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# PREGNANCY IN THE NAVAJO CULTURE

*The expectant mother in Navajo society still follows traditional taboos and rituals, but she also seeks medical maternity care*

BERNICE W. LOUGHLIN

AS A PARTICIPANT in the Navajo-Cornell Health Research Project to determine the health needs of the Navajo people, I was particularly fascinated by one of the findings: Although only an average of 58.6 percent of the babies were delivered by physicians, there had been no maternal deaths in 19 years, and only a very small percentage of the infant deaths (0.99) occurred in the perinatal period.\*

This information prompted me to undertake another study to explore the needs of a selected group of pregnant Navajo women, with the hope that my study might contribute to future planning for maternal and child health programs.

The data presented in this study were gathered through careful examination of the medical records of 230 women who had delivered 428 live children between October 31, 1956, and December 31, 1960. All data which might prove significant in planning future programs and in defining the needs of this group of women were tabulated. As far as possible, all data were verified by the use of documented records. Interviews were conducted with the women to determine their attitudes toward scientific medicine, reasons for seeking care, and the kinds of care which were most acceptable.

## LIFE ON THE RESERVATION

The Navajo Reservation comprises 25,000 square miles in Arizona, New Mexico, Utah, and Colorado, called the "Four-Corners" area. The land is at once harsh, desolate desert, beautiful vistas and blue hazy mountains, all covered by a deep blue sky. There are areas of severe erosion, as well as lush ponderosa forests. The reservation cannot begin to support the 85,000 Navajos living there.

The Navajo people, until recently, averaged no more than a third grade edu-

cation. The majority continue to use the Navajo language and many speak no English at all. They work off the reservation as itinerant, part-time workers in agriculture, on railroads, and in a variety of unskilled and semi-skilled jobs. Those who remain on the reservation subsist largely on a sheep economy. The annual per capita income in 1960 was estimated at about \$520.

There are but a few all weather roads, so the people remain isolated. The majority still live in the traditional 1-room, log and mud octagonal structures, called hogans. A hole in the roof allows smoke to escape from the single potbellied stove used for heating and cooking, and also provides ventilation. Water for personal and household use is hauled, occasionally as far as ten miles, by horse and wagon or by pickup truck.

The Navajos are straddling two cultures, the traditional culture of the "ancient ones" and the tradition-shattering culture of the twentieth century. The traditional family is matrilineal and matrilineal. The matriarch is the leader of her family, although not necessarily its spokesman, and her daughters and their families live close to her. Few major decisions are made without consulting her.

The Navajo concepts of health and disease are interwoven with their concepts of the supernatural. Good health is an indication of a balanced relationship between man and the supernatural forces. If that balance is disturbed, illness is one result.

The Navajo regard for individual autonomy is extremely high. Birth is a personal matter and thus cannot possibly be of interest to anyone else. Modesty creates problems in the examining room except in the very young. Fear of witchcraft often makes it difficult to obtain specimens, such as urine for analysis. Culture values decree that the people endure pain and discomfort without external evidence. Many Navajos still adhere to the traditional "sing," a curing ceremony in which the medicine man uses a complex interweaving of

prayer, chants, and herbal infusions. The very words used to describe illnesses are associated with tradition and cannot easily be used to interpret scientific knowledge.

Poor roads, low level of English literacy, inability to understand scientific concepts of disease, lack of transportation (about one-third of the families have no vehicle), and the widely dispersed hospital facilities all combine to hinder early and adequate care.

## CHILDBEARING

Among the Navajos, childbearing is a natural life experience. It is the ultimate goal of the women to bear children, and it is never considered an illness to be endured for nine months. There are many taboos and rituals to be observed during the pregnancy, not only by the prospective parents but by the entire family. The new arrival is truly anticipated and much to be desired, whether he be the first or the fifteenth. Very little preparation can be made, however, because of a taboo that this might cause illness, injury, or even death to the unborn baby.

The expectant mother continues with her usual chores, including wood chopping. She goes horseback riding and takes long walks. She makes no changes in her dietary habits. This simple way of life, the continuance of normal activities, the expectant happiness, the traditional nonbinding clothes, and the customary diet probably all contribute

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\*The Navajo-Cornell Field Health Research Project was conducted under the direction of Cornell University Medical College Department of Public Health, in cooperation with the U.S. Public Health Service Division of Indian Health and the Navajo Tribal Council. It was located in the middle of the vast reservation in the Many Farms-Rough Rock area on which 2,237 persons lived, as of January 1, 1961. The author was on loan from USPHS when she participated in the project.

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to slow acceptance of medical supervision which might impose adjustments or changes during pregnancy and the puerperium.

The antepartal period is a time of new activity for the Navajo woman as well as happiness for every member of the family. The expectant mother may be concentrating on weaning her soon-to-be-displaced baby; an older child may be planning for his responsibility to administer the cold bath which traditionally takes the present baby out of babyhood and into childhood; father may be selecting a tall, straight pine tree

which will make a cradleboard for the baby after it arrives; even the toddler may have been made responsible for carrying kindling.

The extended, closely knit family provides a great deal of mental and emotional support as well as physical help. Although a basic tenet of the Navajo is their belief in individual autonomy, it is still the prerogative of the matriarch to advise and help when asked. The grandmother of the expectant mother is close to her during this time as are the grandmother's sisters (also called grandmother). The designation of all

the maternal aunts as "mother" is an indication of their deep-seated family cohesiveness.

Since the clinic population in this study was young (78 percent under age thirty-four with 54 percent of these under age twenty) there was a real need for the support and advice of the matriarchs. Further, the expectant woman who had so many mothers, all of whom lived nearby, did not suffer from baby sitter problems.

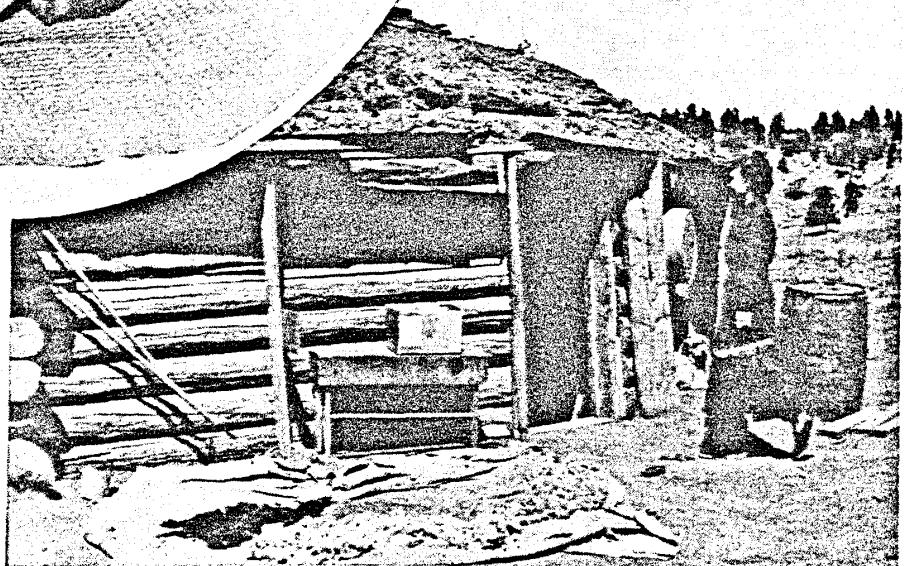
The Navajos, as many ethnic groups, have a reverence for the aged. They ask, "Who could know [about childbirth] better than my grandmother who has had many, many children? What can a man [doctor] or a young woman [nurse] know of the feelings of a pregnant woman? Have they ever had one baby?" Many still prefer to deliver at home, surrounded by family and warmth, in a squatting position, rather than on a hard table in an uncomfortable position, with the glare of surgical lights, and not one person from the family there to help.

Gradually, the younger, better educated women are going to the hospital to deliver, often not because it is safer, but because it removes the necessity for observing the taboos which many now find tedious. Often, too, the young woman lives in town, and the hospital is closer than the family hogan. Con-



Younger women go to the hospital to deliver, often not because it is safer, but because it removes the necessity for observing tedious traditional taboos

However, many still prefer to deliver at home, surrounded by their families, in the familiar I-room log and mud octagonal structures known as hogans



versely, there may be no transportation at the hogan when labor starts, and mother may have to be content with the traditional ministrations.

There is an almost complete lack of any obvious censure for the unmarried, pregnant woman. Because the people feel so strongly that procreation is woman's function, they realize that an extended period of education discourages early marriages, thereby creating sexual problems which may lead to extramarital intercourse. Often the girl's mother has no "creeping" baby and she welcomes the newcomer as her own, while the unwed mother returns to school to complete her studies.

Whereas pregnancy is a natural and normal physiological experience, not all women of childbearing age are physiologically normal. Since the Navajo woman never considers herself to be ill because of a pregnancy and since health is a state of balance between the individual and the supernatural, there is no felt need for a medical examination.

#### SOME PROJECT FINDINGS

The 230 women in the sample study group ranged in age from thirteen to forty-eight, and in gravidity from one to seventeen. During the study period, they had a total of 428 live births. There were four sets of twins, no stillbirths, but 22

abortions of 26 weeks gestation or less. The women in this study had an average of six children each; their average age at first delivery was slightly over twenty.

The fertility rate for this study group was 236.9 per 1,000 women aged fifteen to forty-four years as compared to the United States rate of 120 per 1,000; 68.3 percent of these deliveries occurred at intervals of two years or less. In the total group which was separated into 5-year age intervals, beginning with ages 15-19, 20-24, and so on, every age group included from one to four women who conceived out of wedlock. Under age twenty-nine, these were primarily women who stated they were single; over thirty, they were primarily widows. One significant factor was apparent. Of the women in these groups, only one had any antepartal care. Could this have been because of the known censure in the Anglo culture?

Only 13 percent of the women were seen for the first time in the antepartal period in the first trimester, 17 percent in the second trimester, 23 percent in the third trimester, and 47 percent received no antepartal care from the clinic. While medical care in the first trimester does not of itself insure adequate care, the possibility of adequate care is less likely if it does start in the first trimester. (Adequate care is defined

here as one visit in the first trimester, one in the second, one early and one late in the third trimester.)

Of the 230 women in the study, 36 had complications, including anemia, mild toxemias, hemorrhage, malformed infants, and abortions. It was further found that the probability of complications increased with gravidity; the risk increased with succeeding pregnancies.

Mortality statistics point out that the greatest number of child health failures occur among postneonatal infants, 58 percent of the deaths occurring from age twenty-eight days through age one year. The causes of these deaths are, most often, infections. About one-third of these deaths are due to influenza and pneumonia, including pneumonia of the newborn; another third are due to the diarrheas and dysenteries, including the newborn.

In the course of the Navajo-Cornell project, almost every family was visited every three to six months by the nursing team, regardless of morbidities or priorities. In this way, most antepartal patients were found, and every effort was made to give them information about antepartal care.

The project elicited the fact that there was a close correlation between home visitation and the frequency of visits made to the clinic for medical supervision. Nineteen women who were not visited (or visited too early to detect obvious pregnancy) sought no medical care, while most of those who were visited in their hogans three or more times received adequate care during the pregnancy. Within the study period these same women sought earlier and more care with each succeeding pregnancy.

Acceptance of preventive care has been slow to accomplish, but immunizations are already well accepted, and other preventive measures are being adopted as the people observe their effectiveness.

#### IMPLICATIONS FOR THE NURSE

Anthropologists have long advocated a close scrutiny of the cultural values (often with emotional overtones) that people place on both traditional and scientific care programs. It seems rather

Typically, the nurses found that Navajo mothers were more concerned about a sick or handicapped child than about obtaining health services for themselves



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unnecessary to suggest that we, as nurses, should learn about existing cultural patterns before we suggest new methods. What are the maternal health needs of these people? Is the traditional care adequate? Why do they participate in some health programs and not in others? To what extent can mortality rates be relied on to give the foundation of a program? How much can be accomplished, and what is the irreducible minimum?

In the small group studied the question arises as to whether we have a sound basis for insisting that patients be delivered in the hospital. Should women be encouraged to make their own choice as to place of delivery? Should they be offered support in whatever choice they make and recognition be given to tribal customs and taboos? Despite the lack of proved mortality, it is a fact that most of the morbidities of pregnancy are preventable and at least the small, high-risk group should seek medical care. In this study, this group included the 5 percent of primiparas, under twenty and over thirty; the 15.7 percent with significant histories of previous maternity complications or chronic illnesses; and the 5.3 percent of babies weighing less than 2,500 and over 4,500 grams at birth.

The study has shown that casefinding can best be done as a part of an inte-

grated family public health nursing team service. The best rapport was obtained when the support of the pregnant woman was only one facet of the family visit. Typically, these prospective mothers were more concerned about a sick son or daughter than about care for themselves. As the nurse became known to the people they responded more readily to her suggestions, and with each succeeding pregnancy, they sought earlier and more medical care. As home visits by the nursing team increased, the number of patients who sought medical care increased in direct proportion to the increased number of visits. This implies that the nurse was able to allay fears by advising them of what to expect and by explaining some of the problems which medical care could alleviate.

Over half of the antepartal visits to the medical care center were primarily because of a morbidity. This may point to a need for general rather than specialized clinic programs. It would also seem to indicate that there is a need for more well-qualified public health nurses to serve smaller districts than is now possible, so that they could become known and respected. (The "average" nurse on the Navajo reservation covers 1,500 square miles and has 6,000 patients.)

There were indications that as families

moved into urban and away from rural living, the size of the family presented a problem. A program of family planning could well fill an emotional as well as economic need and should be available to those who wish to limit the size of their family.

Since it seemed apparent from this study that the extended, traditional family offered many strengths, it would be interesting to study a group of women who have moved out of the "family nucleus" setting, to learn about their feelings and problems. As is true of any group in transition, the Navajo tribe today includes the gamut of personality types—from those completely Anglicized and in top-level jobs to those still completely traditional and resistive of all scientific methods.

The high fertility rate and the close spacing of the children, together with the high postneonatal death rates, could well indicate that the period of weaning is the most critical time. A coordinated and comprehensive program of personal and environmental hygiene, utilizing all health disciplines and including some means of implementing improvements, is most important to the people.

Any program of action designed to change attitudes must take into consideration the values and pressures involved in old attitudes and resistance to change, especially those attitudes laid down by cultures which have prospered over centuries of time. It would seem here, as elsewhere in the world, that the health of the individual cannot be sustained or improved without the coordination of all forces which influence daily living—environmental, socio-economic, emotional, and cultural—nor can the health of the individual be markedly improved without some change in the total group. Further studies involving other segments of the Navajo people are needed to substantiate or refute the findings of this study, but some conclusions have been drawn which might point the way to further studies and to future planning in maternal and child health services.

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