

“Hygiene, Agriculture, and Men”: Rural Health in 1930s and 40s Colombia

HANNI JALIL
California State University

Abstract

In 1934, Alfonso López Pumarejo, the recently elected president of Colombia, announced that expanding government programs in public health and education would be a priority for his administration. This article analyzes this period’s cultural transformation programs, examining the establishment and operation of sanitary units, mixed healthcare centers, and itinerant rural health commissions in the 1930s and the 1940s. It proposes a two-part argument. First, it demonstrates how reformers, intellectuals, and doctors associated with Latin America’s first wave of social medicine transformed existing institutional spaces to serve the aims of the government’s new public health model, designing and implementing programs to extend healthcare into the countryside. They proposed shifting from campaigns focused on eradicating a single disease to campaigns that tackled multiple diseases and also advocated for an increase in national, departmental, and municipal fiscal contributions to public health programs. Second, it touches upon the fiscal and resource-related challenges that limited these programs’ reach. These challenges illustrate the fractured and fragmented nature of the Colombian state and its lack of capacity to effectively integrate the countryside by reaching often neglected remote rural areas.

Keywords: public health; Latin America; rural health; *campesinos*; reformism; Colombia

Resumen

En 1934, Alfonso López Pumarejo, el recién electo presidente de Colombia, anunció que su administración priorizaría la ampliación de programas gubernamentales en salud pública y educación. Este artículo analiza los

programas de transformación cultural de este período, examinando el establecimiento y funcionamiento de unidades sanitarias, centros de salud mixtos y comisiones itinerantes de salud rural en las décadas de 1930 y 1940. Propone un argumento en dos partes. En primer lugar, demuestra que los reformadores, intelectuales y médicos asociados con la primera ola de medicina social en América Latina transformaron los espacios institucionales existentes para los fines del nuevo modelo de salud pública del gobierno, diseñando e implementando programas para sanear la población rural. Propusieron pasar de campañas centradas en erradicar una sola enfermedad a campañas que abordarían múltiples enfermedades y se pronunciaron a favor de aumentos en las contribuciones fiscales nacionales, departamentales y municipales a programas de salud pública. En segundo lugar, aborda los desafíos fiscales y de recursos que limitaron el alcance de estos programas. Estos desafíos ilustran la naturaleza fracturada y fragmentada del Estado colombiano y su falta de capacidad para integrar eficazmente el campo al ofrecer servicios de salud a zonas rurales remotas a menudo desatendidas.

Palabras clave: Salud pública, Latino América, salud rural; reformismo, campesinos; Colombia

Introduction

When Alfonso López Pumarejo became president of Colombia in 1934, he gave an address to the national Congress, announcing that his administration would prioritize education and public health reform. He argued that the nation’s lack of development was due not to the country’s geography, climate, or “deficient racial stock” but instead to the “ignorance,” inadequate living conditions, and “poor health” that affected the majority of the country’s inhabitants. According to López Pumarejo, it was the state’s obligation to “prepare its citizens so that they could take advantage of the country’s wealth.”¹ Declaring that the government would undertake a national campaign in these two areas, he explained to his audience the advantages of implementing these reforms:

The national economy carries the burden of supporting that vast economic class, who lives in misery [...] who does not read, wears no dress or shoes, that barely eats, that stays involuntarily and not very consciously on the margins of society [...] on the margins of the scarcely two million Colombians whom *we can say fully exercise their citizenship*. And the exploiting classes, the great agriculturalists look upon their abundant, lowly workers [...]. Only when they study the situation carefully do they realize that they are methodically eliminating consumers, that this traps us in a vicious cycle in which our economic organization closes the

doors on capital with almost as much rigidity as it channels its force toward bring down the proletarian class.² (my emphasis)

As López Pumarejo argued, the nation could not prosper without a concerted program of reforms that would give the masses the education and health they needed to become active members of the nation. Active citizenship required Colombians to live in conditions that would make them apt to work in the nation's factories or fields and to contribute to economic growth and prosperity. Even if many "viewed this as a patriarchal and extravagant mission," President López Pumarejo concluded, the state should intervene in the laboring classes' "kitchen and [at their] table," teaching Colombians to prepare their food, work the land, and practice hygiene.³

Liberal reformers, including medical experts and practitioners who worked for the National Department of Hygiene (hereafter the NDH), set out to sanitize and modernize the Colombian countryside. Doctors such as Laurentino Muñoz Trujillo, Arturo Posada, and Carlos Franco were part of what Eric D. Carter has called "Latin America's first wave of social medicine." According to Carter, during this first wave of social medicine, doctors "advocated for an integrative causal framework that stressed the social, economic, and political causes of health problems [...] and called upon the state to take a strong role in developing and regulating health systems to serve the collective needs of national populations."⁴ Medical doctors in Brazil, Argentina, Chile, Mexico, and Colombia, inspired by the health policies promoted through the League of Nations Health Organization and the International Labor Organization, shifted from "a focus on technical assistance programs" designed to eradicate specific diseases toward broader efforts to understand "disease etiology" and the role of "nutrition, housing, and working conditions" on health outcomes.⁵ Through campaigns in education and cultural transformation that extended beyond the spaces provided by schools, colleges, and universities, the state imagined that it would transform Colombians, especially peasants, into producers, consumers, and active citizens.

These programs promoting cultural transformation attempted to reach into rural homes and teach peasants what to eat, how to dress, how to spend their leisure time, how to avoid contracting communicable diseases, which habits to foster and which to eradicate from their lives and environments.⁶ This article analyzes part of this period's cultural transformation programs, examining the establishment and operation of sanitary units, mixed healthcare centers, and itinerant rural health commissions in the 1930s and the 1940s. It proposes a two-part argument. First, demonstrating how reformers, intellectuals, and doctors associated with Latin America's first wave of social medicine transformed

existing institutional spaces to serve the government’s new public health model, designing and implementing programs to extend healthcare into the countryside. They proposed shifting from campaigns focused on eradicating a single disease to campaigns that tackled multiple diseases and advocated for increases in national, departmental, and municipal fiscal contributions to public health programs. Second, it touches upon the fiscal and resource-related challenges that limited these programs’ reach. These challenges illustrate the fractured and fragmented nature of the Colombian state and its lack of ability to effectively integrate the countryside by reaching often neglected remote rural areas.⁷ Similar to Mexico, which in the 1930s embarked on efforts to expand health provision into its rural areas, particularly its most marginal and neglected ones, the Liberal policymakers in 1930s Colombia saw the expansion of health services into the countryside as “both a tool of social good and a political tool” that would help integrate the nation.⁸

Up until the Liberal Party’s electoral win in 1930, the country’s Conservative Party had ruled consecutively for nearly five decades. In the 1930s, the ruling party faced several challenges, including economic decline and the increasingly frequent mobilization of the country’s labor, student, and peasant movements.⁹ In the 1920s, social mobilization had increased.¹⁰ Thus, in 1934, upon winning the election, López Pumarejo declared that his regime would oversee a revolutionary program that used legal and institutional means to prevent violent unrest and address economic and social problems, including malnutrition, poor health, high illiteracy, and low rates of agricultural output.

In government reports, publications, and public health journals, rural residents are present primarily in fragments and in the form of aggregate figures and statistics. Despite the country’s large agrarian base, rural Colombians show up as symbols and representations produced by medical doctors and public health officials within a set of limited tropes and stereotypes.¹¹ The near total absence of peasant and patients’ voices represents silences in the institutional archives that record the work of units, commissions, and mixed healthcare centers. Specifically, the sources consulted for this article include National Department of Hygiene reports, public health journals, tracts, and speeches, which provide a window into the world of state officials, medical doctors, and public health practitioners as they imagined, moved through, and worked in Colombia’s countryside. These sources capture how these men (except for *visitadoras sociales* [women who visited homes in the countryside to teach good habits to locals], men wrote all the other archival sources cited here) imagined and depicted rural spaces and peasants in their efforts to extend health into the countryside. The public health model promoted by Liberal reformers, despite occasionally citing social and economic causes of health problems, emphasized individual

responsibility, depicting peasants and the countryside as “backward,” “indolent,” and “sick.”¹² It should be noted that these sources rarely capture the reception of these state-led programs among peasant communities. These communities’ diverse responses to the state’s efforts to diagnose, treat, and cure are not the focus of this article and are, therefore, not addressed here.¹³

Among Latin America’s largest states, Colombia is the least-studied case in English-language historiography. Most studies of this nation have focused on the country’s long history of political violence, civil conflict, security policies, and drug trafficking. Although historians have long studied regional experiments in democratization, reform, and attempts to define a national identity in more inclusive terms during the middle decades of the twentieth century in Brazil, Mexico, and Argentina, only recently have they delved into examining this period of reformist regimes in Colombia.¹⁴ Catalina Muñoz-Rojas argues that the history of democracy in Colombia, as in other nations, “is one of expansion and contraction in which claims to inclusion have been accompanied by pervasive inequalities.”¹⁵ This article contributes to debates centering Colombian politics, reform-minded programs, and public health and hygiene policies in the 1930s and 40s.¹⁶ In examining government programs in public health, it shows that Liberal reformers attempted to modernize the Colombian countryside and define themselves as redeemers of the nation.

Considering that Colombia was a predominantly agrarian nation up until the 1970s when it transitioned to a predominantly urban one, many of the problems of this country’s twentieth-century history have been linked to its rural areas. This article sheds light on how the history of twentieth-century Colombia has been marked by the state’s inability to read and govern the countryside and to create and implement effective programs for it. It frames these challenges as historical, demonstrating how they respond to unique circumstances, conceived in the middle decades of the twentieth century, during the period known as the Second Liberal Republic (1930-1946) in the historiography of Colombia, which is “one of the least studied and most misunderstood periods” in the country’s history.¹⁷ This article begins by exploring how reformers designed and deployed programs to modernize, sanitize, and uplift rural Colombia as part of a hemispheric-wide preoccupation with population health that scholars such as Eric D. Carter, Gabriel Jaime Vélez Tobón, Victoria Estrada Orrego and others see as part of the first wave of Latin American social medicine. The second part of this article exemplifies that these programs could not overcome several obstacles, including inadequate and inconsistent funding as well as staffing issues.¹⁸

Liberal Reformism and the Colombian Countryside: Rural Health and the Making of Citizen Campesinos

In his research on agricultural programs in Puerto Rico and Colombia, historian Stuart McCook traces the role of agricultural science, research, and extension programs in these countries' agricultural modernization efforts from 1920 to 1940. He shows that efforts to modernize agricultural production were part of a broader technocratic moment when planters, politicians, and scientists looked towards “practical science” to offer “technical solutions to problems that otherwise had the potential to cause economic and social unrest.”¹⁹ As he demonstrates, agricultural development programs in the 1930s shifted away from advocating for narrow technical solutions, emphasizing instead “the population's welfare as a whole.”²⁰

Concerned with more than just controlling crop yields and tackling plant disease, Liberals in the 1930s turned towards the Colombian countryside, hoping to transform not only farming practices and technical know-how, but also the habits, homes, and tables of rural Colombians. As Stefan Pohl-Valero and Sebastian Alban Maldonado's work demonstrates, the goal was to change everyday habits and consumption patterns to promote economic development, rationalize agriculture, and produce “healthy and efficient human capital.”²¹ López Pumarejo's project of “capitalist modernization” focused on enacting fiscal, institutional, and social reforms intended to transform Colombians, revive the nation's agricultural sector, improve rural living standards, and win the laboring sectors back into the Liberal party's fold.²² With a view to the nation's social, economic, and territorial integration, their goal justified the expansion of the state's functions and the development of an interventionist agenda to transform peasants, imagined by Liberal-party reformers as both the basis of national greatness and that long-neglected “conglomerate” that stayed “involuntarily and not very consciously on the margins of society.”²³ Even though politics in 1930s and 40s Colombia are not typically included under the banner of the Latin American populism that characterized the region in the middle decades of the twentieth century, Liberal reformers proposed changes in areas such as health, education, land tenure, voting rights, and constitutional reforms that helped enshrine the state's social function.²⁴ In the 1930s, as Amy C. Offner has argued, Latin American states implemented ISI (import substitution industrialization) policies which, along with a “new school of structuralist economic thought,” helped identify “primary commodity production and economic liberalism as the sources of the region's poverty.”²⁵ From the New Deal in the US to the Estado Novo in Brazil, Peronism in Argentina, *cardenismo* in Mexico, to Liberalism in 1930s Colombia, “governments established

public financial institutions and social welfare agencies, land reform laws and agricultural stabilization schemes.”²⁶ Public health reform was an essential part of these programs designed to modernize and develop Latin American nations.

As in Brazil, Mexico, and Argentina, this period in Colombia also represented a juncture when governments, social reformers, intellectuals, artists, and civil society groups started to reimagine and redefine their national identity.²⁷ Often, this task involved designing and implementing cultural transformation programs, in which public health reform played a crucial role.²⁸ As historian Muñoz-Rojas argues, these programs advanced by the Liberal party between 1930 and 1946 were unprecedented in the nation’s history. They were connected to a broader agenda of social and political reform that sought to widen the terms of national belonging.²⁹ However, state efforts to transform peasants and workers into active citizens who “fully exercise their citizenship”³⁰ were shaped and limited by enduring ideas of social hierarchy prevalent among party officials, reformers, and intellectuals. As Muñoz-Rojas notes:

The form of rule that took shape during this period, while based on ideas of inclusion and new forms of social intervention and assistance that materialized around the cultural programs of the Ministry of Education, is part of a longer history of state formation within which the visibility and inclusion awarded to the popular sectors have been subject to a strict and vertical social order.³¹

Contradictions between the regime’s rhetoric of inclusion and how reformers materialized their desire to transform workers and peasants in the programs and campaigns they designed were some of the challenges that limited the effective implementation of these programs. Although these broader cultural transformations and social reform programs recommended the establishment of sanitary units, rural health commissions, and mixed healthcare centers in 1930s Colombia, liberal reformers, medical doctors, and health and sanitary inspectors often failed to acknowledge the experiences of marginalized communities or recognize them as subjects with rights. These programs were often underfunded, under-staffed, and plagued with tensions between national, regional, and local-level priorities, powerbrokers, and clientelist networks.³²

In August 1938, an article by Dr. Carlos Franco, medical director of one of Tolima’s rural health commissions, opened the first issue of *Higiene y Sanidad*, the commission’s monthly publication, designed to report on its work and accomplishments. In this article, Franco linked the health of Colombians to national prosperity and happiness. According to Franco, “health was the nation’s most important asset,” and only the strict application of hygiene and sanitary

principles could protect it. He argued that without health, “it was impossible to cultivate lands, exploit mines, or educate minds,” and that without it, “no happiness was possible.” He concluded that the state understood this and was “taking the necessary steps to turn hygiene into a state function.”³³ For Franco and other social reformers at the time, national economic prosperity was tied to their compatriots’ physical and moral health. Government officials, health workers, and medical doctors agreed that hygiene was linked to progress and progress to civilization.

In an overwhelmingly agrarian nation, land cultivation was one of the keys to national prosperity. Thus, government officials argued that state-led public health and education campaigns should be directed toward the countryside. In a NDH report detailing the structure, design, and work of rural commissions and sanitary units, Dr. Arturo Posada, noted that, as Colombia was an “agrarian nation,” its prosperity should rely on “the technical and modern exploitation” of its soil.³⁴ As the nation still possessed vast amounts of uncultivated lands, Posada argued that it was logical that its economic development policies rely on exploiting this resource.³⁵ For Posada, it was obvious that state efforts should be directed toward rural areas. He also highlighted “the necessity of promoting programs in benefit of the race” that considered “national realities that suited the needs of our civilization.”³⁶ Posada, like Franco and other medical reformers, framed the need to extend healthcare into rural Colombia in terms that echoed eugenic and nationalist discourses, anchored in ideas of “racial betterment” and the construction of a mestizo, homogenous national identity.³⁷

In implementing these new policies, including those in public health, Liberal reformers recognized the need to ameliorate racial and class tensions—concepts that politicians often conflated in their rhetoric. To that end, liberals promoted the idea of *la raza colombiana* or the “Colombian people” as a single mestizo nation that included all citizens. While Liberals blamed Conservatives for the economy’s lack of resiliency, they claimed that their leadership would restore national prosperity and prevent future crises. Liberal reformers in the 1930s and 40s were keenly aware that Colombia could no longer ignore the needs of the country’s underclass. The masses would eventually demand better conditions and a larger share of their nation’s prosperity, even resorting to violent mobilization.

This focus on the countryside and campesinos coincided with a left-wing Liberal tradition, which understood that one of the most prominent issues the government needed to address was the concentration of land in the hands of powerful landowners who had traditionally allied themselves with the Conservative Party. Marcos Palacios’s work has shown that peasant mobilization and land seizures occurring in Colombia’s central Andean region—primarily in Cundinamarca, Tolima, and parts of the Atlantic Coast—precipitated government

action. Growing unrest in some parts of rural Colombia led López Pumarejo to include agrarian reform in his political agenda. Law 200, passed in 1936, was partly a Liberal response to agrarian mobilization; for a government concerned with putting uncultivated lands into production and redefining the terms of land tenure, it made sense to promote health programs geared towards rural Colombians who would work these lands and put them into production.

The Model: Sanitary Units, Itinerant Rural Health Commissions, and Mixed Healthcare Centers

In the 1930s, the Colombian government's public health policy changed directions. After 1934, reformers transformed existing institutional spaces, adapting them to the government's new public health model, and designed and implemented programs to expand healthcare into the city and countryside. One key continuity in public health provision from the earlier Conservative to the Liberal period was the Rockefeller Foundation's (hereafter the RF) presence in the country. Under the foundation's sponsorship, the Colombian state focused on single-disease eradication campaigns. In 1919, the RF arrived in Colombia to sponsor a hookworm eradication campaign; later, under Liberals, it helped direct anti-larval units to eradicate yellow fever and malaria.³⁸ Despite continuing to promote RF-style campaigns for some diseases, Liberal reformers in the 1930s set out to discredit Conservatives and promote narratives portraying themselves as the redeemers of the nation, and the Colombian masses—*el pueblo*—were portrayed as the passive target of these efforts and, if transformed, as the human capital through which Colombia could achieve national greatness. According to government officials, medical doctors, and intellectuals, the peasantry's living conditions highlighted the urgent need to implement public health campaigns in rural spaces.

To achieve this transformation, the state proposed expanding its public health repertoire from campaigns focused on eradicating a single disease to campaigns that tackled multiple diseases. It also proposed a shift away from relying on the church and private charities to fund these campaigns and towards increasing national, departmental, and municipal fiscal contributions.³⁹ Ruling elites' concern over population health was not new to this period. In 1886, the national state created the Junta Central de Higiene (Central Hygiene Board) and placed this agency in charge of hygiene and sanitation until it was replaced by the NDH (National Department of Hygiene) in 1923. Under the auspices of the Central Hygiene Board, port sanitation, epidemic disease control, and the drafting and approval of local sanitation and hygiene regulations were official

priorities. The NDH was part of the Ministry of Agriculture until 1936 when it was transferred to the Ministry of Education, which became the Ministry of Work, Hygiene, and Social Protection in 1938.⁴⁰ This shift and the increased visibility of hygiene can be understood as part of a greater involvement of medical professionals in public policy-making. As historians Steven Palmer and Marcos Cueto document in their survey of medicine and public health in Latin America, by the last decades of the nineteenth century, a “national community of physicians” increasingly proposed the need for medical doctors to intervene and participate in their country’s most pressing sanitary concerns. They fought to establish “lasting alliances with state power and sanitary agencies” now directed by medical professionals.⁴¹ In the 1920s, central governments across the region started expanding their authority and establishing national public health systems. By the 1930s, these processes of institutionalization of public health converged with the emergence of “populist social and political movements” and reform-minded governments, of which Colombia is one example.⁴²

During López Pumarejo’s first administration (1934-1938), the NDH launched a program that established sanitary units (*unidades sanitarias*), rural commissions (*comisiones rurales*), and mixed healthcare centers (*centros de salud mixtos*). Although their sources of funding differed—the first two were entirely publicly funded whereas the latter was funded by a mix of public and private sources—, all these entities shared common goals. They were designed to “promote sanitary habits, defend public health, and stimulate our people’s biological capacities thus improving their precarious living conditions.”⁴³ They all followed NDH directives, although they varied in their operations budget and spatial distribution. Sanitary units were funded through national, departmental, and municipal sources. They provided permanent services in municipalities. In theory, these services included soil inspection, home visits, maternal and infant health, school hygiene, campaigns against tropical diseases, epidemic diseases, venereal disease, tuberculosis and leprosy, education and propaganda services, regulation of the medical and pharmaceutical professions, statistics and epidemiology, and schools to train *visitadoras sociales*, midwives, and sanitary inspectors.⁴⁴ As official reports state, rural commissions and sanitary offices followed the same organizational scheme as that proposed for sanitary units, though officials acknowledged the possibility that the reach and capacity of these entities might be limited. Not all sanitary units were created equal; as the previously cited report stated, not all the units could offer all listed services.⁴⁵ On the other hand, the national treasury funded rural commissions, and the latter also received departmental funds in some instances. The NDH assigned these commissions to small and remote rural towns with limited fiscal resources. Unlike sanitary units, these commissions did not establish permanent facilities but

were assigned to multiple localities within a given radius. Once staff completed their designated campaign, these commissions would move to a neighboring area. As these commissions were itinerant, they often provided limited health services. In addition to units and commissions, the NDH set up a system of sanitary offices. Funded entirely by the national treasury, these offices provided additional aid in regions where “due to singular circumstances, public health and sanitation campaigns were of particular importance.”⁴⁶

Finally, mixed healthcare centers combined government and private funds in Colombia’s coffee-growing and banana-growing regions to provide agricultural workers with health and sanitary services. For instance, in the country’s coffee belt, including the Antioquia, Caldas, and Cundinamarca departments, the National Federation of Coffee Growers, established in 1927, funded the region’s mixed healthcare centers. Under the Liberals, the NDH continued and expanded the disease eradication programs that Conservatives had enacted, such as the 1919 hookworm campaign, the establishment of tuberculosis dispensaries, and campaigns against alcoholism.⁴⁷ New in this regime, however, was the allocation of resources to disease prevention and education and the establishment of sanitary units, rural commissions, and mixed healthcare centers.¹⁴ The NDH set up these establishments within a new model of public health provision. Switching to a model based on units, this new system relied on centralization, thereby structuring health provision and program implementation by relying on coordination and cooperation between national, departmental, and municipal-level authorities. According to a 1937 NDH report, the advantages of adopting this model included: (1) fiscal cooperation, as municipal and departmental offices made contributions to the national treasury; (2) the gathering of health statistics at the municipal, departmental, and national levels, which in turn facilitated the implementation of sanitary campaigns; and (3) fiscal efficiency. It relied on education and prevention, running campaigns to prevent and simultaneously counteract multiple diseases and improve sanitation efforts.⁴⁸

The National Department of Hygiene adapted this model from the US Public Health Service’s programs developed in 1919 and implemented in other Latin American nations such as Brazil and Mexico. Dr. Arturo Campo Posada, who prepared the NDH’s 1937 report on rural health, observes in this document that Mexico had achieved impressive results, especially if its extensive territory was considered alongside “the poor living conditions of its peasantry.” In Posada’s view, Mexico provided an excellent example of the merits of establishing a unit-based model of public health provision. This country’s success was laudable given the difficulties in “assimilating Indians and forming among them a sanitary consciousness.”⁴⁹ For Posada, who adhered to the Liberal notion that Colombia was a mestizo nation, comparing his nation’s circumstances to Mexico

allowed him to argue that if rural programs were successful in the latter’s case despite Mexico’s sizeable Indigenous population, Colombia, a mestizo nation, *should* also succeed in its efforts. Posada justified implementing a unit-based system of public health designed and imagined for a racially and ethnically homogenous peasantry, perpetuating a Liberal narrative that rhetorically erased Afro-Colombian and Indigenous identities from public narratives. In fact, rather than using racial distinctions between Indigenous, Afro, or mixed ethnic groups in writing about rural inhabitants, official discourse intentionally used the term *campesino* (peasant), indicating someone whose subsistence was tied to the land. During the nineteenth and early decades of the twentieth centuries, government sources frequently used this word with regional markers to code specific racial or ethnic categories. The fact that Liberal reformers dropped explicit racial distinctions during this period indicates their attempt to unify the nation under a single *mestizo* national identity.⁵⁰ They sought to silence race in public narratives by subsuming it in economic categories that promoted an imagined *mestizo* identity, often using the word *raza* or race as a synonym for national identity.

Adopting a unit-based model for the establishment of a public health agenda made sense from a fiscal and sanitary standpoint; reformers often argued that this was the best system to improve hygienic conditions for most Colombians. Education and prevention became one of the NDH’s central tenets. For these reformers, the previous models of disease eradication (single-disease campaigns) promoted and implemented with Rockefeller Foundation funds were inefficient and expensive. They taught Colombians how to protect themselves against a single disease but did not guarantee protection against other illnesses. Single-disease campaigns left essential gaps in their consciousness, leaving “peasants and workers defenseless against the whip of indolence and disease.”⁵¹ According to Posada, it was necessary to save future generations, especially since the current one was “almost irredeemable.”⁵² Posada echoed public health reformer Laurentino Muñoz Trujillo’s sentiments as captured in his 1935 tract, *La tragedia biológica del pueblo colombiano*.

In Liberal reform narratives such as Muñoz Trujillo’s tract, most Colombians “vegetated in disease and ignorance” trapped by their inferiority as “illness and vice” defeated them. For reformers such as Muñoz Trujillo, it was clear that the government could no longer afford to neglect the masses and that it would be up to the Liberal state to lead the nation towards greatness. Up until that point, Muñoz argued, disease had kept Colombians in “physiological misery,” and ignorance had kept them in “spiritual poverty.”⁵³ There could be no economic prosperity for the nation or economic freedom for individuals without a national plan of action in public health and education. The masses “were

poverty-stricken and lived in a primitive state,” with barely enough energy to survive, immersed in darkness and ignorance. In such a state, Muñoz Trujillo concluded, they could not produce any wealth for themselves or their nation.⁵⁴ In his narrative, state neglect under Conservative party rule had allowed peasants to die in misery and disease, and they, in turn, passively waited for the state to rescue and redeem them.

For Muñoz Trujillo and his fellow reformers, state-sponsored public health and education programs would transform peasants from passive victims of neglect into active participants in developing the nation. In these narratives, redeemed peasants would participate in managing and exploiting nature; they would put the nation’s vast uncultivated lands into production and help the nation reach its productive potential. The nation faced several problems but, for Muñoz Trujillo and contemporary reformers, these boiled down to three: Colombia needed “hygiene, agriculture, and men.”⁵⁵ Echoing nineteenth-century Liberal ideals when he posited that economic prosperity lay in putting the nation’s uncultivated lands into production and in populating sparsely populated regions, Muñoz Trujillo was arguing that the keys to increasing agricultural output were improving current farming methods, teaching peasants modern hygiene practices, and protecting their bodies and minds from vice and disease. In his eyes, Colombia’s potential depended on the state’s ability to redeem and uplift the masses, which passively awaited state action. In his narrative, he compared this “anonymous conglomerate” to plants, irrational beings, or a “malleable raw material.”⁵⁶ In both narratives, Colombian peasants and workers, who, for Muñoz Trujillo, made up the masses, disappeared into anonymity as passive actors without agency. Nevertheless, neither Posada nor Muñoz Trujillo could admit defeat in the face of what they considered to be the masses’ entrenched unsanitary habits, vice, or ignorance. For Posada, the current generation was *almost* irredeemable but, with an efficient program and a robust and capable state, Colombians could yet be saved.

In 1934, the NDH established its first pilot sanitary unit in Pereira, a municipality in one of the country’s principal coffee-growing regions. The choice of Pereira as a test site was not coincidental. This town was in the Caldas region, one of Colombia’s top coffee-growing regions. Coffee was Colombia’s primary export, so in reformers’ eyes, this location was vital for restoring the countryside’s economic viability. Coffee production was different from other agricultural exports in two ways: 1) coffee was the country’s most valuable export commodity, and 2) smallholding farmers in Western Colombia owned most of the coffee-producing estates. Coffee-growing operations differed from other export industries owned and operated by foreign interests such as United Fruit Company or Tropical Oil. The NDH’s motives in extending healthcare into

Colombia's coffee belt were therefore both economic and political. As Charles Bergquist and Marcos Palacios have shown, coffee growers in Colombia were independent landowners and therefore not subjected to the same working conditions as the rural wageworkers that labored in foreign-owned enclaves.⁵⁷ This made coffee growers less susceptible to left-wing ideologies embodied in the anarchist, socialist, and left-liberal ideas circulating in foreign-owned multinationals. In Western departments such as Caldas and the north of the Valle del Cauca, likelier to vote for the country's Conservative party. Liberals, hoping to rescue the economy and garner support for their party, recognized the strategic importance of intervening in and deploying programs in coffee-growing regions.

Given the pilot program's success in Pereira, the department launched sanitary units in other municipalities, drafting agreements between national, departmental, and municipal administrations to finance the project. In addition to establishing these sanitary units in mid- to large cities, the NDH set up mobile rural commissions. In 1936, after several departmental and municipal offices signed contracts with the NDH, this agency allocated an essential part of its annual budget to creating additional sanitary units and rural health commissions. Supporters of the NDH argued that the Liberal government could no longer afford to ignore the countryside and that, to ensure the country's prosperity, the government needed to enlist rural inhabitants as active participants and promote the exploitation of Colombia's extensive and fertile lands.⁵⁸

By 1936, there were a total of 37 sanitary units operating in Colombia. Pereira's sanitary unit had provided a helpful model that public health officials replicated in establishing other units across the territory, in the municipalities of Barranquilla, Cali, Ibagué, Cucuta, Cartagena, Santa Marta, Popayán, Manizales, and Buenaventura, among others. A close examination of the geographic distribution of these units and commissions reveals a regional concentration along the country's principal ports on its Atlantic and Pacific coasts, across its coffee belt—corresponding to areas of intense agricultural production—and strategic trade centers linked to the nation's export industries. National, departmental, and municipal budgetary allocations to fund the 37 sanitary units mirror the spatial distribution pattern of establishing units in the country's economically important regions. A breakdown of monetary contributions for each unit from the national to the municipal level reveals that Barranquilla received 102,658 pesos. Buenaventura and Cali followed suit with 36,810 and 36,411 pesos, respectively. Barranquilla and Buenaventura received the most significant contributions at the national level, which is unsurprising if we consider that Barranquilla was the country's principal port on the Atlantic and Buenaventura the largest on the Pacific.⁵⁹ Cali, located in the southwestern region, was one of the country's growing commercial centers. This city linked the Valle del

Cauca's sugar-producing estates and Caldas and Antioquia's coffee industry to Buenaventura via the Pacific railroad line in operation since 1915.

Additionally, a total of 31 rural commissions were established in small townships and remote rural areas where limited resources made it difficult for local agencies to set up permanent sanitary units. A regional breakdown for rural commissions shows a concentration of commissions in Tolima, Magdalena, and Chocó. In contrast to sanitary units, which offered permanent services in fixed localities, ambulatory rural commissions were assigned to remote areas of the country where local resources and agencies were deemed insufficient to provide essential sanitary and health services. Whereas sanitary units were designed to provide permanent services in strategic areas of the nation, rural commissions serviced primarily peripheral regions.

In 1937, Posada criticized budgetary allocations at the time. He was worried that municipal, departmental, and national agencies had no obligation to designate a percentage of their budgets to hygiene and social assistance. According to Posada, without a law to regulate annual contributions, mandating at least a 10 percent contribution at the municipal, departmental, and national levels, "it would be impossible to organize a public health apparatus effectively and to achieve economic prosperity in a nation that did not defend its human capital with a vigilant spirit."⁶⁰ Throughout his report, Posada reiterated the importance of promoting public health and social assistance programs as essential functions of the state. In addition, he emphasized the importance of enlisting multiple social actors in a mission to tie Colombia's economic prosperity to the health and productivity of its current and future citizens. For Posada, achieving these goals would require "the unfaltering participation of the nation, departments, municipalities, legislative bodies, agricultural, mining, textile industries, and more generally all other citizens in privileged positions to exert influence over Colombia's social destiny."⁶¹ If Colombia was destined to achieve economic growth and enter a new age of prosperity, it needed to mobilize social sectors and invest in its human capital.

Not only should offices at the national, departmental, and municipal levels invest in public health campaigns and sanitation efforts, private companies should also contribute to this cause, financing the establishment of mixed healthcare centers. In rural areas where private companies had set up their production centers, entities such as the National Coffee Growers Association, the Magdalena Fruit Company, and the Santa Marta Railway Company helped fund state efforts by making annual contributions to the promotion of public health and educational campaigns. While the masses wasted away "in disgrace and sterility," a collaborative effort between state agencies and private enterprise would help "redeem Colombia's racial stock."⁶²

Mixed healthcare centers provided sanitation and social assistance services in key agrarian areas, particularly those tied to the country's banana- and coffee-producing sectors, combining private investment with national and departmental resources. By 1939, the National Federation of Coffee Growers, in collaboration with the national government, had opened mixed healthcare centers located in Antioquia (Concordia, Fredonia, Titiribi, and Salgar), Caldas (Riosucio and Quinchia), and Cundinamarca (Viota, Tibacuy, and El Colegio). Each health center was divided into two sections: a sanitary office and a social assistance office. The first ran campaigns on soil sanitation, cleanliness in workers' homes, and better nutrition. The second provided medical, dental, and gynecological services and hospitalization for local inhabitants who worked in coffee cultivation and their families.⁶³

The Liberal government and the political climate it promoted provided an ideal setting for establishing mixed healthcare centers. Initiatives where the government enlisted the help of private companies to provide services geared towards rural workers vested these programs with legitimacy and highlighted the state's pro-worker and pro-peasant rhetoric. It was in relation to Colombia's banana-growing regions, long associated with foreign companies and economic enclaves, that López Pumarejo's government passed Law 1 in 1937.⁶⁴ With the passage of this law, owners of banana plantations needed to provide their workers with health and social assistance services. It gave employers the choice between establishing privately funded centers or contributing to government-sponsored mixed health services. Companies such as the Magdalena Fruit Company and the Santa Marta Railway Company chose to do the latter, contributing to pre-existing centers. This law helped expand the centers' capacity and reach now that more companies were held liable for providing these services to their employees. The first mixed health center on Colombia's Atlantic coast provided services to company workers and their families, which amounted to “approximately 14,000 inhabitants.”²⁶ In 1935, the total number of hectares under cultivation affiliated with this mixed healthcare center was approximately 25,591 thousand, whereas, by 1937, there was a total of 135,591 hectares serviced by this center. Similarly, the average income for these centers increased almost fourfold, from 18,242 pesos to 71,156 in the same period.⁶⁵

Although the urgency and necessity of establishing sanitary units and rural commissions were evident, financing and implementing these programs required a lot of effort. In addition to financial constraints, Colombia's public health establishment needed trained personnel to staff these units and commissions. Posada called on the nation's “patriotic and enthusiastic medically trained youth, whose commitment and energy” would help overcome hurdles such as “precarious circumstances, insufficient budgets, and recalcitrant peasants.”⁶⁶ In addition

to the doctors who directed these centers and carried out the work of educating rural Colombians, auxiliary medical personnel should also mobilize behind this worthy cause. For Posada, the lack of available personnel highlighted the urgency with which the state should train officials to staff these commissions. In addition, the NDH should train sanitary inspectors and *visitadoras sociales* to conduct sanitation campaigns and promote the state's educational message in Colombia's urban and rural homes.

In municipalities where established sanitary units had schools and resources at their disposal, they proposed training local men to become inspectors. This practice would help ensure that future inspectors are familiar with the localities to which they are assigned, "their terrain, its social elements, and the customs of its inhabitants."⁶⁷ This familiarity was crucial to ease the implementation of these campaigns. Moreover, whereas inspectors were male, *visitadoras sociales* were female. They "were the primary contact points between units' and commissions' staff and their audiences."⁶⁸ For the NDH, these women had a clear mission, "to promote education in the home, in schools, and small industrial establishments."⁶⁹ These "patriotic" women should prepare themselves "to work and provide their services in any part of the national territory [...] bringing with them morality, culture, humility, and honesty."⁷⁰ As representatives of the state who were to enter Colombian homes, these women were expected to serve, fulfilling their role as instructors and caretakers of the nation.

Both the inspectors and the *visitadoras* collected crucial information on each site and educated their audiences on the merits of adopting sanitary habits in their everyday lives. Collecting data and health statistics was an essential part of their tasks. Each week, health workers (sanitary inspectors, nurses, *visitadoras sociales*) gathered these statistics from hospitals, Red Cross centers staffed with private medical practitioners, and other entities that provided social assistance. This data-gathering function served multiple purposes. First, it streamlined the state's collection of vital statistics related to health. It helped collect census data, allowing the state to assert its presence in areas where it had previously only cast its shadow. Third, this function was also crucial in providing the basis for further epidemiological studies that might help sanitary units and commissions design and target their campaigns.⁷¹ The NDH's argument for using statistics and epidemiological maps reflected the state's vision of what establishing a modern public health system would entail. According to NDH staff, gathering health statistics and compiling epidemiological data showcased Colombia's move from an antiquated public health system to a modern one.

Public health officials, from sanitary inspectors to nurses to *visitadoras sociales*, worked as intermediaries between the sanitary units, rural commissions, and thousands of Colombians. These health officers represented the

NDH while also gathering vital information on the state’s behalf. However, the implementation of these campaigns on the ground met with several obstacles. In addition to fiscal constraints, these commissions often lacked the personnel to run their programs. One of the biggest obstacles faced by the NDH, and later the Ministry of Hygiene, was a lack of medical doctors and public health officials to staff these commissions.

Obstacles to Health Provision

Available statistics of doctor-patient ratios in 1930s Colombia help to illustrate these staffing challenges. For instance, in 1934, Antioquia, the nation’s wealthiest department and leading coffee producer, had an average of one university-trained medical doctor per every 3,400 inhabitants. Chocó, on Colombia’s Pacific coast, a predominantly Afro-Colombian and Indigenous area, historically marginalized and neglected, had an average of one university-trained physician for every 8,500 inhabitants. The overall national average was roughly one doctor per 7,500 inhabitants.⁷² In 1937, Roberto Concha, director of the vital statistics office of the NDH, estimated that “there were a total of 1,512 licensed physicians in Colombia.” This meant that approximately 65% of municipalities in the country “did not have a licensed medical professional” on hand.⁷³ As noted by Antonio José Rodríguez, physician and director of hygiene for the Chocó region in 1934, in his comments on the limited success of the region’s anti-yaws campaign, the state’s efforts were “insufficient.” This was partly due to the “lack of urban nuclei” in the area and the fact that locals lived “dispersed along” the area’s rivers, which the commission’s personnel could not reach without gasoline-powered boats. Even if these boats were available, he continued, the commissions lacked trained professionals and should at least “double the number of employees.”⁷⁴ This reality, alongside fiscal challenges and what Natalia Botero-Tovar has shown was the effect of graft and corruption at the local level, combined to make the effective delivery of these services, particularly in remote rural zones, a challenge.⁷⁵

In 1949, Colombia’s Minister of Hygiene, Dr. Jorge E. Cavelier, addressed the national Congress recounting the accomplishments and the failures of Colombia’s public health establishment, taking stock of its rural programs and providing a retroactive evaluation of public health programs over the past fifteen years.⁷⁶ Conservative president Mariano Ospina Pérez had appointed Dr. Cavelier Minister of Hygiene, a position he held from 1949 to 1950.⁷⁷ During his tenure as minister, he directed the establishment of rural health services posts. These organizations were designed to give continuity to the commissions launched

under Pumarejo's first presidency and intended primarily to expand rural health services coverage. When Dr. Cavelier addressed his compatriots, he described a medical geography in which peasants and workers were still passive victims who lingered in indolence, indifference, precariousness, or helplessness—trapped in a battle between ignorance and the diseases that attacked the nation's human capital. He claimed that malaria, tropical anemia, and tuberculosis preyed upon the nation's rural inhabitants in warm climates. If tropical diseases threatened peasants, in cities and more temperate zones, venereal disease, malnutrition, and other illnesses threatened workers.⁷⁸ Echoing health officials before him, such as Posada, Muñoz, and Franco—all cited above—, Cavelier spoke of redemption and future prosperity for the nation *if* the state succeeded in its efforts and of the dire consequences if it did not.

Cavelier criticized the current health of Colombia's forgotten peasantry and highlighted the shortcomings faced by a Ministry with limited financial and human capital. Like reformers in the 1930s, he invited his audience to consider the importance of forging a nation of healthy, productive, and educated citizen-workers and citizen-campesinos. While previous efforts in expanding the delivery of public health initiatives to rural areas were signs of the state's commitment to improving the lives of its citizenry, this medical doctor argued that there was still much more to be done.⁷⁹ In his report, Cavelier noted that "several million" suffered from hookworm, malaria, tuberculosis, alcoholism, and venereal disease. The inability to deliver health services and carry out education and prevention campaigns, which resulted in the practical exclusion of millions of citizens, had several explanations, including, but not limited to, budgetary constraints and limited infrastructure.

Peasants, on whose shoulders the nation's economic livelihood rested, suffered because the state lacked the financial resources to extend the reach of its programs and had insufficient roads to connect remote areas to strategic urban centers.⁸⁰ The records documenting the allocation of national and departmental funds to finance rural and urban sanitary campaigns and regional reports from program directors show that a lack of monetary resources was a crucial and ongoing problem in the implementation of these initiatives.⁸¹ Another frequently cited obstacle was the lack of trained professionals to staff these programs. Although Cavelier did not give exact figures for the ratio of doctors to the population at the time of his report, he spoke at length about this problem. He drew several analogies to emphasize this point and highlight the urgency of investing in, educating, and training program staff. He explained that millions of Colombians "were born and died without ever receiving medical attention." According to Cavelier, the lack of trained physicians was so significant that if we divided the population by the number of doctors available in the national

territory, “it would take a doctor all of his life to attend to the needs of the thousands of patients in need of his services.” To make matters worse, most trained professionals chose to live in cities or large population centers, leaving the task of living and working in remote rural areas to a few “dedicated and notable individuals.”⁸²

Why did medical doctors live in larger population centers, avoiding far-off rural zones? In his report, Cavelier suggested that this was not due to a lack of patriotism on the doctors’ part but rather to the fact that these men found little or no financial incentives for choosing to live in these remote communities. He noted that not only were doctors unlikely to earn adequate salaries that would in some ways compensate them for the expenses incurred during years of schooling and the inconvenience of living in areas with little to no comforts, but also that rural dwellers, those who would provide company and comfort to these doctors, were “*poor, ignorant, and superstitious*” (my emphasis).⁸³ Cavalier, accounted for medical doctors’ lack of willingness to live and work in the country’s remote regions describing it as a cultural clash between Colombia’s urban and rural worlds. Medical doctors represented urban, modern, and scientific values whereas peasants lived immersed in traditional values and, according to this doctor, pushed back against the state’s “civilizing” efforts. But despite this “clash”, the lack of and need for doctors in rural areas had yet to be addressed. Cavelier also suggested that medical students work and serve in rural areas for at least a year before graduating with their medical degrees. Promoted by medical doctor, university professor, and founder of the National School of Public Health Hector Abad Gómez and supported by Cavelier, the Obligatory Social Service became law under Decree 3842 of 1949.⁸⁴ It mandated an obligatory one-year social service for graduating medical students in Colombia’s rural areas. For reference, Mexico pioneered the obligatory social service for graduating medical students, establishing it in 1936.⁸⁵

Cavelier’s report, like the reform literature produced in 1930s Colombia, made clear that he believed that reaching out into rural areas and transforming peasants from “stubborn, backward, superstitious, and indolent” individuals into productive, healthy, and modern citizens was a critical yet, at times, insurmountable task for state agencies. For this medical doctor, the challenges included amassing sufficient fiscal resources, building adequate roads to reach these remote areas, and training more nurses, doctors, inspectors, and social workers. As Cavelier’s report demonstrates, these obstacles continued to plague these programs well into the 1940s and brought to light other ongoing structural barriers to delivery that neither the Liberals in the 1930s nor the Conservatives after their return to the presidency in 1946 were prepared to address.

Concluding remarks

Health reformers in the 1930s and 1940s were part of a cadre of officials who helped redefine the state's role and responsibility to its citizens. They helped promote the idea that improving population health was a state responsibility and the basis for national progress, adhering to the tenets of social medicine, particularly those that advocated for “an integrative causal framework” and called for the state to “play a strong role in developing and regulating health systems to serve the collective needs of national populations.”⁸⁶ In the 1930s, reformers such as Arturo Posada, Carlos Franco, Laurentino Muñoz Trujillo, and others sought to re-structure the nation's health establishment, pushing towards greater centralization and administrative efficiency. This prompted a shift towards educational and preventive campaigns that strongly emphasized understanding multi-disease causation rather than relying on single-disease eradication. Despite this shift, public health practitioners continuously emphasized the importance of modifying the peasantry's habits and, as a result, when programs faced limited success, they pointed to material obstacles and blamed peasants for their presumed indolence, continued poverty, and poor health outcomes. Implementing these programs was difficult, and several obstacles limited their reach. Even though these programs highlighted Liberal efforts to establish an unprecedented campaign that incorporated the masses into the national project, meaningful inclusion was not, in practice, the outcome. As this article has shown, medical reformers often set limits as to whom they considered full citizens of the nation, even as they cited social and economic factors as significant contributors to poverty and disease propagation in their work. The conscious and implicit biases and prejudices baked into the design of public health programs and campaigns meant that when public health officials and medical doctors looked at the Colombian countryside and its inhabitants, they did so from a deficit mindset—often privileging solutions focused on modifying individual habits. Ultimately, the shortcomings of these programs could be blamed on recalcitrant peasants, in addition to the material obstacles that these programs faced in their implementation.

Notes

1. Alfonso López Pumarejo, “Mensaje presidencial al Congreso sobre educación nacional,” in *La Política Oficial*, Bogota, 1935, Vol. 1, p. 30.
2. López Pumarejo, “Mensaje presidencial al Congreso,” p. 140.
3. Alfonso López Pumarejo, “Mensaje al Congreso sobre educación nacional. Diciembre 17 de 1934,” en *Obras Selectas*, p. 184. Cited in Álvaro Tirado Mejía, *La Revolución*

- en marcha: El primer gobierno de Alfonso López Pumarejo, 1934-1938* (Bogota: Universidad Nacional de Colombia, 2019), p. 105.
4. Eric D. Carter, “Social Medicine and International Expert Networks in Latin America, 1930-1945,” *Global Public Health*, 14: 6-7 (2019), pp.792, <https://doi.org/10.1080/17441692.2017.1418902>
 5. Carter, “Social Medicine,” p. 793.
 6. See: Catalina Muñoz-Rojas, *A Fervent Crusade for the National Soul: Cultural Politics in Colombia, 1930-1946* (New York and London: Lexington Books, 2022) and Hanni Jalil, “Curing a Sick Nation: Public Health and Citizenship in Colombia, 1930-1940,” Ph.D. Dissertation, University of California Santa Barbara, 2015.
 7. Stefan Pohl-Valero and Sebastián Alban Maldonado, “La más eficaz, la más rápida, y también la más económica: la colonia escolar de vacaciones como proyecto estatal modelo para el desarrollo rural en Colombia durante la república liberal,” *Estudios Sociales del Estado*, 8: 16 (2022), pp. 114-150.
 8. Gabriela Soto Laveaga, “Medicalizing the Borders of an Expanding State: Physicians, Sanitary Reports, and the Frontiers of Mexican Progress, 1930-1950,” in John W.I. Lee and Michael North, *Globalizing Borderlands Studies in Europe and North America* (Lincoln: Nebraska University Press, 2016), p. 222.
 9. For more on peasant mobilization, rural unrest, and land reform in 1930s Colombia see: Marcos Palacios, *¿De quién es la tierra? Propiedad, politización y protesta campesina en la década de 1930* (Bogota: Universidad de los Andes, 2011).
 10. Several scholars have studied protest and social mobilization during this period. See for instance, Palacios, *De quién es la tierra*. Mauricio Archila, *Cultura e identidad obrera: Colombia 1910-1945* (Bogota: CINEP, 1991); Charles Bergquist, *Labor in Latin America: Comparative Essays on Chile, Argentina, Venezuela and Colombia* (Stanford: Stanford University Press, 1986); Catherine LeGrand, *Frontier Expansion and Peasant Protest in Colombia, 1850-1936* (Albuquerque: University of New Mexico Press, 1986), Daniel Pécaut, *Política y sindicalismo en Colombia* (Bogota: La Carreta, 1973).
 11. My thinking on the importance of cultural representations of historical subjects that rarely appear in the historical record or appear as objects rather than subjects in traditional sources has been influenced by the work of Marisa J. Fuentes and Robin Mitchell, particularly Marissa J. Fuentes, *Dispossessed Lives: Enslaved Women, Violence, and the Archive* (Philadelphia: University of Pennsylvania Press, 2016) and Robin Mitchell, *Venus Noire: Black Women and Colonial Fantasies in Nineteenth-Century France* (Athens: University of Georgia Press, 2020).
 12. See: Muñoz-Rojas, *A Fervent Crusade*; Jalil, “Curing a Sick Nation”; Hanni Jalil, “A Sick, Weak and Ignorant People: Public Health Education and Prevention in Rural Colombia, 1930-1940,” *Bulletin of Latin American Research*, 38:1 (2019), pp. 19-34 <https://doi.org/10.1111/blar.12739>
 13. In 1942, as part of the Liberal state’s cultural programs, the Ministry of Education undertook a survey of Colombia’s cultural, social, and educational practices. The ministry relied on schoolteachers as respondents to the survey. Part of the questions inquired about traditional and popular medical practices in the territories. I analyze this survey in my book manuscript currently in preparation. For more information about the survey and methodological suggestions on its use, see: Renan Silva, “Encuesta folclórica nacional, 1942,” *Historia y Espacio*, vol. 18 (2018), p. 7-43. For historical accounts of the survey as a part of the larger Liberal project of cultural transformation see: Renan Silva, *Sociedades campesinas, transición social y cambio cultural en Colombia: la*

- encuesta folclórica nacional de 1942, aproximaciones analíticas y empíricas* (Medellin: La Carreta Editores, 2006) and Muñoz-Rojas, *A Fervent Crusade*.
14. A few examples of this scholarship include Mary Kay Vaughan, *Cultural Politics in Revolution: Teachers, Peasants, and Schools in Mexico, 1930-1940* (Tucson: University of Arizona Press, 1997), Katherine Elaine Bliss, *Compromised Positions: Prostitution, Public Health, and Gender Politics in Revolutionary Mexico City* (University Park: Pennsylvania State University Press, 2001), Christopher R. Boyer, *Becoming Campesinos: Politics, Identity, and Agrarian Struggle in Postrevolutionary Michoacán* (Stanford: Stanford University Press, 2003), and Anne-Emmanuelle Birn, *Marriage of Convenience: The Rockefeller Foundation and Post-Revolutionary Mexico* (Rochester: University of Rochester Press, 2006).
 15. Muñoz-Rojas, *A Fervent Crusade*, p. 1.
 16. In addition to Catalina Muñoz-Rojas's recent book on the Liberal Republic's programs of cultural transformation, several recent publications have examined specific programs and policies undertaken by the Colombian state in the 1930s such as: Iván Darío Olaya Peláez, "The Colombian Healthy Child Contest: In search of Latin America's 'Ideal Child' in the 1930s," *Historia, Ciencias, Saude- Manguinhos*, vol. 30 (April 2023), p. 2014; Natalia María Gutiérrez Urquijo, "La vida del niño es la vida de la nación": La política de protección materno-infantil en Colombia, 1918-1938," Ph.D. Dissertation, El Colegio de México, 2022.
 17. Renan Silva, *República liberal, intelectuales y cultura popular*, segunda ed. (Medellin: La Carreta Histórica, 2012), p. 13.
 18. For an account of rural social medicine in Colombia as seen through official attempts to diagnose and treat yaws, see: Gabriel J. Tobón and Victoria E. Orrego, "Deformaciones y contagios: la lucha contra el pian en Colombia en la primera mitad del siglo XX," *Trashumante: Revista Americana de Historia Social*, vol. 18 (2021), pp. 28-51; and Gabriel J. Tobón and Victoria E. Orrego, "La medicina social en zonas rurales: una historia de la lucha contra el pian en Antioquia, 1918-1941," *Anuario Colombiano de Historia Social y Cultural*, 49: 2 (2022), pp. 97-126.
 19. Stuart McCook, "Promoting the 'Practical': Science and Agricultural Modernization in Puerto Rico and Colombia, 1920-1940," *Agricultural History*, 75: 1 (Winter 2001), p. 53.
 20. McCook, "Promoting the 'Practical,'" p. 80.
 21. Pohl-Valero and Alban Maldonado, "La más eficaz, la más rápida," p. 116.
 22. For an analysis of López Pumarejo's program of reform during his first administration and the ways this period has been framed in the nation's historiography see: Richard Stoller, "Alfonso Lopez Pumarejo and Liberal Radicalism in 1930s Colombia," *Journal of Latin American Studies*, 27: 2 (May 1995), pp. 367-397.
 23. López Pumarejo, "Mensaje presidencial al Congreso," p. 140.
 24. Jalil, "Curing a Sick Nation" and Muñoz-Rojas, *A Fervent Crusade*.
 25. Amy C. Offner, *Sorting out the Mixed Economy: The Rise and Fall of Welfare and Developmental States in the Americas* (Princeton: Princeton University Press, 2019), p. 3.
 26. Offner, *Sorting out the Mixed Economy*, p. 3
 27. Muñoz-Rojas, *A Fervent Crusade*.
 28. Muñoz-Rojas, *A Fervent Crusade*, p. 2.
 29. Muñoz-Rojas, *A Fervent Crusade*, p. 2.
 30. López Pumarejo, "Mensaje presidencial al Congreso," p. 140.

31. Muñoz-Rojas, *A Fervent Crusade*, p. 2.
32. Muñoz-Rojas, *A Fervent Crusade*, p. 2. And Natalia Botero-Tovar, “A School Without Railings: Rural Backgrounds, Social Medicine and the Circulation of Public Health Material in Colombia, 1930-1946,” *Historia, Ciencias, Saude-Manguinhos*, 28: 3 (2021), pp. 795-808.
33. Dr. Carlos Franco in *Higiene y Sanidad: Órgano de divulgación de las campañas Sanitarias rurales del Tolima*, 1938, p. 1.
34. *Unidades Sanitaria y Comisiones Rurales*, Departamento Nacional de Higiene. Sección: Salud Rural, 1936, pp. 5- 6.
35. *Unidades Sanitaria y Comisiones Rurales* pp. 5-6.
36. *Unidades Sanitaria y Comisiones Rurales* pp. 5-6.
37. For an analysis of discourses of racial difference, eugenics, and its relationship to social hygiene and public health in Colombia see: Catalina Muñoz, *Los problemas de la raza en Colombia: Mas allá del problema racial, el determinismo geográfico y las “dolencias sociales”* (Bogotá: Editorial Universidad del Rosario, 2011); Stefan Pohl-Valero, “‘La raza entra por la boca’: Energy, Diet, and Eugenics in Colombia, 1890-1940,” *Hispanic American Historical Review*, 9: 3, pp. 455-486; Jalil, “A Sick, Weak, and Ignorant People”; María Fernanda Vásquez, “Degeneración y mejoramiento de la raza: Higiene social o eugenesia? Colombia 1920-1930,” *Historia, Ciencias, Saude-Manguinhos*, vol. 25, (August 2018), pp. 145-158.
38. For more on the RF’s role in Colombia, see: Christopher Abel, “External Philanthropy and Domestic Change in Colombian Health Care: The Role of the Rockefeller Foundation, 1920-1950,” *Hispanic American Historical Review*, 75: 3 (1995), pp. 339-376 and Emilio Quevedo, *Café y gusanos, mosquitos y petróleo: El tránsito desde la higiene hacia la medicina tropical y la salud pública en Colombia, 1853-1953* (Bogotá: Universidad Nacional, 2004).
39. Beatriz Castro Carvajal’s work on charity and public assistance from 1870 to 1930 argues against the idea that the state left the entirety of public assistance programs to private philanthropy or the Church. Instead, her work shows that public assistance to Colombia’s poor was a joint effort between private and state actions. Despite this, she acknowledges that these efforts only became a unified state concern after 1930, when the national government assigned a slot for social assistance programs in its annual budget. For more on this, see: Beatriz Castro Carvajal, *Caridad y Beneficencia en el tratamiento de la pobreza en Colombia, 1870-1930* (Bogota: Universidad Externado de Colombia, 2007).
40. For an account of the institutional evolution of healthcare and public health provision in Colombia, see Christopher Abel, *Healthcare in Colombia: 1920-1950* (London: Institute of Latin American Studies, 1994). For a history of the transition from a Ministry of Hygiene to a Ministry of Public Health, see Marlin Tellez and Emilio Quevedo, “The Birth of a Ministry of Public Health in Colombia, 1946-1953: Cold War, Invisible Government and Asymmetrical Interdependence,” *Historia, Ciencias, Saude-Manguinhos*, 29: 2 (2022), pp. 461-480.
41. Marcos Cueto and Steven Palmer, *Medicine and Public Health in Latin America: A History* (Cambridge: Cambridge University Press, 2015), p. 65.
42. Cueto and Palmer, *Medicine and Public Health in Latin America*, p.122. See also, Gilberto Hochman, *The Sanitation of Brazil: Nation, State, and Public Health* (Urbana: The University of Illinois Press, 2011). For more on the impact of the Great Depression on Latin American states see: Paulo Drinot and Alan Knight, *The Great Depression in Latin*

- America* (Durham, NC: Duke University Press, 2014). For an overview of Colombia's health establishment and its creation over the first half of the twentieth century see: Mario Hernández Álvarez, *La salud fragmentada en Colombia, 1910-1946* (Bogota: Universidad Nacional de Colombia, 2002).
43. *Unidades Sanitaria y Comisiones Rurales*, 1936, p. 8.
 44. *Unidades Sanitaria y Comisiones Rurales*, 1936, p. 16.
 45. *Unidades Sanitaria y Comisiones Rurales*, 1936, p. 18.
 46. *Unidades Sanitaria y Comisiones Rurales*, 1936, p. 8. In a similar fashion to Mixed Healthcare Centers, and other NDH programs, Sanitary Offices were established in regions of the country that were economically important. These were established in areas of large agricultural production, fluvial or maritime ports, and commercial hubs linked to the export sector.
 47. Memoria del ministro de Instrucción y Salubridad Publica al Congreso, 1926.
 48. *Informe del Departamento Nacional de Higiene*, 1937, pp. 9-10. Archivo General de la Nación, Sección República. Fondo Anexo: Ministerio de Instrucción pública.
 49. *Informe del Departamento Nacional de Higiene*, 1937, p. 15. According to Posada an estimated 48% of Mexico's population belonged to the "Indian stock."
 50. For more on the spatial mapping of race in Colombia see: Nancy Appelbaum, *Muddied Waters: Race, Region, and Local History in Colombia, 1846-1948* (Durham, NC: Duke University Press, 2003). For an extended discussion of the construction of a mestizo national identity that homogenized diverse racial and ethnic identities in Colombia see: Muñoz-Rojas, *A Fervent Crusade*. For similar processes of national identity construction in Latin America more broadly see: Marisol de la Cadena, *Indigenous Mestizos: The Politics of Race and Culture in Cuzco, 1919-1991* (Durham, NC: Duke University Press, 2000); Alejandro de la Fuente, *A Nation for All: Race, Inequality and Politics in Twentieth-Century Cuba* (Chapel Hill: University of North Carolina Press, 2001); Marilyn Grace Miller, *The Rise and Fall of the Cosmic Race: The Cult of Mestizaje in Latin America* (Austin: University of Texas Press, 2004); Hedrick Tace, *Mestizo Modernism: Race, Nation and Identity in Latin American Culture, 1900-1940* (Rutgers: Rutgers University Press, 2003); Sarah Walsh, "'One of the Most Uniform Races of the Entire World': Creole Eugenics and the Myth of Chilean Racial Homogeneity," *Journal of the History of Biology*, vol. 48 (2015), pp. 613-639.
 51. *Unidades Sanitaria y Comisiones Rurales*, 1936, p. 6.
 52. Ibid.
 53. Laurentino Muñoz Trujillo, *La tragedia biológica del pueblo colombiano: Estudio de observación y vulgarización* (Bogota: Ediciones Atena, 1935), p. 2.
 54. Muñoz Trujillo, *La tragedia biológica*, pp. 2-3.
 55. Muñoz Trujillo, *La tragedia biológica*, p.10.
 56. Muñoz Trujillo, *La tragedia biológica*, p. 22.
 57. For more on the structure of Colombia's coffee industry and its political importance see: Charles Bergquist, *Coffee, and Conflict in Colombia, 1886-1910* (Durham, NC: Duke University Press, 1986) and Marcos Palacios *El café en Colombia, 1850-1970: una historia económica, social, y política* (Editorial Planeta, S.A., 2002).
 58. *Unidades Sanitaria y Comisiones Rurales*, 1936, p. 1.
 59. *Unidades Sanitaria y Comisiones Rurales*, 1936, pp. 10-12.
 60. *Informe del Departamento Nacional de Higiene*, 1937, p. 20.
 61. *Informe del Departamento Nacional de Higiene*, 1937, pp. 20-21.
 62. Muñoz Trujillo, *La tragedia biológica*, p. 6.

63. *Memoria del ministro de Trabajo, Higiene, y Previsión Social al Congreso de 1939*, pp. 113-119.
64. *Informe del Departamento Nacional de Higiene*, 1937, p. 17.
65. *Memoria del ministro de Trabajo, Higiene, y Previsión Social al Congreso de 1939*, pp. 119-121.
66. *Unidades Sanitaria y Comisiones Rurales*, 1936, p. 8.
67. *Unidades Sanitaria y Comisiones Rurales*, p. 22.
68. Ibid.
69. Ibid.
70. Ibid.
71. *Unidades Sanitaria y Comisiones Rurales*, p. 20.
72. Jorge Márquez and Victoria Estrada, “Culebrero, tegua, farmaceuta y dentista. El Indio Rondín y la profesionalización médica en Colombia, 1912-1934,” *Anuario Colombiano de Historia Social y de la Cultura*, 45 (2018), pp. 79-104. See also: Jorge Márquez, “El médico de oficio en Colombia en las décadas de 1920 y 1930,” *Mundos do Trabalho*, 7:85 (2016); Victoria Estrada Orrego, Víctor García García y Jorge Márquez Valderrama, “La profesión médica en la regulación del mercado terapéutico en Colombia (1895-1948),” *Historia y Sociedad*, 43 (2002), pp. 92-116, <https://doi.org/10.15446/hys.n43.99652> and Piedad Del Valle Montoya, Víctor García, Jorge Márquez Valderrama, “La profesión médica y el charlatanismo en Colombia en el cambio del siglo XIX al XX,” *Revista Quipu*, 4:3 (2012), pp. 331-362
73. Márquez and Estrada, “Culebrero,” p. 89. See also: Victoria Estrada, “La valeur des chiffres: la production et les usages des statistiques démographiques et de santé publique en Colombie, 1886-1947,” Ph.D. Dissertation, Paris: École de Hautes Études en Sciences Sociales, 2015.
74. Antonio José Rodríguez R., “Apuntes sobre el Pian,” 30 de septiembre de 1934 en *Revista de Higiene*, g. 415.
75. Botero-Tovar, “A School Without Railings.”
76. Dr. Jorge E. Cavelier, *Memoria del Ministro de Higiene al Congreso, 1949*, p. 55. Dr. Cavelier graduated with a medical degree from Bogota’s National University in 1921 and pursued post-graduate work in surgery and urology at the University of Chicago. He was a key figure in Colombia’s medical establishment, serving as dean of the national school of medicine in the late 1930s and an active member of the National Academy of Medicine until his passing in 1978.
77. Colombia’s Ministry of Hygiene was created in 1946 through Law 27. See: María-Teresa Gutiérrez, “Proceso de institucionalización de la higiene: estado, salubridad e higienismo en Colombia en la primera mitad del siglo XX,” *Estudios Socio-Jurídicos*, 12: 1 (2010), pp. 73-97; and Tellez and Quevedo, “The Birth of a Ministry of Public Health.”
78. Cavelier, *Memoria del Ministro de Higiene*, p. 7.
79. Ibid.
80. For a breakdown of budget allocations for sanitary units and commissions see: *Memoria del ministro de Trabajo, Higiene y Previsión Social al Congreso de 1939*, pp. 111-113. For a discussion of budgetary obstacles and the lack of financial resources to run these commissions see: *Informe del Departamento Nacional de Higiene*, 1937 and *Memoria del Ministro de Higiene al Congreso*, 1949.
81. *Memoria del ministro de Trabajo, Higiene y previsión Social al Congreso de 1939*, pp. 111-113 and *Informe del Departamento Nacional de Higiene*, 1937 and *Memoria del Ministro de Higiene al Congreso*, 1949.

82. Cavelier, *Memoria del Ministro de Higiene*, pp. 7-9.
83. Cavelier, *Memoria del ministro de Higiene*, p. 9.
84. Mervin J. Peñafiel, “Servicio Social Obligatorio en Colombia: Incertidumbre de los recién graduados en medicina,” *Revista Médica Risaralda*, 20: 2 (2014), p. 116.
85. Peñafiel, “Servicio Social Obligatorio en Colombia,” p. 115.
86. Carter, “Social Medicine,” p. 792.