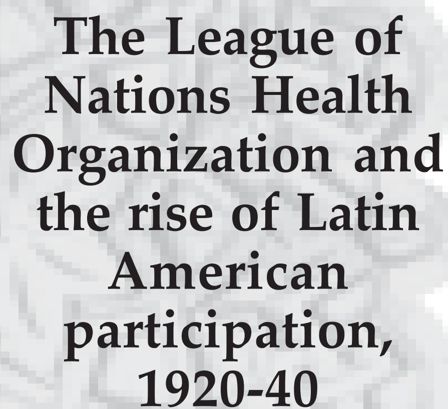

The League of Nations Health Organization and the rise of Latin American participation, 1920-40

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The League of Nations Health Organization collaborated with Latin American specialists in public health and infectious diseases from the early 1920s to the outbreak of the Second World War. The League developed studies of infant health and nutrition, and leprosy. The approach was expert-oriented, and designed to develop public health on a scientific basis. There were conferences, tours and reports in Latin America. This paper demonstrates that the Latin American collaboration with the Health Organization was extensive and multi-faceted.

KEYWORDS: International Health; League of Nations; Latin America; infant health; nutrition; leprosy; Rockefeller Foundation; Céline.

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The League of Nations Health Organization – LNHO was inspired by the ideal that equitable provision of health and welfare could reduce internal social conflicts and help prevent war. It was not enough to contain the spread of infections: improved medical statistics, diagnosis and preventive vaccines were necessary. Ultimately, progressive public health reformers saw that positively healthy social arrangements were required. The LNHO supported expert-led scientific initiatives to advance medical science, and improve health and living conditions, and thereby to secure social cohesion, and to promote "health in the widest sense of the word." The well-trained expert could raise standards of health by developing new research centers and by studying the causes of mortality, morbidity and malnutrition. As an international organization, the LNHO assumed a role, which was in part technical and in part involved analysis of sickness and social deprivation. It set biological standards, disseminated best practice through study visits, publicized model demonstration schemes, produced medical statistics on a comparable basis, and promoted study of health as part of an agenda of social modernization and improvement of living conditions.

At first, the LNHO's focus was on the crisis of epidemics in post-WW1 Eastern Europe. The origins of the Health Organization lay in the League of Nations – LN Epidemic Commission, which was intended to stabilize the new Central European successor states of Poland and Czechoslovakia. The LNHO was at the outset dominated by the British and French, who hoped that the Polish bacteriologist, Ludwik Rajchman, would be a compliant medical director. The Anglo-French hegemony restricted the LNHO to early warning of epidemics, and intended to leave other international medical tasks to the voluntaristic Red Cross, or to the Office of International Public Health – OIHP in Paris. After existing as a Provisional Committee, in 1924 the LNHO was fully established in Geneva.

In the event, Rajchman emerged as a visionary figure, taking an innovative international perspective on health issues. His initiatives appealed to an internationally minded group of medical reformers, who were often at loggerheads with their more conservative national administrations. These global health experts constituted an inspirational group of reformers, although many had precarious political positions in their home countries. The new set of issues concerned how best to organize public health. The foundations were laid for new structures for international collaboration.

The LNHO had to overcome a number of obstacles in reaching out to the Americas. The United States showed no great enthusiasm for the LNHO: politically isolationist, the U.S. Public Health Service preferred to work through the more bureaucratic Office International d'Hygiène Publique – OIHP in Paris, and through the Pan-American Sanitary Bureau – PASB in Washington (DC). The OIHP collated

sanitary legislation and regulations on such topics as disinfection and port health. It documented rather than innovated, and did not seek to identify issues requiring reform or to raise socially challenging issues as malnutrition and the prevalence of chronic diseases. The representative of the British Ministry of Health compared it to an international clearinghouse for statistics and sanitary regulations.

The Pan American Sanitary Bureau – PASB, founded in Washington DC in 1902, and the OIHP in Paris, founded in 1907, were developments from regional sanitary councils, meant to prevent epidemics (Goodman, 1952, p. 234-42, 257; Cueto, 2004). The PASB represented all republics of North and South America (so excluding Canada and various colonies). The U. S. Public Health Service exercised considerable influence on the PASB, and it can be seen as part of efforts to “Americanize” public health, and to displace French and German medical influence. Surgeon-General Cumming opposed LNHO activities in Latin America (Dubin, 1995). Despite this U. S. antagonism, the influence of the LNHO was on the rise. The LNHO was attractively innovative in scientific and social terms in contrast to the isolationist and conservative outlook of the PASB.

As a result of a decision at the Pan-American Sanitary Conference at Lima in 1927, the PASB established links in 1927 to the OIHP in Paris as a regional bureau for epidemic intelligence (Goodman, 1952, p. 242-3; Birn, 2002; Cueto, 2004). Remarkably, the PASB did not formalize links with the LNHO. Whereas the LNHO developed formal links with the International Committee of the Red Cross, the OIHP and the International Labor Office, there was no channel of communication between PASB and the LNHO. The PASB only established a formal linkage in 1947 to the World Health Organization. But this US-imposed isolationism provided Latin Americans with incentives for collaborating the LNHO.

The British representative on the LN Health Council, George Buchanan, insisted that member states were sovereign. He opposed a Venezuelan proposal for setting up a special bureau for collaboration, insisting that collaborative schemes would come between the member government and the LN. He conceded that if a group of South American states agreed to this, then he would not object. The Brazilian bacteriologist, Carlos Chagas, offered to co-ordinate collaborative initiatives.[1]

[1] LN Health Committee, Minutes, 1925, p. 41-43.

Rajchman turned out to be a dynamic visionary in international health, and set out to emancipate the LNHO from having a restrictive agenda. He rapidly established links with the pariah states of Germany and the Soviet Union in the early 1920s (Weindling, 2002). The LNHO was subject to the League of Nations Health Council, which was composed of international delegates, mainly (but not exclusively) leading public health administrators from member-states. Rajchman developed an innovative series of expert programs. Rather than taking

a restricted view that the LNHO should be only a clearinghouse between member countries for sanitary information and statistics, he and his colleagues in the LNHO Secretariat developed optimal guidelines and standards. Rajchman argued that the LNHO should have administrative autonomy, and undertake fundamentally innovative tasks in re-conceptualizing public health and developing quantitative and qualitative measures of health.

The LNHO was a focus for an internationally minded group of health experts, who looked beyond the confines of national politics to develop innovative public health policies. The LNHO was undoubtedly helped in its aspirations for autonomy by the Rockefeller Foundation – RF, which supported its efforts to internationalize public health (Weindling, 1997). The efforts of the RF's International Health Board in developing initiatives in Latin America found a parallel with its funding to the LNHO. The LNHO attempted to be internationalist and innovative in seeking to involve the public health elites of as many countries as possible.

On 7 November 1922 the League of Nations sent a letter to South American ministers responsible for sanitary matters. This brought to their attention the exchange scheme for public health experts, financed by the Rockefeller-funded International Health Board. The third general interchange organized by Surgeon-General Cumming in Washington DC lasted from September to December 1923; this attracted Europeans and representatives from Brazil, Chile, Mexico and Salvador.[2] The section of hygiene contacted the PASB in Washington, receiving a positive response in November 1922.

[2] Health Committee, Minutes of the First Session (1924), p. 90.

From 1921 the League of Nation's Health Committee provided the interface between the member-countries and the emerging LNHO. The Committee was chaired by the Danish serologist Thorwald Madsen and included a number of directors of national institutes of hygiene. Among these were the German malariologist Bernhard Nocht of the Hamburg *Tropeninstitut* and Chagas of the Instituto Oswaldo Cruz from 1923 until his death in 1934 (Weindling, 2000a). The Health Committee appointed representatives from countries which were not LN members, for example, the occupational medicine expert Alice Hamilton from Harvard. The problem was that distance precluded regular attendance of American delegates: Chagas attended the fifth session in October 1925. The Argentineans Gregorio Aráoz Alfaro and Alberto Sordelli were members between 1927-30 and 1935-45, respectively; P. Mimbela represented Peru; and Jose Scoseria acted for Uruguay (Bibliography, 1945). Table 1 shows how these experts engaged in LNHO commissions and conferences, and that Latin Americans served continuously on the supervisory Health Committee from 1922 until 1945.

Among the Health Committee's discussions was Co-operation with the Health Organizations of Latin America. In the mid-1920s, Cuba,

Paraguay and Venezuela proposed various linkages. The Venezuelan proposal concerned a liaison committee between national and international health services. Léon Bernard reported on his visit to Argentina, Brazil, and Uruguay as delegate of the LNHO. This was followed up with a visit by Madsen as President of the Health Committee to South American countries in 1927.

In 1925, the LN Health Council advocated studies of the causes of infant mortality. Aráoz Alfaro proposed to Rajchman an international institute of puericulture to be based in Buenos Aires. Madsen and Rajchman attended the conference of Health Experts on Infant Welfare. This was convened at Montevideo on June 7-11, 1927, coinciding with the creation of the Instituto Interamericano de Protección de la Infancia. This collaborated with the LN and other inter-American organizations in a series of conferences. The German LNHO Secretariat official, Otto Olsen, represented the LNHO at a second conference held in Lima on July 13-15, 1930 (Scarzanella, 2003). Table 2 shows that Brazil was the most active participant, followed by Argentina and Mexico. In all, eleven Latin American countries participated on a formal basis, although we shall see that other countries like Cuba also supported LNHO initiatives.

The LN Health Committee continued to discuss an interchange of public health personnel. Etienne Burnet (a nutritionist on the LNHO staff from 1928 to 1936) undertook a mission to Latin America in March-September 1929. The LNHO published studies of infant mortality in Argentina, Brazil, Chile and Uruguay in 1927-30 (Birn, 2002; Scarzanella, 2003).

Despite the isolationism of the United States, the RF remained a warm supporter of international agencies and medical research. Rajchman's links to RF protégés like the Croatian public health reformer, Andrija Stampar, opened the door to RF funds. The RF supported the developing of a pool of international experts in public health. The enthusiasm of the RF's International Health Board officials, notably Wickliffe Rose and then Selskar Gunn, enabled Rajchman to transcend the limitations of the more minimalist British and French policies for the LNHO. The RF's substantial funds boosted expert autonomy and innovative new thinking in public health, although Rajchman faced accusations that he was disregarding political accountability.[3] His view was that the LN should *not* be treated as a government agency; its special responsibilities "for the welfare of mankind and the prevention of war" rendered it a unique case as a recipient of RF funds.[4]

The LNHO opened possibilities for multilateral initiatives, while sustaining the more traditional bilateral linkages within the emerging "epistemic community." Although Spain was a former colonialist power, it is important to note that Republican Spain was internationalist, and its medical representatives took a bridge-building role.

[3] Rockefeller Archive Center (RAC) RF 1.1/ 100/20/175 Howell to Russell 27.VI.30

[4] Ibid., S.M. Gunn diary 2.VIII.28.

Table 1 – Latin America and the LNHO

Name / Country	Position	Commission/Conference	Date on Health Committee
Alfaro, G. Aráoz Argentina	President of National Health Dept	Infant Welfare Committee TB Commission	1927-1930
Chagas, Carlos Brazil	Dir. Inst. Oswaldo Cruz	Port Health Leprosy Commission Malaria Commission Public Health Schools	1922-1934
Lorenzo, Ramon Cuba	Dir. Inst. Pasteur, Santa Clara	International Rabies Conference, 1927	
MacKenna, Luis Calvo Chile	Medical Dir. Orphanage Santiago do Chile	Infant Welfare Commission/ Conference, 1927	
Mimbela, P. Peru	Prof. Medicine, University of Lima	Port Health Far East Commission	1924-1926
Morquio, Luis Uruguay	Child Health Professor	Infant Welfare, 1927	
Ordonez, Hernando Colombia	Dir. Inst. Physical Education	Physical Education Commission	
Rico, Edmundo Colombia	Hygiene Laboratory, Bogota	Rabies	
Scoseria, Jose Uruguay	Council of Health		1930-1931
Sordelli, Alberto Argentina	Dir. Bacteriological Inst.	Permanent Standards Commission	1936-1945
Zwanck, Alberto Argentina	Prof Hygiene, Buenos Aires	Infant Welfare	

Sources: Iris Borowy 'List of Persons', www.uni-rostock.de/fakult/philfak/fbg/41/conference/index.htm. Bibliography, 1945.

Table 2 – LNHO Latin America Initiatives

Topic	Countries Involved	Dates
Leprosy	Brazil	1926-1940
Housing	Mexico	1939
Infant Mortality	Argentina, Brazil, Chile, Uruguay	1928-1930
Nutrition	Chile	1932-1937
Public Health	Argentina, Bolivia, Brazil, Mexico, Panama, Salvador	1927-1930
Rabies	Argentina	1927
Rural Hygiene	Brazil, Mexico	1928, 1938
Vaccine Lymph / Smallpox	Costa Rica, Panamá, Peru	1926
Yellow Fever	Brazil	1928, 1936

Source: Bibliography, 1945.

Gustavo Pittaluga, a specialist in tropical medicine and parasitology, attended most LN Health Committee meetings until the cataclysmic year of 1936.[5] Pittaluga was active on the malaria commission, and he favored extension of LNHO work to Cuba as well as to Africa (Bibliography, 1945). His career ended in exile in Cuba.

The RF and the LNHO agreed on the need to move international health away from philanthropic relief. The RF gave in the 1930s about 25% of its budget for international health work (Weindling, 1997). This allowed the LNHO to undertake a dynamic program on the social causes of disease. The Milbank Memorial Fund (a U. S. corporate philanthropy with an interest in public health reform and medical statistics) was also a contributor and supporter of LNHO programs; it supported the nutritionist Frank Bourdreau and the statistician Edgar Sydenstricker, who both spent periods in Geneva. Sydenstricker came to Geneva in 1923-24 to develop international health statistics, which Latin American countries vigorously supported. In 1925 the Paraguayan delegate requested a visit from an expert statistician to South America, to ensure statistical comparability.[6]

Rajchman expanded LNHO activities to deal with health in the fullest sense of the word. He developed innovative programs on the social determinants of disease, examining the role of nutrition, occupation and housing. Here the LNHO teamed up with the International Labor Office, which had established interests in occupational hygiene and social insurance. In 1924, the LNHO reported that it was in touch with thirteen American countries. The LNHO documented public health administration around the world in its *International Health Yearbook* from 1924 to 1930, providing monographs on the health administration of various countries. This contained entries on: Argentina (1927), Mexico (1930), Panama (1928), Salvador (1927), and Uruguay (1929). The reorganization of the Bolivian health service received comment in 1928. These entries were a showcase for national health administrations, as well as an opportunity to learn about each other's activities (Borowy, 2005).

The RF supported the LNHO interchange of medical personnel, as an equivalent of its prestigious fellowships program. It represented a way of internationalizing public health at an elite level. Rajchman's assistant, Louis Destouches, took charge of a whirlwind tour by eight Latin American health officers, commencing from Havana in March 1925. These were: Drs. Alba from Mexico, Alvarez from Cuba, Garira from Venezuela, Gubetich from Paraguay, Lerdes from El Salvador, Mattos from Brazil, Schiaffino from Uruguay, and Valega from Peru (Gibault, 1977, p. 258). The tour was a high-status exercise, arousing considerable expectations of future collaboration. For the involved countries, this was a mark of honor.

The Cuban program gives an idea of both the political frame for such a venture, as well as how many features of the public health

[5] League of Nations, Health Committee. Minutes of the Third Session Held at Geneva from Monday, September 29th to Saturday, October 4th, 1924 (Geneva, 1924).

[6] LN Health Committee, Fifth Assembly, p. 39.

infrastructure were on display. After being received by Lopez del Valle, the Director of the Sanitary Office, and by Jorge Le Roy y Casa, the chief medical statistician in Havana, they visited various administrative departments. The next day was spent at the hospital Las Animas, where they heard lectures on epidemiology, and at the national laboratory for sera and vaccines. During the following three days, they inspected several more sites of medical interest – as hospitals, clinics, the immigration department, a dispensary for sexually transmitted diseases, isolation and quarantine facilities, and finally the hygienic housing for the Hershey sugar plantation (Balta, 1971, p. 105-6). The intense program was continued over several months.

After three weeks in the area around New Orleans, they proceeded northwards. The tour was ambitious, taking in innumerable public health and industrial medicine sites, as the Ford factory in Detroit, as well as a reception by President Calvin Coolidge. After visiting the Connaught Laboratories in Toronto, the group departed from Quebec to London. The European program was equally intensive, involving a range of laboratories and primary healthcare clinics. When they reached Italy in August 1925, they were received by Mussolini, and a final bout of intensive visits ensued, covering the draining of the Pontian marshes, and ending with a trip to an agricultural colony. The participants felt weary of model clinics, sewer systems, slaughterhouses and crematoria (Gibault, 1977, p. 265-7; Vitoux, 1992, p. 147-9).

Destouches noted, "Voyage trop rapide et point assez technique" (Gibault, p. 258-9; Céline, 1925).[7] The tour deteriorated into an exploration of more sensuous pleasures offered by European cities. Destouches had previously worked for the Rockefeller Mission in France. As the aspiring author (and fascist) "Céline," he wrote a cruel satire of Rajchman's bureaucracy as a Church – *L'Église* – with a religion of rapprochement between peoples, and of the RF as the *Fondation Barell*, represented by the unsavory Doctor Darling. Céline's iconoclastic diatribe against internationalism prefigured racist and ultra-rightwing attacks on international organizations as leftwing and internationalist.

But it is important not to be led astray by Céline's irreverent and reactionary prose.

The tour had enduring importance, as can be seen with its high-level official support and a range of co-operative initiatives. The Medical Director of the Cuban Health Service, Lopez de Valée, wrote proposing that Havana be a permanent headquarters of public health interchanges by creating a permanent directing board.[8] He also offered general courses in tropical medicine and eugenics on an international basis.

One direction concerned collaborative epidemiology and laboratory research. Chagas in 1925 lobbied the LN to take on board leprosy prophylaxis. In 1931 the LN agreed with the Brazilian government to

[7] Destouches reported on visits to Louisiana, p. 113-6; to Ford in Detroit, p. 116-30; to Westinghouse in Pittsburgh, p. 131-6; and to Montreal and Quebec, p. 136-7.

[8] Letter from the Director-General of the Cuban Health Service, Havana, March 10, 1925', Health Committee, Minutes, 4th Session, April 1925, p. 105-6.

sponsor an international center for leprosy research under Chagas in Rio de Janeiro. The Health Committee acted as governing body of the center, opening on April 20, 1934. The aims were leprosy research, international courses of instruction, and worldwide co-operation in leprosy prevention.[9] Table 1 shows how leprosy was part of a range of disease-focused initiatives.

The LNHO had an established a role in setting biological standards on the basis of international collaboration. A major step was a laboratory meeting in Montevideo held in 1930 by the International Commission of Experts on Syphilis on Wassermann testing (Mazumdar, 2003, p. 456-7). European experts were joined by representatives from Argentina, Brazil, Chile, and Paraguay – one of a series of laboratory conferences, where various methods of sero-diagnosis were compared. In 1935, Chile supported inter-governmental standardization work, and the general directorate of health decreed the use of international standards.[10]

The International Center for Leprosy Research in Rio de Janeiro published annual reports from 1931 to 1939 in LNHO publications. The Secretary of the LNHO Leprosy Commission toured South America in 1929-30, and Nocht from Hamburg (where the *Revista Medica de Hamburgo* was published) visited the center under the auspices of the LNHO in 1931. The LN sent H. I. Cole to work at the Center's laboratory. New therapies were tested at the Curupaity leper colony, where Ozorio de Almeida researched a method of treatment using oxygen under pressure.[11]

The deteriorating European situation increased LNHO interest in other regions of the world, notably in China but also in Latin America. Frank G. Bourdreau stabilized the LNHO administration during Rajchman's absence in China, and became pivotal to the international public health community. After visiting Moscow in July 1936, where Bourdreau met the dismissed former head of the Vienna Municipal Medical Office, Julius Tandler, the dismissed Croatian Stampar, as well as Gunn of the RF, he embarked on a study tour, visiting Latin American health officials in December 1936.[12] Bourdreau was soon to be appointed Executive Director of the Milbank Memorial Fund on April 1st, 1937, where he continued to take a global view of health and population problems.

The development of vaccines and immunological work continued in the 1930s. Zinsser and Nicolle built up a Polish-French-US axis for international collaboration in typhus research with offshoots in Chile, Bolivia, and Mexico. Support came from the LNHO for the international network of vaccine trials (Weindling, 2000b).

With the economic crisis, the standardization program was broadened to include studies of social deprivation, diet, the overall health conditions of a population, and the factors affecting the incidence of diseases. The LNHO sought to lay down minimal dietary

[9] *Bulletin of the Health Organization*, v. 2, p. 752 (1933); v. 3, p. 528-9 (1933), 'Death of Professor Carlos Chagas,' *Bulletin of the Health Organization*, v. 3, p. 730-1 (1934). Cf. *Bulletin of the Health Organization* v. 11, p. 72-3; for listings, 1945.

[10] *Bulletin of the Health Organization*, v. 8, p. 635 (1938).

[11] *Bulletin of the Health Organization*, v. 9, p. 11-3 (1939).

[12] Yale University Milbank Memorial Fund records, 1188 Technical Board Minutes, Dec. 17, 1936. BOX 4 files on Bourdreau.

requirements as well as optimal standards for different age groups and occupations. The circumstances of the Depression revealed the social potential of international standards. Biochemists calculated nutritional standards, by which the individual food factors that make up a healthy diet were identified and the quantity in which they were required. Conferences on vitamin standards, held in London during June 1931 and June 1934, publicized standard units for vitamins A, B1, C, and D.[13]

[13] 'Report of the Inter-governmental Conference on Biological Standardization,' *Bulletin of the Health Organization of the League of Nations*, v. 4 (1935). LN Archives, Geneva, R 6078-9 concerning standardization of vitamins.

The LNHO's Tuberculosis Committee shows a shift from technical issues during the 1920s to social issues by the 1930s. The Committee assessed the efficacy of the French BCG vaccination, which it considered in the light of British Ministry of Health statistics. In 1932, social factors were considered: the committee acknowledged the importance of higher earnings, shorter working hours, better diet, and improved living standards to account for the decline of TB (Burnet, 1932).

Nutrition studies offered scope for collaboration with the LNHO. Nutrition was a major common focus in Latin America. The LNHO sponsored lectures on nutrition by T. Saiki of Tokyo at Santiago de Chile in 1927. There followed the LNHO inquiry into infant mortality with special investigations in Chile during 1928-29. The report considered that a large proportion of deaths under a year as due to defective nutrition of the babies and their mothers. In 1932, the Chilean government approached the LNHO for cooperation in the study of public nutrition.[14] In 1932, Chile requested co-operation with the LN in a study of popular nutrition (Dragoni & Burnet, 1937). Carlo Dragoni, formerly of the International Institute of Agriculture, Rome, and Etienne Burnet of the Pasteur Institute, Tunis, studied the situation in 1935. A report on nutrition in Chile appeared in 1937 (ibid.).

[14] *Bulletin of the Health Organization*, v. 2, p. 504-5 (1933).

The Great Depression prompted the LNHO to challenge the view that it was to have a minimalist role in biological standardization and in tabulating statistical information or factory inspectorate reports of member-countries.[15] The economic and technical organizations of the League pursued policies oriented to ameliorating the rapidly worsening living conditions. Co-operation between the ILO and LNHO marked a highly innovative phase of developing social medicine on an economic basis. A series of studies and conferences dealt with how health was shaped by diet, housing, and economic conditions. The LNHO joined forces with the ILO in organizing surveys of rural hygiene and in analyzing the relations between public health and sickness insurance.

[15] The RF turned down an application to fund the new encyclopaedia in 1924. See ILO archives Geneva (hereafter ILO) HY 104 Relations with the RF. For social science proposals, see RAC RF 6.1/ 1.1/38/465 S.H. Walker memo Aug.-Sep, 1935.

Marcelino Pascua, the socialist, health statistician, and former Rockefeller Fellow, was on the staff of the LNHO secretariat from 1928-30; these were crucial years in the formulating of socially oriented LNHO policy. In 1930, Spain proposed a Conference on Rural Hygiene, and a large Spanish delegation attended the conference on rural hygiene in 1931, presided over by Gustavo Pittaluga. The challenging recommendations included insurance schemes and rural health centers.[16]

[16] League of Nations, European Conference on Rural Hygiene (Geneva, 1931), v. 2.

The International Institute of Agriculture (founded in Rome in 1905) was involved. The LNHO's change in policy was signaled in September 1932 by a report on the "Economic Depression and Public Health." The defects of national aggregate statistics, such as concealing poverty, were pointed out, and the report called for studies of morbidity, nutrition, the psychological effects of unemployment, and of the effects of poverty on children and youth. Mixed committees of various LN organizations correlated socio-economic and medical data. Among the most innovative work was that on malnutrition of mothers, children and adolescents. Nutritionists like John Boyd Orr argued that the vicious circle of agricultural depression and urban malnutrition could be remedied by increasing the production of healthy foods, rich in minerals and vitamins. By the early 1930s Rajchman was sponsoring programs on a broad range of social factors affecting health, like diet, occupation, unemployment and housing (Weindling, 1995a, b).[17]

After losing his place on the Health Committee in 1936, Pittaluga was on the LNHO secretariat in 1937, as one of a number of refugee medical experts from the political upheavals of the 1930s. The LNHO was feeling its way towards a new concept of 'positive health' just as Europe was about to plunge into total war. These socially oriented initiatives were taken up in the Latin American context in the form of rural health studies. The year 1936 saw Latin American pressure for a renewed rural hygiene initiative and for a conference in Mexico. The ILO as well as PASB were involved, and Leonides Andre Almazar, Director of the Mexican Department of Public Health, presided over the initiative. Rural hygiene came onto the agenda in the late 1930s, at a time when the LNHO was developing ideas of 'total health' and health indices. João de Barros Barreto, Director General of the National Health Department in Brazil, contributed on "Curative Medicine in Rural Areas."[18] The idea was to combine curative and social services, linking the hospital and communities, and stressing the role of health visitors and social workers. The conference was postponed. In 1939, Mexico and Peru were among the countries supporting a malaria conference, and although this again did not materialize, it is clear that Latin American experts were now taking significant initiatives in the face of the deteriorating European and Asian situations.

Latin American support became increasingly important to the LNHO. Rajchman recognized the value of Latin American participation in the increasing politically polarized 1930s. Argentina, Bolivia, Brazil, Chile, Costa Rica, Mexico, Panama, Peru, Salvador, Uruguay, and Venezuela contributed to various LNHO initiatives, mainly concerning infectious diseases (as leprosy) and public health organization.

The question arises as to what differences there were in LNHO policies in Europe compared to Latin America. None contributed to questions of social insurance, and interest in social hygiene and social medicine appears limited to rural health. The LNHO itself had a blind

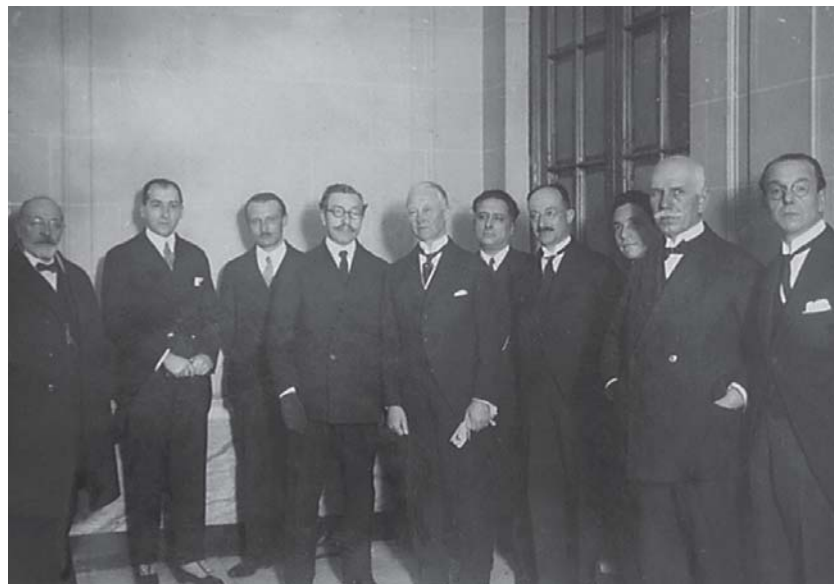
[17] Research Publications LN Documents, spool 3:9, 'Work of the Health Committee at its 19th Session, Geneva, October 10-15, 1932.' ILO Hy 200, Hy 200/2/2 Collaboration of the ILO and League of Nations.

[18] *Bulletin of the Health Organization*, v. 8, p. 988-1015 (1938).

spot as regards birth control, avoiding the controversial issue of eugenics. Nor was there any apparent take up of 'health indices', as in North American studies of factors shaping community health (Weindling, 2002a).

By the 1930s, Rajchman saw the value of greater attention to non-European regions. He spent much time on public health in China in the 1930s. He similarly welcomed Latin American participation in the LNHO. Although Rajchman resigned in 1939, the LNHO struggled on through the war in the isolation of Geneva. The proposal for a South American regional office for the LNHO did not come to fruition because of concerns over U.S. opposition. Unlike the ILO or PASB, the LNHO could not survive the reconfiguration of international organizations in 1945 under the avowedly more global United Nations umbrella. A new phase opened with the founding of WHO and Unicef.

The LNHO emerges as internationalist and innovative in its efforts to include Latin American public health. This paper shows that Latin American support was vigorous and reflected at numerous levels. The focus was elitist rather than health promotion at the level of primary health care. The LNHO supported the expertise of public health officials, laboratory scientists, and medical statisticians and pointed towards a technocratic vision of public health reform. For their part, leading public health experts welcomed the recognition and expertise from international collaboration. The LNHO's model of public health failed to take account of issues as birth control and the dangerous potential of sanitary measures to promote racial segregation and (as in the ghettoization and the use of lethal pesticides) genocide



Mission of Latin American health officers to the League of Nations, 1924. League of Nations Photo Archive, Photo col. 746. Courtesy of the League of Nations Archives.

(Weindling, 2000b). While the LNHO appealed to left-leaning dynamic reformers like Stampar and Pittaluga, in the Latin American case those involved were public health leaders in their home countries. Its various expert committees make these appear as a meeting point of those who were increasingly marginalized in their home countries. The LNHO offered support to public health reformers in Latin America, in an attempt to insulate public health services from the vagaries of politics and to overcome national isolation. Here, it marked an important step towards the regional organizations and technical work of the successor World Health Organization.

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