

This is Public Health: A Canadian History

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A Period of Decline

The stock market crash of October 1929 and the Great Depression that followed had a devastating impact on the Canadian economy. The Gross National Expenditure declined an estimated 42% between 1929 and 1933 and a significant proportion of the population needed government relief to survive. The demands on the federal and provincial governments vastly exceeded the resources available, while voluntary organizations, which traditionally provided free health and social services, were equally hard-pressed.



Medicine Hat and District Historical Society,
Provincial Archives of Alberta, A5150

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On to Ottawa Trek, Medicine Hat, AB, 1935



© McCord Museum, MP-1980.32.1.233

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*Rural children
in Gaspé, 1930*

As the federal government cut back on health spending, provinces and municipalities were left to fill the gaps and some areas of the country fared better than others. Quebec relied on assistance from its well-established religious organizations and Ontario negotiated a system of care with its doctors. Despite high unemployment, these two provinces fared better than the rest of the country with their more diversified, industrialized economies. The economies of the Maritime provinces saw the decline that began in the 1920s continue, but the four western provinces were the hardest hit. Their agricultural and resource-based economies were devastated by the collapse of world markets and a severe drought on the prairies. Cities and towns struggled to provide even basic public health services, while the federal government opened relief work camps

where single, unemployed men earned 20 cents a day. Hundreds tried to trek from British Columbia to Ottawa to protest poor conditions but were denied access to train cars by Prime Minister R.B. Bennett. Two died when a July 1 protest turned into a riot in Regina in 1935 and left-wing political parties and labour unions started organizing the working classes. Unemployed immigrants were deported by the thousands and entrance to Canada for new immigrants was essentially restricted to the British and Americans.

As the economic crisis deepened, the *Canadian Public Health Journal* appealed for adequate appropriations to public health departments, arguing that any short-term cost saving would ultimately be paid for in increased sickness and death. Some new health units were established, including in North Vancouver (1930) and High River and Red Deer (1931) but the pace of growth slowed. Quebec's 1933 *Health Unit Act* made all existing health units permanent and authorized new ones in the remaining counties, while making significant progress with infectious disease control, child health and public health engineering. Ontario re-organized its Health Department in 1934, dividing the province into health districts and amending its *Public Health Act* to permit the uniting of counties, municipalities or districts for the purpose of providing full-time health services. Its first full-time county health unit was established in Eastern Ontario in 1934, with the help of a five-year \$33,000 grant from the Rockefeller Foundation.¹

The field of public health broadened in terms of specialties and professionalism, statistical data gathering and training standards. Education, certification, and training standards in the public health field were strengthened, especially for nurses and inspectors. When the economy gradually began to recover in the latter half of the decade, the Dominion government, the Dominion Council of Health and the Canadian Public Health Association also began expanding the specialization of interests and activities.



John M. Uhrich

*First Saskatchewan
Minister of Public Health*

Dr. Uhrich was the first Minister of Public Health in Saskatchewan. In 1921, he was elected to the Provincial

Legislature and appointed Provincial Secretary and Minister in Charge of the Bureau of Public Health. He was later appointed Minister of Public Works and Public Health. For almost 20 years under Dr. Uhrich's direction, public health work was marked by a great expansion of health services throughout the province, in spite of pressing economic concerns. Free treatment of all who had tuberculosis was introduced under his administration, with the result that Saskatchewan had the lowest tuberculosis mortality rate in the Dominion. As well, there was an increase in rural hospitals, in medical and health services, and Saskatchewan became a leader in cancer control. Dr. Uhrich was appointed Lieutenant Governor in 1948.

—*Canadian Public Health Journal*,
Vol. 31, 1940


Child and Maternal Welfare

The challenges of maternal welfare were the focus of considerable discussion by the Dominion Council of Health in the 1930s, while the national rate of births and marriages declined and many tried to keep their families from growing during the Depression. Birth control was illegal and family planning advocates called unsuccessfully for the relaxation of the restrictions on contraception.

More women delivered their babies in hospitals instead of at home and the medical specialization of obstetrics was growing. As Toronto physician, H.B. Van Wych wrote, “No longer is obstetrics the despised practice of midwifery, but takes its place as a fully scientific branch of practice, a field in which modern concepts of medicine and surgery have a most beneficent application to the function of reproduction.”² Compared to hospital births, however, maternal mortality was considerably lower with homebirths—even when there was no physician present at the delivery. In 1937, an international comparison of maternal mortality ranked Canada 21st and Canadian statistics showed wide variations across regions and ethnicities. For example, maternal mortality rates in 1927 per 1,000 live births were 4.9 for French Canadians, 6.1 for English Canadians and 11.0 for Indigenous Canadians.³ The reasons accounting for the high rates of maternal death during childbirth have been debated, but appear to be linked to inadequate obstetrical training for physicians in obstetrics and poor practices for the prevention of sepsis, such as sterilizing instruments and wearing gloves during delivery.⁴



Provincial Archives of Alberta, A4615

 [click to enlarge image](#)

Nurse Olga Freifeld, 19—

According to Ontario Member of Provincial Parliament, Dr. John Robb, the province’s high rate of maternal mortality in 1930



William Warwick

Developed Public Health Department of New Brunswick

Dr. Warwick joined the Department of Health in New Brunswick in 1920

after extensive public health experience in federal health work and service in France during WWI. Dr. Warwick became Chief Medical Officer for the province in 1932. Under his leadership, there was increased support for public health, which led to the subdivision of the province into 10 health districts, each under the direction of a full-time medical officer. Medical inspection of schools was provided and the efforts for the control of tuberculosis were greatly strengthened by the provision of additional hospitals and by the appointment of physicians with special training in tuberculosis as district health officers. Dr. Warwick also served as Registrar General of Vital Statistics.

—*Canadian Public Health Journal*, Vol. 33, 1942

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could be attributed to the part-time arrangement for most medical officers of health. Thus, as the *Canadian Public Health Journal* reported, “it was his opinion that a full-time health official, assisted by nurses and sanitary inspectors to supervise a county or part of same, would not only be a great factor in the reduction of the maternal mortality rate, but also be of extreme value in the larger field of preventive medicine.”⁵

Despite being severely affected by the Depression, Saskatchewan and Manitoba managed to lower their rates of maternal mortality in the 1930s. Manitoba’s rate of maternal mortality per thousand live births dropped from 6.8 in 1929 to 3.8 in 1934, while Saskatchewan saw its rate drop from 7.1 in 1926 to 4.4 in 1934. A 1938 survey showed that maternal deaths were beginning to decline in 1937, likely due to improvements in nutrition and maternal education.⁶



Sanofi Pasteur Limited, Comnaught Campus, Archives

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*Hamilton Dept. of Health,
early 1930s*

very much a scientific survey that would determine these factors and would allow our government groups to arrive at some basis of determination.”⁷

Nutrition, Food Safety and Pasteurization

The National Nutrition Committee, later named the Canadian Council on Nutrition, was established during the Depression to develop a scientific nutritional standard to help ensure that families on relief could be adequately nourished with the minimal money they received. Before the Council issued Canada’s first dietary standards in 1939, the Dominion Council on Health noted in 1937 that, “at present, they are very resentful and claim they cannot possibly live on account of the rising prices, so that we would welcome



Edna Lena Moore

*Distinguished Leader
in the Nursing Profession*

Edna Moore had a long and varied career in the nursing

profession. She served overseas with the Royal Canadian Army Medical Corps for four years during WWI and saw service in France, Malta, Salonica and England. She spent several years as a social service nurse with the Soldiers Civil Re-establishment and the Division of Preventable Diseases of the Ontario Department of Health. She became the first field worker with the Canadian Tuberculosis Association in Ottawa and in 1931, was appointed Chief Public Health Nurse with the Ontario Division of Maternal and Child Health and Public Health Nursing. When Public Health Nursing became a separate division in 1944, Ms. Moore was appointed as Director. She served on many committees and held the chairmanship of the Public Health Committee of the International Council of Nurses for seven years.

—*Canadian Journal of Public Health*,
Vol. 53, June 1962

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Cow's milk was increasingly viewed as a fundamental nutrient, as well as an efficient vehicle for spreading infectious diseases if not pasteurized. There was wide variation in milk control legislation across the country and if referenced specifically, pasteurization was left to local health boards to enforce, although provincial governments exercised some control through licensing of milk suppliers and vendors.⁸



Glenbow Museum, NA-3258-3

Hospital cars on Hudson's Bay Company Line picked up typhoid patients, 1929

Typhoid and similar enteric disease outbreaks exposed the weaknesses in sanitary controls, especially of milk supplies and milk-borne tuberculosis led to growing calls for compulsory pasteurization. A major typhoid epidemic due to cheese made with raw (unpasteurized) milk in the St. Maurice Valley region of Quebec in 1932 resulted in 527 cases and 45 deaths—the worst milk-borne epidemic since the Montreal's 1927 crisis. Raw milk advocates were characterized by public health officials as little different from anti-vaccinationists

and opponents of obligatory school attendance and child labour laws. As a *Canadian Public Health Journal* editorial noted, "Some of these people are undoubtedly affected by purely selfish motives, some are misinformed, but, in the main, this opposition would appear to be based upon the inherent dislike of the Anglo-Saxon to all measures which are designed to restrict the right of personal choice."⁹

In 1936, 12 out of 32 cities with more than 20,000 people had 95% or more of their local milk supply pasteurized, while six had 50% or less protected. In almost all of the nation's smaller communities, the bulk of the milk supply remained unpasteurized.¹⁰ Close to 8,000 cases of typhoid, scarlet fever, septic sore throat and undulant fever had been traced to milk since 1912, including 688 of which were fatal. The Canadian Public Health Association and the Canadian

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Medical Association strongly endorsed compulsory pasteurization of milk and in 1938, the Ontario government took the pioneering step of implementing compulsory pasteurization across the province.¹¹

Tuberculosis and Indian Affairs

Provincial health authorities continued to express alarm about the threat of tuberculosis spreading to non-Indigenous populations while the federal government still did not act. Recent studies had showed tuberculosis mortality among First Nations in British Columbia to be about 10 times the national rate while in Saskatchewan, Aboriginal TB mortality was almost 20 times the national rate. Saskatchewan had been offering free treatment since 1929 and the province's Deputy Minister of Health told the Dominion Council of Health in 1934 that the populations on reserves under federal jurisdiction were “a menace to the health of the white citizens of the province.”¹²



The Dominion Council of Health advised the federal government to purchase health services from the provinces for First Nations. The federal chief officer of health, **Dr. John Heagerty**, told the Council that with the many reserves spread across the country, “it has always struck me that it is quite impossible for the Department of Indian Affairs, from a central office, to maintain an adequate health service through traveling nurses and through doctors who are on part-time service and cannot give anything like an efficient service in the control of infectious diseases.”¹³

 [click to enlarge image](#)

Sisters of the Assumption with Indian students at Onion Lake, SK

M. Stuart Fraser

*Distinguished Sanitarian
Fought to Alleviate the Suffering
of Children in Manitoba*

Dr. Fraser graduated from the University of Manitoba's Faculty of Medicine in 1890 and undertook post-graduate study in Edinburgh. For some years he was engaged in general practice in Brandon until he became the Provincial Epidemiologist. He established the first provincial public health nursing service in 1917 and was appointed Chief Health Inspector in 1928. Dr. Fraser was one of a small group of distinguished sanitarians who helped lay the foundation of an effective public health organization. He fought to alleviate the suffering of children. On the public platform and in newspaper articles, he outlined how much of this suffering was unnecessary, urging the continued supervision of children by their family physicians, the organization of child health clinics, and the provision of public health nurses to serve the whole province.

—*Canadian Public Health Journal*,
Vol. 26, 1935

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In 1935, the Medical Branch of Indian Affairs had 11 full-time medical officers and eight Indian agents with medical training. Some 250 physicians were employed part time or as needed and there were 11 field nurses working in remote nursing stations, such as Fisher River, Manitoba, which opened in 1930. The Indian Health Service came under the administration of the Department of Mines and Resources in 1936 and began to expand its services and facilities under Dr. Percy E. Moore, who was director from 1939 to 1965, while Dr. Stone remained the medical superintendent.¹⁴

A number of provinces expressed interest in providing health services to the Department of Indian Affairs, with some offering to do it “free of charge for their own protection.” But Heagerty indicated that the federal government “does not want to lose control over Indians” and would not permit provincial health authorities to enter the reserves, leaving “public health among Indians... pretty much neglected.” Saskatchewan health officials tried to provide what they could within their jurisdiction to give reserve communities “some at least of the crumbs that fall from the provincial table” and funds raised by the Saskatchewan Anti-Tuberculosis League’s Christmas Seals campaign supported traveling tuberculosis clinics that some First Nation communities could access, although TB among First Nations remained high. The Department of Indian Affairs indicated that, “it is impossible to admit to sanatorium more than a very small proportion of Indians who are recommended for such care” due to its limited budget.¹⁵

Infectious Diseases

Diphtheria outbreaks persisted in rural areas due to limited and uneven application of toxoid. Quebec launched a concerted effort in 1930 to provide diphtheria toxoid widely through the county health units and Deputy Minister of Health, **Dr. Lessard**, told the Dominion Council of Health that “it is to be hoped that in a few years we will not be ashamed, as we now are,

**Armand Frappier**

Instrumental in the Fight Against Tuberculosis in Canada

Dr. Frappier founded the Institute of Microbiology and Hygiene in Montreal in 1938, and served as director until 1975, when it was renamed *Institut Armand-Frappier*. Dr. Frappier was instrumental in the fight against tuberculosis in Canada and one of the first researchers to confirm the safety and usefulness of the Bacillus Calmette-Guérin (BCG) vaccine. In addition to research into the BCG vaccine, Dr. Frappier made outstanding contributions in the study of blood transfusions and blood substitutes, virus vaccines, and fundamental aspects of infection and immunity. He founded the first French-language school of hygiene in the world at the Université de Montréal in 1945 and served as its dean for 20 years.

—*Canadian Journal of Public Health*,
Vol. 64, March/April 1974

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[click to enlarge image](#)

Gordon Bates, meanwhile, continued to press the issue of venereal disease throughout the 1930s, reminding his public health colleagues about the history of the dynamic national VD control program of the 1920s and lamenting its cancellation. He continued to conduct surveys of venereal disease incidence, particularly in Toronto, where it appeared that between 1929 and 1937 there had been a decrease in and better diagnosis of sypilis. Bates launched the Health League of Canada in the spring of 1936 as the successor organization of the Canadian Social Hygiene Council, focusing on diphtheria control, pasteurized milk and the application of preventive medicine.

[click to enlarge image](#)

at the death-rate from diphtheria.”¹⁶ In Ontario, diphtheria incidence dropped dramatically where it had been consistently used but this excluded many rural areas.

Smallpox outbreaks also continued to the frustration of public health officials. In Vancouver in 1932, a mild smallpox outbreak quickly turned into a significant emergency, resulting in 56 cases and 17 deaths. At least half of the public school population and a large proportion of the general population in Vancouver were unvaccinated.

Sandoz Pasteur Limited, Comaught Campus, Archives

DIPHTHERIA TOXOID



Sandoz Pasteur Limited, Comaught Campus, Archives

Alexander Joseph Douglas

Four Decades of Service to Public Health in Winnipeg

In 1939, Dr. Douglas completed almost 40 years of distinguished service as Medical Officer of Health of the City of Winnipeg. To this post he brought energy, versatility, clear thinking, diplomacy, and a remarkable memory for detail. His work on behalf of the Health Department of Winnipeg won recognition throughout the continent. Dr. Douglas was intimately associated with the Medical College of the University of Manitoba for almost as long a period. As Professor of Public Health, he contributed much not only in Manitoba but beyond the boundaries of the province.

—*Canadian Public Health Journal*,
Vol. 30, 1939

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Hospital for Sick Children Archives, Toronto

Polio Spreads

Polio continued its west to east pattern of infection, with significant epidemics striking Ontario in 1930, Montreal in 1931 and Quebec City in 1932. The Polio epidemic spread and in 1937, there was an alarming number of the most severe form of the disease, which resulted from the polio virus attacking the brainstem's motor neurons. Without an iron lung respirator, death almost always resulted.

There was only one iron lung in Canada at the start of the epidemic, which had been brought to The Hospital for Sick Children in Toronto from Boston in 1930. With serious respiratory paralysis cases mounting, technicians hurriedly assembled a total of 27 iron lungs in the basement of the

hospital over a period of six weeks. Each iron lung was paid for by the Ontario government and rushed to where it was most needed, both in the province and elsewhere in the country.


Convalescent serum remained the main public health action in the 1930s but there was no scientific proof of its value, sparking debate about its continued use. Researchers knew little about the disease and there was pressure to act against in any way possible. In 1937, the Ontario Department of Health approved a plan with the School of Hygiene and The Hospital for Sick Children to test a prophylactic nasal spray on 5,000 Toronto children. After two rounds of spray treatments, the results were alarming. The spray did not appear to prevent the disease and many of the children involved in the study lost their sense of smell—in some cases, permanently.


John J. MacRitchie

Developed Public Health in Nova Scotia

Dr. John MacRitchie was born in 1883 at Englishtown, Cape Breton. Following graduation in medicine from Dalhousie University in 1911, he entered private practice in Guysboro County for 20 years. He remarked that he was probably the only man in the medical profession who reached his patients by walking, by snowshoe, by horse and buggy or horse and sleigh, by motorboat, sail boat, row boat and latterly, by automobile. In 1931, Dr. MacRitchie joined the Nova Scotia Department of Public Health where he stayed for nearly a quarter of a century. He conducted tuberculosis clinics throughout the province and was also responsible for inspecting penal and humane institutions.

—*Canadian Public Health Journal*,
Vol. 47, 1956

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The Provincial Department of Health supplied all Poliomyelitis patients suffering from paralysis with splints and frames designed and built in our workshop.

Provincial governments took an increasingly generous and universal approach to hospital and after-care treatment for polio victims. Parents were instructed on how to care for their polio-stricken children at home following their hospitalization. In Ontario, the provincial government worked closely with the Society for Crippled Children and several visiting nurses organizations to provide follow-up care across the province. In Alberta, a comprehensive *Poliomyelitis Sufferers Act* came into force in March 1938, despite the government being “quite bitterly assailed by many of our political opponents for giving something for nothing.”¹⁷

Accidents and the Automobile

Detailed statistical information was being gathered about the alarming toll of preventable accidents in industry and from motor vehicles but despite much discussion, nothing was done. In 1933, more than 5% of all deaths were due to accidental causes and more than one-quarter of these were related to land transportation. Drowning and water transportation accidents were also significant and accidental deaths were the leading cause of death among 5- to 14-year-olds.

There were rules of the road in the 1930s but minimal regulation of drivers in Canada unlike in Britain and Europe, where driving tests were required before granting a licence. A special CPHA committee was formed to look at driver regulation, as well as at the complex psychological factors behind reckless and irresponsible driving habits, especially among the young. Provincial health departments had no direct jurisdiction in matters related to the control of automobile accidents and the problem grew faster than preventive measures could be applied against it.



Lynn Blair

*Peripatetic Public Health Nurse
Served Manitoba for 41 Years*

Lynn Blair was one of the first nurses hired for the new Department of Health and Welfare in Manitoba in 1929. She was assigned to the

Fisher Branch Nursing Station in north-central Manitoba in 1937, where in addition to nursing she was pressed into service as a substitute physician and veterinarian. She describes this period as one of the happiest and most rewarding in her career as a public health nurse. Ms. Blair and a colleague averaged 1,000 miles a week, searching out suitable families willing to open their homes to children evacuated from war-torn Britain, travelling over roads that were hardly more than trails in some areas. She volunteered with the Canadian Army Medical Corps as a Nursing Sister in South Africa for three years before being assigned to several senior public health nursing positions in Manitoba, including work with crippled children in areas not covered by organized health units and as Nursing Consultant in Venereal Disease for the province.

—*Canadian Journal of Public Health*,
March/April 1975

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As a 1936 *Canadian Public Health Journal* editorial noted, “irresponsible individuals are permitted to run five-ton trucks at an extraordinary speed on narrow highways. Motor cars advertised to go 70 miles an hour are placed in the hands of youths who are only a decade from a perambulator; and a few socially minded people try to control this Frankenstein which they helped to create.” Voluntary groups had made attempts to do something, but there existed “an attitude of laissez-faire among those who are or should be most concerned, namely, the public themselves.”¹⁸



Grandpa Sanitary
Inspector

Professionalizing Canadian Public Health

In 1930, Dr. James Roberts, Hamilton’s Medical Officer of Health, told a meeting of the British Medical Association in Winnipeg of his concerns about the training and regulation of sanitary inspectors. “There are far too many instances throughout the Dominion where the sanitary inspector is the Cinderella of the health department, dreaming among the ashes of the past. Too often we find him bound like Sisyphus of old to the perfunctory performance of his meaningless and unproductive task, and prevented by the limitations of his education and training from becoming the integral factor that he ought to be in the machinery of disease prevention.”¹⁹ In an effort to raise the knowledge, training and professional standing of its members, the Sanitary Inspectors Association of Western Canada was created in 1913 and became a national association in 1920. In its early years, the association adopted the *Public Health Journal* as its official organ and gave every member a subscription so they could expand their knowledge and training and a regular column was included in every issue for that purpose. Active branches of the association began to be established across the country in the 1930s and after some effort by its members, the association was incorporated as the Canadian Institute of Sanitary Inspectors in 1934

Mac Harvey McCrady

Outstanding Public Health Scientist

In 1910, Mac Harvey McCrady’s job was to reorganize the public health laboratory of the Superior Board of Health of the province of Quebec. During his 43 years of service, he laid the foundations of a comprehensive diagnostic laboratory service and became one of the foremost authorities in public health bacteriology on the continent. He took an active part in the development of *Standard Methods for the Examination of Water, Sewage and Dairy Products* for the American Public Health Association and was a co-author, in 1946, of *Water Bacteriology*. Although particularly interested in sanitary bacteriology as relating to municipal problems of water, sewage and milk, he kept ever in mind practising physicians, adapting bacteriological and immunological procedures to meet their needs. Mr. McCrady was considered to be one of the outstanding scientists in the field of public health.

—*Canadian Public Health Journal*,
Vol. 47, 1956

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and CPHA assumed responsibility for the testing and certification of inspectors in 1935. With the cooperation of the provincial departments of health, a course of study and certification examinations were held in the provinces. A manual of instruction was prepared under the direction of CPHA's Committee on the Certification of Sanitary Inspectors.²⁰

The Canadian Public Health Association continued to expand the number of sections devoted to special fields of public health with the assistance of volunteers interested in advancing and growing the field of public health. The laboratory section that was formed in 1917 grew into the Canadian Society of Bacteriologists and began holding annual meetings of its own. The child welfare, venereal disease control, and mental hygiene sections that had been established in its first decade continued, and sections on industrial hygiene, public health nursing, and vital statistics were added in the 1920s. The 1930s saw new sections on public health engineering, epidemiology, and public health education. Committees made up of volunteers collaborated in various studies and presented their findings through the *Canadian Public Health Journal*. The vital statistics committee conducted a number of studies, including the revision of the International List of Causes of Death, phraseology related to the physician's statement of death, and the education of physicians and medical students in the fundamentals of vital statistics.

The Federal Role

Although a resolution was passed in the House of Commons on March 3, 1930 calling for federal grants to the provinces covering one-third of the cost of full-time health units, the government did not act on this. Between 1932 to 1935—the worst years of the Depression—the federal government cancelled its grants to the provinces for venereal disease control and closed the Venereal Disease Control Division. The Child Welfare Division also closed after founding chief Dr. Helen MacMurchy retired in 1934.

CPHA's Hygieia

In 1935, the Canadian Public Health Association introduced a new seal, which depicted Hygieia, the Greek goddess of health, cleanliness and sanitation, whose name was the source of the word, hygiene. Hygieia's father, Asclepius, is more directly associated with healing and medicine, while Hygieia was associated with disease prevention and health promotion. A snake coiling around her arm was symbolic of the patient embodied with wisdom.



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In the last half of the 1930s, however, economic conditions improved and Prime Minister R.B. Bennett was impressed by the United States' New Deal with its social security and infant and maternal care in under-served rural areas. The *Canadian Public Health Journal* said the U.S. "federal action is highly significant, being the first occasion of the participation of the federal government in a county-wide program of assistance to state departments in public health work."²¹

Bennett introduced his government's plans in a series of speeches to the nation in January 1935, which the provincial ministers of health later discussed with their federal counterpart, D.M. Sutherland. The plans included reinstating grants for venereal disease, as well as funding for mental hygiene, cancer, tuberculosis and full-time health units. In 1937, the Department of Pensions and National Health created new divisions of epidemiology, industrial hygiene, and restored the divisions of publicity and health education, and maternal and child welfare. The Dominion Council of Health also established new committees, including one to address the protracted challenge of reducing maternal mortality.

The Depression changed some longstanding beliefs about the free market and the role of the government. When Germany invaded Poland on September 1, 1939, Canada followed Britain and France and entered the Second World War one week later. This war ended Canada's economic downturn and the next decade would see a new approach to governmental health and social programs in Canada in addition to the enormous human and economic costs.

**Arthur Edward Chegwin**

Early Promoter of Dental Health Education

Born in 1895 at Lacombe, Alberta, Dr. Chegwin set up a dental practice in Moose Jaw, Saskatchewan in 1919 and was a part-time school

dental officer. Observing the poor dental health among school children, he soon realized that dental health education was a necessity if general dental health were to be maintained or improved. From that time on, Dr. Chegwin dedicated much of his time and effort to dental health education in the schools, in his practice, and with his professional colleagues. During WWII, Dr. Chegwin enlisted in the Army Dental Corps and served as a senior dental officer in various training centres for the RCAF. Later, he became Director of Dental Health for the Saskatchewan Department of Public Health and took a leading role in the organization of the Saskatchewan Branch of the Canadian Public Health Association and as chair of CPHA's dental section.

—*Canadian Journal of Public Health*, Vol. 52, August 1961