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Social medicine and international expert networks in Latin America, 1930–1945

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ABSTRACT

This paper examines the international networks that influenced ideas and policy in social medicine in the 1930s and 1940s in Latin America, focusing on institutional networks organised by the League of Nations Health Organization, the International Labour Organization, and the Pan-American Sanitary Bureau. After examining the architecture of these networks, this paper traces their influence on social and health policy in two policy domains: social security and nutrition. Closer scrutiny of a series of international conferences and local media accounts of them reveals that international networks were not just ‘conveyor belts’ for policy ideas from the industrialised countries of the US and Europe into Latin America; rather, there was often contentious debate over the relevance and appropriateness of health and social policy models in the Latin American context. Recognition of difference between Latin America and the global economic core regions was a key impetus for seeking ‘national solutions to national problems’ in countries like Argentina and Chile, even as integration into these networks provided progressive doctors, scientists, and other intellectuals important international support for local political reforms.

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Introduction

In recent years there has been rising interest in the history of social medicine in Latin America (Birn & Nervi, 2015; Galeano, Trotta, & Spinelli, 2011; Krieger, 2003; Porter, 2006; Waitzkin, 2011). Meanwhile, there have been calls in the history of public health in Latin America to go beyond national case studies (and even comparative studies) to more fully understand the dynamics of international and/or transnational institutions and networks (Birn, 2006; Birn & Necochea López, 2011; Borowy, 2009). This paper examines the international networks that influenced ideas and policy in social medicine in the 1930s and 1940s in Latin America. While the character, functions, and influence of international networks in Latin American social medicine since the 1970s are relatively well understood, as a result of living participants, better documentation, and the existence of key coordinating institutions, such as ALAMES (Galeano et al., 2011), for the ‘first wave’ of Latin American social medicine, rising in the interwar period and continuing into the 1940s, the contours of such international networks are less well understood.

Nevertheless, there are many assumptions about how ideas travelled internationally in social medicine. One commonplace notion is that the idea of social medicine migrated to Latin America from Europe, passed down from pioneers like Rudolph Virchow, in the mid-1800s, via his intellectual progeny, through academic networks, into Latin American countries, starting with ‘early adopters’ like Uruguay, Argentina, and Chile (Cueto & Palmer, 2015; Waitzkin, 2011). Another school of

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thought points to the efforts of progressive international institutions, such as the League of Nations (LN) and the International Labour Organization (ILO), which helped foster more integrative analyses of population health problems in line with social medicine (Dubin, 1995; Weindling, 1995, 2006).

Such narratives demand further scrutiny. One problem is that the influence of international networks is often inferred from the mere existence of associations or relationships (such as membership in organisations or attendance at conferences). Relatedly, ideas are often seen to flow, in a top-down or centre-periphery pattern, without due consideration of the give-and-take between Latin Americans and their counterparts abroad. We actually know little about how ideas in international health and social policy were received by the Latin American social medicine milieu.

This paper focuses primarily on the role of Latin American scientists and experts in formal institutional networks organised by the LN and the International Labour Organization during the 1930s, in two major policy domains, social security and nutrition. I argue that international networks were not just ‘conveyor belts’ (Plata-Stenger, 2015, p. 108) for policy ideas in these domains from the industrialised countries of the US and Europe into Latin America. Rather, international meetings were sites of contestation over the causes of health inequalities, the universality of liberal welfare-state policy models, and the role of science in policy. Latin Americans’ participation in these networks tended to reinforce perceptions of difference between Latin America and the global geopolitical core regions; prompted the search for ‘national solutions to national problems’ in some Latin American countries; and fostered stronger intra-regional ties among progressive doctors, scientists, and other intellectuals interested in social medicine.

Thus, this paper embraces the newer historiographic tendency to ‘fully reconsider so-called centre-periphery and imperial-colonial relations, emphasising how each party shapes and is shaped by others through multidirectional influences’ (Birn & Necochea López, 2011, p. 519). To understand these relations, I build upon the work of historians who have pored over the Geneva archives for evidence of Latin American participation in the international health and welfare organisations of the interwar period. I extend this important research by emphasising the local reception of proposals from the international health and social policy episteme in two Latin American countries, Chile and Argentina, as conveyed in published and unpublished local materials, such as medical journals and conference proceedings.

Analysis of formally structured networks around social medicine is complicated by the fact that there were no prominent international organisations for the promotion and advancement of social medicine *per se*, despite the fact that the interwar period is understood as a period of florescence for social medicine. Generally rising usage of the term in noun (*medicina social*) or compound adjective (*médico-social*) forms during the 1930s – in journal, book, and article titles; academic departments; conferences and conference sections; and government programmes in Latin American countries – is a cue that the concept was gaining relevance. While no international meetings on social medicine, as such, were organised in the region during this time, it was a cross-cutting approach employed to analyze an array of health and social problems.

Although defining the field of social medicine is a challenge, two features made social medicine distinctive for its proponents and recognisable as an approach in health science and policy in the interwar period. First and foremost, social medicine advocated for an *integrative causal framework* that stressed the social, economic, and political causes of health problems, in tension with reductionist and increasingly prominent ‘biomedical’ frameworks (Löwy, 2011; Packard, 2016). Second, social medicine questioned the model of *liberal medicine* and called for the state to take a strong role in developing and regulating health systems to serve the collective needs of national populations. With faith in classically liberal, free-market principles at perhaps a low ebb during the economic crisis of the 1930s, such proposals were aligned with the ideological tendencies of the era.

In this paper, after examining the architecture of formal international networks I trace their influence on social and health policy in two areas: social security and nutrition. These were key issue domains that were both shaped by international networks and testing grounds for the relevance of social medicine ideas.

Institutional panorama

Major Geneva institutions of the interwar period, the LN and the ILO, were idealistic experiments to sustain an international liberal political order. Due mainly to its failure to prevent the catastrophe of World War II, the LN particularly has long been dismissed as a failure in international governance, but a revisionist history emphasises the Geneva institutions' roles as pioneer in humanitarian internationalism and as a laboratory for social policy (Borowy, 2009; Kott & Droux, 2013; McPherson & Wehrli, 2015). The Geneva institutions developed a technocratic approach to governance, an ostensibly non-ideological style of policy innovation and transfer, which made them a forerunner to post-war international institutions such as the World Health Organization (WHO), United Nations, and the World Bank (Guthrie, 2013).

The League of Nations Health Organization (LNHO) played a key role in international health governance during the interwar period. The economic dislocations of the Great Depression moved the LNHO towards a 'social medicine' orientation in the research it sponsored and policies it supported (Packard, 2016). Ludwik W. Rajchman, a Polish bacteriologist who served in the key role of medical director of the LNHO from 1921 to 1939, was known for promoting a 'conception of a social medicine serving humanity' and the LNHO paid 'growing attention to social medicine in the 1930s, when [member] governments turned toward social welfare policies' (Dubin, 1995, pp. 59–63). The LNHO's activities shifted, from a focus on technical assistance in programmes to combat specific diseases and epidemiological surveillance, to a 'broader inquiry into disease etiology that encompassed the roles of nutrition, housing, working conditions, agricultural production, and the economy' (Packard, 2016, p. 57). In Europe, this new orientation was especially evident in rural hygiene and malaria policies (Packard, 2007, 2016; Weindling, 1995). But institutional weaknesses and concerns over political neutrality tempered the LNHO's leftward tilt (Dubin, 1995).

Similar to the LN, the ILO – generally known in Latin America as the OIT, Organización Internacional del Trabajo – had a high-minded purpose: that 'lasting peace can be established only if it is based on social justice,' and social justice – often used interchangeably with the concept of 'social peace' – could be achieved only through agreements between labour, capital, and the state, meeting together on equal footing (Guthrie, 2013; International Labour Office, 1944, p. 16). Intrinsic to the ILO's governance practices was the 'tripartite' format, whereby representatives of three parties (labour, employers, and the state) were supposed to negotiate and hammer out resolutions, which initially dealt with regulating industrial working conditions, at regular meetings in Geneva. Though the ILO was not conceived as a public health organisation, its policy models integrated labour and health issues in a variety of ways, first by seeking to address workplace safety, such as a ban on the manufacture of 'white lead' (basic lead carbonate), one of the first examples of international regulation of a chemical occupational hazard. In the 1930s, the ILO increasingly looked beyond questions of occupational safety, workplace conditions, and fair labour contracts towards broader questions of worker health and security.

The Geneva institutions, especially the LNHO, were notoriously 'Eurocentric,' and relations with Latin America were sporadic and slow to develop. Partly due to the costly and time-consuming travel to Geneva, Latin American presence in the LNHO was weak, although notables such as Carlos Chagas of Brazil and Gregorio Aráoz Alfaro of Argentina represented their countries at the LNHO (Dubin, 1995; Weindling, 2006). In dialogue with a French school of 'puericulture,' this Latin American contingent pushed for LN involvement in child and maternal health issues. The LN sponsored a conference on this topic in Montevideo in 1927, leading to the creation of the Instituto Internacional Americano de Protección de la Infancia (IPI), also based in Uruguay. The IPI served as a 'bridge' between the LN and American states, including the US though mainly Latin American countries, but at the same time it had considerable autonomy, both in financial terms and in setting an agenda on child health (Birn, 2006; Scarzanella, 2003). Meanwhile, ILO involvement in Latin America began in 1925 when Albert Thomas, the organisation's director, visited Chile to recognise the progressive labour and social laws its government had enacted in 1924. These included the creation of the

Caja del Seguro Obrero (CSO), a large social insurance fund that offered medical services, and Chile's prompt ratification of several ILO declarations (Wehrli, 2012).

During the tumultuous 1930s, in a push for legitimacy and to ensure their survival, the Geneva institutions increased their activities outside of Europe (Packard, 2016). The ILO intensified its engagements with the region in the 1930s, not least because the ILO leadership 'was aware that the organisation was in dire need of Latin American support if it wanted to survive the looming European crisis' (Plata-Stenger, 2015, p. 97). The ILO also recognised that, in comparison to Europe, Latin American countries were relatively peaceful and politically stable, and already showing demonstrable advances in welfare state policies (Herrera González, 2012). With much of the world's territory still colonised by European powers, Geneva found it hard to ignore Latin America's independent states, who were already involved with closely allied US-led health institutions, the Pan-American Sanitary Bureau (PASB) and the International Health Division (IHD) of the Rockefeller Foundation (RF). Such engagements, argue Cueto and Palmer (2015, p. 106), 'would provide the principal blueprint for the fully "international" health apparatus that emerged in the post-World War II era, when the nation-state became the global norm.'

Relations between the US- and Geneva-based institutions were complicated and inconsistent. While the US remained outside of the LN system, some Americans were well-placed within the LNHO's advisory body, and the RF enjoyed a 'symbiotic relationship' with the LNHO, supplying about 30 percent of its budget (Dubin, 1995). And while the ILO's relocation to Montreal, Canada during the war facilitated its work in the Americas, its leadership had to be mindful of Washington's desires and 'the competitive force of Pan-Americanism' (Singleton, 2012, p. 241). Meanwhile the United States reasserted its hemispheric hegemony with the soft diplomacy of initiatives like the Good Neighbor Policy of 1933 and an attempt to create a Pan-American Labor Organization to supplant the ILO in the Americas. As a result, the planning of meetings to discuss seemingly innocuous and technical policy matters often entailed fraught diplomatic negotiations behind the scenes (Herrera González, 2012; Singleton, 2012).

Ultimately, friction with the US kept Geneva's health institutions from developing strong and sustainable ties with Latin America. For example, the PASB was initially indifferent to child health initiatives, so it did not block the LN's sponsorship of the IIPi. However, just a few years later, PASB director Hugh Cumming (of the US) influenced the composition of the expert team conducting the LNHO-sponsored nutritional survey of Chile in 1935 and intervened to block LNHO sponsorship of a rural hygiene conference in Mexico the same year (Birn, 2006). The IHD's heavy involvement in the control of infectious and vector-borne diseases in Latin America deterred all LNHO efforts in this domain, except for a leprosy research centre in Rio de Janeiro (Birn, 2006).

Thus, during this period Latin American social policy experts, bureaucrats, and sympathetic politicians were often required to gauge and triangulate their interests against those of Europe and the United States. However, the root of these tensions did not necessarily lie in philosophical differences about health and social policy. Packard (2016), among others, has suggested that the Geneva institutions championed social medicine's programme of broader, systemic social and economic reforms, in sharp contrast with the outlook of the PASB and the IHD, which tended to support laboratory research and narrow, technical public health interventions, especially against infectious and vector-borne disease. Yet during the 1930s and 1940s the US supported the expansion of welfare states in Latin America, by promoting its own model of social security developed during Roosevelt's New Deal (Cohen, 1942; Jensen, 2011; Singleton, 2012). No doubt, the US exercised outsized influence in the PASB, but at the regular Pan-American Sanitary Conferences, US representatives exercised only loose control over the meeting agendas, and these meetings became a forum for discussion of a wide range of policy approaches, including some inspired in social medicine. As I discuss below, at international conferences on social security and nutrition, Latin American experts seldom took their cues from European social medicine, and offered their own integrative and politically sophisticated analyses of social and structural causes of local public health crises.

Social security

The ILO was pivotal in disseminating social insurance, a product of Western European liberal statecraft, as a policy model around the world. ILO leaders viewed social insurance as one means to adjust the social contract between labour, capital, and the state, and thus to promote social peace. For some Latin American governments, social insurance was attractive since it offered a practical way to fund the expansion of healthcare services to reach a greater share of national populations. Indeed, one reason for governments to be involved with the ILO was to avail themselves of the technical expertise necessary to launch, finance, and administer these complex social insurance systems (Singleton, 2012).

Not surprisingly, the Latin American governments most involved with the ILO already had some semblance of a social insurance system, and Chile stands out in this respect (Cueto & Palmer, 2015; Labra, 2004). The official publications of Chile's CSO, *Acción Social* and *Boletín Médico-Social*, closely followed ILO meetings and conferences, the travels of its functionaries, and the fate of its many resolutions during the 1930s. In Chile, sustained involvement with the ILO depended on the entrepreneurial energy of people such as Francisco Walker Linares, who served as a 'correspondent' to the LN, and Moisés Poblete Troncoso, a lawyer and one of the few Latin Americans to actually hold a position in the central office of the ILO in Geneva (Wehrli, 2012). Poblete Troncoso was recommended as a candidate for this position because of his immersion in social and labour policy in Chile, along with his avoidance of partisan politics, and would go on to serve as advisor to other Latin American countries on social insurance issues (Martínez Franzoni & Sánchez-Ancochea, 2016; Pernet, 2013; Yáñez Andrade, 2012). Poblete Troncoso and Walker Linares also created a Chilean association in support of the LN; it was a small group, but one composed of influential members of a progressive Chilean political-intellectual elite (Wehrli, 2012).

Given Chile's already high level of participation in the ILO, Santiago was a natural choice for the first ILO Regional Labor Conference in Latin America, in January 1936 (Singleton, 2012). Unlike other networks around social medicine – such as eugenics, puericulture, hygiene, and nutrition, which were largely dominated by members of the medical profession and allied sciences – the ILO meetings brought together a wider range of professions, interests, and outlooks. Lawyers, economists, accountants, actuaries, and an increasingly professionalised labour union sector convened to discuss the intricacies of social insurance and industrial labour conditions, while medical professionals, who were protagonists in other expert networks, were mostly at the margins. Labour leaders, for their part, used the occasion of the 1936 Santiago conference to collaborate, strategize, and organise their own networks while adopting a cautious stance toward the ILO governance process (Herrera González, 2013). Coincidentally, the first Chilean National Medical Convention, a landmark in the history of the development of social medicine in the country, was held at the very same time, in Valparaíso, which might also explain the low turnout of physicians at the ILO meeting.

Despite several months of planning for the conference, led by Poblete Troncoso, the deliberations of the meeting largely departed from the narrow agenda set by the ILO. Adrien Tixier, the head of the ILO social security office, wanted to focus on moving Latin American countries toward ratification of declarations on just two issues: 'social insurance and the working conditions of women and children' (Plata-Stenger, 2015, p. 106), but in their speeches delegates covered a wide range of subjects, including immigration, monopolies, international trade, minimum salaries, the special problems of indigenous groups, and housing conditions. Labour union representatives made use of conversations outside of sessions to discuss the common interests of labour across the hemisphere and signed a pact to form a Latin American labour confederation, eventually realised in the formation of the CTAL, the Confederación de Trabajadores de América Latina (Herrera González, 2015). A lengthy discussion of *alimentación popular* (popular or public nutrition, roughly), discussed in more detail further on, was also a surprising departure from the conference agenda.

The discussion of social insurance policy was marked by a general affirmation of the ILO's objectives, but there were also intriguing silences, divergences, and skepticism, particularly from organised

labour. The ILO's social insurance model centred on adjusting the labour contract to include 'sickness insurance' that encompassed, first, 'compensation' for lost wages, and second, 'restoration' of 'health and working capacity' (International Labour Office, 1935, pp. 50–51). The Latin American delegates at the Santiago conference offered a more expansive concept of social insurance, in line with social medicine, 'especially the need to link social insurance to other policies such as medical services' and 'to prevention, worker education on hygiene, and nutrition' (Plata-Stenger, 2015, p. 107). Voicing the concerns of the conference's social insurance committee, Edgardo Rebagliati, the governmental delegate from Peru, pointed to the special circumstances of Latin American countries, 'still in the critical stages of their organization,' which called for integrating social insurance into 'the fight against diseases, [which are] the eternal source of poverty, desperation, and decrepitude of nations' (O.I.T., 1936, p. 245). Some labour delegates viewed social insurance programmes with skepticism. Luis Solís Solís, the Chilean labour representative, rather than praising his country's social security system argued that the CSO was underfunded (due mainly to the meagre contribution required from employers), ineffectual (the country continued to suffer from rampant infectious diseases and high infant mortality, giving Chile 'one of the lowest life expectancies in the world'), and did nothing to address the underlying structural problem for Chilean labour, the gap between low wages and the extremely high cost of living (O.I.T., 1936, pp. 64, 255–256).

In the following decade, the ILO continued to strengthen its ties to Latin American states, by holding two more regional conferences in Havana in 1939 and Mexico in 1946, establishing several branch offices in the region, and working to develop a cadre of technical experts in social security (Jensen, 2011; Plata-Stenger, 2015). Meanwhile, social security was integrated into the hemispheric public health agenda: the Tenth Pan-American Sanitary Conference in Bogotá in 1938, sponsored by the PASB, offered express support for social security as a 'means to defend collective health' (Oficina Sanitaria Panamericana, 1938, p. 4). Unfortunately, the ideological and material commitments of the US to promoting social security systems and labour rights more generally in the region, through its influence on the ILO, diminished rapidly after World War II, while the PASB (reborn as PAHO) largely neglected social insurance as it concentrated efforts on the control of infectious and vector-borne diseases (Cueto, 2007; Jensen, 2011).

Nutrition

During the 1930s, the Geneva Institutions became increasingly focused on the problem of adequate nutrition. Because of its 'clear connections with broader social and economic processes related to the production and consumption of food,' nutritional research was often caught between the integrative approach of social medicine and the reductionist tendencies of physiology and cell biology (Packard, 2016). Corinne Pernet (2013) contends that, compared to the ILO's broad social vision, the LNHO supported 'pure science' research in nutrition, with priority placed on defining international nutrition standards and tracing the health impacts of malnutrition, while largely neglecting how underlying social and economic conditions contributed to malnutrition. Even with this integrative approach, the ILO valued scientific research on nutrition to establish baseline standards for nutritional needs of workers and their families, a key component for calculating a 'living wage' (Pernet, 2013).

Both the LNHO and ILO supported expert missions to Latin America and sponsored conferences on nutrition. Absent a coherent policy agenda from Geneva, discussions of nutrition in Latin American circles were open, fluid, and wide-ranging. However, the same tensions between 'integrative approaches' and 'reductionist tendencies' played out among Latin American experts in nutrition, particularly with the region-wide leadership of Pedro Escudero of Argentina, who sought to elevate nutrition to a science and, quixotically, to isolate the realm of food and agriculture from everyday politics.

In one well-studied event in this larger process, in 1935 the LN sponsored a survey of nutritional conditions in Chile, led by Carlo Dragoni, of the University of Rome and the International Institute

of Agriculture, and Etienne Burnet, formerly of the LNHO and then-director of the Pasteur Institute in Tunisia (Pernet, 2013; Scarzanella, 2003; Weindling, 2006; Yáñez Andrade, 2017). The Dragoni-Burnet survey ‘bewildered European nutritionists’ who found it hard to believe that many Chileans could survive on fewer than 900 calories per day, believed to be less than the minimum for survival (Borowy, 2009, p. 390; Wehrli, 2012). The report was ‘not limited to information about food consumption, but also covered spending on housing, electricity, [and] fuel, offering a complete picture of the living conditions of the Chilean working class’ (Scarzanella, 2003, p. 10).

Some Chilean commentators used the Dragoni-Burnet survey to expose the macro-structural causes of the country’s nutrition crisis. One left-leaning medical journal asserted:

Two technical experts of the League of Nations have reaffirmed what we have so often said about our country. Our people are dying of hunger, live in pigsties, and the level of abandonment and misery can be compared only with the most backwards countries on earth. The figures from Dragoni-Burnet completely confirm our tragedy, which is the same as all the Indo-American countries; a semi-feudal economy, overpowering influence of foreign imperialists and the creole oligarchy of bankers and landowners at their service. (*Boletín Médico de Chile*, 27 March 1937, p. 4.)

Here, as was so often the case, the pronouncements of respected international experts were used by local actors to support their insistent claims against recalcitrant governments and powerful social sectors (Weindling, 2006). The prestige of LN scientists validated what were becoming widespread calls for reform of the agricultural sector in Chile and attention to the social causes of malnutrition (Mardones Restat & Cox, 1942).

At the same time, however, the substance of Dragoni and Burnet’s report was distorted to support certain political arguments. For example, while these European nutrition experts did collect social and economic data, they did not actually go so far as to ascribe the malnutrition crisis to imperialism and latifundia. The fact that the entire report was published only in French in Chile, and not until 1938, probably encouraged wide-ranging and competing interpretations of its findings (Dragoni & Burnet, 1938).

Nutrition dominated an entire day of discussion at the 1936 Labor Conference in Santiago, organised by the ILO, under the rubric of *alimentación popular*. Many delegates called for governments to intervene more directly in the production, distribution, and commercialisation of food, ranging from strict control of food advertising, subsidies and price-setting to reduce the cost of food, adjustments to wages in response to the high cost of living, and the reorganisation of national economies to improve markets for domestic food products, which involved road building and other infrastructure.

More radical perspectives on nutrition came from the labour sector. Vocal Chilean labour delegate Luis Solís Solís said, ‘we are not interested’ in participating in national partisan politics, because ‘we are the opposition to a regime, to a system of exploitation’ (O.I.T., 1936, p. 192). He went on to say, ‘men will eat when food production and trade are in the service of the collective, and not for profit; that is, in a socialist society’ (O.I.T., 1936, p. 192). ‘In the meantime,’ though, he proposed a more practical set of resolutions, calling for the ILO to support conducting more detailed surveys of salaries, diets, and the cost of living in member countries. Solís apparently understood the power of appealing to such numbers to establish the factual basis for policy discussions, even while dismissing the general reformist approach in social policy.

The ILO leadership was caught off-guard by the interest in *alimentación popular* at the 1936 Santiago Conference, and the resolutions related to nutrition approved at the meeting received little attention back in Geneva (Pernet, 2013). But persistent Latin American interest in the issue, along with political uncertainties in Europe, compelled the LN to hold its Third International Nutrition Conference in Buenos Aires in 1939. While the first two of these conferences, held in Geneva in 1937 and 1938, had almost exclusively European representation, in Buenos Aires the situation was reversed. With the exception of the LN’s own representative, Louis Rasminsky, and the U.S. delegate Hazel K. Stiebeling, all of the attendees were from Latin America and the Caribbean. And in contrast to the 1936 ILO-sponsored Santiago conference, where medical and scientific professionals were

largely absent, the 1939 Buenos Aires meeting was dominated by those with a medical background, led by Pedro Escudero, whose Argentine National Institute of Nutrition was widely admired by nutritionists across Latin America (Buschini, 2016). Notably, only one person attended both the 1936 Santiago labour conference and the 1939 Buenos Aires nutrition conference: Alejandro Unsain, Argentina's representative to the ILO (Ramacciotti, 2015).

There was scant consensus at the conference on the best approach to addressing persistent nutritional problems. Escudero and the other Argentine delegates tended to emphasise the high quality of their research on nutrition, including the advanced state of data collection on working class consumption habits. Juan Collazo explained how Uruguay's government had, for at least a decade, given priority to managing and regulating all aspects of the food economy, making the country almost self-sufficient in food, available at reasonable prices, with high nutritional standards that were largely being met. José J. Rada of Peru promoted 'comedores populares' (also called 'restaurantes populares'), which were large government-run cafeterias that offered standardised, balanced menus at subsidised prices, aimed especially at urban industrial workers (Drinot, 2005). Peruvian delegates had also showcased this programme at the 1936 Santiago labour conference, and similar strategies had recently been attempted in Chile, as part of an effort spearheaded by Minister of Health Eduardo Cruz-Coke to improve 'alimentación popular' (Zárate Campos, 2012). Yet Escudero, for his part, worried that *restaurantes populares* were mainly a tool of political patronage, with the potential to 'break apart the family' at meal time, which should be 'the family hour, serving to gather the family together for its spiritual integration.' By contrast, *restaurantes populares*, absent any 'social and technical control' from nutritional experts, would lead to *comunización*, an allusion to socialist collectives of the time in the Soviet Union (Escudero, 1940b, p. 333; 1940c, p. 246).

Despite these differences, by sharing their national experiences, delegates discovered a common set of development problems across the region that tended to make food more expensive and less healthful: lack of good roads, monopolies in the food industry, export agriculture, imported foods, deficient salaries, regional diets, ignorance of the science of nutrition, and economic policy priorities. Summarising the proceedings, Escudero stated that the conference 'had demonstrated the reality of a spiritual union of the Latin countries: the same problem concerns them, the same malady burdens them. All [delegates] felt united to seek out the path towards liberation' (Escudero, 1940b, p. 335). Distinctive socioeconomic conditions and shared cultural roots meant that 'South America should take on the problem of nutrition with an American approach.'

The notion of a culturally distinctive Latin America faced with common social and public health problems was typical of the time, and evidence of a rising class of regional scientific experts resistant to longstanding European hegemony in their fields (Cueto & Palmer, 2015). But this project of Latin American identity formation took on new texture in a pair of articles Escudero wrote in 1940 for the Argentine magazine *Viva Cien Años*, which served as a popular forum for advice on healthy living. Drawing on some of the national cases presented at the 1939 conferences, Escudero adopted an idiom familiar to eugenicists, explaining that, 400 years after the Conquest, indigenous and mestizo peoples of the continent continued in a state of biological 'slavery,' holding on to diets that made them 'obedient, lacking in rebelliousness, without a spirit of improvement' (Escudero, 1940a, pp. 140–145). In line with the prevailing spirit of eugenics, a movement that he was not formally affiliated with, Escudero perceived that social discord and political tensions had biological roots, specifically in the degenerative effects of malnutrition concentrated and passed down, over time, in distinct ethnic groups. In this way, the nutritional studies of Escudero and others fit with the central tendency of so-called 'Latin' eugenics, that genetic endowment was not determinative of health or life chances, which could be shaped by medical and social interventions, guided by science, in nutrition, hygiene, sanitation, and education (Reggiani, 2010).

Despite Escudero's interpretations for a general Argentine audience, the discourse on race was muted during the 1939 conference. Possibly, delegates perceived that it was impolitic to speak in highly racialized terms in international scientific forums. In late 1939, when the conference took place, Europe was already at war and the LN was seen as a failure in international governance.

But the LN was also anti-fascist and its agenda aimed, albeit unsuccessfully, to limit the excesses of virulent nationalisms underwritten, in part, by the science of eugenics. In a way, the LNHO and its sponsorship of nutrition studies anticipated the ‘anti-racist’ rationale of international research in biomedicine of the post-war period (Wade, 2017, pp. 28–29). Thus, international networks fostered by the prestigious Geneva institutions may have tamed or moderated racialized explanations of social problems.

Discussion: Latin America and international social medicine

In contrast to core–periphery or imperial-colonial models, Anne-Emanuelle Birn’s model of ‘circulation’ helps us make sense of how ideas in social medicine flowed through international networks. By circulation, Birn means that ‘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’ (Birn, 2006, p. 57). Using this lens, we can see that there was no purposeful diffusion and slavish emulation of a school of social medicine thought from Europe. Ultimately, the Geneva-led initiatives in Latin America added little to advance an already vibrant ‘social medicine’ movement. If anything, Latin Americans presented a more politically radical and epistemologically integrative view of social medicine and the welfare state that exceeded the modest and technocratic recommendations of the Geneva institutions.

Engagement with broader international networks brought another tension into sharp relief for Latin American experts, between internationalism and universalism (Wehrli, 2012). The ILO, in particular, tried to diffuse social policy models it saw as viable everywhere. Latin Americans at the regional labour conferences were not convinced, instead contending that many ILO resolutions were not relevant for Latin American countries, where industrial development was incipient. At these meetings, Latin American delegates had the eye-opening experience of finding some common interests and even a common frame around the experience of international economic depression from a dependent, semi-colonial position. These core–periphery tensions were subtle at the ILO meetings, but they reflect a larger intellectual project of Latin American identity construction of the 1930s, and anticipate the appeal of geopolitically attuned structuralist and dependency theories in Latin American development during the Cold War era.

The activities of the Geneva institutions may have helped to temper the influence of the Latin American eugenics movement. While ideas about racial degeneration of national populations permeated social policy discourse in the interwar period, at the Latin American conferences sponsored by the ILO and the LN, calls for eugenicist measures to raise the quality of the population were infrequent. Experts in social security and nutrition apparently saw little explanatory power in eugenics, which privileged constitutional-biological or genetic mechanisms to explain population health conditions. In a study of José Francisco Socarrás, a Colombian doctor, Stefan Pohl-Valero persuasively demonstrates that there was no inherent contradiction between reductionist nutritional science and the key eugenicist project of preventing ‘racial degeneration’ (Pohl-Valero, 2016). Yet as the case of Pedro Escudero shows, by the late 1930s Latin American experts were perhaps mindful that the rhetoric of race science and eugenics was inappropriate on the international stage but still acceptable and even persuasive for national audiences. Quite possibly, as the 1930s progressed, the Latin American eugenicists’ network became tighter but also more isolated, cut off from more important currents in health and social policy, and out of step with the movement towards more expansive welfare states, a key legacy of social medicine.

Overall, formal international networks influenced the development of social medicine in Latin America in the 1930s, but probably in a limited way. Latin American experts’ awareness of international health and social policy trends probably resulted more from a lettered culture of scientific publication and diffusion, while interpersonal contacts in professional networks at specific events like conferences may have been secondary in importance. Journals such as *Acción Social* or *Boletín Médico-Social* in Chile reported constantly on health and social policy innovations elsewhere in the

region, the US, the Soviet Union, Western Europe, and even Asia. The news of the 1939 Buenos Aires conference reverberated widely and quickly, thanks to widely disseminated publications like the *Boletín de la Oficina Sanitaria Panamericana*. For example, within months of the conference, the young doctor José María Bengoa – apparently disconnected from these formal networks – incorporated Escudero's recommendations into his treatise on social medicine in the Venezuelan countryside (Bengoa, 1992 [1940], pp. 82–84).

The Geneva institutions were able to conduct studies and convene conferences on important issues like nutrition and social security, but hardly established the deep and integrated networks that led to the building of strong and lasting institutions in Latin America. Unlike international development institutions of the Cold War era, the Geneva institutions had almost no financial or geopolitical leverage, such as development aid, to promote their agenda in the region. The ILO and LN worked most effectively in countries with existing pro-Geneva associations and energetic policy entrepreneurs, like Chile and Argentina. Moreover, it is fair to say that the 'circulation' of ideas was not complete, as Latin America's influence on European social medicine appears to have been minimal. However, it may be the case that their impact was delayed, given the key role played by Latin American states in forming the WHO, based on principles of universal social and health rights (Cueto & Palmer, 2015).

Conclusions

Tracing these international networks is valuable for understanding the development of social medicine and the expansion of welfare states in Latin America. One little-recognized role of these networks is that they did a lot of epistemological 'work,' i.e. defining problems, delineating boundaries between fields of study, propelling the development of new fields, and exploring explanations that crossed between disciplinary domains. Social medicine's tendencies were always centrifugal, integrative, and anti-reductionist, expanding the boundaries of the study and practice of medicine to include the study of the political-economic and social structures that shaped life chances. If the ILO and the LN offered something like a 'social medicine' perspective and advanced the development of strong welfare states, they did so in a Latin American context where such proposals were already gaining acceptance. And while the US stance towards Geneva institutions was often aloof, it is important not to exaggerate philosophical and policy differences between them. At least into the late 1940s, the US lent support to welfare state initiatives in Latin America, through the example of its own progressive social security legislation and the wide-ranging agendas of the Pan-American Sanitary Conferences.

One limitation of this paper is the necessarily partial analysis of international networks, focused on Geneva- and US-based multilateral institutions. More analysis is needed of less obvious, even dissident networks in social medicine, outside the boundaries of international scientific technocracy. As Weindling (2006) and Pernet (2013) point out, most of the Latin Americans involved in Geneva-sponsored policy networks were well-established public health officials, who valued stability and order, and thus looked for ways to manage and reform society scientifically, or technocratically, while staying above the fray of ordinary politics. Yet more politically radical groups of medical professionals, which are often recognised in national histories of social medicine (e.g. anarcho-sindicalist doctors such as Juan Lazarte in Argentina or the socialist-leaning 'Vanguardia Médica' group in Chile that included a young Salvador Allende), were not integrated at all into the networks analyzed in this paper. Tracing these networks would be challenging but rewarding, as their influence shows in the radical, collectivist strands of thought that characterise Latin American social medicine.

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