

STUDY

Childbearing Practices in Kanadier Mennonite Women

CROSS-CULTURAL NURSING HAS FOCUSED ON UNDERSTANDING THE KNOWLEDGE, BELIEFS AND PRACTICES OF UNIQUE CULTURAL GROUPS AND INCORPORATING THIS INFORMATION INTO THE DELIVERY OF NURSING PRACTICE.

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This article describes the findings of an exploratory, descriptive study conducted among Kanadier Mennonites in southern Alberta.¹ A total of 86 individuals were interviewed, but the discussion here is limited to the information on childbearing (i.e., knowledge, beliefs and practices about pregnancy, labour, delivery and the postpartum), generated from the 45 women who were included in the sample. Maternal and public health nurses can use the results presented here to plan and implement nursing practice.

Kanadier Mennonites, sometimes referred to as Low German speaking Mennonites, are the group of Mennonites who migrated to Mexico from Canada in 1922 in order to maintain their conservative religious lifestyle.² Generally speaking, Kanadier Mennonites are a conservative religious group that includes individual members from church groups such as the Old Colony, Sommerfelder, Rhinelander and Kleine Gemeinde (listed from most conservative to most liberal). There is variation between and

ABSTRACT

Cross-cultural nursing practices call for attention to be paid to the unique beliefs and practices of the groups with which nurses come in contact. The Kanadier Mennonites are a conservative religious group who live in Alberta, Manitoba and Ontario. An exploratory, descriptive study was conducted with this group in southern Alberta to generate information about their health and illness beliefs. This article focuses on their knowledge, beliefs and practices in relation to childbearing. Interviews were conducted with 45 women, the majority of whom were married and had been born in Mexico. Among the sample there had been a range of one to 16 pregnancies. The participants noted that childbearing is not a topic openly discussed with others. Women learn about childbearing from their mothers and

other women but also from physicians and books. During pregnancy there are particular activities to be avoided including the use of strong cleaning fluids and hand milking of cows. Foods such as milk need to be ingested to ensure a healthy pregnancy. Prenatal care was not emphasized in Mexico nor has it become a customary practice in Canada but deliveries in

hospital are the norm in both these countries. During the postpartum the women receive support from their immediate and extended family in order to recuperate. Nurses need to explore individual Kanadier Mennonite beliefs regarding childbearing and work with this group in developing acceptable health promotion programs to help ensure healthy pregnancy outcomes. The blending of nursing practice knowledge in a non-intrusive manner with a group of people with differing belief systems is a necessary and achievable goal.

KEYWORDS: childbearing, Kanadier Mennonites, pregnancy



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among individuals and families in adhering to ministerial prescribed activities and behaviours within these four groups. Thus, while living in Mexico, the most conservative Kanadier Mennonites may only travel by horse and buggy, while others in the same group may travel in motorized vehicles. In Canada, their use of cars and trucks is very much the norm. More detailed explanation of the differences between the religious groups is not possible here due to the complexity of their beliefs.

Accurate statistics are not available on the number of Kanadier Mennonites in Canada, but some estimates indicate that there could be as many as 57,000³ with 12,000 to 15,000 in Alberta and the remaining living in Manitoba and Ontario. They have been returning to Canada in order to live in a country that can offer more economic, education and healthcare opportunities. More often they work in the agricultural-based industry. Published literature on this group's health beliefs is limited to a community assessment conducted in southern Alberta, which revealed unique health beliefs such as the use of specific herbal treatments obtained from Mexico for illness,⁴ and a study of the health beliefs of Old Colony and General Conference Mennonite women in Mexico.⁵ Regarding childbearing, it was noted that pregnancy is considered a private topic with no public announcements and interpretation of biblical verses is used to justify large families. A woman who has a child out of wedlock may have a difficult social existence if the man refuses to marry her.⁶

METHODS

This study⁷ was conducted over a two-year period using a partnership model that included academic researchers, local health regions and the Mennonite Central Committee (MCC). Low German speaking Mennonite research assistants (RAs) were hired to conduct the interviews. There were three female RAs, one male RA and one couple. It would have been preferable for only female RAs to speak with the women participants about childbearing but that was not possible or feasible because the childbearing questions were only one part of the larger study and there were few Low German speaking individuals available. Despite the potential limitations, there were no apparent difficulties with the interviews conducted by the male RA because the Kanadier Mennonites see predominantly male physicians and they perceived the RA as a professional who was assisting them.

The participants were located through the research team and existing community contacts. Informed consent was achieved after a lengthy explanation of the study, both on the telephone when booking the appointment and after arriving at the home, where the interviews were conducted. Demographic information was collected on all participants and included a detailed pregnancy history for the women participants.

The interview was conducted in Low German and lasted up to two hours, of which one part focused on childbearing issues. For the family, having the RA come to their home

was a social event; it was not uncommon for all family members to listen during the interview. Only the Kanadier Mennonite women were asked questions about childbearing and in several instances when this topic was about to be discussed, the children were asked to leave the area or the woman and the RA went into another room to ensure privacy. Discussions were held with each of the women about pregnancy, labour, delivery and the postpartum.

Due to the lack of comfort with technology among some of the Kanadier Mennonites, tape recorders were not used, but short notes were taken and subsequently a summary of the interview was taped and later transcribed. The first two authors

ALL MEMBERS OF THE RESEARCH PROJECT WERE REQUIRED TO SIGN A STATEMENT OF CONFIDENTIALITY TO EMPHASIZE THE IMPORTANCE OF KEEPING THE IDENTITY OF THE PARTICIPANTS AND THEIR COMMENTS CONFIDENTIAL

trained the RAs, and continual contact was maintained throughout the research project to provide feedback. The entire research team met on a regular basis and discussed the meaning of the data within the larger social context of the Kanadier Mennonites. All members of the research project were required to sign a statement of confidentiality to emphasize the importance of keeping the identity of the participants and their comments confidential. Ethical clearance had been obtained from the first author's academic institution.

Establishing and maintaining trust among the Kanadier Mennonites was an essential step in successfully conducting the research and has been discussed at length elsewhere.⁸ Meetings were held at the beginning and end of the research with the ministers of the participating religious groups. One group did not partici-

rate, likely due to changes in church membership; despite this, individuals from that church group were interviewed. The findings have been shared with the Kanadier Mennonites through community meetings and Low German tapes of the findings, for those who accept such devices.

FINDINGS

The majority of the 45 women were married and their ages ranged from 20 to 65 years old (with an average age of 38.5). Most were born in Mexico and were educated there for an average of five years. Fewer women than men had attended English classes since moving to Canada. Of the 45 women participants, there was a range of one to 16 pregnancies and zero to 14 children, a few stillbirths with a range of zero to seven and only one therapeutic abortion among the group. Although the interview data indicates that there were few spontaneous abortions or miscarriages within the participant group (range of zero to four), the detailed demographic >

sheets revealed that several of the women had experienced a number of miscarriages. For example, one woman had nine pregnancies and four miscarriages; another had six pregnancies and four miscarriages. One family that had experienced a high number of miscarriages purposely relocated to Canada in the hope of delivering a viable infant. The women attributed the loss of a fetus from differing viewpoints. One woman said that after having three miscarriages she had to “trust in God” and interpreted the loss of the fetuses to God’s grace because the children would likely have been born with health problems. Several women noted that the Mexican physicians did not disclose the reason for the multiple miscarriages. One woman who had miscarried commented that it was likely God’s will because the physicians could not give her any concrete reasons for losing the baby. However, another said that she felt the miscarriages were due to incompetent medical care in Mexico.

Several of the participants noted prematurity as the reason for experiencing infant deaths. Others noted “heart problems” and “birth complications” as the reason but no further information had been given to the women by the provider.

Childbearing as a private subject: There is little discussion between mothers and adult daughters about childbearing. The women had learned about pregnancy on their own, from their mothers or from other women, physicians or books. The majority had not told their children or close friends when they were pregnant. Instead, the children were told that the new baby was delivered to the hospital by a bird or that the baby was bought from the physician. The few exceptions regarding disclosure to children were more often among the more liberal religious groups such as the Kleine Gemeinde.

Based upon the way in which the women discussed their pregnancy history, the RAs perceived that the women did not emotionally attach themselves to the fetus during the first two months of pregnancy. The participants shared that babies born out of wedlock would have greater difficulties going to heaven. Therapeutic abortions that were only done because of the mother’s health were not otherwise acceptable among the group.

Activities and foods during pregnancy: Regular housework activities were conducted during pregnancy with the avoidance of the following:

- use of strong cleaning fluids, i.e., lye or bleach
- going through a fence because the cord would wrap around the baby’s neck
- hand-milking cows
- painting or reaching high
- heavy lifting or heavy work.

THERE IS LITTLE DISCUSSION BETWEEN MOTHERS AND ADULT DAUGHTERS ABOUT CHILDBEARING

During pregnancy the women were to eat a “regular diet,” i.e., milk, meat, vegetables and fruit. Some women noted the importance of ingesting more milk at this time. One woman said that eating raw sunflower seeds alleviated heartburn, whereas roasted seeds would worsen this condition. Others said that pregnant women should avoid eating canned fish and apples. One woman talked about the “chiropractic” treatments in Mexico she had undergone to align the fetus properly for an easier delivery. In Mexico, there is a lack of health providers for the Kanadier Mennonites and hence prenatal care is not common.

In Mexico, a physician or a trained midwife conducted the deliveries either in a hospital, a clinic or, in one instance, in the woman’s home. In Canada, all of the deliveries had been conducted by physicians in a hospital and several women underwent caesarean sections. While in Mexico, the labour and delivery experiences reflected the time period with women who delivered their babies in the 1950s and the 1960s not having their husbands present.

Postpartum support: It was routine in Mexico to provide the new mother with support after the delivery. This support varied, but normally included visits and food provided by other families for up to two weeks after the delivery. Other support included having a young Mennonite girl to assist with childcare and housework, having the husband do the housework or receiving assistance from the woman’s mother, mother-in-law or sisters and friends. In larger families, sisters would take turns giving help for two-week periods. Baby showers were common and provided necessary items for the new infant. The transition to returning to work after delivery varied by family. One woman commented that the day after she returned home she resumed her schedule of milking the cows and doing the housework; another stated that she rested for nine days and had assistance with household tasks from her husband. Another woman rested for four months, slowly increasing her workload.

While they lived in Mexico, it was common during the postpartum period for the women to follow specific beliefs. For example, putting one’s hands in hot, soapy water would decrease breast milk, whereas ingesting alfalfa seeds would increase breast milk. One woman was emphatic that raw foods (e.g., tomatoes, cabbage, bananas) should not be eaten during the first three months of the infant’s life. She believed that certain foods caused infection in the body, led to bad veins in the mother and turned the breast milk such that the infant would become ill. Other foods to be avoided by breastfeeding women were watermelon, cabbage, beans and hot peppers as these would stimulate the baby and prevent sleep. Another woman said that excessive amounts of baked goods, potatoes and raw fruits and vegetables give the baby gas. One woman avoided canned fish and raw apples in the first week after the delivery to prevent her from experiencing pain. In addition, pop and juice were to be avoided but meat and milk were important.

In both Mexico and Canada, the umbilical cord received special attention that included covering it with cotton batting and tape or additionally with salve. Other participants related that little belts were sewn to cover the umbilical cord and hence keep it down to prevent hernias. Another example was to soak the cotton covering in alcohol for its drying effect, and pass the cord through the hole of the covering. Details were not collected regarding how long the covering was kept in place or the rationale for maintaining this practice. Only one mother noted that she followed the hospital's advice about the navel. More often, regardless of the method used to cover it, when the umbilical cord broke off, alcohol was used to clean the navel for a few weeks.

One of the participants noted that the health professionals in Mexico did not assist women who were having difficulties with breastfeeding. One of the young women indicated she was bottle-feeding because she "had nothing for the infant," and did not have any dietary restrictions after birth. This thinking was noted among a few other women who did not perceive that their infants were satisfied with breast milk.

DISCUSSION

The wide variety of beliefs described by the participants point to the need for nurses to explore the individual Kanadier Mennonite woman's understanding and practices surrounding childbearing and to confirm the importance of beliefs and practices held in Mexico for their new Canadian setting. Variation is expected regarding nutrition and activities during pregnancy. Establishing a baseline of knowledge and beliefs will assist in the planning and implementation of culturally appropriate care. The need for privacy regarding childbearing shows that nurses need to approach this topic with sensitivity. When a nurse cares for a woman who has miscarried, for example, an exploration of her beliefs may reveal that she feels it is due to God's will. Such a belief needs to be respected; at the same time, other possible reasons for the miscarriage can be explored.

Prenatal care is not something that is routinely sought among the Kanadier Mennonite women, but they want to ensure a healthy birth outcome. The women need to

be encouraged to seek and use healthcare providers. Interpreters may be necessary in providing a rationale for this preventive health activity, given the Kanadier Mennonite's minimal experience with using healthcare providers during pregnancy. It is crucial to identify women early in their first pregnancy and to provide education to respected Kanadier Mennonite women.

Change is difficult for the Kanadier Mennonites and initial rejection of childbearing health programs is a possibility. Community development approaches can be instrumental in gaining support from certain community members (e.g., ministers and men). Health programs need not be intrusive, and indeed can benefit this group's way of life and religious practices. Nurses need to promote maternal-child health from the stance of ensuring healthy families and communities.

Cross-cultural nursing has focused on understanding the knowledge, beliefs and practices of unique cultural groups and incorporating this information into the delivery of nursing practice. Nurses are well positioned to assist Kanadier Mennonites through provision of health education and promotion of women's health. ♦

Acknowledgment: The authors thank the Kanadier Mennonites who participated in this study; Bill Janzen, research team member; the Mennonite Central Committee, Alberta division; research assistants Mary Belcastro, Ruben Bueckert, Esther Olfert, Tom Olfert and Susan Tashiro; student research assistants Melissa Hart and Lesley Masuk; and transcriber Tina MacQuarrie. The study was supported by a research grant from the Alberta Heritage Foundation for Medical Research.

VARIATION IS EXPECTED REGARDING NUTRITION AND ACTIVITIES DURING PREGNANCY. ESTABLISHING A BASELINE OF KNOWLEDGE AND BELIEFS WILL ASSIST IN THE PLANNING AND IMPLEMENTATION OF CULTURALLY APPROPRIATE CARE

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