

## This is Public Health: A Canadian History

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# A New Perspective on Public Health

After 22 years of expansion in Canada’s health services, the 1970s began with a period of consolidation, rationalization and reduced federal funding for health care. Industrialized countries began to recognize that the substantial declines in mortality achieved over the last 100 years were largely due to improvements in living standards rather than medical advancements. This brought a rethinking of health systems in the 1970s and 1980s, initiating a period of Canadian innovation and leadership in new approaches to health promotion with an impact both at home and abroad. Concerns about the environment, chronic diseases, and the heavy toll of motor vehicle collisions were growing, as were new marketing approaches to deliver the “ounce of prevention” message to the public. Researchers developed systematic methodologies to reduce risk factors and applied an epidemiological approach to health promotion by defining goals and specific objectives.<sup>1</sup>



At the beginning of the 1970s, federal and provincial governments were still analyzing the 348 recommendations of the two-year National Task Force on the Cost of Health Services, which was set up by the federal and provincial ministers of health in 1968 to consult widely with health departments, academics and non-government agencies, including CPHA. The task force suggested a

 [click to enlarge image](#)

*Cigarettes: a dangerous trap*



## Jean Rochon

*Father of Community Health in Quebec*

A graduate of the University of Montreal, Laval University and Harvard University in law, medicine and public health, Dr. Jean Rochon was known by many as the “father of community health in Quebec.” In the early 1970s, he served as advisor to the Castonguay Commission and a member of the MacDonald Committee that led to the creation of the 32 community health departments in Quebec in 1973. He served as chair of the Commission of Inquiry into Health and Social Services for the Government of Quebec, which laid the foundation for the internationally-recognized reform initiatives. Dr. Rochon also served as Director of Program Management of the World Health Organization and subsequently as Director of the Health Protection and Promotion Division at the WHO Head Office in Geneva.

—CPHA Health Digest, 1994

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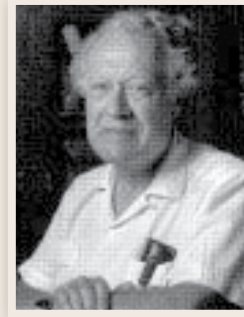
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number of ways to control health care costs, as government expenditures were projected to be \$6.2 billion in 1972, from \$1.7 billion in 1957. The Department of National Health and Welfare commissioned a study of community health centres by health administration expert Dr. **John Hastings** of the University of Toronto, which recommended “accessible and well-managed” community health centres for more efficient delivery of resources, but only Quebec would act on integrating health and social services delivery. A provincial system of CLSCs (Centres local de services communautaires) was developed between 1973 and 1976 with an emphasis on community health services but opposition to this move by the medical profession discouraged other provinces from pursuing this approach.<sup>2</sup>

By the mid-1970s, Prime Minister Pierre Trudeau initiated wage and price controls, rising oil prices slowed economies around the world, while inflation and unemployment persisted. Changes to the *Federal–Provincial Fiscal Arrangements and Established Programs Financing Act* were passed in 1977, shifting from shared-cost funding to block funding for health and post-secondary education, with increases tied to growth of the gross national product. The worst recession since the Great Depression began in 1982 and the 1984 *Canada Health Act* confirmed the trend of reduced federal health spending and the need to re-think ways the government could ensure the best possible health and well-being for Canadians.

**Environmental Concerns**

Environmental health was a growing concern and auto emission controls and the phasing in of unleaded gasoline were introduced in the early 1970s, resulting in a gradual decrease of toxic substances into the air from cars during this decade. Acid rain was described by the International Joint Committee between Canada and the

**John E.F. Hastings**

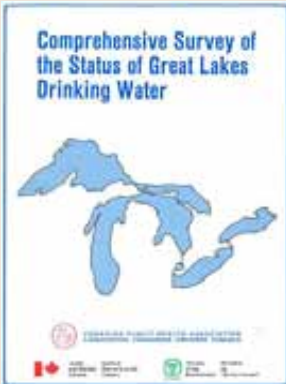
*A Profound Impact on the Development of Community Health Services*

Dr. John E.F. Hastings had a distinguished career as an advocate for community health services and as a

leading educator in community health. In many ways, he continued the public health legacy of his great-uncle, Dr. Charles Hastings (Toronto’s Medical Officer of Health from 1910 to 1929). John Hastings was appointed as a lecturer in the School of Hygiene at the University of Toronto in, where he remained for the next 36 years. In 1965, he completed a report for the Hall Royal Commission on Health Services with recommendations about the organization of community health services in Canada. Building on this work, he produced a seminal report in 1971–72, commissioned by the Conference of Health Ministers. Dr. Hastings worked on national and international projects. He was the founding Associate Dean of the Division of Community Health within the Faculty of Medicine at the University of Toronto and was instrumental in replacing the diploma programs in community health areas with master’s degrees.

—CPHA *Health Digest*, Vol. 16, No. 3, Autumn 1992

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CPHA Health Digest, 1984

[click to enlarge image](#)

United States as one of the most serious problems plaguing North America in 1982, while depletion of the ozone layer, the greenhouse effect from carbon dioxide in the atmosphere, industrial and agricultural waste, urea-formaldehyde insulation, and air pollution became prominent issues in Canada.<sup>3</sup>

CPHA's membership called for a unified effort to establish "realistic standards for environmental control" with enforceable regulations, more in-depth environmental research programs and better information for the public about government environmental regulations. The *Canadian Journal of Public Health* expanded its coverage of environmental issues, such as lead and asbestos contamination, DDT and pesticide residues, and federal risk assessments of environmental health. CPHA also co-sponsored the First National Conference on Recreational Water Quality and Human Health in 1983 with the Health Protection Branch of the Department of National Health and Welfare and subsequently conducted a comprehensive study on the status of Great Lakes drinking water for the federal government.<sup>4</sup>

### Motor Vehicle Safety

In addition to the impact of emissions, governments began regulating to improve the safety of automobiles. The 1971 *Motor Vehicle Safety Act*, modelled on a similar American act, was the first Canadian legislation aimed at reducing road injuries and death. Transport Canada required seat belts in all new motor vehicles in the early 1970s and other North American safety standards significantly changed vehicle design with remarkable results. More than 6,000 Canadians were dying in car crashes every year in the 1970s—a rate that has since been reduced by almost 50%, even though there are more drivers and cars on the road



### Monique Bégin

*Introduced the Canada Health Act*

The Hon. Monique Bégin was born in Rome, Italy in 1936. Early in her career she distinguished herself as the executive secretary-general of the Royal Commission on the Status of Women that was published in 1970. A sociologist by training, she was elected to the House of Commons in Ottawa in 1972 and served as Minister of Health and Welfare from 1977 to 1984, when she twice increased the Guaranteed Income Supplement for pensioners in need; sponsored the Child Tax Credit legislation; strengthened Medicare through the *Canada Health Act* of 1984; initiated reforms of private pensions; obtained significant increases for medical research; and sponsored a policy of Indian health services devolution and created the Indian and Inuit Health Career Development Program.

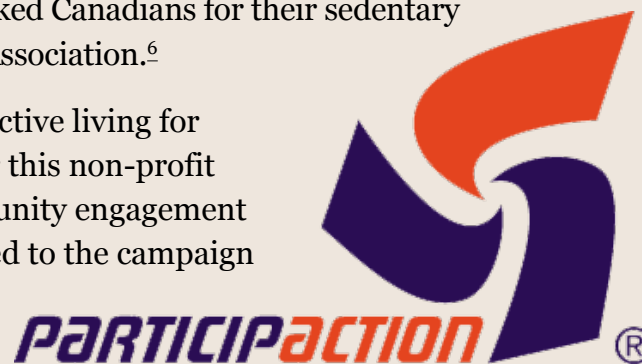
—[http://www.phac-aspc.gc.ca/media/nr-rp/2004/2004\\_01bk3-eng.php](http://www.phac-aspc.gc.ca/media/nr-rp/2004/2004_01bk3-eng.php)

today. In 1976, Ontario became the first Canadian province to make the use of seatbelts mandatory and eventually the other provinces and territories followed suit. Public education campaigns promoting seatbelt use were also a significant component of what has come to be known as social marketing. Campaigns against drunk driving also grew in the 1970s and 1980s. Police were given the ability to demand a breath sample on a roadside screening device when they have grounds to suspect alcohol in the driver's body and provincial anti drinking and driving groups started forming in the 1980s.<sup>5</sup>

### Physical Activity

Promoting health through physical activity was a social marketing success story in Canada during this period. Historically, government interest in promoting physical fitness was motivated by military interests. In 1909, the federal government provided funds to the provinces through the Strathcona Trust Fund for incorporating physical activity programs into cadet training programs in schools and the 1943 *National Physical Fitness Act* was enacted in response to the poor health status of military recruits and provided grants to the provinces to support local health education initiatives. The first indication of broader governmental interest was *An Act to Promote Fitness and Amateur Sport Act*, enacted in 1961 after Prince Philip, during a visit from Britain in 1959, rebuked Canadians for their sedentary lifestyles in a speech to the Canadian Medical Association.<sup>6</sup>

ParticipACTION was established to promote active living for Canadians in 1971 with federal seed money for this non-profit social marketing pioneer. Emphasizing community engagement and fun, extensive media exposure was donated to the campaign and corporate partners matched or exceeded government contributions. The federal



### Russ Kisby

*Health Promotion through ParticipACTION*

Russ Kisby gave sustained and distinguished service to health promotion and public health through 20 years of leadership in ParticipACTION, an innovative health promotion initiative. Mr. Kisby initiated the CrownLife ParticipACTION Challenge, the biggest community participation event in Canada and shared his expertise in health promotion and social marketing with over 150 professional and community groups. He was born in rural Saskatchewan and studied physical education at the University of Saskatchewan. He was the National Physical Education Director for the YMCAs of Canada before joining ParticipACTION the year it began.

—CPHA *Health Digest*, Vol. 15, No. 3, Autumn 1991

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CPHA Health Digest, 1981

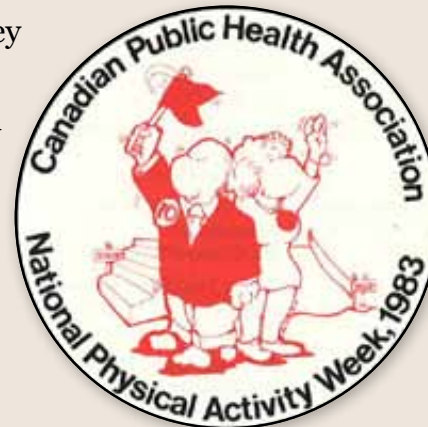
government would continue to fund ParticipACTION for the next 29 years, making it the longest running national-level public health marketing campaign anywhere in the world. ParticipACTION was a remarkably successful national campaign and the comparison of the fitness level of a 30-year-old Canadian with a 60-year-old Swede resonated with many.<sup>7</sup>

A National Conference on Fitness and Health was held in 1972 and in 1976, a FIT-KIT was introduced with a self-administered Canadian Home Fitness Test and distributed nationally by CPHA. The *Canadian Journal of Public Health* published results of a growing body of research on the health benefits of physical activity and workplace fitness programs as part of a broader public health initiative in occupational health protection. The National Nutrition Survey conducted between 1970 and 1972 also identified inactivity as a health threat to Canadians. The survey looked at the prevalence of nutritional diseases and food consumption patterns and reflected an evolution in Canadian health information collection using telephone surveys to gather information on health care utilization, health status and a wide range of health determinants.

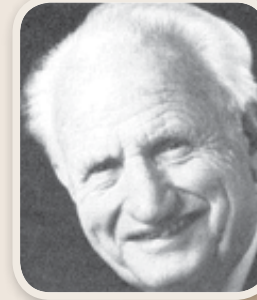
The 1978–79 Canada Health Survey collected data on lifestyle habits and physical activity and although funding cuts prevented the survey from continuing beyond one year, this survey would influence many that followed. In 1981, CPHA was involved in the Canada Fitness Survey to study physical recreation habits, physical fitness and health status and the Association established a Fitness Secretariat, sponsored by Fitness Canada.

 [click to enlarge image](#)

*National Physical Activity Week, 1983*



CPHA Health Digest, 1983



### Cortlandt J.G. Mackenzie

*Expert in Community Medicine and Environmental Pollution*

Dr. Cortlandt John Gordon Mackenzie was one of the guiding forces in the Family Planning Association in British Columbia and served as its president and medical consultant. He also was Director and Vice-President of the Family Planning Federation of Canada from 1970–1974. Dr. Mackenzie played an active role in environmental health issues in British Columbia and elsewhere. He was a member of BC's pollution control board from 1967 and its chairman from 1977 to 1982. His expertise in environmental pollution was recognized by the Canadian Public Health Association when he was asked to head up the Task Force on Arsenic in Yellowknife in 1977.

—CPHA Health Digest, Vol. 10, No. 2, August 1986

## People with Disabilities

Canada's interest in fitness was coupled with a new focus on challenges of the disabled. In 1981, a Special Parliamentary Committee on the Disabled and Handicapped published a report recommending that the federal government direct Statistics Canada to develop a long-term strategy for collecting information on disabled persons in Canada. As a result, the Canadian Health and Disabilities Survey was conducted in 1983–84 to determine the nature, cause and impact of disabilities in the population.

The World Health Organization (WHO) designated 1981 as the International Year of the Disabled—one year after 21-year-old Terry Fox launched a cross-Canada Marathon of Hope in 1980 in support of cancer research, having lost a leg to the disease. International designations and slogans defined this period and played “an essential role in shaping attitudes, defining government priorities and providing the umbrellas essential or individuals to channel their resources.”<sup>8</sup>

## Chronic Disease

Cancer was a growing public health concern in the 1970s and 1980s, because the incidence of various types was increasing as Canadians lived longer on average. The Canadian Cancer Society launched a focused campaign to promote breast self-examination in the mid-1970s and full-page advertisements ran in the *Canadian Journal of Public Health* illustrating how women should do self-exams. The Canadian Cancer Society also sponsored clinics through local health units and nurses associations, where women were taught how to look for signs of breast cancer. These clinics were popular, but there were concerns about low rates of women who did the exams, whether they were being done properly and frequently enough, and whether physicians were sufficiently involved.<sup>9</sup>

### Elizabeth MacKinnon Lambie

*National Leader in Nutrition*

Ms. Elizabeth MacKinnon Lambie was a national leader in public health nutrition who significantly influenced public health policy and programming in Canada. Throughout her professional career as a public health worker and nutrition educator, her commitment to nutrition and public health was said to have been exemplary. She became the first public health nutritionist for the Department of Health and Welfare in Halifax and worked for the Province of Nova Scotia as a public health nutritionist in addition to teaching nutrition in the Faculty of Medicine and the School of Nursing at Dalhousie University. She taught courses on human nutrition, the role of nutrition in health promotion and community development, and the economic, social and physical determinants of eating practices.

—CPHA *Health Digest*, Vol. 21, No.2, Summer 1997

## A Stronger Stand

CPHA's membership adopted stronger positions on a number of policy statements, including calling for abortion to be removed from the *Criminal Code*. Articles in the *Canadian Journal of Public Health* argued for more equitable access to family planning services, while the number of reported abortions, which had been legalized within strict limits imposed by hospital committees, increased from 542 in 1969, to 11,152 in 1970, and 39,500 in 1972. In 1973, Dr. Henry Morgentaler was acquitted of performing illegal abortions, the first in a number of unsuccessful criminal prosecutions in this era which continued until the Supreme Court of Canada ruled that existing legislation against abortion was unconstitutional in 1988.<sup>10</sup>

In 1971, CPHA president Geneva Lewis explained that the Association was striving to become “involved with the complete spectrum of matters concerned with the health of the public and seeking a more active role in political processes,” while promising “a reorientation of thinking.” CPHA's Public Health Practices Committee was also determined to “wade into the battle for a larger share of the budget armed with facts and figures and an ability to talk to the planners and politicians in their own language.”<sup>11</sup>

A 1972 proposal for a new name for CPHA was referred to a committee for further study as some members thought a new name, such as the “Canadian Association for Health,” would encourage more people to become members. Some CPHA members felt the Association should become less of a professional organization, but the idea and new name did not receive a majority vote and the provincial associations expressed little enthusiasm for dropping “public health” from their names.<sup>12</sup>

CPHA moved its office from Toronto to Ottawa in 1973 in order to strengthen its national voice, influence policy and work in partnership with other national and international



### Len Hiebert

*Dedicated Sanitarian and Editor of Environmental Health Review*

Born in Winkler, Manitoba and raised in Alberta, Jacob Lenard Hiebert received

his Certificate in Sanitary Inspection No. 359 in 1945 and began a long and dedicated career in public health. Mr. Hiebert believed sanitary inspection was a 24-hour-a-day profession and his motto was, “We’ll keep you healthy if it kills you.” He served as a Chief Inspector in several communities in BC and was very active in the BC Branch of the Canadian Institute of Sanitary Inspectors. In 1971, Mr. Hiebert became editor of CIPHI's national publication, then titled *The Canadian Sanitarian*, which he professionalized, developed and expanded and, with great foresight, recommended it be re-named as *Environmental Health Review*, over which he became a veritable “one-man army.”

—Tim Roark, Historian, Canadian Institute of Public Health Inspectors, 2009



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organizations and agencies. Dr. Andrew Sherrington became the new editor of the *Journal* and **Gerald H. Dafoe** became the Association's new Executive Director. Dafoe held a Masters of Health Administration, was qualified as a public health inspector and had been previously employed by the Ontario Ministry of Health and the Association would see enormous development and growth during his 30 years of executive leadership.

**The Lalonde Report**

*A New Perspective on the Health of Canadians* was introduced in the House of Commons on May 1, 1974 by Minister of National Health and Welfare Marc Lalonde. This working paper was developed by a free-wheeling policy unit set up in 1971 within the Department of National Health and Welfare under the leadership of Hubert Laframboise. Initially, the report garnered limited attention and mixed reactions in Canada, but it had an immediate impact internationally, where its balanced approach to analyzing major health problems and getting at their root causes generated much discussion. The report described the Health Field concept, an analytical tool in which human biology, the environment and lifestyle were considered significant to health, as well as the health care system. The U.S., Britain and Sweden used the Health Field tool to assess their health systems and develop broader health promotion approaches.<sup>13</sup>

The Department of National Health and Welfare created a new Health Promotion Directorate in 1978, headed by **Ron Draper**, which developed health policy and programs that emphasized individual behavioural change as the most effective strategy for improving health. CPHA, with a renewed sense of purpose and relevance, worked constructively with the Directorate and other federal departments to develop

**Gerry Dafoe**

*Over 30 Years of Vision and CPHA Leadership*

Gerry Dafoe served as the Chief Executive Officer of the Canadian Public Health Association from 1973 to 2003, and was Managing Editor of the *Canadian Journal of Public Health* and the *CPHA Health Digest*. Over the course of his 30 years of leadership, CPHA grew into a nationally and internationally regarded non-governmental organization, highly respected for its contributions to the field of public health. CPHA implemented hundreds of projects during his tenure in areas such as environmental health, fitness and lifestyle, nutrition, AIDS education and awareness, literacy and health, educational resources about prescription and non-prescription drugs, Aboriginal health programs, health reform, child health, immunization education, and human resource planning. CPHA was also very active in research and policy development. After leaving CPHA, Mr. Dafoe was an advisor with the Pan American Health Organization on the Millennium Development Goals.

—*CPHA Health Digest*, Vol. 28, No. 2,  
Summer 2004

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priorities and programs in order to reduce the health risks of Canadians. The Lalonde Report resulted in a broader approach to public health and gave health promotion a stronger focus, although some felt that the focus on personal responsibility for lifestyle choices tended to “blame the victim” and ignore the social, economic and political contexts in which individual behaviours.<sup>14</sup>

The death of **Robert D. Defries** in 1975 marked the end of an era and his key legacy, the School of **Hygiene** at the University of Toronto, closed its doors on June 30, 1975 and re-opened the next day as the Division of Community Medicine in the Faculty of Medicine. A *Canadian Journal of Public Health* report said the new division “represents the culmination of several years of careful consideration of community needs, present and future, of the resources required to fulfill these needs and of the most effective organizational structures to harness and utilize the resources of the University of Toronto to meet these needs.”<sup>15</sup>

Lowering health care costs by shifting attention to health promotion did not prove to be an easy task, however, and in 1976, CPHA President Kenneth Benson warned that, “we are still involved—just as much today as we were years ago—in a nonsensical approach, spending millions in the treatment of preventable disease while continuing to acknowledge (but ignore) prevention *per se*.” The costs of poor nutrition, occupational hazards, inadequate maternal and child care and preventable injuries were “mind-boggling” and Benson identified the need for a larger, more diversified CPHA membership and closer links to the private sector and consumers and a stronger advocacy role, both provincially and federally.<sup>16</sup>

**M. Josephine Flaherty**

*Strong Nursing Leadership  
and an Inspiration to Nurses  
Across Canada*

Dr. M. Josephine Flaherty was born in Toronto and early in her career worked as the Nurse-in-Charge of an isolated Red Cross outpost in the north, where she was involved in generalized community health, school nursing, care of patients and families in the home, and occupational health care in several mines and bush camps. When she returned to Toronto, she worked for several years as a General Staff Nurse and a research assistant at St. Michael’s Hospital, and then as Dean of Nursing at the University of Western Ontario. In 1977, Dr. Flaherty was appointed Principal Nursing Officer for Health and Welfare Canada. She wrote extensively on nursing, health care, ethics and education, and co-authored *Nursing Ethics—Theories and Pragmatics*. Dr. Flaherty was an inspiration to nurses in general and public health nurses in particular in all parts of Canada.

—CPHA Health Digest, Vol. 6, No. 2,  
April 1982

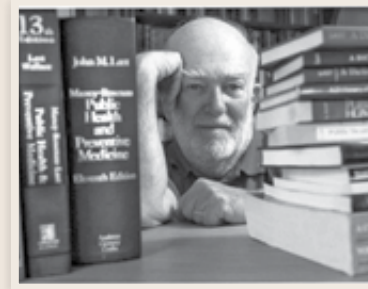
## Expanding Interests

From about the 1970s onward, an increasing number of graduate programs in public health were established in many Canadian universities. These provide advanced training in public health sciences and practice to Masters and in some cases doctoral level. Most are associated with faculties of medicine and/or nursing, a few are free-standing programs.

As CPHA continued to grow, the Northwest Territories Branch of the Association was created in 1976, providing CPHA “with a voice on health matters in the Canadian North.” CPHA’s membership had identified the need to encourage and support the involvement of Aboriginal people in CPHA activities.

The Association also expanded its publishing activities with research monographs, special supplements of the *Canadian Journal of Public Health* and launching a new quarterly newsletter. Dr. **John M. Last** was appointed editor of the Journal in 1981 and brought a broad international perspective, experience in epidemiology and community medicine and an ability to spark lively debate. The quality and number articles submitted grew steadily, while Last wrote most of the lead editorials, including one that decried, “the intolerable situation of ill-health among the Aboriginal peoples of Canada.” Last noted, “the nature of papers about Native health has subtly changed; now we clearly recognize the need for empowerment and local autonomy for communities, replacing the paternalistic outlook that was characteristic of earlier eras.”<sup>17</sup>

A stronger voice for Aboriginal peoples was reflected in the outcome of a commission led by Justice Thomas Berger in the mid-1970s to examine the effects of a proposed oil and gas pipeline in the Northwest Territories. After concerted



### John M. Last

*Professor of Epidemiology and Community Medicine*

Born in Australia, Dr. John

Last graduated from the University of Adelaide medical school in 1949. He held academic position at the Universities of Sydney, Australia, Vermont, USA, and Edinburgh, Scotland and as professor of epidemiology and community medicine at the University of Ottawa. He has authored or edited numerous books, articles, and reports for domestic and international agencies. He was the scientific editor of the *Canadian Journal of Public Health*, 1981–1991, editor of the *Annals of the Royal College of Physicians and Surgeons of Canada* 1990–1998, and interim editor of the *American Journal of Preventive Medicine* in 1988–89. He is the author of *Public Health and Human Ecology* and a *Dictionary of Public Health* and editor of four editions of the *Dictionary of Epidemiology*, which is used by epidemiologists throughout the world. Dr. Last led the initiative of the International Epidemiological Association to develop guidelines on ethical conduct of epidemiological research, practice, and teaching.

—CPHA Health Digest, Vol. 30, No. 2, Summer 2006

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lobbying by Aboriginal leaders concerned about both the environment and the infringement on their land rights, the pipeline was never built. Indigenous rights were also strengthened with the 1982 *Constitution Act* and the *Canadian Charter of Rights and Freedoms*, which recognized the Métis as a distinct Aboriginal people and restored Indian status to women who had been disenfranchised under the *Indian Act* as a result of marrying non-Aboriginals.

Researchers began approaching public health issues among Indigenous populations through a closer involvement with Indigenous communities, working within their cultural contexts. There were also more broadly-based surveys of infant and childhood nutrition and general health needs and more detailed and long-term assessments of infant and general mortality patterns, especially on reserves. Aboriginal infant mortality rates were more than a third higher than the national rate, and among adults, there were elevated risks for all major forms of accidents and violence, diabetes and pneumonia.<sup>18</sup>

The health conditions of Aboriginal Canadians were often compared with the developing world, although a 1982 *Canadian Journal of Public Health* article questioned this practice. T. Kue Young, Medical Director of the Sioux Lookout Zone of Health and Welfare Canada’s Medical Services Branch, argued that equating “health status and medical care resources in the North with conditions in the Third World is statistically misleading and inaccurate.” Epidemiologically, beginning in the mid-1960s, the northern Aboriginal population had “graduated” from the patterns characteristic of developing countries as the main health challenges shifted from infectious diseases to socio-economic and community health issues related to social disruption and violence linked to alcohol and substance abuse. However, Young cautioned the public health community not “to congratulate ourselves on how well we’ve done in the Canadian North,” noting the need to address the socio-economic disparities that keep the gap between northern and southern Canadians “considerable.”<sup>19</sup>

**Jean Goodwill**

*Canada’s First Aboriginal Nursing Graduate*

Jean Goodwill was a leader in Aboriginal health care. A Plains Cree from Little Pine First Nation

near North Battleford, Saskatchewan, Ms. Goodwill graduated in nursing in Prince Albert and subsequently was employed at the Indian Hospital in Fort Qu’Appelle. She went on to become Nurse in Charge of the La Ronge Nursing Station, which opened her eyes to the health conditions of First Nations people. During her 20 years with the federal government, she was instrumental in developing health and social policies for Aboriginal people. Ms. Goodwill helped found the Aboriginal Nurses Association of Canada in 1975, where she served as President for seven years. As a member of the CPHA Board of Directors, Ms. Goodwill raised the profile of Aboriginal health issues and explored ways in which Aboriginal youth could be encouraged to choose careers in the health field.

—*CPHA Health Digest*, Vol. 24, No. 4, Winter 2000

## Tobacco

A major target for healthy lifestyle choices to reduce death and illness related to cancer, heart disease and stroke was the significant rate of tobacco use among Canadians. School children continued to start smoking despite ongoing health education efforts, but a trend towards earlier smoking seen before 1973 began to reverse. A number of surveys of the attitudes of smokers and the general public done in the late 1970s revealed persistently high rates of smoking, particularly among teenage girls. The non-smoking majority was increasingly irritated by second-hand cigarette smoke and as one survey concluded, it seemed clear that “politicians have been too timid in enacting legislation to control the accumulation of cigarette smoke in public places.”<sup>20</sup>

Many at the CPHA 1977 annual meeting in Vancouver were surprised to hear CPHA President Dr. Kenneth Benson tell the assembled audience after a toast to the Queen, “You may smoke now.” A number of letters to the editor appeared in the *Canadian Journal of Public Health* afterwards, noting the contradiction with CPHA’s anti-smoking activities. Benson explained that his comment was intended as “a gentle reprimand” to those who smoked before the toast but asked, “How far do we go in interfering with lifestyles?” That smoking would be permitted at an annual meeting, not to mention a public health meeting, is surprising today but in the 1970s, many health professionals continued to smoke, while warning others of its dangers. As noted in a 1978 article in the *Canadian Journal of Public Health*, “health professionals have not yet realized their full potential in counteracting this very important and preventable health problem.”<sup>21</sup>



### Jill Christensen

*Nutritionist Developed  
CPHA Branch in NWT*

Jill Christensen graduated with a degree in nutrition from the University of Toronto and began her career in the NWT in 1975 with St. John Ambulance, developing and teaching home nursing in Inuit communities. She became Nutrition and Dietetics Consultant with the Department of Health and Director of Dietetics at the Yellowknife Stanton Hospital, where she developed the NWT Nutrition Guidelines. She coordinated the HIV/AIDS and tobacco public awareness campaigns for the McKenzie Regional Health Services and developed and taught nutrition modules at Arctic College. Ms. Christensen was a founding member of the Northwest Territories Branch of CPHA in 1977 and became President of the Branch in 1979.

—CPHA Health Digest, Vol. 16, No.3,  
Autumn 1992

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Canada was accused of addressing the issue of smoking and health “with timidity,”<sup>22</sup> and subsequently CPHA and the Department of National Health and Welfare co-sponsored a National Seminar on Smoking and Health in 1972, which initiated stronger, sustained leadership in tobacco education initiatives. A growing volume of smoking-related research studies illustrated among others, the harmful effects of second-hand smoke and the impact of smoking by pregnant women on the unborn. Researchers also tried to calculate the cost of smoking for Canada’s health system and the estimated \$5.1 billion in 1979 dollars resulted in pressure for more aggressive legislation responses.<sup>23</sup>

Legislation had been proposed for a total ban on cigarette advertising in 1971 but the tobacco industry agreed to voluntary guidelines on advertising before the legislation was debated in the House of Commons. A number of local governments passed by-laws prohibiting smoking in stores, elevators, and escalators and in service line-ups, while the *Canadian Charter of Rights and Freedoms* increased pressure for the legal protection of non-smokers from tobacco smoke in public areas. The 1985 *Non-Smokers Health Act* prohibited smoking in all federal buildings and workplaces and a series of resolutions passed at the 1986 CPHA annual meeting in Vancouver called for bans on smoking in indoor public places and on tobacco advertising and sponsorship.<sup>24</sup>

Smoking would increasingly be seen as “a form of deviant or abnormal behaviour” and the smoker as an addict for whom “all possible measures should be taken” to assist those who wanted to stop. The many social variables that influenced children to start smoking, such as peer pressure and smoking by others in the home, received greater attention.<sup>25</sup>

**John Blatherwick***Moving Force Behind  
Canada’s First Workplace  
Smoking Ban*

Dr. John Blatherwick was the longest-serving Medical Health Officer in Canada when he retired in 2007. Twenty-three of those years were as Chief Medical Health Officer for Vancouver Coastal Health and the City of Vancouver. He was the moving force behind a number of important programs involving youth, people with disabilities, people living with AIDS, people combating drug addictions, and the move to abolish smoking in the workplace. “Our biggest achievement was bringing in the first non-smoking policy in the workplace in Canada and one of the first in North America. It was revolutionary.” He was named Honorary Chair of the Environmental Health Foundation of Canada, the research arm of the Canadian Institute of Public Health Inspectors.

—CPHA interview, June 2009

## Infectious Diseases

Indifference towards previously terrifying infectious diseases continued to grow and low vaccination levels concerned public health officials. Measles outbreaks in Saskatoon and Calgary in 1974 and 1975 led the *Canadian Journal of Public Health* to call for “a much more vigorous campaign... [so that] parents once again realize that measles can be a dangerous disease” and that vaccination could eliminate it.<sup>26</sup>

On the eve of the 1976 Olympics in Montreal, concerns were raised about the potential importation of infectious diseases. Dr. W. Harding Le Riche, President of CPHA’s Tropical Medicine and International Health Division, said in a *Canadian Journal of Public Health* editorial that any cases of cholera or typhoid occurring among international visitors to Canada could “easily be accommodated and dealt with,” but new and emerging diseases were a threat of unknown proportions. The federal and provincial governments should “stop shilly shallying about what they would do if cases of serious epidemic disease, such as plague, louse typhus, cholera, typhoid in large numbers, or even smallpox, were to be brought into the country.”<sup>27</sup>



Smallpox and Its Eradication (World Health Organization, 1968), p. 439

The world was getting smaller as a result of the increased speed of travel, especially by airplane. Canada and the United States had launched a mass smallpox vaccination campaign in the 1960s after a 14-year-old Canadian boy came home with smallpox contracted in Brazil. The World Health Organization launched a global smallpox eradication initiative in 1967, with substantial American funding and significant Canadian involvement. The success of the initiative was officially declared on May 8, 1980 and the global eradication of smallpox was a considerable public health achievement.<sup>28</sup>



### Stephen J. Corber

*A Leading Force in Global Health Programs*

Dr. Stephen J. Corber has been a practising public health professional for over 30 years, serving as

the Medical Officer of Health for the Ottawa-Carleton Health Department and as Director of Disease Prevention and Control Division for the Pan American Health Organization. This PAHO program provides technical collaboration and expertise for the prevention and control of HIV/AIDS and other sexually transmitted diseases in the Americas. Dr. Corber was instrumental in the creation of CPHA’s Global Health Program. He also served as the Scientific Editor of the *Canadian Journal of Public Health* and most recently he was Director of Public Health Practice at the Faculty of Health Sciences at Simon Fraser University.

—CPHA Health Digest, Vol. No. 2008

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Public attention was raised to the threat of new and emerging infectious diseases after a woman arrived at Toronto International Airport on August 2, 1976 from a European vacation with what was subsequently confirmed by the U.S. Centers for Disease Control as Lassa fever. The incident highlighted Canada's need for more efficient diagnosis, better control of exposure and a designated high-security isolation facilities. Ontario built a Level-4 laboratory at a cost of \$5.8 million but when nearby Toronto

residents protested against it, the lab was never opened and the

province decided this was actually a federal responsibility. It was not until 1999, however, that a federal facility was finally opened, in Winnipeg, Manitoba.<sup>29</sup>

The University of Toronto sold Connaught Laboratories to a federal Crown corporation in 1972, which later privatized it. In 1976, Connaught Laboratories announced that it would no longer incur the financial losses associated with maintaining emergency stockpiles of vaccines and antitoxins, which meant relying on foreign producers of vaccines and other critical medical products during emergency situations.<sup>30</sup>



[click to enlarge image](#)

### A New Strain of Swine Flu

Production problems and the denial of liability insurance coverage to American vaccine producers sparked a political debate in Washington in the summer of 1976. A new strain of Influenza A virus, popularly referred to as swine flu, had caused an outbreak in February 1976 among 273 of the 1,321 army personnel at Fort Dix, New Jersey. Amid fears that this strain was related to the one responsible for the 1918–19 pandemic and that the young and middle-aged had little or no immunity to it, U.S. and Canadian officials launched influenza immunization



### Margaret Hilson

*International Health and Social Justice Crusader*

Margaret Hilson was CPHA's Director of Global

Health Programs for 22 years, starting in 1985 when CPHA established its international health secretariat. Ms. Hilson was instrumental in building public health capacity around the world and served as president of the World Federation of Public Health Associations. She trained as a nurse and went to India with Canadian University Services Overseas when she was in her twenties. "That was really a turning point for me," she says, "being involved in international development issues. When I first went to India, it was very evident that the disparities and the health inequities were not going to be addressed by the curative health model."


—CPHA interview, June 2009



programs. Knowing far enough in advance of widespread influenza circulation to be able to prepare and distribute a vaccine is always a challenge and this provided an opportunity to mount a large-scale pre-emptive strike. U.S. President Gerald Ford approved an unprecedented \$135-million plan in March in order to immunize all 220 million American citizens before November. Canada expedited a more focused program targeted at the chronically ill and people over 65 years of age, as provincial authorities did not support a plan to immunize everyone and the WHO saw no signs of the swine flu strain elsewhere in the world.<sup>31</sup>

The CDC reported on a small increased risk of contracting Guillain-Barré Syndrome after the swine flu vaccine (a link that has since been called into doubt). Most provincial immunization programs were halted after eight people in Ontario were reported to have contracted a mild form of paralysis after receiving the vaccine. The remaining swine flu vaccine was stockpiled and never used and what the media referred to as the “swine flu fiasco” did considerable and long-term damage to the public image of vaccines. In an effort to broadly educate the public about the importance of immunization, the Canadian Paediatric Association launched the first annual Immunization Action Month in October 1977—a campaign similar to those in the 1940s. For U.S. vaccine producers, the challenges of the swine flu experience accelerated a retreat from the industry that had begun in the 1960s.<sup>32</sup>

The early 1980s were a fruitful period for the development of a number of new highly purified vaccines based on new recombinant DNA technology that targeted diseases such as meningitis, hepatitis, typhoid, cholera and malaria. Measles control was of particular concern among the Canadian public health community as outbreaks continued due to low immunity levels among children, often despite receiving a measles vaccine. High rates of measles in Latin America and lapses in Canadian and American measles immunization programs and uptake rates created a dangerous situation, despite a 1978 commitment by the U.S. government to eliminate measles in America by 1982.<sup>33</sup>

 [click to enlarge image](#)

*One of the first and most successful of the new generation DNA recombinant vaccines developed in the 1980s was to prevent *Hemophilus influenzae b**



## Sexually Transmitted Infections (STIs)

In the late 1970s, antibiotic-resistant forms of gonorrhea emerged, prompting a 1979 *Canadian Journal of Public Health* editorial to “ask why our campaigns in the realm of sexually-transmitted diseases have so far yielded relatively little in the way of tangible results....One must admire the evolutionary guile and cunning [of STIs] and their ingenious decision to use the human copulatory act as a mechanism for propagation and survival.” Taboo, superstition and general ignorance persisted with regard to STIs and researchers and public health officials hesitated to tackle STIs in the same way as other communicable diseases. In January 1981, CPHA established a Sexually Transmitted Diseases divisional affiliate and sponsored the First National Conference on Sexually Transmitted Diseases in Toronto in November 1982, becoming a key player in the redefinition and broadening of initiatives surrounding STIs.<sup>34</sup>

AIDS was a topic of discussion at the national conference, as the first confirmed Canadian case was reported in 1982. The media referred to it as the “gay plague” because its primary spread in North America was concentrated among male homosexuals. Of Canada’s 14 known AIDS cases by the time of the conference, none survived more than 20 months. There were over 600 cases reported in the United States in 1982 and rapidly increasing media coverage heightened interest in STIs and generated debates about sex education and providing condoms in schools.

The initial public health response case of AIDS (HIV or Human Immunodeficiency Virus was identified in 1984) was described by CPHA’s Director of the AIDS Education and Awareness Program, David Walters, as “fragmented confusion.” Several key factors constrained the Canadian public health response to HIV/AIDS, including the economic recession, inadequate and sporadic funding by different branches of government, a lack of co-ordination of efforts at the local and voluntary agency level, diffused responsibility



CPHA Health Digest, 1986

 [click to enlarge image](#)

*Health Minister Jake Epp names CPHA the education and awareness partner for a major initiative on AIDS*

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for action, reluctance to act due to the social tensions surrounding homosexuality, and fears of contagion. According to Walters, “there seemed to be no safe ground in talking about homosexuality, condoms and needles at national or provincial levels. This reluctance resulted in foot-dragging and unclear messages about needed commitment to educational programs.”<sup>35</sup>

In 1986, the federal government announced \$6.6 million for AIDS research and education that year and another \$39 million over the next five years. A proportion of this supported a CPHA-led AIDS Education and Awareness Program which allowed the Association to assume a significant leadership role in a national AIDS campaign aimed at the public and health professionals. Scientific and public forums enabled health professionals to meet with the general public and CPHA distributed *Facts on AIDS for the Public* as well as a broad education and awareness media campaign.

CPHA’s central message advocated the use of condoms as the symbol and most readily available means of prevention and it was clear that this would be controversial. With the cooperation of the Canadian Broadcasting Corporation and many independent TV and radio broadcasters, the series of public service announcements aired, triggering open discussions about condom use and safe sex. These issues were off-limits for American television at the time and thus the CPHA campaign “was the first such effort to be carried by a national network in North America.” As John Last later recalled, the AIDS epidemic “transformed what we publish, just as it has transformed social values and behaviour.”<sup>36</sup>

**James Howell**

*Developed Community Medicine  
in Alberta*

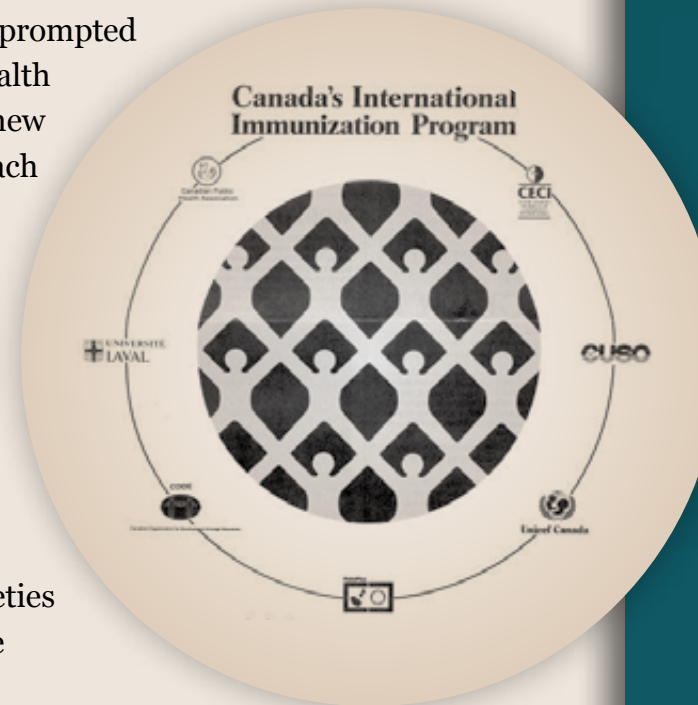
Dr. James Howell was a public health physician, educator and practitioner for more than 30 years. He devoted his life to the promotion and protection of the health of the public and his contribution to public health in Alberta is unparalleled. He wrote extensively on public health and public health issues and as a practitioner oversaw many innovative public health initiatives, such as the establishment of the Boyle McCauley Health Centre in 1979 and programs to address health status inequities, child poverty and strengthening communities. From the beginning, the goal of the Health Centre was to look at the whole person and include that person in decisions about their care.

—CPHA Health Digest, Vol. 18, No. 2, 1994

## Global Issues

International health issues and the global threat of tropical diseases prompted the creation of a Division of Tropical Medicine and International Health in 1972 within CPHA and from this base, CPHA initiated a range of new international health programs, driven by “a multidisciplinary approach where the health team provides the primary health care and where there is a judicious blend of preventive and curative medicine.”<sup>37</sup>

In the late 1970s and early 1980s, the federal government responded to challenges from WHO and UNICEF and strengthened its investment in international health initiatives and dispersed funds through the Canadian International Development Agency to more than 20 Canadian NGOs including CPHA, which took a leadership role and proceeded on several fronts. In 1978, CPHA embarked on a project to build capacity of public health societies and associations in Africa, South and Central America and, after the collapse of the Soviet Union, in Eastern Europe. The onset of the global pandemic of HIV/AIDS gave this initiative new impetus with the development of education and awareness programs about AIDS and HIV infection. These programs, originally based in Harare, Zimbabwe, later moved to a more stable base in Johannesburg where training programs were established. Largely through CPHA and a number of individual Canadian health workers, an international immunization program against all vaccine-preventable diseases in developing Commonwealth and Francophone nations was launched in 1986, in partnership with WHO, UNICEF, and a consortium of Canadian NGOs.



CPHA Health Digest, 1986

[click to enlarge image](#)

*The theme of Canada's International Immunization Program was "A Miracle in the Making." The Canadian International Development Agency chose CPHA to implement the program.*

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It had become clear to the WHO that improving health in the developing world through the extension of western-style medicine was not working. The emphasis on doctors, hospitals and technology and under-emphasis on prevention had little to offer the Third World, where three billion people had no access to any permanent form of health care. As a *Canadian Medical Association Journal* report on the health problems of developing nations noted, “In some ways, Western medicine had actually been counterproductive by setting up models that encouraged some underdeveloped nations to misuse what meagre health-care funds they had.” The fundamental challenges were clean water and effective sewage systems and an estimated 5 million deaths and 10 million disabilities occurred each year among children due to diphtheria, pertussis, tetanus, polio, measles and tuberculosis.<sup>38</sup>

The World Federation of Public Health Associations (WFPHA) was formed in the 1960s by the national public health associations of India, Japan, New Zealand, Pakistan, the United Kingdom, the United States and Venezuela and had grown to 28 of 58 existing national public health associations by 1978. CPHA joined WFPHA in the early 1970s and Executive Director Gerry Dafoe and Journal Editor Andrew Sherrington served on its executive for a number of years in the 1970s. CPHA hosted WFPHA’s second international conference in Halifax in 1978 and attendance totalled 1,100 delegates from 30 countries, due in part to funding from the Canadian International Development Agency, WHO, and UNICEF. CPHA also received significant funding in 1985 from the Canadian International Development Agency (CIDA) for three years of block funding to support international activities.

**Sharon Martin**

*Promoted a Community Model of Public Health*

Sharon Martin was influential on the BC steering committee

that started “Healthy Community” activities in the mid-1980s and in her position with the Vancouver Health Department, helped shift the focus of programs to community development and healthy communities models, strongly promoting the involvement of community members and volunteers in public health programs for program delivery. Ms. Martin chaired the Working Group on Health Services Restructuring which developed CPHA’s position paper on health reform.

—CPHA *Health Digest*, Vol. 20, No. 2, Summer 1996

## Primary Health Care—Health for All by 2000

The Halifax conference focused on primary health care—a concept that emerged in the early 1970s to describe “a complex process involving a basic level of services with a broad health orientation and provided by a variety of health professionals who offer some form of continuity of care.” A follow-up WHO International Conference on Primary Health Care in Alma-Ata, Russia in 1978 aimed to re-orient health care in the developing world towards primary health care, with “appropriate levels of technology within the scope and budget of a country to make such care available to most of the people, especially those in the rural areas.” Primary health care was seen as “basic essential care made universally accessible to individuals and families in the community by means acceptable to them through their full participation and at a cost that the community and country can afford.” The Conference produced the Declaration of Alma-Ata, which the WHO deemed valid for all countries, adopting it as a global strategy two years later for governments, health and development workers. The world community then committed to work towards *Health for All by 2000*.<sup>39</sup>

## The New Public Health

The public health focus on lifestyles broadened considerably to encompass the social determinants of health in the early 1980s, after the publication of Thomas McKeown’s *The Role of Medicine*, which argued that medical care had little to do with the improvements in life expectancy observed in Britain over the last 100 years. In 1981, Ilona Kickbusch and Robert Anderson of the World Health Organization’s European Health Education Unit undertook a study tour in Canada—then considered “the world’s Mecca for health promotion.” The Department of National Health and Welfare was working towards initiating a ground-breaking Health Promotion Survey in 1985, to gather information about the lifestyle behaviours and preventive health practices of Canadians, including alcohol and tobacco consumption, exercise, safety and nutrition.<sup>40</sup>



### Trevor Hancock

*Health Public Policy and Healthy Communities Visionary*

Trained as a family physician in Britain, Dr. Trevor Hancock practised

medicine in Canada for four years before beginning his career in public health. As a public health consultant, he has written and presented around the world on health promotion, sustainable development and healthy futures. Dr. Hancock developed the “mandala of health” model of health determinants with Fran Perkins and promoted the concept of sustainable development by organizing a conference on health and the economy. He was leader of the Green Party of Canada from 1983 to 1985. Dr. Hancock has written extensively on health futurism and was a founding member of Paradigm Health, a Toronto-based health futures think-tank.

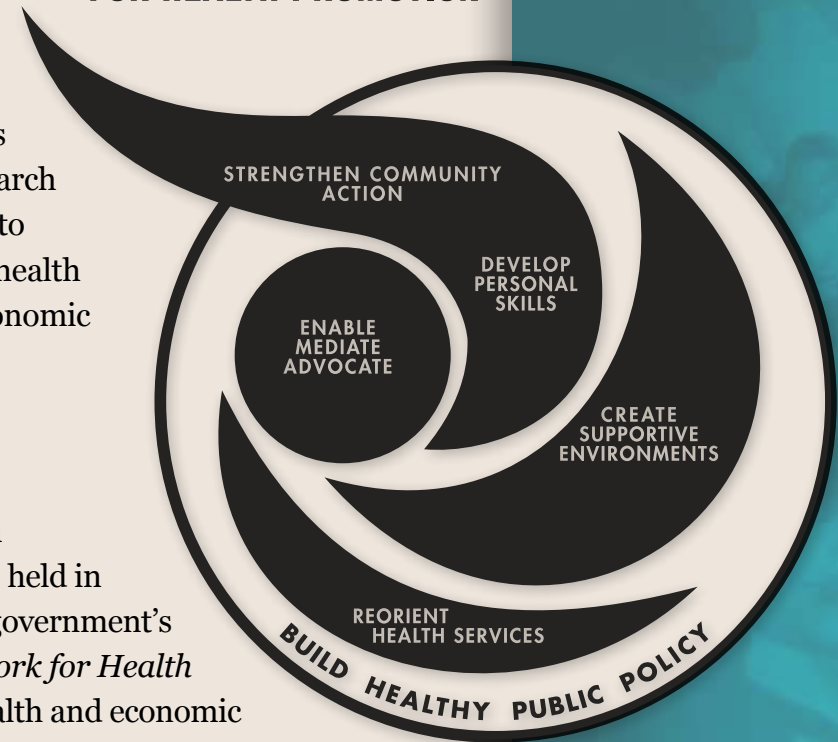
—CPHA *Health Digest*, Vol. 14, No. 3, September 1990

Kickbusch and Anderson were interested Canadian health education initiatives like PARTICIPaction and they attended Beyond Health Care, the first conference on healthy public policy, which was held in Toronto in October 1984. Beyond Health Care was organized by public health practitioner and theorist, Dr. **Trevor Hancock**, and sponsored by CPHA, by the Health Promotion Directorate of Health and Welfare Canada to mark the 10-year anniversary of the Lalonde Report, by Toronto Public Health to mark its centenary, and by the City of Toronto to mark its 150<sup>th</sup> anniversary. The conference helped develop health promotion's emphasis on community-based health planning and participatory action research and launched the concept of healthy public policy. It also inspired Kickbusch to go on to develop WHO Europe's Healthy Cities movement, which focuses on health inequalities, urban poverty, the needs of vulnerable groups and the social, economic and environmental determinants of health.<sup>41</sup>

### Health Promotion: The Epp Report and the Ottawa Charter

In November 1986, Health and Welfare Canada joined the WHO and CPHA in organizing the first International Conference on Health Promotion, which was held in Ottawa. The Minister of Health and Welfare, Jake Epp, presented the federal government's new perspective on health promotion in *Achieving Health For All: A Framework for Health Promotion* (the Epp Report). It emphasized the clear relationship between health and economic status and that "health promotion implies a commitment to dealing with the challenges of reducing inequities, extending the scope of prevention, and helping people to cope with their circumstances. It means fostering public participation, strengthening community health services and coordinating healthy public policy. Moreover, it means creating environments conducive to health, in which people are better able to take care of themselves, and to offer each other support in solving and managing collective health problems."<sup>42</sup>

### OTTAWA CHARTER FOR FOR HEALTH PROMOTION

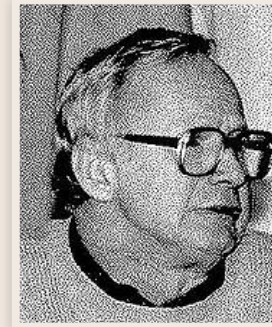


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The Health Promotion conference brought together 212 invitees from 38 countries, including health and public health, governmental, academic and community representatives. Their goal was to build a framework, which became known as the Ottawa Charter for Health Promotion. The framework provides fundamental strategies for major progress in health promotion worldwide.

The Ottawa Charter's framework for health promotion involves enabling people to increase control over their health, a process in which individuals, communities, health professionals and institutions, and governments all have a role. It recognizes that health cannot be separated from people's daily reality and the social and economic determinants of health, such as access to money, power and esteem. Researchers are still examining how these factors affect the health of individuals and groups and how social facts may become biological facts. The public health reformers who fought for sewers and sanitation, nutrition, injury prevention and family planning remain at the roots of Canada's health promotion movement.<sup>43</sup>

**Ron Adrian Draper**

*Major Contributions to the Art and Science of Health Promotion*

Ron Draper was the force behind the First International Conference

on Health Promotion, held in Canada in 1986 and which resulted in the Ottawa Charter for Health Promotion. The first Director General of Health Canada's Health Promotion Directorate, he was the major factor in bringing Canada to a position of world leadership in this field and, indeed, in establishing the whole concept and practice of health promotion globally.

—Trevor Hancock, Health Promotion International, 1998