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Caring for the Low German Mennonites

How Religious Beliefs and Practices Influence Health Care

PURICH BOOKS

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INTRODUCTION

Canadians often reflect with pride upon their Multiculturalism Act, which became federal law in 1988; most believe that it allows Canada to address its societal changes in ways that other countries cannot match. According to some policy experts, this act has historically dealt with only two components of our cultural makeup – ethnicity and race – although there are now calls to formally recognize religious diversity as a third area of focus (Kunz, 2009; Fadden & Townsend, 2009).

Until recently, clear discourse about religious diversity in Canada has been lacking, including how governments and other institutions address it (Fadden & Townsend, 2009). We tend to focus on the religious perspectives of new immigrants and refugees, especially those who are not Roman Catholics or Anglicans, Canada's traditional Christian denominations (Kunz, 2009). Muslim immigrants and refugees entering Canada have received particular attention of late (Kunz, 2009). And though we most certainly do need to understand the beliefs and world views of new arrivals, we sometimes fail to recognize and understand those of minority religious groups who have lived in Canada for many years.

This book aims to advance conversation in Canada about the importance of recognizing and understanding religious diversity in providing appropriate and equitable health care to all individuals and

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communities. This discussion is based in over twenty years of work with a unique religious population, the Low German (LG) Mennonites.

This book has a twofold purpose. First, it underscores the fact that health providers must consider and assess religious diversity if they wish to fully understand their clients. It is essential to remember that religious diversity is not synonymous with cultural diversity; having a strong religious faith is not the same as adhering to cultural beliefs and practices. In this book, "religion" refers to institutionalized beliefs and practices, and is viewed as a subset of culture (Pesut, Fowler, Taylor, Reimer-Kirkham, & Sawatzky, 2008). It is based in the conviction that a higher power exists and that it is linked with one's life course – including such essential elements as whether one becomes ill and when one dies (Anderson, 1990, cited in Hickman, 2006). In contrast, cultural beliefs and practices are generally less spiritually significant and can incorporate a comprehensive range of behaviours that relate to activities such as wedding ceremonies or the celebration of specific events (such as Thanksgiving Day); they may also involve beliefs such as the idea that certain foods have healing properties (Newman Giger, 2012). Although cultural beliefs and practices usually exist in conjunction with religious perspectives, in most cases they form only one element of the larger sociocultural religious context. My research with LG Mennonites revealed that religion was the primary determining factor in all their everyday activities. In most cases, their belief in God was so deeply rooted and strictly adhered to that they went far beyond merely observing tradition. As a result, they shared certain views about health and illness, and whether and how to use health services.

The second underlying contention of this book is that because religion is so important for some individuals, cultural competence is an essential aspect of acute, community-based, or other kinds of care. Educators who work in the health care professions must introduce their students to cultural competence and teach them about its applicability in providing care for diverse clients. Health care organizations must enable their staff to access continuing education that instructs them about the religious beliefs and practices of the clients in their

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geographic area and includes meeting the expectation of cultural competence when providing care. In addition, they need to create policies to guarantee that religious diversity is addressed during the assessment, implementation, and evaluation of care.

Cultural Competence: An Essential Part of Health Care

Providing care to ethnically, culturally, or religiously diverse groups can be both challenging and rewarding. It requires understanding, acknowledging, and working with individuals whose ideas differ from those of mainstream culture. Over the years, there has been considerable discussion in the health care field about the need to address our increasingly diverse society (Erlen, 1998; Wood & Schwass, 1993) through the application of concepts such as cultural awareness, cultural sensitivity, and cultural competence (Wepa, 2003).

Cultural awareness is defined as understanding the ways in which culture forms an individual's beliefs and values (De & Richardson, 2008), whereas cultural sensitivity refers to respecting, valuing, and understanding other cultures while also being aware of one's own (Erlen, 1998). It extends from cultural awareness, asking health professionals to develop their knowledge and change their behaviour to recognize the power differentials between groups, as well as their historical and social roots (Polaschek, 1998). Cultural sensitivity increases one's understanding of how cultures affect both personal and professional identities. Without it, cultural interaction will be ineffective (Narayanasamy & White, 2005); when health care providers demonstrate respect for cultural differences, they are more likely to provide impartial care (Erlen, 1998).

Cultural competence flows naturally from cultural awareness and sensitivity, a point "on a continuum of cultural approaches" (Brascoupe & Waters, 2009, p. 10). It has three components: awareness, knowledge, and skills (Alizadeh & Chavan, 2016). That is, it consists of the culture-related awareness, knowledge, and skills that are necessary to provide effective care to diverse groups, and it exists at both the individual and

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the organizational levels (Dreachslin, Gilbert, & Malone, 2013). In this book, I focus predominantly on the individual level and define cultural competence as a process through which knowledge and skills in relation to a client's attitudes, beliefs, and customs are developed and applied in the provision of care (Parisa, Reza, Afsaneh, & Sarieh, 2016). In the health care setting, such competence leads to effectively addressing the cultural context of the client (Campinha-Bacote, 2002).

Cultural competence is also an important aspect of addressing the health care disparities and social justice issues that arise from inequitable life circumstances among diverse groups (Alizadeh & Chavan, 2016; Dreachslin et al., 2013; Lehman, Fenza, & Hollinger-Smith, 2012; Shen, 2015). It is a way to focus on patient-centred care to allow for collaboration and active participation of patients and their family members (Dreachslin et al., 2013). To achieve this and to acknowledge the multicultural context within which care occurs, providers must work from a stance of reflective practice that is based in critical thinking (Blanchet Garneau, 2016). Working this way can lead to improved clinical care. It also enables providers to consider the social and political structures that can impede the delivery and uptake of care among diverse groups.

The Cultural Competence Development Model

The Cultural Competence Development Model (Blanchet Garneau, 2013; Blanchet Garneau & Pepin, 2015) is a valuable tool for health care providers who work in a variety of culturally diverse settings. It can also be used when religion and beliefs are the main aspect of diversity. This model is based on defining cultural competence as "a complex know-act grounded in critical reflection and action, which the health care professional draws upon to provide culturally safe, congruent, and effective care in partnership with individuals, families, and communities living health experiences, and which takes into account the social and political dimensions of care" (Blanchet Garneau & Pepin, 2015, p. 12). This definition reflects a constructivist perspective,

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which emphasizes multiple, socially constructed realities (Blanchet Garneau & Pepin, 2015) while recognizing that power relations exist and influence one's reality (Guba & Lincoln, 1994, 2005, cited in Blanchet Garneau & Pepin, 2015). Cultural competence is both dynamic and complex but variable according to the social context. It is a "process of reflection and action" (Blanchet Garneau & Pepin, 2015, p. 13) that can lead to the development of new knowledge of providing culturally congruent care.

The Cultural Competence Development Model consists of three levels (Blanchet Garneau, 2013). The first of these, being open to the differing realities of practice, encompasses

- forging a relationship with patients by showing openness to their beliefs and ideas while also emphasizing the importance of communication
- working outside usual practice by building awareness of structural limitations and the care challenges in culturally diverse contexts
- reinventing one's practice in action by acknowledging the gap between theory and practice, and by employing approaches used by one's more experienced colleagues.

The second level, challenging one's practice in a culturally diverse context, involves

- building a relationship with a patient by looking for commonalities between oneself and that person, focusing on the patient, and using a variety of communication strategies
- working outside usual practice by taking the patient's environment into account when care is being provided, and by working within the structural limitations
- reinventing one's practice in action by taking the risk of changing one's own model.

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The third level, integrating the realities of practice within the culturally diverse context, comprises

- building a relationship with the patient by incorporating differences, establishing a partnership, and communicating with discernment
- working outside the usual practice framework, which includes circumventing structural limitations and considering the patient and the provider as core components of a dynamic system
- reinventing one's practice by acting at the right moment and integrating one's model into practice.

Health care providers who apply this model may discover that their current practice does not meet client needs and may come to question and modify their approach. This can occur only if they develop authentic relationships with clients and realize that gaps exist between current theory and practice. It is essential for providers to think critically and to reflect on their practice, acknowledging the diverse environment in which they work. Applying the Cultural Competence Development Model has a dual benefit: it can correct the inaccurate ideas of practitioners regarding religiously diverse groups, and it can aid them in rectifying patients' faulty perceptions of health and illness, thus producing a positive outcome for everyone involved.

Working with Low German Mennonites

Low German Mennonites began to arrive in Canada during the 1870s. Their communities are concentrated primarily in southern Alberta, Saskatchewan, Manitoba, Ontario, and Nova Scotia, with a total population of approximately 100,000. They retain a community-focused lifestyle that dictates their choice of clothing, education, employment, and social interactions, and they purposefully separate themselves from the outside world. They speak a Low German dialect known as Mennonite Plautdietsch (Cox, 2008; Hedges, 1996). Only the church leaders

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(that is, male leaders) typically use Literary Dutch or High German and then only on formal occasions, such as at church services, funerals, and weddings (Sawatzky, 2005). The English-language skills of community members may be imperfect; women, in particular, have more limited exposure to English. LG Mennonites belong to a range of churches, from conservative to liberal, and their beliefs and practices vary both within and across congregations. For example, some conservative LG Mennonites do not use technological devices such as computers, whereas others – though still conservative – use them if they are of benefit to the community. More liberal LG Mennonites may use such gadgets as often as mainstream Canadians. All LG Mennonites rely on the Bible as the primary source of truth and guidance for their decisions and lifestyle choices. They have traditionally been, and continue to be, primarily involved in agricultural work and have greatly contributed to the dynamic nature of rural Canada.

Since 1995, I have learned many lessons from my various community development and research projects with LG Mennonites. The program has required an ongoing commitment to winning and maintaining the trust of this unique, diverse religious group.[1]

My first contact as a researcher with the LG Mennonite community was in 1995, when I supervised undergraduate nursing students in a senior community health course as they carried out cultural-assessment interviews in southern Alberta. To assist them, I conducted the first interview with an LG Mennonite couple and, concealing their identity, shared the transcript with the class to show how I had proceeded. When the project ended, I reviewed all forty-four interviews and prepared a final report for a local health unit (Kulig, 1995).[2] With one of the students, I also wrote an article based on the interviews to highlight the health needs of LG Mennonites in southern Alberta (Kulig & McCaslin, 1998).

Following that experience, I helped found the Southern Alberta Kanadier Association (SAKA), an umbrella group that represents health, education, and community personnel to address the needs of LG Mennonites. Through SAKA and my contacts with the health region,

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I worked with undergraduate nursing students for several years as they created and implemented community development projects with LG Mennonites, such as health fairs, anatomy and physiology classes for women, and babysitting courses for Mennonite girls (accompanied by their mothers as observers). I helped students generate the projects and attended their presentations wherever and whenever they occurred throughout southern Alberta. The LG Mennonites displayed a great thirst for knowledge and were enthusiastic about what they learned. I particularly remember their interest and keenness when the students demonstrated anatomy and physiology using pig hearts, which have a remarkable likeness to human hearts. The women were also fascinated by a project in which they washed their hands and then applied a special substance to their hands. It would glow under ultraviolet light if they'd done a less than thorough job; the glow represented the bacteria that had not been washed off.

In subsequent years, I engaged in a wide range of activities relating to LG Mennonites. In 2001, the Chinook Regional Health Authority asked me to evaluate the work of the health promotion specialist who was responsible for the LG Mennonites in southwestern Alberta; later renamed the LG Mennonite liaison worker, this person provided translation at health care facilities, arranged for families to attend specialist appointments, and educated parents about health conditions such as genetic disorders and diabetes. My evaluation included interviewing LG Mennonite families whom the specialist had assisted to determine their satisfaction and generate any recommendations to the health region. The specialist ensured that the regional health authority increasingly took into account the LG Mennonites' own health priorities in delivering care to the community.

In my capacity as a researcher, I also interviewed LG Mennonite women about nutrition and food issues (Johnston et al., 1997). Because I did not wish to use a tape recorder, I worked with a woman who spoke Plautdietsch. As she translated each of my interview questions and the responses to them, I made brief notes that I later transcribed more fully.

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Throughout such activities, I visited homeschool sites and other facilities used by LG Mennonites and was a guest in their homes. I learned about where they lived and had previously lived, their living conditions, their degree of isolation, their family networks and support systems, and how they interacted with each other. I learned, for example, that the links between individuals formed the essential basis for social relationships and connections within the community.

After I had worked on these various projects, I presented the possibility of conducting additional research in the community SAKA members and respected Mennonites. This led to a more extensive research program than I had imagined. Since then, I have conducted four studies with LG Mennonites to generate information about their perspectives on four issues: health and illness (2000–02); women's health and sexuality (2003–08); death and dying (2009–14); and mental health (2012–16).[3] All the research received ethical clearance from my institution and from the relevant clinical agencies in the provinces where it was conducted.[4]

Some authors contend that researchers must determine whether their projects are morally justified (Liamputtong, 2010). The goal of my research – to help LG Mennonites receive appropriate health care – served as a solid rationale for our studies. Given the desire of LG Mennonites to remain separate from the world, and my opportunity to generate information with them about their health perspectives, I believe that it was morally appropriate for me to act as a conduit for their voices and to share their views in a manner that complemented their ethical and religious beliefs.

During my presentations in all three of the provinces where I performed the research and elsewhere, LG Mennonite and other Mennonite groups responded positively, confirming that my information and portrayal of the community were sound. In one case, when I was presenting via webinar to the Kansas State Farmworkers group, the LG Mennonite liaison worker there commented that my presentation reflected her own upbringing in Mexico. Throughout the years, I have been contacted by nurses with Mennonite backgrounds who worked

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with this population via the Mennonite Central Committee (MCC), a nongovernmental organization with offices in Mexico, and they have endorsed my findings and observations.

All my research studies followed the same process. The investigation was planned and implemented with the full cooperation of an advisory group.[5] Trained research assistants (RAs) interviewed LG Mennonite individuals and sometimes couples.[6] To avoid offending respondents, some of whom believed that the use of technology did not align with their religious values, interviews were not recorded. Instead, a summary – including exact wording and Plautdietsch words on specific ideas and topics – was used to highlight their sentiments.[7] Subsequently, the RA prepared a transcript, which I then checked. I spoke with the RA over the telephone or in person, providing feedback to use in future interviews and seeking clarification about the transcripts when required. In all the studies, our data analysis was conducted in a similar manner. I read the transcripts and field notes many times to identify themes that illustrated the views of participants (Braun & Clarke, 2006; Liamputtong, 2013).[8]

I also conducted fieldwork among LG Mennonites in Belize, Mexico, and Canada. In 2003, through discussions with two local health committees in Belize, I arranged for two nursing students to carry out their senior practicums in the LG Mennonite communities of Blue Creek and Spanish Lookout. In both locales, the health committee consisted of three couples who oversaw the management of services, including organizing and staffing clinics and providing other services, such as ambulances. The committee agreed that the students could come to Blue Creek and Spanish Lookout for their practicums. My fieldwork focused on observing interactions between individuals and at events and gatherings, as well as talking with people about their roles. For example, I observed male and female dress, acceptable types of transportation, and what women and men did at community functions.

In 2010, I attended an MCC biannual networking meeting in Cuauhtémoc, Mexico, with the local Mennonite liaison worker and

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LingLing Fan, who was the project coordinator for the study on death and dying that was under way at the time.[9] We stayed at the Steinreich Bible College and toured the local *Altenheim* (senior residents' home); *Huffungsheim* (home for people with disabilities, including those with mental health or other problems such as fetal alcohol spectrum disorder); *Friedensplatz* (orphanage and safe house for vulnerable children); schools (different ones for children from conservative and liberal churches); and the substance abuse centre, Centro de Rehabilitación Luz en mi Camino (Light My Way Rehabilitation Centre). We also attended choir evenings and Sunday service at Mennonite churches. I drove through the villages, noting their geographical differences, and visited local cheese factories. At the MCC meeting, we presented our preliminary findings from the study on death and dying. We received valuable feedback, which was later incorporated into the revisions, and made contacts with conference delegates from Ontario who would prove invaluable for the subsequent study on mental health and wellness.

In 2012, I visited the MCC office in Durango Colony, Mexico, for eight days. I interviewed women and men in the community, attended a funeral and church services, went to a *pharmacia* (pharmacy) and clinic run by an LG Mennonite woman, and visited a bone-setter (an LG Mennonite who diagnoses and treats a variety of ailments).

In 2013, LingLing Fan and I went to La Crete, Alberta, an isolated community that was established during the 1950s and includes a variety of Mennonite groups. Some of its members had immigrated from Bolivia. During our time there, we met with local health providers, most of whom had a Mennonite background, regarding our research.

Although this book focuses on the lives of Low German Mennonites in Canada, participants who had resided in other countries, such as Mexico or Belize, were asked to speak about their time there. When relevant, their views about life in these countries are also discussed here.

By combining what we observed in homes and at community events, learned in discussions with our advisory groups, and heard in

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our interviews, we compiled a robust body of knowledge not only about this group's ideas concerning health and illness, but also about a range of other topics. By and large, participants had had little opportunity to think about their beliefs or to talk to others about their perspectives, a fact that was especially true for members of the most conservative churches. As a result, the interviews became an empowering experience for many of them.

It is important to note that, according to the Mennonite members of our advisory group, the experience also posed a potential threat to the authority of LG Mennonite ministers. For example, we heard that the clergymen were concerned about the interviews, probably because they encouraged participants to reflect on their own beliefs and practices as well as those of the church. Such reflection is not encouraged in conservative churches. Throughout all our research studies, a number of respondents initially proved reluctant to speak and found it difficult to discuss their beliefs in detail. In part, they were apprehensive about providing the right answers, but this fear gradually diminished as the RA reassured them that whatever they said would be the right answer. By the end of the interviews, they often made comments such as, "I had never given these ideas any thought!" and "I have lots to think about now." Even when they were willing to express their opinions, not all of them – both males and females – could provide details in every instance. We assumed that this arose from feeling uncomfortable with our questions or, more importantly, from never having considered them before.

During my early years of working with LG Mennonites, including my first research studies in Alberta, I attended community events whenever possible. I typically learned about the event from an LG Mennonite woman, who assured me that I was welcome to come. Few non-LG Mennonites attended, so having a contact was helpful; she introduced me to her circle of friends, which enhanced my comfort. Sometimes, I attended concerts given by visiting choirs, usually from Manitoba; these were held in a community hall after Sunday services

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and might include a shared meal at the end of the performance. While the audience waited for the singing to start, it was common to see older women sitting together in the back, eating sunflower seeds and spitting the husks into ice cream buckets on the floor. Children played outside or in the hall, and groups of people – separated by gender – chatted, the pitch of Plautdietsch rising with excitement and emphasis.

The women and men to whom I was introduced showed quiet curiosity about who I was and why I was there. Some posed very blunt questions, asking if I was married (when I first began research with this group, I was not married; after I did marry, I said so and explained that my husband had two sons from a previous marriage). When asked what church I attended, I replied that I went to no church at the moment. Some people merely looked at me, often paying particular attention to my clothing. Others wanted to know if I was a Mennonite, if I had attended singing events before, and whether I worked. After answering such questions, I reciprocated by asking the women where they lived, where their husbands worked, and where they had been born.

Typically, the women with whom I became acquainted had not progressed beyond Grade 4 in school and did not work outside the home. I had, and did. To add to the distance between us, I did not work for any formal agency with which they were familiar, such as the local MCC office or the public education system. My explanation that I was a nurse who taught at the university and did not work as a clinician was not entirely helpful. They reacted positively to my nursing background, and they understood that nursing students needed to be taught. But they did not comprehend why I was interested in *them.* Conscious of choosing my words carefully, I explained that nurses, physicians, and other providers needed to know more about them to give them the best care possible. I would gather the necessary information during my conversations with members of their group, and it would help health professionals to provide care. The question

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of why I was spending time with LG Mennonites and why I wanted to know about them was repeatedly raised during the years that I conducted this research. Whenever it was voiced by any LG Mennonite or stakeholder who worked with the group, I gave similar explanations to those outlined above, hoping to reduce apprehension about my presence and my questions.

Throughout the research, I observed relationships within the LG Mennonite communities and with non-LG Mennonites such as myself. I noticed a number of differences between and within the groups, and that what was said to be happening sometimes contradicted what was actually happening. For instance, no group condoned alcohol consumption among its members, but some individuals did drink (of all ages and both genders), and some were alcoholics. Because of the general denial that alcohol was being used, support was often lacking for people who were struggling to make positive changes in their lives.

Occasionally, I encountered practices that were not compatible with my own beliefs in fairness and social justice. One example was in the treatment of women. Some groups purposefully blamed women for the ill treatment they received from their spouse, claiming that they deserved it. Upon further examination, I found that women's opinions and ideas were not always acknowledged or considered and that they were expected to acquiesce when told what to do. I had experienced similar issues when I worked with other diverse groups, where I had learned that I was not responsible for making changes among them and that I simply needed to accept certain circumstances and situations. I realized that change would arise naturally once the group came in contact with the values and beliefs of the society around it, probably initiated by its younger members (who were exposed to education and opportunities outside their community) and by those who were already questioning its values, beliefs, and behaviours. I learned not to feel responsible for the changes that would occur but to recognize that exposure to outsiders – myself and others – would be part of the process and that change is inevitable for all groups. I

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was also able to reflect on my own cultural background and to perceive that my family was not exempt from this process. My maternal and paternal grandparents came from Poland and raised their children in Canada; as a grandchild, I witnessed how their lives had changed and realized that such changes facilitated integration into the larger society. As aunts and uncles married non-Polish people, diet and customs were naturally modified. This did not mean that Polish customs and values were abandoned, but rather that certain lifestyle behaviours were invariably altered as needed.

Throughout my experiences with LG Mennonites and my exposure to the differences between group members, I benefitted from discussions with the research team – particularly those who came from a Mennonite background. Within the research project, we did what we could to help individuals obtain appropriate assistance for challenging family circumstances or when they needed care for complex conditions. For example, I made referrals to the LG Mennonite liaison worker, who followed up with women and their families and provided support and services as required. I also found that I needed to accept some situations, as I did not have the power to change them. However, when I felt that the legal rights of individuals were being violated, I was professionally obligated to inform human services personnel.

Applying the Cultural Competence Model in LG Mennonite Communities

For LG Mennonites, religion is central to all aspects of life. It dictates everything from their choice of clothing to their social interactions. Their practices and behaviours were originally developed to maintain their separation from the outside world but have also produced misunderstandings between themselves and others. Non-Mennonites who have attempted to provide them with care have not been immune to this problem, and the failure in communication has revealed that we need to find more appropriate ways of working collaboratively with this group. Our use of cultural competence in developing collaborative

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care with LG Mennonites helped us to identify connections between their religious perspectives and the unique factors that place them at risk for health disparities. This work was intended to engender positive outcomes for LG Mennonites by providing guidelines that would enable an engaged and enlightened provider to apply sound principles. The ultimate goal is better health among LG Mennonites and, through the involvement of the community itself, a greater awareness of their care options. This book is a case example of cultural competence in action.

The religious beliefs of LG Mennonites influence the values they associate with wellness and well-being, their understanding of health and illness, and their decisions regarding health behaviours and whether to seek care. For example, they see good hygiene and cleanliness as extremely important. Thus, when a new mother lacks the energy to clean her home because she suffers from postpartum depression, she and her family are frequently perceived as lazy. The people who are responsible for making decisions about her health – including her husband and her minister – commonly do not realize that her listlessness is a sign of depression. Rather than obtaining support for her or helping with the housework themselves, they are likely to exhort her to pray and to apply herself. A health practitioner who has developed cultural competence with the community will understand this context and can help the woman receive the care she needs.

When working with LG Mennonites, caregivers need to remember that ideas about health matters will vary depending on which church their patients attend. Conservative LG Mennonites generally feel that they must remain separate from the mainstream, and their health-related decisions will reflect this conviction. Members of more liberal churches are more likely to accept care that requires interaction with outsiders.

Clergymen play a vital role in the daily lives of LG Mennonites, a fact that culturally competent care must take into account. Parishioners must consult with their ministers regarding care plans, and ministers must agree to the administration of treatments such as

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medication and counselling. Practitioners need to recognize that clients who reject a recommended treatment plan may do so because they or their minister feel that it does not accord with the tenets of the faith. It is always important for practitioners to acknowledge and respectfully inquire about a client's beliefs, so that they can be taken into consideration when planning and providing care; this helps to satisfy both client and family that all their needs are being met.

The lessons from the case study shared in this book can be applied by clinicians, researchers, and policy makers who work with, or are responsible for attending to the needs of, groups that live on the margins of society due to their religious beliefs. By engaging in discussions related to the issues covered here, we can achieve a better understanding of the diversity of our society as a whole and of the unique perspectives of its individual groups. The end result is not only further understanding of health care consumers and improvements to research skills, but also the development of public policy that will help provide equitable care to all citizens, regardless of their religious or cultural identity.

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