# Commentary

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## The 1866 Cholera Scare: Implications for Canadian State-Making and Current Pandemic Management

In early 1866, news came to Canada that cholera was spreading in Guadeloupe and Martinique (Curtis, 2000; Milroy, 1868). This caused widespread panic since Canada had experienced cholera epidemics six times in the preceding decades, resulting in at least 20,000 fatalities (Bilson, 2015; Finkel, 2006). During this time, little was known about the mysterious cholera, which spread rapidly and killed quickly (Bilson, 2015). A lack of understanding around how cholera spread or how it could be treated fueled a great deal of fear around this infectious disease and caused heightened social upheaval (Bilson, 2015). The fears of cholera were exacerbated by early iterations of settler xenophobia once it was determined that the disease was "exotic" and arrived through ships carrying "immigrants" (Bilson, 2015; Curtis, 2000). Ultimately, the 1866 threat proved "benign" (Curtis, 2000; Finkel, 2006), in part due to the widespread preventative measures directed by centralized state actors (Curtis, 2000; Finkel, 2006).

The coordinated response to the threat of cholera included the development of a Central Board of Health by the United Province of Canada (UPC). This Board was responsible for quarantining the sick, organizing local boards of health, data collection and surveillance measures for all ships arriving to the colony, and the rise in "sanitarianism" across Canada (Curtis, 2000; Finkel, 2006). Sanitation issues became a key public health concern and orders were discharged across the UPC that involved the emptying of privy pits and cesspools and improvements to drainage and water supply in Toronto, Montreal, and Kingston (Curtis, 2000).

For the first time in Canada, a public health strategy took priority over "the individual liberties of property, privacy, and movement" (Curtis, 2000; Curtis, 1999; Finkel, 2006). Police were given the title of "municipal health officers" and worked with local boards of health to fine, arrest, or imprison people deemed non-compliant with public health regulations and were given authority to enter "any place" believed to be "filthy" or "degraded" to enforce public health orders "if necessary" (Curtis, 2000). The introduction of these rules resulted in new relational dynamics between the state, police, the people, and domains of life previously assumed to be "private" (Curtis, 2000). People positioned as experts were given the ability to enforce new sets of rules that also functioned as moralizing instruments. Rather than characterizing environments where cholera occurred as unsafe, such sites were associated with moral degradation and personal failing. This practice added a layer of judgement to the public health ordinances in that they were now laden with notions of social respectability in alignment with newly enforced social values of cleanliness (both physically and morally) (Curtis, 2000).

Organized surveillance and data collection with respect to immigration was justified under the auspices of cholera prevention (Curtis, 2000; Finkel, 2006). Ships arriving to Canada from outside the colony were inspected closely and all contents were documented (Curtis, 2000). The presence of anyone on the ships who were considered to be "lunatic, deaf dumb, blind, or infirm" was "noted" (Curtis, 2000), and medical officers were given free access to ship records (Curtis, 2000). The threat of cholera was used to collect information about a great deal more than cholera itself.

By November 1866, the Central Board of Health prepared a report detailing the effectiveness of its prevention efforts, and the strict public health regulations were loosened (Curtis, 2000). Though broad sanitation efforts improved drainage and water supply systems and promoted the Canadian nation-state as a protective force, the simultaneous surveillance and policing of certain populations signified conflicting values of authoritarian domination and social control.

The social control practices that were adopted treated citizens as vectors of cholera rather than addressing the structural and socio-economic factors that made them vulnerable to it, such as poor infrastructure (e.g., use of privy pits), tainted water sources, and lack of scientific knowledge of the disease. The punitive piece of the government's prevention efforts contained the early seeds of individualization that is central to neoliberalism, emphasizing "personal responsibility" while dismissing the role of power relations and material forces of colonialism, capitalism, white supremacy, and patriarchy (Baines, 2011; Finkel, 2006). Through this response, the colonial state asserted itself as the ruler of its political subjects while at the same time penalizing those subjects living under conditions that the state itself created. In this way, the Canadian state deflected accountability by "othering" individuals and populations cast to the fringes of colonial society.

The tension between imposing social control on oppressed populations under the mantle of protection for exalted subjects (Thobani, 2007) has been an ongoing issue in Canada, including during today's COVID-19 pandemic. As a colonial state whose provision of welfare and social assistance has been used to reify hierarchies of class, race, and gender, any efforts to protect one population (namely, white settlers) inevitably poses a punitive threat to those who are othered or deemed undeserving of protection (Finkel, 2006; Thobani, 2007). In Canada, individualizing responses to the pandemic such as race-based data collection and vaccination passports have replaced meaningful policy action to reduce social inequities. Though race-based data has provided information about the extent of illness and suffering disproportionately experienced by BIPOC people throughout the COVID pandemic, it has not delivered on its promised "equity" for marginalized populations—particularly where the political will to act on what is already known about racial injustice is absent (Walcott, 2020). Similarly, the policy measures around vaccine passports have largely replaced discussions about structural policy action on universal paid sick days, increased social assistance rates (Durrani, 2020), affordable housing (Deachman, 2021), eviction moratoriums, a guaranteed living wage, and improved

ventilation practices across workplaces and other communal settings such as shelters (James, Siegel, and O'Campo, 2021).

Though the Canadian government reacted to prevent a seventh cholera epidemic in 1866, the conditions for thousands of deaths to occur again were still present. Though sanitarianism helped address the immediate threat of infected water sources, the cholera epidemics in Canada raised important questions about the unequal distributions of resources in society. The COVID-19 pandemic today has illuminated similar concerns of societal inequities. If governments acted to "provide resources, services and opportunities for the overall benefit of humanity and to afford them protection from harm," (CASW, 2005) the negative effects of epidemics and pandemics could be largely prevented. More concretely, this would involve 1) secure, clean housing for all; 2) decent wages; 3) safe labour conditions; 4) universal basic income; 5) reallocation of police budgets to community services and organizations not implicated in the prison industrial complex; 6) universal healthcare (including dental, foot, and vision care); and 7) the abolition of white supremacy (Walcott, 2019, p. 7).

The cholera scare of 1866 was a landmark historical moment where fear and panic were used to expand surveillance capabilities and consolidate power for the Canadian nation-state. This paper illuminates the ways that threats of "risk" are often capitalized upon to expand and affirm the power of nation-states, infringe on privacy, and scapegoat oppressed populations in times of uncertainty. The social welfare response to the threat of cholera in 1866 can provide lessons for today. Collectively, fear and stigmatization can be refused as they are tools that exploit existing power dynamics to shift blame from the state to its subjects. Further, we can collectively reject requests to participate in invasive data collection and/or research initiatives that offer no guarantees to materially improve the lives of people being studied in an enduring way (James, 2020; Walcott, 2020). Finally, we must commit ourselves to ameliorating the structural conditions that facilitate the propagation and reproduction of preventable health catastrophes.

## References

Baines, D. (Ed.). (2011). Anti-oppressive practice: Neoliberalism, inequality, and change. In *Doing anti-oppressive practice: Social justice social work* (2nd ed., pp. 25-47). Fernwood Publishing.

Bilson, G. Cholera in Canada (2015). *In The Canadian Encyclopedia*. https://www.thecanadianencyclopedia.ca/en/article/cholera

Canadian Association of Social Workers. (2005). *Code of Ethics.* https://www.caswacts.ca/sites/default/files/attachements/casw_code_of_ethics.pdf

Curtis, B. (1999). The moral lessons of miasma: the" Memorandum on cholera" of Joseph-Charles Taché. *Canadian Bulletin of Medical History=Bulletin canadien d'histoire de la médecine*, *16*(2), 317-339.

Curtis, B. (2000). Social investment in medical forms: The 1866 cholera scare and beyond. *Canadian Historical Review*, *81*(3), 347-379. https://search-proquest-com.myaccess.library.utoronto.ca/docview/224252454?accountid=14771&pq-origsite=summon

Deachman, B. (2021, June 6). Resumption of evictions during COVID-19 risks worsening of homelessness, affordable housing crisis. *Ottawa Citizen*. https://ottawacitizen.com/news/local-news/resumption-of-evictions-during-covid- 19-risks-worsening-of-homelessness-affordable-housing-crisis

Durrani, T. (2020, April 24). Low-income Ontarians facing partial claw back of federal assistance during COVID-19. *Healthy Debate.* *https://healthydebate.ca/2020/04/topic/ontario-low-income-cerb-covid/*

Finkel, A. (2006). *Social Policy and Practice in Canada: A History*. Wilfrid Laurier University Press.

Fook, J. (2016). Power. In *Social work: A Critical Approach to Practice* (pp. 45-55). Sage.

James, L. (2020, December 3). *Data & Sovereignty: Resisting Colonial Logics for Racial Justice.* https://www.macvideo.ca/media/Data+%26+Sovereignty/1_2gxgha0l

James, L, Siegel, J, and O'Campo, P. (2021, June 28). How safe are Ontario's shelters and other shared living settings from airborne COVID-19? *The Conversation.* *https://theconversation.com/how-safe-are-ontarios-shelters-and-other-shared-living-settings-from-airborne-covid-19-163063*

Milroy, G. (1868). Notes on the Geographical Diffusion of Epidemic Cholera in 1866 and 1867. *The British and Foreign Medico-Chirurgical Review*, *42*(83), 209. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5165302/?page=1

Thobani, S. (2007). Compassion: The welfare of nationals. *Exalted Subjects: Studies in the Making of Race and Nation in Canada*. University of Toronto Press.

Walcott, R. (2019). The end of diversity. *Public Culture*, *31*(2), 393-408. https://read-dukeupress-edu.myaccess.library.utoronto.ca/public-culture/article/31/2/393/138418/The-End-of-Diversity

Walcott, R. (2020, November 12). Data or politics? Why the answer still remains political. *The Globe and Mail*. https://www.theglobeandmail.com/canada/article-data-or-politics-why-the-answer-still-remains-political/