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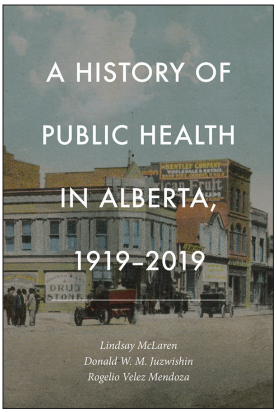

A HISTORY OF PUBLIC HEALTH IN ALBERTA, 1919–2019

Lindsay McLaren, Donald W. M. Juzwishin, and Rogelio Velez Mendoza

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Health Promotion and the Ottawa Charter in Alberta: A Focus on Maternal and Child Health

Temitayo Famuyide, Benjamin Sasges, and Rogelio Velez Mendoza

> *"It shall be the duty of the department . . . to disseminate information in such manner and form as may be found best adapted to promote health and to prevent and suppress disease."*
>
> — An Act respecting the Department of Public Health, 1919

Introduction

Initiatives such as educating new mothers in rural areas on how to care for their babies, enacting legislation to reduce financial pressures for new parents, and providing health-promoting resources at school theoretically follow the principle of enabling people to have control over their health. Health and well-being are facilitated if supportive knowledge, skills, resources, and settings are in place that permit people to achieve their needs and aspirations throughout their lifespan. The creation of these conditions is the essence of health promotion.

In this chapter, we illustrate how health promotion principles have played out over the course of Alberta's public health history, using the Ottawa Charter

for Health Promotion as a framework. Although the strategies and action areas of health promotion as articulated in the charter are contemporary notions, we argue that their essence was apparent much earlier. By using a contemporary framework such as the Ottawa Charter to shed light on history, we can explore how health promotion principles intersect with the socio-historical context.

We begin the chapter with an overview of the Ottawa Charter for Health Promotion — including some key points of critique — and a brief historical overview of health promotion's evolution within the Alberta government. Anchored in that overview, the rest of the chapter is devoted to three case examples that we believe illustrate health promotion principles over the past one hundred years. The examples are united by a focus on the mother/child dyad, which is one of many focal areas that we could have chosen.[1] Our three examples from Alberta's history are: i) preventive health services for mothers and children aimed at reducing infant and maternal mortality, where the health promotion action areas of developing personal skills and reorienting health services were apparent; ii) the introduction of maternity and parental leave legislation and mother's allowances, as examples of building healthy public policy; and iii) school health promotion, focusing on health inspections, vaccination efforts, and shifts in the provincial junior high health curriculum, which we examine through the lens of developing personal skills and building healthy public policy from the perspective of children. In this third example, we also note the significant, albeit historically more recent, trend toward comprehensive school health.[2]

We conclude that, first, although principles of health promotion are apparent in activities to improve maternal/child health prior to the creation of the Ottawa Charter, such efforts incrementally became more encompassing, including efforts to incorporate social determinants of health, after the creation of the charter, suggesting that the charter had some impact, at least symbolically. For example, Alberta lawmakers did not initially make a connection between mothers' allowances and parental leaves on the one hand, and health benefits on the other, but eventually used that connection to justify them. A second key conclusion is that schools in settler-colonial settings have long acted as primary settings for health promotion, and they continue to do so.

Health Promotion and the Ottawa Charter

The Ottawa Charter for Health Promotion has served as a foundation for individual-, community-, sector/system- and societal-level approaches to improving health and well-being for over thirty-five years.[3] Adopted in 1986 by a group of health professionals and representatives of governmental, voluntary, and community organizations from thirty-eight countries, the charter aimed to situate

health as a product of daily life, which it described as follows: "to reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is therefore, seen as a resource for everyday life, not the objective of living."[4]

The charter proposed core values and principles and outlined strategies and action areas that went beyond the traditional boundaries of the health care sector and treatment-oriented practices at that time.[5] The strategies for promoting health are i) advocacy, toward making political, economic, social, cultural, environmental, and behavioural conditions favourable for all citizens; ii) mediation, or coordinating between differing interests in society such as government (including health and other sectors), non-governmental and voluntary organizations, and industry; and iii) enabling, or reducing differences in health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential.[6] The action areas are:

- Build healthy public policy, which requires policy-makers to be aware of the health consequences of their decisions;
- Create supportive environments by generating safe, stimulating, and enjoyable living and working conditions;
- Strengthen community actions, which involves enhancing social support, and developing systems for strengthening public participation in health matters;
- Develop personal skills, by providing information and education for health, and enhancing life skills; and
- Reorient health services, by moving the health sector beyond curative services and respecting difference in cultural needs.

Although the contemporary notion of *health promotion* is commonly traced to the publication of the Ottawa Charter in 1986, three prior documents inspired the charter.[7] As discussed by researchers Potvin and Jones, the first is the preamble of the 1946 World Health Organization constitution, which contains a positive definition of health where health is not merely the absence of disease, but rather a complete state of physical, mental, and social well-being.[8] Second is *A New Perspective on the Health of Canadians* (better known as the Lalonde Report) of 1974, which was notable for, among other things, the *health field* concept, which recognized determinants of health outside of the health care system, stating that "future improvements in the level of health of Canadians lie mainly in improving the environment, moderating self-imposed risks and adding to our knowledge of human biology."[9] Finally, the Alma Ata Declaration, adopted at

the 1978 International Conference on Primary Health Care, called for health as a human right and a responsibility of every nation; the declaration asserted that health is achieved by involving concerned populations and coordination among different sectors.[10]

The first International Conference on Health Promotion, held in Ottawa in November 1986, signified growing expectations for a new public health movement around the world.[11] At the time, some members of the public health community saw the field as overly reliant on a medical model and oriented toward infectious diseases and not going far enough in terms of environmental, social, and economic challenges.[12] Conceived now as an agenda-setting document, the charter took ideas from inside and outside of the health sector and transformed them into a set of possible actions. In essence, it provided a framework for public health communities to seek alliances with other sectors.[13]

Importantly, health promotion and the Ottawa Charter are not without critique. First, it is well recognized that, despite the charter's acknowledgement of equity as a prerequisite for health,[14] health promotion has tended to overemphasize individual health behaviours and the mechanisms that enable healthy choices.[15] Such behaviourally oriented health promotion strategies concentrate efforts on reducing health risks via behaviour change such as smoking and physical activity to improve health status. However, these efforts, when applied at the population level, are shown to be minimally effective in reducing social inequities as the root causes of poor health and well-being.[16]

A second major critique of the charter concerns its embedded systems of power and privilege, which can be seen through a critical analysis of the context of its development. For example, despite the charter's positioning as globally relevant and committed to "Health for All," the charter's core authors did not reflect global representation.[17] With primary authorship from Europe and Canada and lack of representation from non-western countries, the charter's development and some of its content reflect global inequities of power and privilege.[18] Using Canada as an example, the colonial causes of inequities among Indigenous Peoples (rooted in legacies of racism and white supremacy), along with the immense significance of Indigenous world views around health and ways of knowing, were largely ignored in the Canadian contribution to the charter.[19] Notably, more recent efforts are working to try to redress these earlier failures.[20]

Government Health Promotion in Contemporary Alberta

In Alberta, health promotion efforts have taken different forms, which have varied in the extent of their alignment with Ottawa Charter principles. From a government administration point of view, in 1981, the provincial department responsible

for public health created a Health Promotion and Protection Directorate comprising six programs, which gives some insight into what health promotion was (narrowly) understood to entail at that time in government: community health nursing, environmental health, nutrition, dental services, family planning, and health promotion/lifestyle programs.[21] Following the 1986 release of the Ottawa Charter, Alberta's health units, which formed the health services delivery infrastructure in the province until the mid-1990s, shifted their language to adopt health promotion tenets. Importantly, however, as argued by Nancy Kotani and Ann Goldblatt, and consistent with broader critiques of health promotion noted above, in reality the health units remained focused on educational campaigns designed to modify risk behaviours in individuals.[22]

In 1989, the Premier's Commission on the Future of Health Care in Alberta published their final report, The Rainbow Report: Our Vision for Health (The Rainbow Report), which presented a conceptual vision for health in Alberta. The Rainbow Report appeared to embrace the notion of health promotion, but once again it reduced the concept to a rather narrow focus on health education and lifestyle changes, leaving aside the other actions areas outlined in the Ottawa Charter, such as those that focused on strengthening environments and empowering communities.[23] Moreover, and consistent with equity-related critiques of health promotion noted earlier in this chapter, although the rainbow as a symbol of LGBTQ2S+ pride and allyship dates to 1978, the use of rainbow in this 1989 report does not appear to embrace that allyship, but rather speaks to optimism and diversity more generically.[24]

In 1990, the provincial Health Promotion Directorate was renamed the Health Promotion Branch and was included under the Public Health Division of the Department of Health.[25] The branch disappeared in name during the department's restructuring in the mid-1990s, but health promotion activities in the province continued.[26] Notably, one of the main goals for the provincial Department of Health (1988–1999) and then Health and Wellness (1999–2012) was to "improve the health and wellness of Albertans through provincial strategies for protection, *promotion* and prevention" (italics added).[27] Importantly, however, and as discussed in chapters 2 and 4, that language during that time period in particular reflected an ideological orientation that was highly contrary to a broad version of public health because it focused on individual responsibility for health as a way to save money in the health care system. When the department was renamed Alberta Health in 2012, Public Health and Wellness was included as a division within health services, and after the NDP election victory of 2015, the department was reorganized once again to include a Health and Wellness Promotion Division within Public Health and Compliance.[28] At least

in the general structure of the department, the public health administration, including health promotion, seems to have moved up one administrative level during the NDP government period, perhaps (pending future critical analysis with the benefit of hindsight) speaking to health promotion's importance from the point of view of that government.

Focal Area: Maternal and Child Health

We next describe three examples of health promotion strategies across Alberta's history in our focal area of maternal/child health. We define maternal health as the health of women during pregnancy, childbirth, and the postpartum period.[29] We define child health as "the extent to which individual children or groups of children are able or enabled to i) develop and realize their potential, ii) satisfy their needs, and iii) develop the capacities that allow them to interact successfully with their biological, physical, and social environments."[30] This definition echoes the principles of the Ottawa Charter, including a view of health as a positive concept and as a resource for everyday life, with the important contemporary recognition that this positive concept of health is not the lived experience of many children, especially children from Black, Indigenous, or racialized communities in health and social care systems.[31]

Pregnancy, childbirth, and childhood have significant implications for the physical, mental, and socio-economic well-being of women and children, families, and societies more generally; indeed, the early childhood period is considered to be a key social determinant of health.[32] While much effort has been placed on the clinical management of maternal and child health and illness, our focus in this chapter is those non-clinical interventions, including school health promotion, preventive health services for mothers and children, and maternal and parental leave allowances, which potentially align with a broad version of public health as conceptualized for this book.

Example 1: Preventive Health Services for Mothers and Children

Early efforts to improve maternal and child health in Alberta were prompted in part by statistics on infant (see Figure 10.1) and maternal mortality, both of which were high in the early decades of the twentieth century. For example, Alberta's maternal mortality rate in 1921 was 6.7 per 1,000 live births, which was higher than all other Canadian provinces (excluding Québec, which did not report maternal mortality that year).[33] In a 1930 publication, Deputy Minister of Public Health, Dr. Malcolm Bow raised alarm about maternal mortality, arguing that "if, during the year 1928, ninety-four mothers in Alberta had been burned to death or more than 1,300 mothers in Canada [the number of pregnancy related

deaths in Canada] had been drowned, the shock of such a tragedy would have swept the nation. The lives of our mothers have been held far too cheaply."[34]

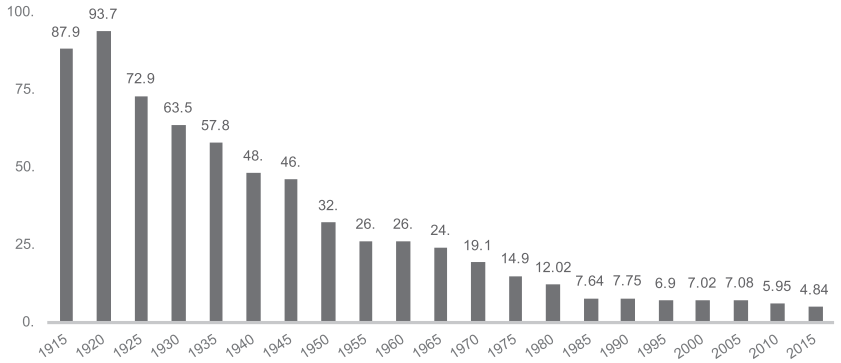

Fig. 10.1: Infant mortality in Alberta, 1915 to 2015. Number of deaths under one year of age, per 1,000 live births, per year. Source: Alberta Provincial Vital Statistics Reports and publications, 1915 to 2015.

The earliest and perhaps clearest example of organized health promotion-like activities on a provincial level is the work of public health nurses. Public health nurses utilized what we might now refer to as health promotion activities to improve maternal and child health across Alberta, including in rural areas. Importantly, although urban/rural disparities in access to preventive health services were a stated concern of government at the time, the absence of a strong social justice orientation is evident in the fact that inequities across other intersecting social identities — such as class, gender, race, and ethnicity — were largely perpetuated by a government and service orientation that assumed a uniform, white Anglo-Saxon, middle-upper class population, with relatively high levels of power and privilege; departures from this norm were viewed as a problem to be solved (see Chapter 1). Additionally, the concentration on educational health promotion activities, with the end goal of behaviour change, is an early signal of an enduring overemphasis on behavioural health promotion strategies noted above.

The early 1920s saw the establishment of child welfare clinics, which were intended to reduce infant mortality by providing education to mothers regarding the care of their children; the clinics illustrate an assumption that lack of knowledge, rather than other factors, was at the root of maternal and child health problems.[35] The first provincial child welfare clinic was established in Edmonton in 1920 and operated twice a week for four hours, at no cost to mothers.[36] Children of pre-school age were "kept well" by the clinic nurses, while cases that required

treatment were referred to a family doctor. Child welfare clinics in Medicine Hat and Calgary opened in 1922, and in Vegreville in 1926.[37] By the end of the 1920s it was estimated that approximately 11,000 Albertans (mothers and their children) had been served by these clinics.[38] Speaking to power dynamics built into the service infrastructure, the 1929 annual report of the Department of Public Health expressed pride at the large numbers of "young mothers of foreign birth, especially Ukrainian" — seen as particularly in need of the service due to embedded classism and racism — who had attended the clinics that year.[39]

Fig. 10.2: An Alberta public health nurse holding a child welfare clinic (between 1920 and 1927). Source: Provincial Archives of Alberta (Image: A6949).

The largely educational nature of the clinic work, with the stated intent of assisting mothers to raise "better babies and healthier school children, thus giving all a better chance in life,"[40] aligns with the health promotion action area of developing personal skills, that is, supporting personal and social development through providing information, education for health, and enhancing life skills, although in a way that belies the significant inequities embedded in Alberta society and institutions of the time.[41] Contextualized in this way, nurses performed a wide range of activities, including screening and examination for a wide range of

concerns including malnutrition, defective teeth, infected tonsils and eye problems. In cases where poor diet or malnutrition was observed in babies, they gave specific advice to mothers about how, when, and what to feed their babies, and breastfeeding was emphasized in most cases. For older children, mothers were given healthy eating tips and educational resources.[42] Other related efforts that align with developing personal skills within this socio-historical context include baby welfare weeks, which included instruction on sterilizing milk bottles, preparing healthy foods, supervision of playtime, breastfeeding as long as possible, and avoiding overuse of medicines; and Travelling Child Welfare Clinics, which provided services in remote rural areas.[43] Public health nurses also made home visits and delivered lectures upon requests from rural school districts.[44]

In addition to recommending improved clinical interventions, such as better obstetrical training and practice, Deputy Health Minister Bow emphasized the importance of adequate and efficient prenatal and postnatal health services in rural areas.[45] This idea aligns to an extent with the health promotion action area of reorienting health services, where the health sector has the responsibility to move beyond clinical and curative services. Indeed, in the context of Alberta's evolving rural public health unit infrastructure, prevention- and promotion-oriented activities for maternal/child health were prominent. Reorienting health services in the Ottawa Charter was intended to "support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic, and physical environmental components." Although embedded assumptions around class and ethnicity meant limited attention to the broader social, political, and economic components now recognized as essential to health promotion, these historical efforts convey an understanding that different groups and sectors, including governments and institutions, had a shared responsibility to "work together toward a health care system which contributes to the pursuit of health."[46] Notably, by the 1960s, there had been a significant decrease in overall maternal mortality. In that year, only seven maternal deaths were registered with a rate of 1.8 deaths per 10,000 live births, the lowest of all the provinces.[47]

In 2018, Alberta Health Services provides well child services in clinics in urban and rural areas around the province. As in the past, the contemporary clinics are staffed by public health nurses and provide both standardized immunization, such as vaccinations for children after two months of age, and non-immunization services. However, service delivery is now considerably more streamlined, specialized, and "patient/family-centered."[48] These trends have occurred within a broader neoliberal context of public sector cuts and individualization of responsibility for health as they have intersected with regionalization

of health care services in Alberta. Compared to the past, concerns around diverse aspects of equity are now explicit in at least some areas of public health service delivery.[49] However, considering the harmful legacies of the past, and the neoliberal context of the present, a considerable amount of work remains to be done.

Example 2: Mothers' Allowances and Parental Leaves

Notwithstanding criticisms for overconcentration on behavioural health promotion strategies, the intention of health promotion as expressed in the Ottawa Charter includes healthy public policy, which recognizes that health and well-being are strongly influenced by public policy in various domains, not just health care. Healthy public policy is similar to the contemporary notion of a "health-in-all policies" orientation, where health and health equity implications of policy and legislation in all sectors — not just health — are considered.[50] A healthy public policy aims to overcome the formidable obstacles presented by political, social, or economic power disparities that create inequitable access to health-promoting resources (see also Chapter 12).

One example of public policy to foster equity and promote health for mothers and children is government-mandated support for parents during the first years of their child's life. *Parental leaves* are a contemporary version of support that usually consists of a timeframe away from the workplace with a guarantee of job protection, accompanied in some circumstances by partial wage replacement and benefits.[51] Importantly, despite their supportive intentions, these arrangements can create and perpetuate social inequity: some parents are excluded because their work is part-time, they are self-employed, or they have not worked for a sufficient length of time to qualify; these circumstances, moreover, may intersect with other social axes associated with more limited power and privilege.[52] Mothers' allowances, which refer to financial benefits received from governments when fathers were absent, were a precursor to contemporary parental leaves, which allow mothers to better take care of their children by alleviating financial concerns.

In the paragraphs below, we track the historical evolution of these two policies in Alberta and examine the rhetoric behind them to explore whether or the extent to which they were conceived as a healthy public policy. A main source used is the *Alberta Legislative Hansard*, which provides a marker of the ways in which policy makers in Alberta understood and discussed such issues.

MOTHERS' ALLOWANCES

Physical and psychological damages from the First World War and high mortality rates from the influenza pandemic of 1918–1919 led to the absence or incapacity of many husbands in Albertan families.[53] Within the gendered and

heteronormative context of the time, Alberta's Mothers' Allowance Act, ascended in 1919, stated that widows or wives of incapacitated husbands who had children could apply for relief in their municipality.[54] The act specified that any widow or wife of a person committed to a sanatorium or jail, who had children in her custody, and who was "unable to take proper care" of her child or children, may "apply to an inspector of the city or town of which she is a resident for assistance." The inspector would present the case to the Superintendent of Neglected and Dependent Children for approval, who would in turn recommend to the attorney general the amount of payment to be given weekly. More and more mothers joined the program as time passed, and by 1925, 825 women in the province were receiving allowances.[55]

At first, within the racially unequal context, the rhetoric behind the mothers' allowances appealed to the white patriarchal view (there is far less attention to the experiences of non-white people in Alberta at that time) that it was the main job of women to raise children to be productive members of society. Both Liberal and United Farmers of Alberta governments viewed children as assets of the province.[56] In cases where husbands could not fulfill their role as providers, the state had to step in to help mothers in their responsibility for "the creation of a valuable product: healthy, morally upstanding children."[57] Recipients were expected to pursue gendered and Anglo middle-class ideals of mothers and housekeepers, and were subject to supervision accordingly.[58] According to Canadian historian Amy Kaler, mothers' allowances were emblematic of the belief that children made it impossible for women to be self-sufficient because care of children was to take precedence over paid work; women receiving the allowance were expected to be good (paid) workers and engage in paid labour to the extent it did not interfere with childrearing.[59] That said, in some jurisdictions such as Ontario, the allowances were deliberately set at low levels, thus necessitating paid work and illustrating the reality that women's paid work could not usually support a family.[60]

Some acknowledgement of a relationship between mothers' allowances and health of children was present early on; the Alberta program was even housed within the provincial Department of Public Health during the late 1930s and early 1940s.[61] However, this connection was made more evident after World War II; in 1945, for example, one MLA stated that "Mothers' allowances should be used for the purpose they were first intended, for children's health. They should not be considered a donation."[62] Although this statement suggests somewhat of a shift in government perspective — from entrusting mothers with the responsibility of raising good citizens during the previous decades to a concern for raising healthy ones — the underlying gendered rhetoric persisted. Infant mortality was an

important concern and putting responsibility on women, in a way that assumed and conveyed class and racial uniformity, was seen as one way to address it.[63]

PARENTAL LEAVES

The evolution of parental leave benefits in Alberta and Canada is complex. Briefly, as increasing numbers of women entered the labour market during the 1960s and 1970s, the model of support for mothers and parents changed; this was part of the broader welfare state development in the second half of the twentieth century.[64] In Canada, the federal government initiated a national program in 1971, where new mothers could claim up to fifteen weeks of maternity leave including benefits, such as extended health benefits. Two decades later, in 1990, ten weeks of parental leave were introduced with the new provision that either parent could use them and that mothers could add them to the existing maternity leave provision.[65] In December 2000, parental leave was increased further to thirty-five weeks, such that mothers could take up to a full year (fifteen weeks maternity leave plus thirty-five parental leave). During the maternal / parental leave periods, employees under the federal legislation were to receive 55 percent of their salary from federal funds through the Employment Insurance program.[66] Finally, in 2017 the federal government extended the benefits to eighteen months, if the employees chose to, but in this case, parents would receive 33 percent of their original salary during the final six months, with the continued guarantee of having their job back.[67] Nonetheless, and significant from an equity point of view, the benefits continue to be restricted to a subset of parents because qualifying for employment insurance parental benefits requires a minimum accumulation of six hundred insured hours of paid employment.[68] It thus excludes or obstructs those who are not in the paid labour force, and those in precarious work circumstances, which tends to co-occur with other marginalized social identities.[69]

As the seventh province in Canada to do so, Alberta was a laggard in enacting parental leave legislation.[70] In 1975, the provincial government introduced an amendment to the Alberta Labour Act (passed in 1976), stating that the Labour Board had the power to order an employer to grant a maternity leave without pay (that guaranteed job protection) for up to twelve weeks before and six weeks after the birth of the child.[71] However, this legislation did not apply to all employers until 1980 when it became "universal and mandatory," albeit with the significant proviso that the mother had been an employee for at least twelve months.[72] In 1998, a *Calgary Herald* newspaper article stated, "while the length of maternity leave in Alberta is in line with other provinces, this is the only province that doesn't also provide for parental leave."[73] It was not until 2001 that the provincial government saw fit to extend the leave to both parents, thereby matching the federal

legislative context and showing some indication of a (belated) shift away from the relatively privileged and cis-gendered views that childcare responsibility primarily lies with the mother. At the time of writing, in Alberta, and again significant from an equity point of view, leaves continue to be contingent on employment circumstances, and employees are eligible for maternity and parental leave if they have been employed at least ninety days with the same employer. Employers are not required to pay wages or benefits during leave, in which case the funds come from the federal Employment Insurance program.[74] These parameters are out of step with prominent characteristics of the contemporary labour market, including growing numbers of poorly-paid, insecure, and non-unionized jobs with no benefits, which are disproportionately held by racialized people who are most negatively affected during periods of crisis, such as the COVID-19 pandemic.[75]

PARENTAL LEAVES AS HEALTHY PUBLIC POLICY

Several studies have demonstrated the health benefits, and to a lesser extent, health equity benefits, of parental leaves. For example, using data from sixteen Organisation for Economic Co-operation and Development countries from 1969 to 1994, economist Christopher Ruhm showed that longer parental leave was linked to marked decreases in pediatric mortality, especially for health outcomes "where a causal effect is most plausible," that is, outcomes seen to be preventable via supportive policy, including post neonatal mortality (deaths between twenty-eight days and one year of age) and child fatalities (deaths between the first and fifth birthdays).[76] Effects on perinatal mortality (fetal deaths and deaths in the first week), neonatal mortality (deaths in the first twenty-seven days), and the incidence of low birth weight, were less pronounced, thus speaking to the validity of the effect.[77] Economist Sakiko Tanaka extended Ruhm's data to 2005 and confirmed the noticeable decrease in child mortality rates with longer parental leave periods.

A study published that same year by social work researcher Lawrence Berger found that mothers' early return to work was substantially linked to reduced breastfeeding and immunizations rates, based on data from the United States.[78] On the other hand, economists Qian Liu and Oskar N. Skans found no impact of increasing parental leaves from twelve to fifteen weeks in Sweden on child health.[79] Economist and health researcher Maya Rossin-Slater and others found that longer maternity leave duration had positive effects on child health outcomes, but only as long as mothers had family support or a secondary income during the leave duration.[80] Overall, there is evidence to support the benefits of parental leaves on child health outcomes, but the effects may depend on context, such as the presence of other forms of support, including policy-level and

interpersonal, and vary by health outcome, speaking to an ongoing need for robust equity-oriented research in healthy public policy.

Alberta legislators did not make the connection between health and maternity or parental leave explicitly until the early 2000s. Prior to that, they appeared to believe they were unconnected. For example, during the first session of the 1975 legislature, Alberta NDP Leader Grant Notley inquired about the introduction of maternity leaves and what the conservative government was doing about it. Notley mentioned that he first directed his inquiries to the minister of social services and health, which was responsible for public health at the time, but was referred to the minister of labour, suggesting that maternity leaves were not viewed as falling within the domain of health.[81]

In recent years, in contrast, health has been mobilized to justify increasing the length of parental leaves. For example, when debating the province's Employment Standards Amendment Act relating to Parental Leave (Bill 209) in 2000, MLA Wayne Cao (PC) stated that the potential benefits of the bill were clear when he said, "study after study shows that the early relationship between parent and child is one of the most critical factors in determining the future health and happiness and success of a child."[82] LeRoy Johnson (PC) likewise spoke in support of increasing parental leave, on health grounds when he stated that "long leaves of over 20 weeks are associated with better maternal health, as measured by mental health, vitality, and role function, whereas the reverse is true for short to moderate leaves of 12 to 20 weeks." Johnson remarked on the benefits of longer leaves for breastfeeding and, in turn, decreasing disease incidence. He cited statistics from Ruhm's report, arguing that "those numbers cannot be ignored." Consistent with a healthy public policy perspective, Johnson furthermore acknowledged broader benefits of extended parental leave, "not only for children and parents but also for employers and the wider society. These advantages include better maternal and child health and well-being, increased time investment of parents in their children's early years, increased retention of female employees, decreased recruitment costs, and improved labour market status for women."[83]

While Alberta lawmakers did not initially recognize the health and health equity implications of mothers' allowances and parental leaves, years after they were first proposed or debated, health benefits were mobilized to justify both policies. These examples suggest a shift in this policy domain, albeit a slow and partial one, toward a health-in-all-policies orientation, which recognizes that "government objectives are best achieved when all sectors include health and well-being as a key component of policy development" and — along with health equity — the orientation is a central tenet of health promotion under the action area of building healthy public policy.

Example 3: Health Promotion in Schools

Our final example of health promotion deals with efforts to improve the health of young people in schools. For better or for worse (with colonial residential schools being the clearest example of the latter), schools have long been at the forefront of state-directed efforts regarding health. However, the ways in which these efforts were deployed changed throughout the twentieth century, reflecting shifting cultural attitudes and priorities. We first describe some early public health interventions in a settler-colonial context that focused on school-based immunization. Then, to demonstrate the changing nature of how health was addressed in schools, we examine a shift that occurred in Alberta's provincial junior high health curriculum during the 1950s and 1960s, followed by acknowledgement of a much more recent shift toward the adoption of the comprehensive school health approach. Overall, these health interventions are seen through the lens of the Ottawa Charter for Health Promotion's action areas of developing personal skills and building healthy public policy. These events played out in contexts that were largely ignorant to or exclusionary with respect to social inequities along dimensions such as class and race.

MEDICAL INSPECTIONS AND IMMUNIZATION IN SCHOOLS

Some of the earliest settler school-based public health initiatives in Alberta perhaps align more with prevention than with health promotion; nonetheless, they are illustrative of the long-standing importance of the school setting in public health. Edmonton's first city health officer, Dr. Thomas H. Whitelaw, wrote in 1914 that "medical inspection of school children has come to stay, and . . . it is to become an increasingly important factor in obtaining the maximum of mental and physical efficiency for future generations."[84] Whitelaw thus conveyed the viewpoint that schools represented an institution well suited to the aims of those who concerned themselves with public health.

Whitelaw's comments stemmed, in part, from his experience about six years earlier, when he had been at the forefront of one of the earliest major public health interventions in Alberta that affected schools: compulsory smallpox vaccinations.[85] In response to considerable backlash from parents who were opposed to their children being vaccinated, Whitelaw authored a piece in the *Edmonton Bulletin* where he doubled down on the importance of vaccinations for school-aged children.[86] For proponents of vaccination, especially those working within the Department of Public Health, making vaccination mandatory was seen as the most effective way to control smallpox, and the benefit of vaccinating children in particular was emphasized.[87] Indeed, Alberta's inaugural Public Health Act of 1907 included a provision that allowed educational authorities, such as

school boards, to pass regulations to deny admittance to schools for unvaccinated pupils.[88]

In response to this call, and speaking to the power held by the early, medically focused version of public health, school boards moved to pass rules to make schools the sites of mandatory vaccinations. An early example was the Bowden Public School District in Central Alberta, which implemented compulsory smallpox vaccination of all pupils attending school sometime before 1906. In the absence of a doctor, the vaccinations were performed by pupils, taught by one of the teachers, with some of the very young students being vaccinated by their parents.[89] In 1908, the Edmonton School Board ruled that students had to have proof of vaccination against smallpox to be allowed to attend school.[90]

These efforts tied early public health and education systems together intimately: schools were not just passive sites of public health intervention, but active partners in the public health apparatus. Now, if parents wanted their children to attend school, they had to buy into a certain version of community-based and expert (largely physician) driven conceptualization of health. This conceptualization was often challenged to varying degrees of success. For example, the 1915 Edmonton School Board policy was quickly challenged and subsequently ruled irreconcilable with the Truancy Act by the Alberta Supreme Court as it prohibited students from attending school despite the act making school attendance mandatory.[91] The policy was repealed and the School Board was ordered to admit students without proof of vaccination.[92] Overall, the story of mandatory vaccination for Alberta school children illustrates ways in which the school could be a battleground — for public health officials, teachers, parents, and politicians — over the direction of public health, and should prompt thoughtful consideration of how to build healthy public policy while respectfully engaging stakeholders with differing views and different levels of power and voice.[93]

Schools remained central to public health during the mid-twentieth century. In a contrasting example, we next examine changes in Alberta's provincial curriculum for health in the 1950s and 1960s.

HEALTH AND THE CURRICULUM

Using curriculum guides for junior high schools that applied to all public schools in the province, we identify a particular turn in approach and content that illustrates the interplay between the nature of public health promotion in schools and popular, and at times hegemonic, conceptualizations of health.

The Junior High School Curriculum Guides for Health and Personal Development are used by all public schools at the junior high level in Alberta. Generally formed through close consultation between the Department of Health

and the Department of Education, these documents reflect the high-level vision for health education in schools, as well as granular direction on, for example, the type of videos to show, guest speakers to invite, and books to read. Evidence suggests that throughout the 1950s, the Department of Public Health had considerable impact on the curriculum and revisions suggested by various members of that department were incorporated.[94] Therefore, a close examination of these curricula permits exploration of approaches to public health promotion in schools over time, including embedded dimensions of equity and power.

In the 1950s, the provincial health curricula seemed to place considerable emphasis on the individual as the main site of responsibility for health, somewhat humorously typified by an assignment from 1952 that encouraged students to write an essay on the topic Others are Inconvenienced When I am Ill.[95] This individual orientation was furthermore infused with a moral dimension. In 1951, for example, the Junior High School Curriculum Guide *for Health and Personal Development* (italics added) proclaimed its mandate as, "to encourage the objective analysis of personal problems common to adolescents and to foster the development of wholesome attitudes."[96] Subsequent curriculum guides produced during the 1950s emphasized personal responsibility for health through the development of a moral toolkit. Through the lens of the Ottawa Charter, and consistent with the critique of overemphasis on behaviourally oriented health promotion, these actions can be understood as early, historically situated attempts to build personal skills, teaching students to understand their own agency and responsibility within their community. However, as historian of education Mona Lee Gleason has noted in the context of sexual education, "sex educators . . . continued to conflate sex education with lessons in acceptable moral conduct."[97] Although teachers were encouraged to "avoid moralizing," the expectation was that students would develop a strong set of core values, with "faith in ideals" through the careful guidance of their educators.[98]

In these curricula, although health was tied to the morals of the individual, it was also associated with acceptance in the community. As the 1953 curriculum guide put it, "everyone wants to be popular — to be liked for himself. The relationship of popularity to one's personal habits, to the way he talks, and acts in 'company,' to the impression he gives to those around him can well be discussed in the group . . . [the curriculum] suggests ways in which the individual can 'sell' himself to the world with which he is in contact."[99] This is not to suggest that schools were in the business of legislating personalities, but instead to highlight the extent to which health was viewed as one part of a certain, holistic definition of self. A morally well-developed student would be popular (as a reward for their

morally appropriate behaviours) and, in turn, would be a student who made positive choices for their health.

By the next decade, however, things had changed. By 1961, health and personal development had been separated, and the curriculum guide was titled Junior High School Curriculum Guide *for Health* (italics added). The name change reflects the shift in content, as principles of individual morality ceded ground to the pragmatic idea of helping students "come to know health principles which they can apply in daily living."[100] By at least the mid-1960s, students were encouraged to see themselves as part of a greater concept of "national health," and there was a focus on enabling students to navigate their larger communities armed with knowledge of "functional health."[101] This new model emphasized students' role as members of somewhat homogenous communities, an identity that carried rights and responsibilities relevant to both individual and community health.

Illustrative of this shift is the changing ways in which curriculum guides discussed the concept of overweight. In 1952, the curriculum guide admonished teachers to "discuss the causes of overweight. Emphasize that it usually results from overeating."[102] By 1964, teachers were instead encouraged to get students to think about diet using Canada's Food Guide to ensure regular meals, and appreciate that "concern about being overweight or underweight should be discussed with one's doctor."[103] The earlier, somewhat singular approach that centered on individualized preventive behaviours such as not overeating, gave way to a more medically grounded regimen of health promotion that was based around a systematized understanding of nutrition, codified by Canada's Food Guide and in consultation with experts, including health professionals and scientists. While remaining largely exclusionary and/or ignorant of many dimensions of equity, these resources allowed school-based health interventions to transform from a moral and individual appeal to an apparently scientifically rigorous and community-based appeal. Overall, the efforts described in the junior high health curricula illustrate subtle shifts in how efforts to enable school children to take control over their health may manifest, including which perspectives are privileged or excluded.

Since the 1990s, and illustrative of growing alignment with health promotion principles, there has been a significant trend in Alberta toward comprehensive school health, which is an internationally recognized, evidence-based approach for building healthy school communities. At the time of writing, Alberta Health Services supported all school authorities in the province in using the comprehensive school health approach to improve student health and educational outcomes.[104] The approach uses a community development process and has four components: teaching and learning, social and physical environments,

partnerships and services, and policy to create healthy school communities. With this broad orientation, use of the comprehensive school health framework may help to address a variety of health issues, such as healthy eating, substance use, mental health, tobacco use reduction, injury, and physical activity. The comprehensive school health approach is heavily anchored in the Ottawa Charter, and its strengths include its attention to multi-level and intersectoral processes.[105] Another example of comprehensive school health is Ever Active Schools, a charity that works directly with Alberta schools to support wellness education and build capacity through projects and competency-based based learning to improve health and social outcomes of children and youth in Alberta. Through collaborative partnerships and knowledge exchange, Ever Active Schools uses a multi-sectoral approach, centres Indigenous populations, and is funded through a collaboration between government ministries, thus providing an example of healthy public policy.[106]

To ensure its ambition of student well-being, critical analysis of comprehensive school health initiatives — which to date is relatively limited — is important to ensure, for example, that the focus on behavioural health promotion, such as physical activity and healthy eating, does not preclude careful attention to population-level equity considerations that may be at play before students come to the school setting. [107] Moreover, such initiatives must always be situated critically within the broader — and currently highly problematic — ideological and political economic context of Alberta education.[108]

Conclusions

In this chapter we provide examples of what are now called health promotion actions that occurred throughout Alberta's public health history and which must be situated critically within socio-historical context including concern — or lack thereof — with dimensions of equity and inclusion. Preventive health services to new mothers and their children, deployed by public health nurses in local settings such as child welfare clinics, illustrate some elements of health promotion strategies of reorienting health services and developing personal skills, although in a context that was largely exclusionary or ignorant to equity along dimensions such as class and race. The mothers' allowance and subsequent parental leave legislation served as examples of building healthy public policy, where a connection with health was not initially recognized but evolved over time. Finally, health promotion in schools resembles the health promotion action areas of developing personal skills — in some cases with explicit moral connotations — and healthy public policy where early experience in Alberta provides a lesson of where policies such as tying vaccinations to school attendance, contributed to or

emphasized fault lines of conflict. Although recent trends concerning comprehensive school health may indicate growing alignment with health promotion principles, these must be interpreted in the broader political economic context of public sector cuts and orientations that threaten to erode health and well-being for all Albertans.[109]

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