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Childbearing beliefs among Low-German-Speaking Mennonite women

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Abstract

Background: Low German-Speaking (LGS) Mennonites are a conservative religious group that has migrated from Eastern Europe to Canada and then to countries such as Mexico. They are now returning to Canada in large numbers. They adhere to religious principles based upon a literal interpretation of the Bible. This conservative religious group provides opportunities for nurses and midwives to implement culturally competent care.

Aim: The purpose of this article is to discuss LGS Mennonite women’s childbearing knowledge and beliefs to develop and implement care that considers and includes their conservative religious beliefs.

Method: An exploratory, descriptive study was conducted to generate information through open-ended interviews with 38 LGS Mennonite women about their knowledge, beliefs and practices related to childbearing. Data collection and analysis occurred simultaneously; discussion of emerging themes were discussed by the research team to ensure a contextual understanding of the data.

Findings: The participants engage in proscribed practices (“turning the baby”) and adhere to specific dietary measures (increase dairy products) during pregnancy to ensure a healthy birth outcome. During the postpartum, extensive support is provided by other Mennonite women to assist the mother and newborn during this important transition.

Conclusions: Building trust and working in a respectful manner with religious groups such as the LGS Mennonites is a cornerstone of culturally competent nursing practice.

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Key words: Mennonite women; women’s health, childbearing beliefs, rural women, Canada, Mexico, Central & South America
CHILBEARING BELIEFS AMONG LOW GERMAN-SPEAKING MENNONITE WOMEN

Gaining an understanding of diverse groups is an important goal for nurses and midwives to ensure provision of culturally competent care (Andrews, 2008). This article presents a detailed discussion of the childbearing beliefs of one group, the Low German-Speaking (LGS) Mennonites, that has a complex history of migration from Europe to Canada and then to Mexico and Central and South America. The information discussed serves as a case example for nurses who work with similar conservative religious groups.

Low German-Speaking Mennonite Women

Mennonites are members of the Anabaptist religious group that believes in adult baptism, pacifism and a literal interpretation of the Bible (DeLuca & Krahn, 1998; Redekop, 1969; Sawatzky, 1971). In the late 1800s, large groups of Mennonites relocated from Europe, including Russia and Germany to other countries such as Canada where they attempted to freely practice their religion (Jaworski et al., 1988). Unease with the Mennonites in Canada grew in part because of their adherence to separate schooling (Janzen, 1990). In 1922, 7000 moved to Mexico where they have lived a separate lifestyle and worked as farmers (Bensen, 1998; Sawatzky, 1971). Since the 1970s, groups of these Mennonites have relocated to Canada either as migrant workers in the agricultural sector or as permanent residents. There are approximately 57,000 Low-German-Speaking (LGS) Mennonites living in Canada with most in Ontario, Manitoba, and Alberta (Janzen, 2004) where they can easily obtain agricultural work. Education is not emphasized among this group and thus a number have low literacy and technology skills. They prefer to be called LGS Mennonites to differentiate them from other groups of Mennonites such as the Russian Mennonites.
The LGS Mennonites attend different Mennonite churches such as Old Colony (less liberal) to the Kleine Gemeinde (less conservative) but not all families within these groups adhere to all the religious teachings emphasized within their church. Thus, some Old Colony families use computers whereas some Kleine Gemeinde families prefer to home school their children using a Christian-based education program. Therefore, generalizations cannot be made pointing to the need for detailed discussion with individual families about their beliefs and practices.

Information on LGS Mennonite women is limited to literature that emphasizes they were to bear many children and work silently beside their husbands (Loewen, 2001). More recent literature on LGS Mennonites in Mexico found that the women believed breastfeeding prevented pregnancy, and that speaking about pregnancy was inappropriate. For some of the participants, family planning was seen as sinful because children were considered to be gifts from God. During pregnancy, women did not engage in heavier work (e.g., milking cows), and during the postpartum period they received assistance from family and friends to ensure an adequate rest (Reinschmidt, 2001). Therapeutic abortions are not supported by church doctrine (Brenneman, 1979).

Other information generated about Mennonite women in Canada reveals that a silence pervades over childbirth leading to an anxiety when discussing such topics (Martens & Harms, 1997). Two recent studies with LGS Mennonites (Kulig, 1995; Kulig & McCaslin, 1998; Kulig et al., 2002; Kulig, et al., 2004) both noted that there was limited knowledge shared about childbearing. Further understanding of this group’s knowledge, beliefs and practices in relation to childbearing was identified as necessary by the regional health care delivery system in order to plan and deliver appropriate care with this group.
Aim

The purpose of the research was to generate in-depth information about LGS Mennonite women’s knowledge and beliefs in relation to sexuality (from menses to menopause) (Kulig, Babcock, Wall & Hill, 2006; Kulig et al, in press). This article is limited to discussing beliefs and practices related to pregnancy, labor and delivery among LGS Mennonite women. The information discussed here is useful in developing culturally competent nursing care for this group while serving as a case example of the challenges and rewards of working with other conservative religious groups.

Methods

A qualitative research design was used to conduct an exploratory, descriptive study (Sandelowski, 2000; Tuck, 1995). Ethical clearance was received from the first author’s institution. Successfully conducting research with LGS Mennonite women has required attention to their social and religious beliefs including not using technological devices such as tape recorders during the interviews (Hall & Kulig, 2004; Kulig, 1995; Kulig & McCaslin, 1998, Kulig et al., 2002; Kulig et al., 2004). It has also been essential to collaboratively conduct the research with non-government and clinical agencies that provide services to this population and to communicate with the leaders and community members of the larger LGS Mennonite community about any ongoing and completed research.

Four LGS Mennonite women were trained by the first author to conduct the interviews. These women were carefully chosen and thus the RAs were not in the same Mennonite communities as the participants. The training included discussion about Low German terms for key concepts (e.g., menses, pregnancy) prior to the commencement of the interviews. For example, there is no word for “fetus” in Low German, and hence “baby” is the term used during
pregnancy and after delivery. Pregnancy is referred to as “being in a different time” (schwanger or droagent). Low German terms vary by geographic region and hence we chose words that are used in our area.

Open-ended interviews that included questions related to all aspects of women’s health were conducted with 38 Low-German-speaking Mennonite women until data saturation occurred (Schatzman & Strauss, 1973). For example, the participants were asked about foods and activities during pregnancy and then probed for specific examples of foods eaten or avoided. Short notes were taken during the interviews. Subsequently, the RA would go to a private location and tape a summary of the interviews, including quotes from the women. The tapes were then transcribed for analysis.

Both purposeful and snowball methods were used to select the sample (Morse, 1989; Streubert, 1995) from throughout Southern Alberta, Canada where 12-15,000 LGS Mennonite reside. A range of participants were included to ensure that they represented demographic variation such as age, length of time in Alberta, marital status, and childbearing experiences. The RAs received informed consent from the participant and then collected demographic information before commencing the interview.

Data analysis and collection occurred simultaneously; the continual reading of the transcripts led to sorting of categories (Glaser, 1978) and constant comparison (Glaser & Strauss, 1967). These categories were discussed at the research meetings where lengthy discussions helped ensure that a contextual understanding, identification and verification of tentative categories in relation to sexuality and reproductive health were developed. The categories are descriptive (Charmaz, 1983; Swanson, 1986) and substantive (Carpenter, 1995; Glaser, 1978) to ensure that a more complete understanding of childbearing among the LGS Mennonites was
achieved. Trustworthiness of the data (Lincoln & Guba, 1985; 1986) was established by hiring Mennonite women to conduct the interviews, including the entire research team in the analysis of the transcripts, and using quotes to ensure that the women’s voices were heard.

The study limitations included the manner of taping that may have led to the loss of some details; the RAs did not always clarify comments made by the participants nor did they always sufficiently probe all topics. For example, not all of the participants were asked about their experiences with depression.

Findings

Demographics

Of the 38 participants, all were married except one who was separated. One woman was a second wife to a man who was widowed with a child. There were 13 who were in the 30-39 age category, 9 in the 40-49 age category and 7 in the 20-29 age category. Twenty had received grade 6 education and at the time of the interview, 18 were members of the most conservative religious affiliation within the Mennonite church system. Twenty-three had initially arrived in Alberta from Mexico with fourteen of the 38 arriving in the 1990s. The majority of participants had relatives in Alberta including siblings and parents. Table 1 highlights their pregnancy histories. There were a grand total of 232 pregnancies with four women pregnant at the time of the interview. The 181 children were born in Mexico (54%, n = 94), Alberta (31%, n = 53) or Ontario (12%, n = 20). One woman had not started childbearing at the time of the interview and two women had each had a set of twins. Two babies had died before two weeks of age, but the mothers did not know the specific reasons for their deaths.

Interviews

“I am in a different time:” Pregnancy Beliefs and Practices
The participants emphasized that it was customary to have as many children as “God wants you to have.” Despite the importance of bearing children, not all of the women were able to recognize their pregnancy. One woman talked about her embarrassment because her in-laws realized her pregnant state before she did. It was commonly believed that pregnancy lasted nine months. Like other topics related to women’s health, pregnancy is one that is a private matter within the family. The newly pregnant woman would confide in her husband and then eventually tell her mother, mother-in-law and sisters, and then sometimes female friends. Otherwise family members and friends would determine the woman was pregnant when there were obvious physical changes. Although most of the women did not tell their children about being pregnant, there were several that did tell their children that babies were gifts of God or came from their mother’s tummy. A few women, including those from the more conservative religious groups, commented that they were more open in their homes than their parents had been, and had discussed where babies originated.

The participants accessed health care through licensed professionals (nurses and physicians) and lay practitioners who may be referred to with professional terms. The latter included Mennonite “doctors” (i.e., female or male), Mennonite “chiropractors” (i.e., bonesetter), “massage therapists” or “lay midwives.” Some of their tasks included conducting prenatal checkups, turning the baby, provision of birth control or medication needed during pregnancy, and assisting with labor and delivery. In Southern Alberta, where the participants currently live, they seek assistance during their pregnancy from a Mennonite “lady doctor,” or a Mennonite “chiropractor.”

While in Mexico, the women sought advice about their pregnancy and the birthing process from other women such as their mothers or sisters. In Canada, the women are more
limited in who they can turn to for advice, particularly since the move has sometimes meant separation from family members. The women have also “figured things out on their own,” whether or not they had family and friends near them.

Most often the participants did not go for prenatal care, either in Mexico or Canada, until late in their pregnancy. One woman stated:

I did not have a lot of advice or treatments. I would not go to the doctor until I was seven or eight months pregnant, because everything was fine and I did not feel that I needed to go. My first pregnancy, I miscarried and then the third one was threatening to miscarry so I went to a Mexican Mennonite doctor who massaged my tummy and ever since then I have had no problems with miscarriages.

Another woman supports the above ideas when she states:

I was expected to go to a local midwife to have my babies turned. My mother told me that that’s the thing I had to do, and the only time I went to a real doctor was when I was really sick.

In one community, the lay helper recommended that pregnant women relax in a tub of water to relieve pain. This same lay helper used chloroform to help the women breathe during labor. Care was also sought from Mexican physicians but this was not ideal because the women did not speak Spanish, and interpreters—even family members—were not always available. In Canada, some of the women sought advice about pregnancy from the local public health nurses.

*Activities to Avoid or Undertake During Pregnancy.* Most of the women acknowledged that there were particular activities, substances and foods that were avoided during the pregnancy to ensure a healthy outcome. Crawling through barbed-wire fences was thought to cause the umbilical cord to wrap around the baby’s neck in utero. Hard work was generally avoided to prevent possible difficulties but some of the participants had done heavy work before realizing that they were pregnant and did not suffer any negative consequences.
The participants were advised that strong fumes from cleaners such as homemade soap made from lye and paints could cause miscarriages. Spicy foods were also avoided because they were perceived to be harmful to the baby. Certain foods such as milk or eggs were avoided because they caused nausea and vomiting. A number of the women talked about needing to “eat well” during pregnancy, which meant that they reduced their caffeine intake, increased their fruits and vegetables, and ensured that they consumed dairy products, particularly milk.

Some foods were ingested to assist with specific symptoms. Whole-wheat toast was believed to reduce any difficulties with gas build-up from eating certain foods. The Mennonite “lady doctor” was also a participant; she indicated that she did not take vitamins during her own pregnancy because she believed that ingesting them would lead to larger babies, something she wanted to avoid.

The majority of women believed it was essential to eat what one craves during pregnancy, otherwise a miscarriage or weakness in the baby might result. These ideas were reinforced by mothers and mothers-in-law, and by Mennonite doctors who espoused the importance of pregnant women eating what they craved. In some cases the women talked about craving and ingesting particular foods (e.g., ice cream) that were not potentially harmful to the baby, or ingesting substances such as dirt. The women also spoke about craving alcohol and needing to consume it, even in small amounts, for the sake of the baby’s health. One woman said:

A woman should eat whatever she craves because that is what the baby needs, and if a woman craves beer or wine, that is okay, because that is what the baby needs and you should have it. And if there’s anything that you crave and you eat it or drink it, it will not affect the baby.

Opinions varied among the women about the safety of alcohol during pregnancy. One of the participants said it was okay to drink alcohol with the physician’s permission. One of the
participants commented that babies born of mothers who drank would be small and appear drunk all of the time. Another woman stated:

I learned that the woman should eat what she craves because it can harm the baby if she doesn’t. I never craved beer or wine. I don’t drink that. I don’t like it if women drink beer when they are pregnant. It’s just not necessary. You hear that adults shouldn’t drink, why would you give babies liquor? I don’t know if the baby gets the alcohol that the mother drinks, but I think it is wrong.

“Turning the Baby.” The women spoke about turning or positioning the baby correctly within the uterus. One woman explained that her baby was in the incorrect position because she did hard work consisting of using a manual washing machine and having to reach over the machine in a specific way. Turning the baby was accomplished through physical touch and massage by specific lay practitioners. It was believed that the pregnant woman would be more physically comfortable if the baby were turned, and that turning would help to ensure that the baby was in the correct position for an easy delivery. Some women were advised to wear a belt that would keep the baby’s position higher within the uterus.

Labor and Delivery

The women who were interviewed had delivered babies in several different countries (Mexico, Belize, Canada & the United States) and in several provinces within Canada (Alberta, Manitoba & Ontario). The women in the sample began delivering babies in 1961 and members of the group were still childbearing at the time of the interviews (i.e., 2004 & 2005). Hence, their responses varied in relation to the geographic context and time period in which they had delivered.

The women noted that in Mexico, the United States and Canada babies were delivered in hospitals, and in Mexico some were also delivered in Mennonite “midwives”’ homes or in their own homes. The babies were delivered by local Mennonite “midwives,” Mennonite “lady
doctors,” Mexican “trained nurses,” “native midwives,” family members such as sisters or sisters-in-law, and Mexican or Canadian physicians. A few of the women had their babies delivered by Caesarean section, but the reasoning behind this was unknown to them. The range of experiences the women had delivering in these different locations varied considerably. One woman explained:

In Mexico I delivered at the midwife’s house. She didn’t have anything ready for me and didn’t want a big mess, so she laid me on a cement surface which was very hard on my back. She wouldn’t let my husband into the room, but her newly married daughter and son-in-law had to stay beside her the whole time. It was very scary.

Another woman related the following incident about her delivery in Canada:

In my fourth pregnancy, I had a difficult labor because the baby was turned the wrong way. The nurses told me to walk lots but I wanted the Mennonite chiropractor lady to come to the hospital but the nurses refused. I went outside for a walk with my husband and visited the Mennonite chiropractor around the corner, so that she could turn the baby. One hour later the baby was born.

The Mennonite “lady doctor” who was interviewed talked about using olive oil to “ripen the door.” She did not perform episiotomies. While in Mexico, this woman requested that her Mennonite pregnant patients have an ultrasound at seven months. She requested that all breech presentations be delivered by a Mexican physician.

*Postpartum*

The women talked about having different individuals assist them for up to six weeks after the baby was born. For example, while in Mexico their mothers or mothers-in-law or young female relatives helped by cooking, cleaning their homes and helping with the other children. Some families had the resources to hire a maid if no family members were available to assist the new mother. When female children were old enough, the mother relied on their assistance to provide the care that they needed when a new baby arrived, as well as to help out with the household tasks. Some of the women commented about how helpful their husbands had been,
and said they had not been required to participate in such activities as milking cows until two months postpartum.

There were limited examples of specific foods to be ingested during the postpartum period. One example was the advice to eat a raw tomato right after delivery to help ensure that the baby would not be bothered by any food the woman subsequently ingested.

Of the 24 women who were asked about postpartum depression, 13 noted that they had experienced it. One woman was encouraged by her husband to seek professional help and she received anti-depressants from a physician. She was not the only individual to take prescribed medication for this condition. Some of the women explained that their sadness, crying bouts and feeling overwhelmed went away on their own. For other women, it was a greater struggle. One woman talked about feeling very sad and “wishing to be in heaven” but did not act on these thoughts. The Mennonite “lady doctor” who was interviewed said that she prescribed her depressed patients a weak dose of *tafeedla* (unknown substance) pills to ensure that the baby was not affected.

Discussion

Nurses and midwives have the privilege and challenge of working with conservative religious groups who have unique beliefs and practices. Despite the privacy that often surrounds these groups, the research with the LGS Mennonite presented here shows that we can discover their knowledge and beliefs if care is taken to establish and maintain trust with them. This discovery fulfills the first step in the development of culturally competent care (Lauderdale, 2008).

Among the LGS Mennonites, subjects of women’s health and sexuality, including pregnancy, labor and delivery were not openly discussed among the participants. They also did
not publicly announce their pregnancies or share such news with select family members. This confirms the findings generated in other literature about this group (Kulig, 1995; Kulig & McCaslin 1998; Kulig et al., 2002, Kulig et al., 2004; Martens & Harms 1997). When topics on sexuality were discussed, the limited information that was shared tended to focus on accepting events as part of a woman’s life and as determined by God. In this way, religious beliefs held by the LGS Mennonites become their main cultural influence. For example, several of the women talked about the necessity of having as many children as God wanted the couple to have. Loewen (2001) also found that the role of women from the Mennonite perspective is to bear many children.

Women provided advice, information and support to one another during pregnancy and the postpartum. Suggestions were made about diet choices, and about how much and what types of physical activity were recommended. By following specific activities such as avoiding heavy lifting, the individuals were able to proactively deal with a vulnerable period in their lives to ensure a healthy outcome from pregnancy. Although the Mennonite women emphasized preventive behaviours, a number of the participants simultaneously emphasized the importance of satisfying cravings during pregnancy—even when this meant ingesting alcohol. There was only limited understanding that whatever the pregnant woman ingested, the baby did as well.

The findings noted here provide various avenues through which nurses and midwives can work with individual LGS Mennonite families to develop culturally competent care (Andrews, 2008; Lauderdale, 2008). One example is acknowledging the women’s efforts to ensure a healthy baby by avoiding activities that they perceive as harmful. The support provided by other Mennonite women can be further enhanced by nurses and midwives through small group teaching about post partum depression or dealing with cravings for substances such as alcohol.
Conclusion

Understanding knowledge, beliefs and practices held by conservative religious groups continues to be an important part of nursing care. The details about the LGS Mennonite women’s childbearing knowledge, beliefs and practice presented here are just one example of this. Nurses that care for conservative religious groups are encouraged to build trusting relationships and ask open-ended questions to determine their adherence to their unique beliefs and practices. Showing sensitivity to different religious beliefs is the beginning step in the development of culturally competent care and is the goal of nurses and midwives to ensure that the diverse families they interact with receive quality care.
References


Table 1
Sample Totals of 228 Completed Pregnancies

(n = 38)

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<tr>
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<th>%</th>
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<tr>
<td>Live births</td>
<td>78.7%</td>
<td>181</td>
</tr>
<tr>
<td>Stillbirths</td>
<td>2.2%</td>
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</tr>
<tr>
<td>Spontaneous Abortions</td>
<td>18.8%</td>
<td>43</td>
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<tr>
<td>Therapeutic Abortions</td>
<td>0.4%</td>
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