshjælpere, jordemødre og læger, og 2) til samfundet generelt og familier specifikt. Det er vigtigt at sikre uddannelse af jordemødre i Grønland, for at løse og anerkende økokulturelle skikke, der understøtter styrkerne i den grønlandske familie. Dette kan indarbejdes i de Familiecentre eller forældreskoler, der allerede er ved at blive etableret i flere grønlandske kommuner. Et sådant omfattende program skal omfatte skriftligt materiale, men bør også omfatte film og mundtligt overleverede historier, der tilskynder familien og samfundet til fortsat at skabe og genskabe kultur, der opfylder behovene i det grønlandske samfund som helhed. Gevinsten for sådanne sundhedsfremmende tiltag er, ikke kun at finde i lavere dødelighed og sygdomsfrekvensmæssig statistik, men også i den forbedrede livskvalitet for mødre, fædre, søskende og herunder hele den grønlandske perinatale familie.

## KALAALLISUT EQIKKAGAQ

### AALLARNIINEQ

Ilisimatuutut allaatigisaq erninnermut tunngasumik imaqarpoq, erninerullu kalaallit inuiaqatigiinni inissisimanera aamma sammineqarluni, erninerup nalaani ataatsimut isiginnittaaseqarluni aammalu arnat, meeqqat, ilaqutaasa najukkamilu innuttaasut ataatsimoornermi naligiittut isigalugit.

### ANGUNIAGAQ

Ilisimatuutut allaatigisami anguniagaavoq, isummat nutaat ilisaritissallugit kalaallillu ilaqutariit meeraalu erninerup nalaani peqqissutsimut ilisimasariaqartut sammineqassallutik. Ilisimatuutut allaatigisap anguniarpaa ilaqutariit erninerup nalaani ilisaritissallugit aammalu erninerup kalaallit inuiaqatigiinni inissisimanera takutissallugu. Peqqinnissaqarnermi allannguutit eqqarsaatigalugit ilaqutariissuseq, isummersortarneq inuiaqatigiinnilu aqqissuussaaneq sammineqarput. Sumi inunngorsimaneq ataatsimut isiginnittaaseqarluni sammineqassaaq aammalu erninerup nalaanni sumi inunngorsimaneq ilaqutariinnut tunaartaanersoq. Allaaserisami paasissutissat Kalaallit Nunaanni erninerup iluani peqqinnissaqarnikkut tunngasutigut aamma statistikikkut, oqaluttuarisaanikkut, antropologiskimik, biofysiskimik, kulturikkullu tunngavilersuutit atorineqassapput.

*Takussutissiaq: Misissuinermit najoqqutat, misissugassanik katersuinerit, periaatsit misissuinermilu peqataasut.*

| ALLAASERISAT | MISISSUINERIT SUUNERI                                                                                                                                                                                                                          | MISISSUGASSANIK KATERSINEQ                                                                                                                                                                                                     | PEQATAASUT/<br>ILISIMATUSARNERMI<br>NAJOQQUTARINEQARTUT                                                                                                                                                                                                                                                                                                                |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| I            | Atuakkanik misissuineq "Daviss' Logics" misissueqqissaarutitut najoqqutaralugu                                                                                                                                                                 | Nunatta toqqorsivia,<br>Paasissutissat<br>oqaluttuarisaanermut tunngasut:<br>Office of the Chief Medical<br>Officer,<br>Groenlandica<br>Ujarliutit nittartakkaneersut:<br>Popline, CSA, CINAHL,<br>AnthropologyPlus and PubMed | Nakorsaqarnikkut nalunaarutit 1953-2001.<br>Nalunaarsukkat 20-it allaaserisallu 1861-miit 2004-mut<br>Ilisimatusartut ilisimatusartoqatiminut allattugaasa<br>nalilersornerat<br>Nalunaarsukkat allattukkallu 22-it piffissami 1861-miit<br>2001-imut,<br>Allaaserisat 4-t ilisimatusartut allataat<br>ilisimatusartoqataannit nalilersorneqarnikut<br>Atuagaq ataaseq |
| II           | Atuakkanik misissuineq imarisanik misissueqqissaarneq najoqqutaralugu, aammattaaq teoriit avatangiisit kulturillu ingerlaarnerannut tungasut najoqqutaralugit (eco cultural pathway)                                                           | Pingaarnertut tulliatut pingajuattullu atugassanik atuakkanik najoqqutassanik ujarlerneq.<br>Ujarliutit nittartakkaneersut:<br>Popline, CSA, CINAHL,<br>AnthropologyPlus and PubMed                                            | Allaaserisat 13-t ilisimatusartut allataat ilisimatusartoqataannit nalilersorneqarnikut<br>Sunniut alliertortitsisoq (Snowball effect)<br>Ujarlernerup aappassaa                                                                                                                                                                                                       |
| III          | Kvalitatiivimik tunngaveqarluni misissueqqissaarnermi, narrativimik periuseqarluni misissueqqissaartoqarpoq                                                                                                                                    | Inunnik apersuinerit 13-it:<br><br>Misissorniakkap najorneratigut allatat nalunaarsuutit                                                                                                                                       | Arnat 10<br>Angut ataaseq, kulturimik attassisoq (kulturbærer)<br>Arnat marluk, kulturimik attassisut (kulturbærere)                                                                                                                                                                                                                                                   |
| IV           | Kvalitatiivimik misissuineq etnografiimut tunngasunik imarisaanik misissueqqissaarneq najoqqutaralugu. Oqaluttuarneq (storytelling) eqqarsaatersuusiormik pilersitsisutut sakkutut atorineqarnera (theory building tool) misissueqqissaarlugu. | Alaatsinaanneqartut eqimattat 7-it:<br><br>Inunnik 5-inik apersuinerit:                                                                                                                                                        | Arnat 35-it<br><br>Ataataasut 4<br>Kulturimik attassisoq (kulturbærer) ataaseq                                                                                                                                                                                                                                                                                         |

## ILISIMATUSARNERMI NAJOQQUTASSANIK KATERSUINEQ MISISSUINERMILU PEQATAASUT

Ukiut arfineq pingasut ingerlaneranni marlussoriarluni atuagaatinik misissuisoqarpoq, Kalaallillu nunaanni paasissutissanik misissoqqissaagassanik katersisoqarluni: Nuummi, Ilulissani, Sisimiuni Tasiilamilu. Paasissutissat ilagaat alaatsinaanneqartunik apersuinerit inunnillu ataasiakkaanik apersuinerit ingerlanneqarsimallutik. Alaatsinaanneqartunik apersuinerit arfineq marluk, taakku katillutik 35-nik peqataasullit ingerlanneqarsimapput, tassungalugu ilanngullugu inunnik ataasiakkaanik 18-iusunik arnanik, ataataasunik, kulturimillu attassisunik (kulturbærere) apersuinerit. Misissukkat allaaserisani sisamaasuni saqqummersinneqarput: 1) Kalaallit Nunaanni nunasiaataasimanerup kingornatigut sumi inunngorsimaneq pillugu atuagassiaqarnikkut misissuineq, 2) meeraq pillugu atuagassiaqarnikkut misissuineq tamatumani meeqqap ilaqutariinni peqqissaanermi qitiusutut inissillugu, 3) arnat nammineq inuttut misigissusaat najoqqutaralugit naartunermi allamut nuunneqartarnermi narrativimik misissuineq, 4) ilisimatuutut allaatigisaq oqaluttuarneq atorlugu ilisimatusarnermi Kalaallit Nunaanni ilaqutariinnut erninerup nalaanni attaveqarfinnik tapertaasunik misissuisoq.

### INERNERIT

Ilaqutariit toqqissisimanermut tunngasumik isumaat ilaquttanut inuiaqatinullu attaveqarsinnaanermut atassuteqarpoq. Ilaquttat toqqissisimaffittut isigineqarput, ilaquttaniillu attaveqatiniillu tapersersorteqarsinnaannginneq toqqaserlunnartutut isigineqarluni. Ilaquttatut inuiaqatitullu isiginnittaaseq kulturimi immikkuullarissuuvoq tassanilu pineqarlutik ilaquttat qaniginerusat, ilaqutarilersimasat eqqarliillu. Ernier Kalaallit Nunaanni kulturitigut inissaqartinneqarsimavoq, ilaqutariit erninerup nalaani peqqissusaat ilaquttaminnut eqqarliminnut inuiaqatigiinnilu attaveqatiminut attaveqatigiinnermi nukittorsarsinnaassusaannut attuumassuteqarluni. Misissuinerimi anaanaasut meeqqaminnik nammaassisutut isigipput; ataataasut sulisussatut ilaqutaasunullu isumassuisussatut isigalutik; inuiaqatigiit, ilaqutaalersimasuttaaq ilaqutariinnut tapersersuisussatut pingaarutilittut attavissaasuullutik.

### INERNILIINEQ

- Kalaallit Nunaanni peqqinnissaqarfik qallunaat peqqinnissaqarnermi aqqissuussisimanerat ilaaqqissaarlugu sanaajuvoq erninerullu nalaani isumaginninneq norskit erninerup nalaani aqqissuusineraniit isumassarsiaalluni. Kalaallit naalakkersuinikkut malittarisassatigullu nammineq aqqissuusinerat napparsimavinnut peqqinnissaqarfinnullu pitsaassusermik qaffasissumik tunisivoq. Kalaallit Nunaanni peqqinnissaqarnikkut isumaginninneq atuisunut akeqanngilaq, ilaqutariillu ataasiakkaat isumaginninnikkut aningaasatigullu inissisimanerat apeqqutaatinagu naligiimmillu atugassaqartitsisoq takuneqarsinnaavoq, sumi erniniarnersut qanorlu erniniarnersut tamanut naligiimmata. Peqqinnissaqarnikkut aqqissuusineq Ottavap charteriata napassutaasa tallimaasut tunngavilersuutigaa taamaalilluni naalakkersuinikkut peqqissumik tunngavilersugaalluni.
- Misissuereernermi inerniliinerimi pingaarnerpaattut taasariaqartut ilaat tassaavoq suna tamaat ataqatigiinnerata paasineqarnera, tamatumani ileqqutoqqat kulturikkullu piginnaanerisa ataqatigiinnerat, soorlu atsiussisarnermi ileqqutoqqat, "Silattorsarpoq" isumaata paasineqarnera, ilasiamik ilaqutartaarneq, meeqqallu ilaqutariinni peqqinnissaqarnikkut inissisimanera. Tamakkua pinngortitami kulturikkullu pissuseqatigiinnermik ilaatigut tunngaveqarput, ilaqutariillu susassareqatigiinnerannut attaveqatigiinnerannullu tunngareermata nakkussaataasinnaallutik. Ilaqutariit inuiaqatigiillu ileqqutoqqanik aallutsisuupput, avatangiisinik kulturimillu paarlaateqatigiinnikkut meeqqap peqqinnikkut siuarsaaqataasutut inissisimanera

pitsanngorsarneqassaaq. Kalaallit inuttut peqqissusaat, peqqissaqarniarnikkut iliuutsit nunallu erninermi malittarisassiai timikkuunerusumik siunertaqarlutik ingerlanneqartut, erninermi peqqinnissap tunngaaticut eqqarsartaatsikkut, isumaginninnikkut anersaakkullu amigaateqarlutik. Suna tamaat avissarlugulusooq isiginnittaaseqarluni peqqinnissaqarnikkut ingerlaaseqarniarsarineq nunarsuarmioqatiittut ingerlaasiusumut tulluarpasinngilaq, tamannami kulturikkut, kinaassutikkut paasinnittaatsikkullu Kalaallit Nunaannut ilanngutsitaaneq tunngavigaa, tamannalu ilaqutariippassuarnut sorsunnermik kinguneqartoq, aqqissuusaanerullu iluani qinigassaticut periarfissanik ujartuisitsisararluni.

- Ilisimatuussutsikkut suliap takutippaa Kalaallit Nunaanni erninerup nalaani peqqinnissaqarnikkut ingerlatsinermi oqaluttuarisaanikkut, filosofeqarnikkut, kulturikkullu tunngaviaticut avissartuunneqartoq, aammattaaq arnat ilaqutaasalu qinigassarititaasa tungaaticut. Ersarinngilaq, Kalaallit Nunaat iliuutsikkut ilisimatusarnikkullu nunarsuarmi pitsaanerpaaffiisigut atuisoq, ingammik nunat Kalaallit Nunaannut geografiskimik nunallu iluani attaveqatigiinnermut tunngasutigit assigusut eqqarsaatigalugit, soorlu Canadap avannarpasittortaata issittuani imaluunniit Australiami nunaannarmi pissusiviusut eqqarsaatigalugit.
- Avissartuunneq pilersarpoq, qinigassaticut periarfissat, erninerup nalaanni ilaqutariiusut anguniakkaticut nutarterisoqartillugu / anguniagalersortoqartillugu isumaqatiginninniarnikkut eqqartueqatigiinnikkullu ingerlanneqartanngimmata malittarisassat atuutilersinnagit. Pisariaqartinneqarpoq qulakkiissallugu, inuit ataasiakkaat piginnaasaaqalersissallugit piginnaatilissallugillu peqqinnissaqarnikkut ingerlatsinermut tunngasunut tamakkununga piginnittuusutut inissisimalernissaat eqqarsaatigalugu. Pingaaruteqarpoq, ilaqutariiusut allannguutitut nalunaarsuiffigiinnarnagit, naligiimmik eqqartueqatigiinnikkut peqataatinneqassasut allannguinerit pilertinnagit. Peqqissarnikkut anguniakkat kisiisa pineqanngillat, oqallinnermut oqaloqatigiinnermullu aamma inissaqartariaqarpoq. Ilaqutariit namminneq imminnut paasinittaasiat ingerlatassani inissittareersimasariaqarput, malittarisassaticut atuutilersigatik. Ilaqutariit nammineq nipertik ”kiinnatillu” ilisarnarsigaangamikkit, peqqinnikkut immirut akisussaaffimmik tiguisartut uppersarneqarpoq. Kalaallit Nunaanni ilaqutariit erninerup nalaani kulturikkut ilisimasassanik naleqquttunik atorfissaqartitsipput, naalakkersuinikkut aalajangiisartutik oqalliseqatigalugit oqaloqatigisariaqarpaat.
- Peqqinnissaqarfiup iluani peqataasunik misissuinermi takuneqarsinnaavoq uppersarneqarsinnaasumik assigiinngissuteqartoqartoq, peqataasummi aningaasaticut isumaginninnikkullu pisuussuteqarlutut, aamma tassaammata, erninerup nalaani inunntut aalajangersimasunut attavigissaarnerminnik nalunngisaminnut inuiaqatigiinnilu atuilluarsinnaasut. Ilaqutariinniik pineqartunik aalajangiiniarnermi aqqissuusamik peqataatitsineq akisusaatitsinerlu pisariaqarmat, ilaqutariit peqqinnissaminnik ingerlalluarnissaminnillu immirut pillutik aqutsisinnaanermik tiguisariaqalermata.

## SIUNISSAQ EQQARSAATIGALUGU ILISIMATUSARNISSAMIK INNERSUUSSUTIT

Ilisimatuussutsikkut misissueqqissaarnermik annertunerusunik pisariaqarpoq, erninerup nalaani napparsimasarnerup pissusaa pillugu kiisalu erninerup nalaani napparsimalersinnaanermi paasissutissanik ilisarnaataasinnaasunik inerisaanissaq annertunerusumik kisitsisitigit misissuisoqarnissaa eqqarsaatigalugu, tamatumani anaanaasup inunngorlaajusullu erninermi piffissarititaasut nalaanni nappaalassutigisinnaasaat erninermilu APGAR-imik uuttortaaneq ilanngullugit. Misissuinissami aamma inuunermit nalillit (tigussaasuunngitsut) ilaasariaqarput, erninerup nalaani malittarisassiukkat ilumut iluaqutaasimanersut uuttortarlunarnerisigut, aammalu aningaasaliissutaasartut aningaasaticut atuinnermut

naleqqiullugit qanoq inissisimanersut. Ilisimasat matumani misissorsimasamiit paasineqarsimasut naalakkersuinikkut aalajangersaaniartunut tapertaasinnaapput, minnerunngitsumik ilaqutariinni najukkamilu inuiaqatigiisunut nalilersussallugu, Kalaallit Nunaanni peqqissarnikkut pilersaarutitigut inerisaaneq pissusissamisut ingerlanersoq. Misissukkat inerneru aamma kalaallit ilaqutariinnut inuiaqatigiinnullu atorfissaqarluarlutillu pingaaruteqarsinnaapput, naartunermilu erninermilu atorfissaqartitanut ujartuineru oqaloqatigiinniissamik tunngaviliilluarsinnaallutik. Kalaallit peqqinnissaqarfiannut iluaqutaasinnaarpassippoq kalaallit anaanaasut illoqarfimmut allamut erniartortinneqartarnerat naalakkersuinikkut nalilersoqqissallugu, ingammik naartusut uloriarnartorsiunngitsut eqqarsaatigalugit.

Erninerup nalaani toqusut amerlavallaarnerata suliarineqaruttornerani, ajornartorsiutit nutaat takkussuupput. Arnat, ulorianaatilimmik naartusut, aammalu illoqarfeeqqaneersut, najugartik sivisuumik qimallugu inuiaqatigiinnut allanut kisimiikkiartortarput. Meeqqamut tunngatillugu maannangaaq pisariaqarluinnarpoq meeqqap peqqissarniarnikkut atugassarititai alakkartissallugit nalilersussallugulu, assigiinngitsutigut inerisaanissaq pisariqarnersoq. Siunissami ilisimatusarnissap tassunga toraarsinissaa pisariaqarpoq.

Inernerit eqqartorneqartut aamma malitsigisaanik innersuussutigineqarpoq, naalakkersuinikkut aalaajangiisartut naalakkersuisullu, qulakkeerniassagaat erninermi ilaqutariiusut qinigassaqartut sunalu anguniagaanersoq inuiaqatigiillu naammalluartunik paasissutissinneqartassasut. Paasissutissat pineqartut eqimattanut marlunnut ukuusunut ingerlateqqinneqartariarput: 1) Peqqinnissaqarfiup iluani sulisunut, peqqissaasunut, juumunut nakorsanullu, aammalu 2) inuiaqatigiinnut ilaqutariinnullu. Juumuut ilinniartitaanerat pingaartumik qulakkiigassaavoq tamatumanilu nunap nammineq pissuserisaa ileqqilu akuerissallugit, tamakkumi kalaallit ilaqutariit nakuussutigimmassuk tapertaralugillu. Tamannalu Ilaqutariit Centeriitut imaluunniit angajoqqaat ilinniarfiitut ilanngutsinneqarsinnaapput, tamakkumi kommunini amerlanerit atuutsineqalereermata. Pilersaarutit taamaattut allattariarsornikkut atortussatigut immersoreersimassapput, kisianni aamma filminik oqaluttuarpalaartunik ilaqarsinnaallutik, ilaqutariit inuiaqatigiillu kulturiminnik piuaannartitsinissaat siunertaralugu, kalaallimmi inuiaqatigiinni atorfissaqareermata. Peqqissuunissamik iliuusissat nalingi taamaallaat toqusartut ikilinerisigut napparsimasarnikkullu pitsanngorsaaneramik napparsimasartullu ikilisarnerisigut kisiat takussutissartaqassanngilaq, anaanaasummi, ataataasut, qatanngutaasut kiisalu erninermi ilaqqat tamarmiut iluaqutigissavaat.

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## APPENDIX 1

Place of Birth 1953-2001

[illegible]



## Henvisning/visitation

PERINATAL OMSORG

Udarbejdet af: Gunver Persson, Peder Kern Dato: 01.12.2000  
Revideret den 08.11.01

Udskrift dato: 12. marts 2013  
Rev. dato: 30.05.02 af PK

### Henvisning og Visitationsretningslinier

**Baggrund:** I Grønland har man på grund af den høje perinatale mortalitet og komplikationer efter graviditet/fødsel, besluttet at intensivere den perinatale indsats. Norge der har en udkants problematik sammenlignelig med den Grønlandske med langt til specialafdelinger, indførte en stram visitationspolitik i begyndelsen af 90'erne og allerede fået særdeles gode resultater. På baggrund af disse erfaringer, er det besluttet at skærpe visitationspolitikken, i Grønland. Da der er betydelige problemer ved henvisning af 1. gangs gravide, i modsætning til norske principper, ikke medtaget som risikopatienter. En pågående analyse af komplikationer eller fravær deraf i denne gruppe, vil senere afgøre om de bør henvises til fødsel på specialafdeling.

**Principper:** Udenfor centre med døgnberedskab for jordemødre, obstetrikere og anæstesiologer anbefales det, at der stiles mod en absolut normal fødsel. For fødsler på lokalt niveau forudsættes:

- \* at der er en faglig forsvarlig dækning på planlagte fødested
- \* at tidligere fødsler er forløbet uden komplikationer eller indgreb (der ses bort fra tidligere præmature fødsler, der i øvrigt er forløbet normalt. De bør konfereres tidligt i graviditeten og følges tæt)
- \* at svangrekontroller ikke har givet anledning til at forvente komplikationer ved fødslen
- \* at der er sikker termin, og at fødslen finder sted efter 36. svangerskabsuge
- \* at der kun er et foster i hovedstilling
- \* at fødslen starter spontant

### Henvisning:

#### Obstetrisk anamnese:

- \* > 6. gangsfødende
- \* > 50% spontane aborter (af ønskede graviditeter)
- \* tidligere dødfødsel eller neonatal død
- \* tidligere besværlig fødsel eller abnorm langvarig fødsel
- \* tidligere vacuumextraction, tangforløsning eller sectio
- \* tidligere IUGR-barn (konfereres i 28. uge mhp. vægtkontrol)
- \* tidligere makrosomi-barn (> 4500 gr.)

#### Tilstande opstået før graviditet:

- \* førstegangsfødende < 16 år.
- \* førstegangsfødende > 35 år.
- \* svær overvægt (BMI > 40)
- \* svær undervægt (Vægt < 50 kg eller betydeligt vægttab under graviditeten)
- \* statura parva (< 150 cm)
- \* uterinanomalier samt fibromer
- \* tidligere uterine operationer (sectio, myomfjernelse o.l.)
- \* tidligere vaginal-, vulva-, perineal- og anal- samt incontinensoperation
- \* diabetes
- \* essentiel hypertension
- \* nyresygdomme med eller uden hypertension
- \* andre betydelige medicinske sygdomme
- \* andre betydelige psykiske sygdomme

**Tilstande under nærværende graviditet:**

- \* Præekklampi
- \* truende præmatur fødsel eller primær vandafgang < 37. uge
- \* IUGR
- \* flerfoldsgraviditet
- \* abnorme fosterstillinger efter uge 37. uge (sædepræsentationer efter 37. uge)
- \* anæmi (hæmoglobin < 6,0)
- \* overbårenhed (> 42 uger)
- \* oligohydramnios
- \* tilstedeværelse af Rhesus- eller irregulære antistoffer, der kan give erythroblastose.
- \* gestationel diabetes mellitus
- \* betydelige psykiske sygdomme
- \* væsentlig utryghed ved planlagte fødested

**Der bør altid konfereres med vagthavende obstetrikere ved:**

- \* vandafgang >24 timer
- \* mekoniumfarvet fostervand
- \* afvigelse i normalt fødselsforløb
- \* og i det hele taget når fødslen ikke skrider normalt frem eller der opleves komplikationer

**Henvisningsprocedurer:**

Ved første besøg hos lægen udfyldes den nye Perinatale journal. Hvis tidligere fødsler ikke har fundet sted på sygehuset/i distriktet rekvireres relevante fødejournaler og epikriser.

Ved første besøg hos jordemoderen i 12 svangerskabsuge gennemgås det eksisterende journal-materiale. Såvel ambulant som indlæggelsesjournal samt fødejournaler fra tidligere forløb skal være tilgængelige.

Der konfereres efterfølgende lokalt og eventuelt med specialafdelingen om relevante tidlige screenings- og eller behandlingstiltag som eksempelvis cerclage-anlæggelse eller henvisning til amniocentese. Risikofaktorer vurderes - og der udfærdiges om fornødent henvisning efter gældende regelsæt.

Inden udgangen af 16. uge (eller når det er praktisk muligt) fremsendes kopi af svangrejournalens side 1, 2, 3 og 8 til ledende jordemoder med henblik på mulige øvrige foranstaltninger. Evt. vedlægges et billed af BPD-målingen.

**Se også:**

*Henvisningsblanket, se omstående.*

*Cirkulære nr. 8. Om henvisning af patienter til undersøgelse og behandling uden for hjemsygehus, Direktoratet for Sundhed og Miljø*

Naartunermut tunngatillugu misissuineq  
Ilaqutaasut

Nuummut aallarluni erniartomeq pillugu apersuineq:  
Ilulissani Sisimiuni, Upernavimmi Tasilamilu apersugassanik misissuivigineqartussanik  
pilersitsisoqassaaq.

Apersuinerlut tunngaviuvoq paasissutissanik ujartuineq, arnat Nuummut  
erniartortitaalluik aallartitaasernerat qanoq misigisimanerissi pillugu.

Ilaqutariittut avissaaqqatillusi eqqarsaatersuutgisimasasi, aqqusaartukkasi, misigisasilu  
pillugit allaaserinnikkusuppunga.

Tusarusupparalu qanoq aniguisimanersusi, qanoq ilillusi avissaaqqanissinni  
qimaniartarsimanersusi.

Apersuinerlut ilaarusunnerlusi nammineerlusi aaliangissavarsi.

Apersuineq katillugu 1 ½ time missaa pissaaq. Kisimillusi peqataasinnaavusi imaluunniit  
ilaqutassinnik peqataaqateqarsinnaavusi. (Peqataasut annerpaamik 3-4 - ussapput).

Apersuineq immiussissummut immiunneqassaaq.

Sullap aqqa: Faces of Childbirth.

Suliamik isumaginnittog:  
Ruth Montgomery-Andersen MPH  
Dr. PH Studerende / Jordemoder  
Nordisk Sundhedsvidenskabelig Skole (NHV)  
Göteborg, Sverige

Sullap adressia:  
Box 602  
3900 Nuuk  
tlf.: 313 234 / 233 132

Apersuinerlut peqataarusuppunga

Nalunngilarsa:

1. Peqataarusunnerluga nammineq aaliangertussaagiga.
2. Apersuineq 1 ½ time missaa pissaaq.
3. Apersuineq immiussissummut immiunneqassaaq.
4. Qaquguluunniit apersuinerlut peqataajunnaarsinna.
5. Paasissutissat immiunniit tunngasut atomeq.

Ulloq: \_\_\_\_\_

Ateq: \_\_\_\_\_

Atsiomeq: \_\_\_\_\_

Samtykkeerklæring

Interview med dig som fødte i Nuuk:

Der laves interviews of fokusgrupper i Ilulissat, Sisimiut og Tasilaq

Formålet med interviewet er at få information om din oplevelse af at blive overflyttet til Nuuk til fødsel.

Jeg vil gerne beskrive dine oplevelser, de udfordringer, og de tanker som du gjorde dig vedrørende at være adskilt fra din familie.

Jeg vil også gerne høre hvordan du klarede det, hvilke metoder du brugte for at holde dig glad mens du var væk hjemmefra i disse uger.

Det er frivilligt om du vil være med til interviewet.

Interviewet tager ca. 1 ½ time i alt, med 3-4 deltagere.

Interviewet vil blive optaget på bånd.

Projekt navn: The Faces of Childbirth.

Projekt Ansvarlig:  
Ruth Montgomery-Andersen MPH  
Dr. PH Studerende / Jordemoder  
Nordisk Sundhedsvidenskabelig Skole (NHV)  
Göteborg, Sverige

Projekts adresse:  
Box 602  
3900 Nuuk  
tlf. 313 234/ 233 132

Jeg vil gerne deltage i fokusgruppe interviewet

Jeg véd at

1. Det er frivilligt om jeg vil være med til interviewet.
2. Interviewet tager ca. 1 ½ time i alt.
3. Interviewet bliver optaget på bånd.
4. Det er muligt at trække mig fra interviewet til en hver tid, også mens det står på.
5. Det er muligt at bede om at personlige informationer ikke tages i brug.

Dato: \_\_\_\_\_

Navn: \_\_\_\_\_

Underskrift: \_\_\_\_\_

## **APPENDIX 4**

1. When did you find out that you would be going to Nuuk for birth?
2. Why if you go to Nuuk for birth?
3. How did you feel about this?
4. How did your family feel about your going to Nuuk for birth?
5. How did you feel about being in Nuuk for a longer period of time?
6. How have you coped/ what have you done to stay happy?
7. What has been difficult?
8. What has been easy?
9. What would you like to tell others

### INTERVIEW THEMES

#### *Interviews With The Women*

The themes for dialogue and interview with the women:

- 1) What was your experience of leaving you community to give birth?
- 2) How did your family/ family members react to the fact that you had to leave the community to give birth?
- 3) What did you do to pass the time?
- 4) What encouraged you/ helped you to stay positive?

#### *Interviews With Fathers*

The themes for semi- structured interview with fathers:

- 1) How do families care for each other?
- 2) The spheres of care- what are the spheres of care for men and what are the spheres of care women?
- 3) A lack of care?
- 4) A consciousness of care?
- 5) The terminology of care?

#### *Interviews With Culture Bearers*

The themes for semi- structured interview with Culture Bearers:

- 1) How do families support and care for each other?
- 2) Have the traditions surrounding childbirth have changed?
- 3) If so, how?

| SARA'S NARRATIVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Interviewer: You are now in Nuuk. When did you find out that you should come here?</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Uhm...on the day that I found that I should come here...I went to the midwife... and at that time I found out...that I would be leaving the following day... I wasn't really ready at that time...I thought about them all the time, leaving them for the first time not being with them, you know... going to Greenland.                                                                                                                                                                                                                                                                                   |
| When we lifted off...the teardrops fell... when we finally go here, I started to relax because I got to talk to them... but then my partner started to miss me...so he started to drink... I got my children ...through the municipality, uhm...I got them to take them... So they would be taken care of ...yeah...So they until now, have been taken care of by the municipality for the time being...and I'll get them when I get home ...Yeah...                                                                                                                                                        |
| You see...it was his first child...I asked him to take good care of my children you know...anyway... it was hard for me and I was angry about my children... anyway...my partner was drinking even though he should have taken care of the children and taken responsibility...and ...you know how it is when you are pregnant...it is so easy to cry...and easy to become angry... so I didn't talk to him for two days... when...I was mad at him...yeah...I was so sad inside... I was disappointed in my partner...he was taking care of the children...he had a responsibility...so I talked to him... |
| <p>"Why don't you take care of my children? Why do you drink? You have a big responsibility..."</p> <p>"I miss you so much" (voice of partner)...</p> <p>"Even though you miss me ...I'll be back..." I had to talk that way...</p>                                                                                                                                                                                                                                                                                                                                                                         |
| It was horrible to leave my children ...for the first time...it was lonesome...but there was nothing that I could do...anyway...when I think of my unborn child...uhm...when I came here and maybe I started to relax ...then my baby started growing...and...I began to eat right and I got rosy cheeks, just because I was so happy... <b>(laugh)</b>                                                                                                                                                                                                                                                     |
| <b>Interviewer: you are right...you are beautiful!</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Yeah its nice...yeah...I can't wait to get home to see the children... maybe I can take them all with me next time that I come here ...uumh... I was quite nervous...you know what I mean...when the baby wasn't growing...                                                                                                                                                                                                                                                                                                                                                                                 |
| <p>I could feel that it wasn't growing...so the midwife in *** said to me:</p> <p>"Sara, the child is going to grow, it's going to grow"...(voice of the midwife)</p> <p>At first she didn't believe me but then she measured with a measuring tape and it hadn't changed then she started to worry...so I was sent here...anyway...it was so hard...yeah...to leave the children and the partner...even though I have some family here...uhm...I don't know where they are...yeah...</p>                                                                                                                   |
| I only talk with my cousin...that was good...and she'll be glad when she hears that I have heard from them...I often talk with my cousin...that's nice...it's nice but my children...its terrible to leave ...Especially ****, who can't really understand anything ...even though...I all the time ...try to tell her what's happening...                                                                                                                                                                                                                                                                  |

"What's my mother doing in Nuuk?" (Voice of the daughter)... things like that...you know...even though I try to tell her, she asks over and over the same thing..."What are you doing in Nuuk mother? What are you doing at the hospital?" ... Even though I tell her...she asks all the time...it's only her...anyway... \*\*\* doesn't understand it.

**Interviewer: How do they feel about it?**

The older ones know what's happening...they understand it They are able to live with it with it...so I was talking to the oldest, you know the baby in my tummy ...I had to go to Nuuk to get a check-up so the baby could grow...and then they understood what was happening...because the baby in my tummy wasn't growing so much ...it was the same with the middle one (child)[sic]...but the youngest had a hard time understanding...why I went to Nuuk It was a shame for her...Yeah...she cried... "What are you doing mother? when are you coming mother? I miss you...you mother...I miss you"... so I try to console her in every way and I try to be strong...anyway

Maybe I would be stronger if I had been at home...if my partner had acted right... Maybe I would make me stronger...Yeah...If it had only been like that... But there was no other way things could have been.

It had to be that way because my partner also had begun to drink...of course it is nice that I soon shall be home...yeah...I am more secure ...yeah...

With the children...Yeah...Its such a shame for the youngest The older ones understand so of course they will be happy when they hear that I am coming home to \*\*\*.

**Interviewer: Where the older children nervous when they found out that you were to come here?**

Yeah ...when I first told them they got nervous cause I had to come here...yeah... I told them that it had to be that way...they called my tummy "Aqqaluk" (little brother to a big sister)...I had to come here so that I could be checked and "Aqqaluk" could grow. They accepted it and stopped worrying...

So she said..."I thought that you were going to pick me up, mother" ...(voice of the Daughter) I was really sad...yeah...I said to her I have gone to the doctor to get "Aqqaluk" checked..."Are you sick mother? Don't you feel well?"(Daughter's voice)  
She sounded like that...(both laugh)...I said no and that we both were doing well... Are doing well Its just so that he can relax...It wasn't hard until she started to cry...it was the first time that I left her...also...went to Greenland

...Anyway ...my children... I left completely alone...the children...them...it was difficult...really hard...I don't know if I have anything else to say...(sniff and laugh)