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Being a Woman: Perspectives of Low-German-Speaking Mennonite Women

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### Abstract

Understanding the beliefs and knowledge related to women's sexuality is important when working with unique religious groups in order to provide culturally appropriate care. An exploratory, descriptive qualitative study generated knowledge, beliefs and practices related to menstruation, ovulation and family planning among Low German-speaking Mennonite women (n = 38). There is a pervasive silence that surrounds sexuality among this group with limited understanding of the physiological changes they experience. Honoring religious principles and family and community expectations through acceptable female behavior is essential. Adherence to religious principles varies by family but is not shared with the group to avoid disfavor.

Word count: 100

Key words: Mennonite women; rural populations; women's health, human sexuality

## Being a Woman: Perspectives of Low-German-Speaking Mennonite Women

Providing care to varying cultural and religious groups who reside in rural contexts can present challenges for health care providers such as midwives and nurses. Gaining access and establishing trust with such unique groups may take considerable time but can lead to a greater contextual understanding of their beliefs, knowledge and practice. Thereafter, care can be developed and implemented in collaboration with the individual and family to help ensure its acceptance. This article is a report of a qualitative study of one religious group, the Low-German-Speaking (LGS) Mennonite women, and their knowledge and beliefs regarding menses, ovulation and family planning.

### Background to the Low-German-Speaking Mennonites

Mennonites are members of the Anabaptist religious group that also includes the Amish and Hutterites. All of these groups believe in adult baptism, pacifism and a literal interpretation of the Bible, which includes maintaining a separation from the modern world (DeLuca & Krahn, 1998; Redekop, 1969; Sawatzky, 1971). Large groups of Mennonites relocated in several waves of migration from Europe, including Russia and Germany in the 1870s and from 1890-1920, seeking countries where they could practice their religion free from interference (Jaworski, et al., 1988).

The LGS Mennonites are a conservative denomination among the Mennonites, with three primary sub-denominations or branches: Kleine Gemeinde (most liberal), Sommerfelder; and Old Colony Church (more conservative). The Rhinelanders are another, less prominent, denomination that falls between the Kleine Gemeinde and the Sommerfelder in its conservatism. In all of these denominations, the ministers are responsible for interpreting the Bible and determining how it applies to everyday life. Therefore, decisions about many forms of activity

(for example, whether a woman can cut her hair for head surgery) may involve the minister. The LGS Mennonites view themselves principally as a religious group because their everyday decisions and lifestyle are dictated by Bible interpretation.

In 1922, more than 7000 conservative Mennonites emigrated from Canada to Northern Mexico (Bensen, 1998; Sawatzky, 1971) and became colloquially known as “Mexican” Mennonites. In some cases, splinter groups developed and moved to other countries, such as Belize and Paraguay (Sawatzky, 1971). In addition, many of the families that had moved to Mexico found it difficult to adapt to the climate and agricultural differences and returned to Canada (Bensen, 1998). By the 1970s and 1980s, other conservative Mennonites had returned to Canada from Mexico and Belize, setting up residence in a number of communities predominantly in Ontario, Manitoba, and Alberta. It is now more common and acceptable to refer to these Mennonites as Low-German-speaking rather than Kanadier or Mexican Mennonites.

Today there are approximately 57,000 Low-German-speaking Mennonites in Canada, of which 12,000 to 15,000 are in Alberta while the remaining reside in Manitoba and Ontario (Janzen, 2004). In Alberta the majority have been attracted to the Southern region, where they live near agricultural communities and work in feedlot operations, and on potato and sugar-beet farms. Most individuals who live in these communities have low literacy skills, a limited education (usually only to age 12), and little exposure to technology. Because of their limited ability to speak, read and write English, they experience many challenges in Canada, including limited access to health care.

Information about Mennonite women is scant but what is available emphasizes that they were the weaker sex and that their role was to bear many children and work silently beside their

husbands (Loewen, 2001). Women's clothing was restricted to plain dresses and prayer caps to ensure that God heard their requests (Hurst, 2003; Kulig, 1995). A silence surrounds childbirth among Mennonites largely as a measure to protect men's sexual interest in their wives (Martens & Harms, 1997). That is, if men understand what their wives endure during childbirth, they will cease having sexual relations with them. Information that is available about LGS Mennonites emphasized family planning as sinful, because the women considered children to be gifts from God (Reinschmidt, 2001). However, younger couples were facing the economic challenges of having large families, and are being encouraged by physicians to use family-planning methods that would be acceptable to them, such as natural methods. Overall, discussion of sexuality and reproductive health is a sensitive area particularly with those from the Old Colony church (Reinschmidt).

Premarital sexual intercourse was frowned upon to the extent that, when married, young women who had engaged in sexual intercourse before marriage wore a particular color of headscarf (Kulig, 1995; Kulig & McCaslin, 1998). In another recent study among this group, the participants confirmed that they were provided limited information about pregnancy (Kulig, et al., 2002; Kulig, Hall, Babcock, Campbell & Wall, 2004).

#### Purpose

The purpose of the research was to generate information about LGS Mennonite women's knowledge and beliefs in relation to sexuality (i.e., menses, sexual intercourse, gynecological tests including pap smears, breast health, ovulation, conception, pregnancy, breast feeding, family planning, & menopause) (Kulig, Babcock, Wall & Hill, 2006). The purpose of this article is to discuss the LGS Mennonite women's knowledge and beliefs in relation to menses, ovulation and family planning.

### Study Design

A two-year study was conducted to address the research questions noted above. An exploratory, descriptive qualitative study was conducted to ascertain knowledge and beliefs regarding menstruation, ovulation and family planning (Sandelowski, 2000; Tuck, 1995) among LGS Mennonite women. Generating information about these topics can help in the development and implementation of appropriate and successful health-promotion programs for the LGS Mennonites who are one example of diverse groups residing in rural communities (Farthing, 1994; Kreps & Kreps, 1997). The study had ethical approval from the first author's institution.

#### *Methods: The Qualitative Interviews and Analysis*

A collaborative team (all authors) conducted the research based upon their professional experiences including development and providing health promotion and community development initiatives with this group that has spanned more than a decade. In addition, the third author is Mennonite and speaks Low German, a definite advantage in her work with this population. The authors were versed in ways to successfully conduct the study based on their prior experience. Examples include avoiding the use of tape recorders in the interviews due to Mennonites' discomfort with such devices, concerns about being tape recorded and at least for some, the incompatibility of the technology with their religious principles. Other details that describe how to successfully conduct research with this population have been reported elsewhere (Hall & Kulig, 2004).

Before the study commenced, the first author telephoned the ministers to notify them of the study and its purpose which was to inform health and social service providers about the beliefs and knowledge by the LGS Mennonite women in order to enhance the care provided to them. Media coverage about the study was limited out of respect for the LGS Mennonites'



preference for privacy. German-speaking Mennonite women were hired as Research Assistants (RAs) to conduct the interviews with the participants. Great care was paid to the selection of the RAs and was one of the first tasks of the research team. The team generated a list of possible RAs and then decided the most appropriate individuals based upon maturity level, reputation in the general Mennonite community, and ability to adhere to privacy regarding the project and the interviews. Thus, the three women who were chosen were respected in the general Mennonite community and were not seen as threatening the Mennonite way of life. In addition, there were no concerns regarding conflict due to membership in the local Mennonite churches because the RAs attended other denominations of the Mennonite churches than the sample.

The RAs were trained by the first author to conduct the interviews. Any issues that arose with the data collection were addressed on an ongoing basis. Importantly, Low German terms for key concepts (e.g., menses, pregnancy) to be used in the interviews were agreed upon during the training session with guidance from the third author to ensure consistency between the RAs. At the end of the study, community meetings were held with the LGS Mennonite women to discuss the findings; the final report has also been distributed to this group as well as complimentary Low German and English CD ROMs and cassettes that emphasize the major findings of the study for individuals who accept such technology.

### *Data Collection*

Open-ended interviews were conducted with Low-German-speaking Mennonite women ages 18 and over until category saturation occurred (Schatzman & Strauss, 1973). Both purposeful and snowball methods were used to select the sample (Morse, 1989; Streubert, 1995) which was located throughout southern Alberta. There were no refusals to participate. The interviews were open-ended using a guide developed by the research team; the questions covered

the full breadth of women's health issues and probes were used as necessary. Due to the nature of Mennonite relationships which necessitated a social visit either before or after the interview, the time in the home could take up to 2-3 hours. The actual time for the interview ranged from 45 minutes to 1.5 hours. Similar to many ethnographic studies, the RAs took short notes during the interviews and then immediately after the interview, they taped a summary of it which was subsequently confidentially transcribed for data analysis. This method was adopted after discussion with Sawatzky (1971) who successfully used this technique when he studied one of the groups of Mennonites who live in Mexico.

### *Data Analysis*

Data analysis and collection occurred simultaneously; sorting of categories (Glaser, 1978) and constant comparison (Glaser & Strauss, 1967) were used. The use of the participants' terminology illustrates that the findings are grounded in the data. Regular meetings with the collaborators and RAs helped ensure that the data analysis was accurate according to the social context of Mennonite religious beliefs. Trustworthiness of the data (Lincoln & Guba, 1985; 1986) was established by specific activities such as hiring Mennonite women to conduct the interviews and including the entire research team in the analysis of the transcripts and field notes to ensure that the socio-religious context was well understood.

The study limitations included that the RAs did not always clarify any discrepancies in the interviews, nor did they probe some topics to the extent they might have; and the manner of interviewing which included a taped summary rather than a tape of the whole interview may have meant that details and direct quotes were not always recorded.

## Findings

The demographic information indicated that one participant was under 20; 7 were between the ages of 20 - 29, 13 were between the ages of 30 - 39, 9 were between the ages of 40-49; 7 were between the ages of 50 – 59 and one was 60 years and over. Twenty of the women had completed 6 years of schooling in Mexico which is equivalent to approximately a grade 3 education in Canada. All were married except one woman who was separated; all but one had commenced childbearing. Among the 38 women, there had been a total of 228 pregnancies plus there were four women pregnant at the time of the interview for a grand total of 232 pregnancies (Table 1). Seventeen of the women had had 0 – 5 pregnancies, 18 had had 6 - 10 pregnancies, 2 had had 11 – 15 pregnancies and 1 had had 16 - 20 pregnancies. Two women had each had a set of twins. One woman was raising her two granddaughters as if they were her own children.

### *The Social Context of Being a LGS Mennonite Woman*

This brief discussion about the social context of Mennonite families and the roles of women is included in order to enhance understanding of the interview themes that follow.

Generally speaking, groups of people take on specific roles that guide their conduct within public and domestic spheres of life. Various controls are established to ensure that these roles are subscribed to by the group. Religious doctrine serves as one guide for male and female behaviour and provides specific expectations in certain groups. However, in the case of traditional Mennonite denominations, religious doctrine and its application varies from one church to another, and behavioural expectations are therefore determined on a church-by-church basis. Examples include the differences between how different churches deal with individuals who use or abuse alcohol, and whether or not they use excommunication to deal with unacceptable behaviours. The low education level among the group dictates that personal reading

and interpretation of the Bible is not possible; religious principles are taught by the ministers in their regular weekly church services.

Among the Mennonite female participants in our study, the woman's roles consistently focused on the domestic sphere of the family. Thus, women were predominantly responsible for childbearing, childrearing, housework and specific chores outside the home (tending to the chickens or doing field work), whether they were in Mexico, Belize or Canada. However, the behaviour of couples varied among individuals and groups. There were differences in how couples acted within their private, domestic lives and within the public sphere which was under community scrutiny. Thus, some husbands and wives made joint decisions that might not have been supported by church doctrine or community expectations. For example, in some cases couples did use family planning even though there is a widely held belief among traditional Mennonite denominations that women are to "bear as many children as God allows."

Keeping women within a domestic sphere was also accomplished by limiting the type and amount of knowledge to which they were exposed. In this way, family honour was also maintained because the women would be kept silent and would not question any decisions that were made. This is supported in the Bible, the First Book of Timothy, 2:11 which states "Let a woman learn in silence with all submission."

Family honour is intricately linked to a woman's behaviours and thus her behaviour in particular requires close scrutiny. One unacceptable behaviour was to become pregnant while unmarried. The participants discussed the difficulties of such a situation. In Mexico and Belize, pregnant unmarried women were forced to get married or were hidden in their homes due to the shame the young woman had caused the family. One young woman was not allowed to be baptized until the infant was a year old, while another was physically abused by her father for her

indiscretion. One of the participants related that teaching youth about sexual intercourse would be helpful to prevent this from occurring.

In addition, controls at both family and community levels were instituted to deal with situations that extended beyond established norms. At the family level, if a father had sexually abused his daughter, the resulting offspring were raised as if they were the daughter's siblings rather than her children. At the community level, the participants provided examples of Mennonite men in Mexico who had sexually abused their children. In Mexico, the Mennonite community was exempted from federal and state government regulations, as per their migration agreement, and generally speaking Mexican police did not interfere with issues that arose within the Mennonite communities. Therefore in the instances of child abuse, the Mennonite male church elders came together and removed the abused children, who were then raised by other families in the community. Sometimes the abusive father was forced to leave the community.

Regardless of adherence to church doctrine or community expectation, most of the women spoke about their husbands as being supportive during the significant life transition of pregnancy. However, in some instances there was only limited support from husbands during this time period, for example in cases where the husband did not help ensure that the wife received any special foods or care. One woman described episodes of physical and emotional abuse, but the marriage had since dissolved and the woman was no longer in danger. Other women talked about having neglectful husbands (e.g., husbands who abused alcohol and as a result did not financially provide for their families). In these circumstances the women decided to concentrate on their children and teach them to be more attentive to their spouses when they were older and married.

*Learning about Being a Woman: Experiencing Menstruation*

Of the 38 participants, 17 were told about menstruation before it occurred, 12 after it had commenced and nine of the women had no explanation regarding this normal body change. For some families, this lack of knowledge was purposeful because it was believed that if sexuality knowledge was shared then inappropriate behaviors such as premarital sexual intercourse would occur. If the women were provided any explanation, either before or after their periods had begun, it was given most often by their mothers, sisters, and friends or in some cases, their husbands and on even rarer occasions, the maid or teacher provided information. One woman noted that her husband's mother had explained a number of things to him, and so he shared the information with her. Most of the participants were told that menstruation was a normal monthly female bodily function that was to be kept private (i.e., not shared with boys) and were advised about necessary supplies.

Periods were considered normal and necessary in order to bear children but the physiological processes behind menstruation remained a mystery to almost all the participants. They believed that the period cleaned out the woman's womb or that menstrual blood would be the foundation for the baby if the woman conceived. Menstrual periods are also thought as "a burden women have to carry," and that "God made it that way."

The range of ages at which the first period occurred among the participants was 10 to 16 years. Some experienced severe pain; one woman commented that it was up to women to take the pain. Others used available pain relief although the names of the products were not known by the participants. *Heing fong* was given as an example of a local remedy purchased over the counter in Mexico for pain relief.

Other examples of difficulties related by the women in relation to menstruation included having periods too frequently (i.e., every two weeks) and heavy periods. There were examples of women seeking out medical assistance and being provided with medications (names unknown) from Mexican physicians to ease the difficulty. A few women commented that they had been prescribed birth control pills to assist with their menstrual difficulties. One woman noted she had problems all of her life because her “uterus was sick,” but she was unable to provide further explanation or information. One woman had a tubal ligation to “assist” with her difficulties which were not explained further.

### *Becoming Pregnant*

The participants were also asked about their knowledge and beliefs regarding ovulation. For some of the women, this word was a new term although they understood that there was a time when they could become pregnant. Some of the women referred to ovulation as their “fruitbearing” days. Five women were able to provide some notion of when they thought they were most fertile during their monthly cycle; the responses included 5 to 14 days after one’s period, or one week before the period at which time one’s back is also sore. Only a few women were able to give some idea of what ovulation was; explanations included that the egg “fell out” or the egg was released. Others understood ovulation to be the time when the “woman’s stuff and the man’s stuff” combines, leading to a pregnancy. Only some of the women believed that ovulation could be stopped.

The majority of the women had not received an explanation about sexual intercourse before they got married. If they did, it was usually a comment that married people have sexual intercourse (sometimes referred to as “being together”), and that they could become pregnant as a result. In some cases, the women’s mothers had advised them to watch the timing of their

periods to determine if they were pregnant and when the baby was due. Some of the participants had read about sexual intercourse in books from Mexican bookstores.

Despite the sensitivity of the topic, the participants did talk openly about how they became pregnant referring to sexual intercourse as “sleeping with their husbands.” All but a few understood that sexual intercourse led to pregnancy; some provided details such as the man’s sperm joining with the woman’s egg. This information had obtained from reading specific books in Mexican bookstores or public libraries in Canada. One stated that during the time when the woman’s discharge is increased and moist, the woman’s egg “catches the sperm.” A few explicitly stated that women become pregnant when having sex and not using birth control. Difficulties in becoming pregnant were experienced by only a few; these individuals had not received any explanation from their physicians in Mexico to assist them in understanding why this had occurred.

### *Family Planning*

The responses to the question about family planning use (Table 2) were sometimes discussed within the context of women’s roles being predominantly to bear children as directed by God. One woman confided that her husband would find the birth control she would purchase and destroy it because he said that “it was a sin to use [it].” One other woman said “using a condom did not feel quite as much as committing a sin [compared to using other products]” although she provided no further explanation.

Despite the general feeling that using family planning was not appropriate in the eyes of God and regardless of which Mennonite church they attended, only four of the participants had not used some form of birth control either during their time in Mexico or Belize or since arriving in Canada. Some of these women said that if their physician advised that they needed a rest from



childbearing or childrearing, it was considered appropriate to control their fertility. One woman talked about having “too much to carry,” and used birth control out of necessity for her own mental health. Another woman commented that after a miscarriage, the Mexican physician gave her monthly injections to prevent pregnancy, “because [my] uterus was sick and needed to heal.” Thus, injections, the birth control pill or an intra-uterine device (IUD) were examples of acceptable family-planning measures that the women used. Other women used the birth control pill allegedly to regulate their menstrual period. Infrequently women mentioned other types of birth control such as the patch which is applied to the woman’s body.

The type of birth control chosen was dependent upon ease of use, possible side effects and cost. For example, a number of women talked about “monthly injections” provided by their physicians or the Mennonite “doctor,” or about purchasing the product over the counter and then injecting themselves or having someone else inject them at home. The participants were not able to specifically name the injection but it was likely Depo Provera. Some of the women wanted to avoid potential side effects that were perceived as being associated with the birth control pill. The cost of the different kinds of family-planning mechanisms was also an issue for a number of the women. Condoms, “counting the days” or withdrawal during sexual intercourse were noted as being affordable.

Using birth control measures did not mean that the women understood how the methods worked. There was also no clear understanding of such words such as “sperm,” “egg” or “fertilization.” The participants were all asked to name the kinds of birth control that they were familiar with and how each of them worked. The women had often “heard about” various kinds, but were not aware of how they worked. When prompted with another example of a specific birth control type, some women also noted that they “did not know anything about X” (Table 2).

The women discussed their perceptions about how some of the mechanical means of birth control worked. They stated that condoms worked by preventing “the male stuff from getting in.” Diaphragms and spermicide were also described as working in a similar fashion thereby preventing joining with the woman’s egg.

“Counting the days” was also noted by a number of women as a family-planning method they used. Exactly when in the menstrual cycle to count the days varied within the group. Examples of how natural family planning worked include avoiding sexual intercourse during “wet days” or taking her body temperature during the month and avoiding sexual intercourse when her temperature rose. “Counting the days” was a method used but the answers about when it when conceived varied from four to 15 days after the menstrual period.

The women provided a number of explanations for how the different kinds of birth control worked. Examples include: Depo Provera worked by “blocking off a vein” or something “close to the egg;” the IUD “helped the womb to open up,” closed off the “mother door;” or prevented the fertilized egg from sticking; and, birth control pills destroyed the egg, prevented the baby from becoming attached to the uterine wall, or prevented ovulation.

Side effects of the different types of birth control were of concern to the participants. Vasectomies were noted by some of the women as being related to the men becoming overweight and having a reduction in their sexual desire. Tubal ligations were believed by some of the participants to reduce a woman’s sexual interest, although other women talked about having increased physical comfort during sexual intercourse after this operation. One of the respondents related that her periods were more abnormal (more pain and excessive clots) after having a tubal ligation. One woman said that tubal ligations were wrong because they were permanent ways of preventing birth.

*Health Promotion among Low-German-speaking Mennonite Women*

The need for health-promotion teaching on a variety of topics was supported by the participants. The women expressed a genuine interest in learning about health topics for themselves and for their children, particularly their daughters. Learning about breast self-examination, prenatal care and child rearing were noted by participants as important for their lives as women. Most of the women also supported the idea that their children needed more education in general but also specifically about human sexuality than they had received as young women growing up in Mexico or Belize. Those who are interested in their children receiving such knowledge believe that topics like menstruation and pregnancy should no longer be hidden, and that talking about them will prevent such undesirable outcomes as premarital pregnancy. Inclusion of the husbands and ministers in this teaching was not supported by a number of the participants. However, a few did admit that in some cases, if the husbands are not involved, the wives will not be allowed to attend.

## Discussion

The religious principles of the Mennonite church affiliations are important aspects of LGS Mennonites' everyday life. Reference to religious principles in order to explain what they had done or believed was frequently mentioned by the participants. The need for "having as many children as God wants you to have" was a common directive accepted by the participants. Specifically, the following Biblical verses provide a source for such beliefs: "Nevertheless, she will be saved in childbearing if they continue in faith, love and holiness, with self-control" (Timothy, 2: 15) and "Behold children are a heritage from the Lord, the fruit of the womb is a reward" (Psalms, 127:3). Having large families was noted in Reinschmidt's study among

Mennonites in Mexico. Loewen (2001) also found that the role of women from the Mennonite perspective is to bear many children.

The information generated from the women in our study supports the premise that in traditional Mennonite communities, family honour is connected to women's behaviours. Not only is sexuality a topic that is generally off limits, when it is discussed the emphasis is placed upon the proper behaviour of young girls and women. When premarital sexual activity occurs, for example, it causes shame to fall upon the individual girl and her family. Several participants related stories of the great lengths to which families of unmarried girls who became pregnant would go to keep the indiscretion hidden from the larger community (e.g., prevention of baptism). Similar findings were noted in other recent studies among this group (Kulig, 1995; Kulig & McCaslin, 1998; Kulig, et al., 2002; Kulig, et al., 2004). The notion of family honour and the importance of a women's role in its maintenance it is a common theme in other Mennonite literature (Hurst, 2003). Hurst relates that according to such literature, while it was believed that sexual feelings needed to be controlled by both women and men, women in particular had sexual power over men which needed to be controlled.

Limiting the type and amount of knowledge to which the LGS Mennonite were exposed also helped ensure that family honour was also maintained. Without the exposure to knowledge, women would be kept silent and would not question any decisions that were made. This is supported in the Bible, the First Book of Timothy, 2:11 which states "Let a woman learn in silence with all submission." In addition, some of the participants connected knowledge about sexuality with subsequent engagement in sexual behaviours. Such beliefs also find their roots in interpretations of the Bible, specifically in this case in the second book of Timothy: "But you must continue in the things which you have learned and been assured of, knowing from who, you

have learned them, and that from childhood you have known the Holy Scriptures, for salvation through faith which is in Christ Jesus (2 Timothy, 3:14 &15). In addition, the second book of Thessalonians states, “Therefore, brethren, stand fast and hold the traditions which you were taught, whether by word or our epistle” (2 Thessalonians 2:15). Such directives support the group in its belief that change and the learning of new ideas are not always appropriate. In general, LGS Mennonites are encouraged to adhere to the teachings of their families, who learn from the ministers, who are responsible for Biblical interpretation. In this way, family honour is maintained because if women are prevented from gaining additional knowledge, they will not question or act outside the realm of expected behaviours.

Even though the LGS Mennonite women were predominantly responsible for traditional tasks such as childrearing whether they were in Mexico, Belize or Canada, the behaviour of couples varied among individuals and groups. There were differences in how couples acted within their private, domestic lives and within the public sphere which was under community scrutiny. Thus, some husbands and wives made joint decisions that might not have been supported by church doctrine or community expectations including using family planning.

Young Mennonite women are more exposed to information in general and have greater knowledge about topics relating to sexuality than did their mothers and grandmothers. Couples are using family planning and although most of the women in the sample included in this study were still bearing children, generally speaking the younger women are having fewer children than their mothers did in part due to economic necessity. Most of the women supported the idea that their children receive information about sexuality.

LGS Mennonites are an example of a religious group in a rural area that requires health providers to consider their unique beliefs and work with them to collaboratively develop and

implement health promotion programs to ensure their success. Building and maintaining trust with this group can be accomplished by respecting their beliefs and learning about their perspectives. It may be essential to address non-sensitive topics, such as nutrition, first among this group before topics such as sexuality are addressed. Taking such small steps will help ensure long-term productive relationships are developed with the group. Identifying and working with key women and men among the LGS Mennonites is also an important component of this success. Finally, it is imperative to recognize that the LGS Mennonites are a group in transition and that the use of family planning by some of the couples will likely become more commonplace among this group. Thus, it is important not to stereotype “what” LGS Mennonites are like but to ask appropriate questions to determine beliefs and practices held by individuals within this group.

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**Table 1**  
**Sample Totals of 228 Completed Pregnancies**

**(n = 38)**

	<b>%</b>	<b>n</b>
Live births	78.7%	181
Stillbirths	2.2%	5
Spontaneous Abortions	18.8%	43
Therapeutic Abortions	0.4%	1

**Table 2**  
**Birth Control Knowledge**

(n = 38)

	<b>Knows About</b>		<b>Knows How it Works</b>	
	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>
Birth Control Pill	100%	38	3%	1
IUD	95%	36	8%	3
Condom	84%	32	61%	23
Spermicide	21%	8	16%	6
Diaphragm	13%	5	3%	1
Birth Control Patch	37%	14	3%	1
Depo Provera Injectable	61%	23	0%	0
Morning-After Pill	8%	3	5%	2
Natural Family Planning	84%	32	16%	6
Tubal Ligation	89%	34	50%	19
Vasectomy	74%	28	5%	2