Uruguay on the World Stage

How Child Health Became an International Priority

The evolution of international health has typically been assessed from the standpoint of central institutions (international health organizations, foundations, and development agencies) or of one-way diffusion and influence from developed to developing countries.

To deepen understanding of how the international health agenda is shaped, I examined the little-known case of Uruguay and its pioneering role in advancing and institutionalizing child health as an international priority between 1890 and 1950.

The emergence of Uruguay as a node of international health may be explained through the country's early gauging of its public health progress, its borrowing and adaptation of methods developed overseas, and its broadcasting of its own innovations and shortcomings. (*Am J Public Health.* 2005;95:1506–1517. doi:10.2105/AJPH.2004.038778)

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THE HISTORY OF INTERNATIONAL health has typically been examined from the perspective of metropolitan institutions such as the World Health Organization, the International Red Cross, and the Rockefeller Foundation.[1–5] While some works trace the interactions of these agencies with far-flung actors, the motives, ideas, and operations of international health are invariably portrayed as centrally determined, then diffused around the world. To broaden this account of the development of the international health agenda, I examine the little-known case of Uruguay and its pioneering role in advancing child health 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 International American Institute for the Protection of Childhood (Instituto Internacional Americano de Protección a la Infancia, or IIPI), the first permanent organization of its kind, founded in 1927, Montevideo became a node of international health which—though lacking the political cachet of Washington, DC, or Geneva, Switzerland—helped shape a worldwide children's health agenda.

The transformation of Uruguay's domestic debates into an influential institute can be observed through the international networks of Uruguayan doctors and child health advocates, the opportunities and interests that gave rise to the IIPI, and its repercussions, including Uruguay's Children's Code. My analysis, unlike a conventional history, highlights the emergence of a significant initiative from a peripheral location through the interplay of local political and social conditions with widely shared health priorities.

THE URUGUAYAN WAY

Despite its small size and its distance from the centers of power, Uruguay became engaged with international health developments beginning in the late 19th century. Founded in 1830 following a longstanding conflict between Spain/Argentina and Portugal/Brazil over possession of its territory, Uruguay enjoyed relative stability and a cattle-based economy after its civil wars subsided in 1851. 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. The country was peopled largely by Spanish and Italian immigrants, with a small elite of French ancestry and a few descendants of African slaves. Uruguay's approximately 1 million residents (one third of whom lived in the capital, according to the1908 census)[6] shared a self-effacing longing for Europe while developing their own brand of state protectionism.

Uruguay differed from most Latin American countries in that the Catholic Church and the landed elites were relatively weak forces as the modern state began

to take shape in the late 19th century. Moreover, the country's sparse institutional infrastructure in the social arena left room for state growth.[7,8] The rapid expansion of public education for both sexes that started in the 1870s—making Uruguay the region's leader in literacy, with 54% literacy in 1900[9]—presaged the welfare state, which emerged in full force under the reformist Colorado Party administrations of President José Batlle y Ordóñez (1903–1907 and 1911–1915). 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 for the civil service.[10]

A severe economic crisis in 1913 accelerated the implementation of various Batllista policies—including an 8-hour workday and exemption from taxes on essential goods—that seemed to prefigure Keynesian approaches to mitigating the social and economic inequalities provoked by capitalism. Indeed, Batlle conceived 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.[11,12] That progress in enacting reforms was slow—in part because the reforms yielded contradictory results, such as lower wages[13–15]—did not cause the country to be viewed as a failed experiment. Instead this stepwise approach elicited 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 those improving 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 had a still largely rural economy. Like other Latin American countries, Uruguay was not tied to a single international mandate, instead interacting with a changing panorama of public health examples.

Mid–19th-century European concerns with preventing the spread of epidemic diseases—and the economic consequences of the resulting 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. The 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 5 years before it broke apart. A 1904 successor convention included reciprocal notification. These treaties presaged pan-American efforts to prevent infectious outbreaks originating from immigrant and commercial vessels.[16]

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 (from Adolphe Pinard's notion of the scientific cultivaiton of childhood and the improvement of child health and welfare through better conditions of childrearing) measures—that was most influential. In the 1930s many Uruguayan social policymakers and doctors admired the Soviet health system. By the 1950s, Uruguayan public health was increasingly influenced by the technical and biomedical approach of the United States. Uruguay was never "passively derivative"[17] of these models, instead selecting features from abroad and melding them with the ideas, reality, and politics at home.

A particular mark of Uruguay's early participation in international health discussions was the founding of the Civil Registry in 1879,

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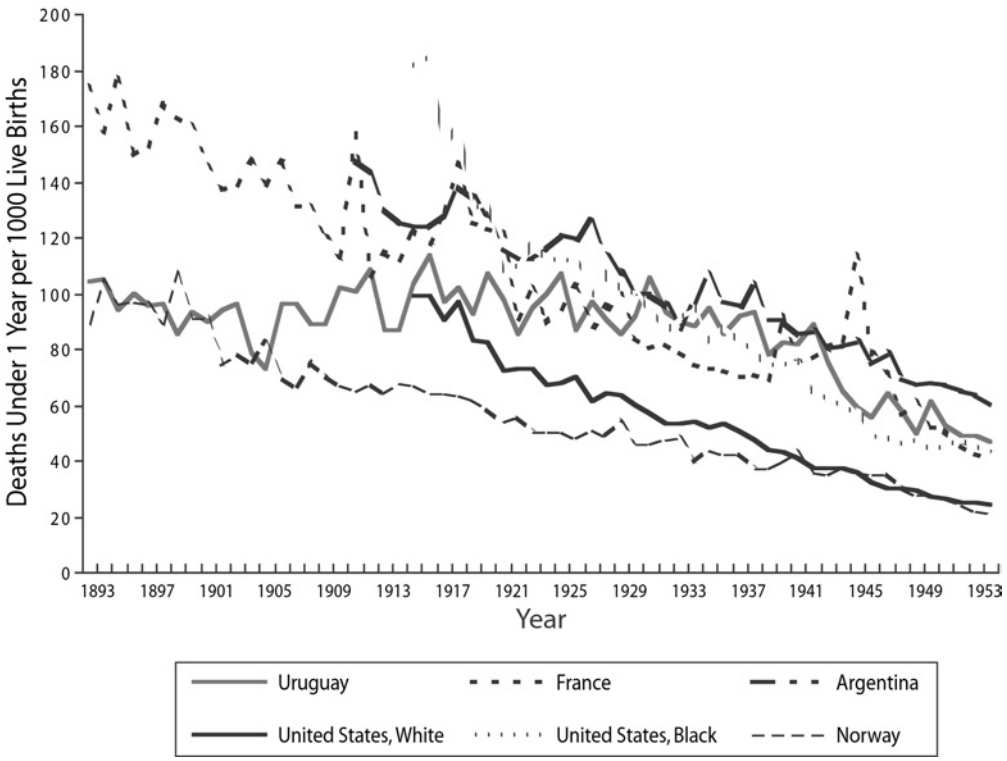
mandating the regular collection of birth and death records. Most of the nations that developed comprehensive vital statistics systems before 1900 were major powers concerned with population health as a sign of economic vitality. Rapidly industrializing England, France, and Germany, for example, monitored the survival of children as an indicator of workforce and military readiness and imperial strength.[18,19] Though it had little industry and no pretense to 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.[20]

The European connections of the Uruguayan elites also propelled data collection. The country's statistical annuals were self-consciously modeled after Parisian volumes,[21] and by the mid-1890s public health authorities in Montevideo had adapted Jacques Bertillon's classification of diseases, making Uruguay's mortality statistics comparable to those in many European settings. These developments were facilitated by Uruguay's rapid medicalization in the second half of the 19th century: more than 40 medical periodicals were founded, numerous hospitals and clinics were 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.[22,23]

Statistical annuals compiling cause-specific mortality data were first published in 1885,[24] 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 per 1000 live births in 1893 to 72 per 1000 in 1905. Over the next 35 years infant mortality stagnated, fluctuating between 85 and 113 deaths and averaging 95 deaths per 1000 live births. Only after 1940 did infant mortality resume its decline. Although other countries reported higher levels of infant mortality than Uruguay at particular points in time, virtually every other setting experienced continuous—if sometimes bumpy—declines[25–27] (Figure 1).

Uruguay was thus unusual on several counts: in establishing a functioning civil registry early on, in achieving lower infant mortality rates than several European countries, and in experiencing a prolonged stagnation in infant mortality rates. The country's early successes and its subsequent setbacks with infant mortality impelled health experts to identify the underpinnings of local circumstances and to search for international approaches that might prove helpful.

FIGURE 1—International comparisons of infant mortality rate,1893–1953.



URUGUAYAN PUBLIC HEALTH ABROAD AND AT HOME

In 1895, approximately a decade after Uruguay's civil registry achieved regular coverage, public health powers were consolidated under the National Council of Hygiene. Uruguay now had information, centralized authority, and a cadre of medical and public health experts keen to participate in international health developments. This group of experts documented Uruguayan health and mortality domestically and comparatively; advised policymakers; ran health and welfare institutions; saw

patients in clinical settings; and participated in international congresses, publications, and other scientific activities.[28,29]

An early member of this group was Joaquin de Salterain (1856–1926), whose career 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 go to Paris for specialized training in ophthalmology. Rather than narrowing his focus, his fellowship widened it, and on his return to Uruguay he became involved in a range of health activities. De Salterain was a constituting member of the National Council of Hygiene, and in the mid-1890s he began to publish detailed analyses of Montevideo's mortality statistics.[30,31] De Salterain headed Montevideo's Department of Public Health and was a program director in the Pereira Rossell Children's Hospital (founded in 1905) and the Dámaso Larrañaga children's asylum (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.

From the 1890s on, Uruguayans participated in virtually every international congress related to public health and social welfare. They published their own presentations in either Uruguayan or international journals and typically issued analytic summaries of the conference discussions in Uruguay's *Boletín del Consejo Nacional de Higiene (Bulletin of the National Council of Hygiene)*. Medical elites from throughout the Americas received advanced training in Europe during this period, making contacts, attending congresses, joining scientific networks, and pressing their own governments to expand activities. But few countries, particularly small countries, achieved as consistent an international presence as did Uruguay. Most countries sent 1 representative to the 1900 Paris conference at which the *International Classification of Diseases* was first revised; Uruguay sent 2.[32] Similarly, the 7-person delegation Uruguay sent to Washington, DC, for the 15th International Congress on Hygiene and Demography in 1912 was larger than that of all but a handful of countries.[33] That this attendance was at state expense—at a time when the National Council of Hygiene relied on a largely volunteer labor force—implies that politicians and bureaucrats believed Uruguay's health learning would take place internationally.

Uruguay's reorganization and expansion of social welfare fit with this notion of selectively adapting foreign developments. In 1907 Uruguay was among the first countries outside Europe and its colonies to found a milk station (*gota de leche*) based on the French model (*goutte de lait*) to distribute pasteurized milk and provide medical attention to needy mothers and their infants.[34] By 1927, 33 milk stations had been established throughout the country, arguably covering the largest proportion of mothers and infants in the world. This number was exceeded only in 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.[35] Uruguay also maintained Anglo-America–style private aid agencies (typically run by women), some of which received government grants to deliver services.[36–38] The full legalization of divorce (including divorce unilaterally initiated by women) in 1913[39]—giving the country one of 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. Equally striking is how Uruguay's self-publicized problems catapulted the country to regional and international attention.

In the late 19th century European countries began to conduct mortality comparisons, a practice Uruguay fully adopted. De Salterain observed in 1896 that Uruguay's mortality rate was dropping steadily and that Montevideo's rate was lower than those of Paris, London, St Petersburg, and Buenos Aires. 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?"[40]

Other colleagues followed suit, especially after the infant mortality rate emerged as an international indicator around 1900.[41] In 1913, Julio Bauzá, the doctor heading Montevideo's milk stations, 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."[42]

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 the country's borders. Luis Morquio (1867–1935), the founding father of Uruguayan pediatrics and a leading authority on both medical and social aspects of child health, was the most prominent translator of the local experience to the international scene. In 1895, upon returning to Montevideo from training in Paris, he became medical director of the external services of the Orphanage and Foundling Home. There he oversaw an extraordinarily low—for the 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.[43,44]

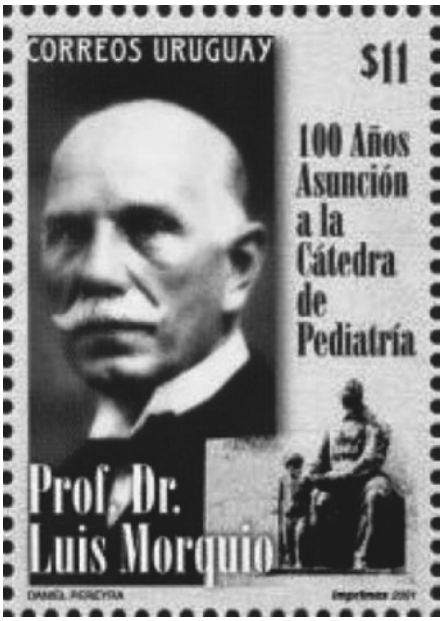


FIGURE 2—Stamp commemorating the 100 years since Dr. Luis Morquio became the Chair of Pediatrics at the Faculty of Medicine at Uruguay's University of the Republic. Bottom right corner includes the statue of Morquio with a child that stands along one of Montevideo's main boulevards. The stamp was designed by Daniel Pereyra. (Courtesy Administración Nacional de Correos, Uruguay.)

Morquio was presenting his analyses of Uruguay's experience to Latin American medical congresses by 1904 and to European audiences soon after. If Morquio agreed that Uruguay's infant mortality rates—rates favored, he believed, by environmental cleanliness, low population density, and high levels of breastfeeding[45]—deserved some international appreciation, he did not dwell on success, arguing that half of the infant deaths were avoidable[46] (Figure 2).

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.[47] Morquio—who by this time had served as the medical director of the largest children's asylum, chief of the pediatric clinic in the main public hospital, and a professor of clinical pediatrics—believed that some of the international measures adopted by Uruguayan health authorities had unintended consequences. He worried that milk stations discouraged breastfeeding by offering free or subsidized milk, and that this milk was often contaminated.[48]

Thereafter, numerous doctors chimed in on sometimes acerbic debates over the role of public health institutions, social and economic conditions, illegitimacy, abandonment, sanitation, climate, and cultural factors in Uruguay's stagnating infant mortality.[49] 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 more than 1000 journal articles related to child and infant health between 1900 and 1940 (estimate based on a bibliographic database compiled by A.-E.B.).

Morquio himself was a major contributor to Uruguay's international renown, writing an average of 9 articles per year between 1900 and 1935. Almost half of his output appeared in foreign publications, including *Archives de Médecine des Enfants* (France), *La Nipiologia* (Italy), *Journal of Nervous and Mental Diseases* (United States), and the *Archivos Latino Americanos de Pediatría*, which he cofounded.[50] Most of his 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*,[51] which introduced it by emphasizing its "universal relevance."

Almost as soon as they began to be compiled, Uruguay's infant mortality statistics were viewed simultaneously in 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.

URUGUAY'S HEALTH INTERNATIONALISM

By the 1920s the international health landscape consisted of a handful of permanent agencies, based 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 the International Sanitary Convention in Washington, DC, at which the International Sanitary Bureau

was founded. The International Sanitary Bureau, renamed the Pan American Sanitary Bureau (PASB) in 1923, was the world's first international health agency.[52]

Operating out of the US Public Health Service under the directorship of the US 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 sixth conference in Montevideo in 1920, at which US 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 was passed in 1924, and cooperative activities with member countries were also initiated in the 1920s.[53,54]

Another key agency involved in international health was the New York–based Rockefeller Foundation, founded in 1913. The foundation's 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.[55,56] Interestingly, Uruguay was virtually the only country in the region untouched by the Rockefeller Foundation (perhaps because it no longer experienced any of the foundation's showcase diseases), leaving the country all the more inclined to pursue public health approaches broadly.

In Europe it took more than half a century to transcend 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 organizations. 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. The head of the epidemic commission, the Polish hygienist Ludwik Rajchman, ably transformed it 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. Under Rajchman (who later helped found 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).[1,57]

Uruguay became involved with the LNHO in the early 1920s, most notably through Paulina Luisi, the country's first woman doctor and its leading liberal feminist.[58–60] Active in regional feminist, scientific, and child welfare circles, Luisi soon leapt to prominence on the international scene. She was the only Latin American woman delegate to the first League of Nations Assembly, participating in various treaty, disarmament, and labor conferences. In 1924 she became an expert delegate on the League of Nations advisory commission on white slavery, and for 10 years she was one of only 2 Latin American delegates on the Committee for the Protection of Childhood (the other being an IIPI representative). Luisi forcefully advocated increased Latin American perspectives in the League of Nations' work for children, including surveys of needs and policies as well as greater representation in governing bodies[61–64] (Figure 3).

THE BIRTH OF THE IIPI

Another key dimension of international organizing in this period consisted of periodic congresses, mostly held in Europe, devoted to questions of hygiene, demography, statistics, and child welfare.[41] Two international associations for childhood protection were conceived in Brussels in 1907 and 1913, but their institutionalization was aborted and their activities were absorbed by League of Nations committees in the 1920s.

In the Americas, meanwhile, 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

FIGURE 3—Paulina Luisi, Uruguay's first female doctor, with her Faculty of Medicine classmates in September 1901. (Photo courtesy of the Department of History of Medicine, Faculty of Medicine, University of the Republic, Montevideo, Uruguay.)

and children. The 8 hemispheric meetings 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.[65] Although the first Pan American Child Congress was organized by "maternalist feminists" who viewed the lot of children as inextricably linked to the rights of women as mothers,[60,66] control over the Latin American child welfare movement was soon seized by male professionals, as evidenced by the preponderance of male presenters at the successful second congress, held in Montevideo in 1919. Even presider Paulina Luisi was upstaged by Luis Morquio's high profile.[67]

It was at this congress that Morquio called for an international institute for childhood protection to be based in Montevideo, a proposal enthusiastically sanctioned by the Uruguayan government through a 1924 decree and approved by the fourth Pan American Child Congress, held in Santiago later that year.[68] But the founding of the IIPI awaited an outside impetus, which—apparently thanks to Luisi—came in the guise of LNHO sponsorship of a conference held in June 1927 in Montevideo.

This conference, the 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 was a prestigious forum for Morquio and other experts in infant health and welfare.[69] Through the IIPI, the LNHO backed a set of infant mortality surveys in Argentina, Brazil, Chile, and Uruguay similar to surveys it had sponsored in Europe.[70,71] The results, presented at the Sixth Pan American Child Congress in Lima in 1930, demonstrated the need for improvements in vital statistics, centralization of services, and a range of public health, social assistance, economic, and educational measures to reduce infant mortality.[72–74]

The IIPI itself was launched by 10 participating countries (Argentina, Bolivia, Brazil, Chile, Cuba, Ecuador, Peru, the United States, Uruguay, and Venezuela; by 1949 the founders were joined by all other countries in the region), each with 1 official delegate. After 1936 the IIPI requested 2 representatives from each country—one technical and based in the home country, the other resident in Montevideo (a diplomat, for example). In the early years, most IIPI operating funds were provided by the Uruguayan government, with intermittent support from other member countries.

The IIPI'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 from and not just derivative or reflective of Europe.[75] At the same time, the IIPI ensured that the region's problems, research, and policies entered into international discussions. The IIPI's widely circulated *Boletín del Instituto Internacional Americano de Protección a la Infancia*, its library, its health education materials, and the child congresses it sponsored rapidly established its strong reputation and generated a large network of collaborators throughout Latin America and the world.[76]

In its first decade, the IIPI was governed by a group of distinguished physicians. Gregorio Aráoz Alfaro of Argentina served as president for the first 25 years of IIPI's existence, with Uruguayan Víctor Escardó y

Anaya as secretary. Morquio was the IIPI's first director; after his death in 1935 his compatriot Roberto Berro held the position 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; and sent information to correspondents around the world.[76,77]

The IIPI navigated complicated waters between 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 IIPI is now known as the Instituto Internacional del Niño, or International Institute of the Child.) The LNHO had hoped that its role in the IIPI would give it a foothold in various South American research and educational instititions,[69] but tight resources in Geneva meant that the LNHO could do little more than encourage activities at the IIPI. (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 as it was in US isolationist politics and a Monroe Doctrinism applied to health—helped derail the LNHO's ambitious plans in Latin America.)

The IIPI propelled Uruguay to 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 other Uruguayans had developed. The Pan American Child Congresses continued to meet until 1942, offering a key venue for exchange of ideas and learning during a period of fertile social policy activity throughout the region.[65]

Perhaps most visibly, the IIPI's *Boletín*, founded shortly after the 1927 conference, brought considerable acclaim to Uruguay. Unique in its scope, the IIPI's *Boletín*—published quarterly 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 or child mortality. It was one of the most international journals of its day: of the 1000 authors published in the journal's first 2 decades, approximately one fifth were from Europe and North America and four fifths from throughout Latin America. Slightly more than one third 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 IIPI's *Boletín* to highlight domestic problems and achievements in infant, child, and maternal welfare.

URUGUAY'S CHILDREN'S CODE

As the Uruguayan public health community grappled with the continued stagnation of its infant mortality rates, it became clear that increasingly specialized medical approaches were insufficiently integrated with social provisions for child health. This realization offered a chance for IIPI 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[78,79]: the IIPI served as a social policy umbrella under which 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,"[80] the commission did not limit itself to the administrative process of merging overlapping agencies. Instead, it called on the country to adopt a children's code spelling out children's rights to health, welfare, education, legal protections, and decent living conditions and creating 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 Seventh Pan American Conference in 1933 that such a code would put Uruguay "in the vanguard," and expressions of broad professional and popular support, the Uruguayan parliament approved the Children's Code in 1934. With passage of the code, the Uruguayan government explicitly recognized the importance of integrating medical approaches to the improvement of child health with social approaches, including better housing, sanitation,

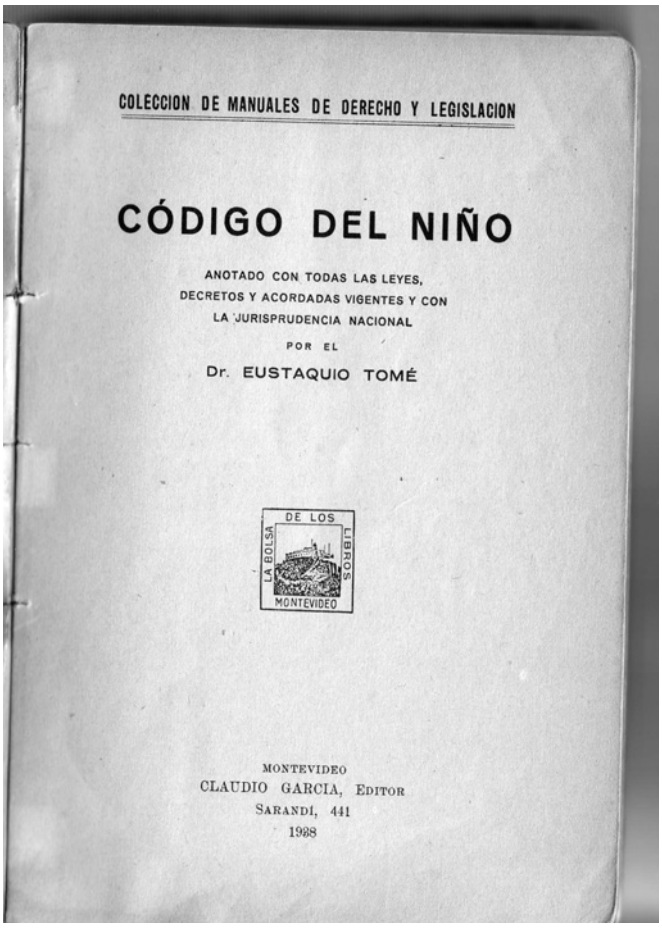
road-paving, schools, and family allowances[81] (Figure 4).

To enable its interdisciplinary work and avoid turf battles with other ministries, the Ministry of Child Protection was refashioned into the Consejo del Niño (Children's Council) 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, child, 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, asylums, 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.[82,83]

The relationship between the IIPI and the Consejo was very close, with ongoing exchange of staff and ideas. Berro, for example, directed the Consejo before becoming head of the IIPI; Bauzá was an IIPI representative before becoming a division head and then director of the Consejo. Descriptions and assessments of Consejo projects were frequently published in the IIPI's *Boletín*, probably bringing Consejo activities to greater international attention than the children's services of any other country.[84, 85]

Although several other countries had previously enacted children's codes—and Save the Children founder Eglantyne Jebb's Declaration of the Rights of the Child had been 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 IIPI, anxiety about infant mortality, and international profile—that offered an implementable model of children's rights in a particular national setting. Through the IIPI, the PASB, the LNHO, and other networks, Uruguay's experience became widely known and discussed, particularly as its infant mortality rates finally began to improve in the late 1930s. Countries with active social medicine movements, such as late-1930s Chile under the leadership of Minister of Health Salvador Allende,[86] built upon and strengthened Uruguay's efforts. The IIPI and PASB jointly issued the Pan American Children's Code in 1948, and in 1989 the United Nations General Assembly adopted the Convention on the Rights of the Child, both of which drew extensively on the Uruguayan code.

Uruguay's Children's 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 that, despite its flaws and slow pace, provided a laboratory of legislation and practice in the area of children's well-being.


COLECCION DE MANUALES DE DERECHO Y LEGISLACION

CÓDIGO DEL NIÑO

ANOTADO CON TODAS LAS LEYES, DECRETOS Y ACORDADAS VIGENTES Y CON LA JURISPRUDENCIA NACIONAL

POR EL

Dr. EUSTAQUIO TOMÉ

MONTEVIDEO
CLAUDIO GARCIA, EDITOR
SARANDÍ, 441
1938

FIGURE 4—Annotated version of Uruguay's Children's Code.

CONCLUSIONS

As this examination of the founding and activities of the IIPI demonstrates, the institutional panorama of international health included more than the "usual suspects" among metropolitan organizations. With existing agencies in place in the United States and Europe, Uruguay did not seem a propitious locale for a new international health office. But the country used its strengths—a stable welfare state, well-placed professionals, leadership in child health—and its weaknesses—small size, remoteness, persistent infant mortality problems—to secure a place on the world stage. A key additional ingredient for establishing the IIPI in Uruguay was the legitimacy provided by the country's ties to another international agency—the League of Nations. In obtaining the League's support, the cosmopolitan physicians who anchored Uruguay's international

engagement in public health benefited from the essential legwork of the "maternalist feminists" who had launched the Pan American Child Congresses.

It might be suggested that Uruguay was able to carve out a niche in international health that was of little moment to the larger community. But given the LNHO's early interest in the IIPI, the extensive worldwide concern with maternal and child health that was manifested during this period,[19] and the international attention that was later paid to children's health through such organizations as UNICEF,[87] this thesis holds little water. Still, in 1927 children did not top the list of concerns of the PASB, which would have been the IIPI's logical patron. With several PASB conferences in the 1920s (including the 1920 Montevideo meeting), there was ample opportunity for sponsorship. But the PASB spent its first decades focused on the interruption of commerce caused by epidemic diseases, even as the delegates to its conferences requested attention to other health priorities.[88] Making faraway Montevideo into "the Geneva of South America" does not seem to have irked PASB Director Cumming: the PASB was officially supportive of the IIPI,[89] though Cumming failed to mention the IIPI in several key overviews of health cooperation that he published.[90]

Once the IIPI was established, maternal and child health took on a higher profile at the PASB, particularly in its *Boletín de la Oficina Sanitaria Panamericana.* Child well-being finally reached the PASB's agenda at its ninth conference, held in Buenos Aires (together with the Latin American Eugenics and Homiculture Congress) ("Homiculture" is a Cuban-coined term expanding Pinard's concept of puericulture to include cultivation of the child from prebirth to adulthood.) in 1934, shortly after the passage of Uruguay's Children's Code. The PASB supported the position articulated by the IIPI'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 United States's focus on heredity and sterilization.[91] Given the IIPI's activities and its very existence—bolstered by the advocacy of several member countries—the PASB could no longer overlook maternal and child health.

The IIPI'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. Owing to the combination of fortunate timing, Uruguayan government support, and the regional backing of child health Pan-Americanists, the IIPI remained unencumbered by imperial or industrial interests. It drew its agenda from the concerns of health experts, feminists, and child advocates grounded in local problems in settings where child health policies were intertwined with burgeoning protectionism. The "Uruguay round" of international health suggests that the field is shaped by more than center–periphery logic. ■

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