Genesis and General Structure

ACTUAL LAUNCHING of the cooperative health program of the Institute of Inter-American Affairs may be said to have occurred with the activation of its first bilateral agreement, that consummated with Ecuador in February 1942.

This inauguration of the program was in effect a projection of one of the decisions reached in the Third Meeting of Ministers of Foreign Affairs of the 21 American Republics, held in Rio de Janeiro in January of the same year. In a resolution unanimously approved, the foreign ministers had recommended the use of the bilateral health agreement as an important instrument for furthering the security and prosperity of the nations of the hemisphere.

Early Activities

Convened against the backdrop of World War II, the Rio de Janeiro conference stands out chiefly by reason of its achievements in line with a mounting concern for a solid hemisphere front in the face of the Axis threat. But, less conspicuously, it was expressive also of a movement which stretched much further back: a slow and more or less sporadic advance in international cooperation in the Western Hemisphere, the beginnings of which had first become apparent in bilateral conventions for control of pestilential epidemics in the first half of the 19th century.

In the wake of these conventions, as the century was drawing to a close, had come the Committee on Sanitary Regulations, created by the First International Conference of American States, in Washington, D. C., in 1889–90. The first half of the 20th century had witnessed the emergence of the world's first international health organization, the Pan American Sanitary Bureau, in 1902; a series of 12 Pan American Sanitary Conferences, beginning in the same year; the signing of the Pan American Sanitary Code of 1924, a provision of which made the Pan American Sanitary Bureau the central coordinating health agency of the 21 subscribing states; and a series of 6 Pan American Conferences of National Directors of Public Health, arranged by the Sanitary Bureau.

The hopes and plans of the farsighted in the field of public health were further translated into concrete measures when the foreign ministers met in Rio de Janeiro at the beginning of 1942. It could have been that the urgencies of defense accelerated an already definite movement. At any rate, the bilateral health agreement was recognized and recommended as a means for closer ties and more effective inter-American cooperation.

In the United States, Nelson A. Rockefeller had long been an outstanding figure in the field of inter-American relations. Even before the Second Meeting of Ministers of Foreign Affairs in Havana, in July 1940, he had sponsored a memorandum to President Franklin D. Roosevelt entitled "Hemisphere Economic Policy." This memorandum was to result in the creation of the Office of the Coordinator of Inter-American Affairs, under which the Institute was later to be established.

Mr. Rockefeller had intimate knowledge of the activities of the international health division of the Rockefeller Foundation. A few years after its establishment in 1913, the Foundation had begun promoting public health, the medical sciences, and the natural sciences in a number of the Latin American republics. Methods employed had included the giving of fellowships, grants-in-aid, and scholarship

grants, and the establishment of special services within the structure of host governments.

The Foundation had placed particular emphasis on the training of nationals in public health and allied fields. Many Latin Americans trained with its aid had risen to influential posts in the health organizations of their countries. They were available to help in forming the nuclei of trained personnel if and when a program of cooperation through bilateral agreements between the United States and its neighbor nations should be launched.

Out of Mr. Rockefeller's experience and first-hand observation, therefore, had come appreciation of the importance of health programs in efforts to attain higher economic levels in the countries of Latin America.

With Pearl Harbor and the subsequent inauguration of the first bilateral program, health in its relation to supply of vital war materials became a matter of immediate and grave concern in measures for defense of the Western Hemisphere. When the Institute became a corporate actuality in March 1942, bilateral health promotion was placed high on the list of major programs.

New Departure

The inauguration in 1942 of the bilateral health programs of the Institute of Inter-American Affairs marked an entirely new departure in United States foreign policy implementation. While evaluation must take into account the emergency conditions under which the programs were launched, it must also consider a purpose extending beyond solution of pressing war-created problems. The record clearly indicates a long-range objective, the attainment of which would mean inter-American cooperation as a permanent contribution to global equilibrium.

The Mechanism

Planning of the bilateral programs had been from the premise that the administrative mechanism of the existing multilateral, national, or private philanthropic organizations could not be adjusted to take care of the new foreign political-technical work seen as necessary for the solution of critical economic, food, and health problems identified as obstacles in the way of attainment of either the immediate or long-range goals. Although the activities of the inter-American system, both governmental and private, had prepared the way for the new programs, it became apparent that a new governmental device would be necessary. Out of this need the program took form.

The mechanism devised had two major parts:

1. A corporation of the United States Government to be known as the Institute of Inter-American Affairs.

2. A unit in one of the ministries of the host government, generally called the *Servicio*, to plan and carry out the projects which would constitute the program in the host country.

These two parts of the mechanism were put and held together by the first interchange of diplomatic notes on the subject of the cooperative program, and by subsequent instruments known as basic agreements between the representative of the Institute and the minister or other designated officer of the cooperating host government.

In the early planning for the health programs, Mr. Rockefeller had made the decision that the administration of health activities should not be carried out directly by the Coordinator of Inter-American Affairs but by a subsidiary corporation. This decision was based in large part on the experience of the international health division of the Rockefeller Foundation, whose years of work had demonstrated the value of placing foreign programs on as flexible a basis as possible without loss of essential administrative control.

The Bilateral Agreements

The Institute's programs were activated from the beginning by agreements entered into with governments of the neighbor nations. After a decision was reached, in consultation with the Department of State, that the establishment of bilateral work was desirable in a given Latin American country, this fact was communicated to the United States Ambassador to that country. After a preliminary authority was given to establish bilateral work, the final authority was usually established through exchange of diplomatic notes between the United States Ambassador and the government of the country selected. This was generally followed by

so-called basic agreements made between the representative of the Institute and the minister of health or a designated officer of an appropriate ministry in the host government. Agreements were in most instances for specific periods of time. At the beginning, 2 or 3 years were usually specified. During the postwar letdown, agreements for only 1 year were made. After 1950, the term was usually 5 years, with funds committed for only 1-year periods.

The Servicio

Under the agreements, both parties provided contributions "in accordance with availability of raw materials, services, and funds," and usually agreed to the establishment of a *Servicio* in the host government.

Before the end of 1942, Dr. George C. Dunham, the first director of the bilateral health work, had supervised the successful establishment of programs in 11 countries. In order of establishment, they were: Ecuador, Haiti, Paraguay, Costa Rica, Nicaragua, Honduras, El Salvador, Peru, Brazil, Guatemala, and Bolivia. In 1943, programs were established in 7 more: Colombia, Panama, Venezuela, Chile, Mexico, Dominican Republic, and Uruguay.

Because of limitation of funds, the programs in Nicaragua, Costa Rica, and the Dominican Republic were terminated in the middle of 1947. The program in Panama was terminated in September 1945. All these programs, except that of the Dominican Republic, were reopened early in 1951.

Table 1. Number and estimated cost of special [1] and cooperative health and environmental sanitation projects in Latin America through June 30, 1951, by class of project

Class of projects	Number	Estimated cost
All projects	1, 665	$103, 015, 915. 56
Special projects [1]	[2] 125	3, 382, 965. 00
Cooperative projects	1, 540	99, 632, 950. 56

[1] Special projects include all projects that were financed directly by the Institute of Inter-American Affairs. These projects did not constitute a part of the country programs that were financed and executed by the *Servicios* in the host countries.

[2] An approximation based on numbering system used for special projects.

Table 2. Number and estimated cost of cooperative health and environmental sanitation projects in Latin America through June 30, 1951, by country

Country	Number	Estimated cost of projects
All countries	1, 540	$99, 632, 950. 56
Bolivia	105	4, 802, 122. 52
Brazil	349	26, 391, 059. 19
Chile	44	9, 082, 780. 21
Colombia	75	8, 961, 382. 04
Costa Rica	43	1, 038, 147. 54
Dominican Republic	24	571, 436. 34
Ecuador	138	6, 860, 722. 44
El Salvador	127	3, 005, 913. 45
Guatemala	38	6, 195, 365. 54
Haiti	89	2, 414, 260. 86
Honduras	69	2, 958, 580. 86
Mexico	125	8, 366, 374. 38
Nicaragua	68	1, 029, 254. 01
Panama	29	684, 608. 97
Paraguay	39	2, 987, 762. 12
Peru	50	5, 872, 413. 00
Uruguay	31	1, 415, 517. 47
Venezuela	97	7, 025, 249. 13

The agreements usually provided that the Institute would send to the cooperating country a small "field party" of professional and technical personnel, including usually a physician, engineer, and nurse. It was also usually provided that the chief of this field party would not only represent the Institute, but would also be the director of the *Servicio* in the host government, subordinate to the minister or other designated officer in the cooperating ministry.

Under the agreements, all work undertaken was to be broken down into projects, and before these were started a project agreement was to be signed by both the chief of the field party as representative of the Institute and by the designated officer of the local cooperating ministry. This arrangement was to encourage joint planning as well as joint financing and execution of all work undertaken.

Personnel Ratios

Servicios were staffed primarily by nationals of the countries with which the Institute was cooperating. The purpose was not only the utilization of nationals, but, through inservice training, to give national professional personnel necessary experience in the maintenance and operation of the projects, all of which by agree-

ment were to be turned over in time to the host country.

As early as February 23, 1943, the estimated ratio of United States to host country technicians in the field programs was 1:25. By the middle of 1945 there were employed 223 United States citizens (including 30 physicians, 52 engineers, 11 architects, and 36 nurses) and 12,278 national personnel (including 356 physicians, 135 engineers, 172 registered nurses, 1,495 other technical and clerical personnel, 1,202 practical nurses or sanitary inspectors, and 8,918 workmen)—a ratio of 1:55.

During the war years most of the United States physicians and sanitary engineers were assigned from the Office of the Surgeon General of the Army. As of June 1952, the number of Latin Americans working on the health programs totaled 7,134 and the number of United States personnel in the field parties and the technical pool, 119—a ratio of 1:60. Included were 462 Latin American and 15 United States physicians and dentists; 298 Latin American and 20 United States graduate nurses; 94 Latin American and 26 United States sanitary engineers; 59 Latin American and 11 United States civil and other engineers; and 40 Latin American and 4 United States health educators.

Program Supervision

The chief of the field party was given very broad authority to carry out the program in terms of projects worked out with the minister of the host country or his designated officer. This was in pursuance of a policy of decentralization and development of local field programs under a system by which all projects for a country would be determined locally by joint agreement.

One of the advantages seen in this policy was that it would operate to allay the expressed fears of "invasion of sovereignty." Some general policy lines were kept in view even in the earliest days, however, by the frequent visits paid to the *Servicios* by Dr. Dunham and other staff members. In 1948 a "technical pool," of always less than 10 persons, was created as an additional arm of the Washington office. The president of the Institute and his immediate staff also made field trips for evaluation of accomplishments. Through analysis of required periodic field reports and of project and completion

Table 3. Number and estimated cost of health and environmental projects carried out by the cooperating host countries in Latin America and the Institute of Inter-American Affairs through June 30, 1951, by category of project

Category of project	Number	Estimated cost of projects	Category of project	Number	Estimated cost of projects
Total	1,540	$99,632,950.56	Environmental sanitation (water supplies, sewage disposal facilities, markets, slaughterhouses, etc.)	494	$21,014,845.10
Administration, rent, and equipment of *Servicios*	134	18,332,724.40	Health education	19	789,307.35
Projects to strengthen directly indigenous national and local health services (administration buildings, laboratories, equipment, technical assistance, etc.)	66	3,398,922.07	Industrial hygiene surveys and studies	2	294,105.93
Training facilities and training programs	118	4,648,556.81	Nutrition (construction, equipment, and operation)	6	458,461.23
Hospitals, health centers, and other medical facilities and services (construction and operation)	431	36,744,967.57	Public health statistics	1	566.21
Special disease control (including malaria control by drainage)	220	12,161,739.54	Special medical research	2	6,287.07
Medical care programs for highway workers, rubber workers, etc	31	974,507.24	Social welfare (construction of buildings, playgrounds)	7	90,349.89
			School health program	1	5,723.18
			Miscellaneous (including matching projects undertaken by Venezuelan Government)	8	711,886.97

Table 4. Program funds available to the 18 Servicios in Latin America for cooperative projects from the beginning of the programs until June 30, 1951

Country	Total	Contributed by the host countries [1]	Contributed by Institute of Inter-American Affairs
All countries	$107, 050, 606. 01	$67, 316, 421. 24	$39, 734, 184. 77
Bolivia	4, 852, 112. 52	2, 967, 112. 52	1, 885, 000. 00
Brazil	31, 357, 520. 55	22, 692, 520. 55	8, 665, 000. 00
Chile	9, 208, 430. 05	3, 808, 430. 05	5, 400, 000. 00
Colombia	9, 580, 396. 22	7, 472, 395. 42	2, 108, 000. 80
Costa Rica	1, 199, 257. 86	359, 382. 86	839, 875. 00
Dominican Republic	575, 000. 00	175, 000. 00	400, 000. 00
Ecuador	7, 074, 431. 08	3, 547, 931. 08	3, 526, 500. 00
El Salvador	3, 115, 504. 84	2, 150, 504. 84	965, 000. 00
Guatemala	6, 196, 732. 63	5, 146, 732. 63	1, 050, 000. 00
Haiti	2, 475, 521. 16	1, 387, 521. 16	1, 088, 000. 00
Honduras	2, 989, 710. 72	2, 014, 710. 72	975, 000. 00
Mexico	8, 591, 081. 50	3, 391, 081. 50	5, 200, 000. 00
Nicaragua	1, 119, 582. 37	269, 582. 37	850, 000. 00
Panama	736, 808. 97	175, 000. 00	561, 808. 97
Paraguay	3, 026, 366. 81	1, 376, 366. 81	1, 650, 000. 00
Peru	5, 936, 170. 66	3, 691, 170. 66	2, 245, 000. 00
Uruguay	1, 727, 298. 76	1, 002, 298. 76	725, 000. 00
Venezuela	7, 288, 679. 31	5, 688, 679. 31	1, 600, 000. 00

[1] Includes financial contributions by State and local governments and philanthropists in host countries, but does not include $6,552,171.01 contributed by host government in other than cash (buildings, land, etc.).

agreements on every unit of work undertaken, additional supervision and evaluation of operations were provided for.

Funds

From the creation of the corporation in March 1942, the United States Government financed its role in the bilateral health work by allocation of funds to the Institute. The estimated costs of projects, the amounts of disbursements by the Institute, and the contributions by host governments, from the beginning of the programs through June 30, 1951, are shown in tables 1–4.

The flow of program funds was determined, in the first instance, by the basic and, secondly, by the individual project agreements signed by both the representative of the Institute and the minister of health or other designated officer of the host government.

Although the total figures give some indication of the project patterns in all of the countries, there was considerable variation from country to country. Projects in Ecuador, for example, were primarily in hospital construction in the early part of the program, and later were primarily to augment water supply. Panama's first program was almost exclusively malaria control. During the first year, construction of water supplies was emphasized in Mexico, but later a wide program including health center organization and construction was developed. The reasons for these shifts in emphasis also varied from country to country.