

Who Is the Public in Public Health?

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Introduction

In 1953, at the age of nine, Leilani Muir was admitted to the Provincial Training School for Mental Defectives in Red Deer, Alberta, which provided care and training for persons thought to be “mentally deficient.” There was no medical examination upon admittance to the training school, and no evidence was provided by the physicians that Muir was in fact “mentally deficient.”¹ Following an inaccurate IQ test, the training school psychiatrist recommended Muir for sterilization, under Alberta’s Sexual Sterilization Act. At the age of fourteen, Leilani Muir was sterilized without her consent.²

Alberta’s eugenics program (operationalized via the Sexual Sterilization Act), administered by the provincial Department of Public Health, was in operation from 1928 until 1972 (see also Chapter 4), and it disproportionately affected marginalized individuals like Leilani Muir, a working class, Irish-Polish, Catholic girl.³ Sociologists Jana Grekul, Harvey Krahn, and Dave Odynak have demonstrated that the primary targets of the program were certain populations deemed to be “vulnerable,” including women, youth, and Indigenous Peoples who often came from lower socio-economic backgrounds.⁴ This raises the question of what “public” in public health meant. Was it aimed at certain individuals and not others? Who was it intended to protect? Who was — advertently or in-advertently — included and excluded?

Muir’s case provides one of many illustrations that the answers to these questions are complex and that who and what constitutes the public is a construct defined by shifting socio-political tides. For early twentieth-century public health officials, medical professionals, social reformers, and politicians, what constituted the public, was an ideal community shaped by British imperialist notions of

race and racial hierarchies. Their ideal community was a white, Anglo-Protestant Canada that prospered not only economically but socially as well. Muir stood on the margins of this imagined community. Her religious and ethnic background was widely perceived as less desirable than those of Anglo-Protestant heritage. Her family was also poor and therefore seen as a burden on the state rather than a productive part of it (see also Chapter 12). As a woman, there were concerns about potential sexual deviances leading to illegitimate births. As a child, she was more a ward of the state than a citizen. Finally, Muir's supposed condition of "mental deficiency" was so broad and subjective as to render it meaningless.⁵

Individuals like Muir were singled out because in nearly every social category they were not what most of the elite elements in society considered "desirable" or "healthy." For them, those labelled as "mentally deficient" did not contribute to the betterment of Canadian society but rather detracted from it. Alberta's eugenics program is a tragic and instructive example of an idealized social construct being used to determine the meaning of public in public health. Public health policies with respect to eugenics were inherently exclusionary. For a field that prides itself on being concerned with upstream determinants of population well-being and health equity, questions about who is — and who is not — considered part of the public in public health are critical ones indeed.

Conceptualizing "the Public"

In this chapter, we explore the idea that the public is a constructed category, reflecting various values and ideologies, and how this has played out in Alberta's public health history. In a wide variety of programs and policies, the socially constituted nature of the public has impacted public health's objectives, implementation, and targets. We illustrate this observation using three examples: first, through the experiences of Leilani Muir and others affected by Alberta's eugenics program; second, through immigration policy in the province; and third, by the framing and deployment of tuberculosis control efforts in Alberta, which marginalized (in fact, aggressively excluded) Indigenous tuberculosis patients in particular.

This chapter contributes to a robust body of contemporary international public health scholarship concerned with defining the public and with paradigms of inclusion and exclusion. For example, in 2007, Marcel Verweij and Angus Dawson wrote the influential paper, "The Meaning of 'Public' in 'Public Health.'" Here, the authors develop the idea that the meaning of the public is not static, but rather a constituency defined by the objectives and aims of a particular health intervention. Therefore, even if the public refers to an indefinite number of people, any given intervention does not necessarily benefit many, or even a

majority, of a population.⁶ In his 2012 book, *What Makes Health Public?*, John Coggon considers the broad span of political, ethical and legal implications of public health, which in turn prompts a need to recognize the legal structures that are used to turn notions of public health into policy.⁷ This critical theorization undergirds the types of analyses done in the present chapter, particularly as it strives to show the ways in which the state constructs public health threats (and their responses) through institutional (including legal) and ethical lenses and means.

There are several examples of how these phenomena play out in the Canadian context. Notably, *Social Determinants of Health*, an edited collection by Dennis Raphael, contains an array of important works, including one by Grace-Edward Galabuzi that delineates and comprehensively deals with the forces that cause social exclusion — and thus poorer health — of various social groups.⁸ Ronald Labonté builds on Galabuzi’s thesis by cautioning against efforts to correct social exclusion by centering social inclusion and placing blame for exclusion on individuals.⁹ Finally, Janet Smylie addresses the ways in which social exclusion affects Indigenous Peoples in particular, focusing on living conditions.¹⁰ In terms of research by Alberta-based scholars, Melanie Rock has considered whether animals, in particular pets, should be included in definitions of the public using data from the City of Calgary. On the discussion of inclusion-exclusion paradigms, Rebecca Haines-Saah demonstrates the phenomenon of “privileged normalization” in marijuana use, whereby media narratives surrounding marijuana use convey greater acceptability of the practice among those with power and status than among those without.¹¹

Bringing these various strands together is the concept of intersectionality, which is increasingly incorporated in public health scholarship in Canada and internationally.¹² The lens of intersectionality draws attention to the impacts that structures and processes that create exclusion and marginalization based on intersecting identities like gender, race, Indigeneity, ability, and age have on well-being and health equity. This chapter builds on these ideas by showing how conceptualizations of the public have informed the deployment of public health, particularly through paradigms of inclusion-exclusion, through Alberta’s public health history.

Immigration, Public Health, and Exclusion

Ethnicity/race, ability, and class were central to Canada’s immigration policy from the late nineteenth century into the early decades of the twentieth century. Although the Immigration Act of 1869 contained very few restrictions regarding entry into Canada, over time federal immigration policy became much more

restrictive and excluded immigrants on the basis of their ethnicity, race, and national origin.¹³ The federal government sought to attract “desirable” immigrants, primarily those from the British Isles and the United States, and it sought to curtail immigration from “less desirable” areas such as central and eastern Europe and Asia.¹⁴ Yet, the federal colonial campaign to attract farmers to settle the West allowed for approximately three million newcomers to enter Canada by 1914, with the majority arriving from non-Anglo-Saxon countries, including Ukraine, Poland, Germany, and Hungary.¹⁵

While the influx of immigrants from central and eastern Europe into western Canada brought out nativism and xenophobia among Anglo-Canadians, and led to hostility toward newcomers in general, there was a hierarchy in the desirability of new immigrants.¹⁶ While central and eastern Europeans were viewed relatively favourably in terms of their likelihood of assimilating into Canadian society, the debate over Asian immigration focused on implementing measures to exclude them from entering Canada altogether.¹⁷ Immigration restrictions, particularly the Chinese Immigration Act of 1885 and subsequent amendments, over time reduced the number of Chinese newcomers in Canada.¹⁸

The discourse over Chinese immigration to Alberta intersected with public health even before Alberta had officially become a province. In 1892, open hostility toward Chinese immigrants resulted in a mass city riot in Calgary, sparked by an outbreak of smallpox that was initially observed in a Chinese man.¹⁹ For the authorities, the case was proof that white Calgarians needed to “remain vigilant against the potential deleterious effects of Asian men on the community.”²⁰ Racial animus on the grounds of health was promulgated through newspapers and state action. For example, the Chinese men who were afflicted with smallpox were treated as deceptive and malevolent in local newspapers, while white patients were treated sympathetically.²¹ The Calgarian experience fed into, and was influenced by, national rhetoric that claimed that in “moral, social, and sanitary status, Chinese were below the most inferior standard of Western life.”²² This nativist rhetoric explicitly constructed a threat to public health as being Chinese, and the public as white Anglo-Saxon Calgarians.²³ The demarcation between who was part of the public and who was not extended to conceptualizations of space: as historian Nayan Shah has pointed out, North American conceptualizations of the condition of Chinese homes were that of filth and decay, in sharp contrast to the supposed hygiene and cleanliness of white, Christian homes.²⁴ The homes and workplaces of Chinese immigrants were sites that were inherently linked with ill health, and their presence needed to be treated, as one would a disease.

In the early decades of the twentieth century, the legacy of othering Asian, in particular Chinese, immigrants continued to be tied with themes of public health.

During the 1920s, the small Chinese population in Calgary and Edmonton was linked with another public health problem, drug consumption.²⁵ Popularized during the 1920s by Albertan reformers such as Emily Murphy, but present since the beginning of Chinese immigration to Canada, depictions of Chinese immigrants as drug addled menaces to the Canadian way of life permeated the mainstream. In response to the Calgary riots noted above, *The Edmonton Bulletin* published an article called simply “The Chinese,” in which the author asserted that Alberta had no responsibility to provide “Christian charity” to those who would “engage in the distribution of opium . . . and the most loathsome forms of vice,” character traits seen as distinct to the Chinese people.²⁶ As also seen with other groups of immigrants, the othering of Chinese immigrants propped up public health policy that — rather than integrate and protect and promote the health of the Chinese immigrants themselves — sought to protect the rest of the public from them. The very idea of a public worth protecting was built around the value of the moral and ethnic character of white Anglo-Saxon Canadians, a definition which firmly excluded the so-called menace that were Chinese immigrants. (A parallel can be made with how Indigeneity in Alberta has been and continues to be linked to alcoholism and drug use; see Chapter 7)

During the interwar period, politicians, physicians, and social reformers in Alberta were concerned about the arrival of “unhealthy” and “defective” immigrants, primarily from central and eastern Europe, to the province. They attributed the spread of infectious diseases and the increase in the “deficiency” of the population to the unhygienic habits and deviant behaviours of the newcomers. The new immigrants were presented as a threat to the well-being of the province and politicians and public health officials were determined to quarantine them, to place them under constant surveillance, or to expel them from the country.²⁷ As early as 1922, Alberta Liberal MP Charles Stewart informed parliament of the situation in western Canada, particularly Alberta, arguing “that too large a percentage of people who are mentally unfitted to come to this country have been allowed to enter Canada. . . . I know whereof I am speaking,” Stewart continued, “because our mental hospital in Alberta has had too large a percentage of people allowed to come to Canada who were mentally unfit.”²⁸ In other words, Stewart implied that Canada’s immigration policy was problematic because it allowed “defective” immigrants to enter, settle in Alberta, and become a public charge.

Similar sentiments were expressed by Alberta’s Department of Public Health where, in 1924, the Deputy Health Minister, W.C. Laidlaw, wrote to Premier John Brownlee objecting to the “cursory” examination of immigrants, because “under this system only the most obvious cases [of “defective” immigrants] would be detected.”²⁹ The minister wanted more effective procedures in place

that would prevent immigrants with mental and physical disabilities, those with criminal tendencies, and those who were likely to become a public charge from entering Alberta. Likewise, Miss Elizabeth Clark from the Nursing Branch of the Department of Public Health forwarded a list of “undesirable” immigrants and immigrant families to Dr. Laidlaw and to the premier arguing that they had passed through the inspection undetected and should be deported. Clark described one newcomer from Germany as suffering from “tubercular glands of the neck,” and had informed the Department of Public Health that deportation paperwork had been filed.³⁰ Historian Barbara Roberts has demonstrated that, according to the statistics provided by the Department of Immigration, deportations peaked during four periods in the first three decades of the twentieth century: 1908–1909, 1913–1914, 1921–1924, and 1929–1930. All these periods represent years of economic recession in Canada. Therefore, those immigrants who were hurt the most by the economic downturn and who had become a public charge were deported.³¹

The concerns over the quality of immigrants in Alberta was also evident in the 1921 report of Alberta’s Department of Public Health, which described Ukrainian immigrants as having difficulties assimilating to the Canadian way of life. According to the report, their language, culture, and traditions increased the likelihood of “feble-mindedness” in the family, and their “ignorance” of health and hygiene made them susceptible to the spread of diseases.³² The Department of Public Health furthermore singled out the living arrangements of central and eastern Europeans as particularly problematic, stating “the foreign element, called collectively Russian although including Galician, Pole and Austrian . . . has no concept of the meaning of the word sanitation.”³³ The supposed inability of some immigrants to adapt to Canadian society meant that new immigrants were often under surveillance. For example, according to historian Erica Dyck, inspectors and public health nurses in Alberta conducted home visits in immigrant neighbourhoods to ensure proper hygiene was practised in the home, and sometimes they sought to force sanitary measures on immigrant families if habits remained unchanged.³⁴ By employing such public health measures, public health officials gained significant knowledge of the living conditions and behaviours in immigrant quarters of the provinces. They presented these living habits as different and even dangerous, and thus helped construct some new immigrants as a threat to the province and as outsiders to the collective idea of the public.

Eugenics and Public Health

Eugenics, including forced sterilization, and public health have often crossed paths. In his work on the history of public health in the United States, historian

Martin Pernick notes that the goals, agendas, and personnel of the eugenics and the public health movements frequently overlapped.³⁵ Concerns over public health were a key incubator in which horrific eugenic ideas could grow; for example, some in public health turned to eugenics to find solutions to seemingly intractable problems, including poverty, criminality, “mental deficiency,” and “feeble-mindedness.”

Although eugenic theory emerged in Britain in response to the social conditions and concerns over perceived degeneration of the population, eugenic ideas and their aims of “human improvement” gained popularity around the world.³⁶ The methods by which these goals were realized and implemented varied between and within countries³⁷ and included so-called positive eugenics, which aimed to encourage the reproduction of individuals with desirable characteristics, and negative eugenics, which discouraged (or, in fact, forcefully prevented) reproduction among individuals with undesirable traits.³⁸ In Canada, negative eugenics found government health policy manifestations in the provinces of British Columbia and Alberta in the form of sexual sterilization measures. As noted above, Alberta’s Sexual Sterilization Act (1928), which fell under the administration of the provincial public health department, allowed for the sterilization of patients in mental institutions, particularly those diagnosed with “mental deficiency.”³⁹ Social and economic changes in Canada during the first decades of the twentieth century provided important context for the act. Many social reformers and politicians were concerned that Canada was becoming less homogenous, and as Erika Dyck suggests, “eugenics offered an appealing solution to the growing problem of social and moral decay by promising to support stricter immigration policies, while focusing on the internal make-up of western Canadian society and even promoting invasive measures to ensure that the so-called unfit members of society were not capable of reproduction.”⁴⁰

The concerns over national degeneration, due to the supposed increase in “mental deficiency,” were intensified by findings from the Mental Hygiene Surveys conducted by psychiatrists C. K. Clarke and Clarence Hincks. Their survey of the province of Alberta in 1921 revealed that the provincial institutions were overrun with “mental defectives,” a term used to describe individuals with intellectual disabilities.⁴¹ As sociologist Gerald V. O’Brien suggests, and as illustrated in the case of Leilani Muir described at the beginning of this chapter, the notion of “mental deficiency” was imprecise and broad, such that its definition could be expanded to include a vast number of behaviours perceived to be deviant, and was often associated with individuals whom society otherwise had already marginalized.⁴² Nonetheless, the findings of the Alberta Mental Hygiene survey were taken up by social reformers in the province, particularly the United

Farm Women of Alberta, who raised concerns about “mental deficiency” and lobbied the provincial government to implement measures, such as sexual sterilization, to reduce the numbers of “defective” individuals.⁴³ By 1928, the campaign would prove successful, as Alberta became the first province in Canada to implement a eugenics program and in fact was considered a pioneer in the British Commonwealth in that regard.⁴⁴

Several scholars studying Alberta’s eugenic past have demonstrated that the provincial eugenics program primarily targeted vulnerable individuals including women, young people, new immigrants, and Indigenous Peoples.⁴⁵ A central aspect of the provincial eugenics program was its focus on individuals who were constructed as “abnormal” and thus a public health menace. As was evident in Muir’s case, socio-economic status, gender, and ethnic background singled people out as ideal candidates for sterilization under the Sexual Sterilization Act.

Tuberculosis and Modes of Exclusion

Our final example of public health examined through the paradigms of inclusion and exclusion is tuberculosis. As historian Katherine McCuaig notes, many reformers and thinkers of the twentieth century believed that “to cure [tuberculosis], one had to cure society.”⁴⁶ Although that fundamental assumption spurred the mobilization of social and economic resources in the fight against tuberculosis, the question of how to “cure society” brought answers that were explicitly exclusionary, particularly along the lines of class and Indigeneity.⁴⁷

In the early 1900s, various political bodies argued that Alberta was receiving more than its fair share of tubercular patients.⁴⁸ Many members of the growing ranks of public health practitioners expressed a sentiment that the Canadian response should be a nationally coordinated and locally deployed system of public health, accompanied by measures to mitigate immigration. The loss of economic productivity was central in the justification of these mobilizing efforts, thus placing tuberculosis at the intersection of public health, public finance, immigration, and race. In this context, it did not take long for narratives to emerge that positioned racialized groups as detrimental to the public’s finances as well as to public health. As an illustration concerning tuberculosis, a 1910 editorial in the *Western Canada Medical Journal* stated that not merely immigrants, but those who came to the western provinces hiding their illness, and indeed, hiding the fact that they were poor, cost the country millions of dollars and were a serious concern.⁴⁹ In these types of narratives, individuals with tuberculosis were seen as insidious threats to the province, leeching off its finances and infecting its citizens with disease. These concerns were paired with eugenic thought, as in this

paradigm an influx of sickly, lower-class citizens would prove detrimental to the racial hygiene of the province.

Inequities within the constructed public are acutely seen when examining the experiences of Indigenous Peoples in Alberta, for whom tuberculosis was yet another reminder of the reality of their existence outside the constructed public. Social exclusion of Indigenous Peoples is the result of a variety of factors, dealt with at length in, for example, the Truth and Reconciliation Commission's reports, but which can be summarized as the workings of colonial apparatuses, including federal and provincial policy arrangements whose goal was coercive assimilation. This often took the form of colonial governments dispossessing Indigenous Peoples of their lands, placing restrictions on their livelihoods, forcing their children into residential schools, and suppressing their cultures (see also Chapter 7).⁵⁰ Across levels of government, racialized conceptualizations of Indigenous Peoples as sickly were prominent. Historian Mary Ellen Kelm has demonstrated that from the 1930s onward the perspectives in public health literature shifted from viewing Indigenous Peoples suffering from tuberculosis as "victims of an imported disease to being infectious agents to white populations."⁵¹ In Alberta, for example, the racialized belief that Indigenous Peoples had a genetic predisposition to tuberculosis was commonly accepted among western Canadian medical professionals in the early twentieth century.⁵² This characterization was maintained despite long-standing efforts by Indigenous persons themselves to show that economic inequality, poor nutrition, and overcrowded living conditions, all imposed by colonial systems and structures rather than genetics, significantly contributed to ill health.⁵³

The misconception that Indigenous Peoples were genetically predisposed to tuberculosis, and were thus a threat to larger society, had significant ramifications in the subsequent years. For example, Indigenous patients were rarely admitted for treatment at provincial sanatoriums.⁵⁴ Physician Anne Fanning, director of Tuberculosis Services for Alberta from 1987 to 1995, recalls how at one time during the history of Alberta, there was no place where Indigenous Peoples could receive tuberculosis treatment, although some of the children in the residential schools were cared for in local health units (see Chapter 13).⁵⁵ The perceived threats to the (white) public's health led to the establishment of Indian hospitals by the federal government from the 1940s onward.⁵⁶ These hospitals were presented as tuberculosis sanatoriums by the federal government but they admitted Indigenous patients suffering from various diseases, ensuring their segregation from the white population.⁵⁷ For example, when establishing an Indian Hospital in Edmonton, the Department of Health and Welfare re-assured the mayor of the city that the "the patients would be confined to the institution

and it would be better than having ‘... tuberculous Indians wandering about the streets of Edmonton . . . and spreading the disease.’”⁵⁸

A racialized conceptualization of tuberculosis manifested in significant disparities in disease incidence and outcomes. In 1939, Alberta’s Department of Public Health recognized that there was “still much to be desired in the Indian tuberculosis problem . . . it appears that no great reduction can be expected in the present Provincial tuberculosis death rate until competent . . . measures are made available to the Indian population.”⁵⁹ Nonetheless, six years later, in early 1945, the Advisory Committee for the Control and Prevention of Tuberculosis Among the Indians, of which Alberta’s deputy health minister was a member, stated that the non-Indigenous death rate from tuberculosis had declined by 39 percent in the fifteen years prior, while the Indigenous death rate had changed very little.⁶⁰ In the context of myriad social and colonial determinants of health, this was likely due in part to poor conditions in the Indian hospitals including understaffing and inadequate medical treatment.⁶¹ Indigenous inequities in tuberculosis treatment continued throughout the 1940s;⁶² even as Alberta’s Department of Public Health was celebrating five years of falling death rates from tuberculosis, the disproportionate burden of deaths in Indigenous Peoples persisted. In 1952, out of 125 deaths from tuberculosis, fifty-two (or approximately 42 percent) were from Indigenous Peoples,⁶³ even though they only made up approximately 2.3 percent of the Alberta population at the time.⁶⁴ In 1956, while the overall death rate from tuberculosis continued to decline, Indigenous Peoples in Alberta still made up nearly a third of all deaths,⁶⁵ which in part reflected that they were “in the hands of harried, if not unqualified staff, in crowded and dismal institutions.”⁶⁶ Recent estimates show that tuberculosis rates among the Indigenous population in Alberta remained very high until the 1960s, at which point they began to decline — first rapidly (until the 1980s), and then more slowly. Despite the decline from the 1960s to the early 2000s, tuberculosis rates among Indigenous populations in Alberta remain higher than in the non-Indigenous population.⁶⁷

Tuberculosis thus provides another illustration of power, resources, opportunities and thus health outcomes being tied to social identity, including racial identity. The constructed nature of the public, which excluded or segmented Indigenous Peoples on colonial, jurisdictional and racist grounds, fostered systemic inequities including differential approaches to prevention and control.

Conclusion

This chapter has illustrated ways in which the public in public health has been constructed throughout Alberta's history. The public has consistently been, implicitly, or explicitly, defined through processes of compartmentalizing, structuring, and conceptualizing a group in ways that contribute to paradigms of inclusion and exclusion. As the consideration of the eugenics program shows, concepts of "mental deficiency" were intimately tied to racial purity, which in turn interacted with socio-economic status to disenfranchise various groups and categorize them as part of the threat. An analysis of immigration further illustrates racialized assumptions about causes of ill health and how the ensuing discourse of social exclusion influenced public policy. And with tuberculosis, some individuals were seen, on the basis of their intersecting social locations of class, race, gender, etc., to be contagions of disease, and therefore morally bankrupt and excluded from particular public services and resources. More extensively, Indigenous Peoples' health concerns were dictated in a unilateral colonial fashion that placed them outside of a broader public, with frailties assigned to them due to their ethnicity that underscored unacceptably paternalistic treatment. In each case, the public was conceived in a distinct way that led to diversions from the idealized norm being treated differently and almost always unfairly.

As acknowledged at the outset of this chapter, considerable work is being done to theorize more equitable ways in which public health can be conceptualized and practised, which necessitates taking into consideration the structures and processes that advantage or disadvantage individuals and groups on the basis of multiple factors (e.g., race, gender, age, Indigenous status, ability), and directing public policy efforts toward redressing the systemic factors that create and perpetuate those inequities. To provide structure to these inquiries within applied public health, the Canadian Public Health Association reminds us of the foundational role of equity in our field.⁶⁸ To a certain extent, the very nature of public health — which is concerned with the conditions of the health of a population — carries the risk of being "equal but not equitable." However, this is a challenge to which we must rise if we wish to retain a robust and relevant vision of public health that embraces the social determinants of health in a meaningful and critical way.

NOTES

- 1 Doug Whalsten, "Leilani Muir versus the Philosopher King: Eugenics on trial in Alberta," *Genetica* 99 (1997).
- 2 Whalsten, "Leilani Muir," 194–195.
- 3 Amy Samson, "Eugenics in the Community: The United Farm Women of Alberta, Public Health Nursing, Teaching, Social Work, and Sexual Sterilization in Alberta, 1928–1972" (PhD diss., University of Saskatchewan, 2014), 2, Harvest database, <http://hdl.handle.net/10388/ETD-2014-12-1975>.
- 4 Jana Grekul, Harvey Krahn, and Dave Odynak, "Sterilizing the 'Feeble-minded': Eugenics in Alberta, Canada, 1929–1972," *Journal of Historical Sociology* 17, no. 4 (2004).
- 5 The Sexual Sterilization Act (1928) did not explain how "mental deficiency" was conceptualized. Patients were usually deemed to be mentally deficient if they scored below 70 on an IQ test, but sociologist Jana Grekul has demonstrated that "the 'mentally defective' status of people passed by the [Eugenics] Board for sterilization is questionable." This is primarily because some patients were labelled mentally defective despite scoring 70 or higher on the IQ test. Jana Grekul, "The Social Construction of the Feebleminded Threat: Implementation of the Sexual Sterilization Act in Alberta, 1929–1972" (PhD diss., University of Alberta, 2002), 123, ERA [education & research archive] database, <https://doi.org/10.7939/r3-5s4e-ez69>.
- 6 See Marcel Verweij and Angus Dawson, "The Meaning of 'Public' in 'Public Health,'" in *Ethics, Prevention, and Public Health*, eds. Angus Dawson and Marcel Verweij (Oxford: Oxford University Press, 2007).
- 7 See John Coggon, *What Makes Health Public? A Critical Evaluation of Moral, Legal, and Political Claims in Public Health* (Cambridge: Cambridge University Press, 2012).
- 8 Grace-Edward Galabuzi, "Social Exclusion," in *Social Determinants of Health: Canadian Perspectives*, ed. Dennis Raphael (Toronto: Canadian Scholars Press, 2009).
- 9 Ronald Labonté, "Social Inclusion/Exclusion and Health: Dancing the Dialect," in *Social Determinants of Health: Canadian Perspectives*, ed. Dennis Raphael (Toronto: Canadian Scholars Press, 2009).
- 10 Janet Smylie, "The Health of Aboriginal Peoples," in *Social Determinants of Health: Canadian Perspectives*, ed. Dennis Raphael (Toronto: Canadian Scholars Press, 2009).
- 11 Melanie Rock, "Who or What Is 'the Public' in Critical Public Health? Reflections on Posthumanism and Anthropological Engagements with One Health," *Critical Public Health* 27, no. 3 (2017); Rebecca J. Haines-Saah, et al., "The Privileged Normalization of Marijuana Use — An Analysis of Canadian Newspaper Reporting, 1997–2007," *Critical Public Health* 24, no. 1 (2014).
- 12 See for example: G.R. Bauer, "Incorporating Intersectionality Theory into Population Health Research Methodology: Challenges and the Potential to Advance Health Equity," *Social Science & Medicine* 110 (2004); Mary Susan Thomson, et al., "Improving Immigrant Populations' Access to Mental Health Services in Canada: A Review of Barriers and Recommendations," *Journal of Immigrant and Minority Health* 17, no. 6 (2015); Olena Hankivsky, *Health Inequities in Canada: Intersectional Frameworks and Practices* (Vancouver: University of British Columbia Press, 2011); Josée Lapalme, Rebecca Haines-Saah, and Katherine L. Frohlich, "More than a Buzzword: How Intersectionality Can Advance Social Inequalities in Health Research," *Critical Public Health* 30, no. 4 (2020).
- 13 See for example, Ninette Kelley and Michael Trebilcock, *The Making of the Mosaic: A History of Canadian Immigration Policy* (Toronto: University of Toronto Press, 1998).
- 14 Kelley and Trebilcock, *Making of the Mosaic*.
- 15 Donald H. Avery, *Reluctant Host: Canada's Response to Immigrant Workers, 1896–1994* (Toronto: McClelland & Stewart, Inc., 1995), 20.
- 16 See for example, Howard Palmer, *Patterns of Prejudice: History of Nativism in Alberta* (Toronto: McClelland and Stewart Ltd., 1982).
- 17 Palmer, *Patterns of Prejudice*, 31–32.
- 18 Valerie Knowles, *Strangers at Our Gates: Canadian Immigration and Immigration Policy, 1540–1990* (Toronto: Dundurn Press, 1992), 136.
- 19 Palmer, *Patterns of Prejudice*, 21.
- 20 Kristin Burnett, "Race, Disease, and Public Violence: Smallpox and the (Un)Making of Calgary's Chinatown, 1892," *Social History of Medicine* 25, no. 2 (May 2012), 370.
- 21 Burnett, "Race, Disease, and Public Violence," 368.
- 22 Ban Seng Hoe, "Structural Changes of Two Chinese Communities in Alberta, Canada," *Canadian Centre for Folk Culture Studies* 19 (1976): 45.
- 23 Burnett, "Race, Disease, and Public Violence," 366.

- 24 Nyan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (London: University of California Press, 2001), 115.
- 25 Palmer, *Patterns of Prejudice*, 82.
- 26 "The Chinese," *The Edmonton Bulletin*, 15 August 1892, 4.
- 27 Erika Dyck, *Facing Eugenics: Reproduction, Sterilization and the Politics of Choice* (Toronto: University of Toronto Press, 2013), 34.
- 28 Canada. *House of Commons Debates*, 23 May 1922. 14th Parliament, 1st Session: Volume 3, 2145–2146, https://parl.canadiana.ca/view/oop.debates_HOC1401_03/2.
- 29 Provincial Archives of Alberta, Premier's Office Files, 69.289, roll 433, memorandum from Dr. Laidlaw to Premier Brownlee, 6 November 1924.
- 30 Letter from Miss E. Clark to Dr. Laidlaw and Premier Brownlee, 10 September 1924, PAA, 69.289, roll 433, premier's office files.
- 31 Barbara Roberts, *Whence They Came: Deportation from Canada, 1900–1935* (Ottawa: University of Ottawa Press, 1988), 47–48.
- 32 Dyck, *Facing Eugenics*, 44.
- 33 Cited in Dyck, *Facing Eugenics*, 45.
- 34 Dyck, *Facing Eugenics*, 45.
- 35 Martin Pernick, "Eugenics and Public Health in American History," *American Journal of Public Health* 87, no. 11 (1997): 1767–1768.
- 36 Eugenics was a term coined by British statistician, Francis Galton (1882–1911) in 1883. See Francis Galton, *Inquiries into Human Faculty and its Development* (London: Macmillan, 1883), 17.
- 37 Marius Turda, *Modernism and Eugenics* (London: Palgrave Macmillan, 2010), 7.
- 38 Dorothy Porter, *Health, Civilization, and the State: A History of Public Health from Ancient to Modern Times* (London: Routledge, 1999), 168.
- 39 *The Sexual Sterilization Act*, Statutes of the Province of Alberta 1928, c. 37, 117–18.
- 40 Dyck, *Facing Eugenics*, 9.
- 41 Clarence Hincks. *Mental Hygiene Survey of the Province of Alberta 1921*. [n.p.]: Canadian National Committee for Mental Hygiene, 1921.
- 42 Gerald V. O'Brien, *Framing the Moron: The Social Construction of Feeble-mindedness in the American Eugenics Era* (Manchester.: Manchester University Press, 2013), 6.
- 43 For more information about the United Farm Women of Alberta and their eugenics campaign see, A. Naomi Nind, "Solving an 'Appalling' Problem: Social Reformers and the Campaign for the Alberta Sexual Sterilization Act, 1928," *Alberta Law Review* 38, no. 2 (2000); Sheila Gibbons, "'The True [Political] Mothers of Today': Farm Women and the Organization of Eugenics Feminism in Alberta." (Master's thesis, University of Saskatchewan, HARVEST database, 2012), <https://harvest.usask.ca/items/f47f616c-7f0a-4c00-82d1-38786f2af9eb>.
- 44 Erna Kurbegović, "Eugenics in Comparative Perspective: Explaining Manitoba and Alberta's Divergence on Eugenics Policy, 1910s to the 1930s" (PhD diss., University of Calgary, 2019), 211, Prism database, <http://hdl.handle.net/1880/109868>; Amy Samson, "Eugenics in the Community."
- 45 See for example, Christian, "The Mentally Ill and Human Rights in Alberta." Jana Grekul, "Sterilization in Alberta, 1928–1972: Gender Matters," *Canadian Review of Sociology* 45, no. 3 (2008); Karen Stote, *An Act of Genocide: Colonialism and the Sterilization of Aboriginal Women* (Winnipeg: Fernwood Publishing, 2015); Erika Dyck, *Facing Eugenics*.
- 46 Katherine McCuaig, *The Weariness, the Fever, and the Fret* (Montreal: McGill-Queen's University Press, 1999), 8.
- 47 While including several different examples of social exclusion in this chapter, we are cognizant of Eve Tuck and K. Wayne Yang's powerful reminder that *decolonization is not a metaphor*: Indigenous inequities are different from other forms of inequities, and decolonization is not just another social justice project. Eve Tuck and K. Wayne Yang, "Decolonization is Not a Metaphor," *Decolonization: Indigeneity, Education & Society* 1, no. 1 (2012).
- 48 McCuaig, *The Weariness*, 17.
- 49 Editorial. "The Question of Immigration," *Western Canada Medical Journal* 4, no. 7 (July, 1910), 328.
- 50 Alberta Department of Public Health, *Annual Report 1939* (Edmonton: printed by A. Shnitka, King's Printer, 1941), 21; Maureen Lux, "Beyond Biology: Disease and its Impact on the Canadian Plains Native People, 1880–1930" (PhD diss., Simon Fraser University, 1996), 343, Summit Research Repository, <https://summit.sfu.ca/item/7012>; see, for instance: Truth and Reconciliation Commission of Canada, *Honouring the Truth, Reconciling for the Future, Summary of the Final Report of the Truth*

- and Reconciliation Commission of Canada (Winnipeg, MB: Truth and Reconciliation Commission of Canada, 2015), www.trc.ca.
- 51 Mary Ellen Kelm, "Diagnosing the Discursive Indian: Medicine, Gender, and the 'Dying Race,'" *Ethnohistory* 52, no. 2 (Spring 2005), 381.
- 52 R. C. Ferguson and R. G. Ferguson, "Activities in a Province-Wide Programme for the Control of Tuberculosis," *Canadian Public Health Journal* 26, no. 3 (March 1935), 134.
- 53 Maureen Lux, "Care for the 'Racially Careless': Indian Hospitals in the Canadian West, 1920–1950s," *Canadian Historical Review* 91, no. 3 (September 2010), 273, 344; Lux, "Beyond Biology," 344.
- 54 Maureen Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s–1980s* (Toronto: University of Toronto Press, 2016), 11; Lux, "Care for the 'Racially Careless,'" 420.
- 55 Anne Fanning, interview by Don Juzwishin and Rogelio Velez Mendoza, 30 August 2018.
- 56 Lux, *Separate Beds*, 9–10.
- 57 Lux, *Separate Beds*, 10.
- 58 Lux, "Beyond Biology," 382.
- 59 Lux, "Care for the 'Racially Careless.'"
- 60 Lux, "Beyond Biology," 379.
- 61 Lux, *Separate Beds*, 103.
- 62 Alberta Department of Public Health, *Annual Report 1947* (Edmonton: printed by A. Shnitka, King's Printer, 1949), 25.
- 63 Alberta Department of Public Health, *Annual Report 1952* (Edmonton: printed by A. Shnitka, King's Printer, 1954).
- 64 This approximation comes from the 1951 Statistics Canada long-form census. According to the 1951 Census Table 34: "Population by origin and sex, for counties and census divisions," Alberta had a total population of 939,501, of which 21,210 (approx. 2.3%) responded to the census question as having "Indian and Eskimo" origin. It is important to emphasize that estimates of the Indigenous population in Canada depend on the source, and different data collection methods impact the estimates. For example, the numbers reported by Statistics Canada from the long-form census "comprise all persons who self-identify as having Aboriginal ancestry and/or Aboriginal identity." This is different from the estimates from the Indian Register administered by Indigenous and Northern Affairs Canada (INAC). Prior to the 1985 enactment of Bill C-31, *An Act to Amend the Indian Act*, many people were disqualified from receiving their Indian Status and any related rights through forcible enfranchisement. For the census figures see Canada. Dominion Bureau of Statistics, Ninth Census of Canada (Ottawa: King's Printer, 1951), Vol. 1, Table 34. For the difficulties in assessing population see, Frank Trovato, and Laura Aylsworth, "Demography of Indigenous Peoples in Canada," in *The Canadian Encyclopedia*, last edited 17 January 2018, <https://www.thecanadianencyclopedia.ca/en/article/aboriginal-people-demography>.
- 65 Alberta Department of Public Health, *Annual Report 1956* (Edmonton: printed by A. Shnitka, King's Printer, 1958), Alberta Department of Public Health, *Annual Report of the Bureau of Vital Statistics*, 3.
- 66 Lux, *Separate Beds*, 129.
- 67 Kianoush Dehghani, et al., "Determinants of Tuberculosis Trends in Six Indigenous Populations of the USA, Canada, and Greenland from 1960 to 2014: A Population-Based Study," *Lancet Public Health* 3, issue 3 (6 February 2018), [https://doi.org/10.1016/S2468-2667\(18\)30002-1](https://doi.org/10.1016/S2468-2667(18)30002-1); Thomas Kovesi, "Respiratory Disease in Canadian First Nations and Inuit Children," *Pediatric Child Health* 17, no. 7 (August–September 2012), 377.
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