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Health Promotion in the Hutterite Community and the Ethnocentricity of Empowerment

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L'optique transformatrice et émancipatrice du pédagogue révolutionnaire Paulo Freire ainsi qu'une théorie sociale critique ont influencé le concept d'appropriation, l'une des pierres angulaires de la promotion de la santé. Le processus d'appropriation est conçu comme une libération de l'oppression, de l'impuissance et de l'ignorance; les notions essentielles qui le caractérisent sont le militantisme de base et le rejet du statu quo. L'article examine de façon critique les difficultés auxquelles sont confrontés les praticiens et les chercheurs promoteurs de la santé qui essaient d'oeuvrer de manière émancipatrice avec un groupe de culture différente, à savoir les huttérites. La vision qu'ont du monde les huttérites, leurs valeurs qui comprennent la primauté de la communauté, le respect des prises de décisions hiérarchiques et une adhésion totale au code traditionnel de conduite, aux valeurs et aux croyances, fournissent l'occasion de critiquer l'ethnocentrisme du processus d'appropriation.

Empowerment, one of the cornerstones of health promotion, has been influenced by the transformative and emancipatory perspectives of the revolutionary educator Paulo Freire and critical social theory. The empowerment process is conceived as one of liberation from oppression, powerlessness, and ignorance, and at its core are notions of grassroots activism and rejection of the status quo. This paper critically examines the challenges faced by health-promotion practitioners and researchers who seek to work in an empowering way with a culturally distinct group, the Hutterites. The Hutterian world-view, which values (a) communalism, (b) respect for hierarchical decision-making, and (c) strict adherence to a traditional code of conduct, values, and beliefs, provides an opportunity to critique the ethnocentricity of the empowerment process.

If the end of the millennium health-care reform rhetoric is to be believed, in the 21st century the principles and practices of health promotion will take on greater significance in nursing practice, education, and research. Similarly, as Canada and many other first world nations become more culturally heterogeneous, through economic globalization and changing patterns of immigration, principles of transcultural health care will become increasingly important.

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Culturally diverse nursing care requires a variety of approaches that respect a diversity of values, beliefs, norms, and practices (Leininger, 1985). There is little argument among nurses and other health-care professionals that health promotion should be conducted in a culturally sensitive way; in practice, however, such an approach poses a plethora of challenges. These challenges stem, in part, from a radical paradigm shift in health promotion, from the traditional "expert" biomedical perspective to one that embraces the concept of empowerment and the primacy of individuals, families, and communities in setting the health agenda. For nurses in the field of health promotion, the combination of cultural diversity – with its array of health-related expectations, beliefs, and practices – and this transformation of professional roles presents additional challenges.

The purpose of this article is to illustrate how one of the core principles of health promotion, empowerment, can be problematic when applied to a specific Canadian ethnic group – the Hutterian Brethren. Our examination points out the ethnocentricity of empowerment and it challenges nurses to ask whether they are practising in a way that respects cultural differences.

Background

Origins of the Problematic

Almost a decade ago, one of us (Brunt) began a program of research based on the epidemiology of cardiovascular disease (CVD) in the Hutterite community. While the initial interest in this area was investigator driven, the research questions strongly resonated with a widespread concern in the Hutterite community about a perceived high risk for CVD. The epidemiologic studies did indeed reveal a prevalence of CVD risk factors, including hypertension, hyperlipidemia, and obesity (Brunt & Love, 1992a; Brunt, Reeder, Stephenson, Love, & Chen, 1994), influenced by the Hutterian high-fat, high-salt diet and sedentary lifestyle. A series of related studies with the Hutterites established the critical role of genetics in their development of hypertension, hyperlipidemias, and coronary-prone obesity patterns (Hegele, Brunt, & Connelly, 1994, 1995, in press). Evaluations have helped document our work with the community and provide evidence that our use of a relatively low-impact screening and educational approach has increased the interest of Hutterites in adopting a more "heart healthy" lifestyle (Brunt & Love, 1992b; Brunt & Sheilds, 1996).

Once the results of these studies were shared with the Hutterites, the obvious question "What can be done?" emerged from the community. It became apparent during discussions with community leaders that they supported the development of a heart-health program. It also became apparent that the investigators, before proceeding further, had to develop an understanding of the cultural meaning of health and health promotion for the Hutterites. Thus a series of multidisciplinary studies was designed to provide information about possible approaches to developing heart-health programming that would be relevant for Hutterian culture.

An ethnographic investigation into Hutterite concepts of health was followed by a review of the theological underpinnings of the themes that had emerged, including literature surveys and field studies: community meetings, key informant interviews, and participant observation. The field studies focused on how heart-health promotion should or could proceed, from the perspective of the Hutterite community. However, as our collaborative program of research and planning evolved we were plagued by a nagging sense that our approach was fundamentally flawed. Our greatest area of concern was the dilemma posed when the world-views of one culture are juxtaposed with those of another. We were concerned that in our efforts to help the Hutterian Brethren improve their heart health we would unwittingly undermine their values and beliefs.

We will outline the nature of our dilemma by examining the theoretical and conceptual meanings of "empowerment." We will illustrate that these meanings represent ethnocentricity and that they come into direct conflict with the Hutterian world-view.

Empowerment

Many researchers, scholars, and community activists concede that a central tenet of health promotion is empowerment (Gibson, 1991; Labonte, 1994; Rissel, 1994; Robertson & Minkler, 1994; Rodwell, 1995). Etymological investigation reveals that empowerment is derived from *power,* which comes from the Latin *potere* or *potent,* to be able to choose or to be powerful (Rodwell). Empowerment is perhaps better understood by its absence: powerlessness, helplessness, hopelessness, subordination, oppression, dependency (Hegar & Hunzeker, 1988; Kieffer, 1984; Rappaport, 1984; Wallerstein & Bernstein, 1988). Because of the issues of power and oppression, empowerment has its roots in community psychology (Rappaport, 1987), feminist theory (Gutierrez, 1990), and social activism (Alinsky, 1972).

Although there is considerable debate about the definition of empowerment, there is agreement that it is both a process and an outcome (Bernstein et al., 1994; Gibson, 1991; Labonte, 1994). Labonte stresses the importance of differentiating between individual and collective empowerment in the development of an empowerment holosphere. This holosphere takes into account personal care, group development, community organization, coalition advocacy, and political action. Furthermore, according to Labonte, one cannot empower another, but one can participate in a process of which empowerment is the outcome. The process can be described as the *how* of empowerment, the outcome as the *what*. Gibson's definition captures the process and outcome of both individual and collective empowerment: "a social process of recognizing, promoting and enhancing people's abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives" (p. 359). Central to these outcomes is a grassroots, bottom-up, emancipatory process rooted in a revolutionary paradigm, rather than an evolutionary one.

The process (the *how*) of empowerment is best described in the literature on community organizing (Minkler, 1990), community development (Labonte, 1994), and health education (Wallerstein & Bernstein, 1988). In these disciplines the thesis is that empowerment is a participatory process of critical consciousness-raising that, through grassroots organizing, promotes emancipation/transformation from oppression and the status quo. The empowerment movement has been greatly influenced by the work of the emancipatory educator Paulo Freire (1973), the critical theorist Jürgen Habermas (1972), and the political activist Saul Alinsky (1972) – through his contention that conflict is a necessary component of critical reflection and social change. Freire's central premise is that education is never neutral, but has a context. Education can be used to either socialize or challenge the status quo. Emancipatory education is the process of critical consciousness-raising through examination of the social structures that lead to oppression and that strengthen the status quo. Freire proposes a dialogical approach to helping people move beyond powerlessness and gain control of their lives: everyone in the educative encounter participates as an equal, as a co-learner, in the creation of social knowledge. The emphasis is on collective knowledge, as members of the group share experiences and come to an understanding of the social forces that influence people's lives.

Freire's methodology for emancipatory education comprises three stages. The first, listening to the experiences of the community, includes

story-telling and the exchange of experiences, issues, and problems. The second stage includes problem-posing dialogue: issues are raised and questions are posed as part of a process of consciousness-raising. The third stage involves envisioning action that leads to positive change; as action is taken, the people reflect on it, and the cycle of emancipatory education continues (praxis). These stages may occur slowly, with change evolving over extended periods of time. Wallerstein and Bernstein (1988) have adapted Freire's emancipatory educative model to elucidate the empowerment process of health education leading to effective change.

Thus the process (the *how*) of empowerment involves members of the community as equal partners and co-learners. Together they explore the issues at hand, engaging in grassroots dialogue, which leads to critical consciousness-raising and awareness, which, in turn, leads to envisioning action and positive change. Thus the *what* (or the outcome) of empowerment is a result of the process of conscientization (Freire, 1973), by enhancing the ability of the community to effect relevant change. Again, central to this understanding of empowerment in community-focused health promotion is openness to a bottom-up approach that questions the hegemony and the hierarchical structures that engender the determinants of health.

Characteristics of the Hutterite Community

The Hutterites constitute the largest single rural ethnic group in Canada. Approximately 30,000 Hutterites reside in some 300 colonies in North America, most of which are located in the Canadian prairie provinces and bordering American states (Evans, 1985). The Hutterites are subdivided into three groups *(leute):* the Dariusleut, Lehrerleut, and Schmiedeleut. Our research has been limited to the Dariusleut and Lehrerleut groups, the only two *leute* resident in Alberta. While the lifestyles and religious practices are virtually identical among the three *leute,* each is endogamous (featuring little or no intermarriage) and has a unique genetic lineage (Hostetler, 1985). The Hutterian Brethren are theologically related to both the Mennonites and the Amish, and they share many Christian beliefs with these two sects, most notably pacifism, adult baptism (anabaptism), and a strict biblical interpretation of human conduct.

Perhaps the three most distinguishing features of Hutterite life are an agrarian communal lifestyle, a simple, uniform dress code, and a dictum that all things are held in common. This translates into extended family units of between 60 and 150 people per farm colony, each

member sharing both the work and the bounty of the farm. Personal and family property are minimal, and most goods and services are fairly divided among colony members. The social order and individual lives are strictly governed by a series of principles that have changed little over the Hutterites' 500-year history. The elders of the colony – all baptized males – are charged with the responsibility of ensuring that the Hutterian vision of a proper spiritual and secular life is upheld. There is well ordered and prescribed hierarchy in the colony, the minister and the farm manager having the greatest responsibility. Those in positions of authority are not seen as "powerful"; rather, they are considered the "servants" of the colony, and thus as carrying the greatest burden.

Unlike the Amish and the Old Order Mennonites, the Hutterites employ up-to-date farming technology and have proven themselves to be highly successful in the competitive world of agribusiness. When it comes to the formal health-care system, they make use of the available allopathic and "alternative" services and their access is limited only by their relative geographic isolation.

Empowerment and the Hutterian World-View

The Hutterite world-view and religious beliefs are inculcated in early childhood, and deviations from the norm are corrected by parents, elders, and other baptized colony members. This is not to say that expressions of individual preference do not exist; however, in terms of beliefs, daily routines, work assignments, dress, and diet, there is a high degree of homogeneity, both within and among colonies. The purpose of social control and a rigid structure is maintenance of the status quo and the spiritual health of the colony. "Status quo," in the Hutterite context, means adherence to values and beliefs, and the term is not used here in a pejorative way.

Based on our work with the Hutterites, we have identified a number of aspects of their lives that, taken together, challenge the utility for the Hutterite community of the notion of empowerment in health promotion. These aspects relate to the Hutterites' hierarchical social organization, which is based on the tenets of communalism and maintenance of spiritual health.

The structure of the Hutterite colony is based on the system developed in the 1500s for the original *Bruderhofes* (Hutterite colonies). All decisions that affect colony life, both sacred and secular, are ultimately the responsibility of the elders. The elders comprise the ministers

(typically two), the farm manager, and several other men in positions of authority. The work of the colony is conducted along gender lines, the men assuming responsibility for farming and business activities, the women for communal child-rearing, housekeeping, and cooking. While each colony is autonomous, a conference of ministers is held at least once a year to deal with issues of common concern.

Changes in colony life usually begin with the introduction of a new idea or technique by a few members in a single colony. As other colonies or individuals begin to adopt the change it will come to the attention of the elders and be raised for discussion at meetings. Eventually, the innovation will be sanctioned or forbidden, depending on its perceived effect on the spiritual health of the colony. A recent example was conveyed to us while we were conducting our fieldwork. One colony found that two-way radios facilitated communication among the various work groups and the managers. This change was reviewed by a council of ministers and, ultimately, banned as too worldly.

The shunning of worldly temptations is a central practice. For a Hutterite, life is a constant struggle against the forces of evil and temptation: between the spirit, the infinite and perfect universe of Heaven, and the flesh, the impermanent and imperfect universe of life (Stephenson, 1991). This world-view is manifested throughout colony life in matters of dress, language, diet, and exercise, as well as in the isolation of colonies from "worldly" towns. Efforts to introduce change related to heart health must take into consideration the way in which Hutterite culture deals with decision-making and control. While individuals and colonies may adopt "heart healthy" changes, at some point these changes require a more general sanction at the level of the council of ministers.

There are prohibitions against a number of secular practices such as smoking, watching television, listening to radio, and engaging in many forms of recreational exercise. While children are permitted to play games and sports such as baseball and volleyball, once Hutterites become baptized adults they are expected to refrain from any exercise that might take them away from work or that could interfere with their spiritual life (e.g., taking part in "childish" activities for reasons of vanity or competitiveness). Each Hutterite is expected to struggle against worldliness and to exercise judgement when confronted with temptation. Choices must be made within the context of communal life, and, for the most part, "correct" and prescribed choices are expected to be made.

Central to an understanding of the Hutterite world-view is the following passage from Acts 2:44: "And all that believed were together, and had all things common; and they sold their possessions and goods and distributed them to all, as any had need." Communalism has persisted, despite periods of forced relocation and persecution, for 500 years. Key to the success of Hutterian communalism is a shared belief in the ideal of *gelassenheit* – to live a life based on selflessness, "giving-up-ness," and sharing. Stephenson (1991, p. 26) describes the experience of *gelassenheit* as a bit of heaven on earth marked by calmness, resigned composure, and deliberate patience.

The commitment to communalism is carefully monitored and controlled by the ministers and elders, and it is upheld by all baptized adults – who serve as guardians of the spiritual and secular welfare of the colony. Thus any change, if it is to have the approval of the elders, must support *gelassenheit. Gelassenheit* demands that attention be paid to the process, as well as the goal, of change. For example, a request for different foods for some members of a colony could be seen as running counter to the principles of "all things common" and thus destructive to the spiritual health of the community.

Not surprisingly, the Hutterian concept of health is largely understood in spiritual terms and is closely aligned with the concept of *gelassenheit.* Good physical, mental, and emotional health are considered gifts from God. Ill health is not considered a punishment, but, rather, a burden that one must bear, partly as a test of faith as expressed in Romans 5:3–5: "We rejoice in our sufferings, because we know that suffering produces perseverance; perseverance, character; and character, hope." Thus Hutterites do not consider it appropriate to pray for good health; instead, they pray for the wisdom to know how to either live a healthy life or bear their suffering without complaint. Hutterian beliefs about death and disability do not provide the negative motivating factors that are often used in health education. Next to baptism, death is considered the most important moment in a Hutterite's life, as it marks entry into eternal life in Heaven. It is a key event in the social life of a colony. Thus death per se is an unlikely stimulus for risk modification. However, the sudden disability of a member in the prime of life has a largely negative impact on the colony, requiring replacement of the affected individual in the workforce and, in some cases, provision of care. Health promotion and education strategies can be designed for the Hutterite world-view; however, empowerment strategies may not be appropriate for a Hutterite community.

Methods of fostering community participation have been greatly influenced by the value placed on empowerment as both a process and an outcome in health promotion. We have therefore been challenged by the prospect of working with a culture in which an emancipatory, grassroots approach runs counter to community norms, expectations, and desires. For example, the approach of holding forums open to all members of a community is consistent with the process of empowerment found in the literature. However, the results of forums for all colony members to discuss their vision for improved heart health yielded unexpected results. Our first discovery was that having men and women participate in the same meeting runs counter to colony norms. Also, one or two male elders or senior women (usually the head cook or the wife of the minister or colony manager) did most of the talking. This deference to hierarchy rendered the grassroots approach, which is ideally predicated on widespread community participation, largely ineffective.

During individual interviews, colony members had many ideas about how health promotion could proceed. However, these ideas largely fell into two categories: (1) the need to work with elders to convince them that changes (i.e., to diet) could take place, and, (2) individuals could make changes as long as they did not interfere with normal colony life. For example, some members owned exercise equipment such as treadmills and stationary bicycles; this was generally tolerated as long as they used it on their own time and did not make an issue of it. Other respondents were concerned that if a large number of people had exercise equipment it could become an issue for the elders to deal with. Such ownership could ultimately be forbidden, if it is seen as a threat to communal integrity and *gelassenheit.*

For a Hutterite, questioning authority and choosing to be different are antithetical to the pursuit of *gelassenheit.* Individual choice is important, but only if it coincides with community expectations. While the philosophical underpinnings of empowerment are based on emancipation, questioning authority, and making individual choices, *gelassenheit* is predicated on surrendering to the wishes of the community as interpreted by the elders. There is an intrinsic conservatism built into colony decision-making that is rooted in both pragmatism and Hutterian spirituality. Researchers and health-promotion professionals interested in working with this population must take into account the hierarchical and communal aspects of Hutterite life.

By using a bottom-up and emancipatory process consistent with the notion of empowerment, we may unwittingly undermine Hutterite

cultural and spiritual values, and thus cause more harm than good (e.g., "The operation was a success but the patient died"). Ultimately, it is the Hutterites who must set the standard for judging the success of health promotion in their communities. It is entirely possible that over the next decade the risk of CVD in the Hutterite community will decrease. However, this improvement will be successful only to the extent that it meets the test of *gelassenheit.*

Based on the results of our research, we have modified our approach with the colonies in accordance with their vision of health and health promotion *(gelassenheit).* We must work with the elders rather than adhere to a grassroots approach, and we must respect the Hutterian system of evolutionary change that attends to communal needs rather than the individual needs of its members.

Conclusion

The construct of health promotion has undergone a radical transformation over the past decades. Health professionals' understanding of the processes *(how)* and outcomes *(what)* of health promotion is continually evolving. The prevailing definition of health promotion, "a process of enabling people to increase control over and to improve their health... a mediating strategy between people and their environment, synthesizing personal choice and social responsibility in health" (World Health Organization, 1984), has been closely aligned with the concept of empowerment. However, empowerment – to the extent that its process is framed in terms of undermining hegemony through collective, grassroots action – is not necessarily appropriate for all cultures. The Hutterites, with their emphasis on respect for hierarchy, for the common good, offer us an opportunity to question the ethnocentricity of empowerment with regard to health promotion.

Has the concept of empowerment become the prevailing hegemony? We must not let our understanding of the principles and practices of health promotion go unquestioned. We must critically examine our practices, to fully realize our potential as caring researchers and practitioners. In our program with the Hutterites, we have now adopted an approach that philosophically aligns more with the concept of *gelassenheit* than that of empowerment. This shift represents our attempt to respect the values, beliefs, and practices of the Hutterian Brethren.

Through our experiences with the Hutterites and through self-critique, we have expanded our understanding and practice of health promotion to include a cultural dimension that was lacking in our work.

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