A Fluid Frontier: Cholera Throughout Latin American History

By

Sarah Auletta

Abstract

This article explores the persistent threat of cholera in Latin America from the 1800s to modern times, attributing its prevalence to systemic ignorance, racism, and classism. The author examines key research on cholera epidemics, including Hutchinson's (1958) work in 1833 Mexico, the Pan American Health Organization's efforts (1995), and Renaud's (2011) study in Haiti.

Keywords: cholera, Latin America, public health issue, historical injustices, equity, healthcare infrastructure

Introduction

Epidemics were seemingly omnipresent in the 1800s, with one bleeding into the next. This paper explores the cholera epidemic and similar outbreaks of disease in Latin America from **late colonization in the 1800s to modern day. In particular, the author will highlight the research of C. A. Hutchinson about the 1833 epidemic in Mexico, the Pan American Health Organization's work with cholera throughout its incorporation, and Renaud's publication on cholera in Haiti in the 2010s. The author posits that the prevalence of cholera in Latin America can be attributed to systematic ignorance fueled by wealthier nations, institutionalized racism, and classism. These factors, in turn, led to a deficient public health infrastructure, hindering the prevention and management of cholera outbreaks in the region.

Historical Overview of Cholera in Latin America

Cholera is a disease that is most spread through the consumption of water infected with the bacteria *Vibrio cholerae*. People who consume this water historically have lived in less developed areas and hold marginalized identities. Some research will state that the first instance of cholera occurred sometime in 1817 in India. However, given etymology artifacts, there is a plethora of evidence to suggest cholera had been around long before its microbial fingerprint was identified. Cholera is believed to have originated in India several hundred years BC; but there are different first records of a 'water-borne diarrheal disease' depending on which source one consults. For example, according to Lacey's (1995:1409) research, cholera was first described in 500 BC in Sanskrit writings although there were also mentions of it in Greek records.

The first writings that name cholera as a pathogenic organism were in 1833 when

> cholera reached Havana on a ship from the United States, and between 1833 and 1836, it carried away some thirty thousand people, including twenty-two thousand slaves (McCook 2011:25).

This account is a prime example of how the developing global environment prompted the spread of disease from one continent to another; introducing foreign pathogens to indigenous communities whose immune systems had no precedence for fighting off such diseases, resulting in almost certain death in the absence of advanced medicine.

Various primary sources from the 1830s detail the conditions under which cholera was allowed to thrive and ravage vulnerable indigenous populations and those at the bottom of the social-political ladder. A bulletin released in 1958 contains direct quotes from leaders at that time about the outbreak, including a startling response from the Minister. The bulletin states

> Dr. Hordas had suggested that the poor should be give facilities for taking baths 'even if only twice a month' but the Minister may have regarded this as too radical or impractical for he omitted it (Hutchinson 1958:6).

Even at the preliminary stages of epidemiology in 1830, there was consensus among public health experts that one of the best strategies to combat disease, specifically diseases spread through sewage, is simple sanitation. Due to the systemic repression that took place and the systematic denial of basic human rights for those in the lower classes in South America, they were not allowed to bathe and, therefore, were vulnerable to diseases and often died.

The government's focus was on money– who had it and how they could make more– even when the country was under siege from bacteria. The Eastern Coast of Central America Commercial and Agricultural Company obtained a three-year extension on their charter to bring more agricultural business and commerce to Guatemala due to the loss of life and general instability of the nation resulting from cholera (Hutchinson 1958:32-33).

Guatemalan officials were inclined to authorize any required, or even unnecessary, measures for the company to relocate its business to the country. Located in Central America, Guatemala was surrounded by British territories and desperate to maintain some grip on any market they could keep on their soil. Thus, despite the tumultuous humanitarian crisis, they focused on business instead of people.

Although it receded slightly as sanitation improved for most people in Latin America, cholera remained a public health issue into the 1900s. Much of the twentieth century in Latin America was centered around the wars taking place--banana wars or military coups, and various dictatorships and regimes. However, it was crucial to public health to maintain clean military camps and quarters. The proximity of men and the nature of sharing spaces and water closets was one of the easiest ways for military personnel to become infected.

After being spared from another major cholera epidemic for decades, this disease returned to the continent between 1991-1993 and claimed 9,000 lives (Guthmann 2020).

Most cholera cases were observed in Peru, with only Uruguay and the Caribbean remaining unaffected as the spread of this disease encompassed most of Latin America. Public health had made great improvements throughout the twentieth century which, in turn, made the chance of survival much greater. However, at the same, fundamental issues continued to revolve around sanitation for the poorest citizens. Tainted water served as an easily accessible reservoir for the pathogen to hold out until it could infect its next victim.

Unfortunately, the gap until the next epidemic of cholera in Latin America made another widespread appearance in 2010. This time the disease was mostly concentrated in Haiti where a devastating hurricane was a clear cause for the outbreak. This epidemic has been written about and studied *ad nauseam*, and there are major takeaways that resemble those of centuries before. The *first* is the issue of the cleanliness of military camps and aid centers. Infectious disease specialist Dr. Piarroux Renaud (2011) stated that aid workers and others must

> rigorously ensure that the sewage of military camps is handled properly" to minimize further disease spread (Farmer & Ivers 2012:8).

Dr. Paul Farmer, a medical doctor turned public health advocate and humanitarian extraordinaire, explained that

> Haiti's best resource is arguably its network of community health workers who were rapidly mobilized to disseminate information and distribute millions of water purification tablets in the first month of the epidemic (Farmer & Ivers 2012:7-8).

Farmer's work centered on delivering care to those who need it now. He also analyzed the social structures in place that allowed such diseases, and such medically under-served areas to exist in the first place (Pan American Health Organization 1958).

To find the answer to the latter point, we must look at history. The creation of an inequitable system was formed by colonization, centuries of oppression, and economic and physical warfare. There were *hot* wars and *cold* wars that contributed to the marginalization of people who inhabited the land of Latin America far before the Spanish set foot on it. Dr. Farmer articulated this by saying: "what we lack is an equity plan linked to a delivery system" (Pan American Health Organization 1995:2). He is correct in this assertion that the key to an effective public health system is having medical care that can be delivered equitably.

Lessons and Implications

Tracing the spread of cholera throughout Latin American history shows the clear impact of colonization

and structural violence on public health and society. On this continent, cholera ravaged communities as they tried to develop, thus halting any progress countries were making toward becoming functioning members of the global economy. This impact had grave consequences for the ability of Latin American countries to stake a claim in the global food chain and to have any sort of dominance on a military, commercial, or political level. These countries became poor and stayed that way. At the same time, the hegemonic forces throughout the centuries– from Spain, Britain, and the United States, perpetrated oppression and why cholera occurred in that region in the first place (Lacey 1995:1409). The determination of these world forces to continue international trade and movement of people brought in a steady flow of disease, inhibiting economically disadvantaged South America from recovering. The wealthy countries stayed wealthy whereas the developing countries faced stagnated growth which further exacerbated the humanitarian health crisis occurring. This power differential puts these developing countries in a position to comply with demands from more powerful, larger nations for their survival.

As the world stage continued to develop in the twentieth century and new organizations came on the scene, various groups tried to reduce cholera risks. One of the most prominent is the Pan-American Health Organization (PAHO), which is a regional branch of the World Health Organization, a working group of the United Nations. The Pan American Health Organization (PAHO) published memoranda and briefings on the cholera crisis in Latin America to contain and improve the public health risks there. In one of these briefings, PAHO described ongoing efforts to create a treatment, stating that

> a small amount of antiserum 0139 for agglutination test is available through PAHO for reference public health laboratories (Accomoglu, Robinson, & Johnson 2003:402).

This appears to be a good faith attempt to help cure cholera, but what it really highlights is an equity issue that runs deep in the health sphere. The countries most affected by the outbreaks are some of the poorest nations and surely *do not* have robust laboratories and equipment to produce advanced antiserum technologies. Not only that, but how would they go to PAHO headquarters and access this antiserum? These are considerations that were simply not addressed at the time and prevented those most affected from being part of the solution. The data also tell the story of how the poor got sick and the rich stayed healthy. In 1995, the United States had five cholera cases but no deaths from cholera. In contrast, in the same year, Nicaragua had 1,021 cases and 21 cholera deaths (Stillwaggon 1998:119). Using the populations of each country in 1995 to compare the incidence rate is even more staggering, with the United States having an incidence rate of 0.00000000187% (5/266,600,00) and Nicaragua having an incidence rate of 0.02% (1,021/4,722,000). Those numbers are small, however, there are seven more zeros in the United States' incidence rate indicating just how rare it was to contract cholera at that time.

Relevance Today

Although this issue has existed for centuries with a known prevention strategy, it is far from over for Latin American countries. As Acemoglu et al. (2003:402) stated:

> the difference between American and European disease environments played a first-order role in allowing rapid and thorough European domination.

If we want to respond holistically and effectively to the issues that plague Latin America, we must address the inequities at play. To do this, we must not only acknowledge their origins but actively claim responsibility for perpetrating the injustices done and work collaboratively with grassroots organizations to find solutions.

Stillwagon (1998) published a book about disease stagnating the growth of communities and countries. She touches on the impact of cholera in Latin America, focusing specifically on Argentina (1998:119):

> What they are up against is a national (and governmental) indifference to the conditions of the negritos, the Indians; decades of neglect of the infrastructure; an ad hoc rather than a planned approach to dealing with problems; denial of the nature of the problem (for example, Menem's insistence that cholera affects rich and poor alike, so that he need not admit that Argentina has more poor people than rich); the tendency to blame not only the poor (they should have read the signs) but also foreign people or entities (Bolivia should have warned Argentina about cholera); and the vicious opportunism that arises in every crisis (the adulteration and hoarding of bleach). There is a fatal synergy among poverty, a dysfunctional government, and a lack of concern for, even hatred of, the poor…

This quote speaks for itself and sums up everything

this paper has discussed, with the complete disregard for the health of the poor and the ignorant response of global giants.

CONCLUSION

To recap, although cholera emerged several hundred BC, this disease was first acknowledged in Latin America in the early 1800s. Because cholera *was not* addressed and prevented, it continued to spread and plague the poor nations of Latin America during the 1900s. After a devastating earthquake in the early 21st century, Haiti was hit hard with another epidemic of cholera. While small grassroots organizers led boots-on-the-ground aid trips and nongovernmental agencies published words on papers detailing the case counts. Over the last fifty years, academics and physicians have called for the same solution: creating a comprehensive public health infrastructure in Latin America.

Those who have been denied access to health care are the ones who need it most. Those who are unaware of what a doctor can do are the ones who need a doctor the most. Those who do not know the importance of clean water are the ones who will benefit the most from sanitation education. International citizens, public health organizations, and engaged citizens in affected countries need to launch a robust campaign for equitable public health to make a dent in *undoing* the centuries of injustice that have plagued Latin America. Now is the time because history teaches people to discern the actions to take today. The history of cholera in Latin America is clear: Care about the people at the bottom, focus on equitable delivery systems, and save lives.

References

Acemoglu, Daron, James Robinson, and Simon Johnson. 2003. "Disease and Development in Historical Perspective." ***Journal of the European Economic Association***. 1:2/3:397–405. http://www.jstor.org/stable/40005189.

Farmer, Paul & Louise C. Ivers. 2012. "Cholera in Haiti: The Equity Agenda and the Future of Tropical Medicine." ***American Journal of Tropical Medicine and Hygiene***. 86(1):7–8. https://doi.org/10.4269/ajtmh.2012.11-0684b.

Guthmann, JP. 2020. "Epidemic Cholera in Latin America: Spread and Routes of Transmission." ***Journal of Tropical Medicine and Hygiene***. 98:6. https://pubmed.ncbi.nlm.nih.gov/8544225/.

Hutchinson, C. A. 1958. "The Asiatic Cholera Epidemic of 1833 in Mexico." ***Bulletin of the History of Medicine.*** 32:1-23. http://www.jstor.org/stable/44444034.

Lacey, Stephen W. 1995. "Cholera: Calamitous Past, Ominous Future." ***Clinical Infectious Diseases***. 20 (5):1409–19. http://www.jstor.org/stable/4458566.

McCook, Stuart. 2001. "The Neo-Columbian Exchange: The Second Conquest of the Greater Caribbean, 1720-1930." ***Latin American Research Review***. 46: 11–31. http://www.jstor.org/stable/41261390.

Pan American Health Organization.1995. "Cholera in the Americas," PAHO ***Epidemiology Bulletin.***16 (2):1. https://iris.paho.org/handle/10665.2/36993.

Renaud, Piarroux. 2011. (July 1). "Understanding the Cholera Epidemic, Haiti." ***Emerging Infectious Diseases***. 17(7):1161–68. https://doi.org/10.3201/eid1707.110059.

Stillwaggon, **Eileen. Stunted Lives, Stunted Lives, Stagnant Economies, Poverty, Disease and Underdevelopment**. New Brunswick, NJ: Rutgers University Press,1998.

Author's Note: **Sarah Auletta** is a 2024 graduate of Simmons University where she earned a BS in public health and a BA in Spanish. She is currently pursuing her master's in public health at the Giesel School of Medicine at Dartmouth College. Outside of academics, Sarah is the Program Coordinator for the Pediatric Transplant Center at Boston Children's Hospital and is committed to expanding access to quality healthcare. In her spare time, she enjoys being active and exploring new (to her) areas of Boston where she is grateful to be close to her many supports.