A ‘Slave’s Disease’: Cholera in Imperial Brazil

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The cholera epidemic of 1855 to 1857 was unparalleled in Brazilian history in its terrifying destruction. No other epidemic killed more Brazilians or caused such economic damage, although little has been written about it. Because cholera often spared free and white Brazilians but killed free and enslaved people of color, no other disease so utterly exploited Brazil’s inequities. Its unequal risks were apparent at the time, and were observed in government reports and newspapers, but it provoked no moral outrage of the type that would occur today. Considering that that the majority of people who died were also distinguished in society by their skin color, hair and other physical traits, low status or enslavement; we might expect that Brazilians, especially those who were on top, to have depicted cholera in racist terms, or for those on the bottom to have used the episode to oppose rule by a small and mostly white elite who evaded cholera’s horrifying risks. After all, doctors in the United States saw cholera as further proof that intrinsic and immutable differences helped explain higher death rates among free and enslaved black. But if Brazilian elite viewed cholera in racialized terms, such views were whispered in confidence or expressed in restricted ways that connected “predispositions” more with unfixed character, attitude, and education then with fixed biology. Cholera clearly exposed what should be called structural racism in Brazilian society, but a language of race was not a tool used in official and elite discourse to explain its unequal destruction. Additionally, as Richard Evans has argued for Europe, sparked no flames of revolution.1


3 Ibid., 148. I borrow Eduardo Bonilla-Silva’s ideas of “racialized social systems” in which social and economic hierarchies “produces definite social relations between the races.” Furthermore, “the race placed in the superior position tends to receive greater economic remuneration and access to better occupations and/or prospects in the labor market, occupies a primary position in the political system, is granted higher social estimation (e.g., is viewed

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Why was a disease so clearly connected to enslavement, poverty and phenotype not put in racial terms? Why did it not provoke much visible anger against mostly white elite who not only controlled most of the country’s wealth and power, but who also seemed to trick death itself during this epidemic? This paper mostly addresses these questions. In doing so, I believe it contributes to broader conversations that 1) use race and disease to make better sense of the other, 2) seek to understand long-term economic and demographic impact of disease and, 3) explore the operation of power or control in state reaction to or creation of disease and pathologies.5

In the following three parts of this paper, I first show how cholera threw social inequalities into stark relief. Brazilians of color faced far greater risks and died in much higher numbers because of precarious and impoverished conditions of life, including the ways owners treated their slaves. Next, I provide evidence that cholera was sometimes associated with race, but the fuller meaning of this association went unrecognized or at least unspoken in published discourse. While the elite did not rely on race to justify their survival, Brazil’s poor and population of color did not rely on their calamity to justify violence. In the final part, I argue cholera did more than expose Brazil’s tragic inequalities in the middle of the nineteenth century; it also helped make Brazil the most regionally unequal country in the world in the twentieth century.

Part I: Cholera’s unequal risks

Cholera struck at a time when the vast majority of Brazilians lived far outside the walls of the largest cities. Agriculture predominated, and most labor was dedicated to small or moderately sized farms or the nonindustrial and guild type enterprises concentrated in the thousands of small towns and

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5 As much as the discursive categories that hold diseases (or “pathologies”), epidemics (or “pestilence”), medical cures (or “elixirs”) are formulated within specific ideological and cultural contexts, and can serve as powerful modes of control within societies (i.e., “biopower”), I also hold these things to have a physicality that changes in ways that are dependent or independent of human action and thought. In other words, we can understand a popular view that cholera was a divinely ordered scourge transmitted by miasma and generated by the filth of a degenerate race. This understanding, and our moral imperative to condone it, does not exclude and may even depend on another, more recent understanding, that cholera has mechanisms for its own propagation and can change in fundamental ways. For example, a hardier but less virulent strain of cholera that is plainly distinguished at the genetic level became dominant in the world in the twentieth century. How the “El Tor” strain replaced the “classical” strain during the seventh pandemic is not well understood, but the best theories demonstrate a deep interrelation of human and environmental factors. El Tor’s dominance greatly altered the ways that cholera sickened and killed well before anyone had identified (categorized) it, and now that it is identified, we understand our relationship to cholera differently.
villages scattered across the country. Brazil was slowly but inexorably becoming a country of coffee rather than of sugar, shifting money and power from the provinces of the Northeast, such as Bahia and Pernambuco, into the hands of Southeastern provinces such as Rio de Janeiro and Sao Paulo. Both commodities continued to depend heavily on slave labor, but no new African slaves arrived when the international slave trade was forced to close under British threat in 1850-51. Brazilian elite saw European immigration as the solution to their labor problems (and, in part, the nation’s dark and mixed racial composition) and dismissed the growing free population as a worthy source of labor. In the mid-1850s, most Brazilians lived no differently than did their grandparents during the colonial period, nevertheless new technology was used by some and marveled at by most. For example, new steamships began to ply the coasts and large inland waterways in the 1850s. While only the wealthy could afford passage, these ships, with their smoke bellowing and paddle wheels turning, vastly increased the speed of communication and strengthened the power of provincial and imperial capitals over their hinterlands. In addition, the first railroad tracks were laid and telegraph wires strung over a few kilometers in Rio de Janeiro. New factories, including foundries, appeared in Brazil’s cities. Other projects trumpeted in official reports, such as gas lighting and urban street paving, were also important symbols of modernity. Optimists promised a country in which agricultural prosperity was woven together by engines, steel and wire. Technology went hand-in-hand with political security under a mixed monarchical and legislative government. Indeed, a two decade period of internal strife and regional revolts that followed independence had nearly torn Brazil apart and jeopardized its rule by mostly white males. By 1850, the nation was secure.

In this decade of hope and change, we must add fear: Two new and terrible diseases washed up on the shores of Brazil. First, yellow fever arrived in 1849, and it worried Brazil’s rulers because it was especially fatal among Europeans, harming its commercial prospects and reputation and the elite's plan

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to attract the many thousands of immigrants already crossing the Atlantic for the United States, Canada and Argentina. Yellow fever probably became epidemic in Brazil’s cities because the *Aedes aegypti* mosquito, the disease’s deadliest urban vector, found passage on ships carrying gold prospectors to California. Unlike the prospectors who rushed on to their hopeful riches, the mosquitoes – and a more effective vector of urban yellow fever – stayed behind.

Cholera left a wake of death as it moved across large parts of the world during its first two pandemics, but neither of these struck Brazil. The second cholera pandemic (1827-1835) was a near miss; it devastated most parts of the Atlantic world including North America, but spared the eastern coast of South America. The fact that cholera, several influenza pandemics and yellow fever had not been problems in Brazil contributed to a commonly expressed opinion among foreign travelers and national officials that Brazil was blessed with an unusually salubrious climate in the first half of the nineteenth century. This rosy reputation wilted after yellow fever arrived with cholera close on its heels.

Cholera was carried to Brazil in the bowels of Iberian settlers and the water barrels they used from on a ship named the Defender (*Defensor*). The ship arrived in Belem (Pará) after a 30 day voyage from Portugal in late April 1855. Between May and December of that year, cholera exploded in Brazil’s

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12 As Sheldon Watts has pointed out, it is highly unlikely that the disease itself was new to Brazil, because most native Brazilians or foreigners who had lived in the country for many years did not contract the disease. That it suddenly became epidemic in Brazil’s large cities is more suggestive of a new kind of disease vector. Entomologists have found that that the geographic distribution of *Aedes aegypti* has changed on a continental scale, adding support that this is what happened in 1849. Watts, Sheldon. *Epidemics and History: Disease, Power and Imperialism*. New Haven (Conn.): Yale university press, 1997, 250. For evidence of large-scale shifts in the distribution of Aedes aegypti in the twentieth century, see Gubler DJ. 1998. "Resurgent Vector-Borne Diseases As a Global Health Problem". *Emerging Infectious Diseases*. 4, no. 3.


14 The Defender opened Brazil’s backdoor to cholera because of a confluence of events and unusual conditions. It was only the second or third ship to arrive with hundreds of settlers to a northern Brazilian port, creating a “critical mass” to permit a disease reservoir. Other Brazilian provinces had sponsored thousands of immigrant arrivals, but Belem was one of the closest Brazilian ports to Europe in nautical miles. The Defender appears to have been built using new principles of size and shape, because it crossed the Atlantic in only 30 days. Only a decade before, ships rarely crossed in fewer than 40 days. The disease “smoldered” on the ship, probably because it was contained within water barrels. By the time it arrived in Brazil, several passengers must have been asymptomatic carriers, since health inspectors did not detect an unusual disease when they examined passengers. The passengers themselves had reason to hide an epidemic disease in order to avoid quarantine and were quick to blame other factors for deaths on board. The ship brought a clean bill of health because the Portuguese government had not yet officially recognized cholera in its city from where it embarked, Porto. Finally, cholera spread more rapidly internally to Brazil because of new steamship services with the Amazon River basin and between Brazilian coastal ports.
four most important coastal and inland waterways. From the banks of Belem, it spread hundreds of miles up the Amazon, carried by steamships that began plying the rivers only two years before. The cholera *vibrio* were carried by ship or multiplied in rivers and bays from the urban waterfronts of Salvador, Rio de Janeiro, and Rio Grande, until it infected the water supplies of most towns and cities within the Todo os Santos (Bahia) and Guanabara (Rio de Janeiro) Bays, Lago dos Patos (Rio Grande do Sul) and nearly every connecting and navigable tributary. In this initial wave, some cities such as Cametá (Pará), Santo Amaro (Bahia), and Pilar (Paraíba) experienced devastation so severe that abandoned corpses rotted in homes and on streets “covered by vultures.” By mid-1856, at the same time the disease mostly disappeared from the agricultural and populated areas of these river basins, cholera escaped these confines and found route in new inland rivers and over wagon paths. This was especially true in the Northeast where it caused local outbreaks in the interior sporadically for the next decade. The majority of cholera deaths occurred in 1855 and 1856, its first two years in Brazil. But the last two year of Brazil’s second epidemic (1861-1868) were also dreadful, with 20,000 to 25,000 Brazilian and Allied soldiers killed by cholera in 1867 and 1868 as they fought against Paraguay for the control of a small muddy stretch of the Paraguay River. By the end of the second cholera epidemic, between 200,000 and 250,000 people had died, or about 2 percent of Brazil’s population.

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Cholera was probably absent from Brazil between 1859 and 1860.


18 Historians have not yet arrived at a consensus on the total number of deaths caused by cholera in Brazil and it has been trending upwards. Francisco de Paula Candido, as a representative to the Minister of the Empire and therefore the imperial government as a whole, estimated 130,000-150,000 were killed. But Candido made this calculation in May of 1856, well before the first epidemic had ended or the second (1861-1868) epidemic had begun. José Perreira Rego, Candido’s successor as President of the Junta Central de Higiene Pública, increased the count to 184,000 in 1873. Since then, Donald Cooper and other historians have estimated 200,000 deaths. I believe this may still be too low. Rego and Candido used figures supplied by provincial presidents who, in turn, compiled their total based on reports given to them by priests and church officials recording Catholic obits in nearby and very distant parishes. Although Rego depends on these provincial tallies of parish deaths, he suspects that they undercount deaths. The epidemic disrupted the normal operation of parishes because many church officials, if they did not flee, had to attend to the bedsides of sick parishioners. Additionally, thousands of refugees died on the sides of roads as they fled the scourge, many whom were not identified. Rego estimated that church and state officials in Rio de Janeiro had missed about 25 percent of all deaths. If he considered this to be true of a wealthy province where he had traveled frequently during the cholera epidemic, then I believe we should also revise all other provincial presidential figures upward by at least 25 percent. This may be a conservative revision, since some provinces such as Sergipe and Paraíba were struck much harder by cholera but had far fewer resources.
Brazilian rivers and waterways became cholera’s principle foci because the *vibrio cholerae* multiplies in water contaminated by fecal material. Its highest death tolls occurred when sewage or water used in washing, especially the effluent from washing laundry, mixed with water drawn or stored for drinking. When such water was swallowed by Brazilians in 1855, most cholera bacteria were killed by acids naturally produced by the human stomach, but when millions of bacteria were quickly swallowed – such as through big gulps of highly contaminated water by a thirsty and unknowing outdoor worker – or when smaller amounts were swallowed by an individual with low gastric acids, cholera breached the intestinal wall where the vibrio rapidly multiplied. People suffering from malnutrition, weakened immune systems, or intestinal helminthes (worm-like parasites) had fewer defenses. Once lodged in the intestinal walls, these bacteria produce a toxin that turns the stomach into a kind of water pump, pulling as much as a gallon of water from the body every 16 hours and allowing very little water back in. It was an exchange of life propitious for the microbe but devastating to hosts: the rapid rejection and ejection of liquids provides both a pathway for cholera to infect other organisms and is also the main cause of death to its human victims. Death from extreme dehydration or more accurately from hypernatremia (elevated sodium) and hypovolemia (a decrease in volume of blood plasma) presents a ghastly spectacle. Pain and seizures thrash the patient’s body, even as he or she ejects bodily fluids through seemingly illimitable vomiting and diarrhea. Within only a few hours of the first symptoms, the victim’s skin tightens like stretched leather and can turn a ghoulish blue-grey. Eyes sink into their sockets, and patients may appear to age one full decade with every agonizing hour that passes. Muscles of cholera victims can twitch and quiver hours after death; life leaves the body before the disease ends its haunt.

As Donald Cooper has pointed out, this horrid death mostly involved Brazilians of color, whether free or enslaved. This was not because this group vastly outnumbered whites. In 1872, 73 percent of people of color were free, and this group was slightly larger than the populations of white

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19 Low or no gastric acid production (hypochlorhydria or achlorhydria) are common to people suffering from malnutrition or with weakened immune systems. Barua, Dhiman, and William Burrows. *Cholera*. Philadelphia: Saunders, 1974, 140-141.
23 Cooper, “The New ‘Black Death’
Brazilians. Thus, free people of color were by no means “minorities,” and they outnumbered whites slightly (by about five to four). While enslavement cut through Brazil’s non-white population, the cholera bacterium made no such distinction. For example, most Brazilian officials drew a connection between cholera and poverty, but a few took a step further to suggest it largely spared whites. For example, Francisco de Paula Candido, Brazil’s President of the Junta Central de Higiene Pública (similar to a national health board), wrote what should be considered Brazil’s “official” summary of the epidemic, attached to the annual public report by the Minister of the Empire. He claimed that the “slaves and poorest classes” were “unquestionably, and you could almost even say exclusively, the victims” and he estimated that about 95 percent of deaths were slaves and the very poor.\(^{24}\) Health officials, foreign consuls and doctors in Pará, Maranhão, Rio de Janeiro, Santa Catharina, and Rio Grande do Sul observed that Brazilians of color were killed in greater proportions.\(^{25}\) Candido’s successor, José Perreira Rego wrote in the first history of cholera in Brazil that “this epidemic preferred to attack slaves and blacks (pretos), people of color and the poorest (mais inferiores) classes of society.”\(^{26}\)

Many of these remarks are anecdotal, but they confirm to what historians have found in case studies of Rio de Janeiro and Salvador, Bahia.\(^{27}\) They also gain weight when we compare them to census records and mortality figures for several parishes and cemeteries. Free people and whites faced fewer risks from cholera in the province of Rio de Janeiro, where slaves were about twice more likely to die from cholera than free people in the towns of Campos and Iguassú. Slaves in Niteroy, Magé and Estrella also died in higher proportions.\(^{28}\) The provincial reports from Rio de Janeiro do not discern race for cholera mortality, but cemetery records from Recife do. There again slaves and people of color were about twice as likely to die from cholera as free people and whites.\(^{29}\) Other parish and cemetery records

\(^{24}\) Candido, Relatorio ácerca da saude, 1856, 22.
\(^{25}\) Cooper, “Another ‘Black Death’,” 240. Only one Provincial President, representing the small province of Alagoas, claimed slaves and free people died in proportions relative to their populations. Presidential Report, Alagoas, March 1855, 21.
\(^{28}\) Iguassú (slaves composed 46 percent of the population in 1848 but 87 percent of cholera deaths in 1855-56); Niteroy (56 and 66 percent); Magé (54 and 63 percent); Estrella (33 and 51 percent). Populations derived from Presidential Report, Rio de Janeiro, March 1849, mappas 1-6. A newspaper correspondent reporting from Macaé, Rio de Janeiro, reported the among free people sickened or killed that “blacks and people of color” were about twice as likely to become sickened or killed.
\(^{29}\) Ariosvaldo da Silva Diniz counted 3,338 burials of victims of cholera in the public cemetery. Of these deaths, 26 percent were slaves and 18 percent were whites. In comparison, of 328 deaths recorded in the cemetery in July and August of 1856 (when there was no epidemic disease) 17 percent were slaves and 26 percent were whites. Diniz Cólera: Representações, 325. Livro de registro dos sepultamentos no cemitério público do Recife, 1856.
support this picture, but not for everywhere surveyed. Table 1 gives figures for four towns and one city in Brazil. Porto Alegre and Taim are located in Brazil’s most southern province and Brejo de Deus, Pilar and Milagres are all in the interior of the Northeast. Of these, only Porto Alegre was a relatively large city located near the coast, while the others were non-coastal townships that depended on agricultural production including sugar (Pilar) or cattle ranching (Taim, Brejo de Deus, and Milagres). All five towns and cities demonstrate higher rates of cholera deaths among the slave populations when compared to deaths during “normal” months (free of epidemic diseases). While the difference was minimal for Porto Alegre, slaves were between two and six times more likely to die in these other towns. People of color also suffered more from the disease in Porto Alegre, Taim, and Pilar, but rates were about equal in Milagres, while whites were more affected in Brejo de Deus.30 Parish records present several problems to researchers and we might question their completeness and accuracy. 31 Nonetheless, data from several primary sources and a range of locations across the Empire support the general impression of Brazil’s top health officials that free people and whites were better able to escape cholera.


31 Parish records are sometimes obviously incomplete, with no obits recorded some months. Additionally, some parishes separated slaves and free people into their own registers, and one set can go missing. We might also be uncertain about how many individuals were buried but not recorded in these books. On the one hand, many Brazilians lived far from churches and chapels and many were buried in family plots. On the other hand, the last rites and ministrations were very important in this Catholic country, and could be performed posthumously and post burial by priests or laity who traveled extensively within their parishes. The records used for this study were chosen because they demonstrated no obvious gaps and did not exclude free or enslaved obits. Mortality figures must be compared to population estimates to discern relative mortality rates. Unfortunately, reasonable population counts are difficult to attain in the 1840s and 1850s, in part because the illicit slave trade. Brazil banned the importation of slaves in 1831, but the trade continued and expanding such that more slaves were imported during the 1840s than ever before. The international trade to Brazil finally ended in 1850, but many elite wished to hide the fact that they had purchased African slaves. Nevertheless a few census records exist.
Table 1. Groups killed from cholera and during non-epidemic months (percent)

<table>
<thead>
<tr>
<th></th>
<th>Period of Data</th>
<th>Total # of Deaths</th>
<th>Cholera Deaths</th>
<th></th>
<th>Non-Cholera Deaths</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>People of Color (including slaves)</td>
<td>Whites</td>
<td>People of Color</td>
<td>Whites</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Slaves</td>
<td>People of Color</td>
<td>Slaves</td>
<td>People of Color</td>
</tr>
<tr>
<td>Porto Alegre, Rio Grande do Sul</td>
<td>Jan 1854 - Dec 1856 (N=3,512)</td>
<td>39</td>
<td>60</td>
<td>32</td>
<td>34</td>
<td>57</td>
</tr>
<tr>
<td>Taim, Rio Grande do Sul</td>
<td>Jan 1855 - Dec 1856 (N=87)</td>
<td>89</td>
<td>89</td>
<td>4</td>
<td>46</td>
<td>49</td>
</tr>
<tr>
<td>Brejo de Deus, Pernambuco</td>
<td>Mar 1855 - Dec 1856 (N=296)</td>
<td>26</td>
<td>45</td>
<td>44</td>
<td>14</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>Jan 1855 - Mar 1856 (N=233)</td>
<td>31</td>
<td>69</td>
<td>26</td>
<td>5</td>
<td>54</td>
</tr>
<tr>
<td>Pilar, Paraiba</td>
<td>Jan 1855 - Dec 1856 (N=315)</td>
<td>18</td>
<td>69</td>
<td>30</td>
<td>4</td>
<td>71</td>
</tr>
</tbody>
</table>

Unequal conditions of life increased risks for slaves, but they also died in higher numbers because of geography. Cholera is often a “lowland” disease because of its water vector. It spreads most easily in low altitude areas with high densities of people who clean, bathe and drink from consistently warm bodies of water, such as the Ganges Delta. The relationship between cholera and the environment is complex and not well understood, but altitude and temperatures give us the best explanation for why cholera struck northeastern Brazil but largely spared the southern, southeastern and western regions. I have found this disease rarely extended to areas higher than 400 meters above sea level. To demonstrate this, we can compare the cholera zones, shown in red on Figure 1, with the low elevation zones, shown in blue and green on Figure 2. It is also evident when we look at the choleric zone in the Bahia lowlands (Figure 3). Additionally, its outbreak in the South, albeit severe in 1855, only lasted for a few months. In contrast, cholera returned and persisted in northeast where there were no cool winters could dislodge it. It was therefore an unlucky accident that tropical lowland areas near bodies of water held some of the highest numbers of slaves in great part because these were suitable agricultural zones for sugar production traditionally labored by slaves. Except for Rio de Janeiro, which held a near monopoly over slaves brought into the Empire after independence, the Northeast had some of the highest densities of slaves in the Empire (Figure 4) in the middle of the nineteenth century because of the legacy of sugar production. Ironically, other diseases endemic to these areas, such as malaria, had helped support the slave trade because owners and investors believed (rightly or wrongly) that these black laborers carried special resistance to tropical diseases with them from Africa.
Figures 2. Cholera zones in Brazil (1855-59, 1861-63) and Elevation map of Brazil
Figure 3. Cholera and elevation in Bahia
Figure 4: Slave population densities and cholera impact
People died (and hundreds of thousands around the world still die) from cholera because they lacked access to water free of *vibrio cholerae*. Phenotype and “race” has nothing to do with propensity, although there are clear correlations between blood type and survival rates. In this regard, it may not be surprising that slaves faced more risks than the free, but historians have long pointed out that Brazilian society was full of poor free people, including many freed slaves or descendents of slaves, who lived with dangerously meager resources. Hunger and malnutrition were realistic consequences of drought, the death of a family member, or many other possible misfortunes. On the other hand, a tiny percentage of slaves lived and served in the wealthiest of homes and mansions, including as servants to Emperor Pedro II. Many more slaves lived and worked in the homes and farms of “middling” income groups whose wealth was usually enough to protect basic needs. Therefore, slaves should not be automatically placed at the bottom of a Brazilian social pyramid. Instead, slavery cut a diagonal line across social strata created by wealth, skill and status. Nevertheless, cholera may give us some of the best evidence that this line did not stray too far from the bottom. Moreover, the idea that cholera may have posed greater risks to people of color, even when excluding slaves, hints at the effects of racial prejudice that are hard to detect among the lower and middling income and status groups at mid-century. This study suggests structural racism, maintained by prejudice and “institutionalized” in the places where people lived and worked, reduced advantages to people of color, including access to the most basic of provisions: clean water.

**Part II: Exposing Race**

Of course, cholera struck Brazil well before most doctors understood that drinking water was the principle vector. John Snow published his famous maps of London’s contaminated well on Broad Street in *On the Mode of Cholera Communication* in 1855, the same year cholera exploded in Brazil. More than two decades would pass before doctors widely accepted Snow’s theory. Instead the dominant mode of understanding cholera was miasmatic or semi-miasmatic and mirrored European discussions.

This perspective held the local atmosphere was poisoned by the decay of organic materials, causing a

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33 Evans, Death in Hamburg, 403-415.
36 It is no surprise that Brazilian doctors mostly turned to Europe to understand cholera, considering the weight the French, English and Germans already had on Brazilian medicine and the two decades of firsthand experience that Europeans had already suffered with this disease.
kind of poisonous air (miasma) that could be stimulated by “telluric” and “meteorological” forces, depending on who was arguing. Such ideas seem less farfetched when we consider that physicists were discovering the basic principles of electromagnetism at that time, but these forces remained shrouded in mystery. Most Brazilian miasmists were also “contingent contagionists” and they believed a contaminating factor was able to move from place to place, but it could cause epidemics only when the air of local environments had corrupted and become prone to a contagious influence. To frame this as a debate between “contagionists” and “infectionists” is misleading, for the emotional argument rested on the degree that people and goods were catalysts for creating deadly miasma (infection). Very few Brazilian doctors argued the “outdated” theory that cholera moved from person to person through human contact or proximity, an etiology of contagion that was broadly accepted for smallpox, syphilis, and the common cold, however. In the middle of the nineteenth century, cholera’s principle vector was nearly always poisoned air created by filth, but opinions differed greatly in regard to the human role in cholera’s movement and, as I will discuss below, conditions that predisposed people to the disease.

Important and expensive policy implications depended on the official view of what sparked a choleric epidemic in a predisposed environment. If humans could personally transport the “seed” or “germ,” then quarantine might halt its arrival. On the other hand, if such a “seed” was swept high above in air currents, or moved below one’s feet in subtle changes of the earth’s composition or magnetism, quarantine was of no use. Holding ships at bay was also foolish and dangerous to commerce if an imported spark could be eliminated through chemical disinfection.

Since the dominant paradigm held general filth to cause choleric miasma and its deadly epidemics, blame largely fell on the local and often intimate environments where people lived and worked. Influential health officials and doctors argued that any inability or unwillingness in changing these environments was largely due to a lack of resources, insufficient education and knowledge, and the

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37 Candido, Relatorio ácerca da saude publica, 51-84
38 Cholera arrived only five years after yellow fever, another newly imported and destructive disease. Although we separate these two diseases today, many doctors of the nineteenth century did not; instead they viewed them as one of several caused by contaminated (“infectious”) local environments that shared the same unhygienic characteristics. Nineteenth century etiology commonly combined a wide range of “fevers” (including malaria, yellow fever, cholera and typhoid). Pelling, Margaret. Cholera, Fever and English Medicine, 1825-1865. Oxford: Oxford University Press, 1978.
popular “superstitions” that cholera was contagious or that God wished his subjects to receive divine punishment without any effort to improve their own lot.\textsuperscript{40}

The orthodox and dominant sanitarian viewpoint gave much less room to argue that the same inherent conditions that colored a man’s skin or bent the follicles of a woman’s hair also opened the door to this disease. Instead color prejudice snuck into the discussion by blending with elite and popular views of Catholic vice and virtue. A person who was too slothful to properly clean his or her house and yard or too gluttonous to abstain from heavy and acidic meals and intemperate drink “obviously” invited illness when they breathed a corrupted atmosphere. In contrast, two of the three Christian virtues, faith and hope, could be psychosomatic shields. Emotional strength, such as not weeping, wailing or running in terror when faced with the disease, improved physical strength and resistance to cholera or at least did not harm anyone.\textsuperscript{41} Such views thinly disguised racism because the mostly white doctors and sanitarians identified vices and counted missing virtues primarily among the poor and people of color, either free or enslaved. While some doctors pointed to specific human behaviors, most simply criticized swampy areas or filthy streets and homes and were less willing to directly target the crowds of people who inhabited these spaces. Masters could also be to blame for not providing better treatment and education to save their slaves (and salvage “property” crucial for agricultural progress).\textsuperscript{42}

I have not found a single instance in which cholera was “biologized” by a Brazilian expert. In other words, doctors and officials attached propensity to characteristics dependent on education and mutable personality traits rather than the physical structure of a person’s body. Brazilian medical elite was highly influenced by European debates that passionately criticized or defended the degree that cholera was infectious but who rarely saw essential racial differences as something that mattered.\textsuperscript{43} This differed from some American doctors who used more racialized language to explain cholera’s demographic propensities. Most infamously, Dr. Samuel Cartwright of Louisiana believed “the negro’s brain and nerves, the chyle and all the humors, are tinctured with a shade of pervading blackness.”\textsuperscript{44} He invented two diseases, “Drapetomania” and “Dysaethesia Aethiopica” to explain why slaves were prone to

\textsuperscript{40} See Presidents’ Reports of every province affected for variations on this perspective. Interestingly, Francisco de Paula Candido and José Perreira Rego, the two most influential medical authorities during the cholera epidemic said very little about human causes or predispositions of cholera. Candido seemed most interested in contributing to the international debate over the ways that cholera was contingently contagious. See Relatorio acerca da saude publica, 54-57. Rego also wrote little about human behavior and hygiene, preferring to focus on cholera’s movement and demographic impact. See Memoria Historica, 1873.

\textsuperscript{41} Almeida, Alagoas nos tempos do cólera, 87-88; Andrade A Cólera-Morbo, 65-74

\textsuperscript{42} Presidential Report, Pernambuco, November 1855, 29-30.


run away or misbehave. But even Cartwright leaned more toward the emotional and mental than the physical when it came to cholera, explaining higher mortality among slaves because of “cholera of the mind.” Like many European doctors, he believed that fright could be as dangerous as the disease. Other US doctors found explanation for cholera in the behaviors and morals of slaves and African Americans; few made a direct connection to physiological difference. But physiology may be implicit if slaves were “naturally” inclined and unable to alter their dangerous fatalism or immorality, and it on this point that American and Brazilian doctors were most likely to disagree. Sloth, carelessness, and intemperance were traits that the Brazilian elite often attributed to the uneducated poor and enslaved (of negligent masters), but not – at least openly – to the fact that they were not white. Cartwright titled what would become his most famous piece of writing, “Diseases and Peculiarities of the Negro Race” in 1851. It seems unlikely that a Brazilian doctor would have received as much acceptance and praise had he published a similar article.

Some American doctors may have connected cholera more directly with race than most Brazilians were willing to do, at least publically, but this certainly did not mean that Brazilian society was largely free of white supremacy. Whites dominated among the wealthiest and most powerful Brazilian families and the poor most often walked among people of color, but explanations of how and why society was stratified in this way was largely hidden from official and published discourse. The association between poverty and phenotype was rarely a topic lent to the press. An ample vocabulary was available to Brazilians to describe and parse society into many social and racial categories. The most common terms hid their racial operation behind a thinly disguised cloak of politeness and objectivity. In Brazilian Portuguese, the word “race” (raça) was seen as rudely applied to people in the 1850s; it was more commonly used to describe breeds of horses, cattle or dogs (Figure 7). When “people of color” (gente de côr or homen de côr) were mentioned, they were described as a “class” (classe) or a “group” and almost never as a raça. “Color” (côr) was a frequently used category to describe and classify people such as baptized infants, prisoners or patients, even though the most common “colors” such as preto (literally, black) or pardo (literally, brown) were often better indicators of legal and social status than the color of one’s skin. Preto, in fact, was a common synonym to “slave.” Mulattos (mulatos) and cabolcos could also be listed under the category of “color” even those these

45 Ibid, 26-43
46 Ibid.
48 Similarly, Dalila de Sousa Sheppard found that US doctors racialized tuberculosis much more than their Brazilian counterparts. She argues that when it came to this disease “doctors in Brazil maintained total indifference to the racial paradigm as a topic of scientific or intellectual interest.” Sheppard DS. 2001. "A literatura médica brasileira sobre a peste branca: 1870-1940". História, Ciências, Saúde--Manguinhos. 8, no. 1, 174
terms referred to a perceived mixture of African/European or Indigenous/European descent and had less to do with an actual skin color or phenotype. Some popular terms appeared to be unbiased colors or shades of color, such as the commonly used word “retinto” (literally meaning double-dipped in black ink; Figure 5). But this and other “colors” associated with blackness were more often used in negative contexts (i.e., describing runaways or criminals), belying any descriptive objectivity.⁴⁹

Figure 5. Brazilian newspaper announcements of a lost “female pointer” and a “retinto” runaway slave

![Image of newspaper announcements]

Correio Mercantil (Rio de Janeiro), 5 February 1850 and 2 August 1849

Some brave Brazilians took to the public stage to decry racial inequities and prejudice, but they used careful language and protected themselves behind pseudonyms. For example, a writer using the penname “Niomitos” expressed his frustration in the liberal newspaper O Grito Nacional. The writer estimated that about half of the free population of Brazil was a “mix” (mestiça) of “Europeans, Indigenous and Africans” even though many among the whites were like “crows who cover themselves with peacock feathers” and “renege their origins.” He complained that there were few or no people of color among the officers of the army and navy, high magistrates, ministers, and foreign diplomats even though the Brazilian Constitution made public offices open to all (free and male) Brazilians, to be distinguished only by their “talents and virtues.”⁵⁰ “Do [mulattos] have less intelligence and less morality?” “Niomitos” asked rhetorically. Antônio Pereira Rebouças, a Congressman from Bahia who identified as a man of color, asked a similarly uncomfortable question in the Chamber of Deputies in 1842. Several of his colleagues replied that it was not necessary for Ministers to be selected “from this

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⁵⁰ “Os Pardos,” O Grito Nacional, Rio de Janeiro, 5 August, 1854; 9 February, 1855

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or that circle, this or that class” because the Ministry is “composed of Brazilian citizens according to the Constitution, elected by the monarch, and having at heart the interest of the country.” This paternalistic response, which was probably a typical defense among the white elite, received greater applause.51

Rebouças’ “unpolitic” question suggests that associating the ravages of cholera with race was equally politically incorrect. Although it seems that it was mostly shared cultural norms that (self-) censored criticism among the elite, silence on the issue may have been also partly strategic. The mostly white elite depended on a larger population of color, many whom had the right to vote for their power and position. Fear of racial aggravations was especially acute after a slave revolt in 1835 in Salvador and large uprising in Pará called the Cabanagem (1835-40). In both cases, there were reports that slaves or people of color had gone into battle shouting “death to whites.”52 Using race for political purposes may have been seen as cynically disingenuous for the white elite.53 By the early 1850s, Brazil faced fewer internal rebellions and revolts, but this did not necessarily mean there were no threats that might be aggravated by pointing out color prejudice. Just three years before cholera’s arrival, the Pernambucan Justice Minister sent an army battalion into the interior district of Paudalho to repress an uprising by “people of color” who believed in the “absurd” idea that census takers were engaged in a secret plot to enslave them.54

We may understand why the Brazilian elite did not want to call too much attention to cholera’s unequal ravages, but the notion that free whites faced fewer risks from cholera could not be easily hidden from the groups who were killed the most. Nevertheless, this disease’s scythe cut down tens of thousands of free and enslaved people of color, but caused no violent rebellion. The Bahian, Paranense and Riograndense presidents all reported “permanent,” “unaltered,” or “complete” peace in their provinces during the year of the epidemic.55 The presidents of Alagoas attributed lower levels of conflict to the destruction of the disease. “Tamed by the painful experience of this past year, the Alagoan people understand perfectly that peace is the first element to prosperity of a country; and giving true importance to this social belief lifts their duty to maintain public order to the highest level,” he wrote – without a hint of irony.56 His colleague, the President from Sergipe, wrote that “despite the demoralization of the lowest classes, […] assassins have not retreated from their practices of atrocities

55 Correio Mercantil, e Instructivo, Politico, Universal, Rio de Janeiro, 19 January 1852
56 Presidential Reports, Bahia (May 1856), Pará (October 1855), Rio Grande do Sul (April 1856)
57 Presidential Report, Alagoas (1856, month unknown), 1.
and crimes." But, in fact, rates of homicides dropped considerably in nearly every province that bore the brunt of the epidemic. Only in Rio de Janeiro province, where cholera killed fewer than other provinces, did homicides increase slightly from the year before.  

In this history of control and barely cloaked injustice, Pernambuco diverged slightly. Cholera spread like a firestorm in Recife, the provincial capital, in the first few weeks of February, 1856. At its peak later that month, more than 50 people were dying each day, more than five times city’s normal average. Within this climate of terror and despair, rumors emerged that an African slave named Manoel da Costa or “Pai Manoel” (“Papa Manoel”) had a remedy not short of miraculous. Costa’s reputation grew, especially when a doctor visited his plantation and reported some “good success” among sick patients. Several days later, Pernambucan authorities installed Costa as a medic in Recife’s Naval Hospital where he gave special attention to slaves and poor people of color. The Pernambucan president argued that it was a difficult but necessary move to diminish “public anxiety,” but the elite medical establishment saw grave danger in giving official authorization to a “charlatan.” The Commission on Public Hygiene, which oversaw the government’s effort to battle cholera through provisional clinics, widescale sanitary projects and ambulances to interior townships, wrote in protest that they would not permit “slaves from the Coast of Africa, with their gross mixtures” to be able to exploit the “credulity of the people.” When Costa refused to stop treating patients, he was arrested, booked under a municipal law against false medical practice, and sent to jail. The president of the Commission wrote that when Costa’s supporters learned of his imprisonment they took to the streets, shouting from the steps of shops and corners. “Slaves and blacks became contemptuous” and “rioters formed groups who roamed the streets over two nights, cursing doctors.” Costa was soon released but prohibited from practicing in the Naval Hospital. Tension diminished a day or two later perhaps because word spread that several of Costa’s patients had died. His remedy, a mixture of pepper, sugar, onions, garlic and lemon root, may have lost its power.  

In a study of Manoel da Costa, Ariovaldo da Silva Diniz argues that the protests in Recife demonstrates how “free blacks and slaves” believed “the disease was being used as a racial solution – to whiten the population, with the replacement of black labor by European immigrants.” This may go too far. The protests for Costa’s release certainly reveal a tension that was in large part directed at the white elite, with attempts by the ruling class to pacify through a controversial gesture of inclusion. Whatever their varied motives, the roving groups of protestors caused very little damage. They hardly
constituted rebellion and should not be considered too different from many other episodes of “social agitation” that occurred in Pernambuco at other points of the 1850s when no disease was epidemic. According to the President of Bahia, Pernambuco experienced fewer assassinations in 1856 “because when a calamity of this order strikes a country, crime diminishes.” Another important reason why social agitation did not leap from cholera’s ravages may be because it quickly followed or occurred concurrently with yellow fever, a disease that clearly spared slaves but killed whites, especially those who had recently arrived in Brazil. Other diseases, like tetanus and smallpox, killed slaves and the poor disproportionately, while some seemed indiscriminate, like tuberculosis and influenza. Cholera should not be seen outside of the fuller context of disease and affliction (and “divine catastrophes”) that prompted little introspection of underlying social conditions and race relations in the nineteenth century.

Cholera did not provoke any collective action to destabilize the provincial or imperial governments of Brazil nor did it nudge a strongly European-influenced medical establishment off its pedestal. Doctors’ inability to prevent or cure cholera did little to help their collective stature, but cholera opened no doors for official recognition of folk medicines in the wake of their failures. Homeopathy may have gained ground, especially since its remedies are almost entirely benign liquids that may have helped stem dehydration. But homeopathy was also a European import, foreign to African and indigenous traditions. I do not claim that the poor, slaves, and people of color did not push back against an oppressive sanitarian agenda in ways available to them. For example, health authorities in Sergipe also faced resistance when they inspected houses to confirm sanitation conformed to municipal code. Furthermore, officials protested with such vigor against the lack of knowledge of proper sanitation of homes and hygiene that they probably confused purposeful ignoring of such norms for ignorance.

Part III: Cholera’s 150 year legacy

If we consider the metaphor of our panel – the experiment – we might say that cholera presented Brazilians with a highly unwelcome experiment in social and racial justice. This microbe tested social resilience and solidarity, as these bacteria have proven deadliest to the poorest and most oppressed the world over. When this “experiment” proved especially catastrophic to particular groups

64 Santos “Controvérsias em torno,” 154-162; Beltrão Côlera, o flagelo, 160-181
65 Neto, "Sob o signo." Home inspections were generally "badly received by the people" in Salvador. But in that city the inspectors may have also “resisted,” since many “avoided the drudgery of home visits.” Presidential Report, Bahia, April 1856, 6
in Brazil, any reflection of social injustice went mostly unseen and unspoken. Piecing together historical sources from across the wide Empire reveals a more accurate history of cholera and Brazil than told by its official reporters. First, cholera exposes structural racism by demonstrating that those most likely to be killed by the disease were poor and people of color. A lack of recognition of these structures of injustice in published discourse reveals the ways that racism operated surreptitiously in Brazil, often under the guise of categories of social division that purported to be more objective and polite than “crude” descriptors of raça. Second, cholera did not provoke rebellion; indeed, the cholera years were two of the most secure and violence-free in the Empire’s history. The disease probably turned people’s attention inward, to caring, burying and mourning for family and friends, then outward as aggression toward Brazil’s social hierarchies and norms of white supremacy. Furthermore, this was one of many dangerous diseases and risks that demonstrated a morality tale of basic mortality and nature’s power guided by God’s hand rather than social disparities maintained by man.

That slaves and people of color were killed disproportionately is cholera’s most tragic legacy. But cholera may have also quickened a few other important trends that helped make Brazil the most highly unequal country in the world in the twentieth century, as I am exploring in a book-length project. To understand how, we need to go back to the colonial period. In the two centuries before independence, the Brazilian Northeast supplied large amounts of the world’s sugar, making it Brazil’s wealthiest region. In contrast, many parts of the Southeast were poor and depended more on internally oriented economies, with the notable exception of mining regions of Minas Gerais. The Northeast’s privileged position was mostly lost by independence, but few would have imagined how much wealthier the Southeast would become even by 1860. These shifting regional fortunes were mostly driven by commodity prices and global competition. Northeastern sugar planters faced increased difficulty selling sugar when international prices were held down by European officials who protected and subsidized their colonial sugar producers, and when colonies such as Cuba improved efficiencies through mechanization. Coffee farmers in the Southeast benefited from rising prices driven by growing world demand, especially among the expanding middle classes in Europe and North America, and much less global competition in supply (Figure 6). They also received far more European immigrants who brought with them human and monetary capital. The “commodity lottery,” global economic forces, and migration patterns provide most of the explanation for why the Northeast – a relatively wealthy region at independence – became one of the Brazil’s poorest regions by the end of the nineteenth century.

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Figure 6. Exports by Province of sugar and coffee (1850s)
But this isn’t the whole picture. I believe cholera to be important contributor to regional inequality when it struck the sugar and cattle industries in the Northeast and almost entirely spared the coffee industry in the Southeast. For every 12 slaves killed in the Northeast, only one was killed in the Southeast. Historians have written much about the great internal slave trade (1850-1880) and how it transferred as many as 100,000 slaves mostly from the Northeast to the Southeast. The amount of “redistribution” caused by cholera was probably more than half as large, but occurred in a much shorter period of time. If we are to accept the impact on relative regional wealth and power caused by the slave trade, we must also hold this epidemic to have similar effects. Slaves constituted the largest and most valuable type of “property” and were viewed by many elite as the only workforce well after 1850. The death of about 50-80 million slaves the Northeast alone devastated the sugar and cattle industries at a moment when many farmers were already facing constraints and risks. Overall, this region experienced about five times more deaths from cholera than all other parts of Brazil combined.

Today, there are many places in Rio Grande do Norte, Paraiba and other parts of the rural Northeast where you will find chickens and hogs foraging on the dirt floors of one-room structures that often provides home for large families. In urban areas, shantytowns (favelas) can stretch to the horizon. In such places of poverty, children of color are the least likely to get more than a few years of schooling and the conditions to support long lives of good health. In another region of Brazil -- not very distant – the mostly white guests of Tivoli Hotel in São Paulo can view a veritable ocean of skyscrapers and luxury apartments from every window of their suites. While it is hard to believe that an epidemic disease that struck Brazil more than 150 years ago could be one of several contributors to such a contrast, it should not be overlooked.

67 This estimate is based on Rego’s calculations of 152,000 total deaths in the Northeast (23,500 in Alagoas, 36,000 in Bahia; 28,000 in Paraiba; 38,000 in Pernambuco; 4000 in Rio Grande do Norte; and 22,000 in Sergipe) and 12,000 deaths in the Southeast (1,600 in Espirito Santo and 9,800 in Rio de Janeiro). I assume that slaves were killed proportionally across Brazil. If we revise these figures upward by about 25 percent (see footnote 18), than about 190,000 people died in the Northeast and 40,000 died in all other parts of Brazil.