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Salinas' Health Struggles as Manifestations of Historical Processes: A Report on the History of Health of Salinas Residents

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THE HISTORY OF THE ALISAL NEIGHBORHOOD

It is unjust that residents of Salinas, California, especially in the Alisal neighborhood, today have had to deal with incredibly high rates of chronic disease, pesticide-induced illness, lack of health insurance, and oftentimes insurmountable language barriers due to antiquated policies from previous centuries. The economic turmoil that is attributable to decades of unjust policies have clearly led to drastic insufficiencies in the forms of care most vital to residents. This is apparent in the rates of disease to even the average life expectancy. We will explain how the current, rampant health inequalities exist today by looking at how historical processes have paved the way for these inequalities.

The district of Alisal, before its incorporation into the city of Salinas on the Central Coast of California, began as a home for Spanish, Chinese, Filipino, and Mexican immigrants and their descendants. Its earliest history dates back to the founding of the first Alisal post office in 1866. The novel railroad invention in 1868 led to an increased number of Eastern and Midwestern immigrants (from states such as Ohio, Illinois, and Missouri) moving to Alisal. From its genesis, Alisal was home to a majority-farmworker population, especially a large number of Chinese immigrants at the time who converted vast acres of land into farming areas for potatoes, wheat, beets, and barley. The Chinese Exclusion Act of 1882 put a temporary pause on Chinese immigration, leading to a waning Asian demographic in Salinas and Alisal that allowed other groups to inhabit the area.

Salinas would remain a generally modest farming town until the Great Depression and World War II. During the former, Alisal quickly began to house hundreds of Dust Bowl migrants from states such as Arkansas, Oklahoma, and Texas. The well-known Salinas-born author John Steinbeck, in describing the state of the city during the Great Depression, wrote:

> ...Our highways swarm with the migrant workers, that shifting group of nomadic, poverty-stricken harvesters driven by hunger and

> the threat of hunger from crop to crop… But it is California which has and needs the majority of these new gypsies… There are at least 150,000 homeless migrants wandering up and down the state.
> (San Francisco News)

At the time, the racial demographic was mainly white, aided by the movement of these "gypsies," or more commonly known today as the Dust Bowl Okies. Besides being a majority-Caucasian town at the time, the minority population of Mexican immigrants, Chicanos, Braceros, and Filipinos was steadily on the rise in Salinas and specifically Alisal. In 1942, The Salinas Rodeo Grounds became a temporary concentration camp for almost four thousand Japanese-Americans as ordered by President Franklin Roosevelt in response to the Pearl Harbor bombings. The population steadily rose during the 40s and 50s, with bigger booms during the latter half of the twentieth century.

One of the most important and well-known moments in Salinas's history, which garnered national attention as well as a more animated farmworker movement, came with the Salinas Lettuce Strike of 1934. Due to the United States acquiring the Philippines in the late 1890s, as a result of the Spanish-American War, a large population of Filipino migrants made its way to California, to work in canneries, farms, and factories all along the West Coast. Due to the unfair treatment of Filipino laborers, who suffered heavy discrimination, low pay rates, and even the prohibition of Filipino women in the workforce, they formed the Filipino Labor Union in Salinas in 1933.

It is important to note that before the early sixties, Alisal was classified as an unincorporated segment of Monterey County. It wasn't until 1963 that Alisal was annexed and officially recognized as a component of Salinas, almost doubling the population. Following a special election to the Alisal inhabitants (who voted in favor of annexation), the issue was taken to Alisal lawmakers who then agreed to accept annexation into Salinas, becoming an official part of southern Monterey County. During this time, Alisal had been growing as an urban retail area, grossing around nine million dollars in annual retail sales alone, making the prospect of its incorporation a benefit to Salinas. Yet, many Alisal residents had already been trying to gain popular support for annexation long before the sixties; in 1949, the earliest date to record, 43.9% of Alisal residents voted for Alisal's incorporation. Annexation efforts were largely ignored from then until 1954, which turned to a vital turning point for Salinas. That year, President Dwight D. Eisenhower passed the Federal Housing Act, an amendment to the earlier National Housing Act of 1934 by Franklin Roosevelt which will be covered later, which provided money to municipalities for housing units. This act distributed money preferentially

to those cities which had imposed slum clearance on their area, which the process of removing inhabitants from
low-income communities to impose demolition and renovation of entire neighborhoods.

There was a significant demographic switch in Alisal that occurred in the 1970s. Prior to the decade, Alisal's population consisted of white, working-class families. The town's most prominent landowners of the time, the Bardin, Sanborn, and Williams Family, are now the names for the largest streets in Alisal. However this time period marked a change towards Alisal as seen today; there was a large migration of Mexican immigrants, due to the proportional rise in population growth and unemployment rates in Mexico. Due to the poor economic state of the country at the time, many Mexican officials encouraged this migration, despite many anti-immigration sentiments by the U.S. government. Many undocumented individuals entered in mass waves to the state of California, and some claimed Salinas and Alisal as their new home, drastically swaying the racial demographic of the town. It is important to note, however, that Hispanics were not counted as a separate race until the 1980 census. Before that, they were considered white. During the 60s and 70s, Alisal showed much promise as a place to settle and raise families: the city's economic state was steadily climbing, with a new working class, revitalized businesses, and a growing size and numbers. Yet today, Alisal is considered one of the most dangerous parts of Monterey County: this significant characteristic of East Salinas did not emerge until the latter half of the 20th century. This rise in crime could have been attributed to the establishment of the nearby Soledad prison in the 50s and 60s, or the farmworker movement of the 70s. The crime was only exacerbated by the rise of gangs in the 90s, the most prominent of them being the Norteños and the Nuestra Familia. The root cause of the increase in both white-collar and violent crime in Salinas was the rise in unemployment and subsequent low tax bases since the 1980s, as Alisal's once-booming economy began to level off. According to Stanford historian Ana Raquel Minian, many Mexican migrants were labeled as criminals upon their arrival to the United States, despite oftentimes being victims of crimes such as theft and unpaid labor.

Many efforts have been made since the turn of the century in terms of Alisal's improvement. Community-led organizations and initiatives such as Building Healthy Communities and Ciclovía have been working to improve the well-being of the town. In 2015, it was reported that violent crime in Alisal had decreased by 75% since the 20th century, as well as more students pursuing a higher education from county high schools.

The aforementioned Federal Housing Act of 1954 was an amendment to the similarly titled 1934 National Housing Act by President Franklin Roosevelt. This act was passed with the intent to reduce

foreclosure rates and increase housing/mortgage accessibility during the Great Depression as a part of the New Deal. This act also created the Federal Housing Administration under the national Department of Housing and Urban Development, its main purpose being to "provide mortgage insurance on loans made by FHA-approved lenders", yet the administration also created specific mortgage underwriting policies which have drastically affected all minority races even today. Through a scrutinous policy known as redlining, the FHA through the Federal Home Loan Bank Board published reviews titled "Neighborhood Standards as They Affect Investment Risk" which marked maps of cities all around the country as "safe" zones or "hazardous" zones, which were aptly designated with the color red. These characterizations were based purely off the presence of minority races, denying mortgage loans to any individuals in the red zones. Despite being outlawed in 1968 because of The Fair Housing Act, the results of such segregationist practices are still witnessed today, as adult earnings for low-income individuals living in "red" areas have been over ten thousand dollars less than low-income individuals from "safe," or green areas. Salinas and Alisal were subject to the same inequalities that came along with redlining. In the 1930's, Alisal specifically was composed of large numbers of Filipino, Chinese, and Hispanic minorities, leading to the FHA designating the neighborhood as hazardous. Despite being a mainly Asian population at the time, Alisal's redlining has now come to negatively affect the predominantly Hispanic communities, not only in Alisal but in the greater Salinas territory as well. Currently, the City of Monterey County has been working on constructing an accessible online map of the historic redlining in the county, officially confirming the hypothesis that redlining had occurred within Salinas. This redlining was unequivocally intended to affect housing prices and homeownership, as continuously witnessed today: average house prices are around $400,000, and monthly rent fees average about $2,000.

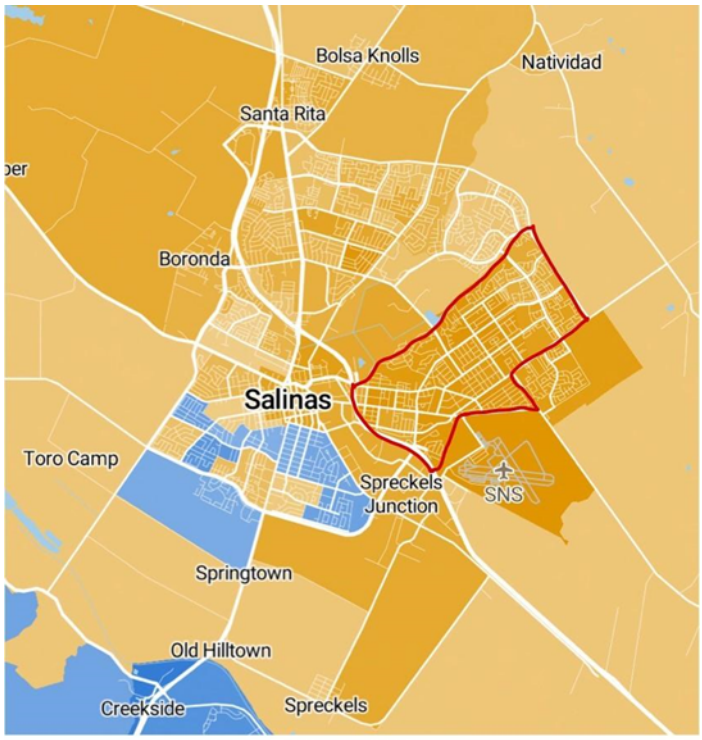
It is important to establish the current and historical context of Salinas before proceeding with its public health challenges. There is a notable correlation between the various laws imposed on the town and the quality of life of its residents, and an in-depth analysis of Salinas's background with its ethnic minorities is required in order to understand the less-than-optimal public health standards of the community.

HEALTH INEQUALITIES IN ALISAL

Alisal has been marked with many inequalities in terms of healthcare access and treatment. Due to the racially segregationist policies of redlining, Alisal has been subjected to a shortage of affordable housing within their communities, with an average house in the neighborhood retailing at around $400,000. Lack of affordable housing leads to

overcrowding and many health/safety concerns such as "respiratory and cardiovascular diseases from indoor air pollution; illness and death from temperature extremes; communicable diseases spread because of poor living conditions, and risk of home injuries" (County of Monterey Health Department, 2018) The Alisal neighborhood has one of the lowest life expectancies in all of Monterey County, at approximately 75 years of age, compared to the 82-year life expectancy of Monterey County as a whole. With over five percent of housing units being designated as "overcrowded," meaning the percent of owner-occupied housing units with more than 1.5 occupants per room, there are parallels with the high lead exposure in housing and as much as 22% of Alisal residents uninsured for healthcare.

The health inequalities that persist in Alisal cannot be addressed without addressing its racial and ethnic demographics. First, the city of Salinas alone has a Hispanic or Latino population of 79% (2020 Census). In Alisal specifically, this figure may very well be even higher, although reliable figures are not available. The Pew Research Center recently came out with an article detailing the healthcare implications for Hispanic Americans (Funk and Lopez, 2022). They state that "Language and cultural barriers, as well as factors such as higher levels of poverty, particularly among recent Hispanic immigrants, are among the social and economic dynamics that contribute to disparate health outcomes for Hispanic Americans" (Funk and Lopez, 2022). In Salinas, we see firsthand the challenges that many Hispanic people face in spaces where bilingual or Spanish-language resources are not prevalent, one of the most common being healthcare spaces. According to the 2020 U.S. Census, over 64% of Salinas residents speak Spanish, making it the most spoken language city-wide. This presents a notable challenge amongst the community in terms of accessing easily-understandable healthcare resources that are oftentimes presented in English. According to a 2019 study by Salinas healthcare professionals, as much as 84% of the 167 surveyed Hispanic adults in Central California were unable to recognize the English stroke recognition acronym "F.A.S.T.", despite Hispanic-Americans having "higher incidence of stroke, worse outcomes after stroke, and receive less stroke treatment than non-Latino/Hispanic whites" (Science Direct, 2019). The majority of education, resources, and support for patients in the community is presented primarily in English, and whether parents require their children to translate, or use their own limited English, this can be a deterrent for many Hispanic adults and families to seek (specifically preventative) healthcare. Additionally, the documented status for many Hispanic individuals and families, many of whom have migrated to Salinas from Mexico, Honduras, El Salvador, Guatemala, etc. fear that if they were to seek medical care, their documented status may become known, which could lead to deportation. Founded or not, these fears are deterrents.



Map 1 - This map illustrates the racial demographics of Salinas. The yellow represents a larger Hispanic population, and the blue a larger white population. The Alisal area is outlined in red.

The lack of accessible healthcare has been especially apparent during the ongoing COVID-19 pandemic. Relative to white persons across the U.S., Hispanic or Latino persons were 1.5 times more likely to contract COVID-19, 2 times more likely to be hospitalized after contracting COVID-19, and tragically 1.8 times more likely to die from COVID-19 (Centers for Disease Control and Prevention, 2022). There are many factors that help explain these statistics, but the racial relation to health is undeniable. One possible explanation for the increased likelihood of contracting COVID-19 for the residents of Salinas is the density within housing units that many Hispanic families endure. Because of the lack of affordable housing, many Hispanic families are forced to live in apartments designed for four to five people with one, two, or even more families. This close proximity to a larger population could explain the more widespread rate of contraction of COVID-19. As for the hospitalization and deaths, the lack of accessibility to a healthy lifestyle characterized by long, strenuous work and food deserts before contracting and the lack of medical care once infected result in the depressing disparities.

Similarly, Salinas is known for being one of the largest agricultural hotspots in the country—hence the nickname “The Salad Bowl of the

World"—and has also suffered many negative effects from the large-scale industry of the area. According to the local news source Monterey County Today, Salinas Valley suffers from extremely high rates of pesticide-induced illnesses, the 2nd highest in the county. The frequent usage of fumigant spray pesticides led to 104 exposure cases in 2017. The California Institute of Rural Studies even reported that "agricultural workers in Monterey County are three times more likely to contract COVID-19 than workers in other industries" (KALW Public Media, 2020). This public health issue not only affects the over 11,000 fieldworkers of Salinas (USDA Census of Farmworkers), but the larger population as well: a 2018 study revealed that pesticide exposure was detected in notable quantities in wristbands worn by Salinas-native Latina teenagers. Another study from 2019 concluded that high levels of a type of pesticide known as acephate were associated with increased cases of testicular germ cell tumors amongst Latino men only, and a specific study within the Salinas Valley found acephate, which is considered a possible human carcinogen, in around 3.1% of urine samples of pregnant women—Latinas making up the majority of the study sample (Science Direct, 2021). It is likely that without necessary pesticide control laws and more refined public safety measures, these statistics will not drastically change in the years to come.

It is important to note the lack of statistics on the health inequalities of Alisal and Salinas. No further extensive research projects or information have been collected regarding health insurance access, life expectancy, and access to healthcare within the city. The majority of the statistical data extracted for this research has been thanks to websites such as PolicyMap.com and Opendatanetwork.com.

It is clear that throughout various scientific and social studies, statistics, and testimonies like the one provided below, that the Hispanic community in Monterey County disproportionately suffers from strikingly low accessibility to sufficient forms of healthcare. The majority of the city's struggles emerge from the decades-old redlining practices imposed by the federal government on Salinas, deeming it less worthy for financial support and oversight due to its racial composition.

To better understand the effects of healthcare access inequalities and the experiences of Hispanic patient care in Salinas, provided is a transcript of an interview with Alisal's Clínica De Salud Del Valle free-clinic Dr. Oguchi Nkwocha MD., MSc. regarding medical access amongst Salinas residents. We felt it was important that we have a personal account with someone who was close to the topics we are discussing. Here's the transcript:

Interviewer: Hi Dr. Nkwocha, I hope you are doing well. With my first question, I was hoping you could explain a little bit about your work at Clínica [De Salud Del Valle] and what your job entails.

Nkwocha: I am a family medicine doctor by profession and I went to my residency at the University of Utah. As soon as I finished residency I came to this part, I came to the Seaside, Monterey area, that's where I started. So during one of my rotations, I found the patient population [to be] more like what I trained at Ventura [California], you know, mostly people in Ventura did not have insurance or were covered by insurance like Medicaid, Mediall-type patients. And so, that's why I decided to stay in the area. And I started around that side of the [Monterey] Peninsula, and, um, you know, ten years later or something like that, I was now at the south Salinas side, of course at Natividad Medical Center as faculty for a while, working with the residents and also working with urgent care centers in Salinas. And then I finally came to Clínica; that was eleven years ago. I started off— my office is in Castroville, so that's where I started off, and, uh, after a few years, I [became] medical director and from there, I got the job of chief medical officer which I have had for going on five years now. As chief medical officer so I have two responsibilities, uh, main responsibilities: one to provide direct care to patients, so I do that 40% of the time. I think 20% of the time is industry standards, so one day a week. But I chose two days a week [for direct patient care] because I really like to work with patients.
The rest of the time I do administrative work, so my office is wherever the headquarters, the administrative headquarters, are. If you are aware, we are moving our headquarters from Airport Blvd to South Main [Street]. So that's where I am from on a day-to-day basis. When I'm in Clínica, I engage with patients and staff. Everything is around the patient, taking care of their needs, making sure we do that in as timely a fashion but, uh, as completely as possible. And then, I go till it's over, whenever it's over. We usually start at 8 o'clock, and usually, we go over time, uh, cause things don't just end at that 5 o'clock. So my administrative duties involve anything that has to do with the clinical aspects of patient care, and also the managerial and sometimes financial aspects we're at the head of, uh, the executive member of the organization. It's not just about the patient and their medication, but uh, now we have to think about the cause to prevent the service, to make sure that the company stays afloat. Make sure that the providers are seeing all their needs, besides the pills and the patient, you know.

Interviewer: Of course, thank you. My next question was in your opinion, what is the most difficult part of your job?

Nkwocha: That's a good question. As far as the patients are concerned, I love the patients so much, I love working with them so much, so it may be difficult, but not difficult in that sense. It's more of a challenge, you know, getting what they need done. It would probably be administration, also the way all administrations are structured, um, sometimes it's how long things

take to get done, versu when you are in the clinic, and you have five or ten minutes to make a decision which could mean life or death. You have to act— you know, this is our plan, for better or for worse. Mostly for better, you know. But yes, administrative things take a while: you have to go through the process, procedures, so that is what I would say is the most difficult. And also the shock of not being the prime decision maker: you know, in the office, it's in between me and the patient and we arrive with a plan, I give them conclusions and a plan, and we talk about [whether] they accept it or not. They say, "let me discuss it with my family" and I say you know that's fine, at least that's something, because they are the patients, the stakeholders, so things have to go through them sometimes, and that takes a while, so that's what I would consider the most difficult.

Interviewer: Right, right. To go off of that last point about having patients consulting their families and taking time for decisions, do you believe that your patients are informed enough to make decisions on their healthcare? When they should seek help, what treatment they should pursue, why check-ups are so important for example?

Nkwocha: Well, I'm not sure that it's a matter of— because of course I'm a patient myself, like maybe I get sick myself or something like that— what I find is that the first response and all the doctor things go away, well now I am the patient and I have to think about myself and what to do about myself and you know, I say "I'm a doctor, you know, I can do this and I can do that." Yes and no. I think that the patient is a human being and they have it in them to make good decisions. That decision may be good for them, but overall, they need to participate, they… I trust their decision, because that's what they're there for, given the amount of knowledge they know, or they have. If that doesn't mean that, uh, in the overall scheme of things that medically it may not be the best decision medically, so it's not the best decision medically or vice versa. There's that room there, and also being in a position of authority where you are writing orders and "go take this, go take that", it kind of humbles you, you know, because if you make an error, you know, that's on you. On the other hand, if you are working with a patient and you're doing this and they're bringing an opinion, so you talk to them, and say "okay well, you may think like this, but this is what's medically needed" and they say "well, I'm not going to do that" and you say, "okay these are the consequences as long as you are willing to take on the consequences". For example with the vaccines, the COVID vaccine, that's a prime example of that. I believe in the right and ability of any one person to make their decision, okay, and they have that right. I also think that a person may not have all the information, uh, professional information, but by that same token, the doctor doesn't have all the information, the

social information, the social determinants of health, they don't have that. They're just looking at strictly the medical part: "I can prescribe this medicine to you," but you haven't talked about what they can actually afford, if you have a certain insurance and that kind of stuff, and I think too if they can see [the office] that month, you know, so I don't know that.

Interviewer: Thank you. My next question is— and you can give a rough estimate— what are the approximate numbers for your patients that are insured for healthcare versus those you are uninsured, or those on Medicare or Medi-Cal?

Nkwocha.: Okay. So we are around 6% on Medicare, now about 7% insured by private insurance, and 12% [with] no insurance at all, self-paid, and the rest has Medi-Cal. So that's about 75% that have Medi-Cal.

Interviewer: Thank you. I wanted to ask, since Clinica provides a variety of services to the patients, what is the most common service that patients come in for, like preventative medicine, or treatment for illness?

Nkwocha: For me, it varies depending on the provider. Since we are primary-care providers, and we see the same population, it's not like, say, the emergency room or urgent care where people come for different things. What we find is that a huge number of patients, especially the older ones, have some of the chronic, so-called chronic conditions: hypertension, diabetes, um, high cholesterol, you know, cardiac diseases, or something like that. So, most of them have that, and we need to be seeing them on a regular basis, um, it's because it flares up— if we do not see them on a regular basis, it's likely to get worse, so for me, when I was much younger, it was different because I was also doing prenatal care and deliveries, somewhere else with my initial patients. When I came over to Clinica I didn't do deliveries, I just provided prenatal care. At that point, I still had a lot of young people in my care, and most young people would come in for acute things like, um, sore throat, bronchitis, and now I'm with the older people, who come in for chronic diseases.

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