



Reaching Out to a Challenging Community

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Imagine that you are fifteen years old and pregnant. You find yourself in a country where you share no common language. You have never seen a health care provider in your life. You know that you want your baby born healthy, and born a citizen of this new country. So you make your way to a clinic, where strangers ask you all kinds of questions you don't understand about a "medical history" you do not have, make you take off all your clothes and touch you in very intimate ways. Now imagine being that health care provider.

Las Islas Family Medical Group in Oxnard, California, 40 miles northwest of Los Angeles, is a county-based community clinic which sees some 1,200 patients per month. Our ten physicians and three Family Nurse Practitioners provide medical care to an agriculture-based community with a large monolingual Spanish-speaking population.

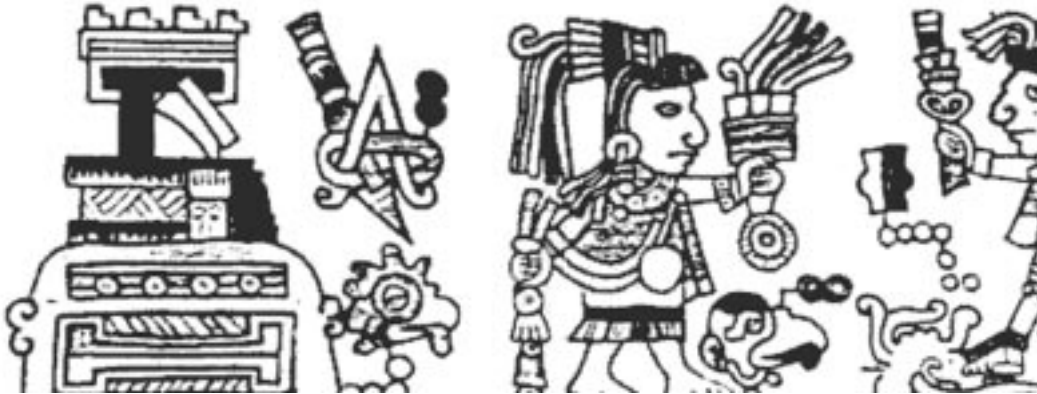
We have long prided ourselves on our ability to provide respectful quality medical care to our patients who are often lacking in educational skills and financial resources. Recently, however, the rapidly growing Mixteco population in our county has challenged our complacency.

The Mixteco are an indigenous people of southern Mexico, mostly the state of Oaxaca. Their existence as an organized community in that area predates Europeans by over 2,000 years. Since the conquest by Europeans in the sixteenth century, the Mixteco and other indigenous

groups have been marginalized into the least fertile, hilly areas of Oaxaca. Subsistence farming was subdivided into smaller and smaller plots as the indigenous population grew. Massive deforestation of the area by the Mexican lumber industry in the first half of the 20th century turned huge areas of Oaxaca into non-farmable wasteland. At the same time, large agricultural interests in both Baja California and the United States began to court indigenous groups as a new and easily exploitable cheap labor source. It is estimated that some 300,000 inhabitants of Oaxaca, mostly indigenous peoples, have migrated over the last thirty years to other parts of Mexico and the U.S. The Mixteco make up a large part of these emigrants.

I had visited Oaxaca several times to enjoy the richness of the agricultural ruins, artisan handcrafts, and to attend the spectacular "Guelegetza," an annual outdoor dance festival which features the music and dancing of all the region's indigenous groups. From these travels, I had a rudimentary understanding of the area and its history. So I was pleased but surprised when I first began to identify Mixteco patients at the clinic. After all, it's a 3,000-mile journey. Over the last year, the number of Mixteco-speaking patients has risen dramatically.

It is estimated that Ventura County now has at least 5,000 and perhaps 20,000 people for whom Mixteco is their primary language. Many of these people are monolingual—they do not speak Spanish, let alone English; most have



never had medical care before in their lives. We see them primarily for prenatal care. (In California, all pregnant women may apply for Medicaid, whether they are legal residents or not.) It often takes them months before they are able to navigate the system, so we see them late in their pregnancies. Often, they do not know their month of conception. If there have been previous births, they are likely to have been at home, without a known birth weight.

The Mixteco as a rule are very small people, so our standard measurements are not really appropriate in accessing fundal height, expected weight gain, etc. Most are field workers who continue to work into very late pregnancy to be able to afford their rent. Most have inadequate nutrition and housing. The majority cannot read or write in any language. And there are several dialects within the Mixteco language, so that not all of these people can even communicate with each other.

As the details of this picture started to emerge, it became clear that we needed to develop a whole new system to bring these patients into the health care network. After getting the green light from my clinic's medical director, I started to publicize a community meeting, where we could begin to explain to people how to access community

resources and the importance of regular and early prenatal care. Our clinic's prenatal educator and my medical assistant helped to get the word out. I solicited donations (like ten cans of menudo), so at least we could give people a good hot meal.

Our first real breakthrough came when a registered nurse who works in a maternal-child health program called to say that not only would she like to be part of the organizing effort, but that she knew a community organizer who spoke fluent Mixteco and Spanish. Antonio works with a group of lawyers who are helping migrant workers attain legal rights, and who received a grant from the U.S. Census Bureau to help get Mixtecos counted for the 2000 census. He agreed to join forces with us and translate from Spanish to Mixteco for the meetings.

Our publicity for the meeting was mainly word of mouth within our own clinic. I was thrilled when twenty-five people jammed into our little billing office and Mixteco Community Organizing Project was born.

Two months later, the successes are great and the challenges greater. We've involved some sixty families in our meetings. By and large, our patients show up for their pre-

natal care visits and are having healthy babies in the hospital. Most continue on with the clinic for well-child visits and family planning services. We've already had to change the name of our meetings from "Reunión Mixteca" to "Reunión Indígena" as families from other southern Mexican indigenous groups have joined us.

We now have a part-time employee at Las Islas who speaks fluent Spanish and Mixteco. She is proving to be a tremendous asset in communicating with our patients and demonstrating our commitment to serving their needs.

The barriers are still incredible. Transportation is a huge issue. Getting to the clinic usually involves walking or taking the bus. ("Lucky" patients who can get a ride may be dropped off at 7 a.m. and picked up at 4.) We are using a County-sponsored taxi voucher program to get patients in labor to the hospital, but this involves a lot of time spent in teaching patients how to use the vouchers.

It is difficult to stay in contact with our patients. Many don't have phones, change addresses often, and leave the area for months out of the year when local employment is scarce.

We need to build our "necessities of life" program. The small amount of food and clothing we are able to provide is far from adequate. Fortunately, as each day goes by, someone new comes to donate time or resources. Our hard-working clinic staff keeps finding new and better ways to communicate and teach.

Our short-term goals include enlisting some of our families in a Public Health program, which will train people to go into their own communities as public health promoters.



Those who are recipients of help now will be the leaders in providing help to the newly arrived in the future. We need to learn more about the Mixteco culture, language and beliefs to be able to provide respectful quality medical care. We need to form links with other immigrant communities in California, Oregon and Washington to ensure continuity of care to the immigrant population.

The work is enormous. But the potential benefits to the entire community—English-, Spanish- and Mixteco-speaking—are enormous also. Quality health care, living wages, decent work and living conditions, mutual respect and celebration of diversity are the bases of a strong and stable community. It's my hope that we are taking the first baby-steps towards those ends.