

# Low-German-Speaking Mennonites from Mexico:

## A Review of the Cultural Impact on Health in Wellington County



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# SECTION 1 BACKGROUND

## 1.1 Introduction

In 2009, Wellington-Dufferin-Guelph Public Health (WDGPH) identified Low-German-speaking (LGS) families from Mexico as a priority population. “Priority populations are identified by surveillance, epidemiological, or other research studies and are those populations that are at risk and for whom public health interventions may be reasonably considered to have a substantial impact at the population level” (Ontario Public Health Standards, 2008, p 2).

Public health nurses who work with LGS families in schools and in homes report health challenges:

- Food choices often consist of carbonated beverages and high-caloric, low-nutritional snack food.
- Families are difficult to access and engage.
- There are problems with access to healthcare, alcohol use, women’s health, mental health, and parenting practices.

Years of data from the Children in Need of Treatment (CINOT) program suggested that despite ongoing education efforts, LGS children display a high incidence of dental decay and account for a disproportionate amount of Public Health’s annual CINOT budget.

## 1.2 Historical Context

LGS families from Mexico are typically Mennonites who are members of the Old Colony Church but they may belong to other churches, particularly after immigration to Canada. Mennonites of various branches share a belief in the separation of the Church and State, pacifism, and non-conformity with the world (Fast, Leach & Hanly, 2002; Kulig, Babcock, Wall & Hill, 2009). The Low-German-speaking families from Mexico are a unique immigrant group, many of whom have settled in the Drayton area in Wellington County. They have spent centuries travelling to new countries as a community in a faith-based effort to retain their separateness from the mainstream society. This group came to Canada originally in the mid-1800s, but left for Mexico and other Latin American countries in the 1920s after government efforts to secularize education. According to the Mennonite Central Committee (MCC), most LGS families in Wellington County have arrived from Mexico. As a result Mexico is identified as the country of origin throughout this report.

The latest wave of immigration to Canada is not a faith-based mass migration, but one born of individual economic hardship. Often landless, even in Mexico, many families come to Canada hoping to earn and save enough money to buy land for farming or to repay debt in Mexico. LGS families are more comfortable in rural settings, having lived in small villages of 75 to 100 people in Mexico. Complicating settlement in Canada is the fact that families may make frequent trips back to Mexico, interrupting employment and/or schooling in an effort to retain ties to their families and community.

Some families report that the community in Mexico experiences a sense of betrayal toward those LGS families who have left the colony in Mexico for Canada. This adds additional stress to the LGS families in Canada. While there are examples of some Mennonite groups (like the Amish in Pennsylvania or the Mennonite Central Committee) supporting LGS families in their settlement, key stakeholders working in the LGS community report that other Mennonite groups in Canada have not always supported LGS families and treat them as inferior.

## 1.3 Current Programs/Services for LGS Families

A review of current programs provided or supported by Public Health helps to describe the needs of the population. This review does not include services provided by other agencies or groups.

### Fluoride Varnish Program

The Fluoride Varnish Program is an initiative that emerged as a result of ongoing poor dental health in the children attending Centre Peel Public School. Over 40% of Centre Peel Public School students were identified as high risk with respect to dental health. This represented a significant amount of Public Health's CINOT budget and led to the piloting of the Fluoride Varnish Program. This involves the application of fluoride to the teeth of elementary students three times a year and is complemented by an in-school tooth brushing regimen. It takes place with parental consent. Staff at Centre Peel Public School have provided qualitative information that the oral health of the children at the school has improved since the initiation of the program.

### Centre Peel Public School

Centre Peel Public School (kindergarten to Grade 8) is primarily populated by Mennonite students. According to the Immunization Records Information System (IRIS) database there are 290 students enrolled at Centre Peel Public School. Approximately 70% of these students have been identified as LGS Mennonite.

Public health nurses are available to schools as consultants to support the curriculum, deliver resources, and help develop strategies to address health issues. The public health nurse at Centre Peel Public School supports efforts to improve nutrition and dental health through health workshops and presentations, helps to build the leadership skills of students and staff, and provides support and information to the school council.

### Newcomers' Education Program (Coalition-WDG Public Health as member)

The Newcomers' Education Program, which has operated for many years in Drayton, provides services to Low-German-speaking Mennonite families who live in Wellington County. The program is a partnership of key health and social service organizations in Wellington County:

- Community Mennonite Fellowship Church
- Community Resource Centre of North and Centre Wellington
- North Wellington Ontario Early Years Centre
- Upper Grand District School Board
- Wellington-Dufferin-Guelph Public Health



Comprehensive education, health, and social services are provided at the Newcomers' Education Program. English-as-a-second-language training is a major focus of this program. Classes are taught by educators from the Upper Grand District School Board.

In 2007, a health-literacy consultant worked with the group members to build their understanding of health concepts. They created booklets about parenting and dental health. Key stakeholders report that this work improved the group's interaction with facilitators, each other, and guest speakers.



The public health nurse who facilitates the group, introduces newcomers to information about Canadian laws, norms, and expectations. The activities of public health staff at the program are outlined below:

#### *Nutrition*

- Assess nutrition; distribute multivitamins and vitamin D, and prenatal vitamins.
- Provide healthy snacks and lunches using recipes from a public health dietitian.
- Provide lunch bags and nutritious lunch ideas once a month to women for their school-aged children.
- Provide muffins for the adults and children each week using recipes from the dietitian and ingredients and baking utensils from the program. This is done by a program participant.

#### *Dental hygiene*

- Speak about dental health issues, sugar content in food, and dental care.
- Offer dental screening and varnishing three times a year and, if needed, refer to CINOT program.
- Provide dental cleaning each May for those who do not have dental coverage.

#### *Speech and language*

- Discuss ways to support children whose first language is not English and suggest activities to develop child speech and language.
- Refer to the Wee Talk program as needed.

#### *Immunization*

- Inform about the role of immunization in preventing the spread of illness and the legal requirements for entry to school.
- Offer influenza vaccinations.

#### *Women's Health*

- Refer to community agencies (e.g., Women in Crisis) or physician at client's request.
- Arrange guest speakers on appropriate topics (e.g., Family & Children Services and healthy relationships).
- Provide individual consultation when requested.

#### *Winter safety*

- Inform group about how to dress for winter, and protect against hypothermia and frost bite.

#### *Parenting*

- Educate about positive discipline and gaining cooperation.

#### *Vision*

- Educate about the role of the optometrist and the importance of eye examinations
- Offer vision screening clinics.
- Refer to an optometrist as required.

#### *Infection control*

- Promote hand washing.
- Discuss family and personal care.
- Discuss how to protect against influenza.

#### *Community outreach*

- Help with referrals to programs, reading and completing forms, preparing and filing taxes, and getting government assistance.

# SECTION 2 SUMMARY OF RESEARCH

## 2.1 Methodology

### Literature Search

We initiated a literature search using the following databases: Medline/Nursing & Allied Health Collection, Academic Search Premier, Canadian Reference Centre, Cumulative Index of Nursing and Allied Health Literature (CINAHL), Education Research Complete, Educational Resources Information Clearinghouse (ERIC), and Google Scholar. The search terms were Low German, Mennonites, nutrition, health, injuries, farm safety, teaching methods, parenting, and child rearing. Given the specific history and nature of the culture, only articles that referred to LGS families from Mexico were retained for review.

The literature was searched for a recent estimate of the population of LGS Families residing in Canada. Efforts were also made to identify the size of the LGS community in Wellington County. Census data was reviewed using the following search terms “Old Colony,” “Mennonite,” “Low German.” Old Colony and Low German did not appear at all in the census data. The ISCIS database was searched using Mennonite names. A list of names was provided by a key stakeholder and verified with other stakeholders in the community. This is a crude way to measure the size of the population; however, this does provide more current information than would have been available from census data. This is critical because, according to stakeholders, the population is very mobile.

### Interviews

To gain a broader perspective of the issues facing the community and to identify possible strategies for addressing these issues, key stakeholder interviews were conducted. Semi-structured qualitative interviews were held with individuals from Public Health programs including Dental Health, Child and Family Health, and Healthy Living, the education community, the Mennonite Central Committee, the Woolwich Community Health Centre, mental health services, and a local Mennonite minister. Key stakeholders were identified in consultation with the Child and Family Health Manager for Centre and North Wellington County.

Key stakeholders were asked to recommend other potential stakeholders in the community. Efforts were made to connect with Family and Children’s Services child protection agencies and alcohol and drug services but interviews were not able to be scheduled. One interview was completed with a female member of the community who acted as an interpreter.

Hall and Kulig (2004) reviewed their experiences doing research among LGS Families and discussed the lengthy process for interviews with community members. Interviews could take as long as five hours for 90 minutes of content. This was because of the involved social interactions necessary to build rapport. They strongly recommended using LGS interviewers when conducting qualitative interviews. Given the challenges of hiring and training LGS interviewers and the cost of lengthy qualitative interviews, it was considered more efficient to limit the research to key stakeholders.

Interview notes were taken by hand and typed for later review. Tape recording was considered, but the interviewers quickly observed that participants were uncomfortable with the taping of the interviews and the decision was made to cease recording the interviews.

As common themes and patterns emerged in the responses, questions were revised, deleted, or added to build on previous information. Distinct interviews were held with individuals who had unique experiences to offer such as a local Mennonite minister, and a university professor with experience researching and interviewing the Low-German community. **The summary of the results is based on the opinions of the stakeholders and is not meant to be universally applied.**

## 2.2 Results

### Literature Review

There is limited research on the Low-German families from Mexico. Because of the distinct history of this group, research information gathered from other Mennonite communities cannot be applied. Communities across Canada are beginning to acknowledge the challenges facing this group as evidenced by numerous formal and informal sources. These sources include preliminary research at the University of Alberta by Judith Kulig; the annual networking day for service providers of the Low-German-speaking community in Aylmer, Ontario; and reports by Ontario health units.

Available research focuses primarily on LGS women and their healthcare needs. LGS women in Mexico often do not seek out care during pregnancy. In Canada, research suggests they may not seek care or may wait until late in pregnancy. (Kulig, Hall, Babcock, Campbell & Wall, 2004; Kulig, Wall, Hill & Babcock, 2008). Pregnancies may not be acknowledged to family and friends. Women may not always recognize that they are pregnant because of their limited knowledge of sexual health issues (Kulig, Babcock, Wall, and Hill, 2009; Kulig, Wall et al, 2008). The importance of childbearing in the role of women is evident by the cultural expectation to “have as many children as God want(s)” (Kulig, Wall et al, 2008).

Elgin St. Thomas Public Health conducted a needs assessment of Mennonite women in 2001. The assessment identified several barriers to healthcare including (a) no regular healthcare provider, (b) language barriers, (c) lack of information/education about health issues, (d) financial barriers, and (e) lack of understanding of the healthcare system.





## Population Data

Nationally, the most recent estimates available place the population of LGS families from Mexico at 57 000 (Janzen, 2004). By examining the census data, it was possible to identify national counts of Mennonite marriages; however no other information was available. Capturing data about Low-German-speaking families from Mexico in population-based databases is challenging because of the unique nature of the group:

- Born in Mexico
- Caucasian descent
- Low-German-speaking

Country of birth and race cannot be used to identify them because neither represents their cultural uniqueness. Language lists do not routinely include Low German. Using religion is not specific enough since most databases group all Mennonite communities together or include them under “Protestant.” Even if more detailed information were captured regarding religion, once in Canada, LGS families sometimes join other churches.

According to the Healthy Babies Healthy Children database, Integrated Services for Children Information System (ISCIS), there were 99 families with Low German names with a total of 295 individuals.

The literature and a LGS community member (Harms, personal communication April 16, 2009; Kulig & Wall, 2008) have referenced the sub-denominations within the LGS Mennonite community. Discussions with MCC representatives, researchers, and key stakeholders failed to identify branches other than Old Colony members in Wellington County. Some LGS community members attend other Mennonite or Anabaptist churches, but the consensus among stakeholders was that there was no sense of separate identity amongst the LGS members who did not attend the Old Colony church. According to Kulig and Wall et al (2008), Old Colony is a more conservative branch of the LGS community. Other branches include Kleine Gemeinde, Rhinelanders, and Sommerfelder (Kulig & Wall et al, 2009).

## Key Stakeholder Interviews

### Identified Strengths in the LGS Mennonite Community

The LGS community has strengths that need to be considered in planning interventions:

#### Resilience

Several stakeholders spoke of the resilience LGS families need to cope with the economic adversity and their frequent migration. A community member relayed to a key stakeholder that this resilience is biblically based. Several references to worry as a sin can be found in the New Testament:

“So do not worry, saying, ‘What shall we eat?’ or ‘What shall we drink?’ or ‘What shall we wear?...’ But seek first his kingdom and his righteousness, and all these things will be given to you as well. Therefore do not worry about tomorrow, for tomorrow will worry about itself. Each day has enough trouble of its own.” (Matthew 6:31, 33-34)

#### Cultural commitment to a virtuous life

There is a strong sense of cultural identity and a desire to lead by example through a virtuous life. There is a sense of pride in one’s work that can be seen in the craftsmanship, baking, sewing and the neatness of home and appearance. This is thought to be faith-based in that, by using their skills fully, they honour God and the gifts they have received. Two stakeholders stated that if the home is in disarray or the children are poorly dressed or unkempt, it is a sign of a family in distress.



## **Priority Healthcare Needs/Healthcare practices**

### **Nutrition and dental health**

Key stakeholders identified dental concerns as a priority healthcare need amongst LGS families from Mexico. Dental care has not been traditionally valued or modeled in Mexico. In fact, dental supplies are seldom available in stores used by families in Mexico. Dental decay is so common that new brides in Mexico may be given dentures as a wedding gift.

Diet is a key factor in overall health including dental health. In Canada, LGS families have access to high-sugar and low-nutritional snacks that were less available in Mexico. Parents frequently provide these foods to their children because having it was a sign of economic status in Mexico. Parents do not always understand the relationship between diet and dental health. Stakeholders in the education system report it is common for a child's lunch to consist only of pop, cookies and chips. Stakeholders working with women report that the LGS women recognize that when they come to Canada they often gain weight but are unable to connect that change with their food choices. As a result of the poor nutrition, health stakeholders predict future problems with diabetes and heart disease in the population.

### **Mental health**

Mental health issues such as depression, low self esteem, and addictions are also reported by stakeholders. Alcohol abuse is often discussed by stakeholders as being a key problem within the community, although some believe the incidence is overstated. Attempts to connect with local alcohol and drugs services to discuss the contradictory reports were unsuccessful. Women are often isolated at home because of their young families, no access to transportation, and the language barriers. In their home communities in Mexico they would have had contact with neighbours or family members on a regular basis throughout the week. They also feel the loss of their home community and family in Mexico. Researchers have reported on the psychological cost of the migration for these women as they are separated from their culture and gradually acculturated into mainstream Canadian society (Good Gingrich & Preibisch, 2010). Stakeholders report women experience the somatic symptoms of insomnia, fatigue, and headaches. Somatic symptoms are commonly experienced by individuals with mental health concerns. The biological root and clinical significance of mental illnesses is not well understood. It is viewed as a sign of individual sinfulness or sloth (laziness) that can be addressed through repentance or increasing efforts to "measure up." "Nerven" or "nerve trouble" is the term commonly used to describe any or all mental illnesses.

### **Reproductive health**

Women's reproductive health is an important area of need. Knowledge of reproductive health can be limited in the Low-German community. Women are not always told about reproductive health prior to the onset of menstruation and sometimes not after. Use of birth control is not condoned by the Old Colony Church, but according to Kulig and Wall et al (2009), many women have used birth control at one point in time. Families are usually large; it is not unusual for a woman to have 10 children (Armstrong & Coleman, 2001). In fact, the LGS community is considered one of the fastest growing communities because of the high birth rate. Stakeholders report that if a family physician recommends delaying pregnancy for the health of the woman, the couple is more accepting of birth control. A culturally based respect for authority may lead to a willingness to comply with suggestions from a healthcare provider.

Community-based interventions for children have many barriers including language issues, barriers getting to the office, and a lack of trust between the family and the individual recommending or providing the intervention. Often LGS individuals will pretend to understand when they don't because they are embarrassed about lack of knowledge.

## Health Concept

Health concept refers to the community's perception of health or illness. LGS women describe health as an absence of illness and consider it in the context of how it affects their ability to work and provide for a family (Armstrong & Coleman, 2001). Illness is often viewed as God's will or even as a punishment from God. Death is also seen as God's will and therefore not preventable. It may even be perceived as a blessing because the individual is in heaven, not suffering on earth (Fast, Leach, & Hanly, 2002). The link between nutrition and health is poorly understood because of the limited knowledge of human biology and disease processes. As a result, disease, injury prevention and health promotion are "concepts without meaning" for LGS families. This creates considerable challenge for public health and healthcare providers.

## Education

Migration to Mexico began as an effort to preserve their control over the education of children. Even now, as families return to Canada, mainstream education in Canada is sometimes feared as a threat to culture and separateness from the world. In Mexico, children begin attending school at 6 or 7 years of age and finish at around 13 years. Girls typically receive slightly less education than boys. The school year follows the farming cycle and thus is only six months in length. High German is taught and classes focus on learning by rote and Bible education.

For LGS families living in Canada, there is little concern given to pulling children from school to travel to Mexico or to participate in farm work as hired hands. This practice often conflicts with mainstream society's values about the importance of education and the strong objection to child labour, especially among individuals with little experience in the farming culture. Because the family unit is so valued, parents can find the separation of the children during the day difficult. Also, the long-term economical hardship has placed a higher value on economic security. Frequent trips to Mexico help to keep the families connected to their culture, the loss of which is feared greatly.

The elementary school has challenges teaching science and biology because parents will sometimes object to content. LGS parents are not only concerned about classes on human biology and reproduction, but also astronomy and earth sciences (including dinosaurs, evolution). Professionals working with young women reported struggling personally with the limits placed on female children's education. Typically, young women finish school in Grade 8 or 9 and are expected to remain in the home helping their mothers until they marry or find work in a store or bakery. Some young women and men have been attending a specialized program at Elmira District High School that is aimed at the Mennonite population. The program hopes to support previous learning in a trade and connect them to Conestoga College so they can receive formal recognition through apprenticeships and certifications. This program has been well received by the community because parents value education more when they can see how it will lead to an increased income or job security.

## Gender

LGS families from Mexico are part of a hierarchical culture where men have more power than women. By limiting the exposure to education and knowledge, women are kept in domestic roles and will not question any decisions made (Kulig & Babcock et al., 2009). Once in Canada, women often will not make decisions about referrals, group attendance or home visits without discussing with their husbands first, because "the influence of the husband is profound." Women introduce themselves as "I'm John Doe's wife" in new group settings.

Being members of a minority culture, particularly one that is hierarchical and patriarchal in nature, LGS women are more vulnerable to domestic violence. Within this community, the rights of men over their families are seldom questioned. In addition, the language barrier, financial constraints, and large family size hinder a woman's efforts to seek support when in an abusive relationship.

Employment opportunities are limited for women because of their lack of education and the fact they often have young children in the home. These practical issues can be compounded by low self-esteem in LGS women, as well as the cultural norms. “What else would I be?” (but a housewife).

Power imbalance in LGS Mennonite families creates additional challenges for public health and education professionals whose contact is primarily with women. Even if health messages are accepted by women, it will be difficult to change practices in the home if her husband does not accept the information. For instance, a woman may try to introduce healthier foods to her children but her husband will continue drinking carbonated beverages for breakfast. As the “head of the family,” the father’s actions have significant impact on the children and their behaviour.



### **Acculturative Stress**

Historically, LGS families have been able to maintain their separateness by living in extreme isolation in Mexico and other countries. Due to their poverty and migration to Canada, LGS families are forced to interact more frequently with mainstream society. This results in acculturative stress for LGS families. Acculturative stress refers to the stress resulting from immigrating to a new culture.

A keynote speaker at the Networking Day in Aylmer (June 2009) stated there was no evidence that alcohol abuse, drug trafficking or domestic violence/incest occurred more frequently amongst the LGS families from Mexico compared to the general population. However, her perspective was from a community with a long settled LGS population. Locally, the population of LGS families from Mexico is newer to Canada and one key stakeholder reported feeling that acculturative stress was the root of some of the social problems such as alcohol abuse, domestic violence and incest, and mental illness described by other stakeholders.

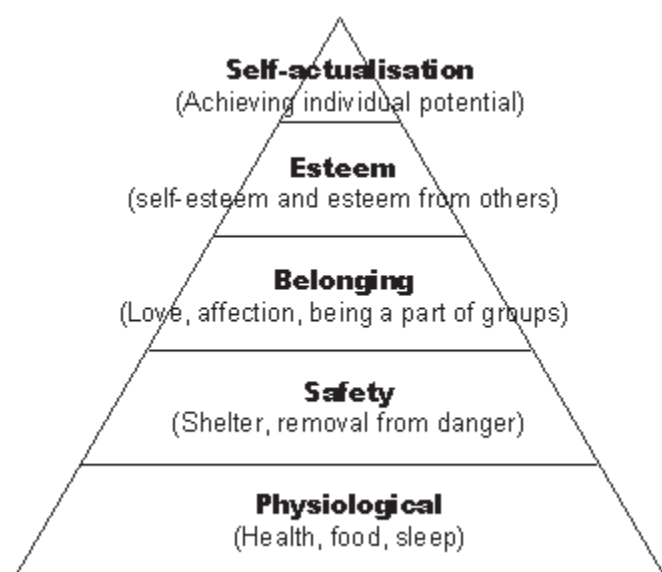


## Poverty/housing

Families leave Mexico often because of economic hardship. One individual stated, “It isn’t unreasonable to ask if all the children have shoes (when they arrive in Canada).” Unfortunately the economic hardship that drives families to leave Mexico remains a factor in Canada. The houses and apartments the families find may be poorly maintained and LGS families from Mexico are unfamiliar with Canadian laws around tenants’ rights. The cultural belief that “life is hard” likely influences their reluctance to complain about plumbing issues, electrical issues etc. Furthermore, the state of their living conditions in Canada may be an improvement over their situation in Mexico.

Maslow’s hierarchy of needs (Figure 1) was often mentioned during interviews and at educational sessions about this population. Because their lives in Mexico have been focused on obtaining the basic necessities of life, little time is available to reflect on higher level issues like love and belonging, esteem, or self-actualization. Resources need to be directed towards helping families meet the needs on which they are currently focused, be it food, shelter, or building a sense of community (Changing Minds, n.d.).

*Figure 1. Maslow’s Hierarchy of Needs*



## Social Supports

Key stakeholders commonly spoke about the strong sense of family within LGS families from Mexico. However questions emerged in other interviews about the level or quality of emotional support provided. One stakeholder described a “culture of silence” within the community. One LGS community member reported never receiving a hug from her mother, and another spoke of there being no Low German word that captured the concept of “encouragement.” A sense of loss of connection to close relatives has been reported to key stakeholders by community members. Individuals differ in their ability to easily immigrate to Canada based on their past ties to Canada. As a result, extended families are often separated as one family unit moves to Canada. The high quality of community support during times of grief was commented on by one stakeholder.

## Child Development

Children are valued but disability can be viewed as a punishment. At the same time, families may be accepting of the child’s disability and wouldn’t see value in seeking additional therapy because this may interfere with God’s plan for the child. Even if a family was wanted support, accessing services are difficult because of the barriers for LGS families such as transportation and language barriers.

Farahbakhsh (2007) discussed the parenting practice of voicing only disapproval to children, “approval, choice, and courtesy was unheard of” (p. 106). In her work building literacy, she helped the women at the Newcomers’ Education Program to reflect upon their own experiences being parented and whether they wanted something different for their own children.

## Interventions

Key stakeholders recommended several interventions to increase the overall health and build capacity within the LGS community. Building long-term, client-focused relationships that work within the client’s cultural context were seen as key. Using metaphors with meaning to LGS women was important in delivering health messages. For instance, to explain the value of child-spacing, a public health nurse from Elgin St. Thomas Public Health used the metaphor of planting tomato plants. Sharing personal information is recognized as a valid therapeutic technique when it is used to benefit the client (CNO, 2006). When any immigrant comes to Canada, they are often faced with different laws and cultural norms. As a result, professionals often focus on what they are doing wrong such as corporal punishment of children. To successfully promote change, it can help to be identified as a peer with similar challenges and experiences than as an expert who tells the individual or group what they are doing wrong. Presentations from males can be a problem for LGS women. They usually don’t feel confident enough to ask questions or participate in a discussion lead by a male because of the power imbalance between the genders in LGS culture.

Create hands-on strategies whether in the home or in some groups. Most individuals learn best through hands-on activities; however, LGS women benefit even further because of their limited experience with formal education and the difficulties with print material due to language barriers. According to Farahbakhsh (2007) a participatory approach in a group setting empowers clients by building their confidence and acknowledging their experience, yet moves them forward in their understanding and action.

Stakeholders repeatedly referred to the need to move slowly and expose clients to the same information many times. This can be a challenge for healthcare providers who face time constraints and have limited experience working with vulnerable populations.

According to Farahbakhsh (2007), healthcare providers need to recognize the opportunity when clients ask questions. Often members of this community will not acknowledge if they have questions or if they did not understand information. It is particularly unusual for a LGS woman to have enough confidence to ask questions in a group setting. Even if the answer is not straightforward, trying to provide as much structure or guidance to an answer will be well received by the group and will reinforce group participation. One stakeholder reported the community responds well to limits and structure, such as clear guidelines for how much sugar is too much. This may be because they are used to strong direction in their lives from the church leaders.

Because LGS families often face significant financial hardship, they may have difficulty buying items like toothbrushes, toothpaste, and child-safety equipment like bicycle helmets and car seats. Living in Mexico, these items would not have been commonplace and since there is no concept of injury or disease prevention, they would not likely prioritize these items as money became more available. Accompanying health teaching with the provision of free equipment may be a better option compared to health teaching alone. Research has suggested that the provision of free equipment can reduce injury (Sznajder et al, 2003).

Providing interventions within the community is also recommended. School-based interventions such as the Fluoride Varnish and Nutrition programs have been received positively. Literacy projects such as *Bringing Out the Best in Children* and *The Smiling Project* that were part of the Newcomers’ Education Program are viewed

as successful. These projects were guided by the women attending the group and were well-received by the community. Finding ways of harnessing the creative skills that are promoted within the LGS community is important in building capacity. Elmira District Secondary School's alternative program for LGS youth is a good example of how a program can build on the strengths in the community in a culturally appropriate manner.

Word of mouth cannot be overestimated. Families come to Canada already aware of problems other LGS families have had with child-protection agencies. As a result, there is fear and mistrust of many community agencies. Positive word of mouth from community members can help build trust in professionals. Dental staff discussed how LGS families began accessing their services in large numbers recently thanks to word of mouth from other LGS families who spoke highly of the service. Families are calling from counties all over southern Ontario. Although WDG Public Health does not provide service to these families, it is an opportunity to connect them to other public health units.

Collaboration between agencies has increased awareness in the mainstream about the issues faced by the community. Networking days are organized on an ongoing basis. This provides opportunities for collaboration, that in turn, creates opportunities to pool resources and decrease duplication of services.

Turnover in healthcare and social services needs to be planned for and capacity needs to be built outside of experts. Staffing or assignment changes are a reality in government and social service agencies. This loss of expertise is felt within those involved with the network of service providers and within the community as well. Trust in formalized agencies that represent government can be difficult because of the faith-based separation between Church and State.

Peer leaders are often used in harder-to-engage groups as a way of removing the barrier of the "expert" from group dynamics. Farahbakhsh (2007) spoke positively about her experiences involving women in presentations and group discussions; however, other key stakeholders relayed concerns raised by women within the Old Colony community. Women feared other community members would view their efforts to lead a group as an indication the peer leader felt she was better than the other community members. One way to address these concerns is to rotate peer leaders within the group to reduce the chance of one member being perceived as putting herself above others. The success of this strategy may be dependent on the members of a group and the facilitator would need to be sensitive to individual group member's feelings about leading or presenting.

The issue of language is unusually complex compared to most immigrant populations. Education in Mexico is traditionally in High German. Low German is spoken in the community and at home. Low German has not been a written language and efforts at translation have mixed results. Recently Public Health received written information that had been translated in Low German. Public Health staff brought the materials to students at Centre Peel School. The students had great difficulty reading the pamphlets, despite being fluent in Low German. More success has been achieved with audio material. In fact, results from research studies have been produced on CD for distribution within the Low-German community (Kulig, Babcock, Wall & Hill, 2006). Unfortunately, while CD players are common in cars, few LGS families will have CD players in their home, preventing this from being a universal intervention.

Some stakeholders felt strongly that facilitators needed to speak Low German in order to engage with community members; however, others felt that not speaking Low German helped facilitate the participation amongst group members. Women with some English would engage with each other in an effort to translate a word into English or vice versa, a process that would have been lost if the facilitator had spoken Low German. Even with an interpreter, language barriers can be a challenge during interactions with healthcare providers because clients may not be comfortable discussing sensitive healthcare issues in the presence of an interpreter.



## Population based interventions

Population-based interventions are desirable because they reach more people and are less expensive and time intensive compared to one-on-one interventions. For instance, primary passive interventions can be very successful and require no effort on behalf of the community being targeted. Fortified food or water is a common example of this kind of intervention.

One population-based intervention that has much support amongst LGS stakeholders is a radio station. The Aylmer community has a radio station with Low German programming. This station is widely viewed as a success amongst service providers and within the Old Colony community. There is considerable interest in Wellington County in establishing a radio station that could provide Low German programming. This presents opportunities for public health to provide health promotion messages.

Accessing children at the school has many benefits including the opportunity to build on current curriculum, addressing the barrier of transportation faced by many families, and the opportunity for peers or older students in the school to role model health behaviours or to explain concepts in a culturally appropriate manner. Having consistent staff work with the population at the school helps to build trust as parents bring subsequent children through the school system.

## 2.3 Relevant Models

Models were chosen based on their ability to address gaps in traditionally provided services. Client-centred care considers the one-on-one therapeutic relationship between client and provider. Popular education is a model for facilitating groups like the Newcomers' Education Program and also has relevance for health teaching within a provider-client dyad. Knowledge management addresses the ongoing issue of capturing and sharing individual and agency knowledge about the LGS community.

### Client-Centred Care

Client-centred care “focuses on the experience of the client from his/her perspective, minimizing vulnerability, and maximizing control and respect.” (RNAO, 2002, p. 10) In 2008, the Child and Family Health program at WDGPH introduced motivational interviewing as an approach for client-centred care. Motivational interviewing (MI) emerged from the addictions field in the 1980s but is easily applied to high-risk home visiting. Motivational interviewing seeks to influence the client by highlighting the discrepancies between her current behaviour and her own goals and values. The principles of MI include:

- Expressing empathy
- Developing discrepancy
- Avoiding argumentation
- Rolling with resistance
- Supporting self-efficacy

Building a trusting relationship is critical in using MI as a tool for facilitating change. Different health professionals and research have reported on the benefits and need for long visits focused on meal preparation and exchange of personal information. The professional needs to recognize that the client is responsible for behaviour change. Goals and suggestions for meeting those goals need to be client-directed.

Client-centred care is appropriate for all clients. However, it has particular resonance when considering the LGS community because of the combined issues of low self esteem amongst LGS women, their faith-based

perspective of the world, and their existence within a society that has gone to great lengths to resist change. The principles of MI provide an approach from which nurses can build their relationships with the client, and support clients in embracing change.

## Popular Education

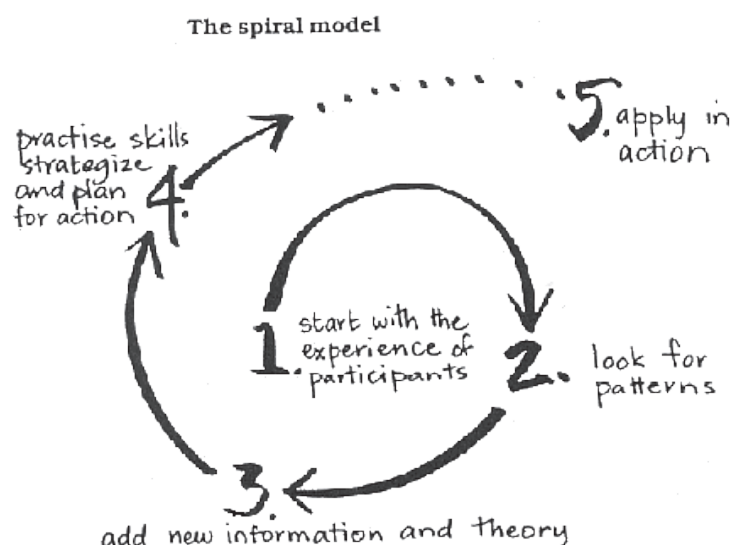
Popular education is a teaching methodology that “aims to empower people who feel marginalized socially and politically to take control of their own learning and to effect social change.” (Peace and Environment Resource Centre, 1995). Popular education requires active participation from everyone involved and acknowledges the vast life experience of participants (Farquhar, Michael, Wiggins, 2005). There is no teacher in popular education, but there are facilitators to promote effective and positive group interactions. Through use of this framework, community members identify pertinent social determinants of health (Farquhar et al, 2005).

*Bob Hale Youth College for Social Justice: Participants’ Handbook* from the Peace and Environment Resource Centre (1995) provides a description of popular education:

In popular education, the learning process starts with identifying and describing everyone’s own personal experience and that knowledge is built upon through various activities done in groups. After the activity, a debriefing process allows us to analyze our situation together; seeing links between our own experience and historical and global processes in order to get the “big picture.” Through the generation of this new knowledge, we’re able to reflect more profoundly about ourselves and how we fit into the world. This new understanding of society is a preparation to actively work towards social change. In fact, in popular education, the education process isn’t considered to be complete without action on what is learned; whether it be on a personal or political level (p. 4).

It has long been acknowledged that people learn best when they are actively involved in their learning and have an opportunity to see, hear, talk about, and have hands-on experiences with a particular activity. It is important to avoid a lecture-style approach to education when using a popular education methodology. Activities need to be interactive and participatory and have a direct link to the everyday lives of participants.

Figure 2. *The Spiral Model* (Arnold, Burke, James, Martin, & Thomas, 1991)



The spiral model of learning developed by the Doris Marshall Institute for Education and Action acknowledges the past experiences of individuals and groups. It recognizes any patterns before new information or knowledge is introduced. There is a reflection or analysis process where the new knowledge is incorporated and plans are made for action. Finally, the knowledge can be applied in action. Since the goal of the process

is to facilitate social change, this last step needs to take place outside of the context of a group or one-on-one relationship. Ideally, participants will return to their own communities and families, share their experience and thoughts with others for further review, and apply actions within their everyday lives (Peace and Environment Resource Centre, 1995).

The principles of popular education guided efforts by the Woolwich Community Health Centre to develop health-teaching strategies for the LGS families in the Region of Waterloo. Farahbakhsh discussed her personal successes using hands-on activities with women attending the Newcomers' Education Program. Health issues she addressed included dental health, nutrition, and high blood pressure. Farahbakhsh (2007) discussed the importance of using metaphor and practical everyday objects to explain health-related concepts. This concept can be translated into teaching strategies that may have value for both group facilitators and public health staff during home visits. Simple activities that explain aspects of human biology, nutrition, and health may offer interesting and concrete ways to explain concepts important to LGS clients.

## Knowledge Management

Knowledge management refers to an organization's efforts to capture and preserve data and information, as well as the judgment and experience of its employees (Kols, 2004). Some of this information is written, however; much is tacit knowledge: knowledge built through personal experience (Sensky, 2002). The goal of knowledge management is to assure that knowledge and information are shared by the right people at the right time. The knowledge management literature refers to three essential components of knowledge management: people, processes, and technology (Kols, 2004). People are key to knowledge management because it is their knowledge and experience with the LGS community that is used on a daily basis and it is this knowledge that needs to be captured and shared amongst current and future staff. This review of the LGS community is an example of the process of knowledge management. It attempts to gather and organize existing knowledge, and share the knowledge with the broader community of service providers who work with the LGS families. Technology offers a way for providers to easily share knowledge and to track information about the LGS families.

Knowledge management is already happening on an informal level, but room for improvement always remains. Frequent turnover in the social services means that knowledge and experience about—and more importantly, trusting relationship with—LGS families is potentially lost. Finding a way to maintain the knowledge and relationships will prevent lost time as newer staff work to learn key information to establish themselves in the community.

Knowledge transfer is a key component of knowledge management. Knowledge transfer involves the creation or capture, organization, and dissemination of knowledge to others (Sensky, 2002). It is more complex than simply communicating the information because the knowledge of the LGS families from Mexico resides within organizational members and their networks and is often tacit knowledge. Final recommendations will include suggestions for improving knowledge transfer.



# SECTION 3 RECOMMENDATIONS AND CONCLUSION

## Recommendations

- Introduce Low-German-Mennonite culture to new staff who will have contact with Low-German families.
- Identify key staff to engage with the community while building internal capacity to support the community. The goal of this is to build recognition of different individuals in hopes of establishing some trust within the community should a change in assignment be necessary.
- Identify opportunities to collect data on the language spoken in the home. This will help improve our understanding of the size of the Low-German population.
- Design activities that use appropriate metaphors or simple, everyday items to teach health and biological concepts to Low-German families.
- Support face-to-face interactions or lower-literacy written health information. Translated print material has little value due to the complex nature of language in the LGS community.
- Build upon the strong oral culture of this community.
- Continue supporting community networks with appropriate agencies. Collaboration between agencies builds group knowledge about the needs of the LGS community.
- Advocate for a means of provincial surveillance for the LGS community.

## Conclusion

LGS families from Mexico lived in a remote, hierarchical culture. It is a culture that directs all aspects of their lives including Biblical interpretation, education, women's roles, and healthcare. The sense of community LGS families had in Mexico is sometimes lost with the immigration to Canada and subsequent isolation. By considering different aspects of LGS family life in the context of the determinants of health, a broader understanding is created of the issues facing these families as they come to our community. Poverty, limited education, social isolation, language barriers, and a strict adherence to gender roles create significant barriers to health for LGS families in Wellington County. As a result of their world view, traditional approaches to providing health information do not meet the needs of this community. Knowledge management, client-centred care, and popular education are concepts that have a role in guiding Public Health's efforts to service and work with the LGS community.

Recommendations for consideration include:

- Focus on building internal and external capacity.
- Build trusting and collaborative relationships with community members and partnering agencies.
- Develop strategies that involve hands on, participatory learning.
- Identify opportunities for surveillance.

LGS families in Wellington County have unique challenges and skills. It is hoped that by building on their skills and helping to reduce the impact of the challenges, the overall health of the LGS community can be improved.

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