Improving Accessibility of Health and Social Services for Low German Speaking Mennonties

Cultivating a Respectful Approach to Client Engagement in Elgin, Oxford and Norfolk Counties

Situational Assessment
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Summary

Low German Speaking (LGS) Mennonites in Elgin, Oxford and Norfolk Counties have been identified as a population of importance by local service providers because of the providers' desire to provide better services to this growing population in these communities. In response, we conducted a situational assessment to understand what health and social services (services) exist and what might be missing for LGS Mennonite children (0-12 years) and families in these regions. We also wanted to understand what made it easier and what made it harder to deliver and access these services.

We found 306 services offered by 126 organizations. More services targeted children than targeted the family unit. However, very few services specifically targeted LGS Mennonite children or families. Service planners should also be aware of a low number of:

- services targeted to females only
- services targeted to males only
- primary health care services
- services in Norfolk County in comparison to Elgin County and Oxford County

Service providers are working to develop or strengthen their understanding of the LGS Mennonite community. They exhibited their understandings of the community in different ways. All recognized the cultural diversity among their clientele and some promoted positive interactions and flexibility with their clients that enabled them to lessen the disconnect between their service environments and the cultural practices and values of their clients.

When accessing services, LGS Mennonites try to fit in between two cultures: their culture and the Canadian health and social services culture. This experience manifests in having to step out of their comfort zone and to balance their family responsibilities and traditions with their desire to see their families be well.

Developing an understanding of the LGS Mennonite culture and community helps providers mitigate some barriers to delivering services to this community. Service planners should consider how to leverage knowledge from their clients and existing supports to develop their understanding of this community.

Improving Accessibility of Health and Social Services for Low German Speaking Mennonites

Background and Rationale

Mennonites are members of the Anabaptist Christian religious group and their movement – born out of the Protestant Reformation in Europe – can be traced back to the 1500s.[1–3] Though their views and practices can vary significantly among their denominations, they are united by their belief in adult baptism, pacifism and living simple lifestyles independent from mainstream society.[1,4] Throughout their history, Mennonites have endured obstacles leading to various periods of mass migration – first to North America in the 1800s, then to Latin America in the early 1900s and subsequently back to North America in the mid-1900s – in pursuit of land in areas where communities could establish colonies and uphold their way of life, free from discrimination.[1,2]

Low German Speaking (LGS) Mennonites, one classification of Mennonites, consist of many sub-denominations or groups which vary in their level of religious conservatism. For example, Old Colony is considered to be on the conservative end of the spectrum.[4] Yet, in light of this, Low German or Plautdietsch is considered the uniting factor among the various groups as it is the oral language predominately used by LGS Mennonites.[1,2,4]

In the 1950s, LGS Mennonites began to return to Canada because of economic hardships they experienced in Mexico.[1,5,6] For many, their return was aided by their ability to obtain Canadian citizenship through their parents or grandparents who had already obtained citizenship due to prior settlement in Western Canada.[1,2] During this resettlement period, many LGS Mennonites returned to familiar or previously established communities in Manitoba and Saskatchewan, while others ventured to new locations in Southwestern Ontario, such as Elgin County and Norfolk

County.[3] Throughout the next several decades, LGS Mennonites continued to migrate back to Canada, increasingly settling in Ontario.[1,4,7]

LGS Mennonites do not have a language or religion recognized in the Canadian Census Program and, because many LGS Mennonites return to their homes in Mexico for parts of the year, accurate statistics are difficult to obtain on this population. Estimates suggest Canada is home to 80,000 - 100,000 LGS Mennonites, with 40,000 - 50,000 living in Ontario, alone.[4] Local estimates from 2002 suggest that approximately 500 reside in Oxford County, 10,000 reside in Norfolk County and 12,000 reside in Elgin County.[8] However, health and social service (service) providers have anecdotally shared their belief that the LGS Mennonite population has increased in these regions since this time.

Low German Speaking Mennonites in Elgin, Oxford and Norfolk Counties have been identified as a population of importance by local service providers because of the local service providers' desire to provide better services to this growing population in these communities. Very little data exists about LGS Mennonites' health outcomes, how they access health services and their social determinants of health. We understand from colleagues who have lived and worked among LGS Mennonites that this community tends to have larger families, lower income and lower educational attainment. Health-care organizations have recognized these intersections and have acknowledged their own lack of cultural competence to work with this population. The South West Local Health Integration Network (LHIN) has recently identified that there is a lack of data available to understand how the social determinants of health impact the quality of health and health care of LGS Mennonites and the challenges this population faces in our communities.[9]

In the Fall of 2017, the former Elgin St. Thomas Public Health[a] (ESTPH) identified LGS Mennonites as a key target population for their public health services. In trying to understand the needs of this population, ESTPH discovered other community partners had also identified LGS Mennonites as a target population. Together, they decided to collaborate on a project to better understand the needs of LGS Mennonites and service providers in Elgin-St. Thomas, Oxford County and Norfolk County. For readability purposes, Elgin County is used below to refer to Elgin-St. Thomas.

[a] Elgin St. Thomas Public Health merged with Oxford County Public Health on May 1, 2018. Both former health units were partners on this project and Southwestern Public Health continued to lead the assessment following the merger.

Purpose and Research Questions

This situational assessment focused on the accessibility and delivery of services to LGS Mennonite children (0-12 years) and families in Elgin, Oxford and Norfolk Counties. The purpose of this assessment is to inform the delivery of health and social services in the three study regions.

The objective of this assessment is to better understand the accessibility of services for LGS Mennonite children and families residing in Elgin, Oxford and Norfolk Counties. This report will answer the following questions:

1. What gaps in programs and services exist for LGS Mennonite children and families in Elgin, Oxford and Norfolk Counties?
2. What barriers and facilitators to program and service delivery exist for providers in Elgin, Oxford and Norfolk Counties?
3. What barriers and facilitators to accessing programs and services exist for LGS Mennonite children and families in Elgin, Oxford and Norfolk Counties?

Secondary research questions, indicators and data sources are listed in the evaluation matrix (Appendix A).

Methods

This assessment had two methodological approaches: an inventory of services and phenomenology – the study of lived experience. The study protocol was reviewed and approved by Public Health Ontario's Ethics Review Board (File # 2018-009.01). Data collection and analysis were carried out simultaneously from July 2018 to May 2019. A full description of the assessment and methods can be found in our Technical Appendix.[b]

[b] Haile R, Funk L. Improving accessibility of health and social services for Low German Speaking Mennonites: technical appendix. Woodstock, ON: Southwestern Public Health; 2019.

Service Inventory

A service inventory was conducted to understand the service landscape for LGS Mennonite children and families in Elgin, Oxford and Norfolk Counties. We searched two online service databases: 211 Ontario (https://211ontario.ca/) and Southwesthealthline.ca.

To be included in the inventory, services had to meet the following criteria:

- located in Elgin, Oxford and/or Norfolk Counties
- targeted to children (0-6 and 7-12 years old) or families of children (0-6 and 7-12 years old)
- addressing health or social issues
- not restricted to rostered patients of a family physician, family health team, nurse or practitioner-led clinic

The service information was stored and analyzed using Microsoft Excel. Pivot tables were used to obtain counts for the service inventory overall and for sub-groups/categories such as type of service and target population (Appendix A).

Lived Experiences

We collected data about two lived experiences: delivering services to LGS Mennonites and accessing services by LGS Mennonites. For the first experience, we conducted interviews with service providers who currently or previously delivered services to LGS Mennonite children and/or families. In these interviews, we asked participants to share stories about their successes and challenges delivering their services. For the experience of accessing services, we interviewed two groups of LGS Mennonite parents or guardians with children 12 years old or younger: new migrants and established residents. These participants had to have at least tried to access local health and social services in the past. In these interviews, we asked participants to share their experiences of using or trying to access services and, in particular, what made it easier or harder to use such services.

Interviews were audio recorded, translated and transcribed verbatim. We used phenomenological thematic analysis to understand the components of accessing and delivering

services. This form of analysis enabled us to describe the essence of the experience (i.e. the underlying concept that exists across all themes) and the essential themes (i.e. vital elements of a particular experience that, without them, would alter the experience).[10,11]

Findings

Service Inventory

We found 306 services offered by 126 organizations. The characteristics of services from our inventory can be found in Table 1 of Appendix B. Services were most often located in Oxford County (142) and Elgin County (114); fewer services were located in Norfolk County (50). Many of the services targeted children (0-6 years, 162 services; 7-12 years, 133 services) in comparison to families of children in these age groups. Most services were available to both males and females (284); 18 services targeted females only and four targeted males only. There were more social services (224) available than health services (82), with secondary health services (e.g. 51)[c] being the most common type of health services represented in the inventory. Lastly, very few services specifically targeted LGS Mennonites (8).

Cross-tabulations of service characteristics by targeted services, type of services, target populations and gender can be found in Tables 2-5 of Appendix B. Overall, based on the service inventory analysis, service planners should also be aware of a low number of:

- services targeted to females only
- services targeted to males only
- primary health care services[d]
- services in Norfolk County in comparison to Elgin County and Oxford County

[c] Secondary health refers to specialists who typically see clients upon referral from a primary practitioner or a specialist (e.g. rehabilitation professional).
[d] Primary health care services did not include those restricted to rostered patients of a family physician, family health team, nurse or practitioner-led clinic.

In addition, there were fewer services available in rural municipalities (e.g. Tillsonburg, Aylmer, Simcoe) than urban municipalities (e.g. Woodstock, St. Thomas).

Lived Experiences

Delivering services

We conducted 11 interviews with service providers (front-line workers and administrators) across Elgin, Oxford and Norfolk Counties. A total of 12 service provider participants participated in the interviews (two participated in the same interview); two separate interviews included participants from the same services organization. Seven participants were from the social services sector and four participants were from the health services sector. Four participants were from Elgin County, three participants were from Oxford County and four participants were from Norfolk County. The draft themes were shared with two service provider participants to determine if they resonated with their experiences. These participants were selected at random.

The concept that underlies all service provider experiences was that service providers were continuously trying to develop and apply a practical understanding of the community into their day-to-day work. The two essential themes that arose from the service provider interviews were: a) the presence of a disconnect between the systems in which providers work and the cultural practices of their clients and b) the need to adapt and provide flexibility in programming at both an individual and an organizational level.

In the section below, participants refer to service provider participants. Where possible, we used quotations directly from participants. Note, these quotations are marked with an initial and a three-digit-code to signify which participant's experience is reflected (e.g. "SP 001" signifies service provider participant, number 001). These codes were randomly selected.

Essence of the experience: Developing and applying a practical understanding of the community

The essence of the experience of delivering services to LGS Mennonite children and families (clients) was that participants were working to develop or strengthen their understanding of the community.

> The more I know, the more I can understand why they do what they do…for me, it's just educating myself. That's what I want to do and I know sometimes they have days in [name of town] where at the community centre…they have community agencies come and people, [Low German Speaking] Mennonites, will give their stories. And to me, this is what I would really love to do. For me, it's to know more, so that I can understand it. [SP 008]

> [The understanding] was me learning to simplify and to get on the same vibration as them. And, and…it doesn't matter whether it's up, down, over, left or right. It's just, again, getting into a position where I can make a positive impact or help this family help themselves. Because if I'm not on the same level of approach as them, then what's the point of me even being here, right? Like, I can't be effective in my role if I'm not a chameleon.
> [SP 010]

Even though participants shared the essence of this experience, it was apparent they exhibited their understandings of the community in different ways. All participants seemed to recognize the cultural diversity within their clientele, but some participants demonstrated a set of attitudes and perspectives that promoted positive interactions with their clients. These participants said they believed this level of understanding enabled them to create a welcoming environment for their clients.

> The [organization's] goal for…everybody is to be sensitive to whatever background they're coming from because, literally like, this is one of the places that absolutely anyone can walk through the door and…we can potentially provide services to them, so…[it's] just general awareness and…[showing] empathy, to a degree, for people. [SP 003]

Participants reported that they achieved their improved understanding of this population through various ways, including attending educational events that highlighted the LGS Mennonite culture or probing area providers who were familiar with this community. They said they applied what they learned by committing to more culturally sensitive practices, such as being cognizant of the clothing they wore (e.g. “covering up”), limiting their jewelry (e.g. wearing less “bling”) and being considerate of the LGS Mennonite culture while engaging in conversations with their clients (e.g. avoid using the Lord’s name in vain). By practicing these understandings, participants were being more open to their clients’ values and beliefs.

Few participants demonstrated their cultural understandings of the community in more pronounced and nuanced ways. In doing so, these participants created more meaningful, trusting and transparent relationships with their clients.

> To provide service in this community, you just have to build relationships and get to know what families need or are looking for. [SP 006]

> Actually, many times they’ll be more than honest with you and many times, you’ll get more feedback than you’re ready to hear, depending on how well they know you. It depends on whether if it’s their first visit here or if it’s somebody that you’ve known for the last 20 years. [SP 004]

> We always want to create a risk-free environment where women don’t feel hesitant to ask a question…so it’s just rewarding that we created an environment whereby those questions could be asked. [SP 011]

In contrast, it was apparent that those who had a less-developed practical understanding of their clients seemingly overlooked the importance of further developing it, as it affected the ways in which their clients interacted with them and their services. We heard on multiple occasions that participants downplayed the challenges encountered by their clients by suggesting, for example, this community and their clients simply did not “stress about things.” Indeed, this may be the case for some clients; however, the quotation below shows that LGS Mennonite clients may be in distress, but complete client transparency with service providers may not yet exist in environments that lack understanding, comfort and safety.

> What you see is not necessarily how things are. [During my time] translating or interpreting many times at doctor’s office, a lady would be bent over and excruciating

> pain when the doctor would come in, she would have a straight face. He would be examining her, she would wait until he left the room and then she would say, “I thought I was going to pass out, I couldn’t bear it anymore,” but wouldn’t dare let the doctor know that she was in excruciating pain. [SP 004]

Participants who created safe environments meaningfully exhibited their understanding of the community by leveraging their respect for the culture and the relationships they developed with their clients. In doing so, they created more equitable partnerships that ultimately enhanced their clients’ experiences. One participant described how they incorporated some LGS Mennonite clients’ suggestions into their programming. Another participant described the importance of asking potential clients what they want before offering services.

> We’ve had some Mennonites suggest some songs in [Low] German that I went and I learned, that I found the words for and there's a few that I remember myself as a child. So, that would be some that I would bring and teach them, too, because it gives them a little bit of…I guess they feel a little bit more valued. I think when we bring some of that into it as well, to teach them, they need to be singing. It doesn’t matter what language they're singing in. If they don’t know it in English, sing it in German. If they don’t know it in German, sing it in English, you know? Whatever language they know or want to, or sing it in, just sing because it’s just that. [SP 006]

> Your services aren’t really worthwhile unless you ask the public what it is that they need. You may have your ideas and you may have all kinds of things that you would want to implement, but if you’re not going to get a positive response or have the public come out, you need to find something that they’re interested in and that they feel that they need, not necessarily what your thoughts are. Your thoughts are to figure out what it is and ask the Mennonite culture what it is that they want. [SP 004]

Further enhancements to client experiences, such as employing LGS Mennonite staff, were also discussed. Generally, service provider participants who reported their organization serviced a high per cent of LGS Mennonite clients were more likely to employ LGS Mennonite staff. Participants said they believed that having LGS Mennonite staff working in organizations helped them create a more seamless connection or rapport with their clients. Participants who identified as LGS Mennonites described their experiences and the connections they developed when working with clients from the community. These participants said that their insider knowledge of

the culture helped them build a relationship with the LGS Mennonite clients because they can speak the language and share stories about where they come from.

> I'm not saying that if you're not from the culture that you can't develop the relationship. It just breaks a lot of barriers, I think, if you are from the culture. [SP 004]

> You know you can relate with them. So, anybody who [does not] speak [English], you make the bond in here, right? They like to come back because you have something in common. So, with these people, now they have something in common. They can talk to somebody, so that in [and of] itself creates a good atmosphere for them when they come here…I can connect a little bit better. Just like all of us have a connection with our patients when we're in here. I have a separate connection. So, in that sense it makes a difference for them when they're in here, for sure. Just like we're creating a good atmosphere for everybody else, they also feel like they fit in. [SP 007]

Non-LGS Mennonite participants understood that, despite not being from the community, they still could play a part in creating safe and welcoming environments for their clients. For example, one participant described how "breaking bread" created an environment whereby clients and providers share a friendly experience to affirm comfort and trust amongst one another. Here, a service provider participant described how openness, sincerity and cultivating safe environments can help organizations achieve an optimal understanding of the community.

> I just think, no matter who you are and what background you come from, if you see needs and want to respond to them, you'd be accepted in a lot of communities. For sure you'd be accepted in the Low German community. But I just think if you're sensitive to the culture and you're respectful to people, people will warm to you…so, um, I just think if what you're willing do as a service provider or as agency is, "I want to sit down with you. I want to get to know with you and I want to break bread with you." And, if you're willing to do that with me, and I'm Low German, then chances are you're trying to reach out to me in a very genuine and sincere way and I'm okay with that. [SP 011]

Essential theme: Disconnect between the system in which the providers work and cultural practices and values of clients

Developing a practical understanding of the community was a process whereby participants sometimes encountered experiences of delivering their services that ran counter to their clients' cultural practices or values. This disconnect was frustrating for some as they were unable to run their services the way they were used to, the way they had run them in the past with others. For other participants, seeing the disconnect between the services and the clients' cultural practices helped them understand their clients' participation levels and health outcomes.

> Typically, when you do a circle time you want all the parents on the floor and the kids on their laps. So, everybody's singing, everybody is paying attention, everybody's looking at that story. [But] they [LGS Mennonite clients] were not interested. Not at all. And I know from the previous girl, it was a challenge for her as well. So, I just kind of went around it [because] for me circle time is my most favourite time. You sit down, you read a story [and] you sing some songs. It's so much fun! But they, it wasn't something they were interested in and after a few months of doing it, I just, it was just not working. It's too frustrating for me and they were just not interested in sitting down and singing with their kids. [SP 008]

> I think it's difficult to come out and really learn the importance of some of [our programs]. Uh, even just play. The importance of coming out to play. It's a little bit difficult to get that piece out to them. To them, play happens at home and they might, you know, just send their children out to play or they play in the house. So, it's harder to get them to drive anywhere to come and look for those specialized activities, whether it's play or [bonding time]...I think it's, it's, um, I think they learn how to, to, to be a mom from their mother. [SP 006]

> I think a lot of it, just culturally and what people they've kind-of grown up with, otherwise there's not a lot of oral health care at home. So, that leads them to have more [cavities], which bumps up their risk level. [SP 009]

Still, participants spoke of how they tried to engage with people in this community. The engagement practices described by participants are consistent with those typically used to solicit feedback from non-LGS Mennonite clients. However, participants experienced challenges when trying to obtain this information, as they cited difficulties gaining a better understanding of

the needs of their clients and the greater community because of the perceived “reserved” nature of this population. In turn, they had difficulties tailoring their services to the community and understanding whether they were reaching those who were most in need.

> [Sigh] I think this is where the barrier is. I don’t even know what I’m not meeting. They’re not going to tell me what their needs are…I mean, we often, for example, in some singular circumstances, we’ll offer rides to the doctors and stuff to the families because the family has no way of getting to the doctor…[but] I don’t think we’ve been taken on any offers of that. They’re trying to meet their needs within their community. They’re not really asking [us] for anything. [SP 012]

> We sent out this mail to every post office box in [name of town] and [name of town] and we were looking for ideas to A) advertise our services and B) to encourage them to give us feedback, with the enticement being they get a [gift] card. All they [had] to do is give us their name, their telephone number and answer one question: What can the [name of service] do to serve you better? We got three back out of hundreds of these things…I’m shocked by the lack of response to that. [SP 011]

> It would be nice if we could…have a focus group. If we could have a focus group and…ask the community, “Okay! What do you want?” “Tell us what you want and we’ll respond to it.” But I think the very nature of this culture is that they don’t necessarily speak up for themselves, so we always have to try and guess as to what the best thing to do would be and then try to…move our hours around them. [SP 011]

Many participants spoke of how people in this community often heard of services through word of mouth or from the people they most trusted, such as their family or close friends. Yet, even though participants recognized this, they did not report using this information to better understand the community and their clientele.

The locations in which participants provided services and the manner in which their services were delivered often posed challenges for their clients. In particular, those who provided services to mothers and/or their children during regular business hours noted their clients had challenges accessing their services because of the hours in which they operated and their inability to obtain transportation to their services during these times. Participants seemed to understand that mothers predominately stayed at home and did not drive or have access to

transportation and fathers – who did have access to transportation – were working during regular business hours.

> Sometimes the means to get here, one vehicle in the household [is a barrier]. If it's not the man of the house coming for treatment or he can't take time off work to get them here, that becomes hard. [SP 002]

Participants noted that some of their clients encountered financial barriers when trying to access their services because their cultural practices and traditional ways of earning income did not align with the system of payment for health services. They described that some families did not have Ontario Health Insurance Plan (OHIP) coverage and/or they did not have access to private health insurance because men, typically the wage earners, worked as labourers or farmers and it was not available to them. As a result, these individuals and families were left to pay out-of-pocket for some services. These situations proved to be challenging for some participants, particularly those who delivered health services. They wanted their clients to reach their optimal health and well-being but understood the implications, financially, that investing in their services would have for families.

> They pay for all of their [tests] because they choose not to have [OHIP]. Yup, they pay, they don't pay for our services, but they do have to pay for their [tests] and their hospital stay. [SP 005]

> They're not going to have OHIP coverage so that is a definite barrier. They're paying lots of money to go to see these visits that they need to go to…a lot of them don't have benefits…a lot of these people are working on farms…so there's no private coverage…they're having to pay out of pocket for all of it. Surgery, follow-up visits, all of it. All of that is paid by them privately. And it's expensive, super expensive, right? So, that is a big downside for their services here. [SP 002]

The time of year in which programs and services were offered was also an element to programming that participants had to consider. In the summer months services were less attended because clients were "in the fields" from early morning until dark. One participant described their organization's challenges when trying to operate during these months.

> We used to be busier in the summers than we are now and I think what it comes down to is, guess what? People are out in the fields working and they're not looking for support

> or paperwork when they're out working. They will go do their paperwork after work or come in on a day – actually it's interesting – on a day when it rains, we notice an increase in business. Well, I think that speaks to the fact that this is largely an agrarian lifestyle that people are working in the fields and take time off only when they can…I know from time to time people come to our office and the office has just closed…we talked about possibly working towards being opened towards the end of the day when one finishes in the fields. But one doesn't know what the end of the day in the summer is because it gets to be so late with the light being out until sometimes 8 or 9 o'clock at night. They continue to work until that time. So, from time to time people try to access our services and they can't. [SP 011]

Essential theme: Adapting and providing flexibility in programming

In light of the disconnect between the systems in which providers work and the cultural practices and values of clients, participants told us that they were open to adapting and providing flexibility in their programming at both an individual and an organizational level.

We heard from participants that LGS Mennonite clients often encountered barriers to accessing their services, such as travelling to their services during regular business hours or attending services in the summer months because of farming demands. Therefore, they adapted to their clients and their challenges in accessing their services by providing flexibility in their programming, in terms of the days, times and seasons they were available.

> I don't have a set day [or] time that I'm here. I just…I just earmark [hours of operation] and I'm usually here those hours. But I can come in earlier. I can stay later. I just flex my day according to when the families need to meet. [SP 010]

> The [program] times are very open-ended…we don't schedule a lot of stuff; it's very open-ended. So, they just play with their children and interact with other families here and with us. [SP 006]

> Start your programs in the late fall or early spring. Work around their schedule. Most, if given an opportunity, would do farming before doing anything else…timing, I think, is everything…it was hit and miss. We discovered that there was a lot that wanted to learn English. We needed to figure out what time of year. There's no point in running a

> program in the summer months, you're not going to see anybody. They're on the field six o'clock until dark. So, if you're going to be running any type of programming it needs to be done starting late fall when the fieldwork is done and the program needs to end before the fieldwork starts. So, it was trial and error. [SP 004]

Understanding that transportation was a challenge for some clients, participants spoke about their organizations' willingness to provide resources so that clients could access their services. They reported their organizations routinely offered to provide clients rides to and from their services or provide taxi coupons or bus fare. One participant also shared that her organization enabled her the flexibility to provide services in the client's home as opposed to the office to limit the need for transportation. This flexibility, according to the participant, enabled her to build a rapport and a lasting connection with her client.

> I had a few…umm…visits with the family in the home because they didn't have transportation when dad had left for work. And just…they're busy little kids and they're nattering and they're doing stuff, but when they see me, it would just be, "Oh, there's somebody different." They would just look up and smile. They didn't have the fast and easy English words to say hello. They would just up and smile and remember that it was a good feeling the last time I was there. People remember feelings, they don't remember words. That part just spoke volumes, that just children remembered… and that mom was…in a good place when I came to visit. [SP 010]

Participants commonly encountered language barriers, especially with new migrants, when delivering services to their clients. In light of this, they reported needing extra time during these interactions because they typically required dialogue between themselves, their clients and an interpreter. This impacted those who worked in settings which required clients to attend appointments, as it affected their schedule with other clientele throughout the day. However, participants understood the importance of providing this flexibility because it enabled their clients to better understand what happened during the appointment, while providing some reprieve for their interpreter.

> Sometimes we will book an appointment a little bit longer. Normally, they're a half-hour or an hour and if we know one of the clients coming in who doesn't have…their English isn't very good, we go ahead and book them for forty-five minutes…the majority of the time we don't have problems booking appointments except when they're with the

> interpreters because the interpreters have so many clients. But we also work it out. For instance, Monday, the interpreter, we're trying to book three of our clients in. We moved people around so that she only needed to make one trip. [SP 005]

Participants also identified the importance of having processes in place with external stakeholders to enable clients to access services. One participant described a partnership with a local agency that helped clients complete paperwork so that they could obtain proper documentation to use their service.

> For somebody to [obtain access to our service], they have to have some form of I.D. and something with an address on it so that we can put something in the database…so, I think…they can actually go to the [name of partner agency] and get a paper there with some sort of — and they can bring that, and we can [grant them access to our service]. We have some ways of bridging that gap if and I think it's a special thing because we really don't do it for a lot of other groups. Not a lot of other groups have that sort of organization that can help. [SP 007]

In making these adaptations to their services, the participants demonstrated and continued to develop their understanding of the LGS Mennonite community. They reported that they kept trying to learn about and meet this population's unique needs so that they could meaningfully adapt their program and service delivery.

> You don't want to offend anyone, right? Just trying to understand the way that they're comfortable doing a task or directing or whatever and just figuring out how to adapt, I guess, based on the subtle cues that they're giving. They don't want to be explicit or come out and say, you know, "We don't do this, we don't like this" or "This is offensive," you know? We would certainly make…changes if we thought it might make them more comfortable or would help in our delivery. [SP 003]

> I think we are fairly flexible and we believe in an individual approach, a culturally sensitive approach. And not only cultural, I mean, pretty much, you do have a recipe for how to do the job but you really don't. Like, I have to say, that I'm very proud that all of our workers really tailor their approach to the families they're working with. [SP 012]

Accessing Services

We conducted 23 interviews (12 established residents and 11 new migrants) with LGS Mennonite parents or caregivers of children who have tried to or have accessed services. All participants were women[e] and lived in Elgin and Norfolk Counties; we were unable to recruit participants from Oxford County. The draft themes were shared with six LGS Mennonite participants (three new migrants and three established residents) to determine if they resonated with their experiences. These participants were selected at random.

The essence of the experience was that LGS Mennonite participants were trying to fit into two different worlds: LGS Mennonite culture and Canadian health and social services culture. The two essential themes included stepping out of their comfort zone and balancing family needs with individual needs.

In the section below, 'participants' refers to LGS Mennonite participants. Quotations from participants are marked with an initial and a three-digit-code to signify which participant's experience is reflected (e.g. "LG 001" signifies LGS Mennonite participant, number 001). These codes were randomly selected.

Essence of the experience: Fitting into two different worlds: LGS Mennonite culture and Canadian health and social services culture

Many of the women who participated in the interviews described experiences of having to overcome challenges in relation to fitting into the Canadian health and social services culture and staying true to their LGS Mennonite culture. This theme manifested in several ways throughout the stories and anecdotes that they shared and it was intertwined with their decisions about accessing relevant services.

Participants spoke about how providers commonly passed judgement about them and their culture, which ultimately affected their decisions about if and where they would seek services. For example, they described experiences of health care providers making quips or judgments

[e] Men were usually at work during the daytime and women were not available in the evenings because they prioritized their family responsibilities (e.g. support, chores, family time, etc.).

about the number of children they had or were to have. Our participants and the second author[f] shared that LGS Mennonite families tend to be larger than the average North American family and children are considered to be contributing members of their household, often completing chores in and around the house at a young age. In this study, women described experiencing a heightened awareness that they belonged to a population that had larger families and the negative connotation attached to this made them feel as though they were not as welcome to attend particular services.

> There were some, they made fun of me for being Dietsche [LGS Mennonite]. How many children we would have and they sometimes made fun of, the nurses made fun of us, that in a year we would be back again…one nurse came in there, laughing right away and she said, "Oh, next year we'll see you here again!" And I was supposed to be okay with that? I felt hurt...I could understand what they said. And my husband was there beside me, he also said so, he also explained it. That hurts. You already feel so down here that you don't know the language and all and then hearing something like that, that hurt. It was very hard. [LG 012]

Generally, newcomer participants spoke English less fluently than their established counterparts. However, regardless of how long they have lived in Canada, participants described difficulties communicating with providers even though many of them had, at the very least, basic speaking and comprehension skills. Providers often used language that was too difficult for participants to understand and yet, instead of asking for clarification, participants chose to sit in silence because they were too scared, uncomfortable or overwhelmed to probe any further.

> I don't find speaking too difficult. Well, [but at] the doctors there are some words, they use different words for various things and I find that hard to understand, what everything means. [LG 007]

> I won't be able to understand them and they don't take the time for me. Here, at [social services program], they always say that you should just ask the doctor if they can repeat it again, [but] you don't dare yourself to ask it again because you think, I've already asked it once so can't they understand it? Or do they not want to understand it?

[f] The second author of this report has insider knowledge of the LGS Mennonite communities in these geographic regions because she was raised in an LGS Mennonite community and speaks Low German.

> Sometimes I do [ask a second time] but they can be quite short with you and I don't like that at all. [LG 018]

> [As this participant shared her experience, she was looking at the floor] I can understand what they want [pretty well], but I have trouble with it and I'm not comfortable saying it back. And then sometimes it's like when they ask if I have questions, even though I [do], I just say no because I'm not comfortable asking them. [LG 004]

These circumstances affected participants in different ways. Some continued to visit the same providers but were more reliant on the assistance of interpreters. Meanwhile, others were more independent and chose to establish relationships with providers who were far more patient, understanding and receptive to their needs regardless of their language proficiencies.

> Later, when I had to have the appointments and go…for checkups, I couldn't drive, I couldn't speak English and I always had to arrange to bring someone [as an interpreter]. [LG 003]

> When I [go] there and it's only the lady who speaks English in there, I can't speak much English, but she can help me so much. I never leave there without getting everything that I need. I can explain to her what I want and it doesn't matter if there isn't Dietsche [Low German] by us both, she can help so much that I never leave there without doing everything that I wanted to...she explains it so [well] and helps me and then I can understand it...I like it …when they really explain it to me, what exactly it is, and if I can't understand, then trying in a bit of a different way to explain it. When doing that, I can figure out what they mean. [LG 013]

> Well, it is hard because I don't speak the language. But still, we have really learned and because this woman…can speak Low German, I can say everything in Low German and she responds in English. We can get by very nicely. [LG 015]

Back in Central America, participants said they taught themselves how to speak Spanish by conversing with employees and customers of their family-run businesses. In Canada, they told us that they learned English using both formal and informal methods: some utilized lessons or classes offered by certain social services programs or schools and others taught themselves by reading books they borrowed from their local library. In both contexts, women spoke of the

importance and value of being proficient in the local language because they viewed it as a way to be unafraid, to be independent and to use their own "voice" to get what they needed.

Participants were particularly grateful for services offered to their children that they had not accessed during their own childhoods. They emphasized the importance and value of their children participating in school readiness-type services that promoted competencies in literacy, numeracy and social skills, regardless of which type of school (public or private) their children attended. There was a sense of fulfillment evident among participants as they described how satisfied they were to see their children happy learning these skills from providers they trusted.

> Well, like how they have it at the [social service agency]. They teach the children from a young age or they teach or help the children learn to get ready for school. That they can prepare themselves a little, that that's how it will be. Or it doesn't have to be bad, you don't need to be scared of it, it's fun. That [my daughter] can be away from her parents. She can sit there a bit and it's fun. [LG 016]

> Like going to school here at [social service program], starting young until they're old enough to go to school every day. And I appreciate that very much. [LG 011]

They also described how much they valued complimentary oral health services for their children. Participants placed a high importance on their children attending oral health services because of their lack of knowledge about their own oral hygiene during their childhoods, though it was at no fault of their own. Their parents were unaware of the benefits of preventative dental care and experienced financial and transportation challenges with accessing services. Participants were shy and somewhat embarrassed, even hiding their teeth at times, talking about how they would have changed their practices if they knew then what they know now. Still, some reported they found it difficult to enforce oral hygiene practices upon their children at home because they were not yet the norm in their household. However, there was comfort in knowing that, at the very least, their children could benefit from the complimentary dental services available to them.

> It just always feels like they [oral health care provider] think they have a good understanding…and the government pays for everything and why don't we listen more and brush our teeth more and try to keep them healthy. And they think, we don't, but we all try to do our best…I just say, "Well, we try to do our best." It's always half in Low German and half in English but, and then I always think, they will think we are just

> Dietsche [Low German] and we don't care and once we've left their office, we will just do as we want and won't brush and the next time when we have an appointment then they'll have to clean it all again. We always make [time] for our children's teeth…I always say to the kids, if we will watch it, when you grow up you will have nice teeth. Their dad and I didn't know this existed. We had such old, useless, rotten teeth and with time, we had them pulled out. Natural teeth are just so much more comfortable. [LG 018]

These examples underscore the ways in which the women in this study try to counter the many challenges they come across. Yet, as detailed below, they face difficulties in various aspects of their daily life that affect their decisions about how they access relevant services for themselves or their families.

Essential theme: Enabled to step out of my comfort zone and make connections

Both sets of participants spoke of how they sometimes felt alone or isolated in their respective environments even though, generally, newcomers appeared not only shyer and less confident during their interviews, but also less aware of services in comparison to established participants.

Many of the women explained they found comfort being at home with their families and their work because they felt inferior or they did not know how to fit in and behave around others in public settings. This belief, in turn, impeded their ability to access the various services that were available to them.

> I don't know. It always feels to me like I don't want to go somewhere because I don't like being around people…I always feel the others are better than I am. I always feel like I should just stay home. That's how I always feel. [LG 002]

> I don't know. I just always feel like I don't know how to behave around people. I prefer to be at home with my work…I don't even know. I'm just more used to being at home and it just feels like I don't fit in. [LG 009]

For others, the isolation arose from something more. They described it as being down on their "nerves," a term the second author knows to be commonly used by this population to express symptoms relating to one's mental and emotional well-being. In this study, women explained their "nerves" were particularly affected after giving birth to a newborn.

> Once I was very down with my nerves and I thought something was wrong with me, it was just the nerves…once you've been through it with a little one, then you have a lot of nerve trouble…when I was down with my nerves, I didn't want to go anywhere. [LG 017]

Accessing services during these times was difficult for participants because, even from the comfort of their own homes surrounded by their families, they still felt alone. Some women explained, however, that it was the encouragement and persistence shown by certain providers that enabled them to participate in these services. Grateful for the assistance they received, the women in this study were adamant to share how valuable it was for them to take part in activities outside of their home, especially after giving birth to a newborn.

> I have a little bit of a, like, where I don't want to leave my house or want people to come over… [home-based service provider] will be like, "Hey, I set you up for [social services program]. It starts at this and that time," blah, blah, blah, right? And then, but I didn't want to say no, so I went and I, then I actually really enjoyed it…it's like, just to get out there and then you see how friendly these people are and it works…I guess [home-based service provider and health care service worker] they've really helped me to get out of the house… [sigh] like after I had [son], I had the whole baby blues thing and I think that they really helped me with that. [LG 020]

> I started with the [social services program]. And then they didn't leave me alone anymore. And if I didn't want to go there, if I gave an excuse…they searched until they found a way that I could come [laughter]. I didn't want to, but now, later, I was glad they didn't leave me alone. The [social services program], when I had the baby, they asked me if I was ready to go there. I wanted to, yeah, I wanted to, but I couldn't do it. I don't know, I felt so strange I couldn't do it, to go there. They didn't leave me alone. They just asked me again and again, and then I went there four days a week. And then the [program] was finished, and now, this year I'm going again. And now I'm happy. [LG 003]

Getting to a place where they could leave their home took a lot of effort for many participants. It certainly helped to have people who were there for them offering guidance along the way, but the participants' comfort with the service and its providers also played a factor in their willingness to seek out and use services for themselves or their families. Participants said it helped, for instance, if providers offered a "welcoming" environment during their visits. This

meant more than that just a friendly greeting, though. In Low German, this term is used to emphasize a concept that encompasses an entire experience. It includes a smile, a warm greeting by name and the hospitality that enables one to feel like they are wanted and they belong. Participants appreciated being in environments where service providers recognized them as valued clients with genuine affection, regardless of their cultural background. This was vital because, in these environments, participants felt like they were back at a place in which they felt most comfortable; it felt like they were back at home.

> I think the most important is when the service or the welcome you first receive there, that's the most so it feels like they want to understand you, they want to…the most is, many would, like if you can't speak English very well yet, they would be patient with you with what you could do. And that for me is worth a lot, then it feels to me like they want to help. [LG 004]

> I don't know, so this [social services program], I think it's just very good, the way they welcome you. It helps me just so very much that I can also move higher. It helps me. Our baby also likes it here so much. She's not as shy anymore as she was. She enjoys it here so much. [LG 010]

> Yeah, he [the doctor] was very friendly to him and he talked to my little boy and he willingly did what the doctor said. And when we were done, he said he was a very good child that he did everything so nicely…It made me very happy. It's so nice when the doctors are friendly to you because it's hard to speak [English]…and when the doctors are so friendly and want you there, then you can get by...I like it very much when the doctors take you in and welcome you, even if you can't speak [the language] well. [LG 021]

The participants valued these welcoming environments and the providers that enabled them to overcome difficult periods in their past that caused the isolation and "nerves" discussed above. They felt accepted and embraced and because of this, they used the opportunities afforded to them as outlets to try and make new friends, learn English or to challenge themselves to step outside of their comfort zones.

> It helps a lot when you're around people and they are very happy like that, when they come during the week and talk to you a bit. That helps a lot. I really appreciated when they came afterward and weighed the baby, see how it's going and talk a bit about how

> you feel afterward. That helps a lot when you can tell someone that, how you feel. I appreciated that a lot. [LG 023]
>
> It's very good for a woman to get out of the house and do something different. And you can make friends here and learn English well and then you can speak [English] at other places, so others don't need to try to help you. [LG 005]

Essential theme: Balancing family needs with individual needs

It was evident during the interviews that the women in this study, who were full-time homemakers and caregivers for their children, took pride in ensuring their homes were orderly: a highly valued sign of a good home. So, it was no surprise to hear about how they sometimes struggled with accessing services because of their family responsibilities.

> Oh, I don't know. You have things pile up at home when you have to go to these places. When you are home, then you have to hurry that you get everything done. [LG 021]
>
> Um, it depends what time of day it is. Like if it was during supper, then it would cost our supper. [LG 005]
>
> It always feels to me like when I've been away before lunch, then the day is ruined. But I want to do what needs to be done. [LG 003]

The hours in which services were available was an important factor that participants had to consider when deciding to access services for themselves or their families. Depending on their domestic duties and the age of their children, there were certain times of the day that made it challenging for them to utilize these services and because of this, they often prioritized their family responsibilities at home before their own interests.

> I have four children and it's quite busy and I'm the mom, to make meals and everything. […] And then when the children depend on me then I don't allow a lot of time if I can't bring the children with me. [LG 011]

In the event they had to seek out health services, participants described how they frequently had to take their entire families (many of the participants had four or more children) to appointments or hospital visits at times their spouses were not at home. Because their spouses

are the primary wage earners for their families, it is difficult for them to miss time from work to care for their children. Child minding made it easier for participants to access services, but it was not always available.

> It doesn't go so well because there you have to wait a fair bit…and it's always a bit hard when you have the kids with you…watching them during that time when you yourself aren't feeling well. And when you have them with you and everything. So, it would be nice if you could just get in right away and then be served right away and then you could leave. [LG 008]

Participants described that they favoured seeking health-care services from walk-in clinics over their family physicians or the hospital because of the hours in which they operated (after school/work) and because they tended to have less wait times. Hospital visits, along with appointments to other health care professionals, had their own set of challenges, as participants had to incur rather significant health care bills because they did not have OHIP coverage. This made it harder for them to use these services because they had to consider the financial burden it would place on their families. Participants were willing to incur the high costs of accessing these services to ensure the well-being of their family.

> In the hospital, it was very good, the way everything was there. I appreciated it very much as well. It was okay that it was so expensive, it was worth it since my husband could stay with me. [LG 022]

> I would think from what we could have afforded would have been $50. More than that, we just couldn't do. We didn't even have that much money in the bank, we could pay it later through billing us and pay it that way with payments. Then we got paid again and we could do a bit more but it was not easy. At times we've been very down.
> [LG 007]

> [The dentist] eagerly wants me to let her have a brace in her mouth where her back teeth were pulled out, but I just don't have money for that. It feels to me like they don't understand me that I don't have the money, that I can't afford it. And it will cost me $500 for both. [LG 013]

> So, when [youngest daughter] was born, just for being in the hospital, we were there for 11 hours, and we had $3,350 in bills. And that was very hard because, I said, if I could

> give it to the midwives, for the service they gave me, I would do that with joy. But just for being in the hospital for 11 hours, paying so much money there, that is very hard. [LG 022]

Discussion

We used three key dimensions to health care access (availability, affordability and acceptability)[12] to assess the accessibility of services for LGS Mennonite children (0-12 years) and families in the three study regions.

This situational assessment showed that Elgin, Oxford and Norfolk Counties appear to have health and social services available to children and families of those between the ages of 0-12 years. Though LGS Mennonite participants commonly used one main service centre in Norfolk County, most of the health and social services identified in the service inventory were in Elgin County and Oxford County and the services were concentrated within larger municipalities (e.g. Woodstock, St. Thomas). This finding is consistent with previous research in Oxford County, which found that rural children, youth and families may have limited access to specialized health services.[13] In addition, there is a low number of LGS Mennonite-specific programs and services. Future service planning for this community should consider the location in which services are to be delivered, as previous findings indicate that this population encounters transportation barriers to accessing services. Providing interventions within LGS Mennonite community settings can also develop long-term relationships and lean on the strengths of the community.[6]

In this assessment, service provider participants addressed barriers to service delivery that reflected the availability and affordability of their services to their LGS Mennonite clients. For example, they described how their clients were unable to obtain transportation to their services during their hours of operation and how certain services were too costly for families to access, especially those who do not have OHIP coverage. In contrast, organizations that were able to adapt and provide transportation alternatives and flexibility in service delivery made it more accessible for their clients.

Though all service provider participants described at least a basic understanding of the LGS Mennonite culture and community, only few described lasting and collaborative partnerships with their clients that informed their programming. Those who lacked a complete understanding of their LGS Mennonite clients' beliefs and values encountered barriers to effective service delivery, such as low client turnout or client disengagement with their programs and services. Building meaningful relationships increased understanding, enabling service provider participants to harbour environments of comfort, safety and trust. These findings are similar to those from previous work or studies within this population. For example, previous research found that meaningfully engaging parents in an open, non-judgmental manner to understand their children's learning needs helps build trust and rapport with LGS Mennonite families. In situations where the goals of service providers conflict with LGS Mennonite beliefs and values, it is helpful to engage in mutual, respectful dialogue and to allow families the autonomy to make their own decisions.[3] Trust can also be developed through positive word of mouth from existing clients to other members of the community.[6]

Low German Speaking Mennonite participants experienced various challenges that affected their decisions about accessing relevant services. When trying to access services for themselves or their families, many faced barriers with regards to service availability and affordability. Low German Speaking Mennonite participants were occasionally affected by the hours in which services were available because they often conflicted with their family responsibilities at home. Some participants reported that they struggled to balance doing what was best for them or their families while maintaining their cultural identity. Further, LGS Mennonite participants said that the costs associated with accessing certain services and the financial burden it would impose on their families affected their decisions about which services to access. Previous research at the local level, as well as throughout Ontario and other parts of Canada (e.g. Alberta and Manitoba), has also shown that LGS Mennonite families encounter financial barriers when accessing health services[3,4,14] and sometimes travel to Latin America as an alternative because of how prohibitive the costs of services are locally.[3] Fee waivers may enable clients to better attend services[14] and pairing health teachings with the provision of free equipment could help clients maintain health promoting behaviours.[6,15]

Services were more accessible when LGS Mennonite participants were able to balance their families and traditions with their desire to see their families be well. For example, LGS Mennonite participants were able to access those services which were available during hours that enabled them to still tend to their family responsibilities. Additionally, providers that offered

services that resonated with LGS Mennonite participants' cultural beliefs and values, such as those that offered welcoming and supportive environments, facilitated LGS Mennonites' access to services because they felt accepted and embraced when doing so, especially during times in which they experienced communication barriers, isolation or mental or emotional health issues. These services facilitated their clients' access to their services by attending to their cultures and beliefs (e.g. acceptability dimension). Programs that are tailored to LGS Mennonite preferences are positively viewed because they offer an environment that communicates understanding of their faith, traditions and values.[3,16] Reflecting upon and understanding the complexity of the LGS Mennonite experience can help providers foster welcoming service environments.[17]

Conclusions

This study showed that, even though there are many health and social services in Elgin, Oxford and Norfolk Counties available to LGS Mennonites, this group experiences barriers (e.g. financial, language and transportation) that affect their decisions about accessing relevant services for themselves or their families. In addition, there is little LGS Mennonite-specific programming, which may affect why services are less acceptable, and therefore, less accessible.

Developing an understanding of the LGS Mennonite culture and community helps service providers to mitigate some barriers to delivering services to this community. For example, services that enable LGS Mennonites to balance their families and traditions with their desire to see their families be well are more easily accessible. Service planners should consider how to leverage knowledge from their clients and existing supports, such as providers who are familiar with the LGS Mennonite population, to develop their understanding of this community. Lastly, welcoming and supportive environments enable LGS Mennonites to feel accepted and help them access services, even when they experience communication barriers, isolation or mental or emotional health issues.

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Appendix A – Evaluation Matrix

Question	Indicators	Data Sources
1. What gaps in programs and services exist for LGS Mennonite children and families in Elgin, Oxford and Norfolk Counties?		
1a. What services exist in Elgin, Oxford and Norfolk Counties?	List of services	Environmental scan
1b. What are the characteristics of each service offered in Elgin, Oxford and Norfolk Counties?	% providing targeted services: - Targeted (LGS Mennonite-specific) services - Non-targeted services % providing particular type of service: - Health services (primary, secondary, tertiary) - Public health services - Social services % targeting or serving each of the following subgroups: **Target population** - Children (0-6) - Children (7-12) - Families (0-6) - Families (7-12) - Other target groups **Gender** - Males only - Females only - Any gender - Other gender group % providing service in each of the following regions: - Elgin County - Oxford County - Norfolk County	Environmental scan
1c. What gaps in service availability exist?	Cross-tabulated frequencies of services in each of the categories:	Environmental scan

	- Targeted services and type of service - Targeted services and target population - Targeted services and region - Targeted services and gender - Type of service and target population - Type of service and gender - Type of service and region - Target population and region - Target population and gender - Gender and region Service gaps identified by: - service providers - people with lived experience	Interviews

2. What barriers and facilitators to program and service delivery exist for providers in Elgin, Oxford and Norfolk Counties?

2a. What are essential themes of service providers' experiences of coordinated service and program delivery?	Essence of the experience and essential themes of the experience from service providers' data	Interviews

3. What barriers and facilitators to accessing programs and services exist for LGS Mennonite children and families in Elgin, Oxford and Norfolk Counties?

3a. What are essential themes of peoples' lived experiences accessing services and programs?	Essence of the experience and essential themes of people with lived experience's data	Interviews

Appendix B – Service Characteristics

Table 1. Health and social services characteristics in Elgin, Oxford and Norfolk Counties

Category	Characteristic	Number of Services*
Targeted services	Targeted	8
	Non-targeted	298
Type of service†	Health	82
	Primary health	12
	Secondary health	51
	Tertiary health	0
	Public health	19
	Social	224
Target population	Children (0-6 years)	162
	Children (7-12 years)	133
	Families of children (0-6 years)	105
	Families of children (7-12 years)	72
Gender	Males only	4
	Females only	18
	Any gender	284
Region	Oxford County	142
	Elgin County	114
	Norfolk County	50

*Category totals may not add up to 306 because services may have more than one characteristic within each category (e.g. they may be offered for multiple age categories)
†Primary health refers to services at first entry into a health care system (e.g. Walk-in clinic). Secondary health refers to specialists who typically see clients upon referral from a primary practitioner or a specialist (e.g. rehabilitation professional). Tertiary health refers to services offered for inpatients and for which a referral from a primary or secondary health care professional is required.[18] Public health refers to services that have an impact on the health of a population (e.g. School Nutrition Program). Social services refer to services that promote the social well-being of individuals or communities (e.g. library services).

Table 2. Health and social services in Elgin, Oxford and Norfolk Counties, characteristics by targeted services

		Targeted	Non-targeted
Type of service	Health	3	79
	Primary health	0	12
	Secondary health	0	51
	Tertiary health	0	0
	Public health	3	16
	Social	5	219
Target population*	Children (0-6 years)	6	156
	Children (7-12 years)	4	129
	Families of children (0-6 years)	5	100
	Families of children (7-12 years)	4	68
Gender	Males only	0	4
	Females only	1	17
	All gender	7	277
Region	Oxford County	0	142
	Elgin County	6	108
	Norfolk County	2	48

*Services could be offered to multiple target populations

Table 3. Health and social services in Elgin, Oxford and Norfolk Counties, characteristics by type of services

		Health	Primary	Secondary	Tertiary	Public	Social
Target population*	Children (0-6)	28	1	13	0	14	134
	Children (7-12)	25	0	13	0	12	138
	Families (0-6)	8	2	0	0	6	97
	Families (7-12)	2	0	0	0	2	70
Gender	Male only	0	0	0	0	0	4
	Female only	3	2	0	0	1	15
	Any gender	79	10	51	0	18	205
Region	Oxford County	36	4	23	0	9	106
	Elgin County	26	6	13	0	7	88
	Norfolk County	20	2	15	0	3	30

*Services could be offered to multiple target populations

Table 4. Health and social services in Elgin, Oxford and Norfolk Counties, characteristics by target population*

		Children (0-6 years)	Children (7-12 years)	Families (0-6 years)	Families (7-12 years)
Region	Oxford County	73	64	27	30
	Elgin County	70	53	63	36
	Norfolk County	19	16	15	6
Gender	Male only	0	2	1	1
	Female only	6	7	10	30
	Other only	0	0	0	0
	Any gender	156	124	94	64

*Services could be offered to multiple target populations

Table 5. Health and social services in Elgin, Oxford and Norfolk Counties, characteristics by gender

		Male only	Female only	Any gender
Region	Oxford County	3	5	134
	Elgin County	1	10	114
	Norfolk County	0	3	50

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