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"You do what you have to do for the babies": The Pregnancy Experiences of Native American Women

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ABSTRACT *Settler colonialism has contributed to disproportionate reproductive health disparities for Indigenous people, however the majority of literature surrounding pregnancy, centers the experiences of White individuals. This paper uses data from a qualitative study exploring reproductive health of Indigenous persons from a United States Gulf Coast tribe to elucidate the pregnancy experiences of 31 tribal members. In interviews, participants described how and from whom they learned about pregnancy and birth, their experiences with miscarriage and complications during pregnancy, working during pregnancy and lack of post-partum or maternity leave, and generational changes in pregnancy. These findings highlight the impact of previous reproductive experiences and family support during pregnancy for women from this tribe. The data also draws attention to the importance of paid leave in the postpartum period and provides an example of collaborative research methods with Indigenous communities.*

KEYWORDS Indigenous; Native American; American Indian; pregnancy; reproductive justice; birth justice

Introduction

There exists relatively little peer-reviewed scholarship specific to the pregnancy experiences of contemporary Indigenous people. What knowledge does exist tends to focus on discrete medical outcomes (e.g., pre-eclampsia,

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teen pregnancy) in contrast to using more holistic or life-course approaches. Current research shows major health disparities exist for Indigenous people in nearly all realms of maternal health. The Center for Disease Control (CDC) has reported much higher rates of complications during pregnancy among Indigenous people as compared with their White peers, and that Indigenous birthing persons are more than twice as likely to die from these complications (CDC, 2020). The top three causes of maternal mortality for Indigenous people during pregnancy are cardiomyopathies, hemorrhage, and hypertensive disorders (Heck et al., 2021).

Current health disparities research also indicates that Indigenous women experience mental health disorders at a disproportionate rate (Raglan et al., 2016). For example, it is estimated that Indigenous women experience more major stressors in the year prior to pregnancy and delivery than any other racial group (Lu & Chen, 2004; Whitehead et al., 2003). Both mental health challenges and emotional stressors are connected to negative birth outcomes and higher rates of preterm birth (Raglan et al., 2016). Indigenous women are also impacted by higher rates of physical health risks like high blood pressure and diabetes, lupus, obesity, and chronic kidney disease, which are tied to pregnancy and birth outcomes and exacerbated by disparities in health equity (Raglan et al., 2016). Although research shows higher rates of miscarriage among women of color, there are relatively few studies that focus on Indigenous persons' experiences of miscarriage more specifically (Gibney & Yang, 2019; Mukherjee et al., 2013).

Data surrounding Indigenous health disparities are important for raising awareness, but do not capture the lived experiences of those most affected. Investigating disparities from the perspective of Indigenous people provides valuable context and richness to these data. This article centers the voices and experiences of Indigenous people using a holistic, life-course approach. This research is unique for its regional focus. To our knowledge, the pregnancy experiences of state-recognized tribal members or of tribal members located in the United States Gulf South, have yet to be explored.

This research builds upon previous research utilizing a resilience and strengths-based approach to look at Indigenous health concerns (Burnette & Figley, 2017; McKinley et al., 2019) and is informed by the Framework of Historical Oppression, Resilience and Transcendence (FHORT) (Burnette & Figley, 2017). Our research question is, "what are the pregnancy experiences, resources, and barriers described by members of a United States Gulf South state-recognized Indigenous tribe?" Semi-structured interviews with 31 members of a state-recognized Indigenous tribe were conducted. The study was specific to participants who identify as cis-gender women. The authors recognize that future research could benefit from exploring the pregnancy experiences of Two-Spirit and non-gender conforming Indigenous individuals. When citing specific research studies, the authors will use the same gender identifiers used by the study. When referring to pregnant people more

generally, the authors strive to use gender inclusive language. The authors recognize that each tribe, community, family, etc., is unique and that the experiences featured in this article are not generalizable to all Indigenous people. However, prior research has shown that the health disparities experienced by Indigenous people in the U.S. are often also experienced by Indigenous people globally (Akter et al., 2019; Voaklander et al., 2020), and exploring in depth the specific experiences of Indigenous birthing people in U.S. tribes may shed light on these issues in other contexts, specifically in other regions impacted by settler-colonialism such as Canada, New Zealand and Australia.

Recent conceptualizations of reproductive justice have emphasized peoples' right to pregnancy and birth support of their choosing, medical or otherwise. This right is important to the reproductive justice framework, in light of the medicalization of pregnancy and childbirth. The process of medicalization has led to defining pregnancy and childbirth as medical phenomena, and has taken place over time and in conjunction with medical advances (Conrad, 1992). While advancements in maternal and fetal medicine have been extremely valuable for lowering maternal and infant mortality, the medicalization of pregnancy and childbirth has narrowed conceptualization of these life occurrences to the determent of more holistic approaches. Viewing pregnancy and childbirth strictly in medical terms is in contrast to many Indigenous concepts of health (Gracey & King, 2009; King et al., 2009). While medicalization assumes that a deficit or issue exists, an Indigenous holistic viewpoint uses the concept of balance to describe and address many phenomena of life (Gracey & King, 2009). Additionally, medicalization positions medical professionals in the role of expert, and fails to account for other types of knowledge and knowledge keepers (Conrad, 1992).

The medicalization of pregnancy and childbirth has encouraged the social control of birthing people by medical professionals (Conrad, 1992). This power dynamic can be further exacerbated by social injustices like racism and settler colonialism. The history of gynecology itself is rooted in violence and racism, as many common gynecological procedures were developed by experimenting on people who were enslaved (Owens, 2017). The reproductive experiences of Indigenous people in particular have been strongly influenced by settler colonialism (Gurr, 2014; Hancock, 2016; Theobald, 2019). In the early 20th century, there was an effort to medicalize pregnancy and childbirth among Indigenous people who gave birth on reservations (Theobald, 2019). This took place in tandem with a broader trend in national healthcare advocating for medicalization as a means of reducing maternal and infant mortality (Theobald, 2019). The movement towards medicalization of pregnancy pathologized the use of midwives, traditional healers and ceremonies, and often failed to improve health outcomes. For example, although Indigenous pregnant people were encouraged to rely on healthcare facilities, these facilities were often inaccessible. As a result, the ability to receive regular prenatal care or

emergency maternal healthcare was severely limited for Indigenous birthing people (Theobald, 2019). Despite the push to medicalize, midwives continued to be used by Indigenous birthing persons throughout the 1900s, and resistance against the pathologization of Indigenous birth practices continues today through the maintenance of traditional practices (Theobald, 2019).

Family and community members, and specifically mothers, grandmothers, aunties, and sisters, play an essential role in providing knowledge and support for pregnant Indigenous people (Dalla et al., 2010; Hancock, 2016; Gurr, 2014; Long & Curry, 1998; Theobald, 2019). For example, among some tribes the expecting parents would relocate to the grandparents' home so that the family could be assisted by biological kin throughout pregnancy, birth, and the postpartum period (Hancock, 2016). Perinatal traditions vary among tribal groups, but often entail that special care be taken with the disposal of the placenta (Long & Curry, 1998). Traditional beliefs about pregnancy include the belief that pregnancy is a normal and natural event that does not require extensive medical intervention, that child rearing begins prenatally, and that important knowledge about pregnancy is passed down to younger generations (Long & Curry, 1998).

Colonization has interrupted this passing down of traditional knowledge and the use of familial support, negatively impacting Indigenous maternal health (Hancock, 2016; Long & Curry, 1998). A history of gross reproductive injustices including high rates of coercive sterilization and forced separation from their children, as well as ongoing institutional racism, has also led to distrust in Indian Health Service (IHS) or the medical community more broadly (O'Sullivan, 2016; Theobald, 2019). As a result, the rate at which Indigenous pregnant people have sought formal prenatal care has been impacted (Long & Curry, 1998). Additionally, stigma surrounding contraception and sex outside of marriage has increased with the growing influence of Christianity and has led to changing believes and values, and less open communication within families (Gurr, 2014; LaFromboise & Heyle, 1990; Mihesuah, 1996; Theobald, 2019; Weaver, 2009). These barriers have affected traditional sharing of knowledge and values surrounding pregnancy and childbirth.

This study investigates the pregnancy experiences of Indigenous women from a United States Gulf Coast tribe. Using a holistic life-course approach, this research provides valuable qualitative data related to the experiences of contemporary Indigenous women who have given birth. These data contextualize existing health disparities research and fill an important gap in scholarship by centering the voices of Indigenous women.

Methods

Research Design

The study used qualitative descriptive methodology. This approach avoids excessive interpretation, maintains cultural context, elevates the voices of participants and is useful for creating information that can be readily transformed into action (Burnette et al., 2014; Sullivan-Bolyai et al., 2005). Guided by qualitative methodology, we strove to honor the words of participants and avoid extrapolating values and ideals from their experience. As such, this approach is well-suited for performing culturally appropriate research with Indigenous groups (Burnette et al., 2014; McKinley et al., 2019; Sullivan-Bolyai et al., 2005).[1]

Setting and Participants

The identity of the Indigenous tribe in this study will remain confidential throughout this project, as recommended by guidance regarding culturally sensitive studies (Burnette et al., 2014). The participants of this study identify as tribal members but were not required to prove tribal membership, because of the historical challenges associated with demonstrating proof of enrollment (Cochran et al., 2008).

The first author is an academic researcher and identifies as a cis-gendered woman of European descent who has benefitted from being a multi-generational United States citizen. She had worked on research projects in collaboration with this tribe for several years before beginning the current project and was invited by one of the Community Advisory Board (CAB) members to do this research. She is honored to work with the tribe in this study. The first author met with tribal leaders and CAB members several times while developing the research project to help ensure the project was culturally appropriate and consistent with tribe's goals. The second author is a doctoral student in Public Health and a novice researcher, who identifies as genderqueer. As a white researcher, the second author has carefully considered how these data are presented and edited to honor participants' words and has reflected on her role in this process. The third author is an Indigenous woman, mother and Indigenous health researcher. She is from the Fort Belknap Indian Community where she is an enrolled Aaniiih Tribal Member. She is also descended from the Cree and Blackfeet Nations. She approaches her research

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[1] Additional related articles emerging from this study include Buxbaum et al. (2023), Carlson & Liddell (2022), Doria & Liddell (2023), Hicks & Liddell (2023), Liddell & Herzberg (2022), Liddell & McKinley (2021, 2022), Liddell & Meyer (2022), Liddell & Stiffarm (2023), and Sheffield & Liddell (2023).

with an Indigenous epistemology, where Indigenous traditional knowledge has value, just as western-based research. As an Indigenous researcher she is committed to doing work that embodies respect, relevance to Indigenous communities, reciprocity, and responsibility. It is with this background that she approaches her work as an Indigenous researcher studying perinatal health.

The first author conducted semi-structured interviews with 31 Indigenous tribal members who identify as women. The criteria for participation in this study were adulthood, identifying as a cis-gender woman, and stated tribal membership (Burnette et al., 2014). Participants were recruited using a combination of purposive and snowball sampling. All participants were over 18 years of age. The oldest participant was 71 years old and the average age of participants was around 52 years. A large majority of participants (87.1%) held a high school degree or equivalent and around half (51.61%) reported continuing education or additional training into adulthood. Most participants (93.54%) described having health insurance. The majority (83.87%) of participants reported having one or more children. On average, participants were 20 years of age when their first child was born and described having two to three children in total.

Data Collection

Approval for this project was obtained from Tulane University's Institutional Review Board (IRB) (study #2018-467), as well as the Tribal Council's IRB process. To aid with cultural relevancy, a community advisory board (CAB) was established, comprised of tribal members who also identify as women. The CAB helped to develop interview questions and assisted with recruiting study participants and disseminating results. Interviews were performed between October 2018 and February 2019 by the first author after informed consent was obtained from all participants. The CAB suggested interviewees be provided $30 gift card to either Amazon or Walmart as compensation for their time. Examples of interview questions are "how did you first learn about childbirth, reproduction, contraception, sexual health?" and "can you tell me a little bit about being pregnant and giving birth?" Participants chose the locations of interviews, which were mostly in interviewees' homes or in community buildings used by the tribe. Permission for the interviews to be recorded and transcribed was provided by participants. The average length of an interview was 66 minutes, with the shortest lasting 30 minutes and the longest lasting 90 minutes. Data and transcriptions were both analyzed using NVivo software (QSR International, 2015). Data are not available to share due to research ethics and privacy restrictions.

Data Analysis

Qualitative content analysis was used to examine the results. After reviewing the recorded interviews several times, the first author created a list of general themes and codes using the interview transcriptions. Then more refined coding was performed to create a hierarchy of codes (Sullivan-Bolyai et al., 2005). This analysis was also informed by Milne and Oberele's (2005) strategies for establishing rigorous standards for qualitative studies. These strategies include (a) flexible and methodical sampling, (b) encouraging participants to speak openly and freely, (c) accurate, word for word transcription, (d) coding derived from participants' direct accounts, and (e) contextual analysis. Upon completion of the project, member checks took place to provide participants with a summary of results. The CAB provided feedback throughout data analysis to provide context for quotes and to review findings. All participants who expressed the desire to know the results were contacted by the first author at least twice. Results of the research were relayed to the tribal council through tribal meetings and gatherings.

Results

In talking about their pregnancy experiences, women discussed the difficulties they encountered and the roles that family and partners played throughout the process. They spoke often about complications during pregnancy, including blood pressure issues and severe nausea and vomiting. Family members who had also experienced pregnancy and birth were described as influential throughout pregnancy in providing guidance and reassurance. Women's previous pregnancies, and in particular their experiences with miscarriage, frequently influenced their later approach and perspectives on childbearing. The types of pregnancy experiences that were most often described by women included how and from whom they learned about pregnancy and birth, experiences with miscarriage, complications during pregnancy, working during pregnancy and lack of postpartum or maternity leave, and generational changes in pregnancy. These categories of experience are addressed in turn below.

"I had a mother that I could always go to": How and From Whom Participants Learned About Pregnancy and Birth

Most women spoke about relying on family members for advice and knowledge during pregnancy. For example, Participant 12 stated that she learned what to expect in pregnancy and birth from a variety of sources, including her family practitioner and her gynecologist, from her own research,

and from a community of her mother's friends: "My first one, no it wasn't a gynecologist…. It was Dr. [name omitted]. And he was a family practitioner… He was so sweet. And then my second one, I went to a gynecologist." She also described doing her own research and reading to learn more about pregnancy and childrearing:

> I did a lot of reading… I guess they gave me some [materials] at the hospital. I went to the library. I love to read. So I would read all the time… And they used to tell me, 'You can't raise a baby by a book.' But I potty-trained my kids by the book. So I was always reading. So anything I could get a hold of I would read.

This participant recounted learning from her mother's friends who would come to her mother's house each morning to talk and have coffee:

> Yeah, they would come to my mom's house in the morning and they would drink that coffee. They would come and drink coffee. And then they would be talking about all kind of stuff. I would ask them questions.

In describing her experience with her mother and her mother's friends, she indicates that birth and pregnancy were normalized in her family. Later, she sought resources and knowledge on her own, in addition to asking her doctors for information and care.

Other participants also described feeling comfortable talking with family members about pregnancy and childbirth:

> I had a mother that I could always go to and I['d] call her… 'what is going on? Is this normal?' And she had 11 [children], so she was definitely in the best position, the best doctor. So she said, [participant's name], she said, 'It's normal. Don't panic. You're okay. You don't have to run to the doctor.' So that's a lot of our [people], didn't have to go to the doctor. Cause, we had a mother that she's been through 11, so she could help me. (Participant 13)

For this participant, her mother's prior experience with pregnancy and childbirth was especially valuable. She describes trusting in her mother's experiential knowledge and relying on her to provide guidance and emotional support. The quotation above shows how family members, particularly mothers, were frequently viewed as experts in pregnancy and childbirth.

In this role, mothers were described as normalizing pregnancy experiences, "like if I was bleeding or if I had severe pain or this was painful or, and she would just explain things like that's normal. You're going to go through that" as well as providing important guidance on when to seek medical care:

> You know, and she knew now, when I was about to deliver, she said now, 'Don't you have that baby at home.' So she would tell me, 'Go [to the hospital], don't play with it.' So, she would always… advise me what to do and I would always take her leading.

The latter quote demonstrates how a participants' mother was helpful in navigating labor and determining when it was time to go to the hospital.

In addition to support from family members, participants also described receiving knowledge from formal supports, like birth classes:

> I did take a birthing class… I took it at [hospital name]… I forgot what it's called, but it was just to help me learn about the birth process, the after process… things that I could do now and after, to help me, help my body get back to normal… that was a three series class… it was helpful… they covered everything that you can think of, okay, they even went through the pain. Like what it's going feel like. And all they kept saying it was, it wasn't bad, or it wasn't good. It was just something that you've never experienced before. So, don't think it hurts. Don't think it, you know, it's just something you haven't experienced. So learn to take it as it comes, and it's going to last a minute, and it's gone in a minute. A minute and then it is gone. (Participant 14)

This participant found learning about pain management from the class to be particularly helpful and stated that she would recommend taking a class like this for new mothers: "Yeah. Cause that pain, I've never felt that pain before." Participant 17 reported getting most of her information from her monthly prenatal visits with her doctor:

> He [the doctor] was very kind and… if I had questions he would answer and if I needed to go in… I liked him. That's why I stayed with him… you would go like monthly and then in the later part [of the pregnancy] every week or every two weeks… and he would check… my blood pressure, my health, and then you would discuss the baby… but then the ultrasound and stuff, we didn't have that.

This participant reported getting important health information from her doctor. She notes that her pregnancies took place before ultrasounds were routinely performed at her hospital. Her quote demonstrates that there was an opportunity to talk about the baby and potentially ask questions.

Women described the importance of getting knowledge about pregnancy and childbirth from both formal sources (such as hospital-run childbirth education classes) and informal sources (most frequently female family members). This knowledge then influenced women's own perceptions and experiences of being pregnant and giving birth, as in the case of one woman feeling more prepared for the pain of childbirth because of taking classes, or another women describing being able to ask her mother what was normal and be reassured throughout her pregnancy.

"That's why my daughter's an only child": Miscarriages Experienced by Participants

Several women reported experiencing miscarriages. Although experiences with pregnancy loss were not specifically probed for, six women reported experiencing at least one miscarriage. These experiences were described as very trying and difficult, though most women did report going on to have full-term pregnancies. Participant 9 stated that her miscarriage following the birth of her first child was so painful it kept her from ever wanting to get pregnant in the future:

> And I got pregnant a second time, but I miscarried, and I was almost five months pregnant. Yeah. It was a long time ago. It was rough. And then never wanted to try that again, so... that's why my daughter's an only child. It was sad. Did I do something wrong? Did I pick up something I shouldn't have? But they [the doctors] just said, 'We can't explain it. It just, probably, Mother Nature's way of saying maybe it didn't work.' I don't know, so... [I] never tried again. I didn't want to go through that again. It was rough.

Participant 31 also described experiencing miscarriages, which made her cautious during her future pregnancies:

> I had had a miscarriage before. In between the last, the two boys… I forgot what she had called it. It's where… you had the sack, but the baby doesn't make it, so it's your body is acting like it's pregnant and it's not anymore. So, I had the miscarriage and then whenever I started noticing the spotting coming back again I called, and she told me as soon as I found out I was pregnant to come in because it's something to do with progesterone levels, so I wasn't able to… keep a pregnancy going… before I got pregnant for my daughter, she [her doctor] had diagnosed me with PCOS… after the miscarriage… they had put me on the progesterone and that's what sustained the [following] pregnancy.

This participant attributed her past miscarriages and difficulties in pregnancy to her diagnosis of polycystic ovary syndrome (PCOS). These quotations highlight the impact that previous reproductive experiences, like miscarriage, had on women's later desires and experiences of being pregnant.

"Worst nine months of my life, but then I had that beautiful little girl": Participant Descriptions of Pregnancy Complications

Most women reported experiencing at least one complication in either their labor or pregnancy. Some common pregnancy complications included blood pressure issues and extreme nausea. Complications ranged in severity. All participants described ways in which their pregnancy stories were shaped by these health concerns.

For example, Participant 12 described almost losing her second pregnancy and recounted the actions taken by her relative, which she credits with saving her pregnancy:

> For my second son too, I had a fast birth. But for my oldest son I almost did a miscarriage… my husband was out working and a friend that was living across from me, and she's related to me too, she said, 'You're not losing that baby, I'm going to tell you right now.' She said, 'You're going to listen to everything that I tell you and you're going to come and you're going to stay at my house,' she said. Because my mom and them were in [nearby state] because my dad was a fisherman… And so she said, 'You're not going to lose that baby, I'm gonna to tell you.'… And she said, 'You're going to stay lying down and you're going to keep your legs like this.' And she told me how to keep my legs and stuff. And she said, 'You're going to be all right.' She said, 'I'm telling you, you're not going to lose that baby.' And I did not miscarriage.

The participant went on to state that she feels her relative saved her child:

> I had started bleeding and the doctor told me just to go home and to take it easy. And let nature take its course, whatever it was going to be was going to be… And she [friend] always, whenever she sees us now, she always says, 'How's my boy doing?'

The latter quotation shows how a family member had a profound impact on the participant's pregnancy experience, which was recalled over time.

Many women reported having issues with their blood pressure during pregnancy. Several participants described experiencing preeclampsia, which led to their pregnancy being classified as high risk: "I had a lot of… swelling like in my arms, my fingers, my face. So they had me on like a high risk… I was still working because I had to work, I had no choice but to work…" (Participant 24). Despite being high risk, Participant 24 describes being unable to take off work to help mitigate pregnancy complications.

Another participant was able to make lifestyle changes to help mitigate pregnancy complications. Participant 20 also reported having preeclampsia: "I developed… pre-eclampsia, with her… I did do a diabetic diet with her… that was so I wouldn't get gestational diabetes and that was his [the doctor's] concern, but she was, she was healthy." This quotation demonstrates how complications during pregnancy can have a widespread effect on ones' health.

Severe nausea during pregnancy was also a complication that was described frequently. Partipant 9 reported experiencing malnutrition as a result of this pregnancy complication:

> Miserable. From the day I conceived that child to the day I had her, I threw-... my guts up. I couldn't keep it [anything down]... Matter of fact, I lost 60 pounds. I weighed less when I had her... One thing that I didn't throw up, coffee. But it was

> miserable. I was so uncomfortable. I kept saying, 'Oh, my god, is the baby okay?' [The doctor would say], 'The baby's getting what she needs... [but] you're not.' It was horrible. And she [daughter she was pregnant with] got pregnant and never had a sick day for either one of those children.

This participant went on to report receiving fluids from the hospital to treat her nausea and dehydration:

> A few times I was put in the hospital because I was so dehydrated. Then they would give me fluids and send me home. But, no, that was pretty much the extent of what they did for me. It was… It was horrible. Worst nine months of my life, but then I had that beautiful little girl.

Though nausea and vomiting are common complications of pregnancy, this quotation demonstrates how severe occurrences can lead to serious health concerns. Although the pregnancy was extremely difficult for the participant, she describes feeling that it was worth it because she had her daughter.

Women described a variety of pregnancy complications. In many cases, they reported relying on family support to deal with these complications, as in the story of the woman who attributes her ability to carry to term to the advice of her family member. They also described barriers to mitigating complications like being unable to take off work, and not receiving comprehensive treatment for severe nausea. These complications deeply impacted participants' pregnancy experiences and had severe health consequences for some. Giving birth to a healthy baby was viewed as fortunate and "worth it."

"You do what you have to do for the babies": Participants' Reports of Working During Pregnancy and Lack of Post-partum or Maternity Leave

Most women did not describe getting formal time off during their pregnancy or after giving birth. Many women spoke about working right up until the day they went into labor and expressed that formal maternity leave could have been beneficial. Participant 24 recalled being at work when she had a seizure from high blood pressure and went into labor:

> My youngest… I worked to the date, the day that I actually had to go… I was actually at work like two hours before I actually got put in the ambulance to get taken to [the hospital]… I was working and I wasn't feeling well, so I went to sit in my vehicle and my, I worked with a relative of mine, so she got her daughter to come pick me up and take me to her house. Well her house is not even five minutes from the hospital…I went, laid down, and my, my, [friend's name]'s husband liked to pick on me, so he went, and he was like messing with my feet and I was in a seizure while he did that. So he realized that.

This participant describes working up until the day that her child was born and experiencing a severe medical complication requiring immediate care. As discussed in the previous section, Participant 24 experienced preclampsia throughout her pregnancy but was unable to take time off work. The preceding quotation demonstrates how unpaid leave can be a major barrier to pregnant people's health.

Participant 27 also described working right up until going into labor – "I worked for the Wednesday. The Friday I had my son" – and stated that she felt proud about going back to work shortly after: "I went back to work right after… the independence… Six weeks. I always taught, and I teach my daughter, we're [tribe name] and we're strong." This participant viewed returning to work shortly after birth as a strength that contributed to her sense of belonging to her tribe. Although resilience is valuable, her quote may also reflect historical influence from colonial values, which prioritize paid work over caregiving. This theme reflects structural barriers as well as societal barriers that limit pregnant people's ability to take time off before and after birth.

"I had to learn it on my own": Participants' Descriptions of Changes in Pregnancy Care and Knowledge

Women with adult children or with large gaps between births often spoke about the changes in pregnancy care or childbirth that they saw or experienced over time. One change that was described frequently was an increase in the availability of formal supports and advancements in medical care. For example, Participant 17 observed the following:

> They [her children] had the ultrasound and epidural, they had the classes and when I was [pregnant], I didn't have that. They have the prenatal, you know, like you go before they'll even show you how to take care of the baby and I had to learn it on my own.

Her description suggests that changes over time have led to greater support for pregnant people. Birth classes as well as technology like ultrasounds have led to an increase in knowledge available via formal sources. As described by Participant 22, these changes have altered the experience of being pregnant: "It's different from now because back then we didn't know the sex of the child."

Discussion

Our study begins to address an important gap in the knowledge base regarding Indigenous persons' pregnancy experiences. The results indicate that participants' pregnancy experiences varied greatly, with some women describing positive experiences, and others describing negative side effects and pregnancy loss. Family members, particularly mothers, were especially important sources of emotional and instrumental support throughout pregnancy and in some cases filled in gaps at institutional levels. Women also described talking to their doctors, conducting their own research on pregnancy and childbirth, and utilizing formal supports like birth classes. These resources were described as newly available by older participants, who recounted a lack of resources when they were pregnant. Women's previous experiences with pregnancy and miscarriage also influenced how they felt about later pregnancy experiences and altered some participants' reproductive decision making. Women in this tribe demonstrated their resilience in seeking a variety of resources and supporting one another during pregnancy and childbirth, particularly when institutional gaps were present.

Accounts of complications during pregnancy were common and most frequently included pre-term birth, bleeding, high-blood pressure issues and severe nausea and vomiting. As mentioned above, research indicates that Indigenous people experience higher rates of complications during pregnancy and increased risk of maternal mortality as compared with White pregnant people (CDC, 2020). Pre-eclampsia is also more common among Indigenous women during pregnancy than White women (Zamora-Kapoor et al., 2016), mirroring participants' reports of high blood pressure issues.

Several women described experiencing a miscarriage and recounted the physical and emotional difficulties of the event. While most participants went on to experience full-term pregnancies, at least one woman reported that her miscarriage discouraged her from pursuing another pregnancy. Previous scholarship notes that women of color have higher rates of miscarriage and pre-term labor although there is a need for a focus on the miscarriage experiences of Indigenous birthing persons specifically (Gibney & Yang, 2019; Korinek & Ahmmad, 2021; Mukherjee et al., 2013).

The findings are consistent with previous health disparities research. Importantly, participant experiences provide context to these disparities and elucidate methods of resilience and coping. Family members played a valuable role in navigating complications like miscarriage and providing guidance and support during pregnancy and childbirth. Although disruptions in inter-generational care have been noted due to assimilation policies and the death of elders, participants described benefiting from their mothers or family members, indicating the resilience of traditional knowledge-sharing (Long & Curry, 1998). Participant quotes also indicated a shift in the types and number of resources available to people in pregnancy. As noted by older participants,

younger women in the tribe benefited from technological advancements like ultrasounds as well as supportive resources like birth classes. In describing where they sought knowledge, some women also demonstrated trust in their providers. However, gaps in care, specifically in response to complications, were also mentioned.

Working right up until giving birth, and a lack of post-partum leave following pregnancy was also described by participants. According to the Organization for Economic Co-operation and Development (OECD) the United States is the only OECD nation-member that provides zero weeks of federally funded paid maternity leave (OECD, 2020). Only nine states in the U.S. offer state funded paid maternity leave, none of which are located in the Gulf Coast region (Kaiser Family Foundation, 2021). Although U.S. citizens are entitled to 12 weeks unpaid leave under the federal Family and Medical Leave Act, many cannot afford to be unpaid (Kaiser Family Foundation, 2021). The primary reason cited by those who had given birth for not taking leave or not taking as long a leave as they were legally eligible for, is that they could not afford it (Louisiana Department of Health, 2019). Research shows that Indigenous women use postpartum maternity leave less than any other racial group in the U.S. (40% less than Whites) (Hawkins, 2020).

Indigenous women are twice as likely to receive late or no prenatal care compared to other groups, largely as a result of structural barriers (Raglan et al., 2016). While participants of this study did report regular prenatal care, this statistical disparity highlights the need to make culture-congruent prenatal care available and accessible. Participants reported receiving formal prenatal care, as well as relying on family and partners. These results lend support to the need for increased culturally competent and sensitive care (Johnson, 2020). Other scholars have emphasized the potential for community collaborations to improve health outcomes (Swapna et al., 2021).

The pregnancy experience of Indigenous women deserve space within the literature. It is not enough to only pathologize and share disparities about the maternal health of Indigenous women. The narrative presented in this article is novel as it differs from the common, deficit-based pathological approach commonly represented in the current literature. This approach aligns with the *UN Declaration on the Rights of Indigenous Peoples* (UNDRIP) Article 24, Section 2 which states, "states shall take the necessary steps with a view to achieving progressively the full realization of this right [an equal right to the enjoyment of the highest attainable standard of physical and mental health]" (United Nations, 2007). The UNDRIP was established in 2007 and provides a crucial framework for the minimum standards of the well-being of all Indigenous Peoples globally (United Nations, 2007). The authors' interpretation of a "necessary step" is to highlight the pregnancy experiences of Indigenous women within the literature. We believe addressing this research gap is a crucial move toward achieving progress in the maternal health disparities unjustly present among Indigenous women in the U.S. and globally.

With this goal in mind, the findings from our study demonstrate the strength and resiliency of women in this tribe. Descriptions of support from family members indicate the longevity of cultural values and traditions surrounding pregnancy and childbirth. Young participants' experiences with pregnancy differ from past generations insofar as they benefited from inter-generational knowledge as well as advancements in medical care and formal sources of support. These are positive changes, however structural barriers like poor access to paid leave and treatment for severe pregnancy complications remain.

Limitations and Future Research

A distinctive benefit of our work is the use of a life-course approach to explore Indigenous women's reproductive experiences. However, this work is limited insofar as it relies on self-report and cross-sectional data. In the future, longitudinal interviews of participants would enrich comprehensive study of this topic. Interviews were conducted solely in English. As a result, tribal members from older generations who do not speak English as a primary language may have been excluded. These results are specific to the participants' unique experiences and the results do not necessarily apply to other tribes. The experiences of federally recognized tribal members in particular may differ because of different access to resources afforded federally recognized tribes, such as eligibility to receive care from facilities. In addition, there is a need to replicate this study among various Indigenous groups and explore the pregnancy experiences of Indigenous women and birthing persons in different countries and contexts. Indigenous nations are distinct and diverse, and it is essential to avoid generalizing from one tribe to another. Another limitation is that only participants who identify as cis-gender women were included. The perspective of Indigenous partners, Two-Spirit, and gender non-conforming birthing persons would also provide important insight into the pregnancy experiences of Indigenous people. Future research would also benefit from the inclusion of midwives, doulas, and other healthcare providers. Finally, researchers should refer to the United Nations Declaration on the Rights of Indigenous Peoples to ensure their approach aligns with the framework presented. This is true for research relevant to perinatal health, especially, to address the stark research gap of strength-based approaches toward the full realization of health in the perinatal period.

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