

Health and Illness Beliefs Among the Southern Alberta Kanadier Mennonite Immigrants

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This article focuses on a two-year qualitative study that was conducted among the Kanadier Mennonites in Southern Alberta (Kulig, et al., 2002). Open-ended interviews, conducted with 86 participants, generated information about the meaning of health, categories of illness and help-seeking behavior. The discussion of these research findings is preceded by a review of relevant literature that addresses an historical and modern perspective of this group in order to understand their health and illness beliefs within religious and social contexts. The primary purpose of this article is to share the findings of the research, thereby enabling the information to be used by health care professionals who care for the Kanadier Mennonites.

In this article the group of Mennonites who migrated to Mexico from Canada in 1922 and those who have since then returned, will be referred to as the Kanadier Mennonites (although recently, this

group has also been dubbed, Low-German-Speaking Mennonites). In countries such as Mexico, the Kanadier Mennonites maintained their agrarian lifestyle. Despite their initial desire to live a conservative religious lifestyle, including the rejection of items such as rubber tires on tractors, other groups in Mexico and Belize have become more modern and have embraced agricultural methods or technology such as the personal use of cars and trucks in their everyday lives. Currently, Kanadier Mennonites are returning to Canada in significant numbers, due in part to the difficult economic conditions in countries such as Mexico, but also to seek a more modern life without religious oppression, rather than wait for such changes to occur in the colonies in Mexico or Belize (Janzen). Most of those who have left Mexico or Belize have moved to Alberta, Manitoba and Ontario. Anecdotally, there are estimates of up to 57,000 Kanadiers in Canada, with 12-15,000 in Southern Alberta (see: Janzen, this issue). In that locale, they work in the agricultural sector and often live near specific communities based upon employment opportunities (i.e., feedlot operations, potato and sugar beet farms) and their religious affiliation.

Within the conservative Kanadier group there are three main religious groups, which from conservative to progressive include the Old Colony Church, Sommerfelder, and Kleine Gemeinde. The Reinlaenders are another offshoot of these three main groups whose members fit between the Sommerfelder and the Kleine Gemeinde. Although some Kanadier Mennonites attend the Evangelical Mennonite Conference (EMC), the Mennonite Brethren (MB) and the Mennonite Church Canada (MC), as well as non-Mennonite denominations, these individuals were not included in the sample and hence their specific religious beliefs will not be discussed.

The Kanadier Mennonites in Mexico

Until recently, research that has addressed those Mennonites living in Mexico or other Latin American countries has been limited to the classic community studies by Redekop and Sawatzky. In addition, there are several isolated individual studies that have addressed fertility issues but relied on data that had been collected up to 20 years previously (see Allen and Redekop, 1987; Felt, Ridley, Allen, and Redekop, 1990). There are, however, several recent research studies related to the research presented here.

A recent dissertation (Hedges, 1996), on several villages in Manitoba Colony Northern Mexico among the Old Colony Mennonites, examined the connections between language, literacy

and identity; her extensive fieldwork adds to our discussion about health and illness beliefs among Kanadier Mennonites in Alberta because of the observations made about community life and the philosophy regarding educational factors that influence health practices. Hedges agrees with Sawatzky and Redekop that the primary purpose of the Old Colony schools is to socialize the children but not to impart skills to them (Hedges, 1996). The determinants of health have clearly shown the relationship between education and health, with those individuals having a lower education experiencing poorer health (Health Canada, 1994). Consequently, it would be anticipated that the health status among these Mennonite children would be lower and skills related to biomedical health prevention would not be addressed. One other relevant point is that some Old Colony churches have allowed their members to attend Alcoholics Anonymous meetings in an attempt to ensure their church membership (Hedges, 1996).

Another recent research project to be discussed here is particularly relevant because of its focus on health among the Old Colony and General Conference Mennonite women in Mexico (Reinschmidt, 2001). Through extensive field work and interviews, Reinschmidt was able to discern ideas and practices about health and illness and their links to the spiritual beliefs among this group of women. The author initially thought that the women would be able to directly answer questions about definitions of health and provide examples of health promotion behaviors, but she soon learned that this was a challenge among this group. Reinschmidt explains that preventive health behaviors based on a Western biomedical understanding are not part of the Mennonite lifestyle. In part this is because of the belief that health originates from God and is based upon relationships between the community and God. Hence engaging in health-promoting behaviors does not fit with the mindset of this group. One example is physical activity, which is not common among this group. Having spare time, coupled with the lack of Old Colony church acceptance of group activities such as baseball or soccer, has contributed to alcohol problems. During Reinschmidt's time there, organized sports activities were becoming more common among the General Conference members in order to address the concern of alcohol abuse.

Several participants from both the Old Colony and Mennonite Church Canada churches were able to give clear examples of health behaviors even though they were not conceptualized as such. Examples included keeping a clean house and eating properly. Being spiritually healthy was important to avoid *Narfenkrankheit* (nerve problems). Within her sample, Reinschmidt found that those from the

more conservative religious group had an increased chance of suffering from *Narfenkrankheit*, which was attributed to the strict social pressures within the group. Physical illness was believed to originate from the soul and from being confronted with evil or the devil. Examples are provided of women who struggled with depression, which they attributed to the devil.

When illness occurred, the Mennonite women and their families relied on home remedies and home treatments before seeking medical help outside their communities. The weakness of Canadian medicine was acknowledged and a number of home remedies were noted including *Heing fong*, which was used for stomach ailments. Furthermore, several of the women had assumed the role of assisting others when they required help with their health problems. Some women increased their knowledge by attending health classes that were taught by Canadian and Kanadier Mennonite nurses and in this way expanded their knowledge and incorporated changes into their belief systems. A number of the study participants equated work with health but also believed that if one were ill, engaging in work would allow the individual to regain her health. Health was also restored through the use of prayer and being assisted by the ministers. Sermons in the church services occasionally discussed the necessity of positive thoughts in everyday life.

Methods of the Current Study

An exploratory, descriptive study based on open-ended interviews was conducted with a non-random sample of the Kanadier Mennonites in southern Alberta in order to generate information about their health and illness beliefs. Questions were asked regarding the reasons health care was sought, how they sought care, what they did in health emergencies, how they dealt with health problems on their own and the use of alternative treatments. For female participants, questions were asked about beliefs and behaviors during pregnancy, labor and delivery and the postpartum. Due to the lack of information about the Kanadier Mennonites and their health and illness beliefs, the emphasis was on understanding these beliefs rather than the impact of acculturation on those beliefs.

The first author had had prior experience with Kanadier Mennonites in both a research (Kulig, 1999) and community development context (Kulig et al., 2000), which eased initial entry into the population. However, conducting research among a religious population can present unique challenges and is formally discussed in another article (Hall & Kulig, 2004).

The following steps were undertaken in order to ensure a successful research project.

1. The research team included a partnership of academic researchers, the MCC and health regions. This was essential in locating potential participants, discussing the interview process and interpreting the meaning of the interviews within the larger sociocultural context of the Kanadier Mennonite lifestyle. Research team meetings that included representatives from all three groups and the research assistants were enlightening and useful when decisions needed to be made regarding preparation of the final report or the most appropriate mechanisms to disseminate the results.
2. Research assistants who were of Mennonite background and spoke Low German were hired to conduct the interviews. We initially employed five research assistants—one male assistant, two women who were Kanadiers, and one married couple that carried out conjoint interviews. One of the Kanadier women was unable to continue with the project due to health problems.
3. The interviews were not taped; instead the assistants took notes and taped a summary after the interview was completed, a method used successfully in a previous study (Kulig, 1999). In this way, trust was easier to establish and the participants were more comfortable in disclosing their ideas. In addition, the research assistants experienced a lengthy socialization period with the participants both before and after the interview, which enhanced the trust.
4. Attempts were made to meet with the ministers of the four religious groups included (Old Colony, Sommerfelder, Reinlaender and Kleine Gemeinde) before the interviews commenced so as to explain the study and secure their support. In our situation only the Sommerfelder group did not meet with us, probably due to the recent split between this group and the Reinlaender s. However, Sommerfelders did participate in the study despite the absence of a meeting with their religious leaders.
5. The research assistants and first author (Kulig, 1995) attended Kanadier Mennonite community events such as

the yearly *Treffen*. In addition, the first author is one of the founders of the Southern Alberta Kanadier Association (SAKA) and has been working with the Kanadier Mennonites since 1995. Hall joined the association in 2000 and has become more involved with this group. These community involvements demonstrate the genuineness of the researchers' concern for, and interests in, the Kanadier Mennonites.

6. After the completion of the project, discussion with the participating religious groups was essential. Hence, community meetings were usually held in their church buildings in the evening. In total, 54 Kanadier Mennonites attended (23 women and 31 men) the three meetings. The same group that declined the initial meeting with the investigators when the research commenced (Sommerfelder) also declined a meeting to hear about the results. The presentation and discussion of the study results lasted about 45 to 60 minutes followed by a socializing period for which the investigators provided refreshments and pastries. It was often during this socialization period that more discussion was held about the study.
7. Finally, a summary of the findings has been tape-recorded in Low German and is available in locations frequented by Kanadier Mennonites, such as public health offices, the Community Help Centre (the newly developed community centre for Kanadier Mennonites in Vauxhall, Alberta), and the MCC—Kadier Concerns office in Lethbridge, Alberta. These tapes can be borrowed or taken home and kept by the family. They are also being delivered to the ministers.

Despite the attention given to the details noted above, there were still challenges in conducting the interviews. One challenge was translating illness categories so that they had meaning for the participants. A second challenge was that participants of the more conservative religious groups (Old Colony and Sommerfelder) did not question their religious beliefs as much as the Kleine Gemeinde and Reinlaender and had greater difficulty in providing explanations for behaviors. Concepts, such as illness and disease processes, were explained according to non-scientific principles. Healing and the use of alternative treatments were developed to complement this belief system. One final challenge was the discomfort of the male research

assistant when discussing reproductive health issues with the female participants.

Ethical guidelines were strictly adhered to in the study. The RAs were required to sign statements of confidentiality indicating that they would maintain confidentiality regarding the participants' identity and the nature of their comments. Explanations were provided to the participants about how confidentiality would be maintained, their right to withdraw from the study at any time, and how the information would be used.

After an initial training session conducted by the authors, the RAs began the interviews. Each research assistant (RA) had been assigned a specific religious group, but when one resigned another RA conducted interviews with more than one religious group. Names of potential participants were generated from the MCC representatives on the research team. The RAs contacted these individuals and (in German) explained the study and requested their participation. When there was verbal consent, arrangements for the time and location of the interview were made. At the beginning of the interview, the study was explained once again and written consent was obtained. All participants provided written consent except for one couple that gave verbal consent, which was duly noted.

During the data collection phase, the RAs maintained contact with each other and the research team through telephone calls and meetings. In this way, concerns and issues were promptly addressed and a greater understanding of the data was achieved. When the interviews were completed continual reading of the typed summaries led to a list of themes which was subsequently discussed with the RAs and MCC members. The initial list of themes ultimately led to the preparation of the final report (Kulig et al., 2002), which has been widely distributed to individuals involved with the Kanadier Mennonites in Canada and abroad. Due to the extensiveness of the data collected, this article focuses on health and illness beliefs, categories of illness, and help-seeking behavior.

Findings: Demographic Background

After securing informed consent, demographic information was compiled with the participants. Forty-seven households were included in the study with a total of 86 participants. As noted in Table 1, there were 41 males and 45 females. The majority (92%) were born in Mexico and married (97%, $n = 83$), with two not stated and one being a widow. The initial province of arrival for the majority was Alberta (56.5%, $n = 48$), while others had first arrived in Ontario (22.4%, $n =$

19), Manitoba (14.1%, n = 12), British Columbia (3.5%, n = 3), or Nova Scotia (3.5%, n = 3). The men had a mean of six years of education and the women had a mean of 5.2 years. However, because most of this education occurred in Mexico in traditional Mennonite village schools, the number of years does not represent an equivalent to the Canadian education system and cannot be compared. In part this is because there are no professional teachers in Mexico, and thus older Kanadiers teach the young the basic skills of reading, writing and arithmetic and bible studies.

The demographic information showed that after moving to Canada, more women (58%, n = 26) than men (37%, n = 15) had taken English as a Second Language (ESL) classes (Table 2), likely because the classes are taught in the daytime when men are at work. Table 3 illustrates the religious affiliations of the participants. Interestingly, the more conservative groups (i.e., Old Colony and Sommerfelder) show a decrease in number and percentage in comparison with the groups that are more progressive, which are showing an increase (i.e., Reinlaender and Kleine Gemeinden).

Table 1

**Kanadier Mennonite Study:
Number of Subjects, Range of Age and Birthplace
n=86**

Gender	Number of Participants	Percentage	Range of Age (in 2000)	Mean	Median
Male	41	48%	21 to 67 years	37.5 years of age	35.35 years of age
Female	45	52%	20 to 65 years	38.5 years of age	34.5 years of age
Total	86	100%			

Birthplace	Mexico	Belize	Ontario	Paraguay	Bolivia	British Columbia
Number of Participants	n=79	n=2	n=2	n=1	n=1	n=1
Percentage	91.86%	2.33%	2.33%	1.16%	1.16%	1.16%

Table 2

**Percentage of ESL Instruction Attended by Subjects
n = 86**

Gender	Yes	No	Range of Attendance in Months	Mean	Median	Mode
Male	37% n=15	63% n=26	0.5 months to 36 months	6.6 months	2.25 months	1.5, 2 and 4 months
Females	58% n=26	42% n=19	1.5 months to 48 months	7 months	3 months	2 and 3 months

Table 3

**Current and Past Religious Affiliation of Participants
n = 86**

Religious Affiliation	Kleine Gemeinden			
	Old Colony	Sommerfelder	Reinlaender	Gemeinden
Current	31% n=27	9% n=8	33% n=28	28% n=23
Past	51% n=44	26% n=22	16% n=14	7% n=6

Health Beliefs

A main focus of the interviews was the Kanadier Mennonites' beliefs regarding health and illness. The majority of the respondents had not previously had discussions about health and those belonging to the more conservative groups had the most difficulty in discussing their beliefs. Progressive participants commonly noted their personal relationships with God whereas the conservative participants did not express their religious views in this way. Thus the progressive participants commented about the links between personal happiness and a personal relationship with God as being related to having good health. The conservative participants did not share this viewpoint. The participants often defined health according to activities such as work one engaged in to be healthy, and one participant narrowly defined health as living without pain. Overall, health beliefs varied between individuals and families but there were common themes as discussed below. Kanadier Mennonites do not practice Western biomedical health models, but their health beliefs do include spiritual, mental, relational and behavioral aspects, as the following discussion will reveal.

Only two participants had holistic ideas about health. One female participant believed that staying healthy was based on taking vitamins, keeping a clean house and being in contact with one's family. One other participant stated that if one engaged in poor self-care, poor infant care, poor housekeeping and lacked personal cleanliness or food sanitation, then one would not be healthy. The remaining participants, however, did not share such a holistic viewpoint. For example, dental health was rarely considered as a component of general health status.

Diet, including the consumption of milk, was seen as an essential component of good health. A number of families talked about drinking milk as an important practice for both adults and children. Several of the women noted that they drank more milk while pregnant and discussed the necessity of children drinking milk for good health. Others mentioned that sweets should not be excessively ingested and that becoming overweight should be avoided. Other aspects mentioned were the importance of hard work, having a clean house and abstaining from alcohol and tobacco. Overall, frequent comments were made about needing to live in a clean house to achieve good health and that good health, was equated with being physically strong and able to work.

Handling of stress and a positive attitude toward health were also noted as important. Specifically, several participants commented that having a good spiritual attitude and being interested in helping others or being active means that you are healthy. Examples included going to church and praying in order to stay healthy. In general, being happy was equated with good health for the more progressive Mennonites. For some, being healthy meant that God was close to the person and helping him or her. Having fellowship, attending church and addressing one's spiritual needs led to happiness. Having a good and open relationship with one's family and friends also meant, at least for some participants, that they were healthy.

It was also believed that those who can recognize and address their problems are healthy. Overall, coping with stress was seen as essential in preventing health problems because stress can cause health problems such as headaches. Talking things out would result in a state of psychological healthiness that would lead to an individual being able to make rational decisions.

One of the women stated that staying healthy was important because the Bible says, "we are one family, one body." Another participant commented that staying healthy helps ensure that the Canadian health system is not abused. Other answers regarding how to stay healthy reflected beliefs congruent with Western scientific health beliefs. Examples include eating healthy foods, decreasing fat

in one's diet, exercising, brushing teeth, immunizing children, coping with stress, maintaining personal hygiene and limiting the amount of sugar, which was associated with developing diabetes. Opinions regarding the amount of meat to be consumed varied, with some noting low fat was important and others feeling that they needed to eat more meat. Ingesting a lot of fruits and vegetables was important to some but a few said that there should be a limit on the number of potatoes consumed.

Smoking was mentioned several times as a habit to be avoided for health reasons, but smoking was noticeable among the men and the male and female teenagers at the community gatherings. The avoidance of alcohol consumption and drug use was also mentioned by a number of participants and will be discussed in greater depth in a subsequent section of this article.

A few participants did mention health prevention activities such as physical check-ups at the physician or dentist's office, but the majority did not invest time in health prevention. There was a sense among at least some of the participants that health professionals did not play a formal role in assisting the Kanadier Mennonites with staying healthy.

Vaccinations were seen as contributing to the health of the individual, with only a few opposed because of reactions to vaccines. Those who were interviewed stated that their childrens' immunizations were up-to-date. One family indicated that they had tried to convince others to have vaccinations.

Categories of Health Problems

The following three categories were identified in the transcripts: physical illness, mental illness and spiritual illness, although not all participants identified all three categories. The three categories were simultaneously separate and interrelated.

Physical illness. Physical illness was noted as "being from flesh and bone" and that women, men and children could have such problems. A lengthy list of examples was provided, such as menopause (i.e., hot flushes and headaches), arthritis, uterus infection, stomach problems (i.e., heartburn), bladder infection, ear infections (especially in children), cancer, broken bones, diabetes, parasites, pregnancy-related problems, high blood pressure, influenza, strep throat, abdominal pain and vomiting, and heart problems. The inter-relationship among the three illness categories was noted in some participant responses. For example, one participant believed heart problems were really signs of a troubled heart, bad

relationships or having troubles caused by Satan. Still another participant believed that emotional stress caused 90% of physical illnesses.

Koppkrankheit was a physical health problem viewed as only occurring among children. This specific condition was described as the child's head growing too fast for the rest of its body. In order to rectify the condition, the ingestion of vitamins was necessary. This specific condition may be a nutrition problem, specifically one of malnutrition with a small body being the major attribute, although the large head is what the family notices.

Mental illness. Women, men and children could also experience mental illness, which was described as originating in the heart. Mental illness was often caused by worry and sadness. However, it could be due to engaging in inappropriate behaviors such as drinking, drugs and being abusive to one's spouse. The participants often referred to having "nerves" or being depressed. One example that was provided illustrated that the family had overspent and was not able to cope with its financial problems, and thus suffered from nerves. One participant did differentiate nerve problems from mental illness, while more often others viewed mental illness as being caused by Satan or by having a bad conscience.

The definitions of health presented earlier noted the links between spirituality and health. When discussing categories of illness, some indicated that not believing in God could lead one to have "nerves" or become mentally ill. Disbelief in God was also described as a "soul problem." Furthermore, nerve problems were based on guilt because the individual did not act according to church rules. Nerve problems were also believed to originate from being excessively angry and tended to occur among people who were too serious or sensitive. Other causes of nerve problems included being depressed, having difficulties thinking, or having mental handicaps.

Being mentally ill led to the individual worrying too much, and also to anger and abusive behaviors. Family problems were also seen as contributors to mental illness. Treatment for mental illness would only be effective if the individual wanted to help himself or herself.

Spiritual illness. Spiritual illness, the final category, was described as having a heavy heart and sadness. It was inter-related with mental illness since Satan is viewed as a source, or it is due to the person's nerve problems. Alcohol or drug misuse was viewed as a spiritual problem and as a drifting away from God. Participants believed that substance abuse was a sin, which confession to the ministers would help alleviate. It was recognized by the participants that the misuse of drugs and alcohol affects the entire family, creating an unhealthy environment for them all and bringing unhappiness. One male

participant noted that he stopped drinking because "it did not please God."

Lifestyle choices such as alcohol and tobacco use were believed to cause physical problems such as liver dysfunction, cancer and breathing difficulties respectively. In one instance a participant noted that a woman was thought to have miscarried because of smoking too heavily. Aggravated breathing in individuals was also noted among those who engaged in this habit. Alcohol side effects also included numbing of the brain, thinning of the blood and generally affecting an individual's behavior.

Due to the nature of alcoholism, its treatment emphasizes spiritual aspects such as prayer and counseling with ministers. There was emphasis on the fact that an alcoholic can only be helped if he or she wishes to be helped. Alcoholic Anonymous meetings were viewed as important in recovery, and parents of children or young people who misused alcohol or drugs should ask for help.

Help-Seeking Behaviors

To further understand health and illness among the Kanadier Mennonites, questions were asked about the circumstances within which they sought health care. Almost all indicated that they would seek help for a child sooner than an adult because a child is unable to explicitly describe to the parent what is the matter. In addition, a child's health is more precarious than that of an adult and needs closer monitoring. Others noted that one should seek assistance quickly for whoever needs the help, regardless of their age.

The reasons for seeking care, the treatment received and patient satisfaction with care were also discussed. A number of ailments such as arthritis, croup, high blood pressure, asthma and personal injury accidents led individuals to seek care. Several participants had their own family physician with whom they could make an appointment. However, the use of two Mennonite community health representatives (CHR) employed by one of the collaborating health regions was a common first step in seeking help. These CHRs belong to mainstream Mennonite groups, are fluent in Low German and are familiar with the religious backgrounds of the Kanadier Mennonites. The CHRs make appointments, translate as necessary, carry out follow-up contact with the physicians, explain illnesses and treatments, and provide emotional and social support. There was a great deal of trust in these individuals and the participants attributed their understanding of the complex Canadian health care system to these professionals. Overall, most of the Kanadier Mennonites seek care

for acute or chronic health problems but do not invest time in health prevention activities. The exceptions were women who accessed a physician for pregnancy check-ups.

Among the progressive participants, the use of chiropractors was noted. Examples of specific health problems were few, but one woman noted she saw a chiropractor or self-taught female chiropractor in Mexico while pregnant if the fetus was too high or too low in the womb. In general, chiropractors were thought to be important to staying healthy.

The participants did accept and use a variety of treatments prescribed by Canadian physicians, including a range of surgeries (i.e., hysterectomies and brain tumor removal) and medications for hypertension, arthritis, cancer and kidney stones. Broken bones were set and casts used as necessary. There was no mention of seeking permission or guidance from their ministers to undergo any of these treatments.

The participants reported a more progressive use of potent medications in Mexico than in Canada. In Mexico it is possible to buy Penicillin pills over the counter. These pills are then broken and used as a powder on cuts. Some participants also indicated that they mix the powder into a solution and inject one another in the buttocks. When seeking care in Canada, they prefer to receive injectable antibiotics and to receive antibiotics, or at least some kind of medication for many health problems. It was noted that Canadian physicians tend not to provide medications as easily as their Mexican counterparts.

Alternative Treatment

Discussions were held with the participants about their use of alternative treatments. A number of them used such treatments on a regular basis; however, among the more progressive participants the usage declined the longer they stayed in Canada. The different categories of treatments include the mixing of treatments and Mexican medication; prayer; external salves, drops and pills; natural herbs and plants and folk treatments.

Several people spoke to the issue of the "mixing Canadian treatments and Mexican medications," indicating that it would be unsafe to use both alternative treatments and Canadian medicine together. One person stated that the physician does not want mixing of both types to occur. One family explained that if they have a Canadian prescription they complete it, then wait a week and start the Mexican medicine. Or, if they have a medicine from Mexico they

will complete that first and then use the Canadian prescription. The decision to mix medications was totally dependent upon the type of medicine and varied from one household to another. For example, it was believed that strong and specialized medicines should not be mixed. Nerve and diabetes medications should not be taken together, but fever medicines could be mixed. Some participants indicated it would be okay to mix external (salves) alternative treatments but not the internal (i.e., oral medications) ones. Some of the participants thought that it would not be appropriate to use alternative treatments in Canada, while several participants stated emphatically that they do not use "Mexican medicines," or substances that could be taken orally or used topically and are available as prescriptions or as "over the counter" in Mexico. For some, topical treatments from Mexico were acceptable, but ingesting oral Mexican medications was not. Others noted that they would try medications they have at home when they are first ill with a cold or the flu, and then seek formal health care if their self-treatment is not effective.

Prayer was discussed as one very important alternative treatment. Those who were more progressive (i.e., Kleine Gemeinde) and saw their religion as a personal experience with God, believed that individual prayer would be helpful when they or other family members were ill. In these instances, the minister prayed over the sick individual, laid hands over the patient and held prayer meetings. Participants believed group prayer meetings to be the most influential forms of prayer. Prayer could also lead the person to seek medical attention and was seen as helpful when the individual was misusing drugs or alcohol.

Applied external salves, drops and pills, especially Doctor Thomas Electric liniment or ZMO Oil, were believed to relieve arthritic pain. Either *Metamizol Sodico* or inhaling ether vapors were said to relieve dental pain. Some suggested that *Yodex* and *Metilsalicilato Yodo* could be rubbed on muscles to relieve pain while bee salve and Vicks could be combined for treatment of arthritis. It was noted Wonder Oil was useful for general aches and pains. It was suggested that Electric Oil and China Oil (a mint product with an ammonia smell to it) could be rubbed on the person's ears and throat to relieve cold symptoms. *Meduril* was used in children for colds and influenza and *Desin Fiol D* was helpful for adults with these same ailments (both of these medications can be purchased over the counter in Mexico). *Dietsche Latjye* (German drops) was listed as helpful when an individual has stomach cramps. *Hiengfong*, mint drops from Mexico that can be ingested internally, were said to cure diarrhea, vomiting, colic or influenza, but it was also noted that these drops could also be used externally and rubbed on bee stings or on teeth that hurt. Wounds and

cuts were treated with Pine oil (*Tjiefaelji*) and gun grease was said to be useful as a salve for treating eczema.

A number of natural herbs and plants were thought to be useful for a variety of health problems, including the use of onions for nerves. Stomach problems could be resolved by using chamomile in babies and children as well as adults. One woman commented that she had ineffectively used apple cider vinegar for fluid retention. Other herbs included dandelion roots or echinacea drops, which were used for colds. Some exclusively use the products of one particular herbal company. One of the families indicated that they used a particular herbal remedy for high blood pressure and another for arthritis, but did not disclose the specific details.

The participants also described folk treatments that were used in Mexico to address a variety of health problems. One example was that in Mexico some physicians cure tonsillitis by pulling a certain hair in the patient's head, which would then rip the nerve going to the tonsils. In this way the tonsils would dry up, alleviating any future concerns. Those who had experienced this treatment stated that they could actually hear the nerve rip. Other physicians in Mexico were believed to be able to give an injection to an alcoholic that would cause the alcohol to taste bad, thereby preventing future consumption. One example provided by a participant was that a physician gave his friend an injection for his alcoholism and was told it would last 5 years and when this time period ended, he was drinking once again.

In children, it was noted, ingesting scalded milk takes their fever down. Eating corn tortillas that have been cooked in a calcium and lime solution can treat *Kopp krankheit*. A participant who had been badly burnt as a child provided the details of her treatment, which included placing a cloth soaked in varnish on her burnt skin to remove the old dead skin. This daily treatment was followed with the use of cottage cheese drippings (i.e., the watery part of cottage cheese) on the burnt area. There were no disabilities or scars on this individual, despite the fact that approximately fifty percent of her body had been burnt.

One other treatment included making a liniment for arthritis by placing avocado stones in alcohol. Rags dipped in sour cream and placed on arthritic joints also provided pain relief. It was also believed that eliminating the ingestion of yeast products would decrease the risk of having arthritis.

Contextualizing the Kanadier Health and Illness Perspectives

A number of points have been raised that identify the uniqueness of the health and illness beliefs of the Kanadier Mennonites who are

currently living in southern Alberta. The Kanadier Mennonites of the most conservative groups had a great deal of difficulty discussing issues concerning their health. This finding is similar to Reinschmidt's who also notes that the Old Colony Mennonites in her sample do not provide any education related to science or the human body. Hence we cannot assume that members of the conservative Kanadier Mennonites know some of the more basic aspects of the scientific and technological components of health and health care. Within the progressive groups there was a greater sense of questioning the world around them, yet they still believe that if they have a positive personal relationship with God they will be happy, which for them translates into good health.

The unifying issue for both the progressive and conservative groups was their difficulty in articulating a concept of health prevention based on the Western biomedical model. Again, this complements Reinschmidt's findings. Her informants provided examples such as the importance of diet, but lacked an understanding of the links between lifestyle behaviors and health. In this respect, health care professionals in Canada need to use the Kanadier Mennonite's recognition of the importance of diet as a strength and build upon it by doing additional teaching regarding healthy eating. Similarly, many of the individuals felt that having a clean house translated into being healthy. In this respect, professionals can begin to teach other forms of cleanliness such as germ control and cleaning food, procedures that are all health promoting.

Study participants felt that closeness to God would reduce the amount of stress and would lead to good health and feeling well. The Kanadier Mennonites' spirituality is one of their greatest strengths. By taking a holistic point of view towards health, it will not be too difficult for open-minded professionals to appreciate the important link of health to spirituality in the overall Kanadier Mennonite self-health model. By disregarding the religious belief systems, health professionals miss out on a complete understanding of the Kanadier Mennonite's health and illness beliefs. Spirituality for this group is a mainstay of their community, which when respected can be utilized in positive ways to promote an initial understanding and education of health and illness. For example, there was a universal agreement amongst the four religious groups that alcohol and tobacco have quite serious negative consequences. This belief provides another opportunity to promote health by supporting a belief that does not interfere with their religious convictions but clearly has a healthy focus.

The majority of Kanadier Mennonites in this sample felt that mental illness was sent to individuals because they had moved away

from God; thus, it was the wrath of Satan. This belief is one that also arose in the research by Reinschmidt and is an example of how enduring beliefs can be and the importance of acknowledging and incorporating this belief when providing care. By appreciating that religion and lifestyle are interwoven, one can understand why the Kanadier Mennonites talk about spiritual illness. Spiritual illness is viewed as drifting away from God, which has been caused by being mentally ill or being involved with drugs or alcohol. Professionals who can accept this concept can introduce educational programs on drugs and alcohol with the hope of eradicating these problems by enhancing the connection that the Kanadier Mennonites have to God. This non-intrusive form of health education will likely be more successful than more intrusive methods.

The Kanadier Mennonites placed a lot of emphasis on the need for their children to be healthy. Childrens' health was put before that of the parent. Here again is another opportunity for health care professionals to re-orient their thinking from the adult world to that of educating the family system. By working with entire families and not excluding the children, they will help ensure that all individuals are given an opportunity to receive health education.

The use of alternative treatments, including folk treatments as well as prayer, needs to be considered in light of the Kanadier Mennonites' overall health belief system, religious viewpoints and length of time spent in Canada. Those who have lived a longer period of time in Canada and belong to a more progressive religious group have incorporated, generally speaking, lifestyle choices and behaviors that are more similar to those of mainstream Canadians. Thus, elaborate detail was provided about how and when alternative treatments would be combined with Canadian treatments. However, health professionals, including physicians, need to understand that a number of Kanadier Mennonites still expect to easily receive medications when they seek health care. It is therefore important to enquire about their use of alternate types of treatment. All health professionals need to be respectful of the importance of prayer as an alternative treatment and recognize that this form (prayer) will often precede any involvement with the physician.

Finally, the findings indicated that the Kanadier Mennonites respond well to community champions such as the CHRs who have been working with them. These individuals are crucial in assisting the Kanadier Mennonites to understand their health and illness experiences, as well as the Canadian health care system. This is yet another strength to build upon because the CHRs are effective advocates in bridging any gaps in understanding that exist between the Kanadier Mennonites and health professionals. A point raised by

Reinschmidt is also noteworthy here: in Mexico she found that the husbands who accompanied their wives to health appointments were engaged in a moral behavior. If this idea were transferred to Canada, the significance of the CHRs taking the Kanadier Mennonite women to health appointments also lies in engaging in this same behavior.

In conclusion, this study revealed that there is much to learn about the Kanadier Mennonites in terms of their health and illness beliefs. Delivery of health care for this population needs to emphasize their strengths, which include the importance of family, children and their religious beliefs. This study demonstrates that Kanadier Mennonites not only have much to reveal about their health and illness perspectives, but that in doing so they experience an educational process through which individual growth is achieved. Future research could focus on combining interviews with Kanadier Mennonites with observation of their everyday life to further enhance our understanding of their health and illness beliefs. Research partnerships with this group are not only possible but also desirable in order to ensure that health topics of particular interest to this group are addressed.

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Notes

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