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Between Education and Memory: Health and Childhood in English-Canada, 1900-1950

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Abstract: Despite contemporary concerns regarding the state of Canadian children's health, historians in Canada have yet to fully explore how conventional medical experts and educators thought about, and safeguarded, children's health. This paper explores the interplay between two sources of information regarding the provision of healthy children between 1900 and the end of the Second World War in the English Canadian context: curricular messages regarding health and illness aimed at public school children and the oral histories and autobiographies of adults who grew up in this period. Rather than simply juxtapose official health curriculum and lived memory, I argue that the two co-mingled to produce differing kinds of embodied knowledge aimed at the production and reproduction of hegemonic social values in the English Canadian setting. These values co-existed both harmoniously and uncomfortably, depending very much upon the priorities of, and socially constructed limitations placed upon, particular families in particular contexts.

Résumé : Malgré les inquiétudes contemporaines concernant la santé des enfants au Canada, les historiens canadiens n'ont toujours pas exploré en profondeur la pensée des experts médicaux ni celle du personnel cadre enseignant à ce sujet. Cet article explore l'interaction entre deux sources d'informations sur les dispositions des enfants en bonne santé entre 1900 et la fin de la Seconde Guerre mondiale, et ce, dans le contexte du Canada anglais : des messages scolaires sur la santé et la maladie visant les élèves des écoles publiques, et les histoires orales et autobiographies d'adultes ayant grandi pendant cette période. Plutôt que de simplement juxtaposer les programmes sanitaires scolaires officiels et les mémoires, nous proposons également d'examiner comment ces deux éléments cohabitaient et produisaient des connaissances différentielles visant la production et la reproduction de valeurs sociales hégémoniques au Canada anglais. Ces valeurs coexistaient de façon harmonieuse et gênante en même temps, suivant les priorités de familles particulières dans des contextes particuliers, ainsi que les limites socialement construites qu'elles devaient supporter.

Despite contemporary anxieties surrounding numerous aspects of children's health, including levels of obesity, diabetes, asthma, sudden infant death syndrome (SIDS), maternal smoking, substance abuse, and

the dangers of anti-depressants for young people, scholars have yet to fully mine the rich history of children and health in the English Canadian context.¹ One of the key insights from the growing field of body studies for our understanding of children's experience with health in the past, particularly from feminist and postcolonial scholars, is that social processes are written upon, and taken up by, and through, bodies.² Sociologist Pierre Bourdieu called such unconscious and embodied reproduction of social structures "habitus." For Bourdieu, the concept of habitus encompasses all the ways human beings learn to be in the world—ways that are often taken for granted and assumed to be 'natural'—and how, in turn, such embodied knowledge contributes to social production and reproduction.³ Attention to the ways children were taught to be healthy in both formal and informal settings provides a window on how such processes of social reproduction—including those fashioned by race, class, and gender—unfolded in the past and continue to resonate in the present.

This paper explores the interplay between two sources of information regarding the provision of healthy children between 1900 and the end of the Second World War in the English Canadian context: curricular

I wish to thank Natalie Chambers for her invaluable research assistance and the Social Sciences and Humanities Research Council, Government of Canada, for funding support.

1. Important exceptions are Neil Sutherland, *Children in English-Canadian Society: Framing the Twentieth-Century Consensus* (Waterloo: Wilfrid Laurier University Press, 2000), and Cynthia Comacchio, *Nations are Built of Babies: Saving Ontario's Mothers and Children, 1900-1940* (Montréal and Kingston: McGill-Queen's University Press, 1993). A recent addition is *Children's Health: International Historical Perspectives*, eds. Cheryl Krasnick Warsh and Veronica Strong-Boag (Waterloo: Wilfrid Laurier University Press, 2005), which features a number of recent articles on Canadian children in English and French Canada. Janet Golden, Richard Meckel, Heather Munro Prescott, and Charles King have made significant contributions to the American context. See, for example, Janet Golden, Richard Meckel, and Heather Munro Prescott, *Children and Youth in Sickness and in Health: A Historical Handbook and Guide* (Westport, Connecticut: Greenwood Press, 2004); Janet Golden, *A Social History of Wet-Nursing in America: From Breast to Bottle* (New York: Cambridge University Press, 1996); Heather Munro Prescott, *A Doctor of Their Own: A History of Adolescent Medicine* (Cambridge, Massachusetts: Harvard University Press, 1998); Richard Meckel, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929* (Baltimore: John Hopkins University Press, 1990); Charles King, *Children's Health in America* (New York: Twayne Publications, 1993).

2. Londa Schiebinger, "Introduction," in *Feminism and the Body*, ed. Londa Schiebinger (New York: Oxford University Press, 2000), 1-24; Bryan Turner, *The Body and Society* 2nd Edition (London: Sage Publications, 1996), 103-125.

3. Pierre Bourdieu, *Distinction: A Social Critique of the Judgement of Taste* (Cambridge, Massachusetts: Harvard University Press, 1984).

messages regarding health and illness aimed at public school children and the oral histories and autobiographies of adults who grew up in this period. This time period coincides with the consolidation of a number of forces which continue to shape conceptions of healthy children, including the increasing role of the state and of “experts”—particularly medical and educational—in shaping the lived experience of children and families.⁴ Rather than simply juxtapose official health curriculum and lived memory, I argue that the two co-mingled to produce differing kinds of embodied knowledge aimed at the production and reproduction of hegemonic social values in the English Canadian setting. These values co-existed both harmoniously and uncomfortably, depending very much upon the priorities of, and socially constructed limitations placed upon, particular families in particular contexts.

The purpose of the study is twofold: first, I hope to add to the small but growing historiography on children’s history generally, and children’s health in particular, in English Canada. In terms of children’s interactions with health professionals, historians of English Canada have concentrated primarily on the role of public health experts in overseeing the well-being of particular populations of children, namely infants.⁵ The part health education played in advancing hegemonic conceptions of healthy children beyond infancy has not been fully explicated by scholars, despite the fact that it joined the public school curriculum in Canada in the late 1800s.⁶ Since education is administered provincially in Canada, these decentralized provincial Boards of Education took the lead in establishing

4. In addition to the sources cited in the first endnote, numerous works in the American and English Canadian context explore these interconnections. In the latter case, see, for example, Jane Ursel, *Private Lives, Public Policy: 100 Years of State Intervention in the Family* (Toronto: Women’s Press, 1992); Cynthia Comacchio, *The Infinite Bonds of Family: Domesticity in Canada, 1850-1940* (Toronto: University of Toronto Press, 1999); Mona Gleason, *Normalizing the Ideal: Psychology, Schooling and the Family in Postwar Canada* (Toronto: University of Toronto, 1999).

5. In French Canada, scholars have also focused considerable attention on infants and mothers. See, for example Andrée Lévesque, *Résistance et transgression: études en histoire des femmes au Québec* (Montréal: Éditions du Remue-ménage, 1995); Denyse Baillargeon, “Entre la ‘Revanche’ et la ‘Veillée’ des berceaux: les médecins québécois francophones, la mortalité infantile et la question nationale, 1910-1940,” *Canadian Bulletin of Medical History* 19 (2002): 113-138.

6. Gale Smith and Linda Peterat take up the history of health education in Canada briefly in “Reading Between the Lines: Examining Assumptions in Health Education,” in *Weaving Connections: Educating for Peace, Social and Environmental Justice*, eds. Tara Goldstein and David Selby (Toronto: Sumach Press, 2000), 242-267.

the official health curriculum.⁷ Often written in partnership with medical professionals, health textbooks conveyed contemporary conceptions of good health, disease prevention, and socially sanctioned morals and values.⁸

My textual analysis of the approximately eleven health textbooks consulted in this study concentrates on a number of emergent themes regarding the provision of healthy children conveyed in various health lessons from beginning to mid-century. Textbooks are an important source regarding not only “whose culture is taught in schools,” but also of the ideological context in which they are conceived and made available.⁹ Scholars of textbook content remind historians that while an examination of such sources cannot tell us how they were taught in the classroom or how they influenced pupils, they can intimate something of the ideological priorities that motivated their production and distribution.¹⁰ The health texts selected for analysis here satisfied three main interpretive criteria: 1) they were published between the early to middle decades of the twentieth century; 2) they represented titles “approved” by the various provincial educational officials for use in public schools across a number of regions in English Canada; 3) they exemplified various themes and preoccupations apparent in a number of health textbooks published around the same time.

Building on this, my second purpose is to use both oral histories and autobiographies to infuse into the expert-driven textbook information a more nuanced appreciation for how individuals experienced health and illness as a dimension of family life. To satisfy this purpose, I draw upon the oral history interviews (seven interviews) and autobiographical writings (eight autobiographies) of fifteen adults born and/or raised in English Canada between approximately 1900 and 1945. The interviews and autobiographies capture some measure of the diversity of regional,

7. The classic history of curriculum development in Canada is George Tompkins, *A Common Countenance: Stability and Change in the Canadian Curriculum* (Scarborough: Prentice Hall, 1986).

8. For an interpretation of curriculum as a reflection of social values, see Bernd Baldus and Meenaz Kassam, “Make Me Truthful, Good and Mild: Values in Nineteenth Century Ontario Schoolbooks,” *Canadian Journal of Sociology* 21 (1996): 327-358.

9. *Ibid.*; Michael W. Apple and Linda K. Christian-Smith, “The Politics of the Textbook,” in *The Politics of the Textbook*, eds. Michael W. Apple and Linda K. Christian-Smith (New York: Routledge, 1991), 1-21.

10. Baldus and Kassam, “Make Me Truthful, Good and Mild,” 327-328. The textbooks used in the study were produced internally by Canadian authors and publishing houses, and also externally, particularly from American sources. See Appendix 2: Textbook Profiles.

racial, ethnic, gender, and class-bounded experience of health and illness while growing up in English Canada.¹¹ This evidence serves to complement and complicate what the official health textbook curriculum was attempting to impart in school children.

Like all historical sources, oral history interviews and autobiographical memories present unique methodological and interpretive challenges. The most often repeated caveat is that they more accurately reflect a memory “created” rather than one truly and accurately remembered. Autobiography, in particular, is occasionally dismissed as an untrustworthy source given its ‘artificial coherence’ as a recreated life story.¹² Even with such caveats in mind, however, these sources have great interpretive potential for helping historians to “get inside childhood,” as Neil Sutherland has argued.¹³ Plentiful evidence generated by a variety of children regarding their own experiences with health and illness in the past is not readily available to historians. Therefore, oral history interviews and autobiographical memories used judiciously, with an eye to their limitations as well as their potential, can give some representation to often overlooked experiences.¹⁴

The years covered in this study correspond with considerable change in Canadian society, and indeed around the Western world. My analysis is divided into roughly two large periods: the turn of the century to World War I and into the 1920s, from the 1920s to the Great Depression and the

11. The interviews used in this paper involved open-ended conversations in which interviewees were encouraged to talk about what they remembered about health and illness in their childhoods. The interviews used here are part of a larger group of approximately 30 interviews. In the case both of the oral history interviews and the autobiographical memories, an attempt was made to highlight experience at least partially representative of women and men from a wide variety of backgrounds. Those oral history interviews used here include adults who grew up in Western, Central, and Eastern Canada, from working-class and lower middle class, and from Anglo-Celtic and First Nations backgrounds. The autobiographies represent memories from Ukrainian Canadian, Inuit, Anglo-Celtic, and Asian Canadians.

12. Michael Marker points out that the uncritical use of autobiographies of First Nations people is particularly problematic. He argues that these works “satisfy White perceptions of what Indians were supposed to think and act like.” Michael Marker, “Review Essay: Ethnohistory and Indigenous Education: A Moment of Uncertainty,” *History of Education* 29 (2000): 84.

13. Neil Sutherland, *Growing Up: Childhood in English Canada from the Great War to the Age of Television* (Toronto: University of Toronto Press, 1997), 3-23.

14. On the problems and potentials associated with autobiography as an historical source, see *Ibid*; John Sturrock, *The Language of Autobiography: Studies in the First Person Singular* (London: Cambridge University Press, 1993), 1-19; Richard Coe, *When the Grass was Taller: Autobiography and the Experience of Childhood* (New Haven: Yale University Press, 1984).

end of World War II. Nested within these broad social transformations, considerable developments in medical science played a central part in curriculum change. As Wendy Mitchinson has recently shown, medical practitioners struggled with their status as “professionals” in the early decades of the century.¹⁵ Developments in the specialization of paediatrics, including the growing acceptance of “germ theory, vaccines, diphtheria toxoid, hormones, genetics, vitamins, and antibiotics,” enabled medical professionals to shift their focus from control of infant mortality, to control of contagious diseases and the promotion of vaccination, to the prevention of accidental death—due in large part to the arrival of the automobile.¹⁶ Shifts in medical science, larger political, social, economic and cultural change, and new educational pedagogical theories brought considerable change to the information contained within health textbook curriculum over the century.

Health Curriculum at the Turn of the Century: Individual Salvation and the Rules of Health

From the turn of the twentieth century to the end of the First World War, health textbooks produced for, and/or used in, English Canadian schools reflected a social context shaped by industrialization, the increasing economic gap between rich and poor, the rise of public health campaigns, the arrival of new immigrants into slowly expanding cities, the Christian temperance movement, and war in Europe. All of these social forces made public schooling an attractive bulwark against social unrest and something of a ‘health laboratory’ for the treatment and prevention of illness in children.¹⁷ The promotion of hygiene—the science of sanitation—was an integral part of early professional efforts on

15. Wendy Mitchinson, *Giving Birth in Canada, 1900-1950* (Toronto: University of Toronto Press, 2002), 19-46.

16. Jacalyn Duffin, *History of Medicine: A Scandalously Short Introduction* (Toronto: University of Toronto Press, 1999), 321; Mona Gleason, “From ‘Disgraceful Carelessness’ to ‘Intelligent Precaution’: Accidents and the Public Child in English-Canada, 1900 to 1950,” *Journal of Family History* 30, 2 (2005): 230-241.

17. The provision of compulsory public schooling for children spread across the country just prior to the period under study, starting with Ontario by the mid-nineteenth century, Manitoba and New Brunswick in 1871, British Columbia in 1872, Newfoundland and Nova Scotia in 1874, Quebec in 1869 and 1888, the Northwest Territories in 1901 and Alberta and Saskatchewan in 1905. On the history of schooling legislation in Canada, see J. D. Wilson, Robert M. Stamp, and Louis-Phillippe Audet, *Canadian Education: A History* (Scarborough: Prentice-Hall, 1970); F. Henry Johnson, *A Brief History of Canadian Education* (Toronto: McGraw-Hill, 1968).

the part of the medical establishment to control contagion amongst individual bodies, in neighbourhoods, and larger communities.

The notion of “science” contained in discussions of germ theory, eugenics, and sanitation in health texts reflected a society steeped in Christian moral values and an acceptance of unequal social relations. That germs and disease cause illness, for example, was often mixed with tenets of eugenics and the dangers of race suicide. *Gage’s Health Series for Intermediate Classes* (1896), authorized for use in middle schools in Manitoba and British Columbia, seized on the discourse of heredity to dissuade young English Canadians from indulging in alcohol:

Probably no one ever suffered from all the diseases produced by alcohol, but all habitual drinkers sooner or later experience one or more of them. And their children are more likely to inherit stronger appetite for narcotics and a weaker will with which to control it...The taking of a single glass of liquor, the eating of brandy sauce or wine jelly, may rouse this inherited desire, though its processor may not have discovered that the taint is in his blood; the appetite, becoming uncontrollable, may bring its owner to a drunkard’s grave.¹⁸

By 1910, authorized health texts conceded that environmental factors—the state of cleanliness, health habits, and dwellings—had an important part to play in determining the state of individual health. Still significant, however, was heredity stock. As Dr. A.P. Knight, professor of physiology at Queen’s University in Kingston, Ontario, and author of *The Ontario Public School Hygiene* (1910) wrote, “If you have followed the teachings of this book thus far, it must be clear to you now that our lives from birth until old age are shaped largely by two great influences: (1) by what we inherit from our parents, grandparents, or other ancestral relatives, and (2) by our environment, that is, by our surroundings.”¹⁹

In keeping with the tenets of Christianity, health lessons conveyed in pre-World War I texts were firmly predicated on notions of Cartesian dualism: the mind and body were distinct and co-existed in a hierarchical, mind over body, relationship. This made possible the recurring reminder in these early textbooks that self-control and an acceptance of one’s station in life were signs of good health. In *The Essentials of Health: A Text-book on Anatomy, Physiology, and Hygiene* (1909), for example, children learned:

...what every boy and girl should aim to do is put his (sic) body under the control of his mind in matters relating to his own health. That is to say, he should so apply

18. W. J. Gage, *Gage’s Health Series for Intermediate Classes Part 2* (Toronto: W. J. Gage & Company’s Educational Series, 1896), 163.

19. A. Knight, *The Ontario Public School Hygiene* (Toronto: Copp Clark, 1910), 229.

his understanding of the uses of the various organs of the human body and the effects of this or that treatment upon them, that he is able for the most part to avoid those things which will be harmful to his health and cultivate those things which will help to upbuild his physical and mental manhood... Control of our own bodies, then, based upon a proper understanding of them, is the first step toward the attaining of true manhood or womanhood.²⁰

Influenced by tenets of the Christian temperance movement, this particular passage called upon girls and boys to view abstinence from alcohol and tobacco as part and parcel of their healthful journey to appropriately gendered adulthood.²¹ Despite the veneer of equality between the sexes contained in health advice such as this, the social context of early twentieth century English Canada meant that girls and boys would be expected to tread along different life pathways. Girls would be expected to parlay healthful habits into motherhood and marriage while boys would prepare for public roles of leadership and governance.²²

School children were admonished in early health and hygiene textbooks to conceive of the avoidance of contagious disease as another part of their Christian duty. Following on this theme, textbooks placed the blame for sickness and disease on the moral failings of the individual. Whether through ignorance, wickedness, or wilful disobedience, poor health was presented as partly a matter of choice. In *How to be Healthy*, a 1911 textbook written by Manitoban doctor J. Halpenny, and used in schools all over Western Canada, good health and vigour were unmistakably moral virtues reserved for those who chose to live “a sensible, normal life.” By extension, those who struggled with poor health were cast with a pallor of immorality, bad choices, and weak wills. Students were instructed that:

...when real difficulties come to us, let us meet them manfully, and win or lose, but never hold onto them or brood over them. This is the cause of much ill-health. Our right to be happy must not be interfered with by anything...Once we begin to

20. Charles H. Stowell, *The Essentials of Health: A Textbook on Anatomy, Physiology, and Hygiene* (Boston: Silver, Burdett and Company, 1896), 253. This text was “prescribed for use in the Public and High Schools of British Columbia.” (preface, i.)

21. On the significance of the temperance movement in Canada see Nancy Christie, *Households of Faith: Family, Gender, and Community in Canada, 1760-1969* (Kingston and Montreal: McGill-Queen’s University Press, 2002).

22. Wendy Mitchinson, *The Nature of Their Bodies: Women and Their Doctors in Victorian Canada* (Toronto: University of Toronto Press, 1991); Veronica Strong-Boag, *The New Day Recalled: Lives of Girls and Women in English Canada, 1919-1939* (Toronto: Copp Clark Pitman, 1988).

brood, our power to do difficult things and our course to face the trouble begins to fail. Thus we weaken ourselves.²³

This discourse of moral weakness causing ill health took on heightened meanings in communities where racial minorities, particularly First Nations peoples, were thought simply incapable, by virtue of their “Indianness,” of looking after their health.²⁴ Government officials at the time repeatedly placed the blame for high rates of mortality amongst First Nations people not on the effects of colonization and the concomitant disruption this caused in the lives of Aboriginal people, but rather to a far more damning and exploitable cause: “conditions peculiar to Indians.”²⁵ The establishment of links between Christian morality and good health cast the program of Christianization and assimilation of First Nations people underway during this period with increased urgency.²⁶ As late as 1949, however, the federally accountable Department of Indian Affairs continued to sponsor “Indian Baby Shows” in various regions. The baby show was a response to the continuation of deeply held beliefs amongst Whites regarding First Nations parents’ neglect of their children, and in particular, their failure to provide good nutrition, adequate clothing and appropriate hygiene.²⁷

The centrality of individual responsibility for healthy bodies was also shaped by the realities of frontier life for many English Canadians. A number of the interviewees and autobiographical writers point out that, when it came to controlling disease, the exigencies of rural life gave many families no other option but to care for themselves. While urban populations climbed slowly during this period, rural families lived in virtual isolation from each other. Verne Nelson, born in 1913 in Bruce,

23. J. Halpenny and Lillian Ireland, *How to be Healthy* (Toronto and Winnipeg: W. J. Gage, 1911), 54.

24. See Robert Bell, *The ‘Medicine Man’ or Indian and Eskimo Notions of Medicine* (Montreal: Gazette Printing Company, 1886); Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950* (Vancouver: University of British Columbia, 1998). See also the discussion of the dangers of homespun health practices in J.W.S. McCullough, “Chatelaine’s Baby Clinic: The Common Diseases,” *Chatelaine* 6 (1934): 54; Ross A. Campbell, “The Spastic Child,” *Canadian Nurse* 42 (1946): 471.

25. From a 1908 report issued by the Government of Canada, as cited in Tina Moffat and Ann Herring, “The Historical Roots of High Rates of Infant Death in Aboriginal Communities in Canada in the Early Twentieth Century: The Case of Fisher River, Manitoba,” *Social Science and Medicine* 48 (1999): 1821-1832.

26. Kelm, *Colonizing Bodies*.

27. John Dewhurst, “Coast Salish Summer Festivals: Rituals for Upgrading Social Identity,” *Anthropologica* 17 (1976): 258.

Alberta recalled “all we knew we learned from our young parents.”²⁸ For many rural and remote communities, professional health care was any number of miles away and, in an era before socialized medicine, potentially expensive. Whether more properly conceived as a Christian duty or a matter of sheer survival, rural families took the provision of good health to be a family responsibility. In 1915, for example, 15-year-old Mike Harbuz suffered a broken leg while working on the family farm in North Battleford, Saskatchewan. When neighbours travelled to fetch the closest doctor in the next town, he was simply not home. Rather than do nothing or risk an amputation later, Harbuz was taken to a neighbour known as a “good bone setter.” He was walking with crutches some three months later.²⁹ William Macklon, born in 1919 in Kinley, Saskatchewan, and one of five children, succinctly encapsulated how many English Canadian children in the early decades of the twentieth century experienced lessons regarding the provision of good health: “for the most part doctoring was a domestic art practised by mothers, and every kitchen cupboard had a medicine shelf where she kept her favourite remedies...what she kept depended largely on the ethnic makeup of the family.”³⁰

Taking personal responsibility for good habits of health and hygiene, in keeping with Christian teachings, was central in the early health curriculum textbooks since contagious diseases such as typhoid fever, measles, diphtheria, small pox, and whooping cough routinely paralyzed communities. Health textbook curriculum encouraged students to follow particular health “rules” in order to avoid these diseases. Students were taught to surround themselves with fresh air, live in well-ventilated, clean, and uncrowded houses, dress in loose clothing, eat a variety of good foods, avoid tobacco, liquor, coffee, and tea, avoid excessive brainwork, get plenty of sleep, indulge in moderate exercise appropriate to one’s sex, carefully train the bowels for regularity, and avoid contact with sick people.³¹ Dr. Knight, professor of physiology at Queen’s University,

28. Verne Nelson, *Barefoot on the Prairie: Memories of Life on a Prairie Homestead* (Saskatoon: Western Producer Prairie Books, 1989), 3.

29. Mike Harbuz, *Ukrainian Pioneer Days in Early Years: 1898-1916 in Alvena and District, Saskatchewan* (North Battleford: Appel Printing, 1980), 15-16.

30. William Macklon, *The Fledgling Years* (Saskatoon: Western Producer Prairie Books, 1990), 18.

31. Such rules were repeated in a number of authorized health textbooks. See, for example, Ontario Provincial Board of Health, *Manual of Hygiene for Schools and Colleges* (Toronto: William Briggs, 1886), 14-15. “Authorized by the Ontario Minister of Education for use in all schools under the control of the Education Department,” preface

reminded young readers “one thing is certain, that, if nations or individuals break the rules of health, they will be punished...Nature will take no excuse for not knowing the rules.”³²

Given that such dictums about spacious accommodations, fresh fruit, and modern household conveniences were steeped in middle-class assumptions, many English Canadian families simply could not measure up. When contagions did make their way into communities, dire warnings like that proffered in school health textbooks offered little comfort. As prairie-born Ferne Nelson recalled when she, her siblings, and her relatives contracted measles in 1913, “our mothers, bone-tired, moved from one sick child to the next, carrying drinks, chamber pots, and hot water bottles and tending to the unending demands of feverish, peevish, and often desperately sick children...they had little rest and no relaxation.”³³

Many families developed their own ways of warding off contagious disease infection that had little to do with the preventative “rules” laid out in school health curriculum. The lengths to which families went to avoid contagions suggest a great deal both about the severity of the diseases and about the tenacity of familial folk remedies. Born in 1910 in Nova Scotia, one informant remembered wearing a camphor bag around her neck during the Spanish influenza outbreak of 1918. “After that [outbreak of 1918],” she concluded, “every winter almost we wore that little bag of camphor around our necks and we were healthy, we never had colds or anything.”³⁴ Into the 1920s and well beyond, families continued to concoct their own folk remedies to check the spread of diseases. An informant born in the mid-twenties in Toronto remembered vividly her father painting the outside of her and her siblings’ necks with iodine to prevent sore throats. “Now that was a strange one,” she recalled, “and of course you hated that because you went back to school with this great big brown throat from the iodine.”³⁵ She also remembered that if any of the children had whooping cough, her father would seek out a newly paved road. “Somebody told my father that if we breathed in the tar it would stop the cough, so I remember him trekking us all out there and we had to stand there and breathe in this tar...and I don’t know if it helped or not!”³⁶

page; Frances Gulick Jewett, *Book One: Good Health (The Gulick Series)* (Boston: Ginn & Company, 1906), 33-35.

32. Knight, *The Ontario Public School Hygiene*, iii.

33. Nelson, *Barefoot on the Prairies*, 39-40.

34. Interview #10, 28 July 2004, Transcript 2.

35. Interview # 6, 15 April 2004, Transcript 6.

36. *Ibid.*

A male interviewee, born just after the Second World War, grew up in Peterborough, Ontario with his father and grandparents. His grandparents, according to him, “had some strange ideas about home medicine...before we we went to school [my grandmother] would take a teaspoon of raw ginger powder mixed with sugar and we’d have to eat that before we walked to school...we’d be spitting half the way!”³⁷ This memory has significant parallels with that of another interviewee, born in the late 1940s on the Sugar Cane Reserve in Williams Lake, British Columbia. Understood as informed by Secwepemc traditions, he recalled that his mother would often prepare medicine: “I think most of the remedies, my mom made them. And some of them were from different plants that she would gather...Or, she would buy certain things and make things...there was a hot kinda tonic that she made—I think it had ginger and honey and some other stuff in it.”³⁸ These familial health strategies ran counter to official school health curriculum that privileged “science” over “superstition.” Despite, or perhaps because of, clear evidence from adult memories about the centrality of folk health remedies in their childhood, textbooks took great pains to challenge these practices: “great and unnecessary waste of life, health and vigour has resulted, and still results, from a neglect of scientific principles in regard to common things.”³⁹

Failure on the part of particularly working-class Whites to heed the advice of established medical practitioners in the treatment of children was presented mostly as a matter of alterable ignorance. In a paper presented to the Canadian Nurses Association meetings in Toronto in 1918, Dr. W. Chipman noted for example that unfortunate babies have to “fight from the very start...Their mothers fought before them—fought in poverty, in ignorance and neglect—to give them birth; and so in poverty, ignorance and neglect the child’s life begins.” Education for motherhood, however paternalistic, was seized upon as a hopeful antidote and was presented as an important job for the schools.⁴⁰

37. Interview # 7, 27 April 2004, Transcript 2.

38. Interview #2, 26 February 2004, Transcript 6.

39. This message of the superiority of medical science in treating matters of health and illness is conveyed in a number of texts. See, for example, Ontario Provincial Board of Health, *Manual of Hygiene for Schools and Colleges*; Halpenny and Ireland, *How to be Healthy*, 174; J. Mace Andress and W. A. Evans, *Healthy Citizenship* (Toronto: Ginn and Company, 1935), 63.

40. W.W. Chipman, “The Infant Soldier,” *Canadian Nurse* 14 (1918): 1453-1463. A number of scholars have focused on experts, mothers, and the state during this period in Canada, Europe and the United States. Some exemplars of this work include Comacchio, *Nations are Built of Babies*; Katherine Amup, *Education for Motherhood: Advice for*

Non-compliance with conventional medicine amongst members of non-White communities, however, was blamed on racial inferiority. George Duncan, Medical Officer of Health for Victoria, British Columbia visited Japan and China in 1894 to “acquaint myself, as far as possible, with the health condition of the people from which at present British Columbia draws the bulk of her immigration.” Without hesitation, he reported, “Chinese immigration is, from the point of view of health, the most dangerous element against which we have to contend.”⁴¹ Davie was similarly certain of the dangers of new Indo-Canadian communities to the health standards of the province. East Indians were hardest hit by plagues of disease in their countries of origin, he noted, because “the natives live in unsanitary conditions...in defiance in every way of the laws of hygiene...the White population, comparatively speaking, obey sanitation laws.”⁴²

In non-White communities around the country, however, White medicine was not necessarily looked upon as effective or accessible. Like First Nations practices, the healing traditions of other non-White communities were certainly not reflected nor sanctioned in school health curriculum. Conceptions of ‘health’ very much reflected the values, traditions, and habits of the dominant society. In an era when entrenched racism shaped the experience of Chinese immigrants who came to Canada, cultivating familiar and effective methods for treating sickness was a matter of survival.⁴³ Sing Lim, born in Vancouver’s Chinatown in 1915, and his family and neighbours turned to neighbourhood herbalists for traditional ingredients for healing. Lim recalled that Mr. Kwong’s remedies were “mostly vegetable... hundreds of little drawers contained

Mothers in Twentieth-Century Canada (Toronto: University of Toronto Press, 1994); *Maternity and Gender Policies: Women and the Rise of European Welfare States, 1880s to 1950s*, eds. Gisela Bock and Pat Thane (London and New York: Routledge Press, 1994); Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare and the State 1890-1930* (Chicago: University of Illinois Press, 1994).

41. Province of British Columbia, *First Report of the Provincial Board of Health* (Victoria: Queen’s Printer, 1895), 541-542. Duncan concluded, “Canton, from which the greatest part of Chinese immigration flows to these shores, is regarded as the most filthy city in the world, and is known to be continually impregnated with cholera.” *Ibid.*, 545.

42. “Introductory Report by the Chairman,” *Second Report of the Provincial Board of Health* (Victoria: Queen’s Printer, 1897), 690.

43. Tim Stanley, “White Supremacy and the Rhetoric of Educational Indoctrination: A Canadian Case Study,” in *Children, Teachers, and School in the History of British Columbia*, eds. Jean Barman and Mona Gleason (Calgary: Detselig Press, 2003), 113-132; Mona Gleason, “Race, Class, and Health: School Medical Inspection and ‘Healthy’ Children in British Columbia, 1890-1930,” in *Ibid.*, 133-148.

herbs: ginseng, seeds, dried buds and blossoms, taro roots, bark and seaweed...other drawers held stranger things: dried insects, rhino skins, dried snakes, and lizards, and animal horns.”⁴⁴ Even into the 1920s and 1930s, the prospect of utilizing White medicine, especially for First Nations people, was threatening and not undertaken lightly. In the case of children, the threat could take on even greater dimensions. When Minnie Aodla Freeman, an Inuit born in 1936 on Cape Horn Island in James Bay, developed impetigo as a young girl, the prospect of receiving care at the hands of White medical practitioners was a source of stress in her young mind. She recalled that “the word *naniasiutik* began to be mentioned often by my grandparents...it can mean medicine, nurse, doctor, or a person who tends the sick...to me, it meant horror, fear and pain.”⁴⁵

From Self to Community: Health Curriculum Between the Wars

Between the end of the First World War and the beginning of the World War II, a number of notable shifts occurred in the social values and messages conveyed in authorized health textbooks. The Christian temperance discourse that blamed ill health on personal wickedness and inferior inheritance was tempered with a more nuanced set of health dictums. By 1925, for example, youngsters were told in health texts: “Now boys and girls should be happy, and they should not worry about sickness at all...they should know that, even though they carefully carry out the rules of health, healthy bodies alone will not protect them from certain diseases.”⁴⁶ This shift reflected changes in the state’s role in protecting public health, the entrenchment of conventional medicine as the arbitrator of healthy bodies, and the ideals of Progressivism or the “new education” that were promoted in official educational discourse in North America beginning in the 1920s. Taking its cue largely from developments in child psychology, progressive educational philosophy sought to abandon what was understood as the worst of “formalist” or traditional pedagogy—strict classroom discipline and learning by memorization and drill—and replace it with child-centred learning which focused on investigation, co-operation, and mutual respect.⁴⁷ In many

44. Sing Lim, *West Coast Chinese Boy* (Montreal: Tundra Books, 1979), 18.

45. Minnie Aodla Freeman, *Life Among the Qallunaat* (Edmonton: Hurtig Publishers, 1978), 98.

46. Donald T. Fraser and George Porter, *Ontario Public Health Book* (Toronto: Copp Clark, 1925), 11.

47. Neil Sutherland, “The Triumph of ‘Formalism’: Elementary Schooling in Vancouver from the 1920s to the 1960s,” *BC Studies* 69-70 (1986): 175-210.

schools, particularly in urban settings, school nurses became regular members of staff and were expected to act as partners with teachers in the presentation of health lessons.⁴⁸

In this context, the “usefulness” of health curriculum became a more overt concern between the wars and suggests that at least some educators questioned its efficacy. The authors of the *Ontario Public School Health Book* (1925) surveyed teachers in the province to determine how to present health curriculum in a more engaging manner. They learned that “a suitable book in hygiene should be interesting to the pupils, free from technical terms, and contain only such physiology as is necessary; and that its aim should be to arouse a desire for proper living, to develop health habits, and to teach the pupils of our public schools some simple means for the prevention of disease.”⁴⁹ This desire to make the subject of health more enjoyable to children and more readily applicable to their daily lives was reflected in a new crop of approved textbooks offered in the twenties and thirties. Teachers could now draw upon textbooks that used stories, poetry, and games to convey important lessons regarding cleanliness, prevention of infection, and “right living.” In *The Safety Hill of Health* (1927), young students, encouraged to keep clean in a poem by the “Soap Fairy,” were to “use water and soap each day, to keep all dirt and germs away, wash your body well with me, once or twice a week, you see.”⁵⁰ Growing up in the 1930s in Penticton, British Columbia, a woman recalled that “we used to have a nurse come around...and she had a little monkey puppet called Cocoa...Miss Twitty was her name and she had a long blue uniform and she’d come and inspect all our nails just to see that they were clean.”⁵¹

Serious structural problems in schools in English Canada in the 1920s and 1930s rendered these whimsical approaches to health with considerable urgency. Many schools across the country were notorious for lack of proper sanitation, washroom facilities, and even physical space enough for the number of students in attendance.⁵² Schools

48. School nursing grew out of the school medical inspection movement. See Sutherland, *Children in English-Canadian Society*, 56-70; Gleason, “Race, Class, and Health.”

49. Fraser and Porter, *Ontario Public Health Book*, preface.

50. Jessie I. Lummis and Williedell Schawe, *The Safety Hill of Health* (New York: World Book Company, 1927), ii.

51. Interview #29, September 29, 2004, Transcript 7.

52. In the British Columbian context, for example, see Gleason, “Race, Class, and Health.” Similarly dire conditions plagued schools in New Zealand at the turn of the century. See Pamela J. Woods, “Hazardous to Children’s Health? New Zealand Primary Schools, 1890-1914,” *Historical News* 66, 4 (1993): 4-8.

themselves were often remembered as unhealthy places for children. Ingrid (Andersen) Cowlie attended a one-room schoolhouse in Wildwood, British Columbia in the early 1920s that housed six grades. While authorized health curriculum during this time warned teachers and children about the dangers of contagious diseases, Cowlie remembered that “the school had no electricity or running water. Water was brought in a bucket from my place, the Andersens. It was kept in an enamel container with a tap. We all drank out of it from the same cup! Near the school were two outhouses, one for the boys and one for the girls.”⁵³ Cowlie’s recollections were not unique. At the Cranberry Lake School in Malaspina, British Columbia, Kay Hodgson recalled that “we had outside toilets until 1933—and no place to wash our hands!”⁵⁴ Not only was the physical plant of many schools inadequate, it was also remembered as a place where disease and illness spread effortlessly from child to child. “We huddled in double-knit sweaters,” recalled Robert Collins in his one-room schoolhouse in Saskatchewan in the mid-1920s, “feet like blocks of ice, noses always clogged, mouths stained black from Smith Brothers cough drops, hacking and sneezing in a cacophony of misery.”⁵⁵

The belief that successful health teaching relied only minimally on physiological knowledge was widespread and tended to characterize textbooks used in primary grades. *Wide-Awake School*, published in 1931 and authorized for schools in Quebec and British Columbia, is a good example of this newer approach to health pedagogy that turned deliberately away from lessons grounded in physiology. Written in the form of a chapter book, *Wide-Awake School* tells the story of the school children of Drowsy Town and their efforts to improve their own health and that of their community. When they are challenged by the children in the neighbouring town to improve their school absentee record, miraculous transformations take place. Thanks to the efforts of the Drowsy Town children to stay healthy and thereby stay in school, the community itself is saved. The Mayor in the book explains:

We older people are trying to keep up with this health procession by cleaning up Drowsy Town. We now have clean streets. We are making a great fight to get rid of flies and mosquitoes; a garbage man has been hired to collect all the garbage every Monday morning, and we have dug several ditches to drain the swamps.

53. Ingrid Cowlie, “Memories of the First Wildwood School,” in *Chalkdust and Outhouses: Westcoast Schools, 1893-1950*, ed. Barbara Ann Lambert (Powell River: Barbara Lambert, 2000), 110.

54. Hodgson, “Malaspina Cranberry Lake School,” in *Chalkdust and Outhouses*, 118.

55. Robert Collins, *Butter Down the Well: Recollections of a Canadian Childhood* (Saskatoon: Western Producer Prairie Books, 1980), 45.

You have noticed that screens are on the windows and the town seems a different place from what it was a year ago. We owe much of this to you, because you were first to wake up.⁵⁶

In the context of the “new education” and a world on the brink of another war, health pedagogy thus became a vehicle for lessons in “waking up” civic responsibility and citizenship. Healthful habits were those that not only improved the individual’s well being, they radiated outward and eventually strengthened entire communities.

Ultimately, the much-touted curricular goal of forming positive “health habits” was to foster happiness in oneself and service to others. In an effort to make the curriculum appealing, teachers of older children were encouraged to have their students fill out health scorecards and to compete amongst themselves and other classes for health points. (See Appendix 1) The health scorecard promoted in *Health Essentials for Canadian Schools* (1938), part of the Canadian Hygiene Series, and prescribed by the Minister of Education for use in British Columbia, encouraged student participation in forming “health habits.” The scorecard was divided in sections such as posture (“3. books carried at arm’s length, extended downward, and changed from one hand to the other, 1 point”), food (“10. no coffee, 2 points”), exercise (“15. one half hour (at least) of enjoyable outdoor recreational activity each day, 5 points”), and home environment (“27. quiet room for study, 2 points”).⁵⁷ Such efforts to make the curriculum appealing, however, could be lost on incompetent or uninspired teachers. In the memories of two informants who grew up in Penticton, British Columbia in the thirties, the subject of health in the higher grades tended to be relegated to the emerging subject of Physical Education. One recalled, “our phys-ed teacher taught health as well but she wasn’t very good...We had to *memorize* the health primer...Oh, you know it was so boring I just couldn’t tell you what was in that book.”⁵⁸ “Once a week or rather every second week, we had a health session,” the other recalled of his Physical Education classes. “He [the teacher] would tell us the facts of life and how important it was to eat properly and all those simple little things and that was the nearest we came to doing anything about health.”⁵⁹

Despite such lost opportunities to use health curriculum for much grander goals, many interwar textbooks aimed at impressing upon young

56. J. Mace Andress, *Wide-Awake School* (Montreal: Ginn and Company, 1931), 181.

57. Andress and Breeze, *Health Essentials for Canadian Schools*, 12.

58. Interview #29, September 29, 2004, Transcript 8. Emphasis in original interview.

59. Interview #20, August 25, 2004, Transcript 4.

English Canadian minds the concept of embodied democratic citizenship. The significantly titled *New Ways for Old* (1938) placed self-conscious emphasis on the connections between strong healthy able bodies, civic pride, and belonging to the nation.

New beliefs about what education should do have made great changes in schools. Learning the three R's was the chief activity of the old schools, but the aim of the new schools is learning to live...“Learning to live,” in a modern school, means that each boy and girl may grow strong and sturdy, in mind and body, and may become the best person possible for him to be, for his own sake, and for his home and community.⁶⁰

Although health curriculum such as this prided itself on being innovative and cutting edge (“the aim of the new schools is learning to live”) several more traditional notions regarding healthy bodies endured. Cartesian dualism, the separation of body and mind, and self-control continued to influence how children and young adults were encouraged to think about their embodied selves. “No matter what you wish to do in the world,” suggested J. Mace Address and Elizabeth Breeze in *Health Essentials for Canadian Schools* (1938), “your ability to control your own mind and muscles must be the basis of your success.”⁶¹ It is significant to note, however, that children who lacked embodied control, the disabled or the mentally ill, could be easily set aside as only partial participants in “home and community.”⁶²

Behind admonishments regarding diet, study habits, and care of the body, textbooks gave credence to White and middle-class assumptions and anxieties regarding gender, race, and class at work in the interwar years. Textbooks aimed at a high school audience, for example, targeted girls’ presumed interest in “beauty” as an opportunity to promote traditional attitudes towards health and gender. Authors discouraged young women from turning to the ever-expanding array of beauty products aimed at young consumers. Far from being healthful, they warned, some products were potentially lethal. “Some of the creams advertised for their miraculous powers contain lead,” cautioned one author, “from which poisoning may arise...No magic should be expected.”⁶³ A 1938 textbook warned young women that the inexperi-

60. Thomas D. Wood, Marion O. Lerrigo, and Nina B. Lamkin, *New Ways for Old* (Newson and Company, 1938), 6.

61. Address and Breeze, *Health Essentials for Canadian Schools*, 242.

62. On assumptions regarding able-bodiedness and access to citizenship, see Helen Meekosha and Leanne Dowse, “Enabling Citizenship: Gender, Disability, and Citizenship Australia,” *Feminist Review* 57 (1997): 49-72.

63. Address and Breeze, *Health Essentials for Canadian Schools*, 243.

enced use of makeup might have the effect of damaging wholesome reputations:

The best-looking people are usually the well-groomed and natural-looking ones. Scarlet cheeks and lips take away from the interest of one's eyes, and from the natural harmony of one's features. A natural glow is more attractive than the most artful make-up.⁶⁴

Securing a “natural glow” was presumed to be an important goal for young girls. All “natural glows,” however, were not equally acceptable. The appearance of acne, a condition that plagued teenagers of both sexes, is discussed solely as a failure to adhere to winning health habits. Harkening back to the notion that bad choices resulted in ill health, textbooks continued to blame the weak individual for their condition. Those youngsters unfortunate enough to suffer from acne, despite efforts to deal with it, would have learned that “skin disturbances are common especially among young people who do not choose a well-balanced diet, or those who neglect sleep, rest, or outdoor exercise, or their habits of personal cleanliness.”⁶⁵

Interwar health textbooks promoted home settings and eating habits associated with urban Anglo-Celtic middle-class traditions as the healthiest and therefore most socially acceptable. Foods such as potatoes, beans, spinach, onions, string beans, squash, cauliflower, parsnips, turnips, daily rations of lean meat, eggs, and whole-grain breads, are singled out and promoted as healthy fare.⁶⁶ In *Healthy Citizenship* (1935), the authors offered detailed descriptions of “good housing,” that included a free standing home, a garden plot, surrounding yard, lots of sunlight and fresh air, and a sleeping-porch.⁶⁷ Children would also learn that particular furnishings, including newer lightweight carpets and draperies, domestic technology such as vacuum cleaners, and washing with ample amounts of hot water, characterized the healthy home. Families in more crowded circumstances, in apartment complexes, or perhaps in multi-family dwellings, without modern conveniences, and who ate foods not sanctioned in health curriculum would not find themselves reflected in state-sanctioned notions of good health.

It is important to consider, therefore, how such curriculum goals might have played out amongst children on the “outside” of mainstream English

64. Wood *et al.*, *Ways for Old*, 282.

65. *Ibid.*, 275.

66. Andress, *Wide-Awake School*, 134.

67. J. Mace Andress and W.A. Evans, *Healthy Citizenship* (Toronto: Ginn and Company, 1935), 51-52.

Canadian society. For First Nations children resigned to various residential schools across the country, encounters with health and illness in the school setting did very little to awaken civic pride. As Minnie Aodla Freeman recalled of her time at St. Thomas Anglican School in Moose Factory in the 1940s, "...their bannock was terrible...I forced it all down...a few times I could force myself...out it would come with the force of a strong leak in a canoe, all over the floor...I would be put to bed, my forehead would be felt and my temperature taken. That's when I felt most lonely, in this great big bedroom with two hundred beds in it."⁶⁸ Through health education in residential schools, as Mary-Ellen Kelm has shown, "children were taught to hate the food their mothers cooked and reject their standards of cleanliness....school officials told students that cultural alienation was to be welcomed as the first step towards healthful living and long life."⁶⁹ Through health curriculum, food and space become not only racialized and classed, but act as indices of membership within the bounds of Canadian citizenship.⁷⁰ The reproduction of social values held by dominant White society could readily take place, therefore, at the expense of other cultural traditions.

Whether or not students took health lessons to heart, and what was at stake for them if they adhered to them, was a complex and varied proposition. Despite the largely negative experience of residential school for Minnie Aodla Freeman, for example, the fact that health and hygiene lessons were offered in classes made a significant difference to her family at least on one important occasion. When her father was struck down with pneumonia, she was able to put what she had learned about health to good use by making a mustard plaster to ease his suffering. She credits this plaster with helping her father recover from his terrible illness.⁷¹ Marion Gallagher attended school in Victoria, British Columbia in the 1930s and recalled "all our belongings had to be labelled and a fresh, clean, ironed cotton handkerchief brought to class every day!"⁷² Robert Collins' experience was, however, very much the opposite. According to him, the teacher rarely discussed health. When it was brought up, the subject matter was distinctly forgettable. "We raised our fingernails for

68. Freeman, *Life Among the Qallunaat*, 104.

69. Kelm, *Colonizing Bodies*, 57-80.

70. On the racialization of Canadian citizenship, see Claude Denis, "Indigenous Citizenship and History in Canada: Between Denial and Imposition," in *Contesting Canadian Citizenship: Historical Readings*, eds. Robert Adamoski, Dorothy E. Chunn, and Robert Menzies (Peterborough: Broadview Press, 2002), 113-128.

71. Freeman, *Life Among the Qallunaat*, 125.

72. Marion Gallagher, "School Days in Victoria," in *Chalkdust and Outhouses*, 276.

inspection,” Collins remembered, “and lied about whether we had brushed our teeth, drunk eight glasses of water and slept for eight hours...so much for the subject known as Health.”⁷³ When asked if she recalled being examined by a school nurse, an informant who grew up in Barrie, Ontario in the 1940s said, “not that I remember. I think I can remember a nurse coming to the school—what was it for—to talk about, to talk about hygiene I think. Maybe it was for shots. I don’t recall. Whatever it was, it didn’t make a big impression anyway.”⁷⁴ Similarly, an informant who attended a First Nations band school in the British Columbian interior in the 1950s stated “I remember rolling this big barrel of skimmed milk and carrying boxes of some kind of crackers or pilot biscuits or something home that the school provided...so that was the school’s nutrition programme.”⁷⁵

Conclusions

Health textbook curriculum was designed to influence how school children not only thought about and cared for their bodies, but how these practices supported social values promoted by the state. Christian tenets of self-control, cleanliness, and adherence to “rules” appropriate to the respectable classes were promoted in health curriculum early in the century. After the end of the First World War, and in the midst of considerable social change, new themes emerged. Spurred on by changing scientific understandings of germ theory and disease prevention, as well as new educational philosophies that privileged progressive approaches to learning, health curriculum aimed to persuade children to foster healthy lives as a conduit to strong national identity and democratic citizenship. On and through children’s bodies, social acceptability, civilizing and colonizing techniques, interests of the state, and so-called ‘good health’ were written, operationalized, and vied for space.

When this expert-driven discourse is complemented with the memories of adults from diverse backgrounds who grew up in English Canada over the period examined, a richer understanding of how these discursive constructions were lived within families comes to the forefront. The lived memories of adults who grew up in different communities in English Canada suggest that the inculcation of particular kinds of health lessons did not go uncontested nor was it simply received and integrated into

73. Collins, *Butter Down the Well*, 42.

74. Interview #3, 27 February 2004, Transcript 9.

75. Interview #2, 26 February 2004, Transcript 1.

childhood experience without question. Health curriculum could indeed make a difference in the way some children learned about their bodies, but it was not simply an expert-imposed process. Taking my cue from the theorizing of Pierre Bourdieu, health curriculum and lived experience with issues of health and illness co-mingled to form a powerful habitus of social production and reproduction. Children and families who could most closely identify with the social status quo, particularly in terms of their racial, ethnic, and class position, experienced this habitus much more contentedly than those whose families remained outside of this hegemonic status quo. What was at stake in terms of cultural safety for either varied considerably depending on where one was positioned in the hierarchical social ladder that characterized English Canada over the twentieth century.

The theoretical scaffolding that helps support my interpretation of these interconnected perspectives places the body—and in this case, the small bodies of children in times of health and illness—at the forefront. The way curriculum and medical experts, teachers, and parents thought about, and treated, children's bodies reproduced and challenged social relations of power, social priorities, social fears, and social prejudices. As intertwined forces shaping children, expert discourse and familial strategies regarding health contributed to children's embodied habitus. Through the body, children learned and took up their various places in the hierarchal world of their families and communities. Twenty years has passed since distinguished historian of medicine Roy Porter remarked "the sufferer's role in the history of healing—in both its social and cognitive dimensions—has been routinely ignored by scholars."⁷⁶ By giving critical attention not just to expert discourse about healthy children but also to childhood memories of health and illness, a reflection of "young sufferers" might begin to take shape and the meanings around their experiences better understood.

76. Roy Porter, "The Patient's View: Doing Medical History from Below," *Theory and Society* 14 (1985): 175-198. See also Veronica Strong-Boag, "Spotlight on Children," *Canadian Bulletin of Medical History* 19 (2002): 5-16.

APPENDIX 1: My Health Record

MY HEALTH RECORD ¹	
Name _____	School _____
Grade _____	Teacher _____
<p>Directions: (1) Count one for every point of the Daily Health Program you have kept each day. (2) Pupils who are up to average weight who are gaining properly may have credit for milk and rest at school, without taking them. (3) Add one point for four glasses of water drunk between meals. (4) Count one off for each of these health faults: (a) Putting pencils in the mouth or anything except for eating, drinking, or cleaning teeth. (b) Sneezing or coughing without using handkerchief. (c) Going a whole day without going to toilet. (d) Eating candy or pickles between meals. (e) Drinking stimulating drinks such as tea, coffee, or coca-cola.</p>	
Month _____	
Wash	
Clean teeth	
Milk for breakfast	
Cereal for breakfast	
Fruit for breakfast	
Milk at school	
Rest at school (or home)	
Wash for lunch	
Milk for lunch	
Fruit or green vegetable	
Milk at school	
Rest at school	
Out-door play after school	
Wash for supper	
Milk for supper	
Fruit or green vegetable	
Stay at home all evening	
Clean teeth	
Bed at (7-8-9)	
Sleep with open windows	
Score for day (20 is perfect)	
Weight	

¹ Prepared for the Elizabeth McCormick Memorial Fund by Miss Maud Brown. Used by permission.

Reprinted from Andress, *Wide-Awake School*, 1931.

APPENDIX 2: Textbook Profiles

TITLE	AUTHOR INFORMATION	PROVINCE(S) USED	OTHER
<i>Book One—Good Health</i>	Jewett was an American public health reformer who wrote a series of books on hygiene and public health, with sales totaling over six million.	BC	Aimed at elementary schools.
<i>Essentials of Health: A Textbook on Anatomy, Physiology, and Hygiene</i>	Stowell was M.D.	BC	It is noted that the book is ‘adapted for Canadian schools.’
<i>Gage’s Health Series For Intermediate Classes (Part Two)</i>	Part of Gage and Company’s Educational Series.	BC, MB	
<i>Health Essentials for Canadian Schools</i>	Part of the Canadian Hygiene Series. Andress was Editor of ‘School and Health’ Department in <i>Hygeia</i> . Breeze was Director of Public Health Nurses, Vancouver.	BC	Breeze was Vancouver’s first school nurse.
<i>Healthy Citizenship</i>	Part of the Canadian Hygiene Series. Andress was Ph.D, Evans was M.D.	QC, NS, BC	Recommended for BC public school grades 1-4.
<i>How to Be Healthy</i>	Halpenny was an M.D. Surgeon at the Winnipeg General Hospital and Lecturer in Surgery at the Manitoba Medical School.	BC, AB, SK, MB, QC, NS, PE	Aimed at elementary and middle schools.
<i>New Ways for Old</i>	Adventures in Living Series. Author was M.D. Lerrigo was Staff Associate of the American Child Health Association, New Mexico State Department of Health.		
<i>Ontario Public School Health Book</i>	Fraser was Assistant Professor of Hygiene and Preventative Medicine, University of Toronto. Porter was Director of Health Service, U. of Toronto.	ON	Reprinted in 1925, twice in 1926, and 1927.
<i>The Ontario Public School Hygiene</i>	Knight was an M.D. Professor of Physiology at Queen’s University, Kingston.	ON	Intended for Forms IV and V of the Public Schools.
<i>The Safety Hill of Health</i>		AB	Part of the Health Reader Series.
<i>Wide-Awake School</i>		QC	