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Reproductive Health Care Resources & Decision Making
for Women in a “Delivery Desert” in Maine

by

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Honors Thesis

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Abstract

This case study examines the reproductive health care resources available to women living in a “delivery desert” context in Maine, as well as the personal and cultural factors that influence their reproductive health behaviors. Through ethnographic methodology and in-depth interviews, I demonstrate how cultural influences converge with issues of quality health care accessibility to affect reproductive health outcomes. The island is isolated from reliable, quality biomedical care, with the nearest hospital offering labor and delivery services located over an hour’s drive away. I define this situation as a “delivery desert”, describing the phenomenon of centralizing maternity care which endangers pregnant women and their children in rural communities and limits the informed choices they are able to make about their pregnancy and delivery. I suggest that utilizing midwives and planned home births be facilitated to work around the “delivery desert” conditions, in conjunction with improved emergency services. These findings may be relevant to other “delivery deserts” in the U.S. and have implications as qualitative research at the intersection of epidemiology and critical theories of the body.

Introduction

One woman whom I interviewed for this study was a volunteer at the island's historical society. She told me the story of twin girls born on the island a century ago. We'll call them Maren and Athena: "Their father was at sea, but he must have had a telegraph. When the girls were born, Maren was evidently not very responsive. So her sister was given right to the mother, but Maren was given to her grandfather who gave her a shot of whiskey and put her in a box under the wood stove to warm her up. And she perked right up! When notice of her [birth] finally got to her father at sea, he said: 'Well, I knew about Athena, but who the hell is Maren?'" As of 2013, Maren was the island's oldest living resident.

This project is an ethnographic case study of women's reproductive health care resources and decision making on a rural, underserved island in Maine, utilizing sociological and anthropological perspectives. The island community faces restricted access to quality reproductive health care resources geographically and economically. Women of the community also face challenges in receiving comprehensive information about their reproductive health care options in the island's specific cultural context—a context which includes limited sex education provided by the local school, an intensely conservative atmosphere, and norms surrounding intergenerational transmission of relevant knowledge. This structural lack of resources combined with cultural context have led to a long history of teenage pregnancy and multiple, unplanned pregnancies.

Scholarly work has been done in the fields of rural public health and the politics of women's (reproductive) body autonomy and of marginalized bodies in general in the face of a medical institution that holds authoritative knowledge and control of biomedical technology. Due to its small size both geographically and in terms of population size, this particular island has not garnered the attention necessary to have these issues investigated. Relevant research for the state of Maine is similarly sparse, though University of Southern Maine's Muskie School of Public Health professor Dr. David Hartley has made important contributions to the field of rural public

health. On a broader scale, qualitative research such as the present study attempts to bridge the gap between policy-centered research, epidemiological studies and critical theories of power and the body in a specific cultural context. The findings may be relevant to other communities across the country that are similarly poor, rural, and racially homogenous. Resulting recommendations may benefit the way local governments, non-governmental organizations and health care systems construct access to reproductive health care in rural communities.

In this study I catalog the reproductive health care resources available to women on the island, addressing if and how the accessibility of these options has changed post-implementation of the Affordable Care Act. Through in-depth interviews and ethnographic methodology I explored how the women assign legitimacy to the various health care options available to them, including formal biomedical hospitals and clinics, traditional providers such as midwives and doulas, complementary/alternative medicine, and informal folk therapies. I attempted to understand the “hierarchy of resort” (Romanucci-Ross, 1969) for island women seeking reproductive health care. In other words, the range of resources utilized in response to medical need, the order in which those different resources are sought out, and the effect that has on both women’s access to reproductive health and which kinds of treatment/providers they seek out. I found that geographic limitations, financial and insurance status, and perceptions of the quality of providers were the greatest reported impediments to seeking reproductive health care. The quality of accessible biomedical resources was found to be lacking, yet complementary and alternative therapies were extremely underutilized in spite of their ready (if often costly) availability.

Cultural factors have an equally important impact on the women's reproductive health care decision making. These include two main factors: (1) An extreme cultural emphasis on privacy and independence. This translates to a lack of intergenerational transmission of knowledge on reproductive health options and on ways of navigating health care systems. (2) The influence of the *values* (most often conservative) of close-knit families and peer groups on women's sexual/reproductive health decision making (i.e. what the women *hear*), versus the influence of the *norms* of those same families and peers on women's sexual and reproductive health decision making (i.e. what the women *see*).

Literature Review

Rural health care access

While the topic of rural health is understudied relative to other public health fields, much important work has been done surrounding poverty, health behavior and health care access in rural America. Such studies are generally centered around the US South, as seen in Leonard Jack's article "Thinking Aloud About Poverty and Health in Rural Mississippi" (2007). In it, Jack points out the many converging factors resulting from isolated poverty that lead to negative health outcomes. These factors include the fact that almost all of the counties in America with the highest rates of child poverty are rural, that health services are limited due to the population diffusion, and public transportation to get to a hospital or clinic rarely exists at all, let alone is adequate. In keeping with many public health theorists including Beach et al. (2005), Jack also addresses the importance of health care professionals treating their rural poor patients with dignity and respect—an outcome that is rare given the prevailing stereotypes and dismissal of such people. (Of course, this analysis of rural Mississippi must take into account more racially

motivated bias than this study, which involved an almost entirely white population). Some of Jack's proposed solutions to these issues are quite relevant to the present study, as he emphasizes increased listening to the actual voices of those who are the subjects of this literature. Jack also points out that policy interventions must be created and implemented in collaboration and consultation with members of these rural communities for them to be successful:

...[W]e must be careful not to impose these new ideas on poor communities without consulting with its members first. Clearly, poor communities—indeed all communities, rich or poor—are more likely to accept and participate in public health interventions if they are developed in concert with community members and if they incorporate community competencies and assets than if the interventions are developed by outsiders without consultation with those who are supposed to benefit. (2007, 3)

While some of Jack's points are generalizable to other rural parts of the country, it is important to remember that the meaning behind the term “rural community” varies greatly across America's regions. This is addressed well in David Hartley's “Rural Health Disparities, Population Health, and Rural Culture” (2004). For example, the differences between rural Mississippi and Maine culturally are too great for their public health concerns to be painted with the same brush. Hartley is at the Maine Rural Health Research Center located in the University of Southern Maine's Muskie School of Public Service. Therefore even though his study is not explicitly about Maine, he is better positioned to incorporate an understanding of the state's unique situation. He states that while “evidence that medical care contributes relatively little to health” and therefore “a pattern of risky health behaviors among rural populations suggests a 'rural culture' health determinant” (p. 1675), there are still distinct and measurable regional differences that should prevent us from leaning on the idea of a hegemonic “rural culture.” Hartley writes:

Grouping characteristics attributable to place of residence under the heading of "culture" risks the reification of this term into a tacit assumption that rural culture is based on standard societal roles that have evolved out of an agrarian history, which does not advance our research and policy agenda. . . . The question must be asked with acknowledgment of the variability and the complexity of rural culture. It must be assumed that there will be many answers to this question because of variations in the economic and educational environment and because of variations in the physical and historical environment. (p. 1676)

Hartley suggests a solution would be to utilize ethnographic methodology, as this paper does, that can focus fully on one cultural context and avoid generalizations in a way large data sets cannot.

Hartley calls for a shift in the field away from a focus on access to hospitals and other *reactive* health services towards a population health approach to rural health. In other words, a shift “upstream,” as characterized by McKinlay (1979). Hartley defends this approach by pointing out that some estimates put health care systems' contributions to health outcomes as low as 3.5%. Researchers have found that social status, education, occupation, and place of residence are significant determinants of health; in addition, other important determinants for positive or negative health behaviors are embedded in relationships individuals have with their communities at every level.

Hartley closes his paper by suggesting a three-pronged health intervention model: activated patients, prepared practitioners, and community resources (p. 1677). This model is very useful in relation to my study.

Reproductive health in rural areas

There is even less research on rural health care specifically regarding reproductive health care options in rural America. Prior research in this area, especially within sociology, is based in developing countries or US urban centers. Those who have most prolifically contributed ideas as

to how to improve the unique situation of women and children in rural America have been professionals in concerned fields, such as community/public health nurse practitioners.

An example of this is “Condom Use Among Sexually Active Rural High School Adolescents: Personal, Environmental, and Behavioral Predictors” (Haley et al., 2013). Published in the *Journal of School Nursing*, the study uses quantitative methods to point to the most common reasons sexually active high school students in northeastern rural school districts do or do not use condoms. The authors found that almost half of high school students nationally are sexually active, and that those in many rural areas are more likely to become pregnant during adolescence than their counterparts in more populated regions. Personal (age, gender, self-esteem), environmental (social norms, perceived social support), and behavioral (substance use, sexual history) factors all contribute to the decision whether to use a condom, with the greatest predictive factors related to youths’ sexual histories, such as number of partners in their lifetime. The authors explore some of the ways teen pregnancy as it occurs in poor, rural communities is a uniquely challenging issue. For example, when preventive services are available, these young people are less likely to seek them out because of the long travel distance or confidentiality concerns within their own small communities. Pregnant rural youth are then more likely to have limited access to prenatal and obstetric care. In rural areas that often face issues with poverty, the costs associated with these sexual health outcomes have a much greater economic impact. All of these factors are extremely relevant for my study in relation to the island’s high rate of teen pregnancy and the accompanying challenges.

It is interesting that Haley et al. found the strongest predictors to be personal and/or behavioral factors rather than environmental, as larger social networks tend to be credited for

such risk-taking health behaviors. Other literature on contraceptive use and pregnancy among teens and young women focuses more on familial relationships and peer group norms. Two different studies based in central Oregon explored how rural environments present unique barriers to communicating topics such as contraception between parents and children (Noone & Young, 2009), as well as how, among young women, pregnancy and being a teen mother can easily become a “fad” (Little et al, 2010). This confluence of social factors is extremely consistent with and relevant to my findings.

In their article, Noone and Young (2009) (who are also nurses) list what they have found to be the greatest factors prohibiting rural mothers from communicating openly and effectively with their daughters about contraception: (1) conservatism; (2) isolation; (3) lack of privacy; (4) stigma; (5) the paradox of the rural environment; and, (6) the uniqueness of rural life. All of these factors could easily be applied to my findings as well, wherein a prominent theme found is the very “hands-off” approach many women reported taking with their daughters when it came to reproductive health questions and issues. Similarly, in a study of a rural Oregon high school with exceptionally high rates of teen pregnancy, one young mother is quoted as saying about her child: “I didn’t want one, it just kind of happened. It’s not an accident, it just sort of happened” (Little et al, 2010, p. 8). The women I interviewed who had had children at a young age spoke similarly about their experiences.

From a more structural perspective, VanTeijlingen and Pitchforth (2010) concentrated on the changing physical availability of maternal health care services. As local maternity units are shut down due to the costs of maintaining them, larger, more centralized hospitals become the only option for obstetrical services (a phenomenon well known to the Maine island). The authors

argue that, while the larger option may have benefits, it fundamentally detracts from local identity, trust in the goods/services, and personalization of service. In the case of labor and delivery wards specifically, barriers to access include factors such as distance, cost, type of transportation available, and even cultural insulation. Just as food chains and megastores have had a key role in the development of food deserts, this centralization of maternal care and resulting scarcity of labor and delivery wards for rural women can be considered what I call “delivery deserts.”

Many scholars have written on the detrimental effects of overly medicalized childbirth (e.g. Helman, 2007). Studies have shown that, for low-risk, normal pregnancies in America, home births attended by midwives actually have better maternal and infant health outcomes and result in higher satisfaction than hospital births attended by obstetricians (Wagner, 2006). However, in the case of high-risk pregnancies and unexpected emergencies, nearby care is of the utmost importance. Thus, for island women delivery deserts can be very dangerous.

Body Politics

Within medical anthropology and medical sociology, there is a rich body of theory and research regarding the politics, medicalization, and construction of the body in the face of a Western biomedical hegemony. Much of this stems from the work of Michel Foucault, whose ideas revolutionized ways of thinking about the contemporary clinic and body autonomy. These ideas include the “medical gaze,” which describes how a physician’s biomedical training teaches them to view the patient as a medical *object* with a collection of pathological symptoms, rather than a *subject* with personhood (Foucault, 1973).

As many theorists following in this tradition assert, modern biomedical culture and practice is deeply, almost inextricably rooted in Cartesian dualism which philosophically separates the body from the mind/soul, allowing for such ingrained, largely unexamined phrases such as “my head/stomach/etc. hurts” to exist. Scientifically we understand that these maladies may be better explained as "I hurt," but this rings untrue or even ominous to the typical Western biomedical practitioner and patient. Early philosophers Descartes, Bacon and Hobbes together established this "body as a machine" concept; here, the natural universe (including the body) is a mechanistic entity that follows predictable laws discoverable by science and controllable by technology. This results, in part, from the Cartesian model of mind-body dualism, placing the soul under the rule of religion, and the body—divorced from the self—in the hands of science and technology.

These foundational critiques have opened the way for other important works that center the inherent imbalance of power between practitioners and patients in our theoretical understandings of modern medical experience. One example is the concept of authoritative knowledge. This concept describes how certain knowledge systems (Western biomedical) come to carry more weight and to be seen as more legitimate than others, usually because they stem from and are endorsed by a more dominant power base. When one knowledge system (Western biomedical) becomes authoritative, it entirely devalues other ways of knowing and healing. Thus people who practice other forms of care are dismissed, creating an environment wherein every participant sees this dominant authority as the naturally, eternally correct one. Brigitte Jordan and Robbie Davis-Floyd (1993) are two of many who apply this concept to America’s flawed—even dangerous—approach to reproductive health.

Another facet of Western medicine that has been critiqued is its tendency towards extreme ethnocentrism, exemplified by a lack of cultural competence often leading to medical noncompliance and devastating health outcomes for minority groups. In many ways cultural competence as a popular concept was created in response to structural and interpersonal issues faced by immigrant groups and ethnic and religious minorities in the pursuit of quality healthcare. Healthcare providers realized that the ability to communicate with patients in their own language and with respect for cultural beliefs that can cause different understandings of disease, treatment, and the body was important for breaking down some of the barriers to equitable care. Cultural competence was developed to be a pragmatic solution to serious issues racial/ethnic minority groups often face in their quest for respectful, informed, and equitable care. Therefore, the public health literature is vast in instructional articles focused on increasing cultural competence in various specialties such as nursing (DePalma, 2006) and health system administration (Shannon, 2010).

The most important facet of cultural competence that must be applied to this research is the idea of communication barriers. As we will see in the findings, communication issues can lead to missteps in achieving informed consent, especially regarding contraception options and delivery plans. Outside of language barriers, one reason Helman (2007) gives for potential communication issues between patient and provider is that there is an inherent culture-clash when biomedical professionals interact with laypeople. In other words, between a physician coming from the clinical world and a layperson there are inherent differences in understanding the body and medicine. Even if they were raised in the same culture (which is rarely true for patients and providers in this study, even at the on-island clinic) these different spheres of

knowledge and power create an inevitable barrier. Effective cultural competence in a clinical setting can improve physician-patient communication, patient satisfaction and compliance.

Politics of Reproduction

Most specifically relevant to this study is how the incredibly wide range of literature on body politics reviewed above has come together with feminist theories to examine the politics of reproductive rights, childbirth and motherhood. A few indispensable theorists in this field are Margaret Andersen, Robbie Davis-Floyd, Emily Martin, Barbara Ehrenreich and Deirdre English. These scholars have made immeasurable contributions to a fascinating and extremely important body of work on women's loss of bodily control and even knowledge in the face of a male-dominated society and hence a male-dominated biomedical institution.

Ehrenreich and English, in “Witches, Healers and Gentleman Doctors” (2005), present an historical account of the struggle between male medical “professionals” and mainly feminine lay/folk healing traditions in the West. The authors frame the clash between the "masculine" and the "feminine" healing traditions as one too often misunderstood as an allegorical struggle of “science versus superstition: on the one side, the clear-headed, masculine spirit of science; on the other side, a dark morass of female superstition, old wives’ tales, rumors preserved as fact” (p. 29). Such representations were a struggle for economic, political and social dominance over women healers and women in general on the part of the male professionals:

His [the male professional's] goal was not to spread the skills of healing, but to concentrate them within the elite interest group which the profession came to represent. Thus the triumph of the male medical profession is of crucial significance for our story: it involved the destruction of women's networks of mutual help—leaving women in a position of isolation and dependency—and it established a model of expertism as the prerogative of a social elite. (Ehrenreich & English, 2005, p. 30)

The authors defend their argument with an account of the medieval European witch hunts. They state that the cases against these “witches” were based in misogynistic fantasies, and motivated at least in part by the competition represented by midwives and female lay healers to the emerging male field of theological medicine. In a pattern we will see repeated, the real competition was not for the ability to effectively heal, but for the lucrative ability to attract respectable, higher-class clientele. This is the beginning of the Western “gentleman doctor” ideal that will continue, arguably, to the present day. In colonial America, because those elite European doctors had no real motivation to cross the Atlantic, medicine was again democratized and open to Native Americans, women, and people of all races because of their knowledge of the land, climate, folk healing traditions, etc. According to the authors, this lasted until white males loosely trained in theoretical medicine once again saw an opportunity to monopolize and commodify the field of healing. Rather than through witch hunts, this time they reclaimed the field by systematically excluding and slandering these healers (Ehrenreich & English, 1973).

Margaret Andersen's 2006 book *Thinking About Women* synthesized much other important work on reproductive body politics. Whichever way a society views childbirth, she argues, it is less about the actual facts of maternal mortality or other biological aspects of childbirth than it is about how that society views women and childbearing itself. Andersen explains that feminist theories are critical of the distress women experience as a consequence of the demeaning treatment they receive in medical institutions, resulting from the fact that men are overwhelmingly the ones making the decisions regarding reproductive health, both in medicine and in law. Reproduction is thus embedded in systems of social power and control, and gender is entangled with class and racial/ethnic inequalities.

Andersen notes that birth control is significant beyond individual body autonomy/relationships because it regulates sexual activity and population size. The availability, form, and cultural significance of birth control directly impacts the role of women in society. Further, the availability and form of birth control has developed into the model we now know and hold dear relatively recently. *Griswold v. Connecticut* (1956) was the first constitutional precedent making use of birth control a right, not a crime— but only for married people. *Eisenstadt v. Baird* (1972) made laws prohibiting dispensation of birth control to unmarried people, or by non-physicians or non-pharmacists, unconstitutional. Even then the actual dispensation depended on the discretion of the doctors and pharmacists, and to a certain extent (at least in this case) that is still occasionally true. This shifts birth control decisions from women to men in medical and judicial positions (Andersen, 2006).

We can see a parallel to the state of abortion policies today, wherein minors almost always need the approval of either their parents or a judge to acquire a safe and legal abortion. This is yet another case where we see women's reproductive choices and bodily autonomy being shifted to a dominant, usually male authority. Yet, prior to the second half of the nineteenth century, in the US abortion was not viewed as morally wrong (unless performed after "quickenings," around five months). It was in fact common practice, with the medical knowledge held in the hands of women. It was viewed as safe, and often assisted by midwives or physicians. The first anti-abortion laws were in 1821 and 1841, but they only placed guilt on those using unsafe methods. They were there to protect women rather than punish them. Trouble came in the mid-1800s, when abortion became a widespread phenomenon among married, white Anglo-Saxon protestant women. Because these women were often wealthy, physicians saw a lucrative

opportunity and quickly commercialized and monopolized the abortion trade—one that had previously been centered around women's bodies, knowledge, community and control (Andersen, 2006; Ehrenreich & English, 1973).

Davis-Floyd (1992) also looks historically, tracing the origin of Western "birth culture." Birth culture is defined by Hahn and Muecke (1987) as inherited belief systems regarding the perceptions of conception, pregnancy and birth among specific cultural groups which "informs members of a society about the nature of conception, the proper conditions of procreation and childbearing, the workings of pregnancy and labour, and the rules and rationales of pre- and postnatal behavior" (Helman, 2007, p. 169). Davis-Floyd places these origins of Western birth culture in the ideas Descartes, Bacon and Hobbes, whose contributions to Western biomedical understandings—in which the body belongs to science and is separate from the mind, which belongs to religion—have already been discussed. Davis-Floyd further argues that Christian theology held women as inferior and closer to nature, so that the philosophers' idea of body-as-machine made the male body the prototype of the machine and the female body a deviation from that, and therefore "inherently abnormal, defective, dangerously unpredictable and under the influence of nature, and in need of constant manipulation by men" (Helman, 2007, p. 170). Davis-Floyd argues that the death of midwifery and the prevalent metaphor of woman's body as a defective machine were the philosophical basis for modern obstetrics.

Brigitte Jordan (1993) (in a book revised and expanded by Davis-Floyd) also discussed women's knowledge, hierarchical access to technology and distribution of knowledge:

"Throughout the labor, participants work hard to maintain the definition of the situation as one where the woman's knowledge counts for nothing . . . what the woman knows and displays, by

virtue of her bodily experience, has no status. Within the official scheme of things, she has nothing to say that matters in the actual management of her birth” (p. 157). Only practitioners are allowed ownership of authoritative knowledge, and it is distributed hierarchically even among them. The mother, on the other hand, is entirely excluded. Her knowledge is entirely delegitimized, even by the woman herself.

Methods

To complete this ethnographic study, I lived on the island for three months as an overt researcher, but also an integrated member of the community. These roles were possible to reconcile as I had previously lived on the island for several years, and in a neighboring town for the majority of my life. During the three months of research I took field notes of my experiences and interactions that were relevant to this study. I located and visited every formal biomedical clinic and complementary/alternative medicine provider within a 20-mile drive from the island’s center that offered reproductive health care services. I defined reproductive health care services as any care related to or providing: birth control, STI screenings or treatment, screenings or treatment for certain types of cancer, abortion, fertility treatments, prenatal care, and delivery. I catalogued these resources, the specific services they provided, and their economic and geographic accessibility for the purposes of understanding the full range of options available to an average island resident.

I personally had appointments at two off-island biomedical clinics (one hospital that was part of a larger health system and one private clinic) that were within the 20 mile range, and two holistic, alternative providers (one on-island and one off-island, but within the 20 mile range). However possible, I scheduled these appointments to address various reproductive health needs.

At the hospital, I received a birth control consultation and prescription that was covered by my insurance. At the smaller, private clinic I received a well-woman exam that was covered by my insurance excluding the cost of a cervical cancer screening. At one of the holistic providers I received a treatment to lessen the effects of premenstrual syndrome. At the other, I attended a yoga class accommodating pregnant women. Both of these services did not accept any form of insurance and had to be paid for out of pocket. These visits were especially relevant to the issues at hand due to the fact that I acquired my Maine state-covered health insurance through the Affordable Care Act marketplace, and so the services I acquired were commensurate to those economically and geographically accessible to island women. After each appointment I recorded extensive, thorough and detailed field notes of my experiences.

In addition to visiting these health care facilities, I also interviewed island women. To recruit interview participants, I posted flyers around the island and handed them out at certain women's organizations, as well as utilizing my personal connections with individuals living on the island. From there I used the snowball sampling method to find women willing to be interviewed about their experiences regarding reproductive health care. I interviewed twenty women, in interviews lasting from 30 minutes to three hours. All women were asked the same, prewritten questions regarding their experiences and perceptions of reproductive health care for island women. Specifically, these interviews addressed the following questions: 1) How do they as individuals, together with the community, assign legitimacy to different providers and construct a hierarchy of resort? 2) How did their perceptions of socioeconomic class affect this? 3) Has this changed for them with the implementation of the Affordable Care Act? And 4) What is the prevalence and perceptions of informal folk therapies on the island? All women

interviewed were 18 years of age or older and had been full-time residents of the island for most of their lives. Many were born and raised there, but that was not a required qualification. Confidentiality was highly stressed in these interviews. All identifying information was kept confidential and never recorded on paper. The name and specific location of the island is also being withheld in this paper because the small population size and tight-knit nature of the community would otherwise risk interview participants being identified by their reported opinions or life experiences alone.

Finally, I conducted extensive research on the history of the island, specifically that relating to women, medical resources, and local folklore of health and reproduction. I did this through examining primary and secondary historical sources at the local historical society and public library.

Results

The island has a long history of strong women supporting each other through hard times and leading their community. Women's organizations were instrumental in building the island's first medical center and recruiting nurses, dentists and physicians to work there, and in leading public health efforts on the island since then. The population also has a long history of high rates of teen pregnancy and multiple, unplanned pregnancies that continues today. Reproductive health care resources are extremely limited for the island women, with the nearest labor and delivery ward located over an hour away from the island's center. Therefore the women tend to construct their hierarchies of resort around proximity first, and a sense of "warmth" second, with very slight room for adjustment based on past negative experiences. This is a fairly reliable model, regardless of the actual medical quality of the providers. While there are many complementary/

alternative medical practitioners based on and around the island (e.g. massage therapists, prenatal yoga instructors, chiropractors and energy healers), these options are hardly ever utilized by the island women. The majority of the women reported having insurance, so cost of services was rarely reported as a barrier to accessing health care. However, for the minority without insurance, cost was emphasized as a major barrier. Additionally, the latter group did not report finding the Affordable Care Act helpful to their situations. The highly conservative culture of the island emphasizes privacy and independence. This translated to concerns about gossip, as well as limited intergenerational transmission of relevant knowledge.

History

Folklorist Horace Beck wrote of Maine in 1957: “One of the first impressions that the outsider has of Maine is that its inhabitants are individualists, each going his own dour way. Nothing could be further from the truth. Consciously or unconsciously, the Mainite is a conformist to a pattern—different from the rest of the country perhaps, but a conformist none the less” (p. 65). While I will argue that individualism is indeed an important value among the island’s residents, otherwise this quote is as apt today as it was then. Similitude and a quiet tribal-mentality (along with hard work and remarkable stubbornness) have always been the backbone of this community, and in many ways are responsible for its survival. It is important to have an understanding of this history in order to fully appreciate the potential of the island, and of its women especially.

One of the island’s earliest European-descended residents was born on the island in 1799. She was her parents’ youngest daughter, and so duty obligated her to wait until all her other sisters had been married before she was allowed to marry her own longtime beau. He built her a

one-and-a-half story house, which is still standing on the island. Together they had six children, only two of which lived to adulthood. She lost three children in one winter—and two in one day—when “distemper” swept the island. She is recorded saying that she never could have survived the grief if not for the support of the friends she had in a ladies’ “benevolent society” which she herself had founded. Together, they gossiped, held fairs, and raised money by selling their quilts and knitting. Their crafts were quite lucrative, and they funded several charities as well as building the island’s first library. Members of this society were extremely influential on the island. They also supported each other through good times and bad, often adopting the children of members who died young. They mourned the loss of their founding member when she died in the home her husband had built her, at age 108 (DeJoy, 2014).

The benevolent society, based in the principals of temperance, did not last forever. However, some incarnation of the women’s group has always existed on the island, because influential and supportive women have always existed on the island. As a public health committee, they brought nurses to the island to give “baby clinics.” As a woman’s club, they fundraised to build and open the island’s first medical center, and then they fought to staff it. When they were unable to attract a full-time physician to the island, a Family Nurse Practitioner stepped up. She held office hours in the Island Clinic, made daily house calls, and put on family planning clinics. Over 20 years later, one of the island’s first female physicians began practicing family medicine and obstetrics at the Island Clinic. Today, many of the doctors and nurses who work at the Island Clinic are women, and women-led health initiatives live on outside of the clinic as well (DeJoy, 2014). Despite this, flawed treatment by the nearest hospital goes unchallenged, even when it closed its labor and delivery ward. Inadequate sex education at the

local school is taken for granted. No effort is made to ensure that island women are informed and knowledgeable about their reproductive lives and health care options. The spirit of community-building and community-leading lives on among the island women, but it must be revitalized in this realm.

Population

I interviewed 20 local women. My only requirements were that they were at least 18 years old and were from the island or had lived there for most of their lives. While most of the participants had never lived off-island and had a long family history there, some were “transplants” or had spent time elsewhere before moving back. Their occupations included bar tending, massage therapy, catering, and administrative work. Many of working age had part time or seasonal employment and were mainly homemakers. Others were retired or receiving state support. Two attended college full time and held summer jobs on the island. Every participant was white, which is representative of the island’s demographics.

(Insert fig. 1, Appendix A)

The participants’ ages ranged from 18 to mid-90s (my oldest interviewee refused to specify her age). Seventeen of the women, or 85 percent, had children or were pregnant at the time of the interview. Six (30%) had three or more children. The average number of children was 1.75 per woman (not counting step-children). Eight participants (47%) reported having had their first child by the age of 21.

Most of the women reported having had unplanned and/or teen pregnancies. This was consistent across the generations. Victoria, a woman in her 60s, presented a typical story:

My first pregnancy was a surprise, yes. . . . I think [the father] said “maybe we should get married.” (Laughs) Or something like that, I don’t know. He wasn’t devastated. I got pregnant soon after I got out of high school, and we had been going together for two years, so I don’t know. I think he figured I was old enough to be married and he was old enough to be married and provide for a family, which he did. And so we got married and lived happily ever after, almost. I think I was 18, he was 21, but back then that was the normal age to, you know... A lot of people went to college but a lot of people didn’t, so.

Andrea was in her 50s. Her report of her pregnancies was similar:

With my first [child] it was difficult, because I was young. I wasn’t ready. So I’d have to honestly say, being excited was not unfortunately how I felt because I was too young. It happened. However, you know, you do what you do... we had her; we’re very glad that we have her, just because she’s grown up to be a very fine young lady. And I had [second child] just a year later, so [first child] was only a year old when... and then [second child] come along exactly a year later, and it was very overwhelming for me at 18 years of age. Very overwhelming. . . . Being young, we just did our best.

Allison, a mother of three in her thirties, was also consistent. When asked whether she was trying to have children when she got pregnant, she answered: “No. All three: no’s.” And, when asked how she felt when she found out she was pregnant, she answered:

I think all three times, I was a little bit excited, a little bit nervous. There’s a lot that plays into having a kid. I don’t know. I was probably more excited with [first daughter] because I didn’t have two other kids like with [third daughter]. I was never... I didn’t cry about it. It wasn’t ideal at some times but I love my kids— they’re all nice little girls... Overwhelmed!

None of these three women noted particularly strong feelings of regret or resentment about their young, unplanned pregnancies. While we may be able to pick out an undertone of regret in their narratives, especially in Andrea’s, it is subdued. This is related to the fact that, while several of the women did discuss feeling overwhelmed when they found out they were pregnant, this was not accompanied by a sense that their pregnancies were interrupting their

plans or larger goals. They indicated that it was the norm to become pregnant in high school or immediately after graduation, and that while they had not been actively trying to conceive, they weren't trying hard prevent pregnancy, either. Like the young women interviewed in Little et al.'s (2010) study, many of the Maine women—while still in high school—had seen motherhood as a kind of impending inevitability, and approached it with ambivalence or even a passive acceptance. An example of this mindset comes from my field notes. One night, while at a restaurant on the island, I heard a young woman seated at the bar tell her friend: “I can go in his truck now that I’m fixed. I used to say, ‘every time I go in his truck I get knocked up.’” With these mindsets, both groups could call their pregnancies accidents and reject full fault while still seeing teen pregnancy as only “a 'situation,' not a problem” with many benefits (Little et al, 2010). In fact, only one woman I spoke to reported serious feelings of distress about an unplanned pregnancy. Emma, the only teenager I interviewed who already had a child, had planned to attend college on an athletic scholarship when she became pregnant due to a birth control failure. Emma’s story is consistent with the numbers we can see in the below charts. Figures 2 and 3 reveal that, although almost half of the women had children by age 21, 85% reported using hormonal birth control.

(Insert fig. 2 and 3, Appendix A)

Emma’s experience reflects what will be shown in the section on reproductive health care resources: that inadequate doctor-patient relationships (including poor communication perhaps

due to cultural differences and/or lack of respect) and inaccessible care can have a major impact on women's health outcomes.

Anna's first pregnancy was planned, even though she was also in her teens at the time.

Now in her 40s, Anna reflects:

Were you trying to have children when you got pregnant?

Anna: "Yes."

How long did you try for?

"Three months. . . . I didn't think it would happen quite so fast. I went off the birth control pill and I waited the three months that I was supposed to wait and that fourth month I got pregnant."

How did the father react?

"He was terrified. We were 18 and 20. He was not as excited about it as I was."

Did you tell him you had stopped taking birth control?

"I did. I said, 'the rest is up to you.'"

Bailey, who was attending a prestigious four-year college, gave a vivid picture of this teen pregnancy trend, based on her observations of the island high school:

There are a lot of kids just in my class [who have children]. Like, at one point I tallied it up and it's like, the number of girls going to a four-year college is about the same as the number of girls who had a baby or are now pregnant. And that was sort of mind blowing to me. But, in my class there were four girls who were pregnant or had babies by the time that I graduated. And then, since then, three more of them have gotten pregnant. It's always surprising, like, "oh, there's another one." I can get out my yearbook and be like, "this one has a baby and this one has a baby and..." There were six babies out of my class, moms and dads, and none of them with each other; so like six separate babies. And my graduating class was thirty-two kids, so yeah.

Lastly, Andrea's story shows how this trend is passed on through generations:

I had just had—bam, bam—two right in a row. I was graduating when I was pregnant with my second child. I was graduating high school. And my mom was a great help. If it hadn't been for my mom, I couldn't have graduated, I couldn't have done it. . . . [My mother was 18 when she had her first child.] That was a normal thing because women back in those days usually didn't go to college. They got married, had their kids... She had just about graduated when she got pregnant with her first. But then she started having them: year-and-a-half, year-and-a-half, year-and-a-half, year-and-a-half. Four: boom, boom, boom, boom.

Andrea’s story in conjunction with the other quotes seen here are a clear testament that the trend of unplanned and teen pregnancies is neither a thing of the past nor a new development. It is an accepted tradition ingrained in the island’s culture, and apparently not entirely related to birth control access. However, reproductive health care access in general cannot in any way be discounted in the experiences of the island women. This will be explored further in the following section.

Resources

There are six towns within 20 miles of the island’s center. Within that radius, I located three biomedical providers offering reproductive health care services and ten complementary/alternative medicine practices offering services related to reproductive health. I also was able to verify three midwives working within the radius, two of which were affiliated with Nearest Hospital.

(Insert table 1, Appendix B)

The closest hospital to the island with a labor and delivery ward was outside of the 20 mile range, so it has not been included in the table. When referenced in the interviews, it is called “Far Hospital.”

Thirteen of the participants, or 65%, explicitly reported that they choose the closest hospital or provider available to them when they need health care. This factor was not always to the exclusion of other considerations, however. I asked all the women interviewed what their “hierarchy of resort” is when they need reproductive health care services—in other words, what

their first, second, and third choice providers/hospitals are when in need. Those who stated that their first and second choice resources were *other* than the first and second closest ones had either had negative experiences that had driven them further away, or had health conditions that necessitated seeing specialists at the state's larger hospitals.

Bailey said: "Mostly, I look for convenience. So, at [her college] obviously the health center is the closest place and it's open a lot so, you know. And here, [Island Clinic] is the closest place." Lucy, the oldest woman I interviewed, had experienced life on the island before Island Clinic was built. Before then, for on-island resources they relied on local doctors who made house calls, or had to make the long trip to mainland resources. She said: "Because they're nearby. That would be the reason [to choose a provider]. [When I was young] you didn't have a lot of choices. Now of course we do, down to the medical center there's a number of doctors there now. But you sorta got one [at Island Clinic] and that's who you stay with."

Carmen made another important point: "Options that are off the island, um... not really great either. I mean, you've gotta go to [Far Hospital] basically. Which is a huge distance, huge expense, huge time crunch. And so I don't think I utilize as much as there is out there as a result, and I don't think that most people do. I think, you know, we just kind of ignore it until crisis happens." She hints here at perhaps the most significant barrier to access facing the island women: geographic isolation. Several factors are associated with the island's geographic isolation: the time it takes to drive to a provider/hospital, the cost of gas associated with traveling that distance, and whether the woman even has access to a car, or must find someone to give her a ride. There is no public transportation to or from the island. Victoria told a story of having to deliver one of her children in her car, when the drive to the nearest delivery ward was too far:

“When [second child] came along, when I realized that I was in labor, in about 20 minutes she was born. Which brought me to the — Road in [nearest town that delivered at the time]. So she was born in the front seat of the car. . . . She was fine by the way, healthiest of the bunch.” Here we see an example of the consequences of “delivery deserts.” Had Victoria had any complication during delivery, the distance to the nearest delivery room could have had devastating effects.

When asked what qualities they looked for in a hospital/provider the participants’ responses were quite consistent. Along with geographic proximity, the most important factor for the island women was the perceived friendliness and respect of the providers. Allison said: “You know, like being able to communicate. And like friendliness or like bedside manner. It’s important how they treat me, would be my biggest thing.” Lily agreed, saying she looks for “someone that listens to you, where you don’t feel like you’re being rushed along. And I think respect, considers your own wisdom around your body or your life or your child, now that I have children. I don’t need to be talked down to – that kind of thing isn’t going to work.”

Another woman, Carmen, had had vaginal cancer. She was an anomaly in my findings in that she was a firm believer in alternative/holistic health care.

(Insert fig. 4, Appendix A)

To treat her cancer, Carmen chose to see a homeopathic doctor in Maine’s largest city, which was over three hours drive away. She drove to her homeopath’s office and back every two weeks for three months: “I had vaginal cancer and there was no one around who could even speak to

that . . . It was a pain in the butt, but it was what had to be done to get better.” Despite the uniqueness of her story, Carmen’s preference for certain providers was the same as the other women’s: “My gut feelings and relationship with the person once I meet them. I’ve been to providers before where I feel like they don’t really listen. They don’t take the time to listen.”

Anna’s preferences were still consistent, but her words reflect the poor quality of the actual health care that sometimes comes with proximity and warm atmosphere: “Um, for me it’s the general atmosphere. How I get treated by everybody. It wasn’t the most cutting edge hospital, but everybody from the custodians to the surgeons were so friendly over there, it just made you feel comfortable. Like they cared.” So in contrast to Anna, Carmen was able to travel the hours necessary to get what she saw as cutting edge care, but that is not everyone’s choice or option.

Within these very consistently reported standards of judgement, the women’s “hierarchy of resort” generally followed suit. As noted above, for the most part their first, second, third and even fourth choices were in order of distance with slight room for adjustment based on perceived personal connections with the providers. Ironically, however, this hierarchy of resort did not match their reported perceptions of the medical *quality* of their chosen resources and of the quality of care they received there. Most women made their decisions based on proximity and “warmth” rather than medical authority. A perfect example of this comes from Carmen: “I’d go to the [Island Clinic first]. Yeah, I’d go on the island. Because of ease of location. However, their services, when they are open, are horrible. I mean they basically just say ‘go to the hospital. Go to [Nearest Hospital].’ So I’d go to [Nearest Hospital next].”

One woman I met had adjusted her hierarchy of resort to account for negative experiences she and her family had had with the closest providers. I recorded our conversation in

my field notes; she said that her mother had gone to Nearest Hospital to have her appendix taken out, and the doctors there had missed a common complication which had resulted in a life-threatening emergency. She said, “When I get pregnant, I’d rather die than go to [Nearest Hospital].” I wrote in my field notes: “People don’t trust [Nearest Hospital] but they still go there because it’s the closest thing.” To fully understand this, I made an appointment with an available OB/GYN at Nearest Hospital for a birth control consultation. As my field notes show, I was quite dissatisfied:

This was a terrible experience, extremely clinical and hurried. He was very curt, and it seemed like he wanted me in and out as soon as possible. He gave me a second to say what I was looking for and then listed three options. He didn’t really listen to what I had to say . . . I was prescribed Nexplanon, the hormonal implant, and he cut open my arm and inserted it right there. After I left, I realized I didn’t know how soon it would be effective, or many other details like that. So I looked it up online and—as well as finding some pretty simple, easy answers to many of my unanswered questions—I also discovered side effects that he had failed to mention even though that was the main thing I had repeatedly asked about (the second time I asked this, rather than answering more thoughtfully, he just said maybe I should go home and think about whether I actually wanted birth control). I also found a list of medications that would deactivate it, which reminded me of the interview with the girl who had become pregnant at 16 because she didn’t know antibiotics would cause her birth control to stop working—it must have been a similar situation.

As I left the doctor’s office, a receptionist handed me a sheet of paper that informed me I would be scheduled for a follow-up appointment within the next few days. I was never scheduled for the follow-up appointment. Many of the complaints I had with Nearest Hospital could have been remedied with more self-advocacy. I learned that it is challenging for a woman to effectively self-advocate in a medical setting when she is shamed by a male OB/GYN for trying.

As tempting as it is to say I would never return to Nearest Hospital for reproductive care, I understand why it remains at the top of many women’s hierarchies of resort. It is the island’s most accessible hospital, and I did leave the appointment with what I had come for. Having

comparable circumstances to the island women—including relying on state-subsidized insurance—meant that I left with a hierarchy of resort similar to what they reported. As I wrote in my field notes, “my need would override my aversion.” A competing first choice for reproductive care would be the small Family Practice in the same town. My appointment there had the warmth and professional quality that was lacking at Nearest Hospital, and the proximity to the island was the same. However, an appointment there required the ability to pay up-front, and not all of the services could be reimbursed by state insurance. This could be a barrier for many women, as I will now discuss.

Another factor in where the island women sought reproductive health care was financial constraints. Some women reported the perceived impact of their income and/or socioeconomic class as a barrier to seeking reproductive health care services. For example, Anna said:

Definitely I have to take [income] into consideration when my doctor is saying, ‘oh, you should have this blood test done, and this done and this done’ and, you know, I ask what is the most important thing you want me to have done, and I will do those, but I can’t afford to do those [others]. So, there are things that I would like to have done and my doctor would like to have done that I can’t afford to have done, like a mammogram I haven’t done yet.

When asked how much income and insurance status affects her health care choices, Carmen said: “It affects 100% what I do for medical care. . . . My husband and I . . . we’re not anywhere near the federal guidelines for being poor. We’re dirt poor.”

Maine, along with the specific health system associated with both Island Clinic and Nearest Hospital, offers vital insurance and financial assistance options to low-income residents. Perhaps thanks to these financial resources, fewer women than I anticipated reported income as having an impact on their access to reproductive health care resources.

(Insert fig. 5 and 6, Appendix A)

However, of the 15% of women whom I interviewed who reported being without insurance coverage, a surprising number reported trying to gain health care insurance through the Affordable Care Act and finding it inaccessible. This was mostly due to concerns over the cost of the policies offered through the healthcare marketplace. Lily had this to say: “No, we pretty much make too much money for Obamacare and not enough money to fork over \$1,200 a month for private insurance, which is what it would be for us. We got really excited about all the changes, we thought it would be a great thing for us but it wasn’t all that different with pricing or anything.” Carmen expanded on this:

I do not have insurance through the Affordable Care Act because it is not affordable. I don't work—well, I work at the library, which is not working. Um, my husband works, he doesn't make a lot of money. So you'd think we could get subsidized. And because I have so many medical issues, when I have insurance . . . we go through the deductible usually in three months. . . . There's no way. I can't afford that. That's not affordable health care. So I don't have it. It's actually cheaper for me to maintain my own health . . . and [pay] the fee for not having health insurance than it is for me to have health insurance. Which is crazy.

Anna’s reason for not getting insurance under the Affordable Care Act was one many Americans had in 2013: discouraging technical difficulties, then procrastination, and finally economic concerns:

Well, when I tried to [sign up for insurance through the Affordable Care Act], I couldn't get onto the website. I was sent to a waiting room for days. And then the day came, it went, and I never really did anything about it (laughs). Like, well, I guess I'll just take the penalty this year and search for something next year. At some point, yes, I would like to get health insurance. But it's hard to find something affordable that offers any type of coverage.

Culture

The women interviewed, along with my own ethnographic observations, revealed some of the island population's most important values. Two of these, perhaps the most integral and time-honored, were the values of privacy and independence. These are undoubtedly tied to the island's long legacy of dependence on seafaring industries (fishing and lobstering, building, captaining and crewing ships), all occupations which are highly individualistic, involving long hours spent in near-isolation with even survival at sea based on complete self-reliance. One woman told me an illustrative story: a class from the island's elementary school had gone on a field trip to one of the state's colleges. There, a marine ecologist spoke to them about lobstering's effects on sea life. He told them about a whale that had gotten tangled in the long lines that connected a fisherman's lobster traps to his buoys, and that after hours of struggling and much injury, the whale had finally been cut free. One of the young boys in the class—a fisherman's son—had raised his hand and asked, "But did he get his traps back?"

These values could also be related simply to the rural, secluded location of the island; not only have the residents been separated from their neighbors by long, often hard-to-traverse dirt roads, but they have also had to exist very independently from mainland resources (medical and otherwise). This was especially true before the bridge connecting the island to the mainland was built. Even now, in the long winter months the bridge is often impassable. All these factors contribute to the fierce, even defensive ethos of privacy, independence and self-reliance that is palpable on the island. Lucy states: "[My daughter], she's the kind of person who you don't tell what to do. That's the way I feel, don't anybody tell me what to do." Bailey has translated this ethos to her opinion on reproductive rights (a stark exception to the general conservative stance of the island's population): "Definitely it's important to me that I'm going to [a provider] who

isn't avidly pro-life or something, you know, like, um, I don't know that I would get an—like I probably wouldn't get an abortion if I found out I was pregnant—but I believe that it's really important that it's my choice and not someone else's."

A point made by Haley et al. (2013) regarding the perceived social risks of seeking sexual health services in a small, tight-knit community was one brought up especially frequently by participants in my study. Many of the women connected the importance of privacy to their worries about small town gossip. As some women pointed out, even if one trusts a medical practitioner not to break confidentiality, there is still a factor of awkwardness attached to most likely having other, additional social bonds with that practitioner (e.g. if they are also your neighbor, relative, classmate's parent, etc.). While that awkwardness may seem like a small price to pay for sexual health, it can be prohibitive especially for young women without a thorough sexual education who decide they would rather "risk it." Bailey also had an opinion on this:

So now, most of my friends are in college, and even if they're in college and they're coming home for the weekend, I'm like 'probably [get reproductive services] up there.' Just because they are trained specifically for that age group, and they are away from anyone on the island. So that way, even though I don't think there's a lot of gossip about like, 'oh my gosh, this person came in for a [birth control] shot!' or something, that way, you make it impossible, sort of, for anything like that to happen.

Other women applied this concern to leaving the island for reproductive health care services.

Victoria said: "One [woman] that I know would go to [Far Hospital] just because of the anonymity thing. She doesn't want anybody knowing... small island, you know? They see you at the medical center, something's going on with you, you know." Emma's narrative was consistent: "I think on the island, like I said, people talk about it. So if something's going on like everybody knows about it and they'll like, judge you. So I think that's a little different than like being in a city or something."

Another effect these values have is on the intergenerational transmission of knowledge related to sexual health and reproductive health care between mothers and daughters. Specifically, most women who had daughters presented a clear theme of withholding related advice from them. Most of the women who did not have daughters (either because they had sons or because they had no children), when asked to give advice to a hypothetical daughter, gave surprisingly similar answers. Even when the women had opinions, this did not necessarily translate to the women feeling the right or duty to give advice. The most common phrases used here resembled “she knows what she’s doing,” and “she’s her own person.” Victoria said:

I don't recommend too much to my daughters. I dunno. Take care of yourself, I guess, the best you can. . . . Don't wait until you're 45 to have kids. . . . Well, I think with your daughters, unless 'it'—whatever 'it' is—is a problem, you're better off to keep your mouth shut. Because sometimes daughters resent advice. They might take it from somebody else better than they would their mother.

Lucy said: “No. I don’t give ‘em advice. I’ve got one grandchild that lives here on the island and she’s got four kids. I snarl and fuss about that because there’s no need to have that many kids any more.” Andrea’s story of her daughter’s pregnancy at age 19 showed much trust in her self-knowledge and decision making also:

What kind of advice did you give your daughter when she was pregnant?
Andrea: “Well, probably the usual things. She pretty much knew what she, you know, was supposed to do. I really didn't have to tell her a lot. She just knew. She was 19, and she knew how to eat, how to take care of herself, and she did a very good job with it. So, I really didn't have to give her advice. She's always been her own person.”

Madeleine said:

[My step-daughter] went on birth control at 14, with her mother's... her mother did it. And I didn't agree with it because I believe you can only be on birth control for so many years before it starts messing things up. But apparently it didn't because she has two beautiful little girls. . . . I suggested she breast feed, I think it's the healthiest thing for the child, and she said no. That wasn't for her. That's probably about the only

recommendation I gave her. . . . We tried to get her to not smoke while she was pregnant but that didn't work. . . . I didn't really give her any recommendations. I just let her do her thing.

Based on all this, one might presume that the island women lack an adequate support system. I found this to be far from the case. Networks of friends and especially families are surprisingly close-knit. There are a handful of island clubs and organizations specifically for women, the most notable of which is a club for “fishermen’s wives” who organize fundraising and recreational community events. All of this is consistent with the island women’s long and rich history of supporting each other through harsh winters, dangerous pregnancies and family tragedies, often while their male family members were at sea for months at a time. Anna tells a sentimental story:

My sister-in-law, my husband's sister, got pregnant. She was due seven weeks before me. And she had chosen this doctor in [Far Hospital]. And since my husband was trip fishing and gone all the time, I decided to use the same doctor she did so we could go together. And as it turned out, she went a week overdue and I was a week early, so our boys were only five weeks apart. So that's pretty much why I chose that doctor, was so I would have somebody to go to the doctor with (laughs).

I found that this support does not need to be emotional or even spoken out loud; it is quiet, downplayed and incredibly powerful and tenacious. A child who needs a home will be taken in by a distant acquaintance before he or she is sent into foster care off-island. A young mother whose husband is lost or injured while fishing will be uncomfortably overfed by neighbors, relatives and local business owners for at least the following year. While the power of these familial and community relationships can cause pressures to conform—as in the trend of young marriage and motherhood—it is also one of the island’s most powerful assets, with great potential.

Finally, it is important to note that the island’s dominant culture is highly conservative and religious. I had many interactions with people which supported this when they found out the

topic of my research. My historical research also supports this. Folklore has it that there was once a young woman of “dubious morals” who snuck out of her parents’ house one cold night to meet a young man. When she returned, she found that they had locked her out in shame. Despairing, she drowned herself in the well. Her grave, which still exists on the island, reads “She Done What She Could” (Beck, 1957, p. 75).

There are a surprising number of churches on the island, of various Christian denominations; driving along one of the two main roads that cross the island, one wonders how the small population sustains so many roadside churches. This religiosity intersects with the focus on privacy when it comes to the island school’s sex education, which is subpar and receives little support. Bailey tells her experience of taking a sex education class at the island school:

I remember in 7th grade or something we did the like, ‘this is how you put a condom on a banana!’ And there were a bunch of kids– they had to send home this letter that was like, ‘we’ll be having sex-ed this week in science class’ or whatever class it was, and there were a bunch of kids who were pulled from it because their parents just didn’t want them knowing it yet. And at the same time, like, I had to get one of my friends Plan B when we were in 8th grade, so. It’s hard.

All of this also leads to most people holding anti-abortion sentiment, even if they do not connect it directly to their religion. Allison, for example, discussed wanting her daughters to get on birth control so that they wouldn’t need an abortion: “I don’t want them to get pregnant before they want and I don’t want them to live with the guilt of having an abortion. *[Here she clarifies emphatically that she does not speak from experience]*. Having a vacuum cleaner suck the baby out of them is pretty traumatic and I don’t want my kids to go through that.” In fact, the topic of abortion was so taboo that it was barely ever mentioned during the interviews. One woman told me that her daughter had tried to write an essay on abortion for one of her classes at the island

high school. Her teacher had told her the subject was too inappropriate and forbidden her from writing it. Only two women admitted to having had an abortion: one woman, who had no children and said that she had never wanted any, and another woman who was a “transplant” from New York City. Another woman said that she had considered it when she first found out she was pregnant, but ultimately could not go through with it because she felt that it was morally wrong.

Discussion

Women have a rich history of mutual support and community-building on the island. They also have a history of high rates of teen pregnancy and multiple, unplanned pregnancies. Both traditions continue today. Reproductive health care resources are extremely limited for the island women. Their hierarchies of resort tend to be based first on proximity, and second on atmosphere. This remained fairly consistent regardless of the medical quality of the providers (real and perceived), with slight room for adjustment based on past negative experiences. There are many complementary/alternative medical practitioners based on and around the island, but these options are underutilized by the island women. Because of the state’s insurance program and available funding from Island Clinic and Nearest Hospital, the women rarely reported cost of services as a barrier to accessing health care. However, for the minority without insurance, cost was emphasized as a major barrier. The Affordable Care Act was not reported as helping those women access health care, mainly because they did not find the insurance options in the marketplace any more affordable than options they had already been aware of. The conservative culture of the island emphasizes privacy and independence, which translated to concerns about

gossip and limited intergenerational transmission of relevant knowledge. Despite the supportive community of women, cultural pressures perpetuated issues related to reproductive health.

Cultural competence may not seem like a theoretical framework that can be applied to the almost entirely white, Christian population discussed in this research, many residents of which can trace their family line to the town's founding. I argue that the concept is in fact relevant, in part because the isolated nature of the community has created a distinct cultural identity. For example, providers should be understanding of the population's staunch ethos of independence and self-reliance, and that medical advice presented as an imperative or in any way that seems condescending will most likely be distrusted and even rejected by the island residents.

Until relatively recently, the island women had to travel about 20 miles to the nearest hospital to deliver their children. Now that that ward has closed, from the island's center the nearest hospital with a delivery room is approximately an hour-long drive away. This is in optimal conditions; bad weather and the long winters' heavy snowfall often leave the bridge to the mainland dangerous to cross at best. As many of the island's women live in poverty, the cost of gas to travel to the delivery room can be a serious concern, if they have access to a car at all. This is an exemplary case of the phenomenon of centralizing maternity care described by VanTeijlingen and Pitchforth (2010). Despite the long trip to the delivery room, one woman even reported that the hospital tried to send her back home to wait until her contractions were closer together. This ties into the cultural competence issues discussed above; it is fundamentally disrespectful if not reckless to ask a woman to travel an hour back to her home—while in labor—and make the return trip when the birth seems more impending. It also shows a poor understanding of the hurdles involved for these women.

“Delivery deserts,” as I have referred to them, can be found in rural areas all across the country. In Alabama, women can travel up to two hours to access obstetrical services, and the number of counties with hospitals with delivery wards is *falling* all the time (Vollers, 2015). Not every woman chooses to deliver in a hospital setting, nor should she, as research has shown that midwife-assisted deliveries—even in a home birth setting—can actually be *safer* for normal, low risk pregnancies (Wagner, 2006). However, every woman should have the right to access to a delivery room. Many high-risk pregnancies necessitate this, and if complications arise during home births, quick access to a hospital is essential for the mother and child’s health. The fact that emergency care is so far away could even be a factor in why so few island women choose to take advantage of the midwives that offer home birth services in their area. Therefore not only are delivery deserts dangerous for rural women, but they also inhibit the choices they are able to safely make about their delivery plans and preferences. This is a public health issue and a reproductive justice issue that should be recognized and prioritized much more than it is today.

As previous research has shown, culture and access to health care resources are distinct but inextricable forces affecting population health behavior and health outcomes. This is very much the case for women on this Maine island. While access to quality reproductive health care was found to be poor, various factors (e.g. MaineCare health insurance, local health system coverage) meant that it was not usually prohibitive to accessing birth control and other preventive reproductive health care services. The paucity of quality reproductive health care resources did not have as much of an impact on unplanned and/or teen pregnancies, according to the island's women, as did cultural factors and expectations. One of these factors was the cultural emphasis on privacy and independence. This can lead to women foregoing some care due to

anonymity concerns, as well as to a lack of intergenerational transmission of knowledge on reproductive health options and on ways of navigating health care systems. Another facet was the contradictory values and norms that the island women were exposed to. On the one hand, conservatism and religiosity were extolled, meaning comprehensive sex education was fought against and abortion was taboo. On the other hand, the reality that young women on the island were exposed to was one of multiple generations of young, unintended pregnancies. Bringing those seemingly at-odds forces together, it is clear to see how the latter wins out more often than not.

Yet, as some of the women interviewed demonstrate, the influential powers of culture, community, and family on individual actions and beliefs were also not an absolute barrier to island women who wish to avoid pregnancy; in short, if they are aware of their options, they are often able to control their reproductive lives. This shows that what the island women truly need, first, is more thorough reproductive health care information. In part this means more comprehensive sex education at school as well as a wider campaign to educate and empower the population regarding their reproductive health care options.

Secondly, I argue that the island women should extend their historical ethos of independence, self-reliance, and trust primarily in the self-knowledge of oneself and one's community to their own bodies. During my research, I met with a professor at one of the state's colleges. She, too, had noticed with concern the lack of helpful "folk knowledge" surrounding healing and wellness in Maine's rural communities, worrying that it further disempowered women there and disconnected them from their reproductive health. She was not shocked by this, however. Instead, she attributed it to the male biomedical takeover of medical knowledge and the

discrediting of midwives and other female healers. Her reasoning was analogous to Ehrenreich and English's (1973) thesis in their groundbreaking feminist book *Witches, Midwives and Nurses*: when male "regular doctors" professionalized and monopolized medicine—especially obstetrics—not only did they relegate women to subservient roles, but they also destroyed a remarkable legacy of women (capably, compassionately) healing women within their own communities. With such a rich history of embodying those qualities, the island women should reclaim their reproductive health. These women are the ones who know what kind of sex education will be effective, how to best increase birth control compliance within their own community, and how pregnant women can be encouraged to safely and comfortably engage with midwives within the delivery desert context. It is not the right of others to decide what the priorities or values of these women should be; they simply ought to be given more information and options, along with the will to control their own lives and bodies rather than passively accepting the authority of dominant institutions.

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APPENDIX A

Figure 1

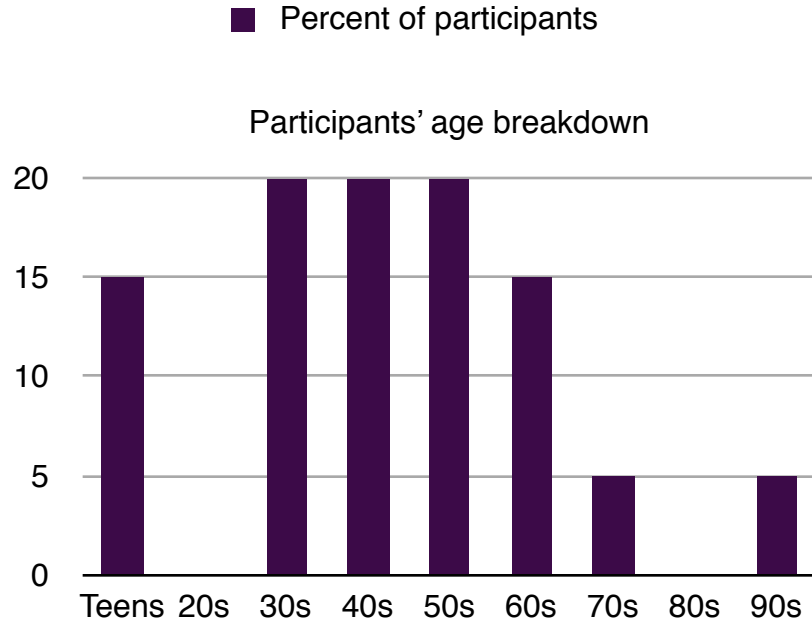


Figure 2

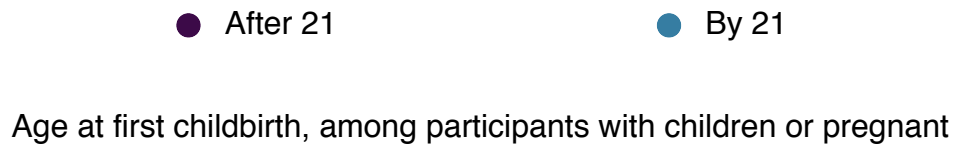


Figure 3

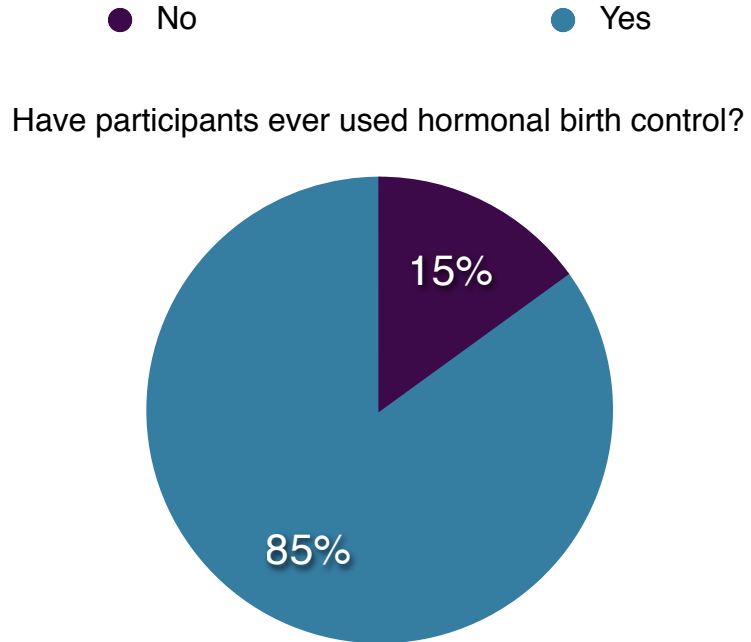


Figure 4

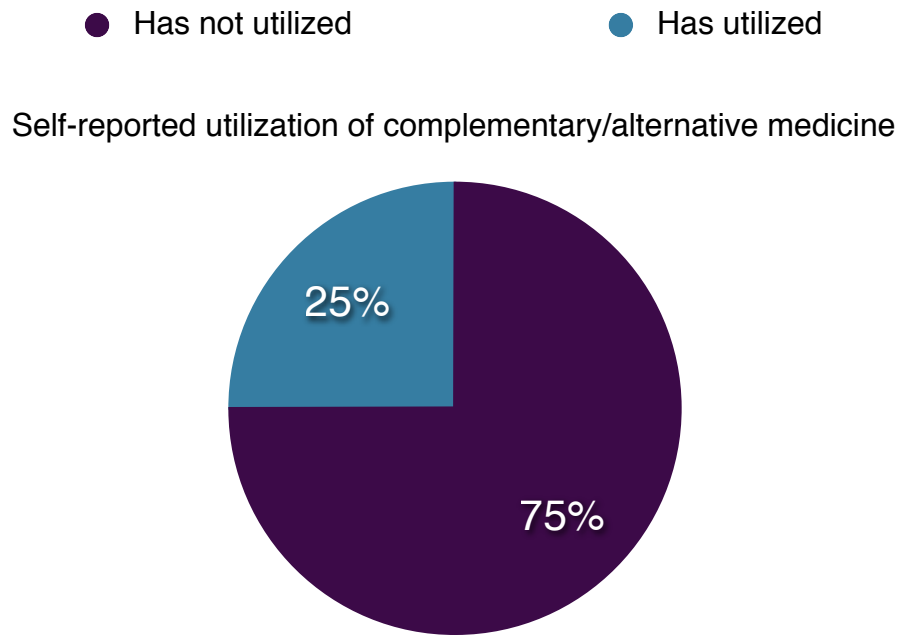


Figure 5

● Does not have insurance ● Has insurance

Do participants currently have medical insurance coverage?

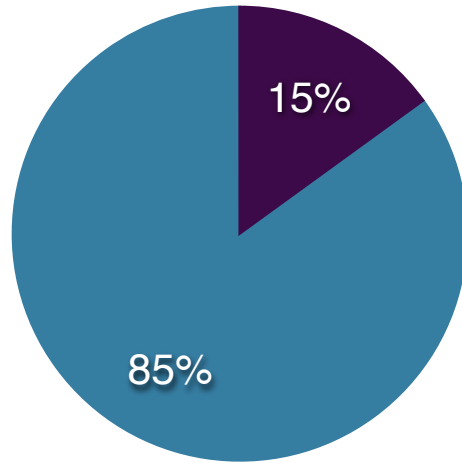
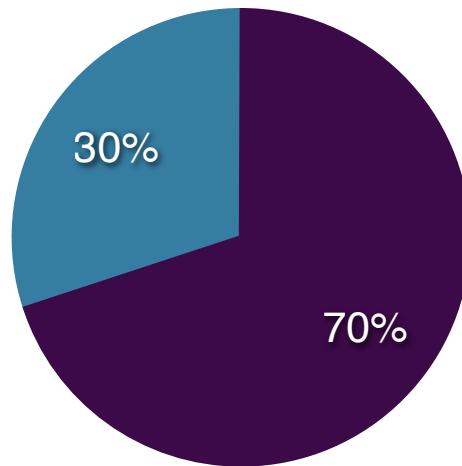


Figure 6

● Income has no impact ● Income has impact

Participants' self-reported impact of income on access to health care



APPENDIX B

Table 1

Provider	Type	Accepts insurance?	Has labor & delivery ward?	Distance from island
Island Clinic	Biomedical	Yes	No	On-island
Nearest Hospital	Biomedical	Yes	No	Approx. 20 miles, 40 minute drive
Family Practice	Biomedical	Through reimbursement	No	Approx. 20 miles, 40 minute drive
Island Massage & Reiki	Complementary/ Alternative Medicine (CAM)	No	No	On-island
Island Chiropractor	CAM	Case-by-case	No	On-island
Yoga & Wellness	CAM	No	No	Approx. 20 miles, 40 minute drive
Shamanic Healing	CAM	No	No	Approx. 15 miles, 30 minute drive
Off-Island Chiropractor	CAM	Case-by-case	No	Approx. 20 miles, 40 minute drive
Integrated Medicine Practice	CAM	No	No	Approx. 20 miles, 40 minute drive
Off-Island Massage & Reiki	CAM	No	No	Approx. 20 miles, 40 minute drive

Provider	Type	Accepts insurance?	Has labor & delivery ward?	Distance from island
Healing Center	CAM	No	No	Approx. 20 miles, 40 minute drive
Prenatal Yoga	CAM	No	No	Approx. 20 miles, 40 minute drive
Abdominal Therapy	CAM	No	No	Approx. 20 miles, 40 minute drive
Midwife 1	Midwifery	Yes (when practicing through Nearest Hospital)	n/a	n/a
Midwife 2	Midwifery	Yes (when practicing through Nearest Hospital)	n/a	n/a
Midwife 3	Midwifery	No	n/a	On-island