International Health, the Early Cold War and Latin America

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Abstract. This article offers a panoramic vision of the development of international health in Latin America during the late 1940s and the 1950s, when a series of bilateral and multilateral institutions, such as the World Health Organization and UNICEF, were founded and reshaped. The language, policies, and activities of these new institutional actors were heavily influenced by the context of the early Cold War between the era’s superpowers: the United States and the Soviet Union. Vertical campaigns against yaws and malaria—implemented under the leadership of Fred L. Soper, director of the Pan American Sanitary Bureau—symbolized international health’s technical orientation, as well as its contribution to the modernization of the countries of the region. The Cold War period has received little attention by historians of medicine, though it bears certain similarities to historiographical discussions of the relationship between tropical medicine and imperialism in the early 20th century.

Résumé. Cet article présente une vision panoramique du développement de la santé internationale en Amérique latine pendant les fins des années 1940 et les années 1950, quand une série d’institutions bilatérales et multilatéraux, tels que l’organisation mondiale de la santé et l’UNICEF, ont été fondés et remodelés. La langue, les politiques et les activités de ces nouveaux acteurs institutionnels ont été fortement influencées par le contexte de la guerre froide entre les superpuissances de l’époque: les États-Unis et l’Union Soviétique. Les campagnes verticales contre le yaws et la malaria, mises en application sous la direction de Fred L. Soper, directeur du Bureau sanitaire-pan américain, ont symbolisé l’orientation technique de la santé internationale Bureau-symbolisée, et contribué à la modernisation des pays de la région. L’époque de la Guerre Froide a suscité
The purpose of this paper is to examine the development of international health in Latin America in the years before and after World War II; this subject has received little attention from historians of medicine, including Latin American scholars. Studies on medicine as a tool of empire, which began to appear in the late 1980s, concentrated on the turn of the 20th century. A larger temporal perspective that takes us well into the 20th century will help to deepen understanding of the changes and continuities in international health and its impact in an important region of the world. This goal of this paper is to contribute to a panoramic perspective on the trends of international health in the Americas during the second half of the 20th century, emphasizing the role played by the United States, and analyzing the interaction of international health agencies during the early Cold War (roughly mid-1940s until late 1950s). This article will not address the Latin American responses to metropolitan policies though it is a subject that deserves a great deal of attention.

After World War II international health was validated as an important tool of foreign and economic policy by a web of multilateral, bilateral, and philanthropic institutions. New technical disease-oriented interventions and administrative schemes funded by Western industrial societies extended to rural areas of many developing countries in an effort to incorporate more people and regions to a market economy. This approach contrasted with previous international health activities which usually were concentrated in urban areas or economic enclaves directly linked to exports.

These developments also helped characterize the early Cold War. Historical studies on this period usually have concentrated on the military,
diplomatic and political confrontations between the USSR and the US in Greece, Turkey, Iran, Germany, and Korea (among other settings), and the American support for loyal anticommunist military dictators in Latin America. However, the scientific dimensions of this period—beyond the technology race between the US and the Soviet Union and the American anxieties created by the launching of the Soviet Satellite Sputnik in 1957—remain understudied. The growing importance of American hegemony in medical and scientific programs overseas took place simultaneous to new modernization proposals for developing countries and to the organization and use of a web of bilateral and multilateral agencies. In order to understand the emergence of this intertwined network of health and politics during the 1940s and 1950s it is important to analyze medical developments of the interwar period and the early 20th century.

THE EMERGENCE OF INTERNATIONAL HEALTH IN THE AMERICAS IN THE EARLY 20TH CENTURY

The origins of international health activities in Latin America can be traced to the creation in 1902 of the International Sanitary Organization of the American Republics (renamed the Pan American Sanitary Bureau in 1920, hereafter PASB, and in 1959 as the Pan American Health Organization, PAHO), and to the Rockefeller Foundation (RF), established in 1913. The PASB was created as a unit of the Pan American Union, a commercial office of the US government that co-ordinated efforts with Latin American governments and with diplomats living in Washington, D.C. Until the 1940s, the PASB concentrated on the establishment of quarantine regulations, health codes, smallpox vaccination, and campaigns against bubonic plague in Latin American ports and cities.

As a number of studies have demonstrated, between 1913 and 1939 the International Health Division (IHD) of the RF was by far the most important health agency or philanthropy institution working in Latin American public health. Campaigns against hookworm, yellow fever and malaria, support for research in the life sciences, and reform of medical education were the main activities of the Foundation in the region. Most PASB and RF activities focused on the protection of maritime commerce, and the safety of ports, cities and economic areas related to world trade, such as plantations and mines.

In addition to the PASB and the RF, a number of little-studied American institutions were involved in health activities in the Americas, including American Universities, the military and the medical departments of American industries operating in Latin America. One significant conglomerate was the United Fruit Company (UFC) which exported bananas from Central America, the Caribbean, and Colombia and established a network of hospitals, laboratories, and sanitation activities beginning in
A few years later the President of UFC recalled his pragmatic motivations for organizing a health service overseas: “We early learned that labourers must be kept in good health if our plantation were to be systematically worked…. There was no philanthropy in the fact that it was necessary to build up a medical and sanitary service that cost thousands of dollars annually. It was simply good business.” However, with the depression of the 1930s the activities of medical departments of industries operating abroad as well as other international health activities were sustained with difficulties. Some businesses operating in the region reduced their losses by cutting the budget of their medical operations overseas.

In the early 20th century, various academic institutions devoted to tropical medicine organized expeditions to Latin America for scientific purposes but also in a search for a niche in the US’s complex and rapidly growing higher educational system. Various universities also secured contributions from the UFC and the RF. Most prominent were the schools of tropical medicine of Tulane, created in 1912, and of Puerto Rico, created in association with Columbia University in the mid-1920s. In addition, short-lived schools of tropical medicine were established at Harvard University in 1913 (by medical scientist Richard Strong) and at the University of California of San Francisco in the late 1920s, as the Pacific Institute of Tropical Medicine. The medical leaders of these institutions advanced their careers by providing scientific advice to American transportation, commercial, mining, and agricultural companies working with or in Latin America, and by concentrating on certain unsolved research and disease control challenges, competing with European specialists, and occasionally with Latin American scientists. The competition with European researchers was important for Americans because since the 19th century the British and other European empires used their colonies in Africa and Asia to study the mode of transmission and identify the best tools of control of malaria, filariasis, and other infectious diseases that threatened colonizers or commerce. By the early 20th century, Americans realized that they could have their own testing ground in the Americas for the study of the region’s tropical diseases such as yellow fever, Chagas disease (identified in Brazil in 1907), and Carrion’s Disease (identified in the Andes in 1885). For some of these diseases, such as yellow fever, there was a race to identify the associated microorganism or to develop a vaccine. RF scientists devoted a great deal of attention to this scientific competition. In addition, American professional and scientific societies and academic journals maintained an interest in health in Latin America such as the Southern Medical Journal, established in 1908, and the American Journal of Tropical Medicine, founded in 1921. The latter frequently included summaries in Spanish at the end of articles. Since the late 19th century the American Public Health Association also included among its leading members distinguished Latin Americans such as Mexican Eduardo Liceaga and Cuban Carlos Finlay.
and even held two of its annual meetings in Mexico City. These professional interests accelerated in the 1940s: membership in the American Society of Tropical Medicine grew from 520 in 1940 to 952 in 1943; the journal *Mosquito News*, began to appear in 1941; and *The Journal of the National Malaria Society* was published between 1942 and 1951.

Finally, another institution that has yet to receive adequate historical attention was the US Army medical department. During a period of US imperialist expansion and dollar diplomacy, the department contributed to the elimination of yellow fever from Havana in 1901 (after the “Spanish-American War”), to the control of malaria and yellow fever starting in the 1900s in Panama (that made possible the completion of the Panama Canal by 1914) and to the fight against a number of infectious diseases that US marines encountered in the Caribbean islands they occupied (such as yaws in Haiti). Finally, a number of US religious organizations played an important but localized medical role in Latin America, such as the work of the Adventist Church in remote regions of the Andes and the Amazon as well as that of other missionary groups.

European scientific and health organizations active in the interwar period, such as the *Office International d’Hygiène Publique* (opened in Paris in 1907), and the League of Nations Health Division (created in 1920), had among their members some prominent Latin Americans, such as Carlos Chagas. Nevertheless they played a less active role in Latin American public health. Starting in 1908, the *Bulletin de la Société de Pathologie Exotique* of Paris published some important articles on Latin America, and the Institut Pasteur had an outpost in Rio de Janeiro for several years. Another respected interwar European agency, with some officers in situ and important publications but few resources, were national Red Cross Societies coordinated by the League of Red Cross Societies created in Geneva in 1919. Notwithstanding the limited influence of these institutions, during much of the first half of the 20th century French medicine was widely admired by Latin American physicians and in many ways overshadowed American efforts. As a consequence, the scope of US international health activities in Latin America before World War II suffered from fragmentation and discontinuity, and the co-ordination between health agencies and US foreign policy was weak. In contrast, during World War II the number of agencies and American fellowships and grants increased dramatically—favouring Latin Americans—and began to be co-ordinated by the US government.

**WORLD WAR II AND US CONCERNS WITH PROTECTION AND DISEASE CONTROL**

US-led international health efforts in the Americas experienced a renewal at the beginning of the 1940s due to two main reasons: the need to protect American soldiers fighting in tropical regions of the world
and the fear of reinfection of the continental US with “tropical” diseases. The US government was concerned that increased contact with less-developed regions due to commerce, war and air transportation increased the risk of importing infections that were already controlled or eliminated domestically.

Protection was a particularly important motivation for the military. During World War II eight million American soldiers were exposed to diseases such as malaria, which had already come under control in the US. Of all tropical ailments malaria had the highest incidence in the US Army during World War II, with a total of 460,872 cases (of which only 4,000 had been transmitted in the American continent). Thanks to “magic bullet” drugs, and “wonder” insecticides such as DDT, mortality rates for malaria among the military were low. These techniques helped the US to win the war in the Pacific and to control diseases among civilians in Italy and Greece. Moreover, this experience convinced the Americans that disease control in “backward” countries was possible without broad public health improvement. Military medical interventions during World War II were perceived as a remarkable success achieved in a short period of time. One military doctor stressed that in the Spanish-American War, 13 American soldiers had died of disease for each one killed on battlefields. In World War I the ratio was one to one. In contrast, during World War II, only one American soldier died of disease for every 85 who were killed on the battlefield.

Military concern with national security also demanded a supply of rubber and quinine (the latter being essential for treating malaria). When the Japanese invaded the Dutch East Indies and Malaysia in 1942, the primary world source for these products was cut off. Almost immediately the US government signed agreements with Andean countries to revive the almost extinct *Chinchona*-bark industry, organized expeditions to quinine areas, established laboratories in Latin American cities and purchased local bark. The North-American Rubber Reserve Company (later called the Rubber Development Corporation) was established in the early 1940s to obtain the product from natural sources in Latin America. In addition, Goodyear factories were installed in cities such as Lima to produce tires for military and civilian jeeps and automobiles in the US. The Peruvian government of the mid 1940s was eager to receive American aid because it was a means to reach the Amazon; a region that was considered “uncivilized” and underdeveloped. Another military justification for protecting Latin America during the War was the strategic location of the Panama Canal and the fear that if Nazis controlled Dakar (a menace that existed until 1943) they would be poised to invade Brazil and Latin America.

It is important to underscore that during the War medical departments of the US military acquired a global role. Before 1939, these units
received insufficient appropriations and had few officers. However, after 1941 they began to receive substantial support. These funds prompted an active Army Epidemiological Board of the Secretary of War (originally established as the Board for the Investigation and Control of Influenza and other Epidemic Diseases in the Army) that functioned between 1941 and 1946.

Paradoxically, part of the growth of US medical interest in Latin America stemmed from Europe’s tragedy. This was certainly true in the case of the RF. After the Nazi invasion, the RF’s work in continental Europe practically ended. In addition, China, a longtime RF focus, was in the middle of a civil war. As a result, the Foundation closed its offices in Europe and transferred some personnel to Latin America. At the beginning of the 1940s the Latin American work of the RF was reorganized in four main field offices located in Rio de Janeiro, Mexico City, Havana, and Buenos Aires. It is important to emphasize that in 1940 only one other IHD field office existed abroad (in India). The Buenos Aires bureau, created in 1939 as the Rio de la Plata and Andean Region Office, operated in Argentina, Bolivia, Chile, Peru, Ecuador, Uruguay and Paraguay. It was active until 1949 when it closed its doors partly because of political tensions between the US and the dictator Juan Perón. Lewis W. Hackett, recipient of the first PhD in public health from Harvard University in 1913 and an RF officer with experience in Central America and Italy, moved from Rome to Argentina to head the new Buenos Aires office.

The Foundation considered its work during the mid 1940s as the beginning of the end of its previous emphasis on yellow fever and a diversification of its interests in the region. In the late 1930s, the RF’s work on yellow fever in Brazil was handed over to the Brazilian government. This was considered the best moment for an expansion of a general public health program throughout South America. This was understood to be the decentralization of health services, the promotion of full-time positions in the ministries of health, the training of nurses in professional schools, and the reform of medical education following the Flexnerian model.

In 1945 Rockefeller appropriations to Latin America were greater than those earmarked for all other world regions combined. During the period 1913-1933, RF expenditures by geographical areas had been 35% for Europe; 49% for the Far East (which included a Medical School at Beijing) and only 10% for South America, Central America and the Caribbean. By contrast, in 1948 Latin America received 44.3% of the IHD annual budget, the US and Canada only 32.8% and the rest of world 22.9%. The relocation of financial resources continued for a few years even after the War. The trend was reversed in the 1950s when the Foundation resumed contact with European institutions and scientists.
In addition to the RF, other US institutions such as the W. K. Kellogg Foundation were involved in the education of Latin American health professionals starting in the late 1930s. Kellogg continued with its regional fellowship program during the 1940s and 1950s. Some grants to Latin American health workers were also provided by the Division of International Health of the US Public Health Service founded shortly after the War; the powerful Medical and Research Program of the National Research Council and a Committee on Medical Research of the Office of Scientific Research and Development. An important leader in the first of these organizations was Henry van Zile Hyde, a US representative to the World Health Organization’s Executive Board between 1948 and 1952 and who, as of 1950, was head of the Division of International Health of the US Public Health Service. Before those years he was Director of the Health Division of the Institute of Inter-American Affairs and worked in a number of bilateral health programs.

The large number of US fellowships intensified the Americanization of Latin American medical and health personnel and institutions. During the late 19th and early 20th century, Paris was the medical Mecca for many Latin American students and it was common to find a preponderance of French textbooks in local medical libraries. By the mid-20th century, enabled mainly by fellowships and grants, American universities became the preferred destination for Latin American medical students pursuing an education abroad, and a command of English became a requirement for this training. From 1942, RF Latin American fellows generally attended an eight-week English course at Johns Hopkins University before the start of the semester. In addition, the Foundation awarded travel grants to allow experienced Latin American health officials and medical researchers to visit the US and pursue research projects in their home countries; these projects were frequently related to the research agenda of American scientists. In these years Americanization was not resisted by Latin American medical doctors, who competed to take advantage of access to technology, financial resources and fellowships. Local governments also saw it as a resource to support a partial modernization of scientific education in the national universities.

In the wake of World War II, famed RF officer Fred Soper made an important argument supporting aid to the region: “Should war come again, the United States will need healthy nations as allies.” A loyal and healthy hemisphere was necessary not only for national security and military reasons. Another important motivation was economic. International health was considered a tool for increasing the productivity of regions under US influence and as a means of raising the standard of living of poor populations so that they could participate in market economies. Protection of plantations, mines and camps—many controlled by US companies—against epidemics, as well as the growth of
consumers and international markets where American products were sold were considered essential. The growth of American business in the region was corollary to the development of industrial medical departments operating abroad. For example, by the late 1940s the United Fruit Company employed 89,986 people in the tropics and maintained 1,830 beds in its hospitals and dispensaries. The medical director of the Company explained the importance of his work in the following terms: “Philanthropy is not only a virtue; it is a basic law of survival.” The link between economics, politics and health would be shaped by a governmental agency that during and after the war was increasingly powerful: the US State Department.

GLOBAL HEGEMONY AND INTERNATIONAL HEALTH

Before World War II, there was no real American foreign-policy agency. However, beginning in the 1940s the conflict with Germany and later the Cold War, pervaded all aspects of US society, necessitating continuous government attention to foreign policymaking. During this period the US State Department became the main foreign relations agency for Latin America and the rest of the world. During World War II the Department created or reinforced its regional bureaus, including an American Republic Affairs Office. An important unit created by State Department during the War was the Office of Inter-American Affairs. The Office was created in 1940 following a proposal by Nelson Rockefeller, the third child of John D. Rockefeller, Jr. and the grandson of the RF’s founder, who had strong ties with Latin America. He had prepared a memorandum for President Roosevelt denouncing Nazi influence in Latin America and recommending a program of bilateral co-operation and propaganda. Roosevelt responded by appointing Rockefeller as head of a new Office of Inter-American Affairs. The office organized a series of economic, health, and educational projects for about 10 years, including hospitals, health centres, mosquito control measures, anti-malaria control campaigns, and training of health professionals. Later the office oversaw the first systematic DDT spraying activities. These programs were directed by Major-General George C. Dunham, an expert in tropical medicine with previous experience in Panama and the Philippines.

The Office’s health activities were run by well-funded local institutions called Co-operative Public Health Services (Servicios Cooperativos de Salud Pública). US experts based at the national ministries of health were usually in charge of these services. Local personnel received good salaries, above what other local public health workers earned. These salaries were justified as a demonstration of the importance of sustaining a full-time commitment in public health. By 1948 approximately 130 American health experts and an estimated 8,000 local physicians, nurses,
technicians, and lay health workers were employed by the Servicios.\textsuperscript{38} In addition 600 Latin Americans fellowships were awarded, typically to study abroad. Initially, it was expected that costs would be shared locally and that governments would take over the work when co-operation concluded. However, the Servicios faced some of the same problems encountered previously by the RF, such as demands to enlarge their responsibilities. In addition, the Servicios were under pressure to obtain rapid results because the co-operative agreements were initially set for only five years, although in many countries their existence was extended. By 1951, when the Office of Inter-American Affairs was closed, over US $30 million had been spent on health activities during the Office’s ten years of existence.\textsuperscript{39}

The Servicios had an important role in the region as powerful programs in the Ministries of Health. At the same time, their administration of significant resources gave them autonomy and political clout. In Mexico for example, water systems were built by the Servicio without consultation with the Department of Health, because the bureaucratic process was considered too cumbersome. In Colombia the government simply abolished its own Division of Sanitary Engineering and turned over its activities to the Servicios.

By no means did the closing of the Office of Inter-American Affairs signify the end of US interest in Latin American health. A crucial personality for US foreign policy during the early Cold War years was John Foster Dulles, the controversial US Secretary of State from 1953 to 1959. Having worked at a prestigious Wall Street law firm that included the United Fruit Company among its clients, Dulles reinforced the relationship between health and foreign policy as essential for US economic hegemony, national security, and self-protection. As Secretary he adapted the political ideas of foreign-policy experts such as George Keenan, who believed that the US should contain the Soviet export of Communism and undermine the USSR’s international influence.\textsuperscript{40} Dulles supported the participation of the State Department in the United Nations and its specialized agencies, which was a major departure from the US Congress’s prewar isolationist foreign policy. Dulles organized a Bureau of International Organization Affairs in the State Department in order to co-ordinate US participation in the UN and its agencies, such as the World Health Organization (WHO).

One reason for this decisive support was that through its participation in UN specialized agencies, the US sought to reinforce its global hegemony. In the eloquent words of Henry Cabot Lodge, Jr., US Ambassador to the UN in the 1950s, it was important to carry out US foreign policies under the aegis of the UN, “as we then get credit for practicing altruism instead of power politics.”\textsuperscript{41} Foreign policy leaders also emphasized the role of world trade in securing America’s well-being. Accordingly, it was
necessary to create new markets and increase the purchasing power of people in areas where per-capita income was low so they could participate in the world economy. In sum, international health served as a tool for consolidating US security in the international arena, raising the standards of living in developing countries, making individuals consumers in market economies and contributing to economic progress.\textsuperscript{42}

Despite the fact that most US foreign aid of the early Cold War period was devoted to Western Europe (through the Marshall Plan) significant aid was also directed to Latin America because of its economic relevance and political importance. By 1955, approximately one half of Latin American foreign trade was conducted with the US (compared to only one-third before World War II) and over 35\% of total US private investments abroad were made in Latin America. In addition, Latin America was, after Western Europe, the second market for US exports (amounting to 27\% of the total). Latin America also accounted for approximately a third of total US imports including important primary goods such as oil, minerals, and coffee.

A second reason for State Department participation in UN agencies was that it sought to spread the expanding burden of American bilateral aid activities. Developing countries protective of their sovereignty preferred to receive aid from multilateral agencies. By the 1950s the UN’s pool of manpower expertise was significant. It was hoped that American involvement in the UN would help to establish priorities and orderly planning, especially for less developed countries. In 1956 a meeting of US bilateral agencies analyzed the health priorities projects in colonial and newly independent countries, including those technically feasible and with the greatest impact on the largest number of people, the strengthening of the economy, the improvement of “citizen morale” and finally the contribution “to our political objectives.”\textsuperscript{43} These criteria were also adapted to the work in UN agencies.

During the early 1950s, critics of the US noted that the UN and WHO were linked to US foreign policy goals. Indeed, between 1947 and the 1956, the Soviet Union and Eastern European communist countries withdrew from the WHO, arguing it was not fulfilling its original mission and had become an instrument of American imperialism.\textsuperscript{44} When the Soviet bloc returned to WHO, a Department of State officer declared that it was more important than ever that the US continue its support to the WHO.\textsuperscript{45} The WHO was portrayed as a mechanism to diminish social tensions and break the vicious cycle of poor health and poverty that could explode into war or lead to communist revolutions. By the mid-1950s the State Department believed that a more active Latin American program of co-operation was needed to deal with poverty, malnutrition, and sickness to avoid these dangers. A US Congress Committee on Foreign Relations declared that technical co-operation in health would help
new nations resist “the totalitarian aggression” of communism that thrived on conditions of want and privation in disadvantaged nations. Deepening the relationship with Latin America had further political dimensions. US political experts feared that the Soviet Union could entice Latin American governments, intellectuals and regimes with attractive opportunities for trade and fellowships, or convince opportunistic local politicians. According to this reasoning, US commerce, foreign aid and international health in Latin America would help to demonstrate that orderly social progress, without a revolution, was possible. This meant a gradual elimination of poverty, the improvement of rural living conditions, and controlling nationalist movements, which could be “manipulated” by communists. Given that communist parties were small or illegal in most Latin American countries, the State Department cautioned about Soviet infiltrators among intellectual circles, and union leaders camouflaged in “front demagogic organizations” promoting non-controversial issues such as peace, democracy, independence, and labour rights, while secretly maintaining links with the Kremlin. According to the State Department, these organizations used Soviet fellowships to indoctrinate intellectuals and labour leaders. In the mid-1950s, following Stalin’s death and with Nikita Khrushchev in power, the US government became concerned that new USSR rhetoric on “peace” and the notion of the Third World might be appealing to leaders of developing countries. Stalin’s successors, meanwhile, perceived that developing countries were questioning the presence and influence of Western Europe and the US in their national affairs. During the late 1950s, Soviet foreign policy sought to achieve a “peaceful coexistence” in continental Europe but was eager to expand its influence in the third world.

The events of Guatemala in 1954, when President Jacobo Arbenz confiscated most of United Fruit Company’s lands and legalized the Communist Party, convinced the State Department that a communist menace existed in the Americas. An inter-American conference that took place in Caracas shortly after a coup orchestrated by the CIA deposed Arbenz established a Cold War principle for the region: the control of any American nation by “international” communism was a threat to the entire region. Another Cold War concern for the State Department in the region was the stormy tour of Vice-President Richard Nixon to South American capitals in May 1958 (with protests and unruly receptions in Montevideo, Lima and Caracas). The Eisenhower administration explained it as a result of communist infiltration but also as the need to better address Latin American social ills. This concern was revived after the Cuban revolution of 1959, prompting the development program known as the “Alliance for Progress” launched by President Kennedy in 1961, and which pledged 20 billion in assistance for 10 years.
By the early 1960s, preventing communism meant the use not only of military force, as in Guatemala or Vietnam, but also the promotion of social reform and international health programs. During the Kennedy and Johnson administrations, Dulles’s policies continued thanks to Dean Rusk, his successor as Secretary of State. He was a former RF President. In addition, modernization, as an ideology of US foreign policy, received a boost with the appointment of MIT professor Walt W. Rostow as Deputy National Security Advisor. Rostow believed that the reinforcement of a managerial elite and the massive transference of technology would prepare the conditions for an economic “take-off” of Latin American nations. According to Rostow the main tension within an “underdeveloped” country was between its “modern” pole—urban, and industrial—and its “traditional” pole—rural, stagnant and subsistence-based. He believed that the spark for modernization would come from the modern pole following a cultural diffusion model. This idea was consistent with the health campaigns that had been launched from Latin American cities.49

NEW INTERNATIONAL HEALTH AGENCIES

As these development ideologies were unfolding, the array of international health actors and agencies was also changing. An important event of the post World War II period was RF’s decision to close its International Health Division in 1951, the most important of its five divisions (the others were Medical Sciences, Natural Sciences, Social Sciences, and Humanities). Part of the IHD merged with RF’s Medical Sciences Division, and a new Division of Medicine and Public Health inherited some of its final obligations. This reorganization was the result of a process that had begun in the early 1940s, when the Foundation began to de-emphasize medicine and to work in agricultural development and the so-called Green Revolution (with Mexico and Colombia as important Latin American locations for the new program). By this time, the Trustees of the Foundation considered food and nutrition, rather than infectious diseases, to be the main problems of “backward” societies. Even so, various medical leaders of the RF, such as Paul F. Russell, would continue as officers of the Foundation and play leading roles in the design of international health campaigns during the first two decades of the Cold War.

In coming to its decision to phase out international health work, the Foundation appointed a review commission that included former US Surgeon-General Thomas Parran, and Warren Weaver, Director of RF’s powerful Division of Natural Sciences and Agriculture.50 The commission based its recommendation to close the IHD on both internal and external factors. First, the Foundation considered that its yellow fever work was done: the origin of the disease was identified, and an effective
vaccine was created. In addition, George K. Strode, the lead player of the RF yellow fever story, and discoverer of the yellow fever virus, retired in 1951 after 34 years. Furthermore, the commission considered that new agencies were doing the work of the IHD and the RF preferred to avoid overlapping. The RF traditionally undertook pioneering endeavors to make a lasting impression and set an example for further developments.

The decision also had a political dimension. It was difficult for the RF to adjust to the political changes of the post-World War II period. Before the War the Foundation operated under the assumption that Western medicine was an aspiration for all societies. However, the Cold War changed the world, making it difficult for Foundation-led philanthropic endeavors to maintain a low profile or formal independence from US foreign policy.

Finally, the RF sought to consolidate all its activities into fewer divisions in order to diminish internal tensions. The greatest source of tension was the IHD. Other divisions resented its annual lump sum budget disbursed by its own Board of Scientific Directors and argued that it worked as an operating division, whereas the other divisions were granting agencies not engaged in running field programs. By this time the Foundation also had become concerned with overpopulation. To some post-World War II critics of international health, RF programs overseas had contributed to uncontrolled population growth. According to one RF administrator: “In some quarters, the finger is being pointed at the IHD… ‘You are going into…backward countries where…you are reducing the death rate while the birth rate is remaining high, and you are adding to the social and economic burden.” The overuse and high costs of the medical departments of American industries operating abroad was a corollary concern. For example the medical director of Standard Oil Company, in charge of 24 hospitals and 92 clinics for 34,000 employees and 166,000 of their relatives, complained that expenses for the Latin American affiliates of the Company had risen from a little less than three million dollars in 1940 to over nine million in 1950: “Hospitals are bulging with invalids—not with employees, but with their dependents—wives, children, aunts, uncles and grandparents…medical service, whether good or bad attracts. When it is excellent, it is impossible to curtail it.... Is this good business?” As this quote suggests, there was growing consensus among American medical leaders and politicians that new or reorganized international organizations should play a more active role in attending to the demands of the poor in developing countries. In order to achieve this goal it was necessary to blend humanitarian and pragmatic motivations, and reinforce international health as a non-controversial technical activity, worthy of trust and governmental support.

This was the case of PASB, which markedly increased its resources and political influence under the leadership of Fred L. Soper. Thanks to
the support of the US and a number of Latin American countries Soper was elected PASB’s director in 1947 and through reelections remained in that position until 1959.57 Soper replaced Hugh S. Cumming, who had been Director of the PASB since 1920 and believed that the US should limit its participation in international health agencies. To the contrary, Soper held that American interests would be better served if his country took the lead in multilateral health agencies. He had extensive Latin American experience, having previously worked for the RF in Paraguay and Brazil and between 1927 and 1942 was head of the International Health Division Office in Rio de Janeiro. During World War II, he served as a US Army advisor in Egypt and Italy. At the PASB he enlarged the staff and budget, created field offices and new research institutes, organized important eradication campaigns against yaws and malaria inspired by military organizational experiences, offered fellowships to train Latin Americans and signed a co-operative agreement with the Organization of American States [OAS], founded in 1948 to replace the Pan American Union.58 By 1956 the PASB received a sizeable annual contribution (over $1.3 million) from the US government, making it, after the OAS, the inter-American agency that received the most funds. Consonant with these new trends, Soper was convinced that the PASB should move from “border and port quarantine …[to] a general direct attack on communicable diseases in their endemic haunts.”59
The PASB was also part of the new multilateral UN agency WHO, created in 1948. WHO became more involved in Latin America after the election in 1953 of the Brazilian Marcolino Candau as its second Director-General. After graduating from Rio de Janeiro’s School of Medicine and Johns Hopkins University, Candau had worked with the RF and the Brazilian Co-operative Public Health Services, supported by the Institute of Inter-American Affairs. In 1950 he became head of WHO’s Division of Organization of Health Services in Geneva, and after two years, he was summoned by Soper to become Assistant Director of PASB in Washington, D.C. Candau knew Soper well, having worked under his command in the fight against the *Anopheles gambiæ* malaria vector in the Brazilian northeast, an important precedent for eradication programs of the Cold War period.

Candau’s directorship marked a shift in direction for the WHO. Reelected three more times, Candau headed WHO until 1973. He replaced the Canadian psychiatrist Brock Chisholm, who had trained in the U.K. and had more of a social medicine perspective on problems of health and disease. Chisholm disliked Soper’s personality as well as his “eradicationist” perspective, but Candau was in Soper’s camp. He backed various Soper initiatives such as malaria eradication which was first approved by a 1954 PASB meeting in Chile and subsequently by the World Health Assembly that met in Mexico City a year later.

Candau’s election was well received by the US Department of State, which considered the Brazilian more closely aligned with its approach. During 1954-1959, the US government covered over half of WHO’s budget. Under Candau WHO increased both its presence and prestige. Candau’s appointment also created a friendlier relationship between WHO and PASB. In the early 1950s, existing tension between PASB and WHO was overcome.

Another UN agency that played an important role in Latin American public health was the United Nations International Children’s Emergency Fund (UNICEF), created in 1946 for temporary relief work in post-World War II Europe. During its early years, UNICEF had to renew its UN mandate every other year, but in 1953 the UN extended its existence indefinitely. What began as a small office located in the UN headquarters became a full-fledged organization with its own headquarters in New York City, and offices in the main capitals of Latin America and other regions. UNICEF’s budget and flexibility were significant. It was the only UN agency that based its primary income from voluntary donations from governments and the public. The prominent position achieved by UNICEF was partly the result of the work of the American Maurice Pate, its charismatic executive director from 1946 to 1964. An able fund-raiser and active US Republican, Pate had worked on relief operations in Europe after World War I and II. He changed UNICEF’s
original emphasis from relief during emergencies to medium and long term projects in health, nutrition, and maternal and child care. In addition, he contributed to a shift in UNICEF’s activities from Europe to the less developed world.

UNICEF began with a remarkable outright gift of over 10 million dollars from the US government. During the years 1947 to 1950, over two thirds of its funds were spent in Europe but the percentage diminished starting in 1951. In contrast Latin America’s share of UNICEF financial resources rose from only 3% in the late 1940s to almost 20% by 1953. 64 This shift had a symbolic component: poor and recently independent countries were perceived by industrial nations as “children” in need of guidance. Under Pate, the perception that UNICEF worked mainly with “children” of underdeveloped countries and with “infant” nations was consolidated. It soon became apparent that food and assistance were not sufficient: health programs to combat diseases to which mothers and children in rural areas were vulnerable also became a crucial concern for the organization.

Initially UNICEF was worried about treading on WHO’s territory, but an arrangement was made shortly after the creation of the two UN agencies to coordinate their activities through a Joint Committee on Health Policy that met twice per year. UNICEF did not operate field projects on its own but rather endorsed programs run by governments and WHO. It concentrated on the provision and shipment of materials and equipment, thereby avoiding the expense of health workers’ salaries. As a result UNICEF became a “supply” agency. The first major UNICEF-PASB campaign was the eradication of yaws from Haiti in the early 1950s through the use of penicillin. The campaign was launched by an agreement signed by PASB, UNICEF, and the Haitian government, which became a model adapted to subsequent malaria eradication efforts in Latin America. According to this model, the agencies would play a complementary role: UNICEF was in charge of vehicles, drugs, and other equipment; PASB provided expert technicians; and host governments provided buildings, local personnel and co-ordinated logistics. Agreements were based on the concept of “matching funds” (a practice that could be traced to RF programs) in which host governments demonstrated their willingness to support the project by promising to double the donation coming from abroad (although the requirement was sometimes partially waived).

The bilateral International Co-operation Administration (ICA), a unit of the US State Department was another important agency in Latin America during the 1950s. A formally semi-autonomous organization with its own financial resources and staff, ICA integrated former technical assistance programs such as the Technical Co-operation Administration and the Institute of Inter-American Affairs. 65 ICA was responsible for
all foreign assistance, except military projects, enlarging bilateral, or country-to-country, ties including agricultural, transportation, health, and housing programs. ICA was funded through Congressional “Mutual Security” legislation, which originated in an important International Development Act approved in 1950 that included military, economic and technical projects. Policy guidance was provided by the Secretary of State, to whom ICA’s Director reported. ICA had country desks generally paralleling the State Department’s regional bureaus. ICA personnel worked mainly in the control of malaria and yaws; environmental sanitation; construction of hospitals; and training of health professionals. In 1961 ICA became the basis for the organization of the United States Agency for International Development (USAID), which played a decisive role in international health developments during the following decades.

The head of ICA’s public health office was Eugene P. Campbell, a medical graduate of Johns Hopkins University with a master degree in public health from the Pennsylvania School of Public Health. He had a rich Latin American experience. He joined the Institute of Inter-American Affairs during World War II and served as the American director of the co-operative health service in Guatemala under the aegis of the State Department. In 1945 he became field director of South American co-operative health services, and a few years later he was stationed in Brazil. In 1955 he was appointed Acting Chief (and later Chief) of ICA’s Office of Public Health in Washington, D.C. He remained in this position until 1961 when he was transferred to India to work with USAID.

During the mid-1950s, Campbell orchestrated ICA’s participation in a number of Congressional hearings that resulted in the full financial backing of malaria eradication as the number one health program in devel-
oping countries. Thanks to Campbell, in 1957 the US Congress authorized several million dollars to malaria eradication, support which continued until the mid-1960s. This was a major campaign that covered all rural locations in Latin America. Financial resources for this campaign were granted on the condition that a large proportion of funds would be spent in the US, the donor country, for buying insecticides, spraying equipment, and pharmaceutical products. The presence of such products in Latin America increased dramatically after World War II, entrenching foreign aid as an indirect subsidy to American business.

As the proliferation of multilateral and bilateral agencies in Latin America shows, these developments were not isolated events but part of a broad process of institutional renewal and change in the international health field, during which new agencies struggled to find a place and validate their mission. A summary of the main institutions that participated in this process appears in Table I.

Table 1
Organizations Working in International Health in Latin America between 1951 and 1953

<table>
<thead>
<tr>
<th>Name</th>
<th>Year of creation (end)</th>
<th>Scope Officers</th>
<th>No. of</th>
<th>Headquarters</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Health Division (Rockefeller Foundation)</td>
<td>1913 (1951)</td>
<td>The globe</td>
<td>49</td>
<td>New York</td>
</tr>
<tr>
<td>Office of Inter-American Affairs</td>
<td>1940</td>
<td>Western Hemisphere</td>
<td>130 (Americans) 8000 (Latin Americans)</td>
<td>Washington, D.C.</td>
</tr>
<tr>
<td>World Health Organization</td>
<td>1946-48</td>
<td>74 states</td>
<td>549</td>
<td>Geneva</td>
</tr>
<tr>
<td>UNICEF</td>
<td>1946</td>
<td>50 countries</td>
<td>N.A.</td>
<td>New York</td>
</tr>
</tbody>
</table>

CONCLUSION

As a result of the developments described in this paper the role and rationale for international health in the late 1940s and 1950s was enlarged by a web of multilateral, bilateral and philanthropic institutions in the Americas. Another novelty of the early Cold War was the design and use of new technical disease-oriented interventions and administrative schemes aimed at controlling and eliminating diseases from remote rural areas. Previously most international health activities had been concentrated in ports, cities and economic areas directly linked to export economies. This new model of international health not only stressed the protection of foreigners living abroad but also the productivity of the capitalist system as a whole so more people, including peasants, could participate in a market economy dominated by US goods. In addition, a key component of multilateral and bilateral aid was the use of technology transfer as an indirect subsidy to American business.

The international health web of the late 1940s and early 1950s was not necessarily coherent, complementary or with clear leadership. It was certainly diverse, somewhat fragmented but shared common goals. Its influence resulted in an increased Americanization of Latin American public health, medicine and society, the design of health interventions following a military format, the notion that governments from developing nations had an obligation to provide matching funds to foreign aid, and the support of a general “modernization” framework. It was only during and after World War II when European medical influence declined in Latin America. In addition, after the War the links between politics and international health were more clearly expressed than in the past.

The idea of international health as a tool of the Cold War appears in the comments of James Stevens, former chief of preventive medicine in the US Army and later Dean of Harvard’s School of Public Health. Starting in 1950 he organized a series of meetings on “Industry and Tropical Health” attended by US health leaders working in international agencies and in the medical departments of corporations. In the welcoming address of the first meeting attended by delegates of medical departments of industries and international health organizations, Stevens warned that “powerful Communist forces” could take advantage of sick and poor people, “exploiting their discontent.” He believed that international health was one of the safeguards against communist propaganda. Moreover, it could contribute to the defeat of “the evil threat of communism.”

His words indicated the merging of medical, military and political motivations for protection, control and hegemony. Indeed, code terms and euphemisms that can be traced to medical or military discourses were commonly used by early Cold War political warriors and international health leaders; these included “enslaving,” “liberation,” “war,” “campaign,” and “crusade.” Although some of these terms could be
traced to the interwar period, and were even present during the Spanish-American War, they found new resonance after World War II. The use of these terms created the basis for recurrent metaphors for some health programs; for example, both “malaria” (a rural disease that usually caused severe anaemia but did not kill peasants) and “communism” were portrayed as “enslaving” conditions for developing countries; and “malaria eradication” and “modernization”—namely the assumption that developing nations should follow the path of industrialized nations—were “liberating” tools for these countries. The osmosis between international medicine and politics would leave a lasting mark in Latin American public health systems and discourses.

NOTES


8 See UFC, Medical Department, *Seventh Annual Report* (Boston: UFC, 1928).

9 See Annette Ramirez de Arellano, “Columbia’s Overseas Venture: The School of Tropical Medicine at the University of Puerto Rico,” *Medicine’s Geographic Heritage*, 5 (1989): 35-40; The Harvard School was later integrated into the Department of Comparative Pathology and Tropical Medicine at Harvard’s School of Medicine. See Marcos Cueto, “Tropical Medicine and Bacteriology in Boston and Peru,” *Medical History*, 40 (1996): 344-64.


12 See article by Ana Maria Carrillo and Anne-Emanuelle Birn in this issue.


22 In a 1943 meeting of the RF it was noted: “Geographically the field of operations has shifted under the influence of the War. While the work in Continental Europe and much of the Far East is temporarily at the standstill, the activities under regular program in South America have increased markedly. RFA, “Analysis of program in relation to changing condition Preliminary Divisional Statement, 5 October 1942.” R. G. 3 Series 908, Box 13, Folder 135, RAC; and “Memorandum about the extension of our IHD Program in South America,” attached to the letter A. J. Warren to R.B.F. 8 August 1940, RFA, Series 908, Box 12, Folder 126, RAC.


24 RFA, “South American region—authorization, November 6, 1939,” R. G. 3 Series 908, Box 12, Folder 126, RAC.

25 RFA, “Report of IHD Staff Conference, 19 May 1948, New York City,” R. G. 3 Series 908, Box 13, Folder 134; and RFA, “Rockefeller Foundation Expenditures during the period 22 May 1913 to 31 December 1933 by Geographical areas,” R. G. 3 Series 900, Box 3, Folder 23, RAC.

26 RFA, Lewis Hackett “Interrelationship of IHD and other agencies operating in Latin America: the problems that arise and their solution. To what extent is coordination possible?” In “Report of IHD Conference, 19 May 1948,” R. G. 3 Series 908, Box 13, Folder 134, RAC.


31 Fred L. Soper, “International Health Work in the Americas, May 3, 1948.” Nelson A. Rockefeller Papers (hereafter NAR), Series 114, Box 111, Folder 932, RAC.


36 The Office was created in 1940 as the Office for Coordination of Commercial and Cultural Relations between the American Republics, changed its name to Office of the Coordinator of Inter-American Affairs in 1945 and in 1946 was called the Office of Inter-American Affairs. In this paper I am using the latest denomination. See Andre L. Campos, *International Health Policies in Brazil: The Servicio Especial de Saúde Pública, 1942-1960* (PhD dissertation, The University of Texas at Austin, 1997).

38 “Cable by Harry W. Frantz, United Press Staff Correspondent, 23 January 1948,” NAR, Series 114, Box 111, Folder 932, RAC.


53 RFA, Excerpt from letter of 6 April 1951, R. E. Morison to R. R. Struthers, _R. G. 3 Series 290, Box 1, Folder 1, RAC._
54 RFA, C. I. Barnard comment at “Meeting of the Rockefeller Foundation Commission on Review of the International Health Division, 19 May 1950,” R. G. 3 Series 908, Box 13, Folder 140, RAC.

55 RFA, A. J. Warren comment at “Meeting of the Program Committee of the Commission on Review of IHD Program, 30 November 1950,” R. G. 3 Series 908, Box 14, Folder 142, RAC.


59 Fred L. Soper, “International Health Work in the Americas, 3 May 1948,” NAR, Series 114, Box 111, Folder 932, RAC.


62 The origin of the tension can be traced to a negotiation that began in the late 1940s, when WHO was being organized, and European medical leaders called for PASB`s absorption into WHO. Soper resisted this move, and he oversaw an agreement that made PASB the regional arm of WHO.


71 “Communism” and “slavery” appeared related as early as 1950 in a report prepared by the Department of State and Defense and cited by Sergio Aguayo, Myths and Misperceptions: Changing US Elite Visions of Mexico (San Diego: Center for US-Mexican Studies at the University of California, 1998), p. 42.