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Childbearing Health Practices as Described by Old Order Amish Women

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CHILDBEARING HEALTH PRACTICES AS DESCRIBED BY OLD ORDER AMISH WOMEN

By

Nancy Lynne Miller

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ABSTRACT

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BY OLD ORDER AMISH WOMEN

By

Nancy Lynne Miller

The Old Order Amish culture influences the health practices of its people. Large families and home births are common practices among the Old Order Amish. Often Amish women lack or receive little prenatal care; the influencing factors are often unknown to the health care professionals. Thus, the dilemma of providing culturally congruent care to this population is presented to the health care professionals. This study described the childbearing health practices as described by Old Order Amish women which can be utilized to provide culturally congruent nursing care to childbearing Amish women. This qualitative descriptive study used a focus group with Old Order Amish women of childbearing age. Leininger's Cultural Care Diversity and Universality theory with the Sunrise Model provided the conceptual framework. The results revealed that faith motivated these Amish women to bear children; childbearing was a private matter and home births are preferred; and formal knowledge of childbearing was limited but support reinforced their childbearing health practices. Traditional professional health care was sought only with a perceived complication during pregnancy or labor.

Dedicated to the memory of
Elizabeth Miller
(1953-1995)
An Amish Friend

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Introduction

Background of the Problem

The United States is a nation with a wide cultural diversity. Culture reflects the background and experiences of a specific group of individuals (Henkle & Kennerly, 1990). Culture is characterized by a pattern of values, beliefs, and behaviors manifested by a particular group and is greatly influenced by traditions and customs learned throughout life (Henkle & Kennerly, 1990). Thorne (1993) states health beliefs are often considered to be those peculiar ideas held by individuals which affect decision making and behavior. Clients can be labeled noncompliant when their choices of care do not coincide with the professional's recommendations and/or when the professional has a lack of cultural awareness (Charonko, 1992). Leininger (1993) defines culture as "the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular group that guides its thinking, decision, and actions in patterned ways" (p. 19). Culture plays a role in childbearing beliefs and practices in America since many Americans have an immigration background in which folkways and "old wives tales" are passed from generation to generation (Starn, 1991).

A unique culture in the United States that has a fast growing population is the Old Order Amish. The Old Order Amish culture influences the health beliefs and practices of its people. Health care professionals are presented with the dilemma of providing culturally congruent care to this population. Large families and home births are common practices among the Older Order Amish. This study focused on the childbearing health practices as described by Old Order Amish women which could increase health care professionals' understanding and promote culturally congruent perinatal care with this population.

The Old Order Amish is a religious group formed after the Reformation in Europe. For further reference, the Old Order Amish will be referred to as Amish. They became what are known as Anabaptist, opposing infant baptismal. Jacob Ammann

brought his people, who were named Amish after him, to the United States in the 1700's to escape religious persecution. The Amish are Protestant with a religious basis in the belief that they are to be in harmony with the earth and themselves (Naylor, 1974). The Amish accept death as a process of life that leads to the entrance to a better life (Brewer & Bonalumi, 1995). Their religion dictates that they maintain a simple way of life. They believe in keeping the "old ways" and avoid modern trends (L. Troyer, personal communications, March 20, 1992). This places them in a rural setting where farming, food preservation, and raising a large Amish family is their priority. Amish believe it is very important to keep and hand-down the Amish traditions (Naylor, 1974). The "Ordnung" either written or unwritten, are the strict rules that regulate church members' lives by dictating style of dress and hair, style of home furnishings, and style of farming methods (Wiggins, 1983).

The Amish believe in separation of church and state. They do not accept governmental social support such as welfare. They are exempt from paying social security taxes as determined by the Federal Supreme Court. They do not believe in formal insurance plans; instead an Amish community will share the burden of cost if a hospitalization is required for one of its members.

Some of the traditions are speaking German as the primary language; this creates an unique language barrier since children do not learn English until they begin to attend school at age six (Brewer & Bonalumi, 1995; Naylor, 1974). The Amish are formally educated by Amish, in Amish schools through the eighth grade. Further education continues at home which includes learning the skills to manage a home and farm (Naylor, 1974).

The Amish maintain a holistic health practice (Henderson, 1981). Before seeking entry into the professional health care system, the Amish rely on their own home remedies and midwifery (Brewer & Bonalumi, 1995; Finn, 1995). Wenger (1995) lists three factors the Amish consider when seeking health care whether folk, alternative, or

professional care as: "1) type of health care problem; 2) accessibility of health services; and 3) perceived cost of health care services" (p. 12).

Amish women often have home births. A study by Palmer (1992) found that the Amish prefer home births and that children are viewed as a blessing from God; contraception is not a practice. If available "midwives or family physicians may attend the home births and if not, the birth takes place in a hospital" (Palmer, 1992, p. 118). Some health care providers will only provide care when the Amish woman agrees to comply with prenatal and postnatal care (McGinn, 1996). A birthing center in one Amish community has been established with the collaboration of the Amish and local health care providers to increase perinatal care, improve prenatal outcomes, and reduce costs of childbirth while allowing the Amish to maintain their cultural values and beliefs (Acheson, 1994).

Patterns of health behavior reflect characteristics of the Amish culture and may be responsible for certain mortality rates among the Amish population (Fuchs, Levinson, Stoddard, Mullet, & Jones, 1990). It is reported that men tend to outlive their wives and it is speculated that high fertility and the stresses of childbearing may have an adverse effect on female longevity (Cross, 1976).

Amish record keeping is usually accurate for live births and stillborns; premature fetal deaths and miscarriages are often not recorded (Acheson, 1994). Even though birth certificates are filed, it is impossible to differentiate Amish births from the general population so as to study infant mortality and morbidity (Acheson, 1994).

> Perinatal risk factors prevalent among the Amish which adversely affect perinatal outcomes, include short birth intervals and more births to older women; grand multiparity; a high degree of consanguinity; a very high rate of twinning; a high-fat, high-sugar diet; obesity; psychological stresses related to temptations of modern technology; lack of medical insurance; late entry to prenatal

> care; few prenatal visits; and a substantial proportion of births attended by lay midwives (Acheson, 1994, p. 173).

Positive health practices which enhance more positive outcomes, however, are also reported. Amish women "do not smoke, consume alcohol, or use recreational drugs; their roles as wife and mother are highly valued; with an extensive psychosocial support system of family and community; and excessive financial burdens of a family are assumed by the community" (Acheson, 1994, p. 173).

The following exemplar serves as an example of Amish women's childbearing health practices can be described. An Amish woman, having delivered a premature infant (third pregnancy) per Cesarean section after an appendectomy, sought advise from this researcher about her fourth pregnancy. The woman was referred to and received care from an obstetrician who delivered her infant vaginally in a birthing room in a hospital; she was discharged 12 hours after delivery without incidence. With her fifth pregnancy, she consulted a lay midwife who did home deliveries. This pregnancy ended at 32 weeks gestation with a precipitous delivery of a stillborn with anomalies. The Amish woman believed she did not need a physician with her fifth pregnancy since she was "cured" with the previous vaginal delivery.

The Amish culture is reflected in the childbearing health practices among Amish women. There are certain lifestyles that promote healthy pregnancy outcomes, but there are also other factors that contribute to poor outcomes. The practices of not starting prenatal care until the sixth month of pregnancy or not receiving any prenatal care at all, home deliveries attended by lay midwives, grand multiparity, and lack of insurance contribute to poor pregnancy outcomes. It is not always clear as to what cultural factors influence Amish women in these childbearing health practices. An understanding from the Amish woman's perspective could give insight into these childbearing health practices so professional health care providers can implement care that would be culturally acceptable and promote positive pregnancy outcomes to this population.

Statement of the Problem

There are over 100,000 Amish in 21 states (Adams & Leverland, 1986). It is estimated that an Amish community can double its population approximately every 23 years (Cross, 1976). A community in Marlette, Michigan, had a population count of 380 in 1995 (Budget, 1996). The Marlette Amish community had 12 live births in 1996 (E. Petersheim, personal communication, December 8, 1996). Record keeping consists of each family maintaining a list of births in the community with parents' and infants' names and the dates of birth. No birth weights or gestational ages are included. There is no record of stillborns or miscarriages; births are registered at the county court house before the first birthday. The Marlette Amish community's growing population is increasing its presence in the health care delivery system.

An understanding from the Amish perspective could provide insight into the Amish's childbearing health practices. An understanding is required by the Advanced Practice Nurse (APN) before attempting to implement interventions such as education relating to childbearing, perinatal health promotion and prevention and accessing culturally congruent professional health care. The care must be culturally acceptable or it will not be followed by the Amish since their childbearing health practices are defined by the Amish culture. If the Amish ways are not followed there are severe consequences of being shunned (Wiggins, 1983).

Research Question

This descriptive study examined the following question: What are the childbearing health practices as described by Old Order Amish women of the Marlette Amish community of Sanilac County, Michigan?

Importance of the Study

This study adds to the body of knowledge about childbearing health practices among this population of Amish women. It provides insight and understanding of the

practices as described by a group of Amish women from an emic perspective. There is minimal information available on this topic.

When obstetric emergencies arise such as fetal distress or breech presentation during attempted home deliveries, the Amish women are taken by car to a hospital over 25 miles away. Hospital personnel lack any knowledge regarding the pregnancy or health care status of the Amish women. Few Amish women seek early or continuous prenatal care unless a known risk/medical emergency occurs during the pregnancy. Opportunities are lost during the prenatal and postnatal periods for health promotion, especially in the form of the newborn screening for potential disease (e.g., hypothyroidism) and immunizations. Further knowledge is needed to understand the childbearing health practices from the Amish perspective so that culturally congruent care interventions can be implemented to promote positive pregnancy outcomes for Amish women.

Additional knowledge will enable the APN, who may care for this unique group of people, to provide cultural congruent care. Trust in the APN by the Amish is an essential first step towards establishing a therapeutic relationship (Palmer, 1992; Wenger, 1991). The APN needs to possess patience and an understanding and respect for the Amish health practices since the Amish will reject a health practice that the church discipline finds unacceptable, such as contraception (Adams & Leverland, 1986; Brewer & Bonalumi, 1995).

Wiggins (1983) reports the best role of the APN is "caregiver" and "educator" (p. 28). The role of caregiver promotes health maintenance and prevention. The APN as educator provides information about health promotion and prevention. Since the Amish have limited formal education, by increasing the Amish's knowledge level about health, it is anticipated that their health practices will improve (Wiggins, 1983). Caring behavior characteristics of health care professionals are described by the Amish as: "takes time, listens, knowledgeable and provides information, allows for choices of treatment and

respects the choices, includes the family, and doesn't ask for money first" (Wenger, 1995, p. 11).

Health promotion teaching about childbearing is an important component to assure successful outcomes (Fuchs et al., 1990; Kemp & Hatmaker, 1992; Kogan, Alexander, Kotelchuchk, & Nagey, 1994; Lewallen, 1988; Tiedje, Kingry, & Stommel, 1992). An assessment of the nature of the health behavior needs to be considered when beginning the interventions related to childbearing health practice (Tiedje et al., 1992). The APN who shows respect for cultural influences is better able to overcome the barriers to health teaching (Scott & Stern, 1985). Combining the "generic folk care with professional care provides culturally congruent care" (Leininger, 1991, p. 37). These concepts provide the direction of the APN's role when offering professional services to the Amish women of childbearing age. The specific roles of the APN are: a trusted primary care provider whose care is culturally congruent; an educator of health promotion and prevention; an advocate when the choices of the Amish woman may not coincide with the routine protocol; and a collaborator with other health care professionals involved with the Amish.

Conceptual Framework

The Cultural Care Diversity and Universality theory (Leininger, 1991) includes several assumptions which explain the phenomenon of care within the context of culture. The theory's assumptive premise that provides the guidance for this study states: "cultural care values, beliefs, and practices are influenced by and tend to be embedded in world view, language, religion (or spiritual), kinship (social), politics (or legal), education, economic, technology, ethno-history, and environmental context" (Leininger, 1991, p. 45). The conceptual definition of childbearing health practices is theoretically defined using the literature and Leininger's theoretical perspective.

Conceptual Definition of Childbearing Health Practices

There is limited literature that specifically defines childbearing health practices. Related literature was examined which defined health practices among various childbearing populations. Kemp and Hatmaker (1992) studied health practices and anxiety related to low and high risk, low-income pregnant women. These authors defined health practices as "the perception of threat if the pregnancy was at risk which increased anxiety levels and health-protective and health-promoting behaviors" (Kemp & Hatmaker, 1992, p. 266). Lewallen (1989) defined health practices of pregnant women in the conceptual framework of loci of control where the pregnant woman perceives control over her own health. Positive health promoting practices were defined by a high belief that the women's "own actions control their health" (Lewallen, 1989, p. 245). The childbearing health practices of black women were studied by Scott and Stern (1985) within the context of the "meaning of menstruation, bathing during menstruation and postpartum, pregnancy, diet during pregnancy and postpartum care along with the care of the infant" (p. 48). Negative pregnancy health practices were defined as "inadequate prenatal care, poor nutrition, smoking, and the use of alcohol" in a study by Tiedje et al. (1992, p. 482). Marshall (1991) defined maternal health practices as "weight control, exercise, smoking, alcohol consumption, sleep patterns, and eating habits" (p. 169). Davis et al. (1991) provide a global definition of health practices as the person's "singularity (demographic characteristics, social influence, previous health-care experiences, and environmental resources, along with expression of motivation, cognitive appraisal of the health-care concern, and the affective response to that concern)" (p. 12).

In summary, the literature defines childbearing health practices as the woman's perception of risk or threat and self-control over her own health (Davis et al., 1992; Kemp & Hatmaker, 1992; Lewallen, 1989; Tiedje et al., 1992). Action or lack of action for childbearing health practices are influenced by the environmental context, specific cultural beliefs, and life experiences (Davis et al., 1992; Kemp & Hatmaker, 1992;

Marshall, 1991). This provides a general conceptual definition of childbearing health practices, but further definition is required in the context of the Amish culture.

The Cultural Care Diversity and Universality theory does not explicitly define health practices but does define "generic care" which can be considered health practices, as "an essential behavior for human growth, health, and survival which includes the home remedies and folk care used by families" (Reynolds & Leininger, 1993, p. 25). Health practices of the Amish can be derived from the literature as practices that enable one to function in the work role one occupies (Wiggins, 1983). Wenger (1991) defines the Amish's health practices as "the maintenance of the culture dictating health care, resulting in rituals" (p. 100). "Hard work, clean living, and a well-balanced diet contribute to good health which is believed to be a gift from God" (Brewer & Bonalumi, 1995, p. 495). For the purpose of this study childbearing health practices are defined as those behaviors, actions, or habits which are influenced by cultural values, beliefs, traditions, ideas, or rituals women related to the pre-conceptual, antepartum, and postpartum stages of pregnancy as identified by Amish women of childbearing age.

Theoretical Model

The Culture Care Diversity and Universality theory and the Sunrise Model by Leininger (1991) provide the theoretical guidance to discover childbearing health practices as described by Amish women. The theory postulates "that in all cultures, human care exists but remains undiscovered; with knowledge of culture the nursing profession could provide transcultural care" (Leininger, 1991, p. 36). The theory "interrelates culture and care" through a qualitative induction theory construction (Leininger, 1991, pp. 20-24). Care is based on a "generic (emic) and professional (ethic) level of care knowledge" (Leininger, 1991, pp. 41-42). An emic knowledge of care is the insider's (person who belongs to the cultural group) perception of care with its "specific meaning, experiences, symbols or processes within the cultural context of its people" (Leininger, 1991, p. 79). The theory supports exploration of unknown childbearing

health practices as described by Amish women from the emic perspective. Leininger's assumption: "cultural care values, beliefs and practices are influenced by and tend to be embedded in world view, language, religion (or spiritual), kinship (social), politics (or legal), education, economic, technology, ethno-history, and environmental context of a particular culture (Leininger, 1991, p. 45), provides the guidance for this study.

The Sunrise Model provides the conceptual map of all the components of the theory (Figure 1). The nurse uses the model to assess all aspects of the care systems to develop culturally congruent care (Leininger, 1991). The sunrise effect depicts culture and care interrelated with influences flowing in either direction. The assumptive premise selected to guide this study is displayed in the upper portion of the model as the seven fanned sections under the Cultural and Social Structure Dimensions.

The Modified Sunrise Model (Figure 2) displays examples of specific influences on care patterns and expressions of childbearing health practices as described by Amish women. Beginning from left to right, the influential technological factors are "keeping the old ways" (L. Troyer, personal communication, March 20, 1992). Modern technology such as electricity, telephones, and automobiles are prohibited. Reluctance to access perinatal care may be attributed to the distance to travel or the need to hire a driver.

Religious and philosophical factors of the Amish culture are based on the doctrine of Christianity and adult baptismal (Anabaptist) (Wiggens, 1983). Children are perceived as a blessing from God which provides the guidance for large families (Palmer, 1992).

Kinship and social factors of a strong sense of family and community supplies the social support to the Amish woman during the childbearing years (Acheson, 1994). The Amish live together in closely connected settlements which provide the needed support for their culture.

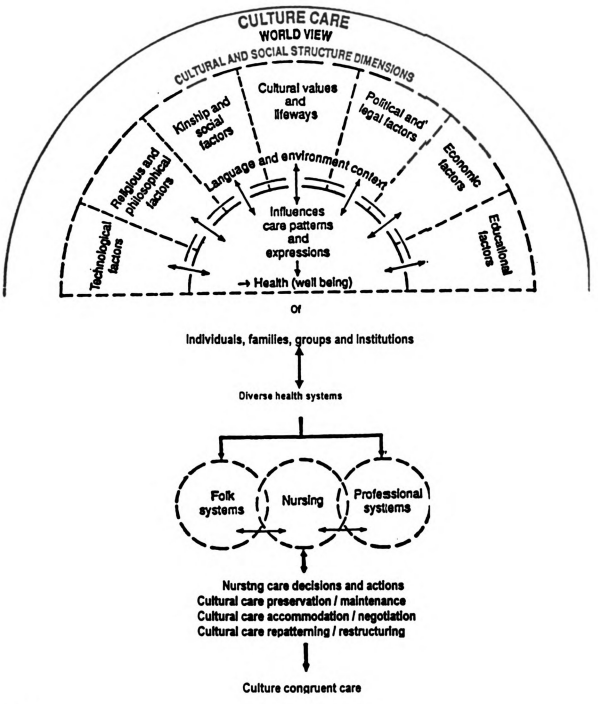

Figure 1. Leininger's Sunrise Model depicts dimensions of Cultural Care Diversity and Universality. (From Leininger, M. (1992). Culture Care Diversity & Universality: A theory of nursing *(p. 43). New York: National League for Nursing. Used with permission.)*

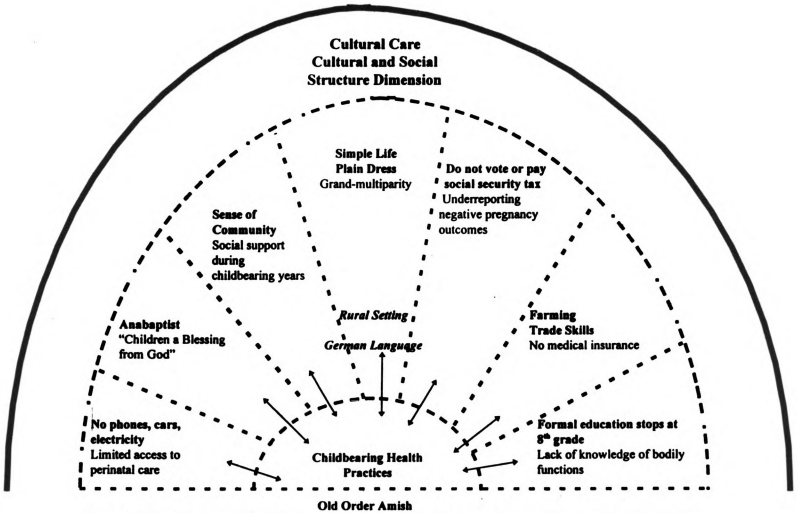

Figure 2 Modified Sunrise Model of Culture Care, Cultural and Social Structure Dimension from Leininger, M. (1992) Sunrise Model.

The cultural values and lifeways are respected and followed; those who do not subscribe are shunned by the Amish community (Wiggins, 1983). The simple lifestyle and plain dress with the beliefs of large families (grand multiparity); a balanced diet, and the avoidance of tobacco and alcohol are major influencers (Acheson, 1994). Contraception is not an acceptable practice (Palmer, 1992).

Political and legal factors influence the Amish culture through their strong belief of separation of church and state. This is demonstrated by not voting, and the limited use of the judicial system to establish Amish schools and to be exempt from paying social security tax (Naylor, 1974). Negative influences are demonstrated as failure to report stillborns and communicable diseases, a high degree of consanguinity, and failure to receive state required immunizations and neonatal screening tests (Acheson, 1994; Brewer and Bonalumi, 1995).

Economic factors are influential since most Amish prefer to be farmers, or if only necessary, work in other areas such as carpentry (Wiggins, 1983). In seeking farms to support the large families, there is frequent migration among the Amish (Wiggins, 1983). The Amish do not use commercial health insurance with the cost of health care a factor in seeking medical treatment (Brewer & Bonalumi, 1995). Low incomes and large families limit the Amish's economic resources.

Education is the final factor. Amish children attend Amish schools taught by untrained Amish teachers only through the eighth grade (L. Troyer, personal communication, March 20, 1992). The curriculum is basic and weak in the sciences, leaving out knowledge of human anatomy and physiology (Adams & Leverland, 1986). This contributes to the lack of formal education regarding the process of pregnancy, labor and delivery, and the postpartum period. It is unknown what additional knowledge is gathered from other sources about childbearing health practices.

These seven factors are in the context of German as the primary language and living in a rural setting. All these factors influence the care patterns and expression of the childbearing health practices as described by Old Order Amish women.

Review of the Literature

The current literature provides limited information about Amish health beliefs and practices with even less known about childbearing health practices. The literature reviewed examines health care practices from a general epidemiology perspective to an extensive qualitative description of the Amish culture. The literature acknowledges the Amish culture as unique to study because strong values and beliefs influence their health care practices. Review of the literature of general health beliefs and practices of the Amish will precede the review of the childbearing health practices of Amish women.

General Health Beliefs and Practices of the Amish. Some of the literature describes with accuracy the lifestyle, health beliefs and practices generally associated with the Amish culture (Acheson, 1994; Adams & Leverland, 1986; Brewer & Bonalumi, 1995; Lucas, O'Shea, Zielezny, Fruedenheim, & Wild, 1991; McGinn, 1996; Palmer, 1992; Wenger, 1991; Wiggins, 1983). The Amish have no religious proscriptions against medical doctors, drugs, or hospitals (Brewer & Bonalumi, 1995; Fuchs et al., 1990; Wiggins, 1983). Lack of higher education prevents an Amish from becoming a physician but there is mention of the Amish "Brauche", a form of healing involving ritual acts and quiet recitation of verses which is often referred to as "pow-wowing" and handed down from person to person (Adams & Leverland, 1986; Brewer & Bonalumi, 1996; Palmer, 1992; Wiggins, 1983). Some Amish deny the practice but others are convinced by hearsay that it provides a cure (Palmer, 1992). The Budget, the national Amish newspaper, often supports cure-alls with its advertisements (Palmer, 1992). Home remedies are often used prior to seeking professional health care (Brewer & Bonalumi, 1995). In general, the Amish children receive few, if any, immunizations (Brewer & Bonalumi, 1995; Fuchs et al., 1990). The Amish consider a healthy person as having a

good appetite, able to do hard work and looking well (Adams & Leverland, 1986). "Good health is considered a gift from God" (Brewer & Bonalumi, 1995, p. 495).

An extensive qualitative study of the Amish culture by Wenger (1991) provides a wealth of information and promotes further investigation to discover the health practices of the Amish. The purpose of the study was to discover and explicate the nature, meanings and expressions of health care practices among the Amish (Wenger, 1991). Using Leininger's Cultural Care Diversity and Universality theory and Hall's concept of culture context, the analysis showed four Amish cultural themes. These themes relate to the general health beliefs and practices of the Amish: 1) "an emic concept of care" as "being Amish" which means care is vital to survival of the social structure; 2) "anticipatory care" which means keeping the community together and helping others; 3) "active participation in care situations" which means the promotion of individual, family, and community well being on a daily basis; and 4) "principled pragmatism is culture care" which refers to a wide range of health care options, a high value in seeking counsel from each other, a focus on day to day consequences, and following the accepted rules of behavior (Wenger, 1991, pp. 161-169).

In a more recent article, Wenger (1995) discusses the Amish culture relating cultural context, health, and health care decision making. Folk, alternative, and professional care services are described along with the Amish's rationale for choosing a particular care service. The folk or "Braucher" is used "to keep cost down, for small children, to avoid drugs, or to get there easier/not as far" (Wenger, 1995, p. 7). The Amish use professional care for "high fever, need surgery or stitches, if you need medicine, or if you need to go to a hospital" (Wenger, 1995, p. 7). Chiropractic care described as alternative health care, was the most often sought alternative care (Wenger, 1995).

A more recent article also supported these findings of Amish health care beliefs and practices. It discussed the importance of providing transcultural nursing care in a

hospital emergency department to the Amish (Brewer & Bonalumi, 1995). The health care professionals lacked knowledge about this unique culture and found that providing appropriate, acceptable health care was difficult. Study findings revealed that Amish prefer home births; a language barrier exists with small children; cost is a contributing factor in delaying health care; a reluctance to use preventive professional health care exists; immunizations are often lacking; and home remedies are used as the first course of treatment (Brewer & Bonalumi, 1995). Health care professionals need to understand these factors in order to provide culturally congruent care. These descriptions of Amish care lack details relating to specific childbearing health practices as described by Amish women.

Childbearing Health Practices As Described By Amish Women. Scant literature was found describing childbearing health practices as described by Amish women from their perspective. The literature available related to Amish childbearing health practices discussed pregnancy outcomes or delivery practices. In one Amish community home births have been reported as the delivery choice preferred by the Amish with a midwife or physician in attendance or when a professional is not available for delivery, then the Amish baby is born in the hospital (Palmer, 1992). Acheson (1994) and Lucas et al. (1991) studied pregnancy outcomes among the Amish and non-Amish women. Both studies found little difference in infant mortality between the two groups, and suggested that error existed in reporting of stillborns or neonatal deaths by the Amish. A study of social support in the rural setting during pregnancy which compared Amish women and women of the general population found social support as an equivalent factor in pregnancy outcomes for both groups (Lucas et al., 1991).

The Amish population has been the focus for only a few epidemiological studies, studying infant mortality and morbidity since the Amish are a homogeneous group (Cross, 1976; Fuchs et al., 1990; Khoury & Cohen, 1987; Resseguie, 1974; Stevenson, Everson, & Crawford, 1989). Even though genetic factors were the focus, the studies

were consistent with some of the childbearing health practices among Amish women. Consanguinity was described as high; stillborns were underreported, grand multiparity with pregnancies occurred until the age of mid-forty, and life expectancy was shorter for Amish women than men.

Literature revealed the Amish culture, in relationship to pregnancy, was significantly different from the general population. Lucas et al. (1991) statistically quantified the comparison of births of Amish and non-Amish using the variables of lifestyle, particularly the prohibitions against smoking and alcohol use by the Amish, and thus formulated the hypothesis that the Amish would have shorter labors. Labors were significantly shorter for the Amish than the non-Amish by three hours, but bias may have been introduced with lack of data from the non-Amish (Lucas et al., 1991). A statistically significant finding was reported between smoking and alcohol use with Amish not using them; however, the small sample size (n=39) for Amish compared to the non-Amish (n =145) may have obscured important differences between the two groups along with a bias of missing values due to lack of information.

A study using Leininger's (1991) Theory of Culture Care and Sunrise Model researched a subculture of a non-Amish communal group living in Tennessee referred to as "The Farm" (Finn, 1995). The Farm had created their own culture with the practice of home births attended by their own-trained lay midwives. It was discovered that the neighboring Amish community sought the services of The Farm's midwives, resulting in these midwives training selected Amish women as midwives (Finn, 1995). This Amish community chose to rely on the folk care system using the professional health care system as a last resort (Finn, 1995).

McGinn (1996) described cultural, practice, and family issues that a family nurse practitioner experienced working with the Amish and Mennonite families living in Lancaster County, Pennsylvania. The family nurse practitioner found an understanding of the Amish culture was needed when providing health care that would be accepted and

followed by her clients. "Clinic appointments were often missed on Tuesdays or Thursdays since these are days wedding occur, but wedding plans are not discussed prior so that planning cannot occur; negotiation became an art to provide care on a mutual agreement; and careful history taking is essential to determine previous home care received" (McGinn, 1996, pp. 56-57).

Critique of the Literature. The literature available is limited about Amish childbearing health beliefs and practices. The available literature supports the need for further study of the Amish culture in order for health care professionals to implement culturally congruent care. Limitations of the literature are: the methodology limits the findings due to small sample size, the lack of control groups, and lack of generalizability. Some of the studies occurred over ten years ago, and the few epidemiological studies lack accuracy due to under reporting of data or lack of records by the Amish (Acheson, 1994; Cross, 1976; Fuchs et al., 1990; Khoury et al., 1987; Resseguie, 1974; Stevenson et al., 1989). The epidemiological studies used data ranging from the late 1890's through the 1970's. Consanguinity relating to genetic risk factors which resulted with pregnancy outcomes of intrauterine growth retardation, prematurity and fetal death was the focus of these studies. Khoury et al. (1997) found prematurity related to consanguinity and inbreeding of the offspring related to intrauterine growth retardation and congenital anomalies. Prospective studies need to be done using methods of collecting accurate data. Acheson (1994) suggests further studies which described the social supports and informal care systems of Amish women to be conducted. Past studies have failed to inform health care professionals of the emic perspective of the Amish such as their values, beliefs and health care practices.

More recent literature indicates the need to study the Amish culture which consistently reflects the general lifestyle and the influences behind seeking alternative care before professional health care. This need is based on having only a few credible sources of anthropological and epidemiological studies available (Acheson, 1994;

Wenger, 1991). Wenger's (1991) study was conducted over a three-year period. It provides a qualitative description of the Amish's nature, meanings and expressions of care. It is quite detailed about the Amish yet true disclosure may not have been given by the Amish if there was perceived lack of trust (Wenger, 1991).

Even though the study by Finn (1995) focused on the non-Amish, it did discuss the Amish and the practice of home deliveries. Training Amish women to be midwives by non-Amish cannot be generalized since this was only one community. Each Amish community makes its own decisions about specific practices with the "Ordnung", therefore, it cannot be assumed this is a practice in every Amish community.

Recent literature (Brewer & Bonalumi, 1995; McGinn, 1996) described the role of nursing in providing transcultural nursing care to the Amish. This supports the need for the APN to understand the unique Amish culture since an understanding is needed to provide culturally congruent care. In order to provide appropriate health care to Amish women, the APN found it necessary to negotiate for acceptable professional health care.

In summary, the studies are limited and provide minimal information about childbearing health practices directly from the Amish perspective. Lack of information indicates the need for qualitative studies of the meaning of childbearing health practices as described by Amish women so that health care professionals can provide culturally congruent care. This study addressed the concept of childbearing health practices as described by Amish women. The conceptual definition provides for the Amish women to describe their childbearing health practices and thus supports the emic perspective.

Methods

Design

This was a qualitative descriptive study. The purpose of the study was to describe childbearing health practices as described by Amish women of the Marlette Amish community of Sanilac County, Michigan. Leininger's qualitative ethno-nursing research method provided the philosophical guidance for the design. This method was designed to

study nursing phenomena in a "naturalistic and emic open inquiry discovery process" (Leininger, 1991, p. 75). The nurse-researcher coaxes care patterns and expressions from people in an open-ended inquiring method in a trusting and relaxed atmosphere. A focus group was conducted on July 16, 1997, for the purpose of gathering emic information about childbearing health practices as described by Amish women of the Marlette community of Sanilac County, Michigan.

Sample

The convenient, homogeneous sample consisted of five Amish women of the Marlette Amish community of Sanilac County, Michigan. The ideal focus group is composed of 7 to 10 people with similar backgrounds (Krueger, 1988, p. 91). Women who had experienced four to six pregnancies with more pregnancies anticipated were included in the study. Since the average Amish family size in this area was ten, with a range of five to thirteen, these women were in the middle of their childbearing years so recall of their experiences was more reliable.

Instrumentation

The semistructured interview guide for the study was a set of carefully worded, focused questions (Appendix A) which were prefaced by a brief statement about the context. The questions were derived from the seven influencing factors of the modified conceptual framework of Leininger (1992). Open ended questions beginning with an introduction or warm-up question, and progressing from general to specific questions was the format. The sequence of the questions progressed from non-threatening to the more threatening questions allowed for expression of the more difficult answers (Kingry, Tiedje, & Friedman, 1990).

A pilot test of the questions, using the same procedure as used for the actual focus group, was conducted on June 23, 1997, with an Amish woman who was not a candidate for the study. The pilot test indicated the questions were understandable to the Amish woman with information freely given over a two-hour period. The pilot study was not

tape recorded since the purpose was to verify clarity of the questions and not to gather data. There were no alterations of the questions for the study.

Procedure

Recruitment of Subjects. Recruitment of the sample population began with gathering a list of 10 names of eligible women who met the eligibility criteria, with assistance of an Amish woman who did not meet the eligibility criteria and was not a potential participant. The eligibility criteria was any Amish woman who experienced four to six pregnancies with more pregnancies anticipated. To these potential women, a letter (Appendix B) was sent on June 24, 1997, providing an explanation of the study and requesting their participation. A self-addressed, stamped postcard was enclosed for each participant to return with an affirmation or decline of her intent to participate in the focus group. After receiving only 3 postcards (2 affirmations and 1 requesting more information), this researcher traveled to Marlette to meet with the remaining candidates. The researcher being familiar with the participants asked if the recruitment letter was received and if the return postcard was sent. All had received the letter but reported they were too busy to return the postcard. A verbal response was given at the time. Of the 8 candidates visited, 2 refused, 2 were soon to deliver babies, 1 accepted but declined due to a previous commitment, and 3 agreed to participate. In total, five Amish women agreed to participate in the focus group. During this time, a mutually agreed upon date was determined for the focus group session. A postcard reminder was sent to all the women who agreed to participate in the study a few days prior to the meeting. An incentive of free transportation to shop at Sam's Club was offered to those who participated in the focus group.

Setting for Focus Group Interview. Since an Amish home was not conducive for the focus group interview due to lack of electricity and privacy, a setting that provided these plus being free of interruptions yet large enough and comfortable was needed. After assessing possible sites, this researcher's home was selected. A large table with

comfortable chairs was used to allow for positioning of audio-taping equipment. Since there was a matter of traveling approximately 15 miles one way, this researcher provided the transportation to and from the focus group session for all the women.

Conduction of the Focus Group. A. The focus group was held in Mayville, Michigan, in the researcher's home. The women were seated around a large table. All women agreeing to participate were requested to read and to sign an informed consent form (Appendix C). Questions relating to their identity in the study were answered by explaining that after the completion of the study, the audio tapes would be destroyed. There would be no direct identification of the participants in the transcription. All five women signed the consent forms.

B. After written consent was obtained, a demographic information sheet (Appendix D) was given to the women to complete. The purpose was to obtain a profile of the group and to stimulate the women to think about their pregnancies.

C. An explanation of the purpose of the focus group was given which was to have the Amish women describe childbearing health practices as described by each of them, so that health care professionals could learn from the Amish through their experiences. Questions were asked only to guide and to keep the discussion focused on the topic of childbearing health practices. It was requested that only one person speak at a time so that a clear recording could be obtained.

D. The focus group discussion was stimulated with open-ended questions (Appendix A). The focus group questions began with a general individual introduction to give all women a chance to speak. Questions progressed from general questions to the more critical specific questions (Krueger, 1988). The women needed much coaxing to begin the discussion; it appeared there was a reluctance to be the first to speak. There were long pauses of silence. One participant spoke very little and when she did, she placed her hand over her mouth speaking softly. Two of the five women usually initiated the discussion.

E. The focus group was conducted by this researcher. A time frame of one and one half-hours was allowed. To gather precise data, tape recorders were used with prior signed consent given by the participants. The researcher took notes to serve as reminders to clarify a participant's comment at the end of each question.

F. One tape recorder malfunctioned and the dialogue at times was unintelligible. Precise transcription of the audio-tapes was not possible. The researcher verified the accuracy of the transcript by comparing the transcript to the audio-tapes.

G. Refreshments were served.

H. At the completion of the focus group, the women were given the opportunity to set up a time for their free transportation to Sam's Club.

Data Analysis

The audio-tapes were transcribed by a paid typist almost verbatim with some dialogue being unintelligible. The participants' confidentiality was protected by coding the information without names and deleting all identifying information from the transcripts of the focus group. The audio-tapes will be destroyed upon completion of the study.

The data was managed manually. Content analysis of the transcripts was done by the researcher to match the themes used in Leininger's Sunrise Model as a method to organize the childbearing health practices as described by the five Amish women. There was no verification of the themes by other researchers. Analysis of the data was done to draw meaningful conclusions about the women's childbearing health practices. The demographic data was organized to demonstrate the group's profile. The demographic information obtained from the group was displayed in a frequency table.

Protection of Human Subjects

Approval of the study was obtained from the University Committee on Research Involving Human Subjects (UCRIHS) at Michigan State University (Appendix E). Guidelines established by the committee regarding confidentiality were adhered to by deleting all identifying information about the participants from the transcripts of the focus group. The audio-tapes will be destroyed upon completion of the study. A follow-up letter was sent to UCRIHS informing the committee of a slight change in the recruitment of the subjects, such that a personal contact was made after two weeks whether or not a return postcard was sent (Appendix F). A written response from UCRIHS was received (Appendix G). Only aggregate data was used with no individual's name used for any presentations or writings. A consent form from each participant was obtained prior to the interview (Appendix C). There were no known psychological, social, physical, economical, or legal risks anticipated for the subjects who participated in this study.

Assumptions and Limitations

Assumptions were:

A. The participants were truthful about childbearing health practices and answered the questions honestly.

B. Amish women's childbearing health practices were identified by the conduction of the focus group.

Limitations were:

A. There was a chance of bias in analysis of the focus group transcript. Conclusions were drawn directly from the dialogue being careful not to change the content in relation to the context.

B. Respondents' answers may have be given so to be socially acceptable and self selected within the group, due to sharing of intimate feelings.

C. Validation of analysis of classifications was not completed by the thesis committee.

Results

Demographics

The five subjects were all married, Amish women living in the Marlette Amish community of Sanilac County, Michigan. All had at least five pregnancies with more pregnancies anticipated.

Table 1 describes the demographic characteristics. The mean age was 35 years with the mean number of pregnancies, 7. The mean age of marriage was 20.6 years. There was a total of 37 pregnancies between the five Amish women. Most pregnancies reported were viable and term (live births at 38-42 weeks gestation). One woman experienced one early birth (< 38 weeks gestation) and a miscarriage. Another woman experienced a miscarriage and a stillborn. A third woman experienced one early birth and one late birth (> 42 weeks gestation). Only four births of the 37 occurred in the hospital; there were more home deliveries reported assisted by the family members (husband, mother and/or mother-in-law). The average interval between pregnancies was 20.5 months when the two extreme births occurring at 44 and 54 months interval were not included. It can be assumed that these women were either pregnant or breast feeding during the majority of this interval. The mean birth weight was 7.75 pounds with the range between 5 to 10 pounds.

Table 1
Range, Means and Standard Deviations of Demographic Characteristics (N=5)

Characteristics	M	SD	Range
Age (years)	35	8.37	31-42
Number of pregnancies/women	7	2	5-10
Number of viable births/woman	7	4	5-10
Number of term pregnancies (38-40 weeks	6	2	5-10
Age @ time of 1st period (years)	11	1	10-12
Age @ time of marriage (years)	21	1	19-22
Age @ time of 1st birth (years)	22	1	20-23
Infant birth weight (pounds)	7.75	1.04	5-10

Results Related to the Research Question

The research results are presented by answering the original research question; What are the childbearing health practices as described by Amish women of the Marlette Amish community of Sanilac County, Michigan? The results of the focus group responses are listed by the categories of the focus group questions with text examples grouped according to the seven factors of cultural and social structure dimensions. The themes that emerged were easily categorized into the seven influencing factors of the Modified Sunrise Model (Figure 2): 1) Technological Factors (rely on neighbors' telephones and cars and keeping the "old fashioned ways"); 2) Religious and Philosophical Factors (childbearing is the Lord's Will); 3) Kinship and Social Factors (childbearing is kept secret and family offers a strong support system); 4) Cultural Values and Lifeways (prefer home births, use home remedies and herbs); 5) Political and Legal Factors (church elders assist in decision making when there is a poor pregnancy outcome) 6) Economic Factors (family and community assist with excessive health care costs); 7) Educational Factors (experience and mother, sisters, and/or grandmothers provide the education about childbearing). Table 2 displays the distribution of the themes as related to each focus group question. The results are presented in the sequence of the focus group questions (Table 3-Table 15) so the context is maintained. Descriptive narrative of the contents are in the first column with categorized excerpts of the dialogue given in the second column.

Table 2

Pattern of Themes Related to the Focus Group Questions

Question	Technological Factors	Religious and Philosophical Factors	Kinship and Social Factors	Cultural Values and Lifeways	Political and Legal Factors	Economical Factors	Educational Factors
#1			◆	◆		◆	◆
#2			◆				◆
#3							◆
#4		◆					
#5			◆	◆			
#6			◆	◆			
#7							◆
#8			◆	◆			◆
#9	◆						
#10		◆			◆		
#11						◆	
#12		◆				◆	◆
#13		◆					
	1	4	5	4	1	3	6

Table 3

Analysis of Focus Group Question 1. The sign of passage from a girl to womanhood is the first period. Describe your feeling and experiences with your first period.

Narrative Discussion	Dialogue Excerpts with Themes
All expressed being scared at the sight of the first blood and felt it would be with them the rest of their lives. Activities were limited at the time of menstruation (e.g., no running or strenuous playing, lifting heavy objects, and hoeing in the garden). It was expressed that the body was weaker and needed to be protected for childbearing. By doing her chores, sisters would be supportive during another sister's period.	Kinship and Social Factors "I was scared, but I was sleeping with grandmother and I used her potty. She seen it so she told Mother. Mother knew right away." "I learned that all my sisters had it too. That helped, too." "Mom explained about it...a sign of womanhood. I just thought it was terrible to have to put up...the rest of my life." "My older sisters told me...I wasn't scared, but I thought it was such a bother." "...if there was some heavy work that had to be done and we noticed this certain sister that's having her flow, we'd be there so she wouldn't have to go out {to do chores}.

(Table 3 continued)

Table 3 continued

Narrative Discussion	Dialogue Excerpts with Themes
	We get there and do it for her so it wouldn't be noticeable."
The boys would ask why the girls could not work, but a diversionary answer would always be given.	<u>Cultural Values and Lifeways</u> "That you gotta' take care, not run around, jump, and play like we normally do." "My mother was old fashioned...my older sisters and I used rags." "It was supposed to be a personal private deal among the girls and not talked to other children that aren't old enough to understand." "...she always told it not be shared with the boys." "If the boys caught on, they never talked about it."
Two of the women described having clothing become bloody at school where upon they were very embarrassed. A teacher (female) or older sister would give discrete assistance. They felt it was due to the use of rags for sanitary pads.	<u>Economical Factors</u> "I used rags, we didn't have expensive pads." "My mother always saved the long-john rags." "Anything that was worn out that you could tear up as rags and be absorbed,

(Table 3 continued)

Table 3 continued

Narrative Discussion	Dialogue Excerpts with Themes
	worked. I guess I got 21 or whatever, I quit using rags."
	"I go back to rags the first few days after a baby."
Only one of the five women stated she had had previous instruction on menstruation before the event. The other four did not learn about menstruation until the first occurrence of menses; a mother, a grandmother, or an older sister gave an explanation. One woman experienced an extreme "belly ache" from her first period resulting in being taken to the hospital where the cause was discovered. It was through the nurses that she learned about menstruation and the related purpose to childbearing. The other four women did not have the understanding of the relationship of menstruation to childbearing	<u>Educational Factors</u> "...will it be the rest of my life?" "She (mother) explained how it would be." "...take care of yourself." "...important to keep yourself clean." "...not talked to other children that aren't old enough to understand." "...she explained it to me...a way of growing up." {First connected menstruation to childbearing}: "When I started working at a place were they had little babies. Like helping take care of the mother and baby." "That's where I learned most of mine, when I helped take care of them."

(Table 3 continued)

Table 3 continued

Narrative Discussion	Dialogue Excerpts with Themes
until they were older when caring for older sisters after childbirth; one woman gathered observations while being with her mother who was a midwife. All expressed they were instructed not to share this information with their younger sisters and never to discuss it with any of the boys.	

Table 4

Analysis of Focus Group Question 2. What was your understanding of childbearing at the time of your wedding?

Narrative Discussion	Dialogue Excerpts with Themes
It was the general consensus that all had received some information about the wedding night but no one would share the details of the information. Two women felt comfortable in approaching their mothers with questions but the other three did not. The woman who had received information about menstruation from a professional also received information concerning the relationship of menstruation and childbearing.	Kinship and Social Factors "Once they get up to years close to marriage, usually all mothers would explain it (wedding night) or they would find out for themselves from their sisters or whatever." Educational Factors "I never did {have an understanding of the wedding night} till after I was married." "I don't think I would have cared to." {prior knowledge}. "I wasn't ready for it." "If I had any questions or anything like that she {mother who was a midwife} explained things to us."

Table 5

Analysis of Focus Group Question 3. What made you realize you were pregnant?

Narrative Discussion	Dialogue Excerpts with Themes
The women all agreed the first indication of pregnancy was a missed period followed by morning sickness. One woman particularly experienced severe morning sickness which prompted the group to discuss remedies for morning sickness. Even though the first indication of a pregnancy was a missed period, no one kept a formal record of the date of the last period.	Educational Factors "I'm not sure who it was that told me, but said there's signs, so you know what's going on." "I thought it's when you missed your period." "I just figured it was part of married life...I skipped my period then I got morning sickness. OH!"

Table 6

Analysis of Focus Group Question 4. How does your faith guide you during pregnancy?

Narrative Discussion	Dialogue Excerpts with Themes
All the participants were in agreement that their faith provided the fundamental belief that a woman's purpose in life is to bear children. It also provided acceptance when a woman could not bear children or when a pregnancy results in a poor outcome. Their own words describe it best.	Religious and Philosophical Factors "The scripture tells us bearing children, we will have more hopes of entering kingdom, Heaven." "Eve sinned." "All of us have inherited that (sin) and women can still..." "...have hopes and keep steadfast and bear children..." "It's almost as if He is forgiving us our sins." "If we patiently bear children, we can feel that we're trying to live the will of God." "My oldest sister doesn't have any children...it's the Lord's will." "I had one complication that I thought...all we could do was to trust...hope, I guess."

Table 7

Analysis of Focus Group Question 5. What are the things you do that are specifically for you and the baby before, during, and after the pregnancy?

Narrative Discussion	Dialogue Excerpts with Themes
Many different home remedies (herbs: i.e., ginger, collage of herbs, red raspberry leaf tea, emu leaf, and comfrey) were discussed to ease nausea. Vitamin and mineral supplements may be taken. The pregnancy is kept a secret as part of the Amish women's culture. Efforts are made to attend church when not feeling well so that others do not suspect. The children are never told about the pregnancy with the exception of an older daughter who may be told when the pregnancy becomes noticeable, but details were not explained. Normal everyday activities continue throughout the pregnancy except for overhead stretching and straining or heavy lifting. Baby clothes are prepared secretly	Kinship and Social Factors "My sister told me not to give up during morning sickness...keep going." "I remember my mom told me calcium was important." "I found out from another lady that she drinks three cups red raspberry leaf tea...I didn't have any kind of pain {during labor}...makes me a true believer." "...too sick to be able to attend {church}, it wouldn't be a bad thing." "...if you had a lot of morning sickness...you might want to stay home from church, so people wouldn't think you were pregnant." "Just try to put up a good front."

(Table 7 continued)

Table 7 continued

Narrative Discussion	Dialogue Excerpts with Themes
at least two weeks before the expected delivery.	"I'd brace up and try to put on a good face and go to church."
Seeking medical attention varied. One woman would see a physician before the last two months of pregnancy just for a check up without follow-visits. A midwife may be consulted a couple of months before to inform the woman of the expected date of confinement. Some women never saw a physician. A woman who knows she is Rh negative seeks professional care for the Rho-Gam injection, yet others are not aware of their blood types. All agreed a sense of well being indicates the pregnancy is progressing without complications. The first step if not feeling well, would be to ask another Amish woman who had either experienced the same problems or who had many children. The purpose of the visit to the professional would be to determine the	<u>Cultural Values and Lifeways</u> "I always aim to go {to a physician} sometime in the last month to have the examination to make sure the baby's turned right and everything's OK, blood pressure and everything for home delivery. I usually ask my doctor if it's OK for a home delivery or ask him if he thinks there is a reason why there may be complications. Other than that if I feel well, I don't see a doctor." "I think it's from experience {recognizing complications}...you've been through so many pregnancies...you know what to expect. If it's something very unusual, I would probably ask another experienced mother if she experienced such a thing or what she knows about it."

(Table 7 continued)

Table 7 continued

Narrative Discussion	Dialogue Excerpts with Themes
baby's position, blood pressure, test the urine and serum iron and to hear the baby's heart beat. One participant delivered in the hospital with the first pregnancy being unsure how labor would progress. All agreed they preferred home deliveries but would not hesitate going to the hospital if there were complications.	"I ask an older lady that has had a batch of children or someone before I go and get an opinion from a doctor." "We just try to help each other out, I guess."

Table 8

Analysis of Focus Group Question 6. What do you do to prepare for the birth? What is the role of your husband and other family members?

Narrative Discussion	Dialogue Excerpts with Themes
The women all agreed that in the early stages of labor, they continue with the usual daily activities. When delivery is eminent during the day, the children are sent to stay with relatives and if at night the children are sleeping in their beds. Husbands are present for the delivery along with a mother or mother-in-law to assist. A brother-in-law may be sent to call the midwife or physician. Baby clothing is ready, a pair of scissors and fabric or shoelace is available to tie and cut the cord. There was no mention of any other necessary equipment.	Kinship and Social Factors "Well as long as our children are old enough, like the girls to take the others outdoors or whatever, we take them to a sister or a relatives. They stay there until the baby was born." "Only my husband would be there." Cultural Values and Lifeways {Early stages of labor} "Send them (children) outdoors to do chores or whatever." "I never lay down until I have to."

Table 9

Analysis of Focus Group Question 7. What is your understanding of the birth process?

Narrative Discussion	Dialogue Excerpts with Themes
The education that the Amish women received was only from the experience of childbirth. Anecdotes described either a physician or a midwife teaching during the birth process. Those that had neither a physician nor a midwife, gathered information about the birth process by the experience. Medical terminology was very limited during the discussion. The primary understanding of the birth process included walking during the early stages, breaking of the water, and bearing down pains. The woman who had experienced ten pregnancies used appropriate medical terminology and described specific procedures she used during the birth process, which were taught to her by a physician or midwife.	Educational Factors "...mother told me you should have your first one at the hospital, but we didn't get there in time...I guess we didn't realize...my mom always told to expect the first one to take quite a long while, so...I guess it didn't." "See that's what I can't understand. I had a breech too, but it was feet first, that one. But I didn't have as much pain and as hard of delivery with that one as I had with some of the others. I can't understand that." "Usually when the bag of water broke, there wasn't that much space between that and when the baby was born. And if there is plenty of moisture it wasn't nearly as hard."

(Table 9 continued)

Table 9 continued

Narrative Discussion	Dialogue Excerpts with Themes
She prefaced a comment while describing breathing patterns that helped. She did not want to be dishonest in not telling what she understood, but she also thought others may look down on her for doing something that may not be the Amish way. One woman had experienced two pregnancies where the amniotic fluid had been ruptured for over 24 hours without labor. She expressed no understanding that this may be a complication. Two of the women experienced breech deliveries: one delivered vaginally at home, and one delivered by Cesarean section in the hospital, but expressed no understanding that this may be a birth complication. Dry births were considered difficult because it took more effort to push the baby out.	"My midwife...told me that it's important that once the head had broken through, pant like a dog. To slow the labor down so it doesn't rush out and tear...But I think that not everyone does this, but I just didn't want to be dishonest, my midwife prefers it. I was at home for all ten." "...but what I didn't realize until the last baby was that it helped to dilate, to help labor, to throw up. Did you know that?" "I guess I also learned with the babies. I never really knew with the first one." "...my mother....said...if you weren't dilated or labor was slow...to sit on a pan of warm steaming water...the last midwife I had...used a towel with hot water...that also helps, it feels good."

Table 10

Analysis of Focus Group Question 8. Describe your childbirth experiences.

Narrative Discussion	Dialogue Excerpts with Themes
One woman gave two relatively lengthy anecdotes about unusual occurrences: a birth that resulted in a Cesarean-section from a breech presentation and a stillborn.	Educational Factors {Anecdote} "I guess I never went into labor, my water broke...till it went on long enough {one full day} that we thought we should check to see what's...I guess I did notice a greenish discharge so we decided it was time to go {hospital}. The baby was breech. I ended up with a C-section because I couldn't deliver the baby...They had to do a C-section to save the baby." {same woman} "The next was another C-Section...There again my water broke and I never labored. It just didn't start...We called her {midwife} and I guess she figured because I wasn't in labor there was no hurry to come...We would have liked it if she would have came to check me to see if everything was OK. And then she

(Table 10 continued)

Table 10 continued

Narrative Discussion	Dialogue Excerpts with Themes
	did come, she said the baby wasn't down like it should be and I had a fever, and that again was a little over 24 hours. We were getting a little bit uneasy but still waited for her to come. We called her a couple of times...one time I think she wasn't there or she went to check another lady before she came to our house, because she figured as long as I wasn't in labor there was no hurry. But when she came she took us in...the nurses checked and felt the cord first. So they done a C-section because the prolapsed cord...I might have an infection."
	Cultural Values and Lifeways
	{same woman} "The next one I had a midwife. I guess she was certified midwife or whatever...The one lady works for family service. She's got a lot of experience. I know she's good.

(Table 10 continued)

Table 10 continued

Narrative Discussion	Dialogue Excerpts with Themes
	(Another lady came with the midwife whom was assumed to be New Order Amish).
	Educational Factors
	"I think she's real good. Learned. I guess we were at the point where we didn't know what to do, we didn't want to go to the hospital. One of the doctors said you should go with a C-section every time after that, but {name of midwife} gave us a lot of hope, she said she doesn't think it's necessary, just because you had one or two you know...doctors might tell you shouldn't try to have it naturally. But she doesn't feel that it's always necessary to go with a C-section. The other lady she's got a lot of herbs and vitamins that she gives and she feels it helps a lot. So we're glad to know her."

(Table 10 continued)

Table 10 continued

Narrative Discussion	Dialogue Excerpts with Themes
The remaining women described excerpts of various childbirth experiences. One woman told in detail how her midwife took a long strip of cloth, (like from a bed sheet) and knotted it at the end. She pulled the strip of cloth through the foot of the bed frame and gave the knotted ends to the woman to hold while pushing. Other women felt the bed was too soft and would deliver laying on table leaves or on the floor.	{Anecdote another woman} "I had one complication that I thought was a complication. But I learned it was OK...I got to a spot I couldn't get anywhere else. When {name} was born, we lived out in Missouri...we had a midwife that had a lot of experience, an Amish midwife...she said it wasn't the head she was seeing. She sees something else. She's not willing to be alone...at the time we had a doctor that would come from house to house to deliver if we called him...she {midwife} didn't want {husband} to go that far to phone to leave her alone...So he quickly went to my brother-in-law's house and asked him to call...the doctor's in surgery, he can't come. So there weren't much choice to be had. And I was progressing pretty good...here she came breech...everything worked out

(Table 10 continued)

Table 10 continued

Narrative Discussion	Dialogue Excerpts with Themes
	great. No complications at all."
	Kinship and Social Factors
	{Anecdote} "Our second was stillborn. My mother was there...the baby went a little early, so {husband} wasn't home, his sister was there with me at the time...she went to call {husband} home. He got there just after the baby was born.
	Educational Factors
	"...just a little bit before the delivery...I had laid down to take a rest at noon, and when I got up, a real bad pain came and my water broke. I never can recall that I felt any movement of the baby after that. I went into labor, it was the shortest that I ever had. Then the baby was born, it was limp and blue looking and it just didn't breathe at all. The cord was limp and white...that part of the cord looked

(Table 10 continued)

Table 10 continued

Narrative Discussion	Dialogue Excerpts with Themes
	pinched or whatever. There was no blood going, circulating through there."

Table 11

Analysis of Focus Group Question 9. The Amish do not possess modern conveniences such as cars, telephones, or electricity. Describe how this may influence your childbearing health practice?

Narrative Discussion	Dialogue Excerpts with Themes
The women did not find the lack of modern conveniences to be a problem. However, throughout the discussion specific times were necessary to use the neighbor's phone or to have transportation to the hospital. The women simply felt adjustments had to be made for every situation.	Technological Factors "We had a hard time getting a driver, the neighbors weren't home. By the time the driver was there, the baby was there, too." "I wouldn't consider it as a hardship, but I see it as a part of life. If we know ahead of time, we'll just try to adjust to it, and make arrangements ahead." "There's always neighbors that are willing to help." "I guess if you would have been used to it, it would be more of a problem."

Table 12

Analysis of Focus Group Question 10. Sometimes a pregnancy ends early with a miscarriage or stillborn. Describe what is done if this should happen.

Narrative Discussion	Dialogue Excerpts with Themes
The woman who experienced both a miscarriage and a stillborn shared her experiences. She was unsure of the gestational age of the miscarriage, possibly 4 ½ to 5 months gestation, but the baby was simply buried. She reported the baby could be named or not, but she did not say what was done. In the case of the stillborn, she vaguely recalled the details, but the bishop encouraged an autopsy. She and her husband took his advice. A lady took the baby, but she did not know her or what agency was involved. The cause of death was from a prolapsed cord.	Political and Legal Factors "They came out and took the baby. It was in the afternoon maybe. And she brought it back again that night. It was quite the experience." Religious and Philosophical Factors {Did you have a funeral?} "Not what would you say, maybe a grave side service, and not a real funeral."

Table 13

Analysis of Focus Group Question 11. If a pregnancy should result in excessive costs such as a large hospital bill, describe how the additional cost is managed.

Narrative Discussion	Dialogue Excerpts with Themes
All the women agreed that the cost of the hospital would not be considered if there were complications during labor. If the birth resulted in a normal birth, then each family assumes the cost. An early discharge would be requested along with monthly payments. However, if a lengthy hospitalization resulted due to complications, the church and family would give financial assistance.	Economical Factors "Well, if it's just a normal baby case in the hospital, we try to pay it ourselves." {Would the cost of the hospital be a decision in whether to go to the hospital or not?} "Not for me, I just don't prefer to go to such a public place and be uncomfortable."

Table 14

Analysis of Focus Group Question 12. Describe the care of the baby after birth.

Narrative Discussion	Dialogue Excerpts with Themes
The care of the cord was described in detail. Items used to cut and tie the cord were primitive. The salvage edge of the white gauze fabric used to make bonnets is used after running it through the flame of a kerosene lamp to sterilize it. Sometimes both ends may be tied and sometimes not. Care of the cord varied with some home remedies from alcohol to cotton bands around the abdomen to nutmeg sprinkled to enhance drying. The babies are bathed and dressed. Breast-feeding occurs if the baby is interested in eating. An anecdote of a cord coming untied was given. Male infants are not circumcised or the foreskin retracted.	Educational Factors {Cord care} "...before they do anything with the cord or bathe, they have a bowl of Lysol water to wash the hands...tie the cord and do the clipping..." "We always soak a...put a little cotton band around it, the belly, the tummy of the baby. Then we try to keep that cotton wet with alcohol every time we change the baby." "They say it's harder to keep it from getting smelly or something. If you keep it open, it's bad." "We had one scare...the midwife had left and I decided that I wanted to take the baby before I fell asleep for the night...his blanket was blood stained...he

(Table 14 continued)

Table 14 continued

Narrative Discussion	Dialogue Excerpts with Themes
	was bleeding...an experienced mother came and helped us tie it again so it was done safely...he probably would have been gone by morning."
One woman described how her first baby could not breast feed due to being tongue-tied; formula was bought but it was too expensive, so a goat was bought. Her mother gave her a recipe for homemade formula from cow's milk.	<u>Economical Factors</u> "We were buying formula but switched to cow's milk...didn't agree with him...had him on soybean...we bought a goat...my mom gave me a recipe that you use cow's milk...I don't know some flour and cooked it and added some Karo...he did real good after that." {Humor} "When you travel you couldn't take your goat with you, if you bought formula at the store, it was high priced."
Introduction of the new baby to the family lead to many descriptions of telling	<u>Religious and Philosophical Factors</u> "I think breast feeding keeps you

(Table 14 continued)

Table 14 continued

Narrative Discussion	Dialogue Excerpts with Themes
the children of where the baby comes from. This was managed based on the Amish faith and descriptions revealed the Amish sense of humor.	close to the child." {Introducing the baby to the children} "We just tell them the Lord gave it to us." "...He's got a way to do it. It's not hard for him to give them to us the ones who want to have babies. And usually the little ones are pretty satisfied with that. We tell them that God has a way to do it, He knows how. They understand that and don't ask as many questions."

Table 15

Analysis of Focus Group Question 13. How is it decided when the next child will be conceived?

Narrative Discussion	Dialogue Excerpts with Themes
This topic was lead into by discussing breast-feeding. Weaning occurred when the child is "too old" which was "when they come and ask". The women felt breast-feeding helps to prevent future pregnancies for some. The next child is planned for "after we know it's coming."	Religious and Philosophical Factors "We just leave it to the power of the Lord."

Discussion

Interpretation of the Findings

The participant comments were selected to give the emic perspective of childbearing health practices as described by Amish women of the Marlette community of Sanilac County, Michigan. Tables 3-15 provide a glimpse of the style of speech and the individual understanding of each participant's childbearing health practices. A contrast of perception was presented with the sense of control over the labor while at home, e.g. by the detailed sharing of methods used, as compared to the perception that hospitals are "public and uncomfortable." Home births were still preferred even after women had experienced Cesarean-section births and a stillborn birth. The descriptions given were consistent with the Amish culture with one woman even venturing to describe a childbearing health practice (breathing pattern during labor) that may not be within the culture. The secrecy of the pregnancy, the use of home remedies, having a strong support system of family and community were consistently described. The only clear difference in the descriptions was the level of knowledge of childbearing of each Amish woman due to various life experiences.

The birth intervals of approximately 20 months suggests that women were either pregnant or breast feeding during this time period. Considering the grand-multiparity, this indicates that a woman's body is experiencing constant physical stress. Cross (1976) speculated the stresses of childbearing may have an adverse effect on female longevity.

The childbearing health practices as described by the sample supported the literature of other studies of Amish women (Acheson, 1994; Brewer & Bonalumi, 1995; Finn, 1995; McGinn, 1996; Palmer, 1992). Multiparity, late entry into prenatal care, few prenatal visits and births attended by midwives were comparable to the Amish in Ohio (Acheson, 1994) as were the value placed on motherhood, the supports system of family and community, and the excessive health costs assumed by family and community.

Home births were preferred which was similar to the Amish in Pennsylvania (Palmer, 1992); the Amish faith provided the acceptance for life circumstances.

The pattern of themes are demonstrated in Table 2 by each focus group question showing which themes emerged. Educational Factors appeared most frequently. The results indicated initial primary knowledge was received from other Amish women (mothers and sisters). Home remedies and the advice of the other experienced Amish women were sought before professional health care. This is consistent with the literature (Brewer & Bonalumi, 1995; Finn, 1995). The three factors that influence using folk or professional health care found by Wenger (1995) are evident in this Amish population: (a) type of problem (folk care for home births and professional care for complications of pregnancy); (b) accessibility of health services (midwife comes to the home whereas a driver is required to access professional health care); and (c) perceived cost (hospitals are used for complications of pregnancy with excessive cost assumed by the community).

Lack of basic knowledge of human anatomy and physiology was substantiated by the specific details describing the Amish women's experiences; very few medical terms were used. The Amish women demonstrated a lack of curiosity about menses and the relationship of pregnancy and the desire not to inquire about details concerning the wedding night. Amish women's understanding of childbearing was based on their own experiences or learned from other Amish women's experiences. Examples of lack of formal knowledge were: (a) failure to keep an accurate record of the first day of menstruation accounting for not knowing exact gestational dates; (b) failure of recognizing prolonged rupture of membranes as a complication; and (c) lack of knowledge about proper cord care or that cow's milk cannot be digested by newborns. There was no mention of a newborn examination or immunizations. The fact that the pregnancy was kept a secret or not discussed openly limits the opportunity for exchange of information. None of the women gave full detailed explanations of menstruation, such as a 28-day cycle, ovulation, or the relationship of menstruation and pregnancy.

The next theme that emerged most frequently was Kinship and Social Factors. This reflected the strong support system among the Amish women, assuring maintenance of the Amish culture. Mothers and husbands were present for the births with extended family assisting in care of the other children. The sisters of an Amish girl menstruating will complete her work. The Amish women concealed their pregnancy from others as much as possible, such as attending church when not feeling well during the early stages of pregnancy.

Religious and Philosophical Factors and Cultural Values and Lifeways occurred with equal frequency. Religious and Philosophical Factors provide the understanding of the Amish's childbearing health practices of multiparity. It is the "Lord's will" to bear children which gives the purpose in life for these Amish women. Cultural Values and Lifeways are demonstrated in the day to day living experiences of the Amish culture; the strong desire for home births and seeking professional health care when perceived complications occurred.

Economical Factors occurred infrequently and included the use of rags for sanitary pads during menstruation, the cost of hospitalization, and the cost of infant formula. Providing sanitary pads for several daughters could be a considerable cost. Standard manufactured infant formula for one month is estimated to cost $80.00. These Amish women breast fed their infants, but on occasion when the breast milk ceased, whole cow's milk was substituted to avoid the cost of formula. Hospitalization costs were not covered by insurance and the family and/or the Amish community assumed the cost.

Technological Factors and Political and Legal Factors were reported only once. These two themes appear to have minimal importance to the participants; women stated that lack of modern conveniences was not a "hardship". The bishops or elders make the political and legal decisions within the Amish community so this was not relevant for the

women (e.g., the woman who experienced the stillborn birth did not question the authority of the outsiders).

What the data does not demonstrate is the critical thinking of the participants. One participant who ventured to describe the breathing patterns she learned, questioned the consent form as to how confidentiality would be managed, and would not sign the consent form until all her questions were answered to her satisfaction. In addition, the woman asked if someone else could obtain the data and print it in the newspaper. The woman was reassured that her name and any identifying information would not be included in any written form.

Following the formal focus group discussion, while serving the refreshments, the participants continued the discussion about home remedies and various herbs. They asked each other for clarification of the preparation, amount, and frequency of use of the herbs. Half of the time the group spoke in German. This sharing of information continued during the ride home with the comments made of how much each one learned which again support the two main themes: Educational Factors and Kinship and Social Factors of knowledge being gained from other Amish women and the strong support system of maintaining the Amish culture. Only a few direct questions were asked of the researcher (e.g., should both ends of the cord be tied, and at what age cow's milk can be give to the infant). The researcher gave each participant the recipe and the materials to make baby wipes out of paper towels.

Theoretical Model in Relation to Childbearing Health Practices as Described by Amish Women of the Marlette Amish Community of Sanilac County, Michigan

The Sunrise Model as it was modified provided an excellent conceptual framework for this study. However, given the findings, modifications could still be made (Figure 3). The Amish faith, culture and lifestyle are all strongly interconnected. Figure 3 displays the cultural and social structure dimensions connecting the seven influential factors to the findings of this study. The technological factor was the need to rely on

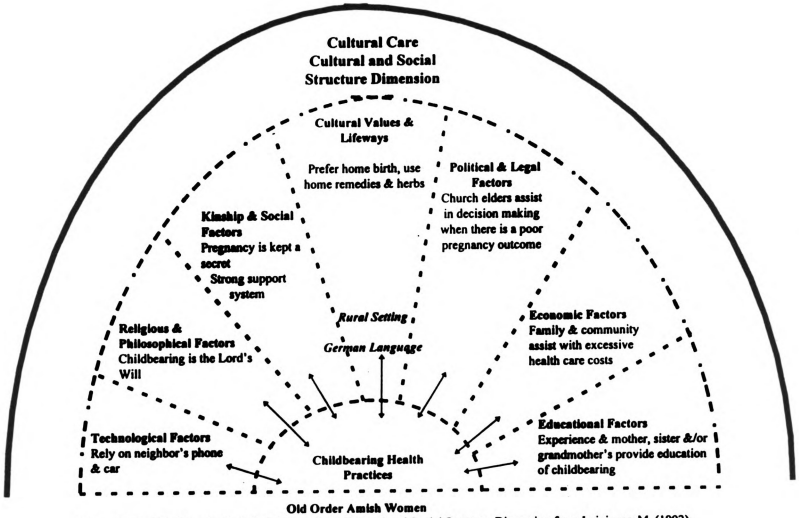

Figure 3 Modified Sunrise Model of Culture Care, Cultural and Social Structure Dimension from Leininger, M. (1992) Sunrise Model based on this study's findings.

neighbors' telephones and cars for communication and transportation. The religious factor was the strong faith that their life was guided by the Lord's Will. Kinship and social factors related to strong support family and community systems and the pregnancy was kept a secret. Cultural Values and Lifeways Factors were indicated by the preference of home births and home remedies and herbs. The political and legal factors incorporated the church elders making decisions with a poor pregnancy outcome occurred (stillborn). Economical factors were evident when the family and community assisting with excessive health care costs. Educational factors were the lacking of formal education about childbearing with experience and female family members providing the education.

Implications for Advanced Practice Nurses

In order to provide culturally congruent care, the APN must become knowledgeable of the Amish culture. Knowledge can be gained through formal education, through informed learning by reading about the Amish culture in professional journals or the few books available that depict the authentic culture, and through research and practice. This researcher gained knowledge about the Amish culture through research with the Marlette Amish community of Sanilac County, Michigan. The Amish are willing to share information about their culture if approached in a respectful, polite manner; intrusive behavior is simply ignored by the Amish, with no information provided.

The APN is most likely to encounter the Amish in a clinical setting. Amish communities are expanding, increasing the possibility of encounter with the professional health care system. Currently, it is unlikely that the APN within the professional health care system would be consulted for preventive care. However, the APN is more likely to be consulted after the folk care system has not produced positive results (Wenger, 1995).

The role of the APN is to establish a trust relationship with the Amish as a primary health care provider and to provide culturally congruent care. The Amish have respect for professional health care providers, but their trust is earned through incorporation of the Amish culture into the professional health care provider's plan of care. The APN needs to creatively combine folk and professional health care to this population seeking health care services receive culturally congruent care (Leininger, 1991). This researcher can attest to this through her own professional health care experiences with the Amish. If an intervention is decided by the APN, but is not culturally congruent with the Amish beliefs, the Amish will politely agree but will not comply. If the APN consistently practices in this manner, the Amish will not seek out this individual provider's care again. Trust in the APN by the Amish is an essential first step towards establishing a therapeutic relationship (Palmer, 1992; Wenger, 1991).

In the process of assessing the Amish client, patience is required in history taking, since answers may be vague and incomplete. Persistence is a quality also needed to secure accurate answers concerning current use of home remedies and herbs, which are used prior to seeking professional health care. It is advantageous if the APN has prior knowledge of herbal therapy as to know what may be safely incorporated into the plan of care.

Cost of care needs to be a consideration when negotiating for a mutually acceptable plan of care since the Amish do not have health insurance. The Amish are not reluctant to pay for necessary professional health services, but are appreciative when appropriate care is also cost contained. In some Amish communities, any community service, such as the Women, Infants, and Children (WIC) Supplemental Food Program, that requires the signature of the beneficiary, is not be an acceptable practice. Thus, Amish women miss out on the opportunity to receive certain community resources which might benefit their health during the childbearing years. Taking all of these financial factors into consideration promotes trust of the APN.

This study found the sample of Amish women lacking basic scientific knowledge of childbearing health practices. An assessment of each individual's understanding needs to be discovered before education is initiated. Offering formal childbirth education classes to a group of Amish women most likely would not be successful since pregnancies are kept secret or not openly discussed in public. However, the Amish woman is open to learning, but care must be taken to teach at her level of understanding. Education with every encounter with the individual Amish woman is an important component to assure successful outcomes (Fuch et al., 1990; Kemp & Hatmaker, 1992; Kogan et al., 1994; Lewallen, 1989; Tiedje et al., 1992). Negotiation with the between the APN and the Amish of the planned intervention is needed so that it is both mutual and acceptable (McGinn, 1996). This may take much creativity on the part of the APN to adapt the appropriate intervention so as to assure engagement and adherence. The following exemplar illustrates this.

This researcher currently has an established independent nursing practice with the Marlette Amish community. Two years ago, a participant of this study who was Rh-negative needed assistance from this researcher to locate obstetrical care with her fifth pregnancy. She was almost six months pregnant and knew she soon needed a Rho-Gam injection. Arrangements were made with a female obstetrician, who was understanding of the Amish cultural practices and complied with the Amish woman's request. The Amish woman "felt well" and refused the initial pelvic examination and opted for only the essential blood work, a complete blood count, and blood type. The woman was scheduled for a Rho-Gam injection which she received, but she refused to comply with the routine antepartum appointments because she "felt well". This researcher felt a professional obligation to both the Amish woman and the obstetrician to ensure appropriate health care during her pregnancy. Therefore, it was mutually negotiated and agreed upon that home visits for the antepartum care would be done by this researcher. During the home visits, it was necessary to assure privacy since the children were

unaware of the pregnancy. Because a fetal ultrasound doppler was being used, the children were sent outside so that they would not hear the sound of the fetal heart beat from the ultrasound since this would surely have generated many questions.

This Amish woman's pregnancy ended with a positive home birth, with the delivery of a term female infant; the woman was assisted by her husband and her mother. The next morning, the husband using the neighbor's telephone, contacted this researcher to obtain the Rho-Gam injection. After a home visit to assess the mother and infant, the Amish couple were persistent in receiving the Rho-gam injection rather than testing the baby for her blood type. The Amish parents felt it was "too cruel" to subject the infant to such a procedure. The next day, the obstetrician approved and allowed the Rho-Gam to be given at home.

The Amish couple commented on their appreciation for all that was done to comply with their cultural practices. However, the infant never received the state mandated Hepatitis B vaccine nor the neonate screening for possible disease (e.g., hypothyroidism). The Amish woman never received a postpartum examination. Often this may lead to feelings of frustration with noncompliance of "professional" health promotion and maintenance practices. This is an area where creativity, patience, and persistence are necessary characteristics in order to gain a trustful therapeutic relationship. Reprimanding for noncompliance will not accomplish this. By openly combining the Amish folk care with professional health care, there will be increased willingness for continued care so that "health can be maintained and health education provided" (Adams & Leverland, 1986, p.67).

For the Amish women in the Marlette community who seek out lay midwives, the APN could assure quality professional care by collaborating with obstetricians at the hospital where an Amish woman may appear suddenly unannounced with a complication of labor. The APN could meet with the current lay midwives involved with the Amish community to gain an understanding of their education and practices. A Certified Nurse

Midwife may have an interest in providing services in these communities. Establishment of a local Amish birth center such as described in Ohio (Acheson, 1994) would not be feasible in some communities where the birth rate is small. This is true for the Amish living in the Marlette community, where only 12 births were reported for 1996.

Changing of childbearing health practices by an outsider would be met with resistance (Adams & Leverland, 1986; Brewer & Bonalumi, 1995). The Amish culture influences are strong; acceptance of change is a slow process. A general knowledge base of the Amish culture is needed as well as an awareness of the individual Amish community's practices. The APN faces the challenge of becoming a trusted primary health care provider. This can only occur by direct individual interactions with respect for the Amish culture. Through education, mutual respect, and negotiation, the APN can begin to give culturally congruent care (Wenger, 1995; Wiggins, 1983).

Implications for Research

There are many areas in the Amish culture that could be researched such as immunizations and safety, as well as more information about childbearing health practices. A study may be attempted among the Amish women in the Marlette Amish community using a similar design but with an one-on-one interview methodology being used in place of a focus group. Without the group's influence, it could be anticipated that more detailed, intimate information could be obtained from a single subject for deeper insight of Amish childbearing health practices. A larger sample including older, experienced Amish women could be interviewed to compare and contrast childbearing health practices from one generation to the next. By examining changes in the folk care system an understanding of the process of change among the Amish could give insight into implementation of new childbearing health practices.

Summary

This study described childbearing health practices of five Amish women. The Amish women were influenced to bear children by their faith. Their faith supports acceptance of life circumstances such as a poor pregnancy outcome (miscarriage or stillborn). These Amish women preferred home births. It was a practice to keep the pregnancy a secret and discussion of childbearing health practices a private matter. The support-network of these Amish women reinforced the practice to use home remedies and recommendations from other Amish women before seeking professional health care. It was discovered that these Amish women had limited formal knowledge of the childbearing process. Education of childbearing was from experience or from other Amish women. Professional health care was sought only when these Amish women perceived a complication during the pregnancy or labor.

The APN who encounters the Amish in a clinical setting needs to have knowledge and respect of the Amish culture to face the challenge of becoming a trusted primary health care provider. Through education, mutual respect, and negotiation, the APN can begin to give culturally congruent care. Future research could examine Amish childbearing health practices from one generation to the next to gain insight into the process of change to implement new childbearing health practices.

APPENDIX A

Sample Focus Group Questions

Introduction

You have previous knowledge the purpose of this gathering is for you to describe your childbearing health practices which will be of a very personal nature. Questions will be asked to guide the discussion and to keep focused on the topic of childbearing health practices so that an understanding of your ways is gained to help health care professionals be able to provide care that would be acceptable to the Amish. All that is said is strictly confidential with privacy maintained during the discussion. It is hoped that you give open and honest answers. The content of the questions range from your first period, your understanding of childbirth, the role of the family with childbearing to planning the next child. It is hoped that each woman will participate and share her unique feelings and experiences. It will take approximately one and one half-hours. Are there any question before we begin?

Warm up

We will begin the focus group session by going around the table with each of you telling us your first name (last initial if two first names the same), the number of children you have, and what you like about being a mother.

Cultural values and lifeways

The sign of passage from a girl to womanhood is the first period. Describe your feelings and experiences with your first period an include any preparation or understanding you may have received.

Kinship and social factors

What was your understanding of childbearing at the time of your wedding?

Educational

What made you realize you were pregnant?

Religious and philosophical

How does your faith guide you during your childbearing years?

Cultural values and lifeways

What are the things you do that are specifically for you and the baby before, during, and after the pregnancy?

Kinship and social factors

What do you do to prepare for the birth? What is the role of your husband and other family members?

Educational

What is your understanding of the birth process?

Religious and philosophical

Describe your childbirth experiences.

Technological

The Amish do not possess modern conveniences such as cars, telephones, or electricity. Describe how this may influence your childbearing health practices.

Political and legal

Sometimes a pregnancy ends early with a miscarriage or stillbirth. Describe what is done if this should happen.

Economical

If a pregnancy should result in excessive costs such as a large hospital bill, describe how the additional cost is managed.

Cultural values and lifeways

Describe the care of the baby after birth.

Religious and philosophical

How is it decided when the next child will be conceived?

APPENDIX B

Recruitment Letter

(Date)

Dear (NAME),

As a woman of the Old Order Amish culture, you are requested to participate in a nursing research study conducted by Nancy L. Miller, R.N., B.S.N., from the College of Nursing, Michigan State University.

The purpose of the study is to describe childbearing health practices as described by Old Order Amish Women so that further understanding can be gained to provide professional health care that would be acceptable to the Old Order Amish. Information will be gathered from completion of an informational demographic questionnaire and participating in a focus group discussion with about five to seven other Amish women. All information received will be confidential.

The focus group discussion will take place at my home: 569 Saginaw Road, Mayville, MI, so that privacy can be maintained. It will take approximately ten minutes to complete the questionnaire and the focus group discussion will last one and one half-hours. Transportation to and from the focus group will be provided. The time will be mutually decided by participants in the group.

For your participation, free transportation to shop at Sam's Club will be provided at a mutually decided time.

Enclosed is a self-addressed postcard to be completed indicating your decision. If you are undecided and want more information please indicate so on the postcard. After receiving the postcards, personal contact will be made to establish a time and to answer any further questions.

Thank you for your consideration to participate. I will be looking forward to hearing from you soon.

Sincerely,

Nancy L. Miller, R.N., B.S.N.
569 Saginaw Road
Mayville, MI 48744
(517) 843-6179

APPENDIX C

Informed Consent Form

Nancy L. Miller, R.N., B.S.N., from the College of Nursing, Michigan State University, requests your consent to participate in the study "Childbearing Health Practices As Described By Old Order Amish Women" of Sanilac County, Michigan.

The purpose of the study is to describe childbearing health practices as described by Old Order Amish women so that further understanding can be gained to provide professional health care that would be acceptable to the Old Order Amish. Information will be gathered from completion of an informational demographic questionnaire and participating in a focus group discussion.

The informational demographic questionnaire will be completed prior to the discussion taking about ten minutes. The focus group discussion will last one and one half-hours which will be taped recorded. Your signature provides your consent to tape record the focus group discussion.

For your participation, you will receive free transportation to shop at Sam's Club at a mutually decided time.

As a participant there will be no beneficial results guaranteed as a result of participating in this study. You are free not to participate at all or to withdraw from participation at any time, and the decision to withdraw will have no direct consequences to you. Concerns or requests of the results of the questionnaire or discussion can be directed to Nancy L. Miller by letter at 569 Saginaw Road, Mayville, MI 48744 or by phone at (517) 843-6179.

The responses and comments made during the discussion are confidential. There will be no identification of you on the questionnaire. The tape recordings will be transcribed without any identification of you and the tapes will be destroyed after being reviewed. There will be no identifying information in any written materials or in any presentation which may result from this study.

I certify that I have read the above consent and I voluntarily agree to participate.

_____

(Date) (Signature of Participant)

_____

(Date) (Signature of Witness)

APPENDIX D

Demographic Information of Participants

Age:_____

Number of Pregnancies:_____ Children born alive:_____;

List each date of birth	Birth Weight	Sex	On Time/Over/Early
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Stillborn:_____ Miscarriages:_____ Age of first period:_____

Age at time of Marriage:_____

Age at time of birth of first child:_____

Number of children born in a birthing center/hospital:_____

Number of children born at home with assistance of midwife:_____

Number of children born at home with assistance of family:_____

APPENDIX E

MICHIGAN STATE
UNIVERSITY

June 6, 1997

TO: Mildred A. Omar
A-230 Life Sciences

RE: IRB#: 97-388
TITLE: CHILDBEARING HEALTH PRACTICES AS LIVED BY OLD ORDER AMISH WOMEN
REVISION REQUESTED: N/A
CATEGORY: 1-C
APPROVAL DATE: 06/05/97

The University Committee on Research Involving Human Subjects' (UCRIHS) review of this project is complete. I am pleased to advise that the rights and welfare of the human subjects appear to be adequately protected and methods to obtain informed consent are appropriate. Therefore, the UCRIHS approved this project and any revisions listed above.

RENEWAL: UCRIHS approval is valid for one calendar year, beginning with the approval date shown above. Investigators planning to continue a project beyond one year must use the green renewal form (enclosed with the original approval letter or when a project is renewed) to seek updated certification. There is a maximum of four such expedited renewals possible. Investigators wishing to continue a project beyond that time need to submit it again for complete review.

REVISIONS: UCRIHS must review any changes in procedures involving human subjects, prior to initiation of the change. If this is done at the time of renewal, please use the green renewal form. To revise an approved protocol at any other time during the year, send your written request to the UCRIHS Chair, requesting revised approval and referencing the project's IRB # and title. Include in your request a description of the change and any revised instruments, consent forms or advertisements that are applicable.

PROBLEMS/ CHANGES: Should either of the following arise during the course of the work, investigators must notify UCRIHS promptly: (1) problems (unexpected side effects, complaints, etc.) involving human subjects or (2) changes in the research environment or new information indicating greater risk to the human subjects than existed when the protocol was previously reviewed and approved.

If we can be of any future help, please do not hesitate to contact us at (517)355-2180 or FAX (517)432-1171.

Sincerely,

David E. Wright

David E. Wright, Ph.D.
UCRIHS Chair

DEW:bed

cc: Nancy L. Miller

OFFICE OF
RESEARCH
AND
GRADUATE
STUDIES

University Committee on
Research Involving
Human Subjects
(UCRIHS)

Michigan State University
246 Administration Building
East Lansing, Michigan
48824-1046

517/355-2180
FAX: 517/432-1171

APPENDIX F

October 16, 1997

Office of Research and Graduate Studies
University Committee on Research Involving Human Subjects (UCRIHS)
Michigan State University
246 Administration Building
East Lansing, MI 48824-1046

RE: IRB# 97-388
CHILDBEARING HEALTH PRACTICES AS LIVED BY OLD ORDER AMISH WOMEN.

Dear UCRIHS,

This letter is to inform UCRIHS a slight revision in the recruitment process from the original proposal. The proposal stated that subjects would be contacted personally after the investigator received postcards giving their decision to participate. However, only 3 postcards were received out of ten sent. After waiting two weeks this investigator made personal contact with the remaining 7 potential subjects. Personal contact was necessary since the Amish do not have telephones. The subjects were approached by asking if they had received the recruitment letter and if the postcard had been sent. All had received the letter, but were too busy to sent the postcards. A verbal response to the recruitment letter was given at that time. Of the ten potential subjects, two refused to participate, two were expecting to deliver soon, and one would like to but had other obligations. Of the ten, 5 women agreed to participate. A date and time for the focus group interview was agreed upon at this time as stated in the proposal.

With this slight change, there was no harm or injury to the subjects and the subjects freely made their own decisions.

If the committee has any further questions please write or call my home at (517) 843-6179. Thank you.

Sincerely,

Nancy L. Miller

Nancy L. Miller

APPENDIX G

MICHIGAN STATE
UNIVERSITY

15 December 1997

To: Dr. Mildred Omar and Ms. Nancy Miller
From: David E. Wright, Chair, UCRIHS
Subject: IRB #97-388 "Childbearing Health Practices as Lived By old Order Amish Women

UCRIHS reviewed each of your responses to a 18 November 1997 letter requesting an explanation why a revision to the above mentioned protocol was implemented prior to review and approval of the revision by UCRIHS. Dr. Omar's letter explains that due to her nine month appointment, she was not available to advise Ms. Miller over the summer. Ms. Miller completed her field work on her own. During that time Ms. Miller sent out postcards to Amish women inviting them to participate in her research project. However, when she did not receive postcards back from all of her potential subjects, she visited their homes. Ms. Miller's letter explains that she had intended to visit the Amish women all along and therefore did not consider it a revision. Upon review of the original application UCRIHS has determined that is clear that Ms. Miller would have visited the homes of the women who did return postcards, expressing an interest in the research project. However, it is not clear that a home visit was intended as a second attempt to recruit potential subjects. Ms. Miller and Dr. Omar explained that the Amish women were patients of Ms. Miller and were known to her. Therefore, although University and federal regulations require that any change in a protocol must be submitted to UCRIHS for review and approval prior to initiating the change, it does not believe that subjects were harmed or put at increased risk due to the implementation of this revision. Therefore, UCRIHS will take no action to restrict Ms. Miller's use of the data in question.

OFFICE OF
RESEARCH AND GRADUATE STUDIES

University Committee on Research Involving Human Subjects (UCRIHS)

Michigan State University
246 Administration Building
East Lansing, Michigan
48824-1046

517/355-2180
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