Emigration and public health: the sanitary question in the control of Portuguese emigrants, 1890s-1950s

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Abstract. Human mobility represents a privileged field for analysing epidemic propagation, as well as identification and control practices at a world scale. Migrants are at the same time agents of disease dissemination and vulnerable persons highly exposed to epidemics in transit spaces such as city ports, ships, and settlement sites in the countries of origin. This paper aims to analyse how a country with a long and strong tradition in transatlantic and European migration, such as Portugal, incorporated concerns of Public Health in the policies and management of massive migration exits from the nineteenth century until the 1950s, particularly through the directives for the control and prevention of epidemics. In this way, we will analyse the intersection of two general state policies, epidemic control and migration surveillance.

1 Introduction

The aim of this paper is to analyse how a country like Portugal, with a big tradition in transatlantic and European migration, dealt with the contagious and infectious diseases of its emigrants? How did Portuguese emigration help develop an emigration policy which included sanitary questions and public health control? How were administrative mechanisms put in place for managing the sanitary question lying at the intersection between epidemic prevention and emigration services? To answer these questions, we will analyse the Portuguese official action since the 19th century until the 1950s, to understand how the emigration and the sanitary questions have been framed during the Constitutional Monarchy (1820-1910), the First Republic (1910-1926) and the Portuguese dictatorship (the military dictatorship (1926-1933) and the Estado Novo (1933-1974)).

2 Elements of contextualization

The literature points to 1899, the year of bubonic plague in Oporto, as a key moment for the development of a public health scheme in Portugal, with the creation of the first Direção-Geral da Saúde Pública e Beneficência – DGSPB (General Directorate of Public Health and Beneficence). According to Rita Garnel, this initiative showed a clear concern of the State in the management/coordination of the sanitary question, in which the country’s land and maritime borders became important areas for preventing and controlling the spread of
epidemics in Portugal. [1, 2] The Public Health Regulation of 1901 reinforced the surveillance of mobility by insisting on the control of ships, a control which had already been established during the 19th century to guarantee better travel conditions, onboard accommodations, and hygiene, and to avoid overcrowding. Physicians of the DGSPB had to check the water supplies, the habitability conditions, the means for preserving food, the medical equipment, the conditions of accommodation of passengers, and to confirm the mandatory presence of a doctor, medicines, and appropriate means of disinfection on board.

In parallel to this, the demand of immigrant workers in Brazil and the lower cost of maritime transports promoted the massification of emigration and socioeconomic impacts in the country of origin. The fear that emigration created a lack of rural workers aroused public demands for a more efficient State action in relation to the migratory process. [3] Other voices defended the need to control exits in Portugal to guarantee the departure of the most fit individuals so that the number of deaths by contagious diseases (especially yellow fever) was reduced in the host country Brazil. [4] For assuming the role of main protector of its emigrants – a situation that was the result of a long process, mainly linked to the impossibility of meeting the labour demands of significant sections of the population until the onset of World War I – the Portuguese State built a complex administrative machine in order to control the different phases of the migratory process. This scheme was based on the collaboration of various public institutions and agents acting in different levels and sites to frame the exit. Until World War I, the departure of migrants was limited by certain conditions, the most important of which was having fulfilled one’s military duties. [5] At the same time, the Portuguese government created a police force in 1896 dedicated to the surveillance of the migration industry in the main port cities, though it lacked functions related to sanitary questions. [6]

It was necessary to wait until 1919 for relevant changes in the law about emigration and the role played by the State in its control. Henceforth, the more restrictive policies helped to reinforce the criteria for choosing those most fit, so the physical robustness and the health of the emigrants became an essential factor in their selection. [7] In addition to complying selection rules imposed by the settlement countries, Portugal was interested in sending its most fit emigrants, in order to guarantee the success of the migratory project. Thus, reducing the social and financial burden of aiding those becoming dependent of public institutions and the Portuguese solidarity structures. The creation of the Comissariado Geral dos Serviços de Emigração – CGSE (General Commissariat of Emigration Services) aimed to exert a large action on emigration, from the selection moment to the ship landing, including the travel. The CGSE police agents had, first, a preventive task, to oversee the exits of individuals and the activity of the migration industry, and secondly, a punitive one, to identify irregularities, namely, to sanction the violation of sanitary regulations during the maritime transport. [8, 9] Besides, the inspector of the emigration service had to guarantee the presence of a Portuguese physician in the ship and a Portuguese team for assisting emigrants, taking part for that purpose in its supervision, which was led by a doctor of the Merchant Navy or the DGSPB. The intervention of police agents in inspection visits and the obligation of ships of transporting a Portuguese doctor constituted important steps towards the construction of the inspector’s figure, in which two separately-developed sets of regulations in relation to emigration – police control and public health – converged.

3 The Military Dictatorship and the first years of the Estado Novo

During the Military dictatorship and the first years of Estado Novo, administrative reforms were applied in different public sectors, including emigration services and public health. The creation of the Inspeção-Geral dos Serviços de Emigração – IGSE (General Inspection of Emigration Services) in 1928 put an end to the task developed by the CGSE. Contrary to its
predecessor, the IGSE concentrated the two functions of exit surveillance/control and assistance to emigrants. The emigration service ceased, thus, to be exclusively constituted by police agents and incorporated the physicians who worked in ports and ships to accompany and support the emigrants. According to the Decree-law of March 4, 1927, “Portuguese physicians in foreign emigrant ships [were] considered during the travel, […] as delegates of the Portuguese government, and chiefs of the support staff of its nationality”. [10]

The combination of functions was reflected in the new figures of the inspector-chief and the medical officer. The former was a public agent who acted as an intermediary between the government and public and private agents, both national and foreign. Its functions reached health matters as well, having the responsibility of leading sanitary control activities in the main city ports (from the medical inspection of emigrants to vaccination; from the issue of sanitary certificates to the inspection of ships without the presence of the health subdelegates or a physician of the Merchant Navy). The medical officer was in charge of travelling with emigrants in order to guarantee adequate travel conditions, accommodation, and food; to detect epidemic situations and prevent its spread; and to ensure the respect of good sanitary procedures. These changes gave an official character to the activity developed by physicians and reinforced their dependence from the Portuguese government.

But, rapidly, the IGSE was suppressed, and its functions, co-opted by the political police, the Polícia de Vigilância e de Defesa do Estado (PVDE) in 1934. [11] Its responsibility in the emigration control reinforced the repressive vision of the Portuguese government about the management of exits. At the same time, the emigrants’ support staff lost its autonomy. Organized in Sindicatos Nacionais (National Trade Unions), the hiring of physicians by shipping companies was maintained, but the supervision of the activity of the support staff in ships was assumed by the political police. [12]

4 The creation of the Junta de Emigração

In 1947, the Portuguese government took a new step in the control of emigrant exits. While the political police continued to be responsible for the repression of irregular emigration, the government decided to create an institution – an economic coordination body – in order to orient and frame exits: the Junta de Emigração – JE (Emigration Board). Heir to previous administrative practices, the objectives of the JE were to control all the migratory process by establishing restrictions in the exit according to national and foreign interests. Emigration rules implied above all determining the number of people authorized to exit, without failing to consider the selection of desirable individuals on the basis of certain criteria (profession, skills, physical and health condition, political and moral behavior).

Organized in two main administrative services – the Office/Secretariat and the Tutelary and Inspection Services (Serviços Tutelares e de Inspeção, STI), the JE activity was carried out by public agents – inspectors and physicians. [13]. Headed by a president aided by inspector-chiefs, the STI activity was guaranteed by the leadership of a General Directorate of Public Health’s (Direção-Geral da Saúde) physician and agents chosen by public tender or by nomination. Physicians and inspectors with a job contract of three years were chosen by the Ministry of Interior. The selection of the inspectors was preferably done among army or navy officers in the reserve. The activity of these services was completed by the creation of a delegation in Oporto and two emigrant houses in Oporto and Lisbon. The latter were areas to receive emigrants waiting to embark on ships with a view to avoid the illegal intromission of intermediaries.

One continuity with the past was STI’s responsibility to control and protect emigrants during the maritime transportation. [14] The regulation of 1947 was not very different from what the government prescribed previously (ship inspections, checking conditions of the
maritime transportation like accommodation, hygiene, and food). The difference was the concentration of the function in the hands of one institution and of the inspector-chief. Helped by the physicians and inspectors of the JE, the centralized and unified administrative machine guaranteed a tight control of every step of the emigration process thanks to preventive/punishment actions towards emigrants and shipping companies. [12] At the same time, the activity of physicians/inspectors and their reports allowed for the exhaustive gathering of knowledge about the conditions of maritime transportation and the conditions of the emigrants’ settlement (conduct, surgical procedures, irregularities in the ships, hygiene education…).

The JE assumed the intermediary functions previously reserved to the private sector. In charge of the organization of the administrative process, the JE collaborated with the city councils to receive the candidates for emigration and some of the documents necessary for the passport provided by the JE in Lisbon or Oporto. The sanitary/health condition was one of the criteria taken into account, following the recommendations of the DGS. The Decree-law n. 13620 of April 28, 1927, and the International Sanitary Convention of 1926 were used as guidelines for the management of sanitary issues of Portuguese emigrants. [15] The DGS had the ultimate responsibility of technical superintendence over the medical protection to emigrant’s services, through the functions held by the Inspector-Chief of Maritime Health. This function was reinforced after World War II with a new Public Health regulation of 1945, in which the role of health delegates was strengthened in order to fight against contagious and infectious diseases in the national territory.

The control of exits of individuals arriving from rural areas and belonging to low social classes – a population considered as the most affected by and the most vulnerable to contagious and infectious diseases – justified a more rationalized and systematic management, with preventive action aimed at identifying and eradicating cases of contagion/infection in the most remote and deprived areas. In contrast with the previous period, the control network was expanded to reach from the emigrant’s place of origin to its embarkation. The local health subdelegate/delegate was requested to make the first medical evaluation of the candidates to emigration, despite the DGS preference for health checks performed in port cities, which possessed more means for the identification of diseases and for (re)vaccination (especially, with BCG). [16].

The function of the health subdelegates/delegates was key to make the first selection between the fit, who received a health certificate, and the temporary/definitively unfit. The temporary unfit were people who suffered from trachoma and ocular infections, pulmonary tuberculosis, or childhood illnesses derived from tuberculosis1. The health certificate should identify diseases and physical deformities. The purpose was to know the disabilities which could prevent a specific professional activity in the host country. In this sense, although the role of the DGS was significant in the emigration process, the final decision to authorize the exit was in the hands of the inspector-chief, who held the most comprehensive knowledge of emigration/immigration policies and settlement conditions. [17]

After the first medical control performed at the place of origin, the medical inspection service in Lisbon and Oporto was responsible for a second inspection. The physicians of the JE completed the health certificate: analyses and medical examinations by specialized physicians were requested in doubtful situations; people diagnosed with tuberculosis were rejected; the success of the BCG vaccination was confirmed with a micro-radiography. At the end of the process, the emigrant received a passport, delivered exclusively in Lisbon or Oporto by the JE’s agents.

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1 Physical deformities, hernias, varicose veins or pregnancy were not considered undesirable criteria for emigration.
Finally, foreign services could eventually intervene in the selection of emigrants in Portugal. The consulate of Venezuela, for example, obliged the emigrants and its ascendants (of first level) to do blood tests in order to identify infectious and non-infectious diseases. [18] In the 1960s, with the emigration to European countries, this practice became more common. France and Germany had its own immigration services in Lisbon and Oporto in order to oblige emigrants to do exams, even if the travel was done by land transportation (train). [19]

5 Conclusions

This paper demonstrates the existence of a convergence in the control of emigration exits and public health surveillance since the end of the 19th century. The importance given to emigration control and selection procedures during the interwar period helped to strengthen public health control in Portugal.

At the same time, the concentration of functions of police and sanitary control during the Military Dictatorship was related to administrative reforms whose purpose was to reduce public expenses and subject migratory activity to close police control.

After World War II, the creation of the JE and new public health regulations supplemented the sanitary control of candidates for emigration with the control of the maritime transportation. This action was developed in different levels and geographical areas. It was possible thanks to the convergent efforts of public agents from different institutions. The public health question became one of the central criteria in the emigration process and in the decision to authorize (or not) the exit.

While the DGS became the institution of reference in terms of public health, it was up to the JE physicians to apply its directives on the ground. Nevertheless, the exit decision was in the hands of the inspector-chief which, as a public agent with a comprehensive knowledge about emigration/immigration regimes, decided who was allowed to emigrate.

Finally, the technical improvement in the control and the tracking of contagious and infectious diseases benefited from Portuguese emigration to European countries during the 1960s, which implied a degree of intervention of host countries in the immigration services in Portugal.

References

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