Public Health and Hemisphere Defense during World War II

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My dissertation explores the history of inter-American collaboration in hemisphere defense during World War II, focusing on the construction and operation of a network of U.S. military bases throughout Latin America. By examining issues such as labor conflict, jurisdictional disputes, social relations, and infrastructure development on and around U.S. bases, I explore how the terms of inter-American cooperation in this aspect of the defense effort were negotiated at the local, national and international levels. I am especially interested in how fields such as public health, development and goodwill were viewed as security concerns during this period and became incorporated into plans for hemisphere defense. In the summer of 2012, I visited the Rockefeller Archive Center (RAC) in search of material that would inform the chapter of my dissertation that explores public health work on and around U.S. bases in the region, and to understand more broadly the growing belief in various sectors of the U.S. government that investment in social and economic problems in Latin America would enhance U.S. national security.

On the eve of World War II, advances in aviation technology and weapons systems had increased the vulnerability of the United States by decreasing the distance between places. It was in response to this new environment that military strategists thought of national security in terms of hemisphere defense and sought to build a network of U.S. bases throughout the

Americas. In the same way that aviation and the shrinking of the globe made the U.S. population more open to enemy inroads in Latin America, it also made them more susceptible to disease. Dr. Alberto Recio, the Cuban Director of Health and Social Welfare, described a similar re-imagining of the map in regards to disease prevention as it was occurring in defense strategy, "with increased air transportation, the countries of the world will be brought so close together that in fighting infecto-contagious diseases … the present concept of national boundaries will have to be changed as far as public health is concerned and be substituted by a "global" concept and if this is not feasible by at least continental boundaries."[1]

Public health and sanitation became linked with the defense effort in a number of ways. First, military strategists who sought to station U.S. soldiers in malaria-heavy regions of the hemisphere saw the minimal public health infrastructure in some parts of the Caribbean and Latin America as a literal threat to the defense effort; Second, tropical disease stood to hamper worker productivity in the extraction of strategic raw materials; and third, a lack of development in public health infrastructure was seen as a threat to the defense effort in a less concrete fashion, in that some figures within the government argued that the U.S. must invest in socio-economic problems in Latin America to counteract the appeal of fascism. As Vincenzo Petrullo of the Office of Strategic Services explained in a memo to the State Department in June of 1941,

> Nazism has offered a 'better' political and economic way of life, a positive program of action, an incentive and a goal, in short—a hope. It also offers freedom from Yankee domination … To a considerable degree however, its strength lies in the weakness of the 'opposition' and in that no feasible alternative is being offered to the Latin American peoples … the Democracies have been depending on diplomatic accords, polite expressions of faith, and the hit or miss goodwill of commercial entrepreneurs … Very little has been tried in fields which effect the daily life of the ordinary citizen and no direct action has been taken to sell the democratic way of life to the people at large.[2]

Warnings such as this resounded especially loud with those concerned with the security of the hemisphere. According to the invasion scenario that helped shape many U.S. plans for

hemisphere defense, the support of a "fifth column" of Axis sympathizers already living in Latin America would aid any military initiatives that Axis powers might initiate in the region. This meant that the U.S. sought not only the cooperation of Latin American political leaders, but the allegiance of the Latin American *people*—an allegiance that could not be negotiated through a series of diplomatic exchanges, but could perhaps be won by investment in development.

Ultimately, in the spring of 1942, the Institute of Inter-American Affairs (IIAA) was created through the Office of the Coordinator of Inter-American Affairs (CIAA) with a mandate to conduct health and sanitation work to address all three of these concerns. However, the IIAA was not the first attempted solution to the "problem" of public health around current and projected overseas bases. First, the Navy and War Departments experimented with public-private collaboration with the Rockefeller Foundation's (RF) International Health Division (IHD).

Between the outbreak of war in Europe and the attack on Pearl Harbor, the foreign ministers of the American republics held two meetings to discuss plans for hemisphere defense. While a united front was agreed upon in broad strokes, much of the plans for active collaboration in defense, such as allowing U.S. soldiers to utilize airfields on foreign soil, were contingent on an attack on an American nation. The U.S. armed forces already occupied territory in Guantanamo and the Panama Canal Zone, and while secret plans were drawn up to construct further airfields throughout the region, overt negotiations with the governments of Panama and Cuba were carried out to expand the reaches of their existent facilities. Meanwhile, the U.S. attained the right to bases in the British Caribbean. Consequently, public health at these locations became an early concern of the Armed Forces. The War and Navy Departments reached out to the IHD for assistance.

In a letter to IHD staff, Wilbur Sawyer, the Director of the IHD, explained the basic premise of the RF's potential contribution to the war effort, "four of the diseases in which the Division has specialized—malaria, yellow fever, influenza and typhus—are of paramount importance in this war. Also, the Division's activities in Latin America and in the Far East are obviously essential."[3] In another letter, this one to Secretary of War Henry Stimson, Sawyer elaborated further, "the Surgeon General of the Army and his officers entrusted with preventative medicine … have pointed out that, as a civilian organization with an international field of activity, we are in a strategic position to work with foreign governments in studying and improving health conditions near the new bases in the Caribbean and elsewhere."[4] In other words, the RF already had an existing international network of resources and relationships, as well extensive knowledge and experience that might enable them to erect a public health strategy more quickly and effectively than would be possible for U.S. government or military officials.

In addition to the utility of the IHD's experience, the fact that the RF was a private organization staffed with civilian doctors was especially appealing. When Sawyer consulted with the Surgeon Generals of the Navy and Army regarding offers from some of the IHD's medical staff to join the Armed Forces, they responded that they believed the IHD personnel "might perform a much more useful service to the government in a civilian rather than a military status."[5] In fact, in the months that followed the attack on Pearl Harbor and the U.S. declaration of war, the IHD was given reassurance that its staff would be granted deferment from military service.[6]

One reason for the preference for civilian doctors was that while a doctor sitting on an Army commission could not engage in similar work for the Navy, the IHD could support both forces.[7] Another reason was that splintering the existing structure of the IHD by putting its

members into new, unfamiliar positions would weaken its advantage.[8] Except, perhaps the most important reason that a civilian agency was preferred, particularly for work in Latin America, had to do with perception and reception abroad. The presence of the U.S. military in Latin America was an extremely sensitive issue. U.S. occupation of Guantanamo and the Canal Zone was long seen as a symbol of Yankee imperialism. Furthermore, the War and Navy Departments were not only concerned with health and sanitation infrastructure on the bases, but they wanted work done *around* the bases, as disease did not respect such artificial boundaries. This would require the encroachment of U.S. intervention into new territory. It seemed that the RF, which already operated on a cooperative basis with many Latin American governments, would be viewed in a more amenable light as an agency independent of the government.

In the case of attempted health work around the Guantanamo Bay Naval Reserve, this is did not prove to be entirely the case. The RF had been cooperating with the Cuban Department of Health continuously since 1935, when it launched two projects: a Malaria Commission, charged with the task of conducting health surveys of the island, and a Malaria Control Demonstration Unit, that later expanded into a multi-service County Health Unit in Marianao. The Marianao Health Unit was meant to serve as a model to be replicated in other Cuban counties, ultimately overhauling the public health system. In line with the RF's traditional model, the RF and the Cuban government each contributed a determined amount of the money required to run these programs. Each year, the RF's share of the cost decreased while the government's share increased, until a projected date when the program would become fully funded and operated by the Cuban government.[9]

The Navy Department approached the IHD in 1941 about establishing a health unit in Guantanamo County as cases of malaria began to appear among the increasing number of U.S.

soldiers stationed at the naval base. The U.S. ambassador to Cuba told the IHD he believed that "the activities of the U.S. government in the area should be as restricted as possible and that the malaria control and health unit activities in the area could be done with less friction by our organization and is therefore favorable."[10] Henry Carr, the IHD's representative in Cuba, did a survey of the area and submitted a report in May of 1941 on health problems in the county.[11] His report noted that the Navy's proposal was in line with the IHD's larger mission in Cuba, as Guantanamo could be the first county in which to replicate the Marianao Health Unit model. He validated the Navy's concerns about off-base health conditions, stating "of what avail to protect the health of these men while they are within the Reservation if they are to be exposed to very considerable and very active sources of infection when making periodic visits outside the Reservation."[12]

The desirability of conducting this work through a private foundation was especially strong as tense negotiations between Havana and Washington were ongoing. The Navy sought to expand the territorial limits of the Guantanamo Naval Reserve to meet the expanded vision of U.S. overseas defense, but these efforts were impeded by the new Cuban constitution, which forbade the ceding of further national territory to a foreign power. The ambassador explicitly told IHD officials that "he did not feel inclined to complicate his present negotiation by presenting our project to the Cuban government but had no objection to our doing so."[13] Ultimately, however, this public-private collaboration was not as successful in practice as it seemed it might be in theory. Despite the legal difference between the government and the RF, the plans for a health unit in Guantanamo stalled out along with the negotiations regarding the expansion of the base.[14] The IHD ultimately withdrew its proposal, though it did successfully undertake health work around bases in the British Caribbean, where questions of sovereignty

were quite different. Not insignificantly, the RF was not completely divorced from the war effort, because the Malaria Commission that the RF created, remained active in Cuba after the RF's withdrawal, and went on to assist the U.S. military in health work around military bases in other parts of the island.[15]

In January of 1942, in response to the attack on Pearl Harbor, the Ministers of Foreign Affairs of the American Republics met for a third time. Article thirty of the Final Act of that meeting called for the improvement of health and sanitary conditions in the Americas and resolved that "the governments of the American Republics take individually, or by complementary agreements between two or more of them, appropriate steps to deal with problems of public health and sanitation, by providing, in accordance with ability, raw materials, services and funds."[16] Just a few months later, the Institute of Inter-American Affairs (IIAA) was created to coordinate public health work with Latin American governments with the threefold objective of protecting the health of soldiers, enhancing the productivity of those engaged in vital resource extraction, and fostering goodwill and unity in the Americas.

The IIAA did not displace the RF; indeed, it gained a lot from the RF, as the IIAA consulted IHD staff a great deal in elaborating projects and hiring personnel. A delegate of the IHD sat on an advisory council to the IIAA, beside delegates from Departments of State, War, Navy, the U.S. Public Health Service, the Pan American Sanitary Bureau, the War Production Board, and the Office for Emergency Management.[17] However, the greatest legacy of the RF appears to be in the model that the IIAA adopted in carrying out its work—the agency established cooperative programs with Latin American governments, paid for by a shared budget for which the Latin American government's share increased annually. As I continue my research, I hope to gain a better understanding of why this institutional shift took place within the

changing global context and how the more central role of the U.S. government in overseas health work, beginning in 1942, influenced the way that post-war international public health projects would be conducted.

ENDNOTES:

[1] Dr. Alberto Recio, "Statement on Global Health," forwarded from Frank Calderone to W.A. Sawyer, September 1943. RF, RG 2, Series 200, Box 242, Folder 1677.
[2] Suggestions for Political-Economic Warfare to Prevent Nazification of Latin America Vincenzo Petrullo, June 4, 1941. NAR, RG 4, Series O, Subseries 1, Box 1, Folder 2.
[3] Wilbur A. Sawyer to Members of the International Health Division (IHD), January 1, 1942. RF, RG 3.1, Series 909, Box 1, Folder 12.
[4] Wilbur A. Sawyer to Henry Stimson, April 22, 1941. RF, RG 3.1, Series 909, Box 1, Folder 12.
[5] James Magee to Wilbur Sawyer, December 15, 1941. RF, RG 3.1, Series 909, Box 1, Folder 12; Ross McIntire to Wilbur Sawyer, December 15, 1941. RF, RG 3.1, Series 909, Box 1, Folder 12.
[6] Edward Lyon to Wilbur Sawyer, May 16, 1941. RF, RG 3.1, Series 909, Box 1, Folder 12.
[7] IHD Collaboration with Army and Navy Advisory Commissions, January 20, 1941. RF, RG 3.1, Series 909, Box 1, Folder 12.
[8] Wilbur Sawyer to all IHD staff, January 1, 1942, RF, RG 3.1, Series 909, Box 1, Folder 12.
[9] Henry Carr, Annual Report of the Cooperative Public Health Work in Cuba During 1939. RF, RG 5, Series 3, Box 163, Folder 2000.
[10] Andrew Warren to Sawyer, April 18, 1941. RF, RG 1.1, Series 315, Box 2, Folder 12.
[11] Henry Carr, "Memorandum Regarding Health Problem in Guatanamo Municipality in Cuba," May 1 1941. RF, RG 1.1, Series 315, Box 1, Folder 9.
[12] Ibid, 2.
[13] Andrew Warren to Sawyer, April 18, 1941. RF, RG 1.1, Series 315, Box 2, Folder 12.
[14] Sawyer to Stephenson, June 23, 1941 RF, RG 1.1, Series 315, Box 2, Folder 12.
[15] 1943 Annual Report. RG 5, Series 3, Box 165, Folder 2018.
[16] "Final Act of the Third Meeting of the Ministers of Foreign Affairs of the American Republics." In *The American Journal of International Law* 36: 2 Supplement: Official Documents (April 1942), pp. 61-95.
[17] Wilbur Sawyer to Hackett, March 16 1942. RF, RG 2, Series 200, Box 229, Folder 1588.