

**The national-
international nexus
in public health:
Uruguay and the
circulation of child
health and welfare
policies, 1890-1940**

BIRN, A.-E.: The national-international nexus in public health: Uruguay and the circulation of child health and welfare policies, 1890-1940. *História, Ciências, Saúde – Manguinhos*, v. 13, n. 3, p. 33-64, July-Sept. 2006.

This paper examines the emergence of child health policy as a global concern from the perspective of Uruguay's interaction with the international public health community in the early 20th century and its role in the circulation of child health ideas and practices. It considers two facets of national-international interplay: a) Uruguay's exploration of and interrelationship with the international panorama of policies, research and lessons on the improvement of child health; and b) the translation of Uruguay's domestic debates into the influential Instituto Internacional Americano de Protección a la Infancia – IIFI and the purveying of Uruguay's policies, research, and lessons on child health improvement to other countries and to international health and welfare agencies.

KEYWORDS: history of international health; child health; Uruguay; Paulina Luisi; Luis Morquio; Instituto Internacional Americano de Protección a la Infancia – IIFI.

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In recent decades, there has been a veritable renaissance in the international history of public health. Older institutional and intellectual narratives of regional or national public health developments have been replaced with a set of dynamic studies nourished by theoretical and methodological approaches from social, demographic, and economic history as well as from science studies and the socio-anthropology of medicine. These new perspectives on the history of public health since 1850 have flourished throughout the world, but are particularly evident in Europe and, more recently, in the Americas. We now have a comparative basis for studying “contagion and the state,” (Baldwin, 1999) or “public health and the state” (Porter, 1994) in Latin America, much as has begun in Europe.

Most of the new studies, vibrant as they are, remain bounded by the strictures of national cultures (or cultural nationalism), traditions, politics, and social context. The role of international influences and developments in national histories of public health is underexplored, even though the modern history of public health is perforce an international phenomenon. When national studies mention the effects of outside agencies, ideas, and actors, these interactions are rarely problematized; eg analyses of child health movements in late 19th and early 20th century Mexico, Argentina, and Brazil (Stern, 1999; Mead, 2000; Rizzini, 2002; Di Liscia, 2005) typically note the role of French puericulture in national developments but pay less attention to the terms, filters, and give-and-take around these influences. After all, the authors are intent on elucidating the history of particular national contexts and may not perceive international engagement to be central to their story. Part of the problem is also one of order: how can one understand international interchanges without a clear understanding of the contextual trajectories of each partner?

Parallel to the developments in national histories of public health, the last few years have also witnessed a growth in the historiography of international health. Here, too, historians have sought to replace ‘insider’ accounts and chronological documentation of international health with analytically deeper and archivally-based understandings of the contextual and direct effects of ideologies, political economy, and international social and scientific movements (Afkhami, 1999; Cueto, 2004; Gillespie, 2003). Still, the history of international health is typically examined from the perspective of metropolitan institutions such as the World Health Organization, the International Red Cross, and the Rockefeller Foundation (Siddiqi, 1995; Weindling, 1995; Packard, 1998; Hutchinson, 1996; Farley, 2004). While some works trace the interaction of these agencies with farflung actors, the motives, ideas, and operations of international health are invariably portrayed as centrally-determined, then diffused around

¹ Partial funding for the writing of this paper was provided by the Global Health Trust’s Joint Learning Initiative on Human Resources for Health and Development and the Canada Research Chairs program. The initial research was funded by Grant #16813-01 of the National Institutes of Health, National Institute of Aging and Grant #37962-02 of the National Institutes of Health, National Institute on Child Health and Human Development. This is a revised, reframed, and expanded version of an article that appeared earlier in the *American journal of public health*, 2005, v. 95, n. 9, p. 1506-17. I am grateful to Gregory Kim for carrying out the author analysis of the *Boletín* of the IPI. My thanks to Sandra Burgues, Fernando Mañé Garzón, Raquel Pollero, Wanda Cabella, Nikolai Kremontsov, Gilberto Hochman, and the anonymous reviewers for their helpful comments and suggestions.

the world. Most studies which explore the interaction of metropole and periphery either examine public health within a particular imperial context or examine the interplay of a single international organization with a particular setting (Harrison, 1994; Hewa, 1995; Manderson, 1996; Solomon & Krementsov, 2001; Echenberg, 2002).

Recently, studies of the reception, negotiation, interpretation, and adaptation of international ideas and practices in Latin America have flourished (Abel, 1995; Gadelha, 1998; Palmer, 1998; Labra, 2004; Birn, 2006; Castro-Santos, 2002; Faria, 2002). We know far less, however, about the influences of public health ideologies, institutions, and approaches from Latin American settings to other countries and regions.

This study is a nascent attempt to understand the simultaneous national-international nexus of interactions around the development of public health in the late 19th and early 20th centuries, from the vantage point of Uruguay. We will examine Uruguay's domestic concerns with child health and its pioneering role in advancing this arena as an international priority between 1890 and 1940. Uruguay became involved in international health at least in part to search for solutions to its intractable infant mortality problem, and it ended up offering local approaches – including a Children's Code of Rights – that had global appeal. As the home of the world's first permanent "Instituto Internacional Americano de Protección a la Infancia" (IIFI) founded in 1927, Montevideo became a node of international health which – though lacking the political cachet of Washington, Paris, or Geneva – helped shape a worldwide children's health agenda.

This paper considers two facets of national-international interplay: Uruguay's exploration of and interrelationship with the international panorama of policies, research and lessons on the improvement of child health; and the translation of Uruguay's domestic debates into an influential institute and the purveying of Uruguay's policies, research, and lessons on child health improvement to other countries and to international health and welfare agencies. We will examine the international networks of Uruguayan doctors and child health advocates, the back and forth between domestic and foreign ideas and practices, the opportunities and interests that gave rise to the IIFI, and its repercussions internationally. Not a conventional institutional history, this analysis highlights the emergence of a significant initiative from an unlikely location through the interplay of local political and social conditions with widely-shared international health priorities.

Building a healthy state

Notwithstanding its small size and distance from the centers of power, Uruguay became engaged with international health

developments starting in the late 19th century. The country enjoyed relative stability after its civil wars subsided in 1851, and relative prosperity from a cattle-based economy. Its high levels of urbanization and school attendance, tiny indigenous population, secular government, uniform and accessible geography, and mild, Mediterranean-like climate differentiated Uruguay from most of its neighbors. Peopled largely by Spanish and Italian immigrants, with smaller contingents of a French-ancestored elite and the descendants of African slaves, Uruguay's approximately 1 million residents (one third of whom lived in the capital – 1908 census; Anuario, 1911) shared a self-effacing longing for Europe while developing their own band of state protectionism.

With the Catholic Church and landed elites as relatively weak forces, and a sparse institutional infrastructure in the social arena, there was considerable room for state growth as Uruguay's modern state began to take shape (Panizza, 1997; López-Alves, 2000). The rapid expansion of public education for both sexes starting in the 1870s – making Uruguay the region's leader with a 54% literacy rate in 1900 (Engerman, Haber et al., 2000) – was a precursor to the welfare state, which emerged in full force under the reformist Colorado party administrations of President José Batlle y Ordóñez (1903-07 and 1911-15). Enabled by relative prosperity and the sidelining of the opposition Blanco party, Batlle's first administration opened a wide-ranging dialogue on issues such as universal suffrage, maternal benefits, and working conditions. Concretely, it established retirement and other benefits to the civil service (Nahum, 1994).

A severe economic crisis in 1913 accelerated the realization of various Batllista policies – including an 8-hour workday and exemption of taxes on essential goods – seeming to prefigure Keynesian approaches to mitigating the social and economic inequalities provoked by capitalism: Batlle's conception was of a protective state that offered compensation for injustices suffered by various segments of the population. His ambitious agenda of centralization and redistribution included old-age pensions, worker protections, state monopoly of finance and other sectors, and public assistance for women, children, and the poor (Vanger, 1980; Pelúas, 2001). That progress in enacting reforms was slow – in part because they yielded contradictory results, such as lower wages (Barrán & Nahum, 1985; Filgueira, 1995; Bértola, 2000) – did not isolate the country as a failed experiment. Instead this stepwise approach seemed to elicit greater attention: a variety of voices engaged in decades of lively debate – domestically and internationally – over the effectiveness of the Batllista state and of its particular features, such as child health and welfare.

Uruguay's place in the globalizing health system was at once peculiar and typical. Like Central and Eastern European countries

at the time, Uruguay shared many of the modern state-building and cultural values of Western Europe but in a still largely rural economy. As in other Latin American countries, Uruguay was not tied to a single international mandate, instead interacting with a varied landscape of public health examples. Mid 19th century European concerns with preventing the spread of epidemic diseases – and the economic consequences of trade interruptions – were echoed in a series of meetings held in Montevideo and Rio de Janeiro starting in 1873 aimed at standardizing quarantine measures and maritime sanitation. The meat- and hide-exporting economies of Argentina and Uruguay were particularly intent on guarding against yellow fever from Brazil, since most ships entering the Río de la Plata after leaving Brazil stopped in both Buenos Aires and Montevideo. An 1887 Sanitary Convention signed by Brazil, Argentina, and Uruguay – the first of its kind to be ratified in the Americas – detailed quarantine periods for ships bearing cholera, yellow fever, and plague and was in effect for five years before it broke apart. A 1904 successor Convention included reciprocal notification. These treaties presaged later Panamerican efforts to prevent infectious outbreaks from immigrant and commercial vessels (Moll, 1940).

Gauging infant mortality

In the late 19th century, Uruguay began to consider social policy an important underpinning of public health. Initially it was French legislation – maternity leave, welfare provisions, mandatory breastfeeding for abandoned infants, milk hygiene, and other puericultural measures – that served as a reference point. In the 1910s and 1920s, Uruguayan developments reflected and were echoed in South American debates around child health and welfare. The 1930s witnessed admiration of the Soviet health system and of Mexican advances in rural health. By the 1950s, Uruguayan public health was increasingly influenced by the technical and biomedical approach of the United States. Uruguay was never “passively derivative” (Peard, 1999) of these models, instead selecting and molding features from abroad with the ideas, reality, and politics at home.

While this process of selectively adapting social policies and scientific ideas from abroad characterized most Latin American societies, Uruguay stands out in another regard. By the 1920s, Uruguay became a net exporter of its own innovations and approaches, both to other Latin American countries and to the international community writ large. As we shall see, this contribution was facilitated both by Uruguay’s extensive international interactions and by its persistent search for means to resolve its infant mortality conundrum.

A particular mark of Uruguay's early participation in international health discussions was the founding of its Civil Registry in 1879 mandating the regular collection of birth and death records. Most of the nations that developed comprehensive vital statistics systems before 1900 were major powers concerned with population health as a sign of economic vitality. Rapidly industrializing England, France, and Germany, for example, monitored the survival of children as an indicator of workforce and military readiness and imperial strength (Fildes, Marks et al., 1992; Koven & Michel, 1993). Though it had little industry and no pretense of empire-building, Uruguay had plenty of livestock to count: its first statistical annual, published for the 1873 World Exhibition in Vienna, was sponsored by the Uruguayan Agricultural Association (Vaillant, 1873).

Uruguay was not the only country in Latin America to follow European developments in vital statistics matters: Peru and Mexico passed relevant legislation in the 1850s, Argentina founded its Civil Registry in 1871, and Brazil followed suit in 1888. But though Buenos Aires data were deemed relatively complete by the 1890s and statistical annuals covering Brazilian state capitals began a brief period of publication in 1894, neither country compiled reliable national records until the 1940s. Peruvian and Mexican registries, as in most Latin American countries, did not achieve national coverage until the 1950s (Hakkert, 1996). Uruguay had some distinct features that accelerated the Civil Registry's reach: its small size and accessible geography, its relative cultural uniformity, its early urbanization, and the overlapping roles played by doctors, civic leaders, policymakers, and cultural elites, who reinforced the importance of vital statistics.

The European connections of Uruguayan elites also propelled data collection. The country's statistical annuals were self-consciously modeled after Parisian volumes (Rial, 1983), and by the mid 1890s public health authorities in Montevideo had adapted Jacques Bertillon's classification of diseases, making its mortality statistics comparable to those of many European settings. These developments were facilitated by Uruguay's rapid medicalization in the second half of the 19th century: over 40 medical periodicals were founded, numerous hospitals and clinics organized, and the country's first friendly society (providing mutual aid for unemployment and medical care) was established in 1854. The University of the Republic's Faculty of Medicine was founded in 1875, and by the time its state-of-the-art research facility was built in 1911, there were several dozen graduates per year (Buño, 1992; Mañé Garzón & Burgues Roca, 1996).

The relatively late beginnings of Uruguay's Faculty of Medicine, decades – if not centuries – after the founding of medical schools in most leading Latin American cities, meant that Uruguay's medical

establishment was less entrenched than its counterparts elsewhere (Castro-Santos, 1998) and thus more open to new international developments in bacteriology and related fields. Indeed, in 1895, the respected Italian bacteriologist Giuseppe Sanarelli was invited to head the University's new Instituto de Higiene Experimental (founded 1896), where, fresh from the Institut Pasteur, he imparted the latest scientific ideas from France (Sanarelli, 1895; 1896). Carrying out research both in Montevideo and Rio de Janeiro, Sanarelli focused on the region's yellow fever problem and (erroneously, as it turned out) identified the icteroid bacillus as yellow fever's causal agent, for a few years putting Uruguay on the world map of cutting edge bacteriology research (Benchimol, 1999).

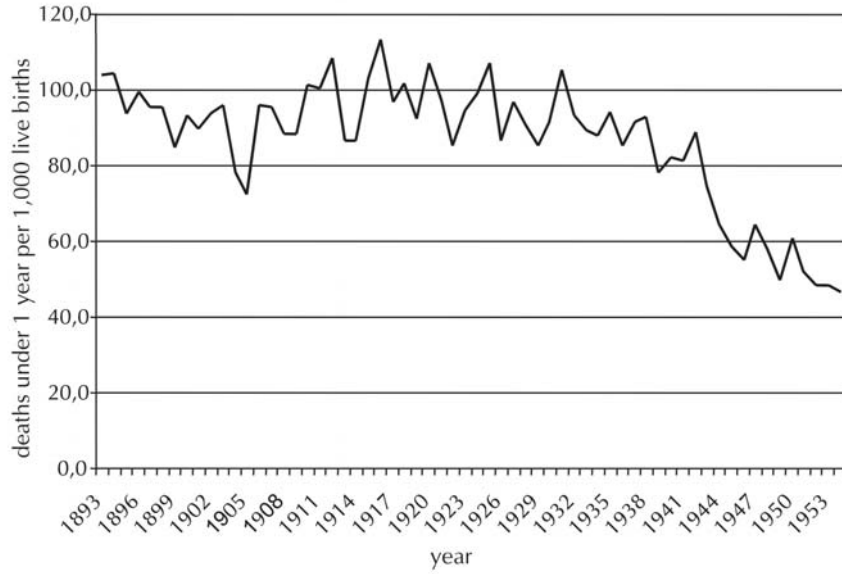
Uruguay's modern medical capacity was also reflected in its precocious compilations of national mortality figures, akin to such medico-administrative developments in Europe. Statistical annuals compiling cause-specific mortality data were first published in 1885 (Dirección de Estadística General, 1885), with infant deaths added in 1893. This allowed health experts to follow the country's uneven but sure decline in infant mortality from 104 deaths/1,000 live births in 1893 to 72/1,000 in 1905 (See Figure 1). Over the next 35 years infant mortality stagnated, fluctuating between 85 and 113 deaths/1,000 and averaging 95 deaths/1,000 live births. Only after 1940 did infant mortality resume its decline. Although various countries reported higher levels of infant mortality than Uruguay at particular points in time, virtually every other setting experienced continuous – if sometimes bumpy – declines (Ramiro Fariñas & Sanz Gimeno, 1999; Wolleswinkel-van den Bosch, Poppel et al., 2000; Corsini & Viazzo, 1997) (See Figure 2).

Uruguay was unusual on several counts: in establishing a functioning Civil Registry early on, in launching its faculty of medicine late, in achieving lower infant mortality rates than several European countries, and in experiencing a prolonged infant mortality stagnation. But it was not alone in its efforts to identify health problems based on routine data collection; virtually every country in Europe and the Americas did so, even when data were deficient and collection limited to just a few locales. Uruguay's early successes and its subsequent setbacks with infant mortality impelled health experts to address the underpinnings of local circumstances and, as in many other settings, to search for international approaches that might prove helpful.

Uruguay, abroad and at home

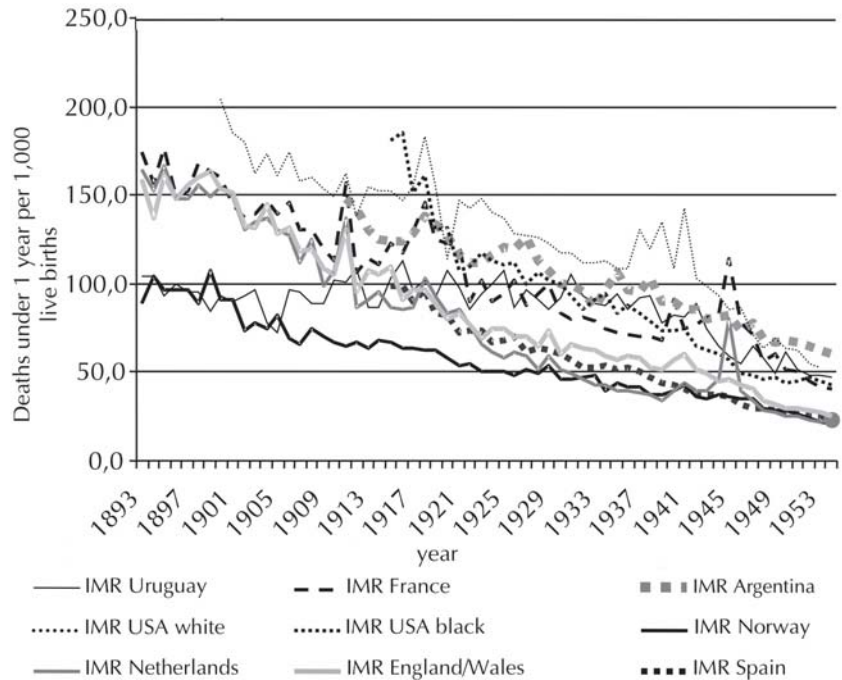
In 1895, approximately a decade after the Civil Registry achieved regular coverage, public health powers were consolidated under the Consejo Nacional de Higiene. Uruguay now had the information,

Figure 1. Infant Mortality Rate - Uruguay



Sources: Anuario Estadístico de la República Oriental del Uruguay. Montevideo: Dirección de Estadística General, 1893-1953; Estimación de Cabella, W. y Pollero, R. (2004). Programa de Población, Facultad de Ciencias Sociales, Universidad de la República, Montevideo, Uruguay.

Figure 2. Infant Mortality (IMR): Some Cross-National Comparisons



Source: From Mitchell, B. R. *International Historical Statistics: The Americas, 1750-2000 and Europe, 1750-2000*, 5th ed., New York: Palgrave Macmillan, 2003.

the centralized authority, and a cadre of medical and public health experts keen to participate in international health developments. It was this latter group that – at one and the same time – documented health and mortality in Uruguay and comparatively, advised policy-making, ran health and welfare institutions, saw patients in clinical settings, and partook in international congresses, publications, and other scientific activities (Exposición, 1907; 1913).

One of the earliest of these elites was Joaquin de Salterain (1856-1926), whose trajectory illustrates the back and forth between international and Uruguayan developments in health. Of French and Spanish parentage, de Salterain was among the first graduates of Uruguay's Faculty of Medicine in 1884 and won a government scholarship to spend four years in Paris for specialized ophthalmology training. Rather than narrowing his focus, his fellowship widened it, and upon his return to Uruguay he became involved in a range of health activities with ophthalmology as a secondary employ. De Salterain was a constituting member of the Consejo Nacional de Higiene, and in the mid 1890s he began to publish detailed analyses of Montevideo's mortality statistics in Uruguayan medical journals as well as in French and British publications (Soiza Larrosa, n.d.; de Salterain, 1899).

This work led him to a particular focus on tuberculosis mortality in Uruguay, a problem which he discussed as a representative to the IXth Congress of Hygiene and Demography held in Madrid in 1898. Around the same time he became familiar with the effectiveness of social measures – such as improved nutrition and regulation of working and living conditions – undertaken in other countries (Panizza Blanco, 1957). He published a much-cited study of tuberculosis in Buenos Aires and Uruguay (de Salterain, 1901), and he carried out some of the earliest analyses of tuberculosis mortality in Latin America. In 1902 de Salterain founded the Liga Uruguaya contra la Tuberculosis, and he relayed Uruguay's experience in controlling tuberculosis at a variety of international venues and publications in Europe, the U. S., and Latin America over the next several decades.

De Salterain's career also saw him heading la Dirección de Salubridad de Montevideo, and running services in the Pereira Rossell Hospital de Niños (founded 1905) and in the Asilo Dámaso Antonio Larrañaga (de niños) (established in 1818). His work helped set the stage for Uruguay's role abroad, but he was perhaps most effective at using his international interchanges to leverage increased attention and resources at home.

The work of Uruguayan physician Rafael Fosalba offers a somewhat different example of public health interactions radiating from Uruguay (Fosalba, 1909). As minister of Uruguay's official legation to Havana circa 1910, Fosalba carried out a penetrating

set of studies of the causes of infant mortality and stillbirths in Cuba, among the worst known recorded rates at the time. Fosalba's work, published in Cuba's prestigious journal *Sanidad y Beneficencia* between 1909 and 1914 both responded to discussions of Cuba's menace to health – one of the justifications invoked for U. S. sanitary invasion of Cuba under the Platt Amendment – and stimulated further research and responses such as by Cuba's well known chief of sanitation, Dr. Juan Guiteras. Winning a prize from Cuba's Academy of Sciences, Fosalba's research highlighted the relation of economic and social factors to poor health, such as high food taxes, low meat consumption, and substandard housing conditions (Stepan, 1978; Riverón Corteguera & Azcuy Henriques, 2001), drawing from ongoing debates that were taking place in Uruguay.

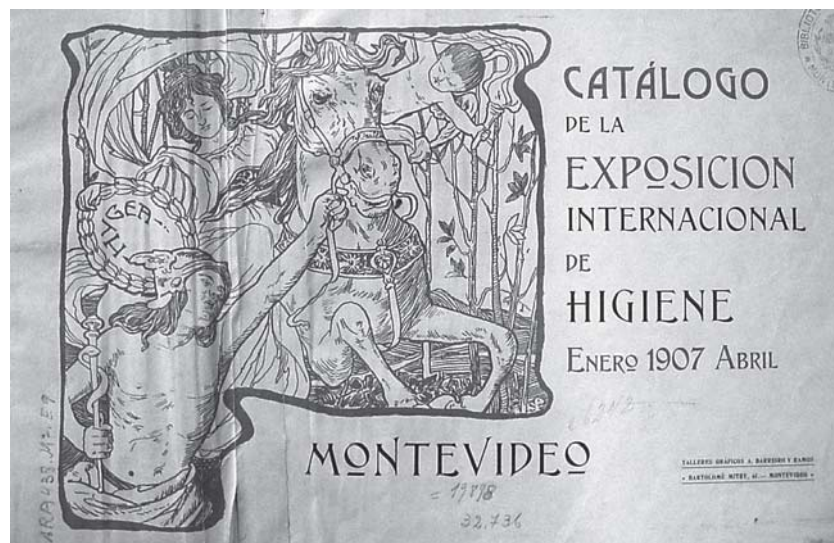
From the 1890s, Uruguayans participated in virtually every international congress related to public health and social welfare; they published their own presentations either in Uruguayan or international journals and typically issued analytic summaries of the conference discussions in Uruguay's *Boletín del Consejo Nacional de Higiene*. The few meetings to which professional emissaries were not sent were attended by Uruguayan diplomatic envoys. Carlos Nery, the Uruguayan consul general to Great Britain, for example, spent considerable effort researching social welfare institutions in Europe. He represented Uruguay at the International Conference on Public and Private Welfare held in Milano in 1906 (Nery, 1907) and directed Uruguay's first nursing school upon his return. Batlle himself was a close observer of European political and social developments, spending much of the four-year interval between his two Presidential administrations in France.

Medical elites from throughout the Americas received advanced training in Europe in this period, making contacts, attending congresses, joining scientific networks, holding regional panAmerican medical and public health meetings (See Figure 3), and pressing their own governments to expand activities (see article by Marta de Almeida in this issue). But few countries – particularly of Uruguay's size – achieved as consistent an international presence. Most countries sent one representative to the 1900 Paris conference at which the International Classification of Diseases was first revised; Uruguay sent two (Bertillon, 1900). Similarly, the seven-person delegation Uruguay sent to the XVth International Congress on Hygiene and Demography held in Washington in 1912 was larger than that of all but a handful of countries (Fifteenth, 1912). That this attendance was at state expense – when the Consejo Nacional de Higiene relied on a largely volunteer labor force – implies that politicians and bureaucrats believed Uruguay's health learning would take place internationally.

The extensive circulation of scientific knowledge starting in the late 19th century coincided with the international exchange and professionalization of specialists, the flourishing of technological and practical applications in a range of areas including public health, and the genesis of the welfare state which could enable the wide distribution of these measures. Uruguay, like its neighbors, received visits from prominent European scientists, and had, for example, a special Comité France-Amérique de Montevideo to organize such exchanges (Le Professeur, 1924). Latin American countries were well-poised to pick and choose from various tendencies in public health –sometimes drawing from French-style universal maternal benefits, other times from Anglo-American-style targeted programs for poor women, and so on (Scarzanella, 2003).

Uruguay's reorganization and expansion of social welfare fit with the notion of selectively adapting foreign developments, often outpacing efforts in other Latin American countries. In 1907 Uruguay was among the first countries outside Europe and its colonies to found a *Gota de Leche* based on the French model of *Goutte de Lait* to distribute pasteurized milk and provide medical attention to needy mothers and their infants (Rollet, 1997). Following a pattern of radiating out from the capital, in 1913 there were 7 gotas de leche in Montevideo and by the mid 1920s some two dozen more of these community infant health clinics had been established throughout the country, with continued expansion to over 40 stations throughout the country in the 1940s. In 1914 there were 24,000 maternal/child visits to the gotas de leche (Morquio, 1916), almost doubling to 45,000 ten years later, with hundreds of

Figure 3



From Biblioteca Nacional, Sala Uruguay, Montevideo, Uruguay.
Photo Courtesy of Sala Uruguay.

thousands of liters of milk distributed each year (Bauzá, 1929). Uruguay's gotas de leche arguably covered the largest proportion of mothers and infants in the world – with the total number of stations exceeded only by France.

The 1910 nationalization of Uruguay's charity institutions into the *Asistencia Pública Nacional* was likewise self-consciously patterned on France's *Assistance Publique*, then expanded into one of the most far-reaching social assistance programs in the world (Becerro de Bengoa, 1921). Its founding director, Dr. José Scosería, later President of Uruguay's Consejo Nacional de Higiene, became a highly sought after delegate to international health and welfare agencies and congresses (Turenne, 1946). Uruguay also maintained Anglo-American style private aid agencies – typically run by women – some of which received government grants to deliver services (Ehrick, 2001; Asistencia Pública Nacional, 1918; Asociación Uruguaya de Protección a la Infancia, 1925). The full legalization of divorce (including unilaterally by women) in 1913 (Cabella, 1998) – at the time among the world's most liberal divorce laws – was further evidence of Uruguay's 'borrow and change' social policy approach.

Thinking comparatively, contributing internationally

Uruguayans were clearly adept at participating in international health networks and adapting foreign innovations to serve local needs. As striking is how Uruguay's self-publicized problems catapulted the country to regional and international attention.

In the late 19th century, mortality comparisons began to be conducted in Europe (Armstrong, 1986), a practice which Uruguay fully adopted. An early example was de Salterain's 1896 observation that Uruguay's mortality rate was dropping steadily and that Montevideo's rate was lower than that of Paris, London, St. Petersburg, and Buenos Aires. Seeking answers for Uruguay's unexpectedly favorable mortality levels, de Salterain boasted "What other explanation could there be for such pleasing results than the progress of our public welfare institutions, health administration, and hygiene education?" (de Salterain, 1896).

Other colleagues followed suit, especially after the infant mortality rate emerged as an international indicator around 1900 (Rollet, 2001). In 1913, Dr. Julio Bauzá, then head of Montevideo's gotas de leche, went so far as to argue that little attention needed to be paid to infant mortality because Uruguay's rates were so much lower than those of Chile, France, Russia, and Germany. He affirmed, "The truth is we are in an enviable position for a myriad of European and American countries" (Bauzá, 1913).

These early comparative analyses were aimed mostly at domestic audiences, but local experts soon recognized that Uruguay's well-

documented mortality patterns had relevance far beyond its borders. Dr. Luis Morquio (1867-1935), the founding father of Uruguayan pediatrics and a leading authority in both medical and social aspects of child health, was the most prominent translator of the local experience to the international scene (See Figure 4). In 1895, upon returning to Montevideo from training in Paris, he became medical director of the external services of the Asilo de Expósitos y Huérfanos. There he oversaw an extraordinarily low – for its time – mortality rate of 7% of children, which he attributed to careful attention to infant feeding, including weekly visits to his clinic by wet-nurses and their charges (Morquio, 1900; Escardó y Anaya, 1935). By 1904, Morquio was presenting his analyses of Uruguay's experience to Latin American medical congresses and soon after to European audiences. If Morquio agreed that Uruguay's infant mortality rates deserved some international 'appreciation' – rates favored, he believed, by environmental cleanliness, low population density, and high levels of breastfeeding (Morquio, 1907a) – he did not dwell on success, instead arguing that half of the infant deaths were avoidable (Morquio, 1904).

Morquio's moderation proved perceptive. As of 1915 Uruguay's infant mortality record, although still better than most European levels, was stationary, if not worsening. This was particularly troubling given that the national birth rate was steadily declining (Primer, 1916) Morquio – who by this time had served as the medical director of the largest children's asylum (Cuna del Asilo de Expósitos), chief of the pediatric clinic in the main public hospital, and professor of clinical pediatrics – believed that some of the international measures adopted by Uruguayan health authorities had unintended consequences. He worried that *gotas de leche* discouraged breastfeeding by offering free or subsidized milk and that this milk was often contaminated (Morquio, 1916).

Thereafter, numerous doctors chimed in on sometimes acerbic debates over the role

Figure 4 – Statue of Morquio in Montevideo.



of public health institutions, social and economic conditions, illegitimacy, abandonment, sanitation, climate, and cultural factors in Uruguay's stagnating infant mortality (Birn, Pollero et al., 2003). Such discussions were not unique to Uruguay, but they were unusual in the international attention they generated. Uruguayan authors were extremely prolific on this question, publishing over 1,000 journal articles related to child and infant health between 1900 and 1940.²

² Author's estimate from a bibliographic database she compiled.

Morquio himself was a major contributor to Uruguay's international renown and a well-recognized leader in public health and pediatrics in Europe and the Americas. Author of an average of 9 articles per year between 1900 and 1935, almost half of his publications were in foreign publications, ranging from the French *Archives de médecine des enfants* to the Italian *La nipiologia* to New York's *Journal of nervous and mental diseases* to the *Archivos Latino Americanos de pediatría*, which he co-founded (Escardó y Anaya, 1938). He served as his era's most important interlocutor of French and Latin American pediatrics, with his seminal 1907 *La Pediatría en París*, surveying the relevance of French institutional and research developments for Latin America (Morquio, 1907b), followed by numerous pieces outlining Uruguayan developments to French audiences (Morquio, 1929).

Most of Morquio's articles focused on specific childhood medical problems, giving him credibility in the worlds of medicine and research as well as public health. Morquio became widely known for his 1917 book on gastrointestinal problems of infants, which was published in several languages and bridged his various interests. Numerous pieces he published in Uruguay were reissued by international journals. In 1928, for example, a talk he gave in Montevideo on infant mortality was reprinted in the *Boletín de la Oficina Sanitaria Panamericana* (Morquio, 1928) which introduced it by emphasizing its 'universal relevance.'

Although he maintained a permanent base in Montevideo, Morquio traveled frequently to Europe and other Latin American countries to lecture and work with colleagues. Like Salterain and other Uruguayan public health specialists, Morquio was a member of numerous international professional societies and the recipient of multiple honors; he was elected a member of the Academies of Medicine of Paris, Buenos Aires and Rio de Janeiro, and in 1931 Morquio was named an officer of France's famed Légion d'Honneur.³

³ Dossier, Luis Morquio, Bibliothèque de l'Académie National de Médecine, Paris, France; Grande Chancellerie de la Légion d'Honneur, décret 5 février 1931 et 11 août 1931.

Almost as soon as they began to be compiled, Uruguay's infant mortality statistics were viewed in simultaneously national and international terms. Scrutinized through comparative lenses, Uruguay initially deemed itself a success story. Conversely, as the problem of infant mortality stagnation unfolded domestically, the repercussions went far beyond the national realm.

International health and Uruguay's health internationalism

By the 1920s the international health landscape consisted of a handful of permanent agencies, principally in Europe and North America, with limited but growing prestige. In December 1902 the Union of the American Republics (precursor to the Organization of American States) sponsored an International Sanitary Convention in Washington, D.C. which founded the International Sanitary Bureau (renamed the Pan American Sanitary Bureau in 1923, hereafter PASB), the world's first international health agency (First General, 1902; Cueto, 2004).

Operating out of the U. S. Public Health Service under the directorship of the U. S. Surgeon-General until the mid 1940s, the PASB worked on treaties and commercial concerns related to epidemic diseases, with quadrennial congresses creating an important venue for public health exchange among the region's professionals. In 1907 the PASB established an 'International Sanitary Office' in Montevideo for the collection of health statistics from South American countries, but the precariously-funded office disappeared within a decade. The PASB's 6th conference in Montevideo in 1920 – at which U. S. Surgeon-General Hugh Cumming became director – marked a renewal of activity: the PASB's widely-distributed *Boletín de la Oficina Sanitaria Panamericana* was founded in 1922, the Pan American sanitary code passed in 1924, and cooperative activities were initiated (Bustamante, 1952; Moll, 1941).

Another key agency involved in international health was the New York-based Rockefeller Foundation, founded in 1913. Its International Health Board launched a series of campaigns against hookworm, yellow fever, and malaria in Latin America and throughout the world, as well as establishing schools of public health in Europe, the Americas, and beyond (Fosdick, 1952; Cueto, 1994). Interestingly, Uruguay was virtually the only country in the region untouched by the Foundation (perhaps because it no longer experienced any of the showcase diseases), leaving it all the more inclined to pursue public health approaches broadly.

In Europe it took more than half a century to transcend inter-imperialist jealousies in order to establish a uniform system of disease notification and maritime sanitation. The culmination of 11 international sanitary conferences held since 1851, the Office International d'Hygiène Publique was founded in Paris in 1907 to hold periodic conferences, regulate quarantine agreements, and conduct studies on epidemic diseases. It also served as the international repository for health statistics before this responsibility was assumed by the World Health Organization in 1948.

The devastation of World War I lent new urgency to international health organization. In 1921 the Geneva-based League of Nations

founded an Epidemic Commission to control outbreaks of typhus, cholera, smallpox and other diseases in Eastern and Southern Europe. Its head, the Polish hygienist Ludwik Rajchman, ably transformed the Commission into the League of Nations Health Organization – LNHO in 1923. The LNHO helped war-torn nations reorganize their health bureaucracies and pursued an ambitious program of surveillance, research, standardization, professionalization, and technical aid that eventually reached as far as Southeast Asia.

Although initially focused on Europe, the LN reached out to Latin American sanitary authorities in 1922, and various Latin American health specialists became involved in LNHO committees and conferences (see article by Weindling in this issue). As early as 1923, Carlos Chagas tried to bring LNHO representatives to Brazil,⁴ and in 1923 Latin Americans began to form part of LNHO international exchanges of public health personnel, funded by the RF. In 1925 Uruguayan school health expert Dr. Rafael Schiaffino formed part of a prestigious half-year long North American-European tour for nine Latin American public health specialists. Upon his return, Schiaffino published a detailed account of some of his site visits: “La Sanidad en Canadá, Italia y Alemania,”⁵ which became a springboard for Uruguayan discussions around the creation of a national Ministry of Health. Notwithstanding considerable mutual interest, it took several more years for the links between the LNHO and Latin America to develop into a full-fledged partnership – in an arena in which Uruguay would prove pivotal.

Under Rajchman – who later founded Unicef – the LNHO expressed a special concern for the health and welfare of children, working closely with the war relief agency ‘Save the Children’ (founded in Britain in 1919, with an international counterpart established in Geneva in 1920) (Balinska, 1995; Weindling, 1995). It was this interest that would be transformed into a bona fide cooperative effort between the LNHO and Latin America.

Uruguay had initially become involved with the LNHO in the early 1920s, most notably through Paulina Luisi, the country’s first woman doctor and its leading liberal feminist, who founded the Uruguayan National Women’s Council in 1916 (Ehrick, 1998; Sapriza, 1998; Lavrin, 1995). Having learned from missteps by feminist organizations in Argentina and elsewhere – and abetted by Uruguay’s secular and welfare state context, which encouraged women’s civic roles – Luisi was able to parlay an initially awkward alliance with elite women involved in social and moral assistance to the poor into a regionally influential movement for women’s equality (See Figure 5).

Active in regional feminist, scientific, and child welfare circles, Luisi soon leapt to prominence on the international scene. She

⁴ Extract of letter from Dr. Rajchman to Dr. Madsen dated 22nd June 1923, Registry No. 8F/18921/321 League of Nations Archives, Geneva.

⁵ Rafael Schiaffino, “La Sanidad en Canadá, Italia y Alemania,” Montevideo, Consejo Nacional de Higiene, 1926, Registry No. 126/43977/40227 League of Nations Archives, Geneva.

was the only Latin American woman delegate to the first LN Assembly, participating in various treaty, disarmament, and labor conferences. In 1924 she became an expert delegate on the LN's advisory commission on 'white slavery' and for 10 years was one of only two Latin American delegates on the Committee for the Protection of Childhood, the other

being an IPI representative. Luisi forcefully advocated for increased Latin American perspectives in the League's work for children, including surveys of needs and policies as well as greater representation in governing bodies (Luisi, 1948; Scarzanella, 2001; Miller, 1995; Rooke & Schnell, 1995). Luisi's presence at the LN would prove instrumental to the founding of the IPI.

Figure 5



Courtesy of Administración Nacional de Correos, Uruguay.

The birth of the IPI

A key dimension of international organizing in the early 20th century were the periodic congresses devoted to questions of hygiene, demography, statistics, and child welfare, mostly held in Europe (Rollet, 2001). Two international associations for childhood protection were conceived in Brussels (1907 and 1913), but their institutionalization was aborted and their activities were absorbed by LN committees in the 1920s.

In the Americas, meanwhile, a series of Pan American Child Congresses were launched in Buenos Aires in 1916, serving as a vibrant forum for Latin American reformers, feminists, physicians, lawyers, and social workers devoted to improving the health and welfare of poor and working class women and children. The eight hemispheric fora held before World War II influenced the passage of dozens of laws delineating rights in such areas as adoption, infant health, state assistance, and child labor (Guy, 1998). Although the first Congress was organized by "maternalist feminists" who viewed the lot of children to be inextricably linked to the rights of women as mothers (Miller, 1991; Lavrin, 1995), feminist control over the Latin American child welfare movement was soon displaced by male professionals, as evidenced by the preponderance of male presenters at the successful second child congress held in Montevideo in 1919. Even president Paulina Luisi was upstaged by Luis Morquio's high profile (Guy, 1998).

It was at this congress that Morquio called for an Instituto Internacional Americano de Protección a la Infancia in Montevideo,

a proposal enthusiastically sanctioned by the Uruguayan government through a 1924 decree and approved by the 4th Child Congress held in Santiago later that year (Instituto Internacional Americano de Protección a la Infancia, 1925). But the founding of the IPI awaited an outside impetus, which – in part thanks to Luis’s advocacy – came in the guise of LNHO sponsorship of an inaugural conference held in June 1927 in Montevideo.

This “South American Conference on Infant Mortality” was the first League of Nations conference of any kind to be held in Latin America. Attended by both Rajchman and the LNHO’s president, Danish bacteriologist Thorvald Madsen, the conference brought a prestigious world stage to Morquio and other experts in infant health and welfare (Madsen, 1927a; b). Through the IPI, the LNHO backed a set of infant mortality surveys in Argentina, Brazil, Chile, and Uruguay, similar to surveys it had sponsored in Europe (Scarzanella, 2003). The results – presented at the 6th Pan American Child Congress in Lima in 1930 – called for improvements in vital statistics, centralization of services, and a range of public health, social assistance, economic, and educational measures to reduce infant mortality (Debré & Olsen, 1930; Aráoz Alfaro, 1931; Debré & Olsen, 1931; Morquio, 1931).

The IPI itself was launched by 10 participating countries (Argentina, Bolivia, Brazil, Chile, Cuba, Ecuador, Peru, United States, Uruguay, and Venezuela; by 1949 joined by all the region’s countries), each with an official delegate. After 1936 the IPI requested two representatives – one technical and based in the home country, the other resident in Montevideo, such as a diplomat. In early years, most operating funds were provided by the Uruguayan government, with intermittent support from other members.

The IPI’s charge was to collect and disseminate research, policy, and practical information pertaining to the care and protection of infants, children, and mothers. It sought to ‘[Latin-]Americanize’ the study of childhood so that the region was understood as distinct and not just derivative or reflective of Europe (Fournié, 1934). At the same time the IPI ensured that the region’s problems, research, and policies entered into international discussions.

The IPI’s widely-disseminated *Boletín*, library, health education materials, and the Child Congresses rapidly established its strong reputation and generated a large network of collaborators throughout Latin America and the world (Escardó y Anaya, 1952).⁶ A budding friendship between Morquio and U. S. delegate to the Congresses Katherine Lenroot, a feminist social worker who served as deputy and then chief of the U. S. Children’s Bureau (1934-1951), helped to renew the earlier alliance between feminist reformers and public health doctors in the child rights movement throughout the Americas (Guy, 1998).

⁶ Luis Morquio, “Institut International Américain de Protection a L’Enfance,” December 1930, Registry No. 11C/34573/322, League of Nations Archives, Geneva; Luis Morquio, “Instituto Internacional Americano de Protección a la Infancia, Organización y Actividades,” January 30, 1933, Registry No. 8F/18921/321 League of Nations Archives, Geneva.

Dr. Gregorio Aráoz Alfaro of Argentina served as President for the IUPI's first 25 years, with Uruguayan Dr. Víctor Escardó y Anaya as Secretary. Morquio was the IUPI's first director, succeeded after his death in 1935 by compatriot Dr. Roberto Berro until 1956. In addition to editing the *Boletín* and working with the international advisory board, the director oversaw a small permanent staff who ran the Institute's library and archive; collected laws, statistics, and reports on child protection from member countries and beyond; sent information to correspondents around the world; and managed the publication of the IUPI's quarterly (Morquio, 1930).

The IUPI maneuvered complicated waters of independence and patronage. It was a consulting agency to both the League of Nations and the Panamerican Union until World War II, and in 1949 it was integrated into the Organization of American States. The IUPI's relationship with the PASB, by contrast, was less clear. Given its preeminent role as the official public health agency of the Americas, the PASB might have been the IUPI's logical patron. Indeed, with several PASB conferences held in the 1920s –including the 1920 Montevideo meeting –, there was ample opportunity for sponsorship. But in 1927 children's health was not a top PASB concern: the agency spent its first decades focused on the epidemic interruption of commerce, even whilst the delegates to its conferences requested attention to other health priorities (Birn, 2002). Making faraway Montevideo into a “Geneva of South America” does not seem to have irked PASB director Cumming and the PASB officially supported the IUPI (Moll, 1935). Still, Cumming failed to mention the IUPI in several key overviews of health cooperation that he published (Cumming, 1938); moreover, he was jealous of the LNHO's increasing engagement with Latin America, and in behind-the-scenes maneuverings he helped derail the LNHO's sponsorship of a rural hygiene conference in Mexico in 1938.⁷

⁷ Memoirs of Hugh Smith Cumming, Sr., p. 565. RG Cumming Family Papers. Box 5, Folder 6922, Manuscripts Department, University of Virginia Library.

Once the IUPI was established, maternal and child health took on a higher profile at the PASB, particularly in the *Boletín de la Oficina Sanitaria Panamericana*. Child well-being finally reached the PASB's agenda at its 9th conference in 1934 in Buenos Aires (held together with the Latin American Eugenics and Homiculture Congress). The PASB supported the position articulated by the IUPI's Berro, which fostered ‘positive’ eugenics as embracing a “broad, non-coercive public health and social welfare approach directed toward the child” in contrast to the U. S.'s focus on heredity and sterilization (Stepan, 1991). Given the IUPI's activities and its very existence – bolstered by the advocacy of several PASB member countries – the PASB could no longer overlook maternal and child health. Further, the LNHO's involvement in IUPI meant that the PASB now had a rival in the region.

⁸ Selskar Gunn, August 31, 1927, Diaries from RG12.1, Rockefeller Foundation Archives, Rockefeller Archive Center, Sleepy Hollow, New York.

⁹ A lingering question is why the LNHO rather than the PASB provided the organizing spark for the IIPi and whether the PASB's territoriality – based on U.S. isolationist politics and a Monroe Doctrine applied to health – helped derail the LNHO's ambitious plans in Latin America.

¹⁰ Erik Ekstrand to Paulina Luisi, February 1, 1931, Registry No. 11C/34573/322, League of Nations Archives, Geneva.

¹¹ Erik Ekstrand to Luis Morquio, Jan 11, 1933, Registry No. 8F/18921/321 League of Nations Archives, Geneva.

¹² Luis Morquio, "Instituto Internacional Americano de Protección a la Infancia, Organización y Actividades," January 30, 1933, Registry No. 8F/18921/321 League of Nations Archives, Geneva.

¹³ Report of the Advisory Commission for the Well-being of Children and Youth, 9 May 1933, Registry No. 8F/18921/321 League of Nations Archives, Geneva.

The LNHO had hoped that its role in the IIPi would give it a foothold in various South American research and educational institutions (McKenna, 1927). Its ambitious plans in South America, proposed to include research on plague and leprosy, the founding of schools of public and child health in Brazil and Argentina, and support for expanding health insurance in Uruguay,⁸ but limited resources in Geneva meant that the LNHO could do little more than encourage activities at the IIPi⁹. Enthusiastic Child Congress delegates urged the LNHO to sponsor an infant mortality survey in Peru similar to those of other South American countries, but it was never carried out. Thereafter, beyond encouragement to study particular topics – such as the condition of indigenous children, the standardization of birth certificates or the existence of institutions to reform young delinquents – Geneva had little sway over IIPi's activities.

In 1935 the LNHO bypassed the IIPi to conduct a study of nutrition among the popular classes of Chile, a thorny venture that required the LNHO to satisfy Italian demands for participation and to avoid offending PASB interests in the country. The study led Chile to create a Nutritional Advisory Board in 1937, but it was unable to secure further LNHO involvement (Scarzanella, 2003). The LNHO's tight resources, its commitments in Asia, and – in all likelihood – the PASBs' jealousy derailed the LNHO's plans for Latin America with the exception of a leprosy research center in Rio de Janeiro.

But in Geneva, Paulina Luisi helped assure that the IIPi would receive continuing attention. She sent a steady stream of IIPi articles and reports to various LN committees,¹⁰ and in early 1933 she arranged to put a discussion of the IIPi's work on the top of agenda of the March meeting of the LN's Committee for the Protection of Childhood.¹¹ Morquio sent a detailed report to Geneva (translated into French and English in record time), promising cooperation with the committee and emphasizing "We are working in that spirit of solidarity which is the mark of all our efforts – efforts devoted exclusively to the welfare of the child 'irrespective of race, nationality or religion'."¹² Deeply impressed with the IIPi's work, the US and British delegates recommended a resolution – which was passed in May 1933 – paying "homage to the IIPi, to its activities and its director, and to the influence exercised by Uruguay upon the orientation and progress of its work."¹³

The IIPi propelled Uruguay to further international attention. In 1930 Morquio was named to the Presidency of "Save the Children" in Geneva, providing a worldwide platform for the policies and practices he and others had developed. The Pan American Child Congresses continued to meet until 1942, offering a key venue of exchange of ideas and policy learning during a

period of fertile social policy activity throughout the region (Guy, 1998).

Perhaps most visibly, the *Boletín del Instituto Internacional Americano de Protección a la Infancia*, founded shortly after the 1927 conference, brought Uruguay to considerable acclaim. Unique in its scope, the *Boletín's* quarterly issues – published in English, French, and Spanish – covered topics ranging from the organization of children's social services to summer camps, school health, sports, education, health campaigns, marginalized children, and the causes of infant and child mortality. It was one of the most international journals of its day: of the one thousand authors in the journal's first two decades, approximately 1/5 were from Europe and North America and 4/5 from throughout Latin America. Slightly over 1/3 of the authors were Uruguayan. A small number of Uruguayan pieces profiled child welfare systems in other countries, but for the most part Uruguayans used the *Boletín* to highlight domestic problems and achievements in infant, child, and maternal welfare.

The IPI locally and beyond: Uruguay's Código del Niño

As the Uruguayan public health community grappled with the continued stagnation of infant mortality, it became clear that increasingly specialized medical approaches were insufficiently integrated with social provisions for child health. This realization offered a chance for IPI influences to be expressed through local developments, but in 1933 Uruguay's liberal era came to a sudden end with the dictatorship-cum-conservative-populist government of Gabriel Terra. Rather than impede integrated child welfare policy, however, Terra's efforts to rationalize and centralize power reinforced the country's widely-supported protectionism (Caetano & Jacob, 1989; Caetano, 1994): the IPI served as a social policy umbrella where new initiatives were researched and debated.

In 1933 Morquio, Bauzá and other colleagues were invited by the just-founded Ministry of Child Protection – the first of its kind in the world – to form a legislative advisory commission to organize the various programs and agencies involved in infant and child welfare in Uruguay. Under the leadership of Roberto Berro, a disciple of de Salterain and Morquio and an advocate of 'Childhood Social Medicine' (Berro, 1936), the Commission did not limit itself to the administrative process of merging overlapping agencies. Instead, it called on the country to adopt a 'Código del Niño' which spelled out children's rights to health, welfare, education, legal protections, and decent living conditions and which created specific institutions to run and oversee child and maternal aid programs. Following a lively debate in Uruguay's National Assembly, the unanimous recognition by foreign delegates to the VIIth Pan American

Conference in 1933 that the 'Código del Niño' put Uruguay 'in the vanguard,' and expressions of broad professional and popular support, the Uruguayan parliament approved the code in 1934. With its passage, the Uruguayan government explicitly recognized the integration of medical approaches to the improvement of child health with better housing, sanitation, road-paving, schools, and family allowances (Tomé, 1938).

To enable its interdisciplinary work and avoid turf battles with other Ministries, the Ministry of Child Protection was refashioned into the Consejo del Niño under the Ministry of Public Education. Although the Consejo was headed by a series of doctors, it was purposely separated from the new Ministry of Public Health (established in 1934) to emphasize its social – rather than medical – approach to child well-being. The Consejo organized its services by age group (prenatal, infant, childhood, and adolescent divisions) and jurisdiction (education, law, social services, and school health divisions), establishing offices throughout the country and absorbing a series of kindergartens, orphanages, asylas, homes, camps, and reform institutions. With this purview, the Consejo reached virtually every Uruguayan child, at minimum through school health exams and, for poor and working class children, through extensive coordinated services (Consejo del Niño, 1937; Consejo del Niño, 1950).

The relationship between the IUPI and the Consejo was very close, with ongoing exchange of staff and ideas. Berro, for example, directed the Consejo before becoming head of the IUPI; Bauzá was an IUPI representative before becoming division head, then director of the Consejo. Descriptions and assessments of Consejo projects were frequently published in the IUPI's *Boletín*, probably bringing Consejo activities to greater international attention than the children's services of any other country (Quesada Pacheco, 1937; Bauzá, 1943).

While several other countries, including Chile and Brazil, had also enacted Children's Codes – and 'Save the Children' founder Eglantyne Jebb's 'Declaration of the Rights of the Child' was adopted by the League of Nations in 1924 – these efforts were more symbolic than substantive. It was Uruguay – with its well-developed welfare state, close links to the IUPI, anxiety about infant mortality, and international profile – that offered an implementable model of children's rights in a particular national setting. Uruguay's centralization of children's health and welfare services in the Consejo del Niño established this arena as a policy priority and enabled the transcendence of bureaucratic duplication and competition. The *Boletín* of the IUPI offered a ready 'exporting' and publicity machine for the challenges, experiments, and achievements of the Consejo del Niño, and the integrated

Uruguayan approaches were discussed in important international meetings.

For example, at the 13th meeting of the International Association of Childhood Protection held, ominously, in Frankfurt in 1938, Ricardo Jalambert, Examining Judge for Minors in Montevideo, was invited to give a keynote presentation on the question: “When should legislative measures or public institutions make up for the lack of parental care?” based on Uruguay’s Código del Niño and “the final radical transformation” of the protection and vigilance of child health and welfare.¹⁴

¹⁴ XIII Jahrestagung der Association Internationale de Protection de l’Enfance, Frankfurt (Main), 12-18 juni 1938, Registry No. 8F/18921/321 League of Nations Archives, Geneva.

Through the IIPi, the PASB, the LNHO and other networks, Uruguay’s experience became widely known and discussed, particularly as its infant mortality record finally began to improve in the late 1930s. Countries with active social medicine movements, such as late 1930s Chile under the direction of Minister of Health Salvador Allende (Illanes, 1993), built upon and strengthened Uruguay’s efforts. The IIPi and PASB jointly issued a Código Panamericano del Niño in 1948, and in 1989 the United Nations General Assembly adopted a Convention on the Rights of the Child, both of which drew extensively from the Uruguayan code.

The Code was the effort of decades of activism on the part of several generations of Uruguayan public health and social welfare advocates whose domestic work enjoyed international recognition. It was the interaction between Uruguay’s international leadership and the protectionist Batllista state which – notwithstanding its flaws and slow pace – provided a laboratory of legislation and practice in the area of children’s well-being.

Conclusions

The ideologies and policies surrounding child health in Uruguay and the founding of the IIPi in Montevideo examined in this paper demonstrate that national institutional developments in public health were intricately intertwined with international health activities, agencies, and ideas. It was Uruguay’s national need (drawing from international concerns on this question) to address the infant mortality problem that fueled its international interactions; the partnerships it forged in Latin America and Europe (while offering only partial solutions to domestic problems), in turn, enabled Uruguay to develop institutions, policies, and research that had international bearing and influence.

Given existing organizations in the U. S. and Europe, Uruguay was not a propitious sponsor or locale for a new international health office. But the country shaped its strengths – a stable welfare state, well-placed professionals, leadership in child health – and its weaknesses – small size, remoteness, persistent infant mortality

problems – into an effective candidacy. A key additional ingredient for establishing the IUPI was the legitimacy that ties with another international agency – briefly, the League of Nations – might provide. In obtaining such support, the cosmopolitan physicians who anchored Uruguay's international engagement in public health benefited from essential legwork by 'maternalist feminists' who had launched the Pan American Child Congresses.

The IUPI's modus operandi differed significantly from that of other international health agencies. Rather than evolving into a regional outpost of the LNHO or the PASB, it maintained cordial relations free of 'parental' constraints. In a stroke of timing, Uruguayan government support, and the regional backing of child health panamericanists, the IUPI was unencumbered by imperial or industry interests: its agenda drew from the concerns of health experts, feminists, and child advocates grounded in local problems in settings where children's health policies were intertwined with burgeoning protectionist states.

One reading of this story suggests that Uruguay was able to carve out an aspect of international health that was of little moment to the larger community. But given the LNHO's early interest in the IUPI and the extensive worldwide concerns with maternal and child health in this period (Fildes, Marks et al., 1992), and subsequent international attention to children's health through such organizations as Unicef (Gillespie, 2003), this thesis holds little water. Instead, the founding of the IUPI and the export of child health and welfare ideas that originated or were refashioned in Uruguay pushes us to rethink the politics and epistemology of international health movements.

Certainly, this 'Uruguay round' of international health reaffirms the research of the last decade that science, medicine, and public health in Latin America and other underdeveloped regions have been shaped by far more than the standard center-periphery logic, whereby international health ideas and practices are understood to emanate asymmetrically from the world's economic and political centers of power and consensus to peripheral locales. Indeed, this so-called "bottomless triangle" (Cueto, 1994) theory of scientific diffusion has faced a crescendo of critique in recent years, with far more complex understandings of the national and local filters through which international developments have been selected, rejected, shaped, accommodated, and returned (through so-called "Atlantic" or "South Atlantic Crossings"; Rodriguez, 2004). Also replacing the theoretical unidirectionality of scientific and policy evolution have been notions of "scientific excellence in the periphery," exemplary national or regional medical and public health pioneers, and local exceptionalism. While these conceptions usefully counterpose centrifugal models of knowledge and practice,

they do not necessarily transcend the center-periphery dichotomy and are at times understood as *sui generis* cases that defy any particular logic.

This study, by contrast, suggests that as much as Uruguay borrowed ideas and practices from afar, it also promoted and exported its own approaches through the tools and media of the day: specialized institutions, scientific journals, scholarly conferences, international agencies, and public health networks. Combining the critiques of diffusionism with the idea of Uruguay as ‘exporter’ – through active contributions to and influence over the international health arena – leads us to a potentially more useful metaphor (and analytical tool) for understanding the evolution of national and international public health in the modern era: that of circulation, whereby health and scientific ideologies, policies, and practices undergo an intricate process of give and take among multiple actors who are linked in particular professional, political, and practical circles. Figures such as Luisi and Morquio may be understood to be simultaneously national, transnational, and international. Their ideas, practices, and physical locations embody the very notion of circulation, even as their provenance in and from the particular context of Uruguay remains clear. As such, the child health problems, conceptualizations, and solutions (scientific, political, and social) discussed in this paper involve a sense of trajectory, back and forth, and all around, suggesting a rich and complex understanding of international and national public health developments in the early 20th century.

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Submitted on March 2006.

Approved on May 2006.