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FIT TO BE CITIZENS?

PUBLIC HEALTH AND RACE IN LOS ANGELES, 1879-1939

NATALIA MOLINA

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Introduction

Health Officer Dr. Walter Lindley assured city residents in 1879 that Los Angeles had “everything that God could give” a city.¹ Among L.A.’s many virtues, the doctor emphasized “the health giving sun [present] almost every day in the year . . . the ocean breeze just properly tempered by hills and orange groves . . . pure water pouring down from a mountain stream [and] . . . the most equable temperature in the civilized world.”² Such healthful abundance, however, did not lessen the need for the services of the city’s chief health officer and his fledgling department. In stressing the importance of improving sanitary conditions in Los Angeles, he called for the construction of a municipal sewer system and appealed to the city council to eradicate Chinatown, “that rotten spot [that pollutes] the air we breathe and poisons the water we drink.”³

And so began what became a long tradition among city health officials of tracing any blemish on the pristine image of Los Angeles—including all forms of disease and any manner of disorder—to the city’s marginalized communities. As the chapters that follow will show, between 1879 and 1939, areas home to L.A.’s Chinese, Japanese, and Mexican populations were separately and serially targeted as “rotten spots.” Armed with institutional power buttressed and legitimated by the language of “scientific objectivity,” public health officials developed discourses that attributed the serious health problems confronting these minorities to purported deficiencies in the groups’ biological capacities and cultural practices. Thus, from the start, Los Angeles health officials’

efforts to promote the reputation of the city as modern and healthful were interwoven with their role as local arbiters of the meanings of race and racial identities.

Portraying people of Chinese, Mexican, and Japanese ancestry in Los Angeles as threats to public health and civic well-being obscured the real causes of communicable disease and illness—inadequate medical care, exposure to raw sewage, and malnutrition. Misled by their own racial assumptions, health officials betrayed their institution's mission. They devoted inordinate attention and disproportionate effort toward policing racial groups while neglecting the dangers posed by the incidence of communicable disease among the rest of the city's residents. Issues of race, class, and gender were considered in all aspects of health officials' work, from identifying and defining problems, to developing preventative health care programs, to handling disease outbreaks. Disease itself was defined as much by sociocultural beliefs in the inherent uncleanliness of immigrants and nonwhites as by biological explanations. Such definitions effectively stigmatized entire populations of already-marginalized groups in the city.

Perhaps most important in the long term was the public health department's gatekeeper role. Indeed, health and hygiene norms increasingly became standards for "Americanness," and health officers helped determine who was considered part of the body politic. They had the power to restrict people's sense of social membership and shape their relationship to the nation-state. As the historian Suellen Hoy argues, "[C]leanliness became something more than a way to prevent epidemics and make cities livable—it became a route to citizenship, to becoming American. It was, in fact, confrontation with racial and cultural outsiders that transformed cleanliness from a public health concern into a moral and patriotic one."⁴ It was health officers, for example, who had responsibility for deciding who was healthy enough to work or attend public school. Public health ordinances dictated where Chinese fruit and vegetable vendors could establish businesses and even prescribed the architectural style of the produce markets. They determined when Mexican railroad laborers could leave their work camps and where Japanese residents could seek institutionalized health care. They approached these communities, which they considered a "menace,"⁵ with the attitude that they needed to "safeguard the public" against them.⁶

City and county public health officials in Los Angeles consistently failed to distinguish between U.S.-born and foreign-born individuals in the Chinese, Japanese, and Mexican communities (even *Californios*,

those Mexicans who had lived in California when it was still Mexico), thus marking all members of these groups as permanently “foreign.”⁷ Suspended indefinitely in this “not-yet-American” state, Japanese, Chinese, and Mexican residents of Los Angeles were excluded from the benefits of full social participation in the life of their city. Social membership is usually equated with citizenship status, but it is important also to investigate how those who are not citizens negotiate a sense of national identity, calibrating notions of citizenship and democracy in the process.⁸ By shifting the focus to the local level, one can see the ways in which social membership is negotiated every day.⁹ In this study, examining local institutions, particularly those whose mission was to promote public health, is crucial to demonstrating how institutional policies affected a sense of social membership. As an institution, the department of public health regulated immigrants’ everyday life practices. Moreover, the city and county health departments’ official standards, guidelines, and recommendations were routinely evoked by the city council and others to prevent Chinese, Japanese, and Mexican residents from bargaining freely over wages and working conditions; from owning land or accumulating other assets that might appreciate in value and be passed on to subsequent generations; and even from moving freely about the city in search of housing, employment, and business opportunities.¹⁰

The growth of Los Angeles and the increasing national recognition of public health as a prominent profession in the nation and important institution in the city were closely entwined. Just as demographic growth and increased immigration warranted the attention of government legislators and private investors, so too they demanded the attention of health officials. Sanitation and good health were central to the image of Los Angeles, and public health officials remained thoroughly committed to promoting the reputation of the burgeoning city. The many connections between the health departments and the broader municipal infrastructure challenge the idea of public health as being driven by pure principles of “scientific objectivity.”¹¹ Overarching social and political issues of the time played essential roles in the development of the city and county health departments, determining where clinics were established and what types of programs were offered to whom.

Health officials not only incorporated their racially charged visions into policies and ordinances that targeted ethnic communities but also helped shape the ways mainstream populations perceived ethnic peoples. Moreover, people operating at various levels of power, in and out of government, routinely appropriated public health discourses to ad-

vance goals of their own, including the shaping of racial categories and meanings.¹² “Experts” from the fields of public health, public service, law, and social work reinforced each other’s ideas, thereby increasing the legitimacy that the general public accorded to their claims. The process by which public health as an institution and a discourse evolved into a key site of racialization in late-nineteenth- through mid-twentieth-century Los Angeles—how it came to exert an influence that extended far beyond the realm of health—is the central question this book addresses.¹³

REFINING THE RACIAL HIERARCHY

In 1875, the Southern Pacific Railroad extended its line from San Francisco to Los Angeles. Additional connections to railroad lines during the 1880s made Los Angeles the terminus of two cross-continental railroads. Each new link precipitated another, larger jump in the size of the city. Census data place the total population of the city in 1880 at slightly over eleven thousand. By 1900, Los Angeles claimed a population of more than one hundred thousand within city limits and an additional seventy thousand residents in the county.¹⁴ But in Los Angeles, unlike comparable cities in the Midwest and East, population density grew only modestly. As a result, the city and county developed into a sprawling metropolis with a much higher ratio of land per capita than was common elsewhere.¹⁵

If L.A.’s geographical limits seemed infinitely expandable, its social boundaries did not. The city and surrounding county were the site of persistent struggles between the white elite and the racially diverse remainder of the population.¹⁶ Sparring matches over politics, civil rights, housing, employment, and the distribution of city and county services occurred regularly, increasing social polarization throughout the city. These conditions made having a stake in assigning L.A.’s ethnic groups their proper place in the city’s racial order especially important. Public and private discussions of the need for maintaining a high standard of public health were laced with references to the perils presented by the city’s immigrant minorities. Health officials recorded their racial concerns in quarterly and annual reports, in internal memos, in their correspondence with other health and government officials, and in the press. The multiethnic population of Los Angeles preoccupied public health officials because of a widespread perception that immigrants threatened the health of the nation in both a real and a metaphorical sense.

From the late nineteenth to the early twentieth century, Americans across the country struggled to adapt to the broad changes that accompanied industrialization. Large numbers of people moved from rural to urban areas, and major sites of labor shifted from the fields to the factories. The composition of immigration changed as well. In most cities, southern European newcomers replaced earlier Irish and German populations as the largest immigrant groups.¹⁷ Public dissatisfaction and calls for reforms in various arenas, from business to social welfare programs, accompanied these sociopolitical and cultural transformations. As the country embarked on a “search for order” that would calm growing fears of chaos,¹⁸ public health, which emerged as a field toward the end of the nineteenth century, seemed an ideal solution.¹⁹ With its promise of “scientific objectivity” and its embodiment of many of the values championed by the Progressives, it was an institution well suited to the era.²⁰

On the East Coast and in the Midwest, health workers and social reformers directed their efforts at the newly arriving white immigrants from southern Europe, whom they attempted to assimilate into American culture. In Los Angeles, the situation was more complicated. Los Angeles health officials dealt only infrequently with the city’s ethnic white (southern and eastern European) immigrants. Their main concerns, instead, were the health issues posed by Chinese, Japanese, and Mexican residents. Asians and Mexicans were not easily classified into racial categories. They were neither white nor black. What position should they occupy in the racial order? The highest levels of government determined legal citizenship, but institutions, such as public health departments, determined who had access to social membership. Public health officials were able to inject new concepts and ideas into delineation processes that are usually informal and carried out at a much lower level (such as a city or even a neighborhood), marking some people as worthy, capable, and deserving members of society and others as correspondingly unworthy and incapable of participation. What degree of social membership and/or legal citizenship should be extended to which groups? Public health officials, with their standards and guidelines, programs and policies, helped answer and institutionalize responses to these questions. I argue that by examining public health as a site of racialization, we will see how public health workers at the local level contributed to the construction of racial categories. In Los Angeles County, the earliest interactions between public health officials and Mexican and Japanese immigrants reveal how race relations in this area differed from those in the rest of the nation.

DEVELOPING A REGIONAL RACIAL LEXICON

In the country as a whole, race was commonly perceived in dichotomous terms as the categories of “white” and “black.” The general public identified other major “races” as Slavs, Hebrews, and Mediterraneans. Los Angeles had its share of these groups, but they were rarely mentioned as racially distinct. The black/white imagery that dominated conceptions of race elsewhere gave way in Los Angeles to a notion of race as a graded continuum shading from white, at the top, downward through various forms of “nonwhite,” represented by the city’s Chinese, Japanese, and Mexican populations. In Los Angeles, people “saw” race differently. The numerically small size of the African American population, combined with the fact that Asians and then, later, Mexicans were highly sought after as laborers, displaced the prejudices usually reserved for African Americans onto these three groups (table 1).²¹

The history of the development of the nonwhite category in contrast to the widely accepted black-white paradigm highlights the fluidity of racial understandings and the many ways in which racial categories evolved. In the wake of the major changes nationwide brought about by large-scale immigration and industrialization, the notion of “an unquestioned hegemony of a unified race of ‘white persons’” broke down.²² Poor and ethnic whites continually needed to define themselves against the “other,” most often African Americans, in order to establish their racial privilege.²³ The fervor with which whites guarded their racial privilege is not surprising. Whites’ position at the top of the racial order resulted in heightened access to institutionalized power.²⁴ By definition, racialized populations, since they were constructed in structural opposition to whites, had limited access to institutional power.

The ambiguity that resulted from retooling racial categories also meant that people who were neither white nor black had no clearly defined position in the racial hierarchy. The “nonwhite” category helped stabilize the new racial order. Like whiteness, nonwhiteness was neither a monolithic nor a static category; it incorporated degrees of access to privilege, and its composition changed in response to national factors (e.g., labor needs, immigration laws, and economic cycles) and more regional pressures (e.g., the presence or absence of other marginalized populations). The racial ordering within the category of “nonwhite” also was affected by the process of racialization itself. As Tomás Almaguer has shown, in nineteenth-century California, groups were racialized in relation to one another, falling into different places along a graded continuum that began with whites, who were followed by

TABLE I. POPULATION OF LOS ANGELES
BROKEN DOWN BY RACE, 1880-1940

Year	White		Negroes		Japanese		Chinese ^a		Mexicans ^a		Total Population (County)	Total Population (City)
	in County	in City	in County	in City	in County	in City	in County	in City	in County	in City		
1880	31,707	10,379	188	102	1	1	1,169	604	1,721 (FB)	N/A	33,381	11,183
1890	95,033	47,205	6,421 ^b	1,258	36	26	4,424	1,871	1,293 (FB)	498 (FB)	101,454	50,395
1900	163,975	98,082	2,841	2,131	204	150	3,209	2,111	1,613 (FB)	817 (FB)	170,298	102,479
1910	483,478	305,307	9,424	5,101	8,461	4,238	2,602	1,954	11,793 (FB)	5,632 (FB)	504,131	319,198
1920	894,507	546,864	18,738	15,579	19,911	11,618	2,591	2,062	33,644	21,598 (FB)	936,455	576,673
1930	1,949,882	1,073,584	46,425	38,894	35,390	21,081	3,572	3,009	167,024	97,116	2,190,738	1,238,048
1940	2,660,042	1,406,430	75,209	63,774	36,866	23,321	997	4,736	59,260	36,840 (FB)	2,765,569	1,504,277

SOURCES: U.S. Census Office, *Statistics of the Population of the United States at the Tenth Census* (Washington, DC: Government Printing Office, 1883); *Report on the Population of the United States at the Eleventh Census: 1890* (Washington, DC: Government Printing Office, 1895); *Abstract of the Twelfth Census of the United States* (Washington, DC: Government Printing Office, 1904); *Thirteenth Census of the United States* (Washington, DC: Government Printing Office, 1913); *Fourteenth Census of the United States Taken in the Year 1920* (Washington, DC: Government Printing Office, 1923); *Fifteenth Census of the United States: 1930* (Washington, DC: Government Printing Office, 1933); *Sixteenth Census of the United States: 1940* (Washington, DC: Government Printing Office, 1943).

^a From 1890-1920, Mexicans were legally considered white. The values entered for these years for Los Angeles City reflect the numbers of foreign-born (FB) Mexicans, not the native born of Mexican origin. In 1930, the census classified Mexicans for the first time as a nonwhite group; the figure represents all people of Mexican origin, foreign and native born. In 1940, the figure once again reflects only foreign-born Mexicans.

^b In 1890, the census included Negro, Chinese, Japanese, and Indian in one category.

Mexicans, African Americans, Asians, and, finally, Native Americans.²⁵ As Claire Jean Kim has pointed out, the racial order is not a “single-scale hierarchy (A over B over C), but a field structured by at least two axes: that of superior/inferior and that of insider /foreigner. Blacks and whites constitute the major anchors (bottom and top respectively) of this order, and incoming immigrants and other groups get positioned relative to these two loci.”²⁶ In Los Angeles, Mexicans were positioned above the city’s Chinese and Japanese residents in many respects. For example, until the Depression, health officials extended Americanization programs to Mexicans.²⁷ Asians, meanwhile, remained labeled as outsiders, a threatening “yellow peril,” simultaneously inferior and alien.

Mexicans’ higher status relative to Asians, however, did not enhance their position vis-à-vis the city’s white population. They continued to be regarded as subordinate, foreign, and disease ridden. This racialized view had significant and direct consequences for public health in Los Angeles and equally important indirect effects on the city’s social structure. During the 1916 typhus epidemic and the 1924 plague, for instance, public health officials focused on “reforming” Mexicans, whom they “knew” to be naturally dirty and inherently too ignorant to rectify their unsanitary living conditions. Because medical discourse had the power to naturalize racial categories, it also had the effect of naturalizing societal inequalities. Rather than addressing the structural inequality that produced the unhealthy environments that hosted virulent diseases, public health departments consistently identified the root problem as racialized people who were in need of reform. By shaping racial categories and infusing them with meaning, health officials helped define racialized people’s place in society.

DEFINING THE MEANING OF *MEXICAN*

Throughout this book, I focus primarily on Mexicans because, by 1930, they were the largest immigrant group in Los Angeles. Beginning in the early 1900s and continuing through World War II, health officials in Los Angeles were more involved with Mexicans than with any other ethnic groups. Throughout the first half of the century, city and county health officials in Los Angeles tracked Mexican communities more consistently than they did the Chinese or Japanese populations (especially after a series of federal laws, culminating in the Immigration Act of 1924, severely restricted immigration from Asia).

Examining the connections between the experiences of the city's Chinese, Japanese, and Mexican residents demonstrates how immigrants were racialized in relation to one another, a process that often resulted in the institutionalization of a racial hierarchy. How the health officials came to view and treat Mexicans, however, was directly tied to their assumptions about and experiences with L.A.'s Asian residents. Indeed, from 1869 until 1920, the Los Angeles City Health Department used only two racial categories: "Chinese" and "the rest of the population."²⁸ As chapters 1 and 2 will make clear, in important ways, "Mexican" was a category constructed from what it was not: not white, not Chinese, not Japanese. Thus, in 1924, for example, what it meant to be "Mexican" in Los Angeles was determined in part by what it meant to be "Japanese." The relational nature of L.A.'s racial categories makes it imperative to include the public health experiences of the "Chinese" and "Japanese" in this study, even though the city and county health departments' policies and programs addressed these groups only intermittently.²⁹ A comparative examination of all three groups clarifies how racialization projects can differ in their intent, application, and impact, depending on the specific group targeted.³⁰

Despite Mexicans' centuries-long history in the Southwest, L.A.'s city and county departments of health overlooked them until the early 1900s. Health officials subscribed to the then-popular belief that Mexicans, like Native Americans, were a race that eventually would fade away.³¹ They essentially dismissed the city's Mexican residents as transients. By the early 1900s, however, officials realized that the number of Mexicans in Los Angeles was not diminishing but growing. Starting in the 1910s, Mexicans began to fill a manual labor void created by the exclusion of Asians. First, Chinese laborers were forced out, through the 1882 Chinese Exclusion Act (and repeated ten-year extensions of its provisions); later, Japanese workers faced a similar form of exclusion through the 1907–8 Gentlemen's Agreement and state laws passed in 1913 and 1920 restricting land ownership by "aliens."³² As the number of Mexicans in Los Angeles increased, so too did concerns about how this group's presence might affect the economic, social, and physical landscape of the city.³³ Until the 1930s, labor shortages shielded Mexicans from some of the worst discriminatory practices leveled against the city's Asian communities.

City and county health departments' reports and policies indicate that Mexican women occupied a central place in public health officials'

response to immigration. During the first decades of the twentieth century, L.A.'s resident Mexican population consisted mainly of single males. Mexican women immigrated in low numbers in the early twentieth century.³⁴ Nonetheless, an examination of institutional records and discourses reveals department-sponsored prenatal, birthing, and well-baby programs that targeted Mexican women and children. Public health officials viewed Mexicans and their “backward” culture as antithetical to their efforts to make Los Angeles a “modern” city. They launched Americanization programs in hopes that assimilation would eliminate Mexicans as an obstacle to progress. Mexican women and children may have seemed the best vehicles for achieving this goal. Officials considered Mexican women malleable and influential within their families, and they may have thought that infants, being too young to have absorbed their birth culture, stood a chance of being successfully Americanized.³⁵ In addition, they wished to stem the threat of unwanted births and alleged bad parenting.³⁶ Thus, although Mexican women were considered “*socially* peripheral” and represented only a small portion of the population, they were “*symbolically* central” because, unless they could be won over, Mexicans as a group would continue to threaten health officials’ construction of Los Angeles as a bastion of health.³⁷

In the early decades of the twentieth century, health officials’ efforts to Americanize Mexicans sometimes consisted of little more than rhetoric. Still, even half-hearted assimilation programs indicated a possibility that this group, although not classified as white, might be capable of blending into American culture. No similar possibilities existed for Asians. Neither city nor county departments developed any significant health care programs for the Japanese and Chinese communities. Instead, members of these groups, recognizing that meeting institutionally defined standards for health and cleanliness was a precondition for social membership, often used their own funds to hire public health nurses to work with their communities.

When the U.S. economy collapsed and the Great Depression began, attitudes toward Mexicans shifted rapidly. In Los Angeles, with jobs scarce, white residents and government agencies increasingly regarded Mexicans as an economic burden, and the idea that Mexicans’ social inferiority arose from their biological inferiority returned. Buttressed by ideologically defined medical standards, the inferiority of Mexicans soon became “indisputable.” Assimilation programs were replaced with repatriation drives. Now public health discourses—especially the notions that Mexicans were disease carriers and an exceptionally fertile people—were

mobilized to legitimize the removal of the same population that only a few years earlier had been deemed an essential source of cheap labor.

Beginning in 1930, many of the changes in health departments' programs and discourses with respect to Mexicans involved applying assumptions, terms, and actions once reserved for the city's Chinese and Japanese residents to this population. Now it was Mexicans who were deemed "aliens" and targeted for deportation. Thus, in the course of less than fifty years, three entirely different populations were assigned the lowest position in L.A.'s racial hierarchy: a powerful example of how rapidly racism can be repackaged, re-energized, and relegitimized.

CHALLENGING RACIALIZATION: RESPONSES TO PUBLIC HEALTH DISCOURSES

Public health policies and discourse played an important role in shaping and promoting images of Asians and Mexicans as non-normative. Even today, stereotypes of the overly fertile Mexican woman, the unclean Mexican man, the wily Asian vendor, and the germ-spreading Chinese launderer persist.³⁸ Yet analyses of Chinese launderers' protests over restrictive ordinances and Mexicans' appeals to the Los Angeles City Council for public housing, for example, reveal that from the start these groups were not passive targets of discrimination. They appropriated legal and medical discourses to challenge dominant assumptions, made gains for their communities, and participated in defining the racial order.³⁹ As the chapters that follow will show, Chinese, Japanese, and Mexicans fought back in court, petitioned the city council, stalled the enforcement of city legislation, resisted through refusals to attend health clinics, utilized alternative health practices, refused to let housing inspectors into their homes, and wrote letters to state and national officials protesting unfair treatment. Sometimes they succeeded in having their demands met. Other times they did not. At the very least, they brought their concerns into the public forum.

CENTRAL THEMES AND ORGANIZATION OF THE BOOK

In the chapters that follow, I examine the role of public health as a key site of racialization by tracing several interrelated themes. Chapters 1, 2, and 3 highlight the importance of looking at racialization from a comparative perspective. The book as a whole is concerned primarily with Mexicans, but examining the experiences of nonwhite groups in

Los Angeles in relation to one another, as well as in relation to the dominant white population, reveals the ways in which racial logic assumed different forms during the same historical moment. The evidence these chapters provide regarding public health's role in the development of a regional racial lexicon also contributes to the main theme of chapter 4, namely, how powerful the idea of scientific objectivity became when it was harnessed to the institution of public health. Chapter 5 demonstrates how Mexican American activists appropriated the language of public health to make civil rights demands. Cumulatively, all five chapters confirm not only that race is best understood as a subjective, social construction but also that racialization is a dynamic, ongoing process.

In chapter 1, I argue that as a fledgling institution, public health in Los Angeles had a dual mission: promoting and preserving the biological health of the citizens *and* promoting and preserving the economic and cultural health of the city. Public health officials' commitment to making Los Angeles a "modern" (meaning sanitary and healthful) metropolis influenced the way they perceived and treated the city's nonwhite residents. The chapter assesses some of these booster narratives, focusing on public health departments' prominent role in projecting an image of Los Angeles as a healthy "Eden" where people lived carefree lives, surrounded by economic prosperity. Health officials often seemed just as concerned as the chamber of commerce that this idyllic image of Los Angeles reach its intended audience (white, financially secure Easterners and Midwesterners) without being marred by any reference to the presence of ethnic communities in the city.

Chapter 1 shows that public health discourses (often embedded in media narratives and newspaper photographs, as well as in policies and guidelines) characterized the Chinese in Los Angeles as dirty and unhygienic, disease carriers who, as launderers and produce vendors, threatened the health of citizens. City officials, including members of the city council, then used these stereotypes to justify developing legislation that undermined Chinese entrepreneurs' economic viability. By tracing the early interactions between Chinese communities and health officials, I demonstrate that health officials, far from embodying "scientific objectivity," had a history of racializing space and immigrant groups before Mexicans made their mark on the urban landscape beginning in the 1910s. The same public health discourses—and often the same public health officials as well—that racialized the Chinese later racialized Mexicans.

Chapter 2 focuses on the formative years of the Los Angeles County Health Department, when health officials nationwide first began to take stock of the country's large-scale health issues. I argue that as one of the early and primary contacts with Mexican and Japanese residents, public health officials helped establish a regional racial lexicon that categorized and ranked county residents as white, Mexican, Japanese, or other. The health department's records, including correspondence, testify to the far-reaching influence that county officials had in shaping what local, state, and national leaders, as well as the general public, knew about ethnic communities in Los Angeles.

Chapter 2's analysis of the county's response in 1916 to an outbreak of typhus fever in the Mexican labor camps run by the railroad companies reveals an important source of the stereotype of Mexicans as dirty and disease ridden. Under the guise of protecting the health of all residents, officials gained the authority to closely inspect the bodies as well as the living quarters of Mexican railroad workers and their families, force them to undergo delousing "baths," and quarantine anyone even *suspected* of being infected by typhus.

The 1920s were an important period of growth for the Los Angeles County Health Department. In chapter 3, I analyze the public health policies of the decade and trace the increase in services to Mexicans. The department introduced a system of health care centers, placing the largest center in Belvedere, a predominantly Mexican area. The chapter also examines county health programs directed at women and children (such as well-baby clinics) and these programs' underlying tenets. The department used well-baby clinics to intensify the programs it directed at Mexican mothers. Tropes of Americanization and citizenship permeated the program lessons directed at Mexican mothers. Health officials preached that embracing the benefits of a hygienic and healthy lifestyle was the first step on the road to assimilation—for Mexicans. No such possibility was extended to the Japanese, then the county's second-largest ethnic group. Because the racially coded language of public health constructed the Japanese as a threat to white Americans, this group was viewed as permanently ineligible for either legal or social participation in the community at large.

I contrast these proactive steps toward improving Mexican communities with the treatment of Japanese communities, showing how the Japanese continued to be marginalized. Local politicians, connecting Japanese birth rates to discussions of "yellow peril," fanned fears and

resulted in calls from the general (white) public for increased immigration restrictions.

Chapter 4 examines city and county public health policies directed at Mexicans during the Depression. The health departments played a key role in the repatriation programs that gained popularity as the economy continued to worsen. Public health discourses appropriated by various government officials legitimated local efforts to force the city's Mexican residents to return to Mexico. The Americanization efforts of the 1920s were abandoned as health officials in the 1930s adopted racial assumptions emphasizing more immutable biological traits that rendered Mexicans unassimilable. Chapter 4 also assesses changes in attitudes and actions regarding the Chinese. Whereas in the 1910s zoning laws had circumscribed the location of Chinese laundries and produce markets, in the 1930s citizens used public health ordinances to drive Chinese launderers out of business.

Chapter 5 recounts Mexican Americans' demands in the late 1930s for better health and housing conditions in Los Angeles. Despite twenty years of county health programs and services, Mexicans' health and housing conditions languished in comparison to those of whites. In their appeals for change, Mexican Americans described the same dismal conditions in their neighborhoods that health inspectors had reported for decades. They, however, rejected inspectors' claims that they were to blame for their poor living conditions. Turning the tables, they indicted the city and county for perpetuating these conditions and for undercutting Mexican American communities' chances to thrive.

Encouraged by newly created New Deal programs, Mexican Americans, both as individuals and as members of labor and civil rights organizations, demanded that the city build public housing. This quest for better housing, which Mexican Americans saw as a way to improve overall health conditions in their communities, also signaled a major demographic shift. Mexican communities no longer consisted primarily of sojourners or seasonal laborers, typically single men who rented rooms while they were working in the area and who returned to Mexico for part of the year. In contrast to the 1910s, when the first waves of Mexican immigrants had arrived, the Mexican population in Los Angeles in the 1930s included a large proportion of family units and second-generation Mexican Americans.⁴⁰ Permanent housing, and single-family dwellings in particular, had become essential. Mexican Americans' demands for public housing marked their desire to be recognized as citizens, deserving of the same rights as all other Americans.