The Health of First Nations Children Upon Entrance to a Residential School in a Northern Manitoba Community

by

Amanda Woods

A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

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Abstract

For over a century, First Nations children were removed from their families and put into Residential schools where they spent the majority of their youth. During their time in Residential school, thousands of children suffered physical, sexual, emotional and spiritual abuse as well as a neglect of needs. The trauma experienced within the Residential schools has continued to inflict enduring pain and difficulty in the lives of Residential school survivors and their successive generations, and is known as the intergenerational impact of the Residential school experience.

It is now recognized that there may be links between the experiences children had in Residential school and current health problems experienced by First Nations people. Therefore, it is important to examine the health of the children at the time of admission to the schools in order to establish a baseline measurement of health prior to the influence of the Residential school system.

This study examines and describes the overall health of First Nations children at the time of their admission to, and during their stay in, a Residential School. This is an historical qualitative inquiry using a set of historical documents which consist of Residential school records. Through this research, a better understanding will be gained on how healthy children were when they first came to the school, what life at the school was like, and if, and how, their health changed while they were at the school.

This research can initiate additional research into Residential schools, as similar records exist for other schools across Canada. It will also inform people about what occurred in the Residential schools in terms of the health of the children who attended. Perhaps most significantly, the information from this research has the ability to be a tool

for healing and empowering Aboriginal people by reaffirming the fact that they are not to blame for the existence of Residential schools or their tragic effects.

Personal Perspective & Acknowledgements

Prior to starting my university education, I had a general understanding of what Residential schools were, as well as awareness that my own family had been impacted by this system. I began to study history of the Residential school system in Canada and quickly realized that there was much to be learned in order to begin to understand the severity of the effects of these schools on the First Nations population. I decided that I needed to look into the deeper meaning of this system and what types of impacts and outcomes it created for the First Nations population of Canada.

Within the Department of Community Health Sciences I was able to begin my research of this issue with the help, guidance, and support of professors and Departmental staff. Throughout my time in the Department I felt supported and valued as an emerging researcher and for this I thank the Department of Community Health Sciences.

As an Indigenous researcher trained in the discipline of Anthropology, I felt it would be useful to include a reflexive element to my writing and to include discussion on how writing this thesis made me as a researcher feel and how my experience researching and writing impacted my own life. However, I was concerned that adding a reflexive component to my writing would affect the way it was viewed within the Department and Faculty and so I had to limit how much I included about myself in the writing of my thesis. In considering who my audience was and who I wanted my audience to be, I realized the need to write differently for different types of audiences.

The one thing that I did not expect when I began my research was how much I would be affected by the lives of the children who were forced to attend the schools. I

found myself very emotionally affected by stories of devastated, broken-hearted parents having their children ripped from their arms in the most emotionally violent acts. Or children watching their parents disappear as they were taken by strangers to unfamiliar and frightening places. Harmful acts committed by those who felt, for some reason, had the right to do so.

In reading through the literature, I would often find myself at my desk in tears, trying to comprehend how parents could ever make it through these traumatic situations of loss and devastation. I would imagine how frightened and confused these little children must have felt as they were separated from their parents who were powerless in this situation. I wonder how many children thought their parents were willingly abandoning them. This made the literature review portion of the thesis especially difficult at times.

After the birth of my daughter, I tried to imagine how I would feel if she was taken from me. I am not sure I could have faced another day. Yet these parents had no choice. Through this reflection on my own feelings, I began to understand why so many people searched out methods to numb their emotional pain. It was a matter of survival for many of the parents, grandparents, and other family and community members. For others, there was no way to escape the trauma as they succumbed to the pain of the loss of their children with the loss of their own lives.

Within my own family, I see the effects of the Residential school system. My grandmother attended a Residential school and this undoubtedly impacted her and the way she was able to mother her own children. Therefore, this is not simply a research project, but is instead part of my own personal and family history. I have experienced the intergenerational effects of the Residential school system.

As a child, my perspective on my First Nations identity was to acknowledge that it existed, but only partially. I never lived on reserve land, participated in any traditional ceremonies, or took on any traditional teachings. As a family, we would attend certain events such as Pow Wows or other public displays of First Nations culture, but it was if we were attending as spectators along with all of the other non-First Nations entertainment seekers. I never felt invested or grounded in my First Nations identity. This lack of connection coupled with the racism experienced throughout my school years, made my First Nations identity something I preferred to deny rather than embrace.

It was not until my undergraduate years that I began to develop a connection to my First Nations identity. As my understanding of the concepts of colonialism and assimilation developed, the pieces of my own history and the history of my family all began to come together. As I continued to take in information, I began to get a deeper understanding of the origin of the characteristics expressed by my father and grandmother. Overtime I have learned not to resent my First Nations identity, but instead to be proud. I have learned not to be ashamed to have received funding for my education, but to be determined to use every opportunity presented or available to me in order to give back to the people and try to improve the lives of First Nations people across Canada.

A most heartfelt thank you to Dr. Sharon Bruce; my advisor, my mentor, and my friend. For five years, Dr. Bruce kept me on track academically despite numerous obstacles, and saw me through my engagement and marriage, the pregnancy and the birth of my daughter, and training and dieting for fitness competitions. Throughout our years together Dr. Bruce has provided me with invaluable guidance, training, knowledge and confidence. Dr. Bruce has provided me with research experience that has encouraged my

development into the researcher that I am today. With Dr. Bruce by my side, I feel that I have accomplished what at times felt like the impossible.

Thank you to Dr. Paul Hackett who located the documents in the Manitoba Archives and brought them to my attention. Without his investigation into the Residential school system I may have never know that these documents were stored at the Archives and available to be studied. Also, for setting up the Access database which was crucial in order to organize the data and for the use of the laptop computer which allowed me to work from home, especially following the birth of my daughter. Even after relocation to another province, I still received immediate responses to questions, and support and guidance through telephone calls and email.

Thank you to my committee members for taking the time to read my proposal and thesis. Feedback was very much appreciated and helped guide me along the research path. Each person contributed something different and made me look at my work from a different perspective. I have learned something from each committee member that I will take forward into my post-student life.

Thank you to my husband Brent. For all of the time we have known each other, I have been a student, either high school or university. Thank you for your patience and support. Life as a student can be draining both financially and emotionally yet I always knew I had someone to lean on during the difficult times, and someone to celebrate with after I accomplished a goal.

Thank you to my family, who also supported and encouraged me throughout my university career. Thank you for always expressing how proud you were of me and my

research efforts. It was that support which gave me the energy to keep working towards my goals.

Thank you to Linda Diffey and the NEAHR program, formerly known as the ACADRE program. Without the funding I received through this program, I might not have been able to complete this degree. With this funding I was able to concentrate on my studies while still being able to contribute to my family, purchase much needed research materials, and presented my research at conferences along the way. Through the NEARH program I was able to meet fellow graduate students at the annual student gatherings. These gathering were extremely informative and inspiring and many friendships were made over the years.

Thank you to the Centre for Aboriginal Health Research who saw my potential as a researcher and gave me the opportunity to make a smooth transition from student to career life. Thank you for allowing me the time to finish my thesis writing and work at the same time. I feel blessed to have support and understanding from everyone at CAHR.

Thank you to the education coordinators at Couchiching First Nation who organized and administered my post-secondary funding throughout my university years. My goal was to use this funding for my education so that I could give back to the people. I often encounter the stereotype that views educational funding as misused or wasted money. I wanted to break this stereotype, and I feel confident that I have succeeded.

For all of the children listed in the documents. Though I attempted to understand how you felt during your time at the Residential school, I will never fully understand the traumatic experiences you faced at such young ages. Although within the thesis I assigned study numbers to each child in order to protect their identity, during the research

process, I took time to study each individual child's name. These names came to hold significant meaning and importance. These are not simply names on a list, but are names of innocent children and youth who had no choice but to live torn apart from their parents and families, and open to the personal, family, community, and cultural destruction that resulted.

I studied the stories of these children because I feel that more people should know about what happened to children inside of the schools and what is now occurring to those who attended the schools as well as their multiple generations of family members. Survivors have been talking about their experiences at the Residential schools for many years now, but it seems that some people will not fully understand the severity of the impacts unless they have numbers to show proof. I hope that by discussing these realities, First Nations youth will continue to learn about the history of their ancestors, especially in regards to the processes of colonialism and assimilation. It is up to our youth to be strong leaders for the future and to initiate changes that will lead to an improvement in the well-being of First Nations people. Perhaps in understanding that many of the current problems faced by First Nations people including physical health, mental health, poverty, and socioeconomic factors, are connected to what happened to people as a result of colonialism, the feelings of embarrassment over our families and communities will be replaced with compassion and an inner drive to take back what was wrongly taken away.

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Chapter 1

1.1 Introduction

Significant disparities exist between the health of First Nations people and the general Canadian population. The reason as to why First Nations people experience higher rates of poor health may, in part, be rooted in a historical context. First Nations people were forced to undergo changes to environment, diet, and lifestyle over a brief amount of time. One of the mechanisms of this forced change was the Residential school system. In the Residential school system, children were removed from the care of their families and communities and forced to uptake language, diet, religion, and daily customs that were foreign. Residential school experiences involved a neglect of needs, along with physical, sexual, emotional, and spiritual abuse. It was also the means by which First Nations children, and later adults, lost much of their identity including cultural practices and traditions, family and community connections, languages, and spiritual understanding. For many children, the Residential school experience was traumatizing. There is some literature to suggest that negative or adverse experiences in childhood such as abuse, neglect, and a lack of parental care, can lead to poor health in adult life. This suggests that the traumatic experiences of Residential school students may have an influence in the health of these individuals as adults. In order to begin to understand the link between Residential schools experiences and effects on adult health, it is important to first understand the health status of the children when they were initially admitted to the schools and throughout their years as students in the schools. This will provide a baseline measurement of health prior to the influence of the Residential school system as

well as an opportunity to track some of the changes in the health of children as documented in the school records.

The purpose of this study was to examine and describe the overall health of First Nations children at the time of their admission to, and during their stay in, a Residential School in a community in northern Manitoba during the time period spanning from 1930 to 1953. This research may stimulate additional research into Residential schools across Canada. It may act as a catalyst for other research on the links between childhood experiences, including Residential school experiences, and adult health. This information may be used as a healing tool for Residential school survivors and their families, providing a sense of validation and verification of the experiences they had in the schools. This research will inform people about what occurred in the Residential schools, giving a voice to those who attended the schools as well as their families and communities. Finally, this research will be a means of spreading information about the Residential school system and empowering First Nations people by validating knowledge about the health of their children upon initial admission to Residential school, while also providing evidence of changes in children's health in connection with Residential school policies and practices.

1.2 Background

For First Nations people, health is an issue that brings forth many concerns and unanswered questions. First Nations people experience a lower overall health status compared to the general Canadian population. This disparity is manifested in lower life

expectancy, higher rates of infectious diseases, chronic health conditions, mental health disorders, some cancers, addictions, tobacco use, suicide, injuries, obesity, and greater infant mortality, and with respect to healthcare utilization, First Nations people often have less access to, and lower utilization of, health care services (Waldram et al. 2006, Newbold 1998, Adelson 2005, First Nations Centre 2005, MacMillan et al. 1996, Young et al. 2000, MacKinnon 2005, Wilson and Young 2008, Allec 2005).

One of the major contributors to the current problems in the health and healthcare of First Nations people is the shared responsibility for healthcare between the federal and provincial governments (MacKinnon 2005, Allec 2005). With the 1867 Constitution Act, healthcare was made a provincial responsibility while Indian affairs was made a federal responsibility, a decision that created a system of confusion as to who was responsible for the health of Aboriginal Canadians (Lavoie 2004). For Registered First Nations people living on Manitoba reserves, the federal government is responsible for community health services, wellness programs, public health nursing, non-insured health benefits, two hospitals in northern Manitoba, and emergency and non-urgent treatment services in some remote or isolated areas. The provincial government is responsible for physician and hospital services covered under the Canada Health Act, and other provincial services located off-reserves. For Registered First Nations people living off reserves in provinces, the federal government is responsible for limited community health services and wellness programs, as well as the non-insured health benefits, while the provincial government is responsible for all other health services (Lemchuck-Favel and Jock 2004, Allec 2005). The federal government maintains their view that federal health services are provided as a matter of policy and not by treaty right. The provincial governments maintain their

view that non-insured health services for Registered Indians living on reserves are not a provincial responsibility. These jurisdictional confusions often lead to lags and gaps in the healthcare system which in turn contribute to the disparities that exist between Aboriginal and non-Aboriginal health and healthcare in Canada (MacKinnon 2005, Allec 2005). However, there are other issues that precede problems in health care management; issues that are rooted more deeply than the common determinants of health, and which have contributed significantly to the origin of the unequal health status of the First Nations population.

1.3 Historical Context

In researching the health of First Nations, one cannot begin to understand the extent of the problem without first understanding the history of First Nations people in Canada. The colonial relations between Aboriginal people and the French and British played a central role in shaping the ways of life experienced by First Nations people after contact and throughout the last two centuries (Waldram et al. 2006). The power and domination enforced by colonial leaders forever changed the lives of a people who had previously existed fairly successfully in their environments (Waldram et al. 2006, Young 1988). The cultural change that was forced through colonialism disrupted the lives of First Nations people to the point where total recovery has not yet been possible. Every part of life was affected by colonialism. The health of First Nations people was not spared; in fact, it is becoming increasingly evident how devastating colonialism has been

on the health of First Nations people in Canada (Waldram et al. 2006, Young 1988, Adelson 2005, Hill 2002).

In his summary report on the health and wellness of First Nations people in Manitoba, Allec (2005) concludes that one of the most damaging products of the colonization of First Nations people in Canada was the Residential school system. It has been stated, "The colonization process including the policy instrument of the residential school system has contributed significantly to the sad state of First Nations health seen today in Manitoba" (Allec 2005:11).

1.4 Residential School Overview

The development and establishment of the Residential school system in Canada occurred during the mid-to-late 19th century. Prior to this period, various missionary organizations attempted the education of Aboriginal children, but these attempts were without a formal system of organization, and most of the first attempts failed (Miller 1996, Milloy 1999, Grant 1996). As the areas inhabited by Aboriginal people became more populated, the British Imperial government and later the Canadian Federal government felt that Aboriginal people were creating obstacles to settlement and development of the country (Milloy 1999, Grant 1996). The government decided that a policy of assimilation was the answer to what they had termed the "Indian Problem" (Grant 1996:57). By the mid 19th century, the colonial powers decided that Aboriginal Canadians should be kept under the control of the government and that actions needed to be taken in order to civilize the people they considered savages. After Confederation, the

policy of civilization evolved into a policy of assimilation. The ideas within the dominant society were that Aboriginal people and cultures were inferior to those of Euro-Canadians and that Aboriginal people were uncivilized savages that needed to be assimilated into white society. Therefore, the system of Residential schools was built upon the dominant ideology of the 19th century, which promoted white superiority and saw First Nations people as savages (Miller 1996, Milloy 1999, Grant 1996). According to these authors, by the late 1800s the federal government along with various religious orders, the Roman Catholic, Anglican, Presbyterian, and Methodist churches, and later the United Church, had come together to develop a system in which Aboriginal children were to receive education. The government intended this school system to be the main agent in the process of assimilation. It was decided that in order to achieve the goal of assimilation, change would have to be implemented among the youngest generations. Therefore, in order to successfully change the ways and cultures of these children, and in turn First Nations people, the government decided that children must be separated from their parents, families, and communities, and remain separated for as long as possible. As well, many people felt that it was their duty, as civilized Christian people, to convert the Aboriginal people to Christianity and prohibit them from practicing their own cultures and spirituality (Milloy 1999, Grant 1996). The authors explain that day schools had failed because children would return home after school to their families where they would continue to practice their cultures and receive traditional education from their parents and elders (Miller 1996, Milloy 1999, Grant 1996). The government saw Residential schooling as a solution to this problem. "Of all the initiatives that were undertaken in the first century of Confederation, none was more ambitious or central to

the civilizing strategy of the Department, to its goal of assimilation, that the Residential school system" (Milloy 1999:21-22).

1.5 Residential Schools

The Aboriginal Healing Foundation defines *Residential school* as, "the residential school system in Canada attended by Aboriginal students. This may include industrial schools, boarding schools, homes for students, hostels, billets, residential schools, residential schools with a majority of day students or a combination of any of the above" (AHF 2006:iii). Throughout Canada, there were over 130 schools in operation at various times during the 19th and 20th centuries (AFN 2007). According to The Assembly of First Nations (2007) Residential schools as partnerships between the federal government and church bodies were officially in operation between 1892 and 1969. After 1969 the federal government assumed full financial responsibility for the schools still in operation. As the system of integrated education for Aboriginal children developed, the Residential school system was phased out. The last federally managed Residential school was the Gordon Residential school in Saskatchewan which closed in 1996 (Chansonneuve 2005).

In Manitoba, the first Residential school to open was the Anglican-run Lake St. Martin Indian Residential School at Fisher River, which opened in 1874, and the Anglican-run MacKay Indian Residential School at Dauphin was the last Residential school to close in 1980. Within Manitoba there were a total of 17 schools some of which were rebuilt, relocated, or renamed throughout their existence (AHF 2006). Throughout Manitoba, Residential schools were home for thousands of Aboriginal children from

early childhood through the teenage years. For these children and for the children who attended Residential schools across Canada, life was drastically changed in an instant. Life at Residential school was extremely different from the life that children had experienced with their parents and families in their homes (Miller 1996, Milloy 1999, Grant 1996). At Residential schools, children were forced to abandon everything they had been taught and forced to uptake environments, language, and culture that were totally foreign to anything they had known. For young children, this forced change was difficult and upsetting. Miller (1996), Milloy (1999), and Grant (1996) all describe how many children suffered physically and emotionally throughout their entire childhoods in Residential schools. While in the schools children were subjected to the policy of assimilation dictated by the government and church bodies which included forced disconnection with family and community ties, devaluing of Aboriginal culture, spirituality, and people, a ban on using Aboriginal languages, strict rules and harsh disciplines, indoctrination with Christian religion, and forced adoption of Euro-Canadian lifestyle practices. As well, children were provided an inferior education compared to non-Aboriginal children and did not receive the necessary skills to compete and succeed in employment or social environments when they were discharged from Residential schools (Miller 1996, Milloy 1999, Grant 1996).

For the majority of students, the Residential school experience was filled with much physical, emotional, psychological and spiritual pain. The memories of many Residential school survivors reflect these difficult childhood experiences and the grief that children felt as a result of growing up apart from their parents and families in environments that were neither supportive or understanding to the needs of children

(Grant 1996, 2004, Jaine 1993, Haig-Brown 1988, Foxcroft 1996, Chrisjohn et al. 2006, Deiter 1999, Fortier 2002, Graham 1997, Jack 2006, Callahan 2002, Ing 2000, Furniss 1988, Knockwood 1992, Dalseg 2003). These memoirs, stories, poems, reflections and other personal writings depict an environment of abuse and neglect, with a lack of nurturing, love, or care in which children were forced to spend their childhoods. It is now understood that the impact of negative Residential school experiences did not leave the children when they were discharged from the schools as teenagers but has left lasting impacts on these individuals that affect their lives as adults (Miller 1996, Milloy 1999, Grant 1996, 2004, Jaine 1993, Haig-Brown 1988, Foxcroft 1996, Chrisjohn et al. 2006, Deiter 1999, Fortier 2002, Graham 1997, Jack 2006, Callahan 2002, Ing 2000, Furniss 1988, Knockwood 1992, Dalseg 2003).

In addition to individuals, the impact of Residential school experiences was felt by entire families and communities. This impact has been termed the intergenerational effect of Residential school experiences. The Aboriginal Healing Foundation defines *intergenerational impacts* as, "the effects of sexual and physical abuse that were passed on to the children, grandchildren and great-grandchildren of Aboriginal people who attended the residential school system" (AHF 2006:ii). Many families and communities continue to suffer from these intergenerational effects. In the 2002/2003 First Nations Regional Longitudinal Health Survey (FNRLHS), 49% of First Nations adults had one or more parent attend Residential school, 40% had one or more grandparent attend Residential school, and 15% had one or more parent and grandparent attend Residential school (FNC 2005:136). Among First Nations children 12 years of age or younger, 16%

had one or more parent attend Residential school, and 59% had one or more grandparent attend Residential school (FNC 2005:296).

1.6 What happened to the children?

Some of the most compelling evidence of the negative experiences of children in Residential schools can be found in the discussions of the treatment and care of the children in the schools. Literature on the health and healthcare of children, the food and clothing provided to children, and the abuse and neglect inflicted on children provides insight into what life was like for the children of Residential schools across Canada and begins to make evident how this experience in childhood could affect the later health of these individuals as adults as well families, entire communities, and possibly the larger First Nations population of Canada.

It may be argued that the colonial powers thought that they were doing the best thing possible for the children in that the schools would provide for the children what they could not receive at home (Miller 1996, Milloy 1999, Grant 1996). However, regardless of the intentions of church and state officials, the implementation of the policy was difficult on many of the students who attended. Life at the schools was a damaging experience for many students (Miller 1996, Milloy 1999, Grant 1996, 2004, Jaine 1993, Haig-Brown 1988, Foxcroft 1996, Chrisjohn et al. 2006, Deiter 1999, Fortier 2002, Graham 1997, Jack 2006, Callahan 2002, Ing 2000, RCAP 1996, Furniss 1995).

1.6.1 Health and Healthcare

According to Grant (1996) children at Residential schools lived in environments which created increased risk of sickness and injury. Most schools were located far from hospitals and doctor's visits were sparse and irregular, leaving the school staff to manage healthcare on their own (Grant 1996). Very early on in the existence of the Residential school system, there was evidence of severe problems. Reports to the Department of Indian Affairs include issues of overcrowding, poor sanitation, poor ventilation and air flow, poor drainage, poor design and layout of the schools, poor location of the schools, safety issues, and lack of care of the children (Milloy 1999, RCAP 1996). All these issues had negative effects on the health of the children and in particular, on the rates of tuberculosis infection within the schools (Milloy 1999). ..."many of the children who went to the schools were healthy, but they entered environments that were ideal for the dissemination of disease" (Kelm 1996:67). Therefore, the Department of Indian Affairs was warned of the poor conditions of the schools and the potential health risks they posed but they continued to operate the schools without making the suggested changes. School staff were left to manage the healthcare of the children on a day-to-day basis, yet the government was the party responsible for providing medical services to the schools (Milloy 1999, RCAP 1996). The government and churches did put policies into place to ensure that only healthy students were admitted to the schools and that schools were kept in good condition, however, these may have been only ideas rather than expected practices as the policies were ignored and broken more than they were followed (Miller 1996). One such policy created by the Department of Indian Affairs was a regulation

which stated that all children must have a medical certificate signed by a doctor before being admitted to a Residential school (Milloy 1999). Enforcement of this and other health regulations was not handled as a top priority by the Department of Indian Affairs; there were no systematic inspections of the schools and no guarantee that doctors were examining children or filling out the required forms (Milloy 1999, RCAP 1996).

In terms of the construction of school buildings, most were constructed poorly and unprofessionally. It was Department policy to construct the schools as simply and as cheaply as possible (RCAP 1996). Therefore, many of the buildings constructed by both the churches and the Department were poorly built, located on inappropriate sites, and were inadequate to serve as schools and residences for children (Milloy 1999). Reports coming in to the Department were clearly pointing out the connection between the poor conditions of the schools and the poor health of the children (Milloy 1999, RCAP 1996).

One of the major contributing factors to the health problems within the schools was systemic overcrowding (Miller 1996, Milloy 1999, Grant 1996, RCAP 1996, Kelm 1996). Reports to the Department warned of this practice and the potential health risks to the children. Overcrowding led to the increased risk of the spread of infection and was a means of disease transmission within the schools. Within the schools there were outbreaks of various diseases. The most common threat to the health of the children in the Residential schools was tuberculosis, but other common infections and health problems included influenza, measles, tonsillitis, chicken pox, scarlet fever, typhoid whooping cough, smallpox, mumps, pneumonia, chorea, diarrhea, tubercular meningitis, eye disease, scrofula, scabies, intestinal parasites, and dental problems (Miller 1996, Grant 1996, Kelm 1996). There were also some appalling accidents at the Residential schools,

some of them fatal, including falls from upper stories of buildings, drowning, hypothermia, fatal dog maulings, limbs caught in machines, and children run over by vehicles or machinery (Miller 1996). One major complication in terms of healthcare was that there were often not enough doctors employed within the system to care for all of the children. The Department did not provide enough medical staff to keep the children healthy (Milloy 1999). "...it was abundantly clear that the real priorities of both the churches and the government was to care for Aboriginal children only under the cheapest circumstances possible" (Kelm 1996:71). Departmental files show that there was extreme disregard for the well-being of the children. Reports "not only chart the persistence of all of the conditions that were known to undermine the health of the children but reveal, in some cases, the neglect, the lack of love, for those suffering and dying in the careless arms of schools authorities" (Milloy 1999). Miller (1996) also notes that "The deficient school conditions caused by poverty and neglect ensured that health problems were serious and recurrent" (Miller 1996:302).

By the end of the first decade of the 20th century, it was well known by both the churches and the government that there were alarming rates of disease and death within the schools (Milloy 1999, RCAP 1996). Milloy (1999) and Grant (1996) note that in contracts signed in 1911, the Department made new recommendations and created new regulations in order to correct and prevent dangerous conditions within the schools. Once again, the new regulations were more theory than practice. Despite these new concerns for the children, the schools continued to exist in poor condition, with poor management and a lack of supervision. This led to a continuation of harmful and fatal effects on the health of the children (Milloy 1999, Grant 1996).

Professional healthcare, scarce as it was, may have brought students harm rather than health. There are numerous reports of students being abused by medical or school staff when they were sick (Grant 1996). Many children chose to suffer through pain and discomfort rather than admit that they were sick or hurt. Students often hid symptoms of illness due to fear of having to be treated by school staff and were afraid to ask school staff for help (Grant 1996, Graham 1997). Residential school students across the country reported "inhumane treatment" of sick children (Grant 1996:131). This included being punished for having diarrhea, being forced to eat regurgitated food, ignoring broken limbs and forcing children to walk on broken legs, pulling out teeth, and physically and emotionally abusing hurt children (Grant 1996, Graham 1997). Even when in good health, children suffered greatly while they were in the Residential schools. Certain aspects of Residential school life brought the children much physical, emotional, and psychological pain including toilet facilities, laxative use, cleaning chores, bathing facilities, and temperature of children's classrooms and dormitories (Grant 1996).

Tragically, many children died at the schools. Though thousands of children succumbed to diseases contracted while in the schools, not all deaths were due to illness. Former students recall staff inflicting vicious beatings on children. There are reports of children who were beaten and then hospitalized or beaten to death (Grant 1996). "Deaths at schools were not discussed by staff and students. When a child died at a school, most often the child simply disappeared and other children were forbidden to speak of the death or ask any questions. At other times the dead child was quietly buried, prayed over, and forgotten" (Grant 1996:132).

Therefore, the weak, deteriorating and unsafe conditions of the school buildings along with the lack of or insufficiency of medical supplies and services, the negligence of the school staff and doctors in preventing the spread of diseases and infection in the schools, the lack of healthcare and hygiene provided by school staff, and the chronic neglect of the children at the Residential schools were all major contributing factors to the health problems within Residential schools (Miller 1996). Even when the Department was presented with evidence of the mistreatment or lack of care of the children within the Residential schools, there was little action taken to remedy the problems. One man who recalls his life in Residential school writes, "The point is that the atmosphere in which hundreds of Indian students spent their forming years was an insult to human dignity" (Miller 1996:316).

1.6.2 Food and Nutrition

The lives of Residential school students often revolved around the food that they ate, or did not eat, while they were in the schools. Many former students recall that they were always hungry as children in the Residential schools. The food served to the children at the Residential schools was inadequate in quantity and quality while the food served to school staff was higher in quantity and quality (Miller 1996, Milloy 1999, Grant 1996, Graham 1997, Chrisjohn et al. 2006, Foxcroft 1996, RCAP 1996, Haig-Brown 1988). Some descriptions of the foods served to the students include: unfit for consumption, mush, slop, sickening, bland, lacking variety, bad, awful, tainted, stale, insufficient, disgraceful, and rarely fit for swine (Miller 1996, Grant 1996, Graham 1997,

Chrisjohn et al. 2006, Foxcroft 1996). Some actual reported meals consisted of bread and drippings or boiled beef and potatoes or a piece of bread and a raw carrot, food/porridge containing worms, grasshopper legs, bird droppings and mouse droppings, meat boiled in laundry pots leaving it tasting of soap, moldy and stale bread, and sour milk (Milloy 1999, Miller 1996, Grant 1996, Graham 1997). If children complained of hunger, complained about the food, became sick from the food, were caught stealing food, or were caught practicing any other means of survival they faced harsh punishment including having food withheld and going to bed hungry, having hair cut off, beatings, and being made to eat regurgitated food (Miller 1996, Milloy 1999, Foxcroft 1996). The abrupt change in diet was upsetting to both the personal emotions of the children as well as their stomachs. There was a lack of traditional foods in the schools, especially meat and fish, and this had a negative impact on the children (Milloy 1999). Students noticed that the foods were very different from those at home and that patterns of eating times were also foreign (Foxcroft 1996). In the later period of the Residential school system it was recognized by some that the change from a traditional Aboriginal diet to the diet of the Residential schools was problematic in terms of the wellbeing of the children, however, by this time years of damage had already been done, still no major changes were made, and the system continued to function as it had before (Milloy 1999).

Another major problem was that the children spent much of their days working on farms, gardens, or dairies producing food which was intended to increase the sufficiency of the school diet as well as provide revenue for the school by selling the products at the market (Miller 1996, Milloy 1999). However, the work was intense and led to the children being overworked. This, along with being chronically underfed compounded the

already negative situations within the schools concerning the health of the children (Miller 1996, Milloy 1999, Chrisjohn et al. 2006, RCAP 1996).

Doctors, Indian Agents, and some school staff and Departmental officials realized that there was a definite connection between the inadequate diet of the Residential school and poor health of the students. Even so, reports were rare, as there was no systemic monitoring or reporting procedures for the food in Residential schools (Milloy 1999, RCAP 1996). The few reports that were conducted on food in the Residential schools found that meals were not properly balanced and foods were lacking in nutritional value and had insufficient vitamin contents (Miller 1996, Milloy 1999, Chrisjohn et al. 2006, Foxcroft 1996). It was apparent that there was not enough food for growing children as some children reported losing weight while they were at the schools, a time when they should have been gaining weight with regular growth (Grant 1996, Haig-Brown 1988). Reports include information on inadequate and unclean food preparation areas and equipment, leading to further risk of sickness and production of poor quality food for the children (Miller 1996, RCAP 1996). One school Principal reported that he had to serve the cheapest foods available such as "hot dogs, bologna, garlic sausage, macaroni..." (RCAP 1996:363). Some school staff questioned whether the children would have been better off in their own communities, noting that "children on entering the schools likely left behind a better diet, provided by communities that were still living on the land, than that which was provided to them by school authorities" (Milloy 1999:121).

For thousands of First Nations children, food was a negative aspect of childhood. The reality is that for most children in Residential school, the school officials made food and eating a source of fear and emotional pain that has continued on into their adult lives.

"...food was used as yet another way to dehumanize and break the spirits of the children in their care" (Grant 1996:117).

1.6.3 Clothing

Clothing was another issue which caused Residential school students stress and discomfort. In the early years of the Residential school system, children wore fairly good quality clothing which was either purchased or made in the schools (Milloy 1999). It was during these early years that the schools often adopted a military style uniform for the boys and a dress and smock uniform for the girls (Miller 1999). Uniforms were seen as a way to break down individuality and European style clothing was intended to signify the transition from savage to civilized being (Milloy 1999). "Replacing each student's personal clothes with a standardized uniform was blatant rejection of their own particularity and, at the same time, the first step in the zealous struggle to remake them in a completely new image" (Foxcroft 1996). As the Residential school system developed, and with the introduction of the per-capita grants system of funding, many schools could no longer afford such uniforms and school clothing became less formal. School officials began looking for the cheapest ways to clothe the children (Miller 1996, Milloy 1999). Some of the conditions that the children had to face in terms of clothing include ragged clothing, dirty clothing, damaged clothing, clothing that did not fit, not enough undergarments, undergarments made out of uncomfortable materials, not enough shoes, damaged shoes, shoes that did not fit, and boots and clothing that lacked insulation during the winter (Miller 1996, Milloy 1999). These authors note that Residential school

clothing has been described as substandard, uncomfortable, uncongenial, ridiculous, deplorable, unsatisfactory, and disgraceful. Children were left unprotected from the elements and constantly feeling cold during the winter months and at night (Miller 1996, Milloy 1999, Haig-Brown 1988). One of the major complaints of Residential school survivors was that they were very emotionally hurt when their clothing was taken away, as personal clothing was almost always taken away and replaced with school issued clothing (Miller 1996, Foxcroft 1996). Having this clothing taken away was devastating to these children. They suffered a major sense of loss, anger, resentment, and confusion as a result (Foxcroft 1996). A second major complaint about clothing was the punishment and abuse inflicted on students if clothing or bedding became lost or damaged, or soiled (Miller 1996, Milloy 1999). Students were made to either wash their own soiled clothing or bed linens or wear soiled clothing or bed linens over their heads in front of the other students (Miller 1996, Haig-Brown 1988), and one child had his face rubbed in clothing he had accidentally soiled (Miller 1996).

1.6.4 Abuse and Neglect

One of the most detrimental aspects of Residential schools for the children was the neglect and abuse inflicted upon the students. Abuse included physical, sexual, emotional, and spiritual abuse and this was accompanied by neglect of the children in terms of their health, needs and general well-being. Mel H. Buffalo, an Aboriginal advisor from Alberta, noted that "every Indian person I have spoken to who attended these schools has a story of mental, physical or sexual abuse to relate" (Miller 1996:333).

There are numerous files from the Department of Indian Affairs, the schools, and the churches which show that the punishments and other incidents at the schools were not in order with the societal norms even at that time (RCAP 1996). It was also recognized that the abuse that was occurring was unique to First Nations students in Residential schools. An Indian Agent noted that the abuse inflicted by one particular teacher "would not be tolerated in a white school for a single day in any part of Canada" (Milloy 1999:141). The abuses and neglect that children experienced at the hands of those who were supposed to care for them as surrogate parents, teachers, and general givers of care was harsh and damaging to the children. Particular individuals are remembered as exceptionally violent and monstrous beings in the minds of numerous former students (Miller 1996). There are numerous reports of abuses inflicted on children in Residential schools. These include being forced to kneel in a public place or on gravel with arms outstretched for hours, privileges taken away, needles stuck in tongues and other parts of the body, beating, strapping, spanking, whipping, hitting, choking, burning or scalding, having hair cut or heads shaved, pulling or twisting ears, shattering eardrums, slapping heads, hitting knuckles, breaking bones, electrocution, public humiliations, depriving children of food and water, confinement in closets, cupboards, rooms, and basements, faces rubbed in excrement and urine, forcing children to eat regurgitated food, making children lay on the floor, exposure to the elements such as cold, rain, snow and darkness, refusing to give medical treatment those injured by abuse, and pouring castor oil down the throats of children (Miller 1996, Milloy 1999, Grant 1996, RCAP 1996, Haig-Brown 1988, Chrisjohn et al. 2006). Children were punished for things they could not control. School staff were insensitive to the common accidents and events that children

experience during childhood and through maturity. Humiliating and cruel punishments were inflicted on children for bedwetting (Milloy 1999, Grant 1996, Haig-Brown 1988) and for menstruating (Grant 1996). Grant (1996) notes that children were taught to hate their bodies and made to feel that any body part or function was dirty and sinful. Despite reports to Department and church officials, no systemic measures were created to ensure that the abuse stopped or the abusers were removed from the system (Miller 1996, Milloy 1999, RCAP 1996).

There were also acts of sexual abuse of students by school and church staff. This included forced sexual intercourse, forced oral sex, sexual touching both forced and inflicted, inspections of genitalia, and forced abortions for female students impregnated by men in authority (Chrisjohn et al. 2006). Sexual abuse ranged from fondling to rape to sodomy (Grant 1996). Sexual abuse was inflicted upon students by both male and female staff (Miller 1996, Grant 1996, Chrisjohn et al. 2006).

In addition to physical and sexual abuse, children were subject to emotional, spiritual, and psychological abuse. There was a lack of emotional support, or any parental-type care, love or nurturing, and as a result, children were emotionally deprived (Miller 1996). Miller maintains that the school staff were responsible for the raising and caring of the children yet they put the interests of the Residential school institution, their own religious denominations, and their own personal desires and needs before that of the children. One of the most common complaints of former students was feelings of loneliness (Miller 1996, Grant 1996). Almost every child faced some sort of psychological abuse in their daily life at the Residential schools (Grant 1996). Many issues caused the children emotional and psychological distress including isolation and

loneliness, harsh punishments, beatings, sometimes naked, in front of other students or officials, public strip searches, neglect, abuse, witnessing abuse of other children, inconsistent rules, forced labour, withholding of personal items such as clothing letters, and gifts, separation from siblings, separation of the sexes, separation from parents, separation from elders, suppression of First Nations languages, suppression of First Nations spiritual practices, racism, verbal abuse, belittling or threats, devaluing of First Nations culture, lack of care for sick and dying children, and no guidance in dealing with death (Miller 1996, Milloy 1999, Grant 1996, RCAP 1996, Haig-Brown 1988, Chrisjohn et al. 2006). Once children were taken from their homes, they were not allowed to acknowledge who they were as First Nations people, or have pride in their families or cultural practices. There was systemic discrimination throughout the entire Residential school system which affected every child as well as many of the families and communities from which children came (Grant 1996). "Their trust in humanity was shattered at a time when their lives should have been rich in moral and spiritual development, as well as in physical and mental growth. Instead of love and acceptance, they lived with terror and rage" (Grant 1996: 28).

The school staff were not the only ones who were abusive. One woman testified that "Native women have been raped, fondled, and abused mentally physically and spiritually by doctors at residential schools and elsewhere" (Miller 1996:330). Miller (1996) also notes that there were reports of abuse by community priests not necessarily employed in the schools and by sexual predators not associated with the school or church in any way. There was also abuse inflicted by other students (Miller 1996, Grant 1996, Chrisjohn et al. 2006). These authors describe how students who were abused often

learned to be abusive to other students and abusive to others as adults. They were taught that this was a means for getting out their anger and frustration and gaining a feeling of authority over others. "Student sexual abuse was often a feature of a general environment of violence, sexual and otherwise" (Miller 1996:336).

Despite some early warnings from the Department concerning the use of corporal punishment and guidelines on the acceptable way to strap children, no systemic actions were taken to ensure that children were protected from abuse. "As with the dietary and health regulations, these dicta on punishment... verged on administrative fiction" (Milloy 1999:139). Milloy (1999) notes how there were never directives issued on the permissible and prohibited acts of punishment in Residential schools and Department officials repeatedly chose not to deal with neglectful, abusive, and even criminal instances brought before them. The Department continued to do nothing and children continued to be abused and neglected. Students often felt helpless as they had nobody to turn to when they were being abused by school staff. The children had no help, no protection, or no means of defending themselves from the abuse. Miller (1996) discusses the fact that many of the children believed that it was only happening to them and they were too ashamed to tell anyone and in turn, they blamed themselves. Neither student, staff, departmental or parental resistance to the abuse and neglect could change the pattern that had become systemic within Residential school system.

The results of the abuse and neglect had both immediate and long term effects on the students. While at the schools, the children often internalized their anger and emotional pain (Miller 1996). Many children became violent to others inside the schools while others retreated within themselves and became depressed (Grant 1996). When

students were discharged from the schools they often returned to reserves as either "angry, contemptuous, superior, rebellious children" or "apathetic, timid, insecure and heart-broken children" (Grant 1996:224). Grant (1996) goes on to describe how as a result of this destruction of identity, traditional bonds between parents, elders, communities, and the children, and community support networks were broken and continued to deteriorate with each generation of children who attended Residential schools. These children then became parents themselves at young ages without the proper parental skills and so the cycle was repeated generation to generation. Formers students have stated that "for most children, the school experience was really detrimental to the development of the human being" (RCAP 1996:374). Miller (1996) notes that from this and other studies, it is evident "that the damage inflicted on students by abusers has been and continues to be extensive and persistent" (Miller 1996:334).

It is now acknowledged that the abuse and neglect suffered by the children in Residential schools has negatively impacted multiple aspects of life for those individuals as adults as well as their successive generations and entire communities. Residential school graduates found themselves unable to function successfully as adults in either the First Nations or non-First Nations community (Miller 1996, Milloy 1999, Grant 1996, RCAP 1996). These impacts have affected numerous areas of life, and the health of First Nations people is one area where the Residential schools have left a lasting negative impact.

There is an abundant amount of evidence depicting the poor health and lack of appropriate health care, the neglect of needs, and the abuse of the children in Residential schools across Canada (Miller 1996, Milloy 1999, Grant 1996, 2004, Jaine 1993, Haig-

Brown 1988, Foxcroft 1996, Chrisjohn et al. 2006, Deiter 1999, Fortier 2002, Graham 1997, Jack 2006, Callahan 2002, Ing 2000, RCAP 1996, Furniss 1988, Knockwood 1992, Dalseg 2003). Those who were supposed to have the welfare of the children as their main concern were often too focused on enforcing assimilation with no acknowledgement that the children were deteriorating under their care. "As a result, all too often, the 'wards of the Department', were overworked, underfed, badly clothed, housed in unsanitary quarters, beaten with whips, rods, fists, chained and shackled, bound hand and foot, locked in closets, basements and bathrooms, and had their heads shaved or hair closely cropped" (Milloy 1999:154-155). The Residential school system failed in its attempt to house and educate young Aboriginal people so that they could have an equal chance of success in a world that was in the process of development and change. Instead, the system left thousands of children with horrible memories of being abused and neglected. Now former student of Residential schools have carried the effects of being physically, sexually, emotionally, psychologically, and spiritually abused into their adult lives and as a result, experience numerous negative impacts of this tragic legacy.

1.7 What is happening to the adults?

First Nations children had numerous negative experiences in Residential schools such as changes in health from good to poor, lack of healthcare, chronic abuse and neglect of needs. It is now known that the effects of these negative experiences on those children at the time, as well as the effects they continue to have in the lives of adult survivors and the lives of their families and communities, may have associations with

many of the mental and physical health issues currently experienced by First Nations people (FNC 2005). In one community in British Columbia, researchers looked at the health and quality of life of residential school survivors. In their study Barton et al. (2005) found that compared to the non-Aboriginal population, Aboriginal residential school attendees as well as Aboriginal people who did not attend residential school, but who still may be affected by intergenerational effects, both experienced poorer health and quality of life, and specifically, higher rates of diabetes. The Aboriginal Healing Foundation has created a list of intergenerational effects of Residential schools which have an impact on First Nations people. These effects include issues related to the themes of substance abuse and its effects, past and continued abusive behaviours, psychological illness and disorders, effects on personal relationships with spouses, children, families and communities, physical illness, emotional problems, social problems, spiritual problems, problem behaviours, flashbacks and triggers, and cultural destruction (AHF). A more detailed list of intergenerational effects is listed on the website for the "Where are the Children?" exhibit produced by the Aboriginal Healing Foundation which can be found at www.wherearethechildren.ca/en/impacts.html.

While there are no studies which show direct links between Residential school experiences and long-term effects on adult health, there is some research which examines the relationships and associations between Residential school experiences and effects on former students as well as their successive generations.

In the 2002/03 First Nations Regional Longitudinal Health Survey, (FNRLHS), a survey of a sample of on-reserve First Nations people in Canada, 1 in 5 (20%) people surveyed had attended Residential school and the average amount of time spent in a

Residential school was approximately five years. Among those who attended Residential school, 47% reported that attendance at Residential school had negatively affected their overall health and well-being (FNC 2005). Within this report is a list of aspects that survivors of the Residential school experience felt had caused negative impacts on their health and well-being and these included; isolation from family, verbal or emotional abuse, harsh discipline, loss of cultural identity, separation from Inuit or First Nations community, witnessing abuse, loss of language, physical abuse, loss of traditional religion or spirituality, bullying from other children, poor education, harsh living conditions, lack of food, lack of proper clothing, and sexual abuse. Those who attended Residential school also reported higher rates of sickness and disease compared to those who did not attend and health conditions included arthritis, diabetes, high blood pressure, chronic back pain, hearing impairment, stomach or intestinal problems, cataracts, tuberculosis, heart disease, thyroid problems, rheumatism, osteoporosis, chronic bronchitis, glaucoma, effects of stroke, and liver disease (FNC 2005). This suggests that "the residential school experience has had enduring psychological and health effects on survivors" (FNC 2005:134). Within the report there is discussion of the difficulty of creating links between these experiences and later health outcomes. They state, "Although direct causal links are difficult to demonstrate with quantitative methods, researchers strongly indicate that there is clear and compelling evidence suggesting that the long history of cultural oppression caused by residential schools has contributed to high levels of mental health problems and other negative health effects found in many First Nations communities (FNC 2005:134).

1.7.1 Historic Trauma and Health Outcomes

In terms of the impact of Residential schools on health there is a limited, but increasing, amount of research which examines the long-term effects of Residential schools in those who were forced to attend as well as the intergenerational or multigenerational effects of the Residential school experience.

One area of interest has been the connection between the Residential school experience and trauma. Chansonneuve (2005) discusses how the experiences people had in Residential school caused a form of trauma and how this trauma, as well as the forced disconnections with self, family, and culture, are responsible for many of the issues that Aboriginal people now face. The author refers to the concept of historic trauma defined as "a one time event or a series of on-going experiences over the life span of an individual, as well as across generations" (Chansonneuve 2005:49) to help explain the context of the long-term impacts of residential schooling. Therefore, the losses of family, culture, language, and identity associated with the traumatic experiences in Residential schools, can affect survivors as well as those who have suffered the impacts through intergenerational means. "The profound loneliness and grief arising from multilayered dis-connections and accumulated losses are directly linked to the most acute problems facing Aboriginal families and communities today" (Chansonneuve 2005:45). The author states her beliefs in saying, "The urgent health and social problems of Aboriginal people in Canada are now believed to be directly related to multiple generations of children who were not only abused in residential schools and disconnected from their families and

communities, but were also taught to feel shame in their heritage, language, customs, and spiritual traditions" (Chansonneuve 2005:40).

Corrado (2003) looked at the abuse, health, and mental health profiles of 127 survivors of the Residential school system in British Columbia who had undergone a psychological assessment. All participants were involved in litigation against the government or religious organizations for abuse suffered at Residential school. The author notes that there has only been a small amount of published research examining how issues related to mental health have affected or created other issues such as alcohol and drug abuse, employment issues, physical health problems, criminal history, victimization, and problems within the family. In his study, mental health information was included in 75% of the case files. Of these, there were only 2 cases where the participant did not suffer from a mental disorder of some type. Mental health conditions reported included post traumatic stress disorder (PTSD), substance abuse disorders, major depression, and dysthymic disorder (a type of depressive disorder). Other participants reported a co-morbidity of PTSD and other disorders including major depression, substance abuse disorder, avoidance personality disorder, anxiety disorders, obsessive compulsive disorder, and other various personality disorders. The condition known as Residential School Syndrome was mentioned in 4.3% of the case files (Corrado 2003). This syndrome is explained by the author as mental health issues that have developed as a result of the abuse and subsequent trauma experienced as a result of the Residential school system, and is a sub-type of PTSD. He writes "The individual trauma of the residential school era has been so severe that clinicians have begun to identify a distinct cluster of problems and behaviours termed 'residential school syndrome' to explain the

mental health outcomes of Survivors of the residential school system" (Corrado 2003:23). In the study, of the 43 case files containing information relating to physical health, every file mentioned the presence of chronic headaches. Other conditions reported included heart problems, high blood pressure, arteriosclerosis, angina, hypertension, arthritis, cancer, liver disease, stomach disease and ulcers, diabetes, HIV, fetal alcohol syndrome, meningitis, and lupus (Corrado 2003). The author also looked at the effects of Residential school experience on other social and demographic issues. It was found that many children left homes where both parents were legal guardians, yet only a small minority returned to intact families. This indicated that family breakdown was a common occurrence while children were at Residential school. In terms of education, 55% did not continue their education after they were discharged from Residential school. Alcohol abuse was also indicated as significant outcome for survivors with 90% reporting alcohol abuse in the post-residential school period. Out of all of the case files, only 4% reported not experiencing abuse while in Residential school, while all other case files contained reports of sexual assault and emotional or psychological abuse, and 90% also reported physical abuse. In 18% of the files there is mention that the abused became an abuser thmsleves, and of these, 83% indicated that the abuse was directed towards their partner, and to a lesser extent, their children. Fourty nine percent of the files indicated that the former student was convicted on criminal charges, 52% for sexual assaults and 55% for assault, and 65% for major driving offences. The authors also looked at effects including: family alcohol patterns; family deaths; family interactions; marital, intimate, family relationships; family contact and Residential school exit and entry profile; discipline at Residential school; and sexual problems or deviations (Corrado 2003). The author

maintains that Residential schools have been named as the source of the high rates of health problems, addictions, substance abuse, mortality, rates, suicide rates, criminal activities, violence, self destructive behaviours, and the breakdown of families and communities, however, it is very difficult to create direct links between issues such as alcoholism, family violence, crime, sexual abuse and other community problems and negative Residential school experiences. He states, "While these causal links are very difficult to establish, the research literature clearly indicates that serious abuse and trauma was experienced by many of the Aboriginal children who attended these schools" (Corrado 2003:25). With this type of information, links can begin to be established between the abuse and neglect suffered in Residential schools and mental and physical health disorders. This research provides information which allows for a better understanding of the effects of the various types of abuse and neglect on the health of Residential school survivors, as well as how the effects on health are connected to other social problems.

Dalseg (2003) also looked the physical and mental health effects of Residential school experiences on former students, as well as the intergenerational effects, and how they affect psychological functioning of adults. Forty former Manitoba Residential school students were interviewed about their experiences in Residential schools. Dalseg (2003) found that physical abuse, sexual abuse, and emotional harm were three main themes that emerged from the data. From these three themes, five main groupings of perceived effects of Residential schools were noted. The perceived effects involved issues that affected the children as students in the schools as well as after the Residential school period and included an inability to express emotion or feelings as children, and later as

adults; a loss of identity; a breakdown of family and community bonds, including relationships between siblings, parents, extended family, and community; and many difficulties in relationships. The author also found a positive fifth effect based around the idea that some people had positive outcomes as a result of their experiences in Residential schools. Three additional groupings were found for continued effects in the post-residential school period, and these included problems with alcohol, low self-esteem, and parenting difficulties (Dalseg 2003).

This research on the connection between residential school experiences and mental and physical health provides a good basis of evidence from which other researchers can continue to build. The next step may be to research how exposures to specific traumas in residential schools are more or less associated with specific mental and physical health outcomes.

1.7.2 Residential School Syndrome

Residential School Syndrome is a type of disorder that is believed to be the direct result of the trauma of Residential school experiences. Brasfield (2001) describes how some survivors suffer a disorder with symptoms quite similar to post-traumatic stress disorder. Although there is no formal agreement on what constitutes the diagnostic criteria, symptoms can include recollections, nightmares, flashbacks, avoidance of anything related to Residential schools, detachment from others, relationship difficulties, lack of interest in or knowledge of traditional activities, culture, or skills, sleep problems, concentrations problems, anger issues, lack of parenting skills, and tendency for

substance abuse (Brasfield 2001). The author feels that by understanding the need for this type of disorder classification, those who suffer will begin be able to receive the necessary treatment and healing. He states, "...children were damaged. To deny the existence of the damage is to deny these now-adult survivors the possibility of redress and compensation" (Brasfield 2001).

This concept is also explored by Robertson (2006) in his work that defines and compared the concepts of Residential School Syndrome (RSS) and Historic Trauma. RSS criteria imply that the residential school experience was a specific exposure to trauma and this exposure has led to lifelong health effects. Also, the trauma of the residential school experience can be passed intergenerationally and so those who have not attended a residential school can still suffer from the effects of the trauma (Robertson 2006). Historic Trauma is believe to be more encompassing and included as the traumatic event the widespread colonial and assimilative history of Aboriginal people across the Americas. In this case, the overall assimilative history of Aboriginal populations is seen as traumatic and therefore there is no need to focus on one specific event such as the Residential School experience. Historic trauma also continues to be past intergenerationally in that the trauma continues to be recreated in each generation (Robertson 2006). However, the author explains that RSS theory is based on the individual and their experiences and can be diagnosed as a specific disorder; while Historic Trauma is based on the collective population and even entire cultures being negatively impacted. He notes that in terms of the type of trauma and the types of associated symptoms people experience, some researchers suggest that there are differences between those who attended Residential schools compared to those who did

not attend Residential schools. Robertson (2006) describes a study conducted in British Columbia, in which participants whose fathers attended Residential school were more likely to report violence by their father against their mother. He also notes that in Canada, that rates of PTSD diagnosed in Residential school survivor is substantial. Robertson feels that while more research is required in order to make conclusions on this matter, the findings from these studies supports the concept of a specific Residential School Syndrome over a more general idea of Historic Trauma, which in theory, could affect all people who experience the negative impacts of colonialism, and not specifically in Residential schools. Robertson also speculates the idea that there were supports built into First Nations cultures to help deal with the effects of stress and hardship which were not able to be passed on to children who were taken from their families and communities and put into Residential schools. This may be another means by which the transmission of culture was disrupted and in turn the development of children was negatively affected. He argues that the benefits of having a specific RRS and not just using the PTSD diagnosis include allowing for a more flexible diagnosis, the inclusion of the idea that the trauma can be transferred inter-generationally so other family members can receive the needed treatment, and the understanding of mental health which takes into account the effects of colonialism and Residential schools specifically (Robertson 2006).

For years, survivors have been telling of their experiences and explaining their symptoms to health care professionals, but often without any meaningful diagnosis. Perhaps now, with the understanding among healthcare professionals that survivors of Residential schools are indeed suffering from a specific set of symptoms related to a

specific type of exposure, people can finally being to find success in their healing journeys.

In terms of the physical effects the Residential schools, Kelm (1996) discusses how the conditions under which children were forced to live while in Residential school detrimentally affected the health of the children at that time, as well as left lasting effects on the bodies of Aboriginal people. She notes how the power imposed on Fist Nations people from Euro Canadians in Residential schools "...shaped Aboriginal bodily health and representation in profound ways" (Kelm 1996:52). She notes that while the schools were entrusted with the bodies of these children and expected to care for them, instead they continuously exposed them to disease, abuse, malnourishment, and overwork. The author's strong viewpoints on how the Residential schools have affected those who attended are felt in her statements that, "Overwork and corporal punishment, combined with hunger and malnutrition, shaped the bodies of the students" and "Children's bodies and psyches were scarred by the beatings administered in the schools..." (Kelm 1996:72-73). The author maintains that the Residential school system weakened the bodies of the children instead of making them strong, and the rates of morbidity and mortality among the students are evidence that the schools did not successfully care for their health. She looks at the physical impact of the schools on the students and concludes that the system of Residential schooling negatively impacted the well-being of First Nations peoples rather than enhancing it as they claimed was their part of their purpose (Kelm 1996). The poor conditions and lack of health care contributed to the poor health of the children in the schools as well as home communities when children transferred their sickness to family members at home. The author notes that after being released from the schools,

students continued to face numerous physical and mental health concerns, and that many students convocated "to the sanatorium, the hospital and the grave" (Kelm 1996:79).

In terms of this research project, a match of the names of the students who died at the schools, or shortly after being discharged, with their Physical Examination forms, may produce even stronger evidence that the schools did not adequately care for the children. If the majority of children were healthy upon admission to the school, stronger evidence will exist for the argument that the schools caused a decline in the health of the children.

1.7.3 Parental Skills and Knowledge

In terms of the impact of Residential schools on parenting, both Ing (1991) and Redman (2000) discuss how the Residential school system has led to an erosion of traditional parenting practices. Redman (2000) interviewed 25 former students of Residential schools in Saskatchewan in order to better understand their subjective experiences and interpretations of their time in Residential school and how their own parenting has been affected. This author discusses the breakdown of the role of the Elder as a traditional teacher as an effect of the Residential schools. He notes "at residential school, these relationships were nullified, as Elders were not involved in raising the children" (Redman 2000:8). Ing (1991) interviewed three former Residential school students and examined the effects of Residential school experiences on parenting. She discusses how historically, child-rearing was shared within the family and community and Elders played vital roles in educating children and teaching them life skills. She goes

on to discuss how the loss of traditional languages contributed greatly to the breakdown in the transmission of culture between generations and how the lack of guidance, support, and instruction from Elders and family, led to the loss of self-identity and self-esteem for many students. As children were removed from their home environments, the importance of cultural continuity was lost (Ing 1991). Both authors discuss how children did not learn First Nations parenting or value systems and that this has now caused problems for generations of families (Ing 1991, Redman 2000). Redman (2000) also discusses failure of the schools to prepare the children for adult life and especially for parenthood. Both authors discuss how there were no role models from whom the children could learn parenting or relationship skills. As a result students often adopted the negative elements they were exposed to in Residential school into their own parenting styles (Ing 1991, Redman 2000). Redman (2000) found that 20 out of the 25 individuals he interviewed had experienced a traumatic event at a Residential school. The traumatic events that children had to endure were another factor which worked against the development of parenting abilities. Unresolved emotional pain would lead to situations where anger or anguish would be taken out on spouses and children (Redman 2000). "By not coming to terms with the incidents, the participants repeated the cycle of violence and negative parenting to which they had been subjected" (Redman 2000:39). As the process of acculturation continuously enforced the idea that First Nations culture was inferior to that of Euro-Canadian society, children developed a resentment of who they were as well as their parents, family, and community (Ing 1991). These changes in identity have now been transmitted through the generations so that children and grandchildren of those who attended Residential schools also feel these affects in their lives. All of these issues have

affected the way First Nations individuals have learned to parent their children and grandchildren.

The FNRLHS (FNC 2005) found that individuals who were surveyed expressed their concerns over the lack of parenting skills taught to those in the Residential schools. Forty-three percent (43%) of people surveyed felt that their parents and grandparents attendance at Residential school negatively affected the parenting they received as children, and 73% felt that it negatively affected the parenting their parents received as children (FNC 2005).

Morissette (1994) also looked at how parenting has been affected by the system of Residential schooling. He noted that the effects of Residential school remain a major contributor to the problems facing Aboriginal families seeking therapy. He discussed how it is difficult for many people to discuss their experiences, and how many former students "have been left with haunting memories and deep emotional scars" (Morissette 1994: 384). He discussed how children felt a sense displacement as they were placed in unknown settings, forced to give up their culture and identity, and were disconnected from family. This led to loss of self-esteem and feelings of personal ability, as well as created confused or negative understandings of Aboriginal culture. As a result, many survivors have used substances or self-destructive behaviors as a means of coping with their feelings and those who are parents put their children at risk of neglect and harm (Morissette 1994). He states, "The lack of role modeling and decision making experience appears to have contributed to current family hierarchy disruption and parent-child conflict. The Native parent is left unsure of generational boundaries, behavioral expectations, and limits" (Morissette 1994:386). He maintained that a combination of

traditional and non-traditional (clinical) practices can be used to assist First Nations parents and their families to heal from the emotional pain associated with the Residential school experience and rebuild their lives, identities, and families.

In other research, Ing (2000) examined the issue of the intergenerational effect of Residential schools among those whose parents attended Residential school. She referred to these groups and the 2nd generation, those who had parents that attended in the 1920s to the 1930s, and the 3rd generation, who had parents that attended in the 1930s to the 1950s. Among the 2nd generation, there were feelings of shame and confusion over culture because parents were in denial about their own identity. Second generation group participants also felt that parents were very controlling, as this behaviour was learned in the schools and then repeated by the students on their own spouses and children. Along with the 2nd generation, the 3rd generation also noted many effects of Residential schools within their families including the inability to communicate feelings which often led to an angry silence within families, issues with alcoholism, parents who were especially strict and regimented, not being given age appropriate tasks, various forms of abuse from family members, personal feelings of resentment and loss, and racism and stereotyping from the non-Aboriginal population. One respondent stated, "I feel like a large chunk of my culture was not given to me" (Ing 2000:91). The intergenerational impact is discussed in terms of feelings of shame and confusion over identity, issues of control, a lack of ability to communicate, and unresolved feelings of sadness and anger. She notes that "Being distant was a coping method from Residential schools when expression of emotions was taken away" (Ing 2000:95). These coping mechanisms were carried into post-Residential school life and have continued to affect individuals and families. For

many of these 2nd and 3rd generation individuals, it was not until they were adults themselves that they were able to understand the concept of Residential schools, which in turn led to answers to questions about their family and life. The stories of parents and grandparents created emotional burdens as children took in the reality of their family member's past experiences. Some felt that they became victims themselves by internalizing the pain of their family members while also generating their own feelings of anger. However, knowing what their parents and grandparents were forced to experience allowed some individuals to gain a sense of compassion and understanding as to why their parents had these issues, especially the lack of parenting skills (Ing 2000). The author notes that some families were able to overcome the negative experiences of Residential school, and this could be due to having strength within the family or perhaps due to a strong upbringing prior to attending Residential school. In terms of the next generation, it appears that the children of these 3rd generation adults are experiencing less of these types of issues. Parents are now beginning to recognize that negative Residential school experiences were the source of many of the problems in their family and personal lives and as a result, have made efforts to break the cycle caused by these negative experiences so that their children can be spared the emotional, spiritual, physical, and mental pain that they themselves had experienced (Ing 2000). The author maintains that discussing and understanding the system of Residential schools, as well as revealing what happened to people in the schools through the sharing of experiences, will help in the healing process and help overcome the trauma of the Residential school experience.

Smith, Varcoe and Edwards (2005) found that when asking questions on the issue of Aboriginal parents' views on pregnancy and parenting, the intergenerational impact of

the Residential schools was often noted as a barrier to equal health status and equal access to health care for women. They conducted interviews and group discussion with community members, clients, family members, providers, managers, administrators, policy decision-makers and community leaders affiliated with two Aboriginal healthcare organizations within one region of a Canadian province. The sample included 57 participants, 36 (63%) were of Aboriginal decent, and 51 (89%) were female. Participants of the study discussed their vision for "turning around" the impact of the Residential schools so that women could have more opportunities for good health and healthcare. "Participants felt that understanding and acknowledging the IGIRS [intergenerational impact of Residential schools] as a root cause of poor health and social conditions such as poverty, addictions, and violence was imperative for healing and building strength" (Smith et al. 2005:41).

FASE/D

In another area of research, Tait (2003) examined the issue of fetal alcohol syndrome and how it might be linked to the intergenerational effect of Residential schools. She reports that the Residential school system is linked to the high rates of alcohol abuse among those who attended the schools as well as many of the parents and community members who had their children removed from their care. She notes that many people have used alcohol as a coping mechanism for the pain and sadness caused by the Residential school system (Tait 2003). The author also notes that there are links between the Residential school system and alcohol abuse among the subsequent generations, including women in their child-bearing years. Substance abuse among Residential school survivors is both an outcome of the Residential school experience and

a contributing factor to other negative health and social problems among survivors and their subsequent generations (Tait 2003). Therefore, the use of alcohol as a coping mechanism is both an outcome of the Residential school experiences as well as a risk factor for poor health outcomes among current generations.

Also examining the issue of alcohol, Rothe et al. (2006) looked at the connection between Residential schools and alcohol abuse and impaired driving in one First Nations community. Utilizing the method of the talking circle, community members discussed their perceptions of how the experiences people had in Residential schools have led to issues of alcohol abuse. Community members expressed how the Residential schools stripped First Nations people of culture, including traditional roles and values, and left people with negative feelings about life and themselves, and many feelings of loss (Rothe et al 2006). Community members understood the Residential school experience to be the source of many of the problems currently experienced among First Nations people. The authors note how the youth see the disconnection between the different generations of people as one of the problems within their community. Youth are left to take care of the parents and older family or community members as they suffer through their alcohol addictions. Children are forced to watch and interact with their parents while they are intoxicated, and are exposed to drinking and impaired driving from early ages and children and youth are sometimes given alcohol from their older family and community members. In an attempt to escape from this world of addiction and to search out a sense of belonging, they turn to spending time with other youth, where they encourage each other to get involved in their own destructive behaviors such as alcohol use and impaired driving (Rothe et al.2006). There is a silence between parents and children which affects

the way children are raised and cared for which is quite different from traditional parenting practices. Community members understand that this silence was something their parents and elders learned in the Residential schools, and therefore is another way that the school experience has negatively affected the lives of First Nations people (Rothe et al. 2006). One participant stated,

> *"The meaning of anything we did in residential school did not represent anything that we brought with us from our reserve communities. Soon we quit talking about our experiences and our families. Instead, I quickly learned that "silence was golden." From that first day, we lost our voices. Lost is probably not the right term, because when you lose something one may assume that you might have misplaced it and you may eventually find it. Our voices were silenced. We spoke when we were spoken to. We never had an opinion, there was never an argument; creativity was discouraged. How has this affected our communities? We still feel voiceless, we still fear disagreement, we still keep our opinions to ourselves, we still fear expressing creative alternatives to our problems, and without intention, we pass this down to our children. Our communication and relationship skills are limited" (Rothe et al. 2006: 19).*

Therefore the issue of alcohol use and impaired driving is a social issue deeply routed in the colonial past.

1.7.4 HIV/AIDS

Barlow (2003) examined the link between the legacy of Residential schools and HIV/AIDS. He notes that while it is difficult to state direct links between HIV/AIDS and the legacy of the Residential schools, it should be acknowledged that some survivors are living with HIV/AIDS. He states that while there is not enough known about the issue, "An argument based on the intergenerational impacts can be made due to the multigenerational nature of both physical and sexual abuse and unresolved trauma. The

loss of culture and the marginalization that survivors, their descendants and other family members feel might also be contributing factors" (Barlow 2003:1). The author goes on to say that the two main aspects of life that have been affected by the Residential school legacy are cultural identity, which includes "loss of language, traditions, and connections to family and community", and the individual which results in "shame, rage, lack of trust and engagement in negative coping patterns including substance abuse among others" (Barlow 2003:2). It is the adoption of the harm inducing coping patterns that people use to deal with the pain and anger of what has happened to them and their culture that creates health risks and in turn the connection to HIV/AIDS. He states that feelings of marginalization and isolation are effects of the Residential school experience and these feelings combined with negative coping patterns may create risk for HIV infection (Barlow 2003).

1.7.5 Suicide

Kirmayer et al. (2007) discuss the issue of suicide as an effect of the residential school experience. The authors discuss how the suppression of culture along with the institutional violence and abuse that children experienced in the Residential schools has connections to many of the individual and social problems that exist among Aboriginal peoples currently. They also believe that the impacts of the Residential school experience come not only from what happened to children in the schools, but also from what has happened in terms of the intergenerational impact on subsequent individuals, families, and communities. The authors list a number of what they refer to as transgenerational

effects of Residential schools. They feel that in addition to exposure to negative situations within the Residential schools, there are other factors involved in the post-residential school period suffering which has led to the many problems faced by Aboriginal society. They note that there are associations between suicide and personal histories of issues such as early life separations, losses, and emotional deprivation. These are the types of experiences children were forced to endure while in Residential schools. "Total institutions such as prisons and boarding schools, increase suicide risk when they isolate and seclude the individual" (Kirmayer et al. 2007:71). They feel that there is a connection between the Residential school environment, which involved abuse, cultural oppression, and prison-like daily activity and other poor conditions, and mental health disorders and suicides. Kirmayer et al. (2007) believe that the forced assimilation, central to the system of Residential schooling, resulted in disruption in the transmission of culture, cultural marginalization, identity formation issues as well a feeling of not being able to be accepted into non-Aboriginal society, and these effects could be risk factors for suicide. The authors note, "The historical roots of current problems must be recognized and addressed to develop effective interventions that can transform intrafamilial and intergenerational cycles of suffering" (Kirmayer et al. 2007:78).

1.7.6 Inadequate Education

In considering more of the negative effects on the socio-economic status of former students, Barnes et al. (2006) looks at how Residential schools were unsuccessful at educating Aboriginal students. They note that issues such as inadequate and

inappropriate curriculum, unqualified teaching staff, limited time in the classroom, prohibited parental involvement, racism, a ban on the use of traditional languages, and abuse and neglect of the children all worked to create an education institution that failed to educate the students to a level that was equal to the education of the non-Aboriginal children in Canada. Instead these practices created a legacy of poor academic achievement, decreased ability to continue education post-residential school, limited opportunities for employment, and limited income opportunities (Barnes et al. 2006). Each of these socio-economic factors can be associated with conditions of poor health.

1.7.7 Childhood Trauma and Adult Health Status

The lack of a substantial body of research in the area of the physical and mental health effects of the Residential school experience is a signal that more research needs to be done in this area. Continued research will allow us to better understand the health effects of Residential school experiences on First Nations people.

As there is only a limited amount of research done in this area, it is necessary to examine existing literature on the health effects of related or similar experiences on non-First Nations populations as those experienced in Residential school in order to understand the possible health effects of Residential school experiences. There is an abundance of research in this area which examines the effects of experiences such as those experienced by Residential school students on the long-term development from child to adult. Some of this existing research has examined the relationship between adverse childhood experiences and adult physical health.

Using data from the Ontario Health Survey, a health survey of the residents of Ontario fifteen years or older, Chartier et al. (2007) examined the relationship between childhood abuse and adult health, and healthcare utilization. An association was found between childhood physical and sexual abuse and multiple health problems, poor or fair self-rated health, pain that interferes with activities, disability due to physical health problems, and frequent emergency room and health professional visits. Chartier and colleagues conclude that physical abuse in childhood is related to poor adult health and higher healthcare utilization for both women and men. However, there is a stronger association between physical abuse and multiple health problems for women than men. Also, while there was a clear negative effect of sexual abuse on health for women, there was little evidence of this effect for men. An explanation for the differences could be that childhood sexual abuse might be more traumatic than physical abuse and since more females than males experience sexual abuse, they would be more likely to report it and suffer from its effects. Also, females and males may be affected differently by childhood abuses, having different types of outcomes. They also found stronger associations for some health measures among younger respondents. The reason for this could be that for the older respondents, more time has passed since the abuse and therefore other things are contributing to their health status (Chartier et al. 2007). The authors also comment on the possible links between childhood abuse and poor adult health such as adverse changes to the brain development and stress response in young children as a response to negative and stressful environments, as well as the use of health risk behaviours to help relieve the negative experiences and effects of the abuse (Chartier et al. 2007).

Felitti et al. (1998) found that there was an association between childhood abuse and household dysfunction, and physical health risk behaviours and disease. The data came from the Adverse Childhood Experiences (ACE) Study based at the Kaiser Permanente's San Diego Health Appraisal Clinic. This portion of the study included a sample size of 9508 adults. The purpose of this study was to assess the long-term impact of abuse and household dysfunction during childhood on adult health outcomes including risk factors for disease, disease incidence, quality of life, health care utilization, and mortality (Felitti et al. 1998) The authors found a cumulative effect in that the greater the exposure to abuse or household dysfunction the greater the risk for health risk behaviors and disease in adults. Those who had experienced four or more exposures to abuse in childhood had a 4 to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, 50 or more sexual intercourse partners, and sexually transmitted disease; and 1.4- to 1.6-fold increase in physical inactivity and severe obesity compared to those who had not experienced abuse (Felitti et al. 1998). Adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. Childhood abuse exposure included childhood abuse (psychological, physical, and sexual), exposure to substance abuse, mental illness, experiencing violent treatment of mother, and criminal behavior. Risk factors for health included smoking, severe obesity, physical inactivity, depressed mood, suicide attempts, alcoholism, drug abuse, parental drug abuse, high number of lifetime sexual partners, and a history of having a sexually transmitted disease. Disease conditions included ischemic heart disease, cancer, stroke, chronic bronchitis, emphysema, diabetes, hepatitis, jaundice, skeletal fractures, and self rated health. "The

findings suggest that the impact of these adverse childhood experiences in adult health status is strong and cumulative" (Felitti et al 1998:251). An interesting discussion by the authors is based around the idea of the possible links between adverse childhood experiences and health risk behaviors and adult disease. They propose a "biobehavioural" explanation in which those who may have suffered adverse experiences in childhood may turn to behaviours that offer some type of relief as a coping mechanism, even if that behavior is also damaging to their health such as smoking, alcohol or substance abuse, sexual behaviours, and even overeating. This is a form of stress relief for those who suffer from the effects of adverse childhood experiences, and those with higher amounts of stress would tend to use these coping devices more chronically. These behaviours then lead to the development of adult disease (Felitti et al. 1998).

Using data from the National Comorbidity Survey with a sample size of 5877, Goodwin and Stein (2004) examined the association between childhood trauma and physical disorders in adult life. They found that childhood physical and sexual abuse and neglect were significantly associated with an increased risk of physical illness in adult life including lung disease, peptic ulcer, arthritic disorders, cardiac disease, diabetes, and autoimmune disorders (Goodwin and Stein 2004). They maintain that childhood abuse may lead to changes in physiological systems just as it leads to changes in the brain, and that both types of changes can affect negatively affect health (Goodwin and Stein 2004).

Also using the National Comorbidity Survey data, Sachs-Ericsson et al. (2005) found that childhood physical and sexual abuse was associated with the prevalence of serious health problems for adults. They found that those who reported physical abuse in childhood were more than twice as likely to report a physical health problem compared to

those without a physical abuse history, and those who reported sexual abuse in childhood were nearly one and a half times as likely to report a health problem compared to those without a sexual abuse history (Sachs-Ericsson et al. 2005).

Walker et al. (1999) found that a history of childhood maltreatment was significantly associated with several adverse physical health outcomes in women including perceived poorer overall health status, greater physical and emotional functional disability, increased numbers of distressing physical symptoms, and a greater number of health risk behaviours. The sample included 1225 women members of Group Health Cooperative of Puget Sound, an HMO in Seattle, Washington who were given a health survey. They found that those who had experienced maltreatment in childhood had higher rates of physical diseases, symptoms, and a greater number of health risk behaviours. Many women then use coping behaviours which act as health risks and in turn lead to health problems. These include somatization, smoking, alcohol abuse, unsafe sex practices, and obesity (Walker et al. 1999).

Arnow (2004) in his examination the literature found that those who experience maltreatment in childhood including abuse neglect, or serious family dysfunction are more likely to experience psychiatric illness, to have more symptoms of illness, and to engage in more health-risk behaviours as adults than those who did not experience childhood maltreatment. He also found a cumulative effect where severity of childhood maltreatment is associated with the seriousness of dysfunction in adulthood (Arnow 2004).

Springer et al. (2003) provide an overview of the research on the long term effects of childhood abuse on physical and mental health and the potential pathways of these

effects. In her overview Springer discusses the work of Kendall-Tackett who describes four possible pathways by which abuse in childhood relates to health problems in adults. It was found that childhood abuse is related to adult health problems through behavioral, emotional, social, and cognitive factors and these pathways function individually or in combination with one another in order to produce health outcomes. The emotional pathway relates to outcomes on mental health, the behavioural pathway relates to health-risk behaviours such as obesity, smoking, substance abuse etc., the social pathway relates to the ability of the abused to build and maintain relationships, and cognitive pathways are related to the way a person perceives their own health (Springer 2003). For example, researchers found that adults with a history of abuse consistently report symptoms of sickness more often that those without such a history. In terms of mental health, they found associations between childhood abuse and adult depression, aggression, hostility, anger, fear, anxiety disorders, and personality disorders (Springer et al. 2003). Both of these types of effects can then negatively impact physical functioning in adults. The authors also note how family environmental factors often play a role in the link to adult health outcomes, such as how much support you have in order to overcome the history of abuse (Springer et al. 2003).

This is interesting in terms of the Residential school issue, as children often left the schools only to return to homes where there was no support to help them deal with the effects of the years of abuse and neglect. Therefore, being discharged from Residential school often came with a whole new set of problems which were not able to be resolved through family or community support. This in turn caused further trauma for many

former students and increased the risk for the development of mental and physical health problems.

Researchers have also found associations between childhood adversities and suicide ideation and attempts (Enns et al. 2006, Afifi et al. 2008). Afifi et al. (2008) found that abuse and adversities in childhood such as neglect, psychological abuse, and physical abuse are strongly associated with suicidal behaviour later in life. Enns et al. (2006) found an association between childhood physical abuse, sexual abuse, and witnessing of abuse and psychiatric disorders and suicide ideation and attempts. Given the fact that suicide is such a large issue among First Nations communities, examinations of historical documents such as Residential school records can be very useful in gaining a better understanding of the reasons for such high rates of suicide behaviours and the connection to colonial processes such as loss of culture and identity, residential schooling, and forced assimilation.

1.7.8 Specific Health Problems

A number of researchers have examined the relationship between adverse childhood experiences and specific health problems or conditions in adults.

A number of findings came out of the Adverse Childhood Experience (ACE) Study. This was a retrospective cohort study which examined the associations between multiple adverse childhood experiences and specific adult health behavior, health outcomes, and healthcare utilization (Anda et al. 1999, Dube et al. 2002). The adverse experiences included abuse (verbal, physical, and sexual), neglect (emotional and

physical), and household dysfunction (domestic abuse, substance abuse, mental illness, parental separation or divorce, and crime) (Dong et al. 2003). The study population included adult patients of a primary care clinic in San Diego California who responded to a mailed questionnaire that was sent to them following a standardized medical evaluation at the clinic (Anda et al. 1999). There were two survey waves of this study, with the Wave II questionnaire having some additional questions in order to collect more detailed health information (Dube et al. 2002). The final study cohort included 18,175 individuals with a 68% response rate (Dong et al. 2003).

Anda et al. (1999) using a sample of 9215 patients, found that smoking was strongly associated with each category of adverse childhood experiences. They explain that people tend to use nicotine as a means of self medication in order to cope with the effects of their negative experienced in childhood (Anda et al. 1999).

In their examination of alcohol use as a response to adverse childhood experiences, Dube et al. (2002) found a positive relationship between number of adverse experiences (abuse, neglect, and household dysfunction) in childhood and higher risk of alcohol misuse or abuse as an adult.

Dong et al. (2003) found that each of the adverse childhood experience categories increased the risk of liver disease. They note health-risk behaviours such as alcohol consumption, drug abuse, and sexual promiscuity are associated with adverse childhood experiences and are known to increase the risk of liver disease. These behaviours act as mediating factors and therefore a possible pathway in the relationship between the adverse experiences and liver disease (Dong et al. 2003).

Other researchers have found positive associations between childhood maltreatment or abuse/neglect or adverse experiences and diabetes (Kendall-Tackett and Marshall 1999, Goodwin and Weisberg 2002), PTSD (Spatz Widom 1999), pain/chronic pain (Sachs Ericsson 2007, Davis et al. 2005), increased risk of heart disease and heart attacks (O'Rand and Hamil-Luker 2005), cardiovascular disease and lifetime depression (Batten et al. 2004), chronic fatigue syndrome and psychopathology (Heim et al. 2006), panic attacks, depression, and lung disease (Goodwin et al. 2002), gastrointestinal problems and migraine headaches (Goodwin et al. 2003), HIV health risk behaviours and heavy drinking (Bensley et al. 2000), HIV related risk behaviours (Klein et al. 2007), binge eating disorder (Grilo et al. 2001), adult obesity (Williamson et al. 2002), and body dismorphic disorder (Didie et al. 2006).

1.7.9 Mental Health

Researchers have also examined the effects of adverse childhood experiences on adult mental health. Maughan and McCarthy (1997), examine the relationship between childhood adversities and psychosocial disorders in adults. They note that "many adverse childhood experiences, especially those involving inadequate parental care, are reliably associated with increased risk for psychosocial disorders in adult life (Maughan and McCarthy 1997:166). They also note that there is little specificity in the linkages between certain adversities and certain health outcomes and that many different aspects of a child's development can be impacted by adversity. They feel that it is a matter of small intervening steps which eventually connect childhood adversity to problems with

psychological functioning and that there are many mediating factors to consider which may influence the types of outcomes people experience (Maughan and McCarthy 1997).

In a study which used participants from the 1990 Ontario Health Survey, MacMillan et al. (2001) also found that a history of abuse in childhood is associated with an increased likelihood of lifetime psychopathology including anxiety disorders, alcohol abuse/dependence, and antisocial behavior.

Battle et al. (2004) examined the relationship between childhood abuse and neglect and personality disorders. The sample included 600 personality disorder or major depressive disorder patients from the Collaborative Longitudinal Personality Disorder Study done in the US. They found that reports of childhood maltreatment were high among these groups with 73% reporting abuse and 82% reporting neglect.

By uncovering these types of connections between Residential school abuse and neglect and later physical and mental health disorders among adults, there is a chance for survivors to being to feel validated in terms of how they feel that have been affected by the Residential school system. By educating the larger society on the connections between the historical trauma experienced by First Nations people many of the health problems currently facing this population within Canada, perhaps some of the stigma and stereotypes inherent in the colonial and post-colonial understanding of First Nations people will be replaced by compassion, understanding, and an urge to assist in making environments that are based on equality rather than racist judgments.

Much discussion in the Residential school literature concerns the effects early life separation of children from their parents and families. This break up of families is noted to have numerous negative effects on the lives of First Nations individuals, families, and

community today. Often "students languished in schools for years with little or no contact with home, in part because insufficient or indifferent staff made transmission of pupils to their homes difficult" (Miller 1996:312). Although not related to Residential schools specifically, a number of researchers have examined the relationship between childhood parental loss-separation and effects on adult health.

In a study, which surveyed a sample of older adults taken from the Health Care Finance Administration Medicare Beneficiary Eligibility List (HCFA), Krause (1998) found that early parental loss combined with certain recent stressful life events are associated with a decline in self-rated health and are associated with a number of chronic and acute conditions, and therefore compromise health in late life (Krause 1998). The author stresses the importance of examining early life events in order to understand the health of older adults. He notes, "the data suggest that researchers cannot fully understand the impact of recent life events on health, without also taking into consideration stressors that were encountered decades earlier. The fact that early loss of a parent through death or divorce can influence physical health status over half a century provides dramatic support for this view" (Krause 1998: 416).

Krause (1993) in a study which used data from the 1978 Quality of American Life Survey, a nationwide survey of those 18 years and older examined the relationship between early parental loss and feelings of personal control in later adult life. The sample used in this study included those 65 years or older and resulted in 519 participants. The author found support for a theoretical sequence of linked events which include early loss of parent, followed by low levels of educational attainment, which leads to financial problems later in life, which is in turn associated with diminished feelings of personal

control among older adults (Krause 1993). This is interesting as this is similar to the pattern of life during and post-residential school reported by former students in their discussion of how Residential schooling affected their lives.

Researchers examined the relationship between childhood attachment and loss experiences and the effects on adult cardiovascular and cortisol function (Luecken 1998) and on adult cortisol response to stress (Luecken 2000a) on 61 Duke University and North Carolina University students using saliva samples and blood pressure and heart rate monitoring. The author notes that "Considerable evidence suggests that early developmental stressors and caretaking experiences can modulate the development of adult physiological reactivity and disease susceptibility" (Luecken 1998:765). The results of the study suggest that both childhood loss of a parent and poor quality of caretaking after the loss of a parent are associated with an altered neurohormonal response to stress (Luecken 1998, 2000a) as well as increases in blood pressure (Lucken 1998). Therefore, this is evidence that early disruptions in attachment relationships can affect health in adulthood by possibly sensitizing individuals to the health damaging consequences of stress (Luecken 1998, 2000a). Luecken (2000a) points out that the type of bond developed between the child and the remaining parent/care giver after the loss of a parent is especially relevant to the development of long-term cortisol responses to stress. She also notes that for a child, the lack of a good attachment to a parent may work in the same way as the effect of the loss of parent (Luecken 1998).

Nicolson (2004) found a similar effect of an increase in cortisol levels and lasting effects on the HPA axis in men when there was a parental loss in childhood prior to the age of 17.

Other researchers have examined this issue and have found positive associations between early parental loss or separation and clinical depression and psychiatric episodes (Harris et al. 1986), major depression, bipoloar disorder and schizophrenia (Agid et al. 1999), and nonengodenous depression (Roy 1985).

In terms of general psychopathology, Tennant (1988) in a review of the literature found that parental loss through separation had more significant effects on later psychopatholgy than did parental loss through death. This may be important in considering that children taken to Residential schools knew that they were being separated from their living parents.

Breier et al. (1988) found that the mediating factor of having a non-supportive relationship with the surviving parent is associated with the development of adult psychopathology. That it is not so much the loss which is a causal factor, but the adequate parenting and positive quality of home life subsequent to the loss that may be a stronger factor. Again, in considering the Residential school experience, the negative conditions and lack of care the children experienced at the schools would have contributed more harm to the children in addition to the separation from their parents. They also found that those who experienced childhood parental loss had increased hypothalamic-pituitary-adrenal (HPA) axis activity which may be related to the loss experience (Breier et al. 1988).

Kendler et al. (1996) found that childhood parental loss through separation (but not death) prior to age 17 is a significant environmental risk factor for the development of alcoholism in women. The study looked at a sample of 1018 female twin pairs. Interestingly, they also found that both paternal and maternal alcoholism substantially

increased the likelihood that parents would be separated from their children (Kendler et al. 1996). This type of cycle would allow for the continuation of the removal of children from their parents and in turn the transfer of these negative outcomes of early parental separation throughout the generations, as is the case with the intergenerational transfer of the negative effects of Residential schools.

Some research has also been done which examined the perception of parental caring and how it relates to subsequent health.

In a 35 year follow-up study of the Harvard Mastery of Stress Study which surveyed male Harvard undergraduates, Russek and Schwartz (1997) found that parental caring and loving may have important regulatory and predictive effects on biological and psychological health and illness, and can predict later physical health across various disorders such as coronary artery disease, hypertension, duodenal ulcer and alcoholism (Russek and Schwartz 1997). In a study of a group of males and females from the University of Arizona, Russek et al. (1998) found that positive perceptions of parental love and caring are associated with reduced psychiatric and somatic symptoms.

In research which examines the quality of parental care and its effects in a case control study of 125 depressive neurotics, Parker (1983) found that those with depressive disorders are likely to report their childhood parental care was insufficient and that their parents were overprotective.

1.7.10 Body Composition

One of the last issues that should be addressed here is the changes in health that have occurred over time, in particular the change in the body composition of First Nations children. According to the 2002/2003 FNRLHS, from 1981 to 1996, the prevalence of children who are overweight has increased from 15% to 29% for boys and from 15% to 24% for girls. Over the same time period, the prevalence of obesity has increased from 5% to 14% for boys and from 5% to 12% for girls (FNC 2005). In terms of First Nations children, the risk of obesity is particularly high. ..."the data reveal that Canadians of Aboriginal descent have consistently higher rates of being overweight compared to the overall Canadian population" (FNC 2005:256). The FNRLHS found that 41% of the children interviewed are considered to be normal of underweight, 22% are considered overweight, and 36% are considered obese. They also found that while there were no differences between boys and girls, older children were more likely to be in the overweight category and younger children were more likely to be in the obese category (FNC 2005).

Residential school experiences are unique to First Nations culture and not replicable in other situations. The studies that represent non-First Nations populations will never be directly comparable to the experiences of Residential schools; however, since there is a lack of these types of studies concerning First Nations populations and considering Residential schools specifically, these studies are an appropriate starting point in this process to build rationale for why there should be concern over the effects of Residential school experiences on the health of First Nations people. An examination of

these types of research may be useful in the process of discovering how the health of the children of Residential schools was affected by their experiences in the schools as well as the long-term health effects on Residential school survivors as adults and their successive generations.

Chapter 2

2.1 Purpose

The purpose of this study was to examine and describe the overall health of First Nations children at the time of their admission to, and during their stay in, a Residential School in a community in northern Manitoba during the time period spanning from 1930 to 1953.

2.2 Objectives

1. To describe the overall health of children at the time of admission to a residential school in a community in northern Manitoba during the years 1930 to 1953.

Research Questions:

a) what type of illnesses were common in children first being admitted to the school?

b) what types of illnesses were deemed allowable in rendering a decision on admission?

c) what were the BMIs of the children?

2. To compare the health of the children over three time periods (1930 to 1939; 1940 to 1949; and 1950 to 1953) and between home communities/bands.

Research Question:

Were there differences in the health of the children upon admission by time period and by home community?

3. To examine the health of a few specific children who reappear in the documents (i.e., follow their path of health from admission, to illness, to recovery/death).

2.3 Materials and Methods

2.3.1 Design

The design of this research is an historical qualitative inquiry using a set of historical documents, specifically Residential school records. The original records are public access documents held in the Library and Archives of Canada, in Ottawa, but for the purposes of this study microfilmed copies held in the Provincial Archives of Manitoba were consulted. Four types of documents were used: (1) Application for Admission forms: (2) Physical Examination forms; (3) Admission/Discharge forms; and (4) Letters.

The documents used in this research cover a period of 23 years. In order to study whether there were any changes in the health of the children over time, these years were broken down into three time periods by decades. Therefore 1930 to 1939, 1940 to 1949, and 1950 to 1953 are the time categories.

2.3.2 Data Sources

1. Application for Admission (Form)

This form was filled out for each child for whom application to attend the Residential School was being made. It was the responsibility of the Indian Agent to fill out this form

and ensure the information was correct and complete. Indian Agents were employees of the Department of Indian Affairs and were in charge of many administrative duties on reserves. In terms of the Residential school, their duties included registration, and in some cases recruitment, of children. The Indian Agent would sign the completed form along with another witness who was not the Principal of the school to which the child was making application. The father of the child was also required to sign the **Application for Admission** form and if the mother or any other guardian was the one to sign, an explanation was needed as to why the father did not sign the form. The form recorded information on the child and the parents of the child including; name, age, band and treaty number of child, names and treaty numbers of parents, religion, information on general health, language and previous education. For complete list of information included on this form see Appendix A.

2. Physical Examination (Form)

A medical examination was performed on each child for whom an application to attend the Residential School was being made. The exam was guided by this form and the results were recorded on the form. The doctor from the Agency area conducted the health exams and signed and dated each health examination form that he completed. It was the responsibility of the doctor to ensure that the information on the form was correct and complete. There are two types of **Physical Examination** forms; one type titled **Certificate of Health** appeared during the earlier years, there were 8 of these forms in the data set, and the other titled **Physical Examination,** which accounts for the majority of the forms, appeared later. This form contained health information pertaining to the

particular child such as name, age, height, weight, pulse rate, temperature, and any medical or health conditions of the child. For a complete list of information included on this form see Appendix B.

3. Admission/Discharge (Form)

This form was filled out by the school Principal at the end of each quarter of the school year; September, December, March, and June. On this form the Principal listed all children who had been admitted or discharged. The form was signed by the Principal and it was the responsibility of the Principal to ensure all information on the form was correct and complete. Information on the form included the child's name, school number, date of admission or discharge and age on admission or discharge, parent's names, education level, reason for discharge. For complete list of information included on this form see Appendix C.

4. Letters

Letters were written between the Indian Agent, the Principal of the school, and the government officials involved in the operation of the school. Letters included information on specific admissions and discharges and reasons for these. They also contain information on students and their families in matters concerning the school. They also include general discussion of school policies and practices relating to admissions and discharges. For an example see Appendix D.

*see Appendix for list of Fields and Notes on Fields for 1. 2. 3.

2.3.3 Methods

Document analysis is a distinctive research method in which previously created materials are used in the process of research (Mason 1996). Document analysis has been referred to as an unobtrusive method, meaning that the researcher can gain an understanding of cultural or societal meaning by examining existing sources of information (Bernard 1994, Rice and Ezzy 1999). The documents to be used in this research are available to the public through the Provincial Archives of Manitoba and there are no restrictions on their use. The documents are available in Microfilm version which allowed them to be scanned onto computer files and saved to disc. This research is unobtrusive in that there will be no involvement of live participants in the main research process. Any contact that is made with the community in which this research is based will be for ethical purposes such as keeping the community informed of the research, obtaining community input, and for the dissemination of research findings.

An important reason for choosing to conduct a document analysis is that this research concerns a sensitive topic which makes methods in which there is direct communication quite complicated. In keeping my research based in documents only, I will not need to engage in research for which I do not have the resources to support. For example, discussions on experiences in Residential schools can often evoke painful memories and bring up strong emotions. Researchers involved in this type of research must provide the appropriate resources (e.g. counseling services) to help their participants deal with their reactions to the sensitive topic. At this point in time I do not have these

resources, so I feel that it would be ethically inappropriate to conduct research of that nature.

2.3.4 Advantages

One of the advantages of document analysis is that it has the potential to give power to voices that often go unheard; the voices of the marginalized, the oppressed, the ignored, the undervalued, the silenced, and the alternative (Hodder 1994). In some of the letters written between the Indian Agent, and the school and church officials, there are discussions about what a parent of a student or other member of the community had said. If it had not been recorded in the letters, this information would have otherwise been lost. Through the examination of these letters, information can be revealed regarding what the parents said or thought about the school, or what was happening in the lives of the parents whose children were taken to the school. Therefore, these documents are a valuable tool in providing a voice to the people who never got a chance to be heard. Another advantage to using documents is that they can provide access to information on sensitive topics that otherwise may be guarded or difficult to access (Rice and Ezzy 1999). In order to conduct certain types of research and have accurate results, the researcher must spend considerable time and effort to establish relationships with participants and communities, especially when the topic is sensitive. In terms of my research, I would certainly need to build trust relationships with community members if I was to interview them on the topic of their childhoods and their experiences in the Residential school. It could take years to build such relationships and so this particular

project could serve as a beginning point in that process. By examining the pre-existing information available through documents, this issue can be researched without facing such expected barriers to access and information. Therefore, a third advantage in using documents is that it can act as a starting point for other research projects.

2.3.5 Limitations

One of the limitations of using document analysis is that biases of the person who created the documents might affect the research results. The quality and accuracy of the data may have been affected by some unknown reason. If the documents are historical, it is often difficult or impossible to contact the person who created them. The reality is that the information analyzed may not be accurate (Rice and Ezzy 1999). In terms of my research, I am relying on many people to have completely and correctly filled out the forms for which they were responsible, and for the letters to be written truthfully and without mistakes. As these are historical documents and there will be no contact with living participants, there can be no cross-checking with people for accuracy. Another limitation is that in using historical documents, there can be difficulties in checking the accuracy of researcher interpretations. With other methods such as participant observations, researchers can continually check with participants to learn whether their interpretations are correct. When using historical documents, there is less or no opportunity for this as the interpretation occurs far from the time and place in which the documents were created (Hill 1993). One means of correcting this problem is to have other researchers also analyze the documents and then perform a cross-check with them

regarding accuracy of interpretations. In terms of my research, this could be carried out by my committee members. A third limitation of using documents is that the researcher can only use the information contained within the documents. Research may lead to additional questions that cannot be answered using the information in the documents (Stewart and Kamins 1993).

2.4 Theoretical Orientations

Often a theoretical framework will come from a particular research tradition. A research tradition that has influenced my thought and perspective is medical anthropology. One theoretical perspective within medical anthropology is critical medical anthropology. Using this theoretical perspective, researchers attempt to uncover the ways in which power differences shape social processes. The critical medical anthropology perspective guides researchers in understanding issues of health within the larger social, political, and economic forces that influence cultural meaning, social behaviours, patterns of human relationships, and collective experiences (Baer et al. 2003). According to this view, within some populations, social, political, and economic forces have overpowered other means of development and meaning. This is especially true for First Nations since the time of contact with Europeans. Baer et al. (2003) maintain that critical medical anthropology works to uncover the ways in which these overriding powers contribute to sickness and disease; the social origin of health. The study of the resistance against manipulation, oppression, and exploitation, or lack thereof, is common in the work of critical medical anthropologists (Janzen 2002).

A second theoretical perspective that influences my thought and research is post-colonial theory. Researchers using post-colonial theory study the effects of colonialism and attempt to break down the processes that give power to the colonizers over the colonized. The research, theory, and concept chosen by those who use a post-colonial theoretical perspective usually enables them to study exploitive and oppressive political, social, and economic relationships, processes, and contexts. Post-colonial research involves cross-cultural understanding, recognition of the value of diversity, empowerment of a people who have been exploited, a respect for cultural differences, and support for self-determination (Howitt and Stevens 2000).

2.5 Analysis

This research consists of an analysis of the contents of documents. The term content analysis has been used to describe a number of techniques for extracting information from documents or text. One way of doing a content analysis involves making hypotheses about what might be in the text, coding the material and doing a statistical analysis, and then interpreting the results based on historical or ethnographic information (Rice and Ezzy 1999). The content of the documents then becomes organized into more relevant and manageable pieces of data and inferences can be made from the documents (Weber 1990, Patton 2002). Another method used in the analysis of documents is thematic analysis. With this method the material is examined for themes and the themes become the categories of analysis (Rice and Ezzy 1999). According to these authors, an important note about thematic analysis is that it also has been referred to

as grounded theory. In grounded theory, concepts are grouped to form categories, and relationships between categories are then identified to develop theory, emphasizing the inductive nature of theory building. Therefore, some researchers feel that there are two distinct methods of analysis where content analysis calls for the codes to be developed prior to studying the data and thematic analysis calls for the development of codes from the data. Rice and Ezzy (1999) note that other researchers do not consider these methods of analysis to be rules based and use the term content analysis to refer to the more general inductive methods of thematic analysis.

A third method of analysis is semiotic analysis. In using this method, researchers look beyond the written words in order to understand the deeper meaning within the data. By studying what is not clearly written, researchers can become aware of suppressed, repressed, omitted, and hidden themes, and reveal information about the social and political contexts of texts. With this method researchers remain aware of pre-existing theories that might influence research and results (Rice and Ezzy 1999).

Overall, the method of document analysis requires considerably more than simply reading what is written in the documents. In terms of my research, none of these three distinct methods of analysis fit perfectly with the ideas, plans, and goals of my study. Instead of choosing one method specifically, this research uses pieces of each of these methods. Despite the rules and guidelines that have been developed for each of these methods, I believe that a more general approach can be taken in the analysis of content and themes in documents that can blend components of each idea in a less formalized and more encompassing way.

The analysis of the data includes a number of different methods of examining the content of the documents, including looking at the information both directly and indirectly. The documents were available on Microfilm at the Provincial Archives of Manitoba. This allowed for the documents to be scanned onto computer files, the files burnt to discs, and the discs taken back to the workspace for analysis. With the forms on computer discs, each form was studied closely for content.

With the **Application for Admission** forms, the **Physical Examination** forms, and the **Admission/Discharge** forms, I examined and recorded specific information which was decided on prior to the analysis of those documents. Analysis of the content of the **Application for Admission** forms and the **Physical Examination** forms began by entering the information into a Microsoft Access database, making the data more organized and accessible. With this database, the data can be viewed either in table or form format. The data were then analyzed in a number of ways in order to extract as much information as possible. All the fields listed on each form were recorded and studied to see what they could reveal about the students at the school. Microsoft Excel sheets were then created for each year from 1930 through to 1953 which listed all of the sicknesses or other health related conditions that were noted on the **Application for Admission** form or the **Physical Examination** forms for each child. Information on any type of health concern was entered into the Excel sheet and organized by study numbers assigned to each child in the database. Counts of certain items of interest on the documents were generated. Content analysis was used for this portion of the study as well as a systematic coding and descriptive statistical analysis. Therefore, specific information

on sickness and health conditions was recorded and organized in order to determine patterns of occurrence.

Information from each of the four types of documents was entered into Microsoft Word files in order to assist in the retrieval of information and the analysis and coding of content and themes within the data. Again, with the **Admission/Discharge** forms, counts were generated of particular items of interest in order to determine patterns of occurrence. A number of themes emerged from the documents and include numerous aspects of the process of admissions at the Residential school. Thematic analysis was used for this portion of the study and categories were allowed to develop through the analysis of the text. The thematic analysis also allowed for the following of a few particular children from their admission to the school through to their discharge and what happened to them in terms of their health and healthcare. Semiotic analysis was also utilized through looking beyond the written text in order to gain an understanding of the social and political context surrounding the health of the children in the Residential school. This involved looking at what was not written in the documents, what information was omitted from the documents and files, what information was seen as important and required at that time, and what it means by the types of fields used on the documents.

There is an extremely large element of power and control associated with the Residential school experience and these types of analyses are used to uncover what is recorded, as well as hidden and repressed, within these documents. Therefore, this research utilizes ideas of content, thematic, and semiotic analysis, making note of information that is recurrent in the text as well as information that stands out as interesting on its own. The combination of the different types of information taken from

the different types of documents will allow for a better understanding of the health of the children were when they were first admitted to the Residential school, what life was life, and if, and how, their health changed while they were at the school.

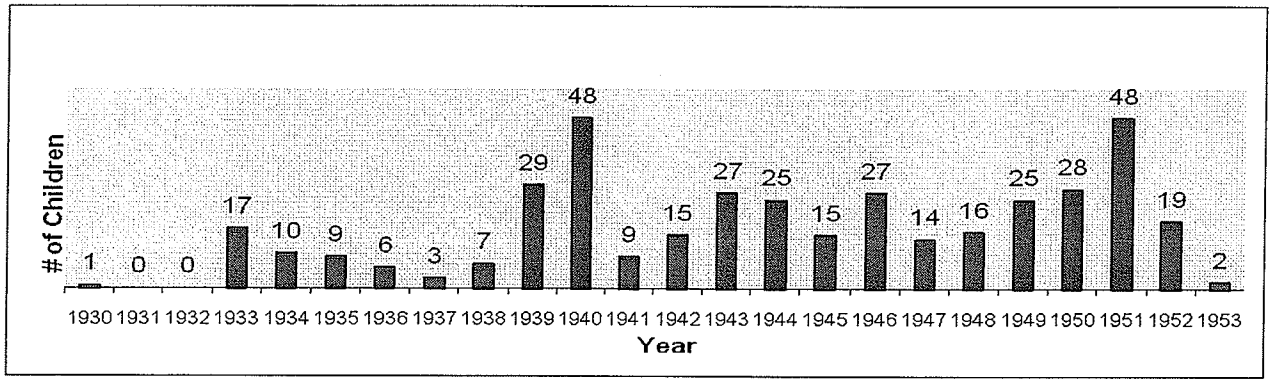
Chapter 3

3.1 Results

Study Population

In total, there were 400 applications made for children to attend the school from 1930 to 1953. In some years there were no applications made to the school (e.g. 1931 and 1932), while in other years there were numerous applications (e.g. 48 children in 1940 and 1951). See Figure 3.1 for a complete list of number of children admitted per year.

Fig. 3.1 Number of children admitted per year.



3.1.1 Sickness

An examination of the **Application for Admission** and the **Physical Examination** forms shows that children were being admitted into the school with sicknesses and other types of health conditions.

3.1.1.1 Undernourished

One of the categories on the **Physical Examination** form was "Undernourished". Out of 400 children, 36 or 9% were identified by physicians as "Undernourished". In terms of gender, 19 (53%) of the children were female and 17 (47 %) of the children were male. Of these 36 children, the doctor wrote *"slightly"* in the "Undernourished" space for 3 children and *"yes"* in the "Undernourished" space for the remaining 33 children. There is no indication as to how the determination was made. BMI scores of those children listed as undernourished were calculated. Thirty-one of the 36 "Undernourished" children (86%) had BMI-for-age percentile scores that fall into "Normal Weight" category according to the CDC Weight Status Category Ranking Chart, 3 (8%) had BMI-for-age percentile scores that fall into the "Underweight" category, and 2 (5%) could not be calculated due to insufficient data on the Physical Examination forms.

Number of children listed as Undernourished per decade and per Band.

In the 1930s, of the 82 children who had an application to the Residential school, 3 (4%) were listed as "Undernourished". All three of these children were female. In the 1940s, of the 221 children who had an application to the Residential school, 31 (14%) were listed as "Undernourished". In terms of gender, 14 (45%) were female and 17 (55%) were male. In the 1950s, of the 97 children who had an application to the Residential school, 2 (2%) were listed as "Undernourished". Both of these children were female. There were no patterns found for number of "Undernourished" children by Band.

3.1.1.2 Skin Conditions

The most common skin conditions affecting children were scabies and head lice.

i) Scabies

Of the 400 children who had an application made to the Residential school, 27 (7%) were listed as having scabies on their **Physical Examination** forms. All of these children were approved for admission by the Department of Indian Affairs. In terms of gender, 11 (41%) were female and 16 (59%) were male.

Number of children per year listed as having scabies.

All cases of scabies noted in the documents occurred in four separate years. The number and percentage of children admitted to the Residential school with scabies is as follows: 3 of 27 (11%) in 1933; 1 of 27 (4%) in 1937; 9 of 27 (33%) in 1939; and 14 of 27 (52%) in 1940.

ii) Head Lice

Head lice were identified in 5 of 400 (1%) children. All cases of head lice occurred in 1939 and all of the health exams took place on either August 8 or 9 of that year. In terms of gender, 2 were female, and 3 were male. All 5 of the children came from Band 2.

3.1.1.3 Tuberculosis

The **Physical Examination** forms contained a number of questions that related specifically to tuberculosis. Of the 400 children who had an application made to the Residential school, 10 (2.5%) had **Physical Examination** forms on which the doctor

indicated a tuberculosis-related concern. Of these 10 children, 2 had the indicator box checked off by the doctor which reads, "Does this child have Tuberculosis in your opinion?" There is no indication of why the doctor did not check off this box for the other children. One of these two children has the comment *"arrested tuberculosis"* written by the doctor in the comment section, while the comment for the other child was *"possible – to be x-rayed"*. The following is a list of the children, by their study numbers and the year of their application to the Residential school, which describes the type of tuberculosis related health concern noted by the doctor on the **Physical Examination** form.

Table 3.1 Tuberculosis Related Concerns in Children

Date of Application	Child No.	T.B related concern
1934	No. 18	arrested pulmonary. T.B.
1935	No. 30	not very active T.B.
1940	No. 47	Guarded
1942	No. 146	suggestive of T.B
1943	No. 155	roughened breath sounds, needs x-ray
1945	No. 200	arrested T.B.
1946	No. 234	possible T.B. needs x-ray
1946	No. 232	possible T.B. needs x-ray
1946	No. 231	possible T.B. needs x-ray
1952	No. 387	probably T.B.

The number and percentage of children per decade admitted to the school with some type of health condition related to tuberculosis is as follows: 2 of 82 (2.4%) in the 1930s; 7 of 221 (3.2%) in the 1940s; and 1 of 97 (1%) in the 1950s.

There were also 10 additional children for whom the doctor or Indian Agent noted on the application forms that there was tuberculosis within their family.

Table 3.2 Tuberculosis in the Family

Date of Application	Child No.	Note about T.B in the family
1934	No. 19	T.B. in family, father
1935	No. 36	T.B. in family, mother
1936	No. 43	T.B. in family, mother
1940	No. 121	T.B in family
1940	No. 122	T.B. in family
1947	No. 258	Mother died in Sanatorium
1948	No. 270	T.B. in family, needs x-ray
1948	No. 271	T.B. in family, needs x-ray
1953	No. 399	Father in Sanatorium
1953	No. 400	Father in Sanatorium

3.1.1.4 Cozyra and Colds

Of the 400 children who had an application made to the Residential school, 22 (5%) were admitted having a cold or cozyra (the terms cold and cozyra were both used to describe the same sickness). In terms of gender, 13 (59%) were female and 9 (41%) were male. By decade, the number and percentage of the children admitted to the Residential school with a cold/cozyra was 7 out of 82 (8%), 14 out of 221 (6%) and 1 out of 97 (1%), in the 1930s, the 1940s, and the 1950s respectively. The split by gender in the 1930s and 1940s was similar with approximately 57% of cases noted among females and 43% among males.

3.1.1.5 Swollen Glands

Of the 400 children who made an application to the Residential school, 9 (2%) were listed as having some type of swollen gland(s) on their **Physical Examination** form. Most of these forms also contained some information on the cause of the swollen glands

and this provides additional information as to what types of sicknesses were affecting children being admitted to the Residential school. In terms of gender, 3 (33%) were female, and 6 (67%) were male.

Table 3.3 Specific Reasons for Swollen Glands

Year	Child No.	Cause of Swollen Glands
1935	No. 30	possible T.B. enlarged cervical gland
1939	No. 61	due to scratching infected scabies
1939	No. 66	due to infected tooth
1939	No. 71	due to infected scratches due to head lice
1940	No. 99	healed cervical glands
1942	No. 139	due to tonsils
1948	No. 263	cervical glands swollen, inflamed throat
1949	No. 289	healed glands
1952	No. 396	cervical tonsillar lymph nodes and tonsils enlarged

By decade, the number and percentage of children being admitted to the Residential school with swollen glands is as follows: 4 out of 82 (5%) in the 1930s, 4 out of 221 (2%) in the 1940s; and 1 out of 97 (1%) in the 1950s.

3.1.1.6 Respiratory System Concerns

In addition to the tuberculosis related concerns, there were other respiratory system concerns noted by the doctors on the **Physical Examination** forms. Six of the 400 (1%) children had respiratory concerns other than tuberculosis noted on their Physical Examination forms. Some of the doctors also provided additional information about the nature of the respiratory system concern.

Table 3.4 Type of Respiratory Concerns

Year	Child No.	Type of infection or health problem
1937	No. 45	"slight lagzing in chest"
1939	No. 64	"exaggerated breath sounds"
1946	No. 236	"Pharangitis"
1946	No. 238	"occasional crep."
1946	No. 240	"Pharangitis occ. Rhonchi"
1946	No. 234	"rhonchi"

By decade, the number and percentage of children admitted to the Residential school with some type of respiratory system concern is as follows: in the 1930s, 2 out of 82 (2%); in the 1940s, 4 out of 221 (2%); and none in the 1950s.

3.1.1.7 Dental Concerns

Although not infectious to the other children, some of the doctors commented on the state of the child's teeth if they were in poor condition. There was no specific section for comments related to oral health on the **Physical Examination** form; however doctors did include comments about teeth in the general comments section. Twelve of the 400 (3%) children were listed as having some type of dental concern. In terms of gender, 8 (67%) were female, and 4 (33%) were male. The doctors often provided some information as to what type of problem with the teeth/tooth the child was experiencing.

Table 3.5 Type of Dental Concern

Year	Child No.	Teeth/Tooth Concern
1933	No. 5	teeth in need of extraction
1938	No. 47	cavity
1938	No. 50	cavities
1938	No. 51	cavities
1939	No. 66	infected tooth
1939	No. 60	unhealthy teeth
1939	No. 64	cavities
1939	No. 68	cavities
1939	No. 71	cavities
1943	No. 154	cavities, infected tooth
1952	No. 385	cavities
1952	No. 389	cavities

By decade, the number and percentage of children admitted to the school with some type of dental concern in as follows: 9 out of 82 (11%) in the 1930s; 1 out of 221 (0.45%) in the 1940s; and 2 out of 97 (2%) in the 1950's.

3.1.1.8 Other

There were health concerns noted on the **Physical Examination** forms which did not fit into any of the other categories above. Most of them are not contagious sicknesses; however they are listed in order to provide additional information into what types of conditions were affecting children being taken into the Residential school.

Table 3.6 Other Health Concerns

Year	Child No.	Condition
1939	No. 68	"cleft lip", "fifth finger on each hand", "slight impairment of hearing"
1939	No. 70	Heart condition, "slight impairment of hearing"
1939	No. 56	"feeble minded"
1939	No. 689	"mentally retarded"
1939	No. 280	epileptic
1940	No. 109	deaf
1941	No. 135	"small primary lesion in apex"
1942	No. 152	"cross eyes"
1942	No. 150	"low I.Q."
1943	No. 175	broken arm and is in hospital
1943	No. 158	"none too bright"
1943	No. 156	"just had measles"
1944	No. 187	"cross eyes"
1944	No. 189	fever due to inoculation
1944	No. 188	fever due to inoculation
1944	No. 191	fever due to inoculation
1944	No. 192	fever due to inoculation
1944	No. 190	fever due to inoculation
1946	No. 243	finger deformity, "congenital scaly eruption on face"
1946	No. 211	"verruca vulgaris on right hand" (wart)
1948	No. 274	"getting over mumps"
1952	No. 385	"slight funnel chest"

Overall, there was only a small number and proportion of children identified as having an illness or health condition at the time of their admission to the Residential school. There were also no significant patterns of sickness or poor health based on year (decade), gender, or Band. It should also be noted that there was often a lag in time between when the **Application for Admission** form was filled out and when the **Physical Examination** was completed for each child. Upon examination of the list of children identified as having some type of sickness or condition of poor health upon admission, it was found that among these children, this lag of time varied from 2 weeks to 26 weeks. This may have had an impact on the types of health concerns presented at the time of the health

exam, as certain sicknesses could have been contracted during this time when the child was residing at the school awaiting their health examination.

3.1.2.1 Illnesses Which Precluded Admission

As each of the sicknesses and other health concerns previously discussed were found in children who were granted approval of admission to the Residential school, it can be assumed that they were considered allowable health conditions for admission by the authorities and administrators of the school including the Department of Indian Affairs, the school Principal, and the Indian Agent. There were only a few occasions on which a student's application for admission was denied due to poor health of the child. The instances that were found through a search of the documents are as follows.

Case 1 - Child No. 18

This female child, age 6, had an **Application for Admission** form dated October 2, 1933 and an accompanying **Physical Examination** form dated November 9, 1933, approximately one month and one week later. On the application form the Indian Agent wrote, *"this child is motherless and with no near relations able to care for her"*. Therefore, this child was an orphan at the time the application was made for her to attend the Residential school. On the **Physical Examination** form it is noted that the child has *"chronic otitus media"* (ear infection), and that, *"child is not robust and will require a good deal of extra care and attention"*. The Department sent back a letter dated December 4, 1933 which stated that they would not approve the admission of the child to

the school as a student. This was approximately one month after the **Physical Examination** date, and two months after the **Application for Admission** date. However, the Department did suggest that she be kept at the school so that she could receive care in order to regain her health. The Department stated,

> *"She may be placed in the school, but, in view of the medical officer's report, it has been decided to defer approval of her admission".... "She should receive special care and attention and if, in two or three months time, the school authorities consider that her health has improved, you may again apply for her formal admission to the school".*

There is a second **Physical Examination** form for this child dated February 17, 1934, approximately two and a half months after the child had been denied admission. On this form, the doctor noted that she had *"corneal opacities both eyes"*, *"chronic otitus media has cleared up since last examination"* and *"has arrested pulmonary tuberculosis"*. The doctor also noted that,

> *"child is an orphan. Has arrested pulmonary tuberculosis in both apices. No cough and seems to be gaining satisfactorily fat, is in my opinion better off in a school that on the reserve."*

Along with the second set of application forms, a letter dated April 3, 1934 was sent from the Indian Agent to the Department which stated,

> *"I would recommend the admission of the girl to this school, and we will keep watch on her progress. Should at any time her condition prove to be a menace to the other children, we will have her removed from the school, on the consent of the Department."*

The Department responded in a letter dated April 17, 1934, in which they approved the admission of this child to the Residential school but only if she remained in good health. Therefore, this child was first denied admission to the school because she had an ear infection but the doctor advised that she be taken into the school and cared for there until she was well enough to have a second application and health examination submitted for her. Approximately two and a half months after the Department had denied her admission, the doctor felt that she was healthy enough to be formally admitted to the

school despite the fact that he thought she had arrested pulmonary tuberculosis, meaning she had been previously sick with tuberculosis but was now recovering. Importantly, this there was no indication of tuberculosis on the Physical Examination form from November 1933. This child was eventually discharged from the school at age 13, when her parents would not transfer her over to the re-built Cross Lake Residential School. She must have reconnected with some family members by this time.

Case 2 – Child C_1 (C_1 represents this child who was not assigned a study number)
A student appeared on the September 1934 Quarterly Return but no **Application for Admission** or **Physical Examination** forms were ever completed for this child. In a letter dated December 11, 1934, the Department advised the Indian Agent that,

> *"No application or certificate of health has yet been received for* C_1. *The necessary form for this girl should be forwarded as soon as possible".*

The Indian Agent wrote back to the Department in a letter dated January 18, 1935 which stated,

> *"to say that* C1, *whose name appeared in the September quarterly return of the Cross Lake R.C. Indian Residential school, as pupil* C1 *was not passed as fit by the Doctor, who told the Rev. Father Chamberland to wait a month or two, to see how the girl would progress. I was speaking to Father Chamberland yesterday, and he informed me that this girl was not in a fit state of health to go to school. This girl's name, it will be noted, is not included in the December quarterly return for this school".*

Therefore, this child was listed on the September 1934 Quarterly Return even though she was never officially approved for admission by the Department of Indian Affairs, and was likely residing at the school during this time. Evidently, the doctor decided that she (C_1) could be watched for a month or two to see if she regained her health. Therefore this child could have been residing at the Residential school for approximately four months before the school principal decided that she was too sick to attend. In this case it was not

the Department who denied the admission of this child as there was never any **Application for Admission** or **Physical Examination** forms for the Department to review. When the Department asked for the proper forms to be submitted, the school decided she was not actually fit enough to attend. The state of this child's health upon her being taken into the school was not documented and there was never any mention of which particular sickness was affecting the child.

Case 3 – Child No. 200

An **Application for Admission** form for this female child, age 10, was dated September 20, 1944, and an accompanying **Physical Examination** form was dated December 15, 1944, approximately three months later. A letter sent to the Department of Indian Affairs from the Indian Agent dated December 15, 1944, stated that this child was in hospital with active tuberculosis at the time the health exam was completed, which is why he did not sign the **Application for Admission** form. Also, the space for "State of the Child's Health" was left blank. On the **Physical Examination** form, the doctor noted *"yes"* this child had tuberculosis, as well as *"Lungs. Minimal"*. Also, *"Tuberculosis"* is written under the heading "Cause of Fever". The forms were forwarded to the Department on December 15, 1944, the same day as the health exam. Approximately three weeks after the forms were forwarded, the Department sent back notice that the child was denied approval of admission due to her ill health. A second set of **Application for Admission** and **Physical Examination** forms both dated January 8, 1945 were forwarded to the Department. This was approximately three weeks after the Department denied the first admission. On this second **Physical Examination** form the doctor noted that,

"This girl has been in the hospital for a period of 72 days. I consider her condition arrested and strongly advise this girl be taken into the school. She is an orphan, her father having died last month."

These forms were forwarded to the Department on January 8, 1945 and the Department sent their approval of admission on February 12, 1945, approximately one month later. Therefore, this child's first application to the Residential school was denied approval by the Department due to the fact that she was sick with tuberculosis. A second application was made for her three weeks later which stated that the tuberculosis was now arrested and that Dr. Corrigan felt that she was healthy enough to be admitted to the school. Dr. Corrigan noted that this child and her sisters were now orphans without guardians and asked that they be officially admitted to the Residential school. The Department decided to approve her admission but there is no indication that the Department asked any more questions about the health of this child before approving the application. This child was eventually discharged from the Residential school at the age of 14 with reason being that she was at the Sanatorium.

3.1.2.2 Denial of Admission Due to Sickness in the Residential school.

There was only one instance throughout all documents which shows that the authorities took action and denied the admission of any children due to poor conditions within the Residential school.

Case 1

In a letter sent to the Indian Agent from the Department of Indian Affairs dated April 1, 1943, it is noted that,

> *"In view of the recent report of Dr. Corrigan regarding health conditions at this school, the Department feels that it is inadvisable to admit any further children at the present time. Consequently, we are not prepared to approve their admission".*

The actual report from Dr. Corrigan was not included in the archived file, so the specific details of his complaints are not known. This letter referred to three children who had applications submitted to the Residential school numbers 151, 152, and 153, whose **Application for Admission** forms were dated October 1, 1942 and **Physical Examination** forms were dated March 4, 1943, approximately five months later. The forms were then forwarded to the Department approximately three weeks later on March 23, 1943. A letter from the Indian Agent to the Department dated April 19, 1943, discussed a follow up visit by Dr. Corrigan to the Residential school as well as a message he had received from Winnipeg advising the school that there were to be no new admissions. The Indian Agent wrote,

> *"I beg to acknowledge the receipt of Dr. P.E. Moore's Radiogram of the 8th instant, sent from Winnipeg, and reading as follows: Mr. HOEY INSTRUCTS THAT SENIOR PUPILS WILL BE DISCHARGED FROM CROSS LAKE SCHOOL AND NO FURTHER ADMISSION UNTIL PERMISSION GIVEN.... In connection with this matter, and the reports that Dr. Corrigan has forwarded direct to the Department regarding the conditions at the Cross Lake R.C. Residential School, I beg to advise that Dr. Corrigan made a trip to Cross Lake on the 13th instant, and has to-day written to me in connection with what he accomplished while there at the above school. A copy of Dr. Corrigan's letter is enclosed herewith for the Department's information. The pupils mentioned in Dr. Corrigan's letter, with their numbers, ages, and grades, are as follows..." "...with reference to the last three names of the above list, I may say that these are the three mentioned in official letter No; 123-1-10 of April 1st, the admission of whom was not approved".*

A letter from Dr. Corrigan to the Indian Agent dated April 19, 1943, discussed the number of sick children at the school. Dr. Corrigan wrote,

> *"On April 13th I traveled across to Cross Lake in order to interview the Principal on the condition of over-crowding in the Cross Lake Boarding School. I was only partially successful on this trip as I found that the Principal was away. However I took the matter up with the Nursing Sister there and explained the situation to hereafter carefully. ...On arrival at the school I found that Father Trudeau had already discharged certain girls for one reason or another. Thus,* Child No. 56, Child No 33, Child No. 80, *and* Child No. 46 *had already been sent home. Three children had been sent to the Norway House Hospital namely,* Child No. 137, Child No. 97 *and* Child No. 135 *and on my return here I brought* Child No. 92 *with me for admission to hospital. I instructed the nurse to admit as patients*

> *in their infirmary* Child No. 116, Child No. 63, Child No. 74, Child No. 60, *and* Child No. 52. *These students have or have had very recently Erythema-Nodosum* [a type of skin inflammation] *and were running temperatures. I instructed her to have* Child No. 153, Child No. 152 *and* Child No. 151 *discharged from the school as they had not been accepted by the Department. This disposes of 16 children who together with the one child who died in the school with what I have every reason to believe was Tubercular Meningitis reduces the enrollment by 17".*

In a letter dated May 5, 1943, the Department wrote to the Indian Agent to advise him that they approved the discharge of the children mentioned in the letter sent by Dr. Corrigan dated April 19, 1943. A letter was also sent to the Department of Indian Affairs from the Principal dated April 17, 1943, in which the Principal noted that he received a letter from the Indian Agent which stated that the Department could not approve the admission of the three children who had recently made an application to the school. The Principal then went on to explain why the children were in the school and why they should be formally admitted. He wrote,

> *"I wish to point out to the Department that these children were not admitted to the school since the recent visit of Dr. Corrigan, but have been in the school since the 1st of October 1942. The applications for Admission of these children could not be sent before as I had to wait for the coming of the doctor to fill in the physical examination. The doctor came in the beginning of September and his next visit was only in March. Six months without the visit of the doctor seems to be too long. ... Since the visit of the doctor I have discharged two girls at the end of the March quarter, and then two boys and one girl have been sent to Norway House hospital. Another girl who was sent to the hospital and was under doctor's examination for three weeks was sent back to her home by the doctor. I have also sent home two girls who had been sick for more than a month. In fact the doctor told me to send one home as he thought she had T.B.... So at present we have only 89 children in residence counting* Child No. 153, Child No. 151 *and* Child No. 152*". ... "Dr. Corrigan thought that if we had so much sickness lately, it was because our school was too crowdy. The only reason, I think is that there has been an epidemic of influenza on the reserve since the middle of January which reached its peak in March. Nearly all the Indians had it twice and so the children. There was no doctor and no nurse on the reserve to stop this epidemic and the nurse of the school had more than she could do here. Even if she had wanted to try to do it, she did not have the medicines to do it". ... "The health of the children seems to be fairly good now".*

The Department responded back to the Indian Agent in a letter dated June 15, 1943, in which they explained that they decided to approve the admission of the three children who had been denied as they had already been in the school for several months. Therefore, these children were taken into the school without the approval of the

Department. When the Department denied their admission, the Principal then explained that the children were already living at the school. The Department, considering the actions that had taken place in order to resolve the problems at the school, approved the admission of the three children in question.

3.1.2.3 Child Discharged From the School Due to Poor Health

In addition to the few instances of denied admission to children who were sick, the discharge forms document numerous cases where children who were admitted into the school as healthy children were later dismissed due to illness. The following is one of these cases.

Case 1 - Child No. 10

The **Application for Admission** form for this female child, age 5, was dated August 10, 1933 and an accompanying **Certificate of Health** (old style **Physical Examination** form) was dated August 1, 1933 and signed by Sister St. Agatha OM. On the application form it was noted that the father was alive but the mother was dead, yet they referred to her as an orphan. The space for "State of Child's Health" was left blank on the **Application for Admission** form and only the height and weight information was filled out on the **Physical Examination** form. Therefore, little is known about the health of the child at the time of her admission into the Residential school. The admission of this child to the Residential school was officially approved by the Department on January 24, 1934, almost six months after the health exam. It is likely that the child had been residing at the

Residential school from the time her **Application for Admission** form was completed. A few years later, this female child, now age 9, again appeared in the documents when the school requested her discharge due to poor health. A letter from the Indian Agent to the Department dated September 13, 1937 stated,

> *"I beg to advise you that I have received a letter from Rev. F.X. Gagnon, Acting Principal of the Cross Lake R.C. Residential school, stating that* Child No. 10 *of that school has been examined by the doctor, and has been found rather weak, and her eyes in poor condition, and on this account recommends the discharge of this pupil for at least a year to see if her condition will improve."*

Her discharge was approved by the Department on September 16, 1937, approximately three years and eight months after her formal approval of admission. If this child was living at the school from the date when her **Application for Admission** and **Physical Examination** forms were filled out, which was August 1933, this would make her a resident at the Residential school for four years and one month. The Department recommended that, *"If her health improves in a year's time, she should be returned to the school."* Therefore, this child who was first admitted in August 1933 with a **Physical Examination** form left mostly blank and signed by a nun, not the doctor, was discharged four years later because she was weak and her eyes were in poor condition. There was no discussion of where this child was to go after her discharge. A letter sent from the Department to the Indian Agent stated that if her health improved in a year's time she was to be returned to the Residential school. There is no record to indicate that this child was ever readmitted to the school.

3.1.3 Body Mass Index

BMI is a measure of weight for height and was used to gain an impression of children's body composition. When the Physical Examination form was filled out, the doctor was required to enter the name of the child, their age, weight and height. BMI was calculated from this information.

Table 3.7 Weight Status Categories

Weight Status Category	Percentile Range
Underweight	Less than the 5th percentile
Healthy weight	5th percentile to less than the 85th percentile
At risk of overweight	85th to less than the 95th percentile
Overweight	Equal to or greater than the 95th percentile

(CDC 2009a)

Table 3.7 shows the weight status categories defined by the CDC when measuring BMI percentile scores for children.

3.1.3.1 BMI -Total Sample

From the total sample of 400 children, 310 children had both heights and weights recorded. For 90 children, either height, weight, or both were missing which prevented a calculation of a BMI value. Therefore the BMI analyses are based on 310 out of 400 children.

Table 3.8 BMI by Sex

	Female		Male		Total	
	#	%	#	%	#	%
Underweight	12	8	0	0	12	4
Healthy weight	136	87	139	91	275	89
At risk of overweight	7	4	10	6	17	5
Overweight	2	1	4	3	6	2
Total	157 (out of 206)		153 (out of 195)		310 (out of 400)	

In the total sample of children for which a BMI could be calculated, the vast majority, 89%, were in the "Healthy weight" category. A small proportion of children, 5%, was classified as "At Risk of Overweight". An even smaller proportion, 2%, was classified as "Overweight". In the "Underweight" category, 8% of the girls were classified as "Underweight" but none of the boys fell into this category.

3.1.3.2 BMI By Sex and Decade

The total sample was divided into three time periods in order to observe whether there were any differences in BMI over time. (Table 3.9)

Table 3.9 BMI by Sex and Decade

Category	Decade	Female		Male		Total	
	1930s	#	%	#	%	#	%
Underweight		0	0	0	0	0	0
Healthy weight		40	89	31	91	71	90
At risk of overweight		4	9	3	9	7	9
Overweight		1	2	0	0	1	1
Total		45 (of 46)		34 (of 35)		79 (of 82)	
Category	Year	Female		Male		Total	
	1940s	#	%	#	%	#	%
Underweight		11	11	0	0	11	5
Healthy weight		88	86	95	91	183	89
At risk of overweight		3	3	6	6	9	4
Overweight		0	0	3	3	3	1
Total		102 (of 110)		104 (of 112)		206 (of 221)	
Category	Year	Female		Male		Total	
	1950s	#	%	#	%	#	%
Underweight		1	10	0	0	1	4
Healthy weight		8	80	13	87	21	84
At risk of overweight		0	0	1	7	1	4
Overweight		1	10	1	7	2	8
Total		10 (of 50)		15 (of 47)		25 (of 97)	

Throughout each of the three time periods, most of the children in the sample for which BMI numbers could be calculated were within the "Healthy weight" category; almost 90% in the 1930s and 1940s, and 84% in the 1950s. The "At risk of overweight" and "Overweight" categories each had fairly small percentages of children throughout all three time periods. Interestingly, 11 out of the 12 children classified as "Underweight" were girls admitted in the 1940s. The distribution of incomplete forms was 2 out of 82 (2%) in the 1930s, 16 out of 221 (7%) in the 1940s, and 72 out of 97 (74%) in the 1950s.

3.1.3.3 BMI By Sex and Band

The total sample was divided by Bands in order to observe whether there were any differences in BMI percentile categories between children coming from different home communities. (Table 3.10)

Table 3.10 BMI By Sex and Band

Category	Band	Female		Male		Total	
	1	#	%	#	%	#	%
Underweight		4	8	0	0	4	5
Healthy weight		42	88	30	94	72	90
At risk of overweight		1	2	1	3	2	3
Overweight		1	2	1	3	2	3
Total		48 (of 57)		32 (of42)		80 (of 99)	
Category	Band	Female		Male		Total	
	2	#	%	#	%	#	%
Underweight		4	5	0	0	4	3
Healthy weight		67	88	55	87	122	88
At risk of overweight		5	7	5	8	10	7
Overweight		0	0	3	5	3	2
Total		76 (of 81)		63 (of 70)		139 (of 151)	
Category	Band	Female		Male		Total	
	3	#	%	#	%	#	%
Underweight		0	0	0	0	0	0
Healthy weight		20	100	32	89	52	93
At risk of overweight		0	0	4	11	4	7
Overweight		0	0	0	0	0	0
Total		20 (of 45)		36 (of 46)		56 (of 91)	
Category	Band	Female		Male		Total	
	4	#	%	#	%	#	%
Underweight		4	36	0	0	0	0
Healthy weight		6	54	14	100	15	94
At risk of overweight		1	9	0	0	0	0
Overweight		0	0	0	0	1	6
Total		2 (of 10)		14 (of 25)		16 (of 35)	
Category	Band	Female		Male		Total	
	5, 6, 7, 8	#	%	#	%	#	%
Underweight		4	36	0	0	4	21
Healthy weight		6	54	8	100	14	74
At risk of overweight		1	9	0	0	1	5
Overweight		0	0	0	0	0	0
Total		11 (of 13)		8 (of 11)		19 (of 24)	

More than half of the children from Band 4, (19 out of 35) had incomplete height and weight data. In addition, 25 of 45 girls from Band 3 were missing data and therefore were unable to be included in the analysis. No real patterns were found for BMI by Band. The girls classified as underweight were from Band 1(4/48); Band 2 (4/76) and Band 5,6,7,8 (4/11). As reported previously, 2% of all children were classified as overweight. Five of the six children were from Bands 1 and 2.

In summary, almost 90% of all children for whom there was height and weight data fell into the "Healthy weight" category at the time of their admission to Residential school. The other three categories contained only small proportions of children, 4% of children were classified as "Underweight", 5% as "At risk of overweight", and 2% as "Overweight". Throughout all of the years there were no boys classified as "Underweight". Of the 12 girls classified as "Underweight", 11 were admitted during the 1940s. The category with the smallest proportion of children was the "Overweight" category with 1% of girls and 3% of boys. There were no patterns found when BMI was compared across Bands. Seventy –two forms with incomplete data were from the 1950s. The medical examinations during this time were completed by two different doctors.

3.2.1 Process of Admissions

There are a number of letters and documents which provide information which helps to clarify some questions about what was occurring in terms of admissions and other administrative practices at the Residential school and with the Department of Indian

Affairs. The following are some of the theme areas that I developed out of a review of the historical Residential school documents.

3.2.1.1 Admission of Underage Children to the Residential school.

Of the 400 children included in this research 33 (8%) were under the age of 7 years at the time of their application for admission to the Residential school. As the minimum age of acceptance to the school was set at 7 years, these children were underage. For 13 children there was no explanation as to why they were accepted into the school. Explanations were provided for 20 of the accepted underage children.

Table 3.11 Reason for the Admission of Underage Children

Reason for Admission	# of children	Ages of children
Child is an orphan	6	5, 6
Mother died, father in Selkirk mental hospital	1	6
Mother of child is sick with T.B and children are neglected	2	3, 6
Child is living in poor home conditions	1	5
Mother is dead, father is living	3	5, 6
Father is dead, mother is living	5	4, 5, 6
Mother is alive but almost dying (Died March 2)	1	5
Father has been sentenced to jail for 2 years	1	5

For a few of the children, there was additional information found in letters explaining why they should be admitted to the school despite the fact that they were underage.

Case 1 - Child No. 10 and Child No. 11

Both of these children were 5 years of age. In a letter dated December 22, 1933 the Indian Agent wrote,

> *"Both of these little girls have lost their mothers, and have been kept in the school for a considerable time, although they are underage, I would recommend their admission. I think that children taken into the Boarding schools at an early age, do better, both physically and mentally, than many of those who are taken later, and this is more especially true with regard to motherless girls".*

There are also separate letters for each girl, both dated November 10, 1933. The letter for Child No. 10 states,

> *"St. Joseph's Ind. Residential school Cross Lake Nov 10/33. The child herewith mentioned,* Child No. 10 *who is only 5 years and 9 months old, being an orphan, we asking for her admission to school."*

The letter for Child No. 11 states,

> *"St. Joseph's Ind. Residential School - Cross Lake Man. Nov 10/33. The child herewith mentioned,* Child No. 11 *who is only 5 years old, being an orphan, we are asking for her admission to school."*

Therefore, these children had already been living at the school for some time as they were both orphans, though the exact length of time cannot be determined through the existing documents. As stated previously in the section on children who were discharged from the school due to poor health, Child No. 10 was discharged at the age of 9, because she was *"weak"* and had *"poor eyes"*. Child No. 11 was discharged from the Residential school at age 14 due to *"Indiscipline and bad conduct"* and was *"sent to Good Shepherd"*.

Case 2 - Child No. 28

This boy, age 6, had an **Application for Admission** form which noted that, *"mother is dead, father is in the Selkirk mental hospital"*. In a letter dated January 15 1935, the Indian Agent wrote,

> *"It will be noted that* Child No. 28 *is a little under the school age, but as the mother is dead, and the father in the mental hospital at Selkirk Man, I would recommend that this boy's admission be approved".*

Therefore, the reason for approval of this child's admission, although underage, was that one parent was deceased and the other was unable to care for the child. This child was

eventually discharged from the Residential school at the age of 15 because he had reached the maximum age.

Case 3 - Child No. 36 and Child No. 37

These children were 6 and 3 years of age respectively and were siblings. A letter from the Indian Agent noted that the mother of these children was sick with tuberculosis and as a result the children were neglected. There was also a third sibling who was too ill to be admitted at the time these two children were admitted to the school. On the second **Application for Admission** form for the third sibling it is noted that the mother had died. At age 16, Child No. 36 was granted permission to complete her Grade 8 at the Residential school, while Child No. 37 was discharged from the school at age 16.

Case 4 - Child No. 105

This child was between 5 and 6 years of age. A document explained that this child was living in poor home conditions. It read, *"Home conditions are such that is it desirable to have this child placed in residential school"*. This child was eventually discharged from the school and transferred to another Residential school at the age of 14.

Overall, the most common reason for making an application to the Residential school for an child under the age of seven was because the child was an orphan having either one or both parents deceased or in some type of institution.

3.2.1.2 Children Being Kept at the School Before Formal Approval of Admission.

From an examination of the documents, it appears that it was common practice to allow children to reside at the Residential school before they were formally admitted as students by the Department of Indian Affairs. There is some information in the documents as to why this happened as well as evidence to show that it occurred regularly at the school.

A letter dated January 27, 1942 was sent to the Indian Agent from the Department which concerned ten pupils for whom there were still no applications and health forms forwarded. It states,

> *"The pupils numbered as follows have been in the Cross Lake School for several months:"... "On different occasions we have requested you to forward the application forms but we have not yet received them. It would be appreciated if you would give this matter immediate attention".*

Therefore, it appears there were difficulties in sending the application forms to the Department in a timely manner. During these delays, children lived at the school for periods of several months before they had their applications approved.

Some of these cases found in the data are as follows.

Case 1 - Child No. 18

This female child, age 6, was discussed earlier in the section about children being denied admission to the school. This child was denied admission to the school because she had an ear infection but was allowed to reside at the school until she was well. After approximately two and a half months, the doctor felt that she was healthy enough to be formally admitted to the school despite the fact that he thought she had arrested

pulmonary tuberculosis. Therefore, this child would have lived in the residence before being formally admitted to the school as a student and could have been in residence for up to six months before the second set of application forms were forwarded to the Department of Indian Affairs. The second **Physical Examination** found that the child still had some health concerns. However, the Department approved her admission despite this, on the condition that her health was carefully watched. Therefore, this child was at the school from at least November 9, 1933 but most likely October 2, 1933, before she was officially approved for admission to the school by the Department on April 17, 1934. She was eventually discharged from the Residential school at the age of 13, because her parents would not agree to transfer her from the Norway House section of the school to the rebuilt school at Cross Lake.

Case 2 - Study No. 10 and Study No. 11

These children were also discussed earlier in the section about admission of underage children to the Residential school. These children had **Application for Admission** forms dated August 10, 1933 (Child No 10) and August 20, 1933 (Child No. 11). A letter dated December 22, 1933 indicated that these children had already been at the school for "*some time*" and that they should now be formally admitted as students. The Department approved the admission of these two children in a letter dated January 24, 1934. Therefore, these girls were most likely living at the school for 5 to 5 ½ months before they were approved for admission by the Department.

Case 3 – Child No. 258

A letter was sent along with the application forms for a female child, age 6, which explained why her application forms were sent to the Department late. In the letter it stated,

> *"Enclosed please find Application for Admission to Cross Lake Indian Residential School of the above named. There has been some delay in submitting this application as the mother was still living but away in hospital and I endeavored to get her signature. However she died in St. Boniface Sanatorium before returning original application which became lost... This second application had to be submitted and a fresh physical examination taken...This child who is an orphan entered the Cross Lake Indian Residential School at commencement of present academic year. I therefore recommend that the per capita grant be made retro-active to September 1st 1947".*

The first **Application for Admission** form and accompanying **Physical Examination** form are both dated August 25, 1947. The forms were not sent in to the Department until February 18, 1948, approximatley six months after they were filled out. The Department sent back a letter which noted their approval of admission on March 3, 1948. The letter stated, *"Her admission is effective from September 1st, 1947".* Therefore, this child was in residence at the school for approximately six months before her application forms were forwarded to the Department for approval. There is no discharge information available for this child.

Case 4 - Child No. 380

The name of this male child, age 11, first appeared on the **Admission/Discharge** form for the March 1952 quarter. This form shows the date of admission for this child to be January 1, 1952. The Department sent a letter dated April 21, 1952 which requested the admission forms for this child. Therefore, approximately four and a half months after the child was taken into the school the Department asked the Indian Agent to send in the application forms. The Indian Agent responded in a letter dated May 19, 1952 which

stated that the child was awaiting a medical examination and the form would be forwarded as soon as the examination was complete. Therefore, the child had been in the school for 4 ½ months without having had a health exam. The **Application for Admission** form has the date January 5, 1952, while the **Physical Examination** form has the date June 2, 1952, approximately five months later. Before approving the admission of this child, the Department, in a letter dated June 13, 1952, questioned the necessity of this child even attending the Residential school as his parents were both living and he had previously attended the Roman Catholic Day School. A letter from the Principal dated July 1, 1952 stated,

> *"One of the main reasons for the parents of* Child No. 380 *to put him in the school is that the father has a large family and on account of health conditions is having a hard time to provide for the needs of the whole family. ... Many a time also the child had to miss school as the father would need him to help him in his trap line. Also when the father would be away with the canoe the child could not attempt to come to school. As the parents wanted to give him a better education to their boy and seeing they could not do so by keeping him home to attend only day school they decided to put him in the Residential school".*

In a letter dated July 22, 1952 the Indian Agent explained that he was sending the letter from Father Trudeau, the principal of the school, which explained why this child should be admitted to the Residential school. Following this, the Department approved the admission of this child to the Residential school in a letter dated July 30, 1952. A few months later, still at age 11, this child's name again appeared on the **Admission/ Discharge** form for the September 1952 Quarter. The date of discharge is listed as September 1, 1952, and the reason for discharge is listed as *"unfit to learn"*. The discharge form lists him as being in the school for one year but it was only approximately nine months, and only two months from the official approval of admission by the Department. Therefore, this child was in the school for seven months before he was approved for admission by the Department.

3.2.1.3 Children Being Kept at the School before Having a Medical Examination.

In studying the documents it became apparent that another common practice was to keep the children at the school as students before their health examinations were completed.

Table 3.12 Length of time until medical examination by decade after admission. (For the conditions: Undernourished, Scabies, Head Lice, T.B., Respiratory Infections, Swollen Glands, Eye Problems, Ear Problems, Teeth Problems, Cold/Cozyra).

Length of Time Between Admission and Physical Examination	**Number of Children per Decade**			
	1930s	**1940s**	**1950s**	**Total**
10 days or less (incl. those done on the same day)	24 (51%)	23 (30%)	4 (57%)	**53**
2 weeks to less than a month	13 (28%)	16 (21%)	1 (14%)	**30**
1 month to less than 2 months	5 (11%)	20 (26%)	1 (14%)	**26**
2 months to less than 3 months	4 (8%)	7 (9%)	0	**11**
3 months to less than 4 months	1 (2%)	6 (8%)	0	**7**
4 months to less than 5 months	0	1 (1%)	0	**1**
5 months to less than 6 months	0	1 (1%)	1 (14%)	**2**
6 months to 26 weeks	0	3 (4%)	0	**3**
Total	**47**	77	7	**131**
Percentage of total admissions per decade	**(47/81) 58%**	**(77/222) 35%**	**(7/97) 7%**	**(131/400) 33%**

Overall, 53 (41%) children listed as having some type of sickness or heath concern had their heath exams completed within 10 days of the date of their **Application for Admission** date. For the rest of the children admitted to the school with some type of sickness or health condition noted on their **Physical Examination** form, the length of time varied between two weeks to six and a half months. There was some variation by decade, with 51% of the children receiving their health exam within 10 days during the 1930's, 30% during the 1940s, and 57% during the 1950s. The longest wait times were between six and six and a half months, which occurred for three children during the

1940s. The other 269 admissions to the school during the study period did not show any sicknesses or health conditions on the Physical Examination forms and are not included in the table.

Table 3.13 Percentage who waited longer than 10 days for their medical exam.

Health Condition	% of children
Undernourished	78% (28/36)
Scabies	31% (8/26)
Head Lice	40% (2/5)
T.B.	90% (9/10)
Respiratory Infections	67% (4/6)
Swollen Glands	55% (5/9)
Eye Problems	67% (2/3)
Ear Problems	0% (0/1)
Teeth Problems	50% (6/12)
Cold/Cozyra	64% (14/22)

Of the 36 children who were listed as being "Undernourished", 28 (78%) had waited longer than 10 days for their Physical Examination based on the date the Indian Agent filled out their **Application for Admission**. The sickness category which contained the largest proportion of children was the tuberculosis category. Nine out of 10 (90%) children who were listed as having tuberculosis on the Physical Examination form waited longer than 10 days for their health exam. The above table shows the proportion of children in each of the sickness categories studied.

3.2.1.4 Reasons for the Time Lag.

It appears that part of the problem with delayed medical examinations was that doctors were not resident in the community and made infrequent visits. In a letter dated

March 3, 1949, there was discussion about applications being sent late to the Department and how it was difficult to get the doctor to complete the medical examinations. The Indian Agent stated,

> *"I am enclosing 8 applications for Admission for children who are already attending the Cross Lake Residential School".... "These applications were left at this office just recently by Father Trudeau. He states that the reason these applications are so late is due to the fact that he had some difficulty in getting the Medical Examinations completed. Apparently on several occasions when he has asked the Doctor to complete these applications, he found the Doctor was traveling by aircraft and was just ready to leave the reserve".*

Therefore medical exams did not always occur when they should have and school officials felt that it was due to a lack of availability of doctors.

In a letter dated April 8, 1950, the Indian Agent noted that an application for a child was being withheld because they were waiting for the medical examination.

> *"Father Trudeau further advised me that this procedure is almost always followed at Cross Lake. The child is admitted almost invariably prior to both the Doctor's examination and the Superintendent's approval of admission application. About the only exceptions to this procedure occurs when the doctor is able to examine children during the summer on the various reserves, when it is known definitely that these children will enter Residential school in September. ...In view of the difficulties inherent in the transportation field in this part of the country, it would seem that, in the past at least, Departmental regulations concerning applications for admission to Cross Lake School have been relaxed somewhat for good reason, as otherwise a long period of tine might elapse before a child's admission to school could be approved".*

Again this demonstrates that medical exams did not occur according to policy and that because of circumstances relating to physician availability, policy could not be adhered to. It is also interesting that in this letter, the Indian Agent admitted that this procedure of taking the children into the school before the proper approval almost always happened and that it was a good thing that Departmental regulation was relaxed for the Cross Lake Residential school, otherwise it would have taken too long to get children admitted to the school.

This same type of explanation is found in a letter dated April 15, 1950, where the Principal wrote to the Indian Agent and noted that,

> *"Parents often decide to put their children in the school just when they are about to leave for their camps or in such circumstances. The greatest difficulty arises from the medical examination. Quite often we have to wait quite awhile before the children are examined; the doctor or the technician are away, the weather is not permitting etc...It is not so simple as one might think. Practically the children must be in the school. In any case, I would like you or the other officers of the Department to feel free to give your approval or refusal even if already the child is in the school. We do so at our own risks".*

This same situation concerning difficulties in carrying out the medical examinations is addressed in a letter dated November 26, 1951, in which there was discussion about applications and why they had not been sent to the Department. The Indian Agent explained that the doctor had not completed the medical portion of the applications and returned them. He noted,

> *"these applications were handed to Dr. Millar, Medical Supt. Norway House Hospital on October 10th last. In spite of repeated requests, medical portion of applications has not been completed and returned to this office. They will be forwarded when completed by the Doctor".*

Therefore, while all applications were supposed to be formally approved prior to taking the children into the school as students, it appears that is was difficult and sometimes impossible to follow these rules and regulations at all times. Each administrative body, the school, the Indian Agent, and the Department of Indian Affairs, played a part in not following procedure in some manner. It appears that this was done as a matter of necessity which did not seem to cause any serious concern to those in charge of the Residential school system. In a letter dated October 31, 1950, the Indian Agent wrote to the Department and noted that, *"The above children were taken and placed in the Residential school and their applications submitted to the Superintendent later".* A simple note which demonstrates that procedures were not followed as stated by the Department of Indian Affairs.

Case 1 - Child No. 32 and Child No. 33

In a letter dated November 28, 1935, the Indian Agent noted that he was forwarding the return for the quarter ending September 30, 1935. He noted that there were two new pupils listed on the return and they had not yet been examined by the doctor. He writes,

> *"The Principal informs me that he has the application forms for these two pupils, filled in, and signed by the parents, but as yet, he has not been able to have them medically examined by the doctor and has therefore not sent the forms in for consideration and approval. The Principal however states that both these pupils are in good health, and as they have been in residence at the school, awaiting medical examination, since the conclusion of the summer holidays, he asks that grant be paid for them for this period. I may say that Dr. Turpel of Norway House, expects to visit the Cross Lake Reserve within the next week, and he will no doubt examine these two pupils".*

Therefore, these two female children, ages 10 and 7 respectively, were living at the school as students since at least September 1935, approximately two months time, without having a medical examination as required because the school was waiting for the doctor to visit the community. Child No. 32 had an **Application for Admission** form dated August 26, 1935 and Child No. 33 had an **Application for Admission** form dated September 3, 1935. Both of these children had their **Physical Examination** forms dated December 6, 1935, approximately three months later. All of the application forms were sent to the Department on December 16, 1935. The Department sent back a letter stating their approval of admission on December 31, 1935. Therefore, Child No. 32 was living at the school approximately four months before formal approval of admission by the Department and about three and half months before the health exam was completed. This child was also sick with cozyra when the health exam was done, which means she probably became sick while in the school. Child No. 33 was in the school for approximately four months before formal approval by the Department and approximately three months before the health exam was completed. Child No. 32 was eventually

discharged from the Residential school at age 14 with the reason that she "ran away", while Child No. 33 was eventually discharged from the school at the age of 16 because she had reached the maximum age.

Case 2 – Child No. 151, Child No. 152, Child No. 153

These three children were previously discussed in the section on denying approval of admission to children. A letter from Principal G.E. Trudeau dated April 17th, 1943, explained why these three children, a female age 7, a boy age 8, and a boy age 7, were in residence and why they should have been allowed to stay. This was during a period of time when the doctor had written in to the Department stating the poor conditions within the school. In the letter, the Principal noted that these three children had been in the school since the beginning of October 1942. The Department sent their approval of admission for the three children on June 15, 1943. These three children had been in the school for six and a half months before they had their health examination or their forms sent to the Department. There was sickness among the children at the school during this time and these three children had never been examined to see whether they were sick before being taken into the school. After reading the Principal's explanation of the situation, the Department approved the admission of these children even though the doctor reported poor conditions at the school. Child No. 151 and Child No. 153 were eventually discharged from the Residential school at the age of 15 at the maximum age and there is no discharge information available for Child No. 152.

3.2.1.5 Other Interesting Admissions

Case 1 – Child No. 146

The doctor advised the Department that this child should be admitted to the school even though the child was sick, possibly with tuberculosis. On the **Physical Examination** form for this child it is noted, by the doctor, that last year he had pneumonia and that his history, along with his present condition, was suggestive of tuberculosis. However, despite this finding, the doctor suggested that this child be placed in the school. The **Application for Admission** form is dated July 7, 1942 and the accompanying **Physical Examination** form is dated August 5, 1942, approximately one month later. The forms were sent to the Department on August 22, 1942. The Department sent their approval of admission in a letter dated August 31, 1942. This child was eventually discharged from the Residential school at the age of 15 with the reason that the child *"did not return to school"*. There is no discussion of where the child had gone.

Case 2 - Child No. 234 Child No. 231 Child No. 232

This case involves the application of 3 children with similar health concerns.

Child No. 234

On the **Physical Examination** form for this female child, age 10, it was noted that she possibly had tuberculosis and needed to be x-rayed.

Child No. 231

On the **Physical Examination** forms for this male child, age 12, it was noted that there were some health concerns and that an x-ray was needed in order to properly diagnose the child.

Child No. 232

On the **Physical Examination** form for this male child, age 11, it was noted that this child was in need of an x-ray in order to rule out Tuberculosis.

The **Application for Admission** forms for all of these children are dated August 15, 1946 and the accompanying **Physical Examination** forms are dated September 19, 1946, approximately one month later. The forms were sent in to the Department approximately one week after the health exam, and the Department sent back their approval of admission for all of these children approximately one week after that. There is no further discussion on whether the children had received the x-rays requested by the doctor. Child No. 234 and Child No. 231 were both discharged from the Residential school at age 16 at the maximum age. Child No. 232 was discharged at the age of 15 with the reason that the child *"Did not come back to school"*.

Case 3 - Child No. 155

The **Application for Admission** form is dated July 24, 1943 and the accompanying **Physical Examination** form is dated October 4, 1943, approximately two and a half months later. This female child, age 8, had her health listed as *"Good"* on the admission form. On the **Physical Examination** form the doctor noted that the child had

> *"some roughened breath sounds in right lung"* and *"will not pass this child without x-ray examination"* and *"Believe this child should not be admitted to school until x rayed and passed this period of examination. History of tuberculosis in family"*.

The forms were sent into the Department on December 21, 1943. This is approximately two and a half months after the health exam and approximately five months after the application was filled out. The Department sent their approval of admission in a letter dated January 6, 1944. Therefore, if the child was in the school from the time the application form was filled out; the child would have been residing in the school for five and a half months before the Department approved the admission. Also, the Department sent back their approval of the admission within two weeks of receiving the forms. There were no additional papers stating that this child had been x-rayed and cleared of having Tuberculosis, yet the Department approved the child for admission, despite the doctor's advice. This child was eventually discharged from the Residential school at the maximum age of 16.

In regard to all the above cases, there were never any letters discussing the results of the requested x-rays. These types of situations indicate a lack of clear communication between school authorities, the doctors, the Indian agents, and the Department officials.

Case 4 – Child No. 195 and a child not assigned a study number

The names of two children, Child No. 195 and one without a study number were first seen on an **Admission/Discharge** form for the September 1944 Quarter as new admissions to the school. Then in a letter dated January 31, 1945, the Department noted that they still needed the forms for both of these children. These 2 male children, ages 12 and 7 respectively, had been in the Residential school for four months without being officially admitted by the Department. The Indian Agent responded in a letter dated March 1, 1945 where he noted that one of the children, the one not assigned a study

number, was in hospital at Norway House with tuberculosis since January 29, 1945, and that he would be there for some time. As such, the child's application was being held and would be there for some time so his application was being held and that he was taken from the school to the hospital on January 29, 1945. The Agent noted that in regard to Child No. 195, he was waiting for the application to be forwarded from the Missionary Father Burlot from Poplar River. A review of the documents shows that there never was an application submitted for the child not assigned a study number. Therefore, this child was never officially admitted to the school by the Department, but had lived at the school for four months and was then taken to the Norway House hospital with tuberculosis. There was no further mention of this child in the documents. As for Child No. 195, he was also at the Residential school for four months when the application forms were requested by the Department. The school did not have the forms as they were waiting for them to be forwarded from another community. Child No. 195 was eventually discharged from the Residential school at the age of 14 with the reason that the child *"Has not come back to school"*.

Case 5 - Child No. 387

In this case a female child, age 8, was admitted to the school with a possible tuberculosis infection, seemingly without question or hesitation by the Department. This child had an **Application for Admission** form dated July 1, 1952 with an accompanying **Physical Examination** form dated August 21, 1952, approximately one month and three weeks later. Her health was listed as *"Good"* on the application form, but the doctor noted at the time of the health exam, that this child probably had tuberculosis. The forms were sent in

to the Department on September 3, 1952, approximately two weeks following the health exam, and the Department sent their approval of admission approximately one week later on September 12, 1952. There is no evidence within the documents that any more questions were asked about this child, nor is there any confirmation regarding a TB diagnosis. There is no discharge information available for this child.

There were also letters in which more general practices at the Residential School were discussed. For example, there was one instance recorded in the documents where the Department questioned the practices of the school and advised the school to not take in children before they had received formal approval by the Department. In a letter dated November 8, 1950 it is noted that,

> *"These children should not have been accepted at the school before all the facts had been placed before the Department and our decision given".*

Despite this warning, the practice of taking children into the school before formal approval continued to occur.

At one point, one doctor suggested a means by which the school could improve the conditions of the school and in turn the health of the children. In a letter dated March 4, 1946, Dr. Corrigan wrote to the Indian Agent about overcrowding within the school and day students being taken into the school. He wrote,

> *"I suppose I do not need to point out my opposition to this idea. But aside from the daily and constant exposure of a select group of children to the common acute infections they are exposed to such things as lice, scabies, and impetigo with its resulting disadvantages. As a matter of fact, this was how the matter was first drawn to my attention. I noticed that one of the Boarding School students was lousy. Father Chamberland has told me it is a very bad arrangement to have day students and boarders mingling together as it is so much harder to maintain discipline".*

Therefore, Dr. Corrigan brought up the fact that overcrowding at the school resulting from attendance by day students led to poor health outcomes for children. Missing documents in the file may indicate a lack or organization and this may have contributed

to problems within the Residential school in terms of the health of the children. For example, a child is listed on the **Admission/Discharge** form for the September 1946 Quarter as a discharge from the school. The date of discharge is listed as September 30, 1946 and the reason for discharge is listed as *"T.B"*. A review of the documents finds no **Application for Admission** or **Physical Examination** forms for this child. In a letter dated July 16, 1945, the Department asked about this child who appears on the September 1946 **Admission/Discharge** form as a discharge but not on the June 1946 return. After this letter nothing more is said about this child. Also, the student number that was assigned to this child by the school had been previously assigned to another child who had been discharged to the Norway House Hospital adding to the confusion in the records.

3.3.1 Following the Path of a Few Children from Admission to Discharge.

The general practice within the Residential school was to discharge children at the age of 16. This was considered by the Department of Indian Affairs to be "Of Age" to be discharged. As noted on the **Admission/Discharge** forms, children were discharged from the Residential school with no higher than a Grade 7 education, however most children were discharged at lower grades. Grades obtained by children at the time of discharge ran from Grades 1 through 7. Skills for girls included cooking, sewing, knitting, gardening, care of the house, and embroidery. Skills for boys included mechanics, care of cattle, gardening, carpentry, farming, and general work. For all of the children for whom there

was discharge information recorded, 44% (109/246) were discharged because they had reached age 16. Some of the other reasons for discharge can be seen in Table 3.13

Table 3.14 Reasons for Discharge

Reasons for Discharge	No. of Children
Death -not specified (5) -during holiday (2) -at school (1) -at home (3) -at hospital (1)	12
T.B.	6
General note of sick/ unhealthy	21
Child transferred to another institution	19
At Sanatorium	7
Parents kept child at home/Children needed at home	9
Subnormal mentally/Unfit to learn/Unfit for Residential School	6
Ran away	1
Parents would not allow the child to be transferred to CL school	4
Poor eyes	2

Following the path form admission to discharge provides some insight into the Residential school experience. A few such cases can be seen in the following.

Case 1

Story of Child No. 1

This child was not granted admission with his first application to the Cross Lake Residential School, as the school had burned down and was not able to admit children. The first **Application for Admission** form for this male child, age 10, is dated August 5, 1930, and the accompanying **Physical Examination** form is dated September 12, 1930. The Department sent in their denial of admission in a letter dated December 1, 1930. By

this time, this child had already been in residence at the Norway House Roman Catholic Mission since at least October 18, 1930, possibly since the date of his application form. The Indian Agent forwarded a letter in which he explained that the family of this child could not take care of him. A second **Application for Admission** form was sent in with the date July 1933 with an accompanying **Physical Examination** form dated May 20, 1933. This boy was now 12 years of age. The Department sent back an approval of admission in a letter dated September 12, 1933, which was approximately four months after the date of the health exam. This child's name then appeared one year later in a letter dated July 5, 1934, in which the Indian Agent asked for the approval of the discharge of this child because he had tuberculosis. On May 20, 1933, Dr. W.N. Turpel listed this child as not having tuberculosis, but on July 5, 1934 he was tubercular. The Department sent their approval of discharge in a letter dated July 19, 1934.

Case 2

Story of Child No. 120

This female child, age 7, has an **Application for Admission** form dated August 24, 1940 and an accompanying **Physical Examination** form dated August 15, 1940. On the application form her health was listed as *"Good"* and on the health exam form the doctor wrote *"note that child has a pulse of 120 while crying and a temperature of 100 1/5 degrees"*. The forms were sent in to the Department on October 26, 1940; approximately two months after the forms were filled out. The Department sent their approval of admission on December 4, 1940, approximately one month and one week later. This child's name appears again on the **Admission/Discharge** form for the June 1942 Quarter.

It shows that this child died on May 29, 1942 at the age of 9. Therefore, this child could have been residing in the school for approximately two years and three months before her death. The Department then sent a letter to the Indian Agent dated July 14, 1942 and asked why an inquiry into the death of this child had not yet been carried out and forwarded to the Department. The letter stated,

> *"Child No. 120 is stated to have died at the school on May 29. However the Department has not yet received the usual form concerning inquiry into the death of this girl. As you are aware, the inquiry should always be made in the case of a death of a pupil at a residential school and the information required by the Department forwarded to us on the form provided for that purpose. I will expect to hear from you in this regard in the near future".*

Therefore, this child died at the Residential school after being a pupil at the school for approximately two years. The **Physical Examination** for this child taken upon admission does not indicate that she was sick when she was admitted. This is evidence that deaths at the school were not handled properly as the Department had to ask the Indian Agent to complete and forward the proper paperwork. There is no indication in the data set that this inquiry took place or that the proper papers were ever filed. It is interesting that the Department had noted that every death of a child at a Residential school requires and inquiry. In this case, the procedure was not followed properly.

Case 3

The story of Child No. 122

The name of this male child, age 11, first appeared on the **Admission/Discharge** form for the September 1940 Quarter as a new admission to the school. The Department then asked for her application forms in a letter dated December 4, 1940 as they had not yet received the forms for this child. The forms were sent in to the Department on January 9,

1941. The Department sent their approval of admission in a letter dated January 23, 1941. Therefore, this child had been residing at the school for approximately five months before the Department either received the application forms or approved the admission. Both the **Application for Admission** form and **Physical Examination** form were dated August 24, 1940. On the application form it is noted that several of the child's family members had died of tuberculosis. Approximatley two years after the application forms were filled out this child was discharged because he was sick with tuberculosis. The date of discharge for this child is listed as June 30, 1942 and the cause of discharge is listed as *"At home with T.B."* He was 13 years of age at the time of his discharge. Therefore, this was a case where a child was admitted even though the doctor noted that there was a problem of tuberculosis in the child's family. The Department approved the admission without questioning the tuberculosis concern and within a short time discharge was requested for this child as he was also sick with tuberculosis.

Case 4

The story of Child No. 132

This female child, age 11, was shown on the **Admission/Discharge** form for the September 1941 Quarter as a new admission in September 1941. The Department had to ask the Indian Agent for the application forms for this child on November 8, 1941 and January 27, 1942. The forms were finally sent into the Department on January 28, 1942. The **Application for Admission** form for this child is dated August 5, 1941 and the accompanying **Physical Examination** form is dated July 29, 1941. On the **Physical Examination** form it is noted that the mother is said to have died of tuberculosis but that

the child's chest x-ray was negative for tuberculosis. The Department sent their approval of admission in a letter dated February 10, 1942; approximately two weeks after the forms were forwarded. Therefore, this child was residing in the Residential school for approximately six months before the Department approved the admission. A few months later this child's name, now age 12, appeared on the **Admission/Discharge** form for the September 1942 Quarter as a discharge. The date of discharge is listed as July 1942 and the reason for discharge is listed *as "sick, Discharge on Doctor's Advice"*. A few months later this child again appears on the **Admission/Discharge** form for the December 1942 Quarter as an admission with the new admission date of October 23, 1942. This was approximately three months after being discharged from the school for being sick. In a letter sent to the Department the Indian Agent stated,

> *"This ____ has been discharged from at the end of the September Quarter 1942 on recommendation of Doctor Corrigan who was keeping her in the Norway House Hospital. On the 23rd of October Doctor Corrigan sent her back to the school without notifying me".*

A few months later, this child's name again appears on the **Admission/Discharge** form for June 1943 Quarter as a discharge. Her age is not stated on this form. The date of discharge is listed as June 11, 1943. This is approximately seven and a half months after she had been re-accepted into the school. The reason for discharge is listed as, *"Died at hospital"*. Therefore, children who may have been advised to stay away from the school were admitted back into the school, possibly before they were healthy. In this case there was a lack of communication between the Indian Agent and the doctor, as this child was sent back to the Residential school by the doctor without first getting the proper approval from either the Indian Agent or the Department. The procedure for admissions was not followed in this case.

Case 5

Child No. 127 (and Child No. 128)

This male child, age 7, and his female sibling, age 6, were first mentioned in a letter sent to the Department by the Indian Agent dated December 14, 1939. In the letter, it is explained that these children were orphans and should be taken into the school. The Indian Agent wrote,

> *"In the beginning of October an application for admission of .... (orphans) into Guy School, Sturgeon Landing, Sask., had been sent to Mr. Lazenby, Indian Agent at Norway House. You might have not received the application yet as apparently there was no mail service from Norway House since last October. I am also told by the local agent that no confirmation from Ottawa has been received yet. So as these children belong to the Norway House Agency, I am asking that the admission of these children should be granted for St. Joseph's Indian Residential School, Cross Lake, Manitoba, where the children are being sent on request of the Indian Agent of The Pas, Manitoba".*

A letter dated December 28, 1939 was sent to the Indian Agent from the Department which stated that the application forms for these children had not yet been received, and that they should be forwarded to the Department as soon as possible. In letters dated April 20, 1940 and August 25, 1940, the Department again asked the Indian Agent to forward the appropriate forms for Child No. 128 and Child No. 127. Then in a letter dated October 26, 1940, the Indian Agent explained that,

> *"With reference to the two ___ children, pupils* Child No. 128 and Child No. 127, *the Principal advises me that he is having some difficulty in securing the Application forms for these children. They formally lived with their parents at The Pas, until both of their parents died. They then spent some time in hospital at The Pas; were examined for admission to a residential school first without being approved by the medical examiner. Later they were passed by the doctor and their admission to Guy Residential School was approved. However they did not go to that school, but were brought to Cross Lake School, and up to the present time, no proper applications for Cross Lake School have been sent in. The Principal advises me that he has written to Father Trudeau at The Pas to get the necessary particulars and signatures on the application forms, and will then have the children examined by Dr. Corrigan on his next trip to Cross Lake".*

In a letter dated January 23, 1941, the Department again asked for the application forms for Child No. 127. The application forms were finally sent to the Department on March 6,

1941. This was approximately one year and two months after the Department first asked that they be forwarded. The **Application for Admission** form is dated December 4, 1940 and the accompanying **Physical Examination** form is dated February 26, 1941, approximately two and a half months later. The Indian Agent also sent a letter, in which he wrote,

> *"The Principal advises me that the two ____ children, who are orphans, were left in the care of Father Trudeau when their parents died, and he has signed the applications for these children, as their guardian".*

The Department sent their approval of admission in a letter dated March 14, 1941. A few months later this child appeared on the **Admission/Discharge** form for the September 1942 Quarter as a discharge at the age of 9. The date of discharge is listed as September 1, 1942, and the reason for discharge was listed as *"died during holidays"*. Therefore, if these children came to the school shortly after the first letter was written to the Department which asked for them to be admitted to the school, they could have been living at the school for approximately one year, and three months before they had a health examination or formal approval of admission by the Department. The discharge form does not give any more detail into how this child died. However, this child was an orphan and had been placed in the care of the Principal of the school. Child No. 128 was discharged from the school at the age of 16 as she had reached the maximum age.

Case 6

The story of Child No. 130

In the letter written by Dr. Corrigan and sent to the Indian Agent on April 19, 1943, the Doctor noted that one child had recently died at the school from tubercular meningitis.

Then in a letter to the Department from the Indian Agent dated April 24, 1943, the Indian Agent noted that he was sending in the return for March 1943. He wrote,

> *"It will be noted from this return, that during the quarter, pupil, Child No. 130, died on 25th February, and the discharge of this pupil is noted on the discharge sheet. ...The Principal of the school did not forward the usual report regarding the death of this pupil with his return, and I am writing to him in the matter....It will be noted from the letter written to me by Dr. Corrigan, dated 19th April, a copy of which was forwarded to the Department with my letter of that date, that he is of the opinion that this pupil died of Tubercular Meningitis".*

The **Application for Admission** form for this female child, age 7, is dated April 4, 1941 and the accompanying **Physical Examination** form is dated January 23, 1942, approximately nine and a half months later. The forms were sent into the Department on January 28, 1942. The Department sent their approval of admission in a letter dated February 10, 1942. Approximatley one year later this child died while at the school at 9 years of age. This child appears on the **Admission/Discharge** form for March 1943. The date of discharge is listed as February 25, 1943 and the reason for the discharge is listed as *"Died"*.

Case 7

Story of Child No. 200

The name of this female child, age 10, and her siblings first appeared in a letter dated July 3, 1944. This was a letter sent to the Indian Agent by the Department asking him to prepare a report on the girls and make applications for them. Upon receiving the report the Department would decide on whether or not they could be admitted to the school. A report on the girls was sent to the Department on August 17, 1944. On August 31, 1944, the Department sent a letter which stated that they were willing to accept the admission of the two siblings of this child to the school as long as they were considered wards of the

Department. The **Application for Admission** form for this child is dated September 20, 1944 and the accompanying **Physical Examination** form is dated December 15, 1944, approximately three months later. The **Physical Examination** form noted that child had a temperature of 101 due to tuberculosis and the Doctor confirmed that *"yes"* she had tuberculosis and wrote, *"Lungs. Minimal"*. The forms were sent in to the Department on December 15, 1944. It was noted that the doctor did not sign the health form of this child as he stated that she had active tuberculosis and that she was in Norway House Hospital at the time. As a result of the doctor's comments, the Department did not approve the admission of this child, but noted that if her health improved enough to attend school, the Department should be notified. A few weeks later a second application was submitted for this child dated January 8, 1945. The **Application for Admission** form listed the health of this child as *"Good"*. On the **Physical Examination** form the doctor noted,

> *"This girl has been in the hospital for a period of 72 days. I consider her condition arrested and strongly advise this girl be taken into the school. She is an orphan, her father having died last month".*

The Department approved the admission of this child temporarily in a letter dated February 12, 1945. This child's name later appeared on the **Admission/Discharge** form for the September 1949 quarter as a discharge at the age of 14. The date of discharge is listed as September 30, 1949 and the reason for discharge is listed as *"At Sanatorium"*. Therefore, she was again sick with tuberculosis.

Chapter 4

Discussion

People are beginning to acknowledge at the damaging effects of Residential schools including the intergenerational impact. A statement in the Final Report for the Aboriginal Healing Foundation explains the current situation in regards to the effects of Residential schools.

> *"The long-term consequences of residential schooling continue to reverberate in Aboriginal communities, families, and individual lives. Canadian society is more prepared than ever before to recognize that rupturing bonds between generations of children and their parents for purposes of the state, disrupting the transmission of cultural heritage through prohibition of Aboriginal language use, and leaving thousands of former students suspended between worlds, ill-equipped to function in either, constitute violations of human rights as we have come to understand them" (AHF 2006).*

Throughout the past few decades, those who attended Residential schools have begun to speak out about their experiences in the schools as well as the events of their lives in the post-residential school era. This sharing of experiences has been used as a form of healing for many Residential school survivors. Many survivors have told of their experiences through participation in interviews or even published their own books so that they can reach larger audiences. However, there seems to be a lack of research on existing Residential school documents. This study begins the process of research by examining records from Residential schools in Canada, in order to describe children's lives at the time of admission to, and during their stay at Residential school.

One limiting factor of this study is that it looks at only a small sample of children out of the many thousands of children who attended the schools across Canada. However, as one of the first studies of this type, it opens the doors for similar types of studies to be carried out for other Residential schools and for different time periods. Also, because this study used archived historical documents, the examination is limited to the information

that is available or what exists in the archived file. The availability of information is dependent on a number of factors such as how well or completely the documents have been archived, what may have happened to the documents prior to being archived, and what the authority figures chose to document or the accuracy with which the information was recorded at the time. This type of deep examination of these documents does not appear to have been carried out on documents from other Residential schools in Canada. Therefore there is great potential for additional research of this type. While direct linkages between Residential school experiences and later health and social problems cannot easily be made, a look back to the beginning of the school experience will allow for a better understanding of how health has been affected as a result of the Residential school system by establishing a baseline idea of the health status of children before they resided in a Residential school. There were a number of findings and themes that emerged from the data during the process of analysis. As these themes were investigated more closely, a picture of what was occurring at this particular Residential school was generated. With this information a better understanding can be gained on what life was like at this school and possibly at other Residential schools. The main themes that emerged from that data and which will be addressed further in the discussion include: sicknesses of the children upon admission, the policies concerning the admission of the children to the school and the management of the school, and the types of experiences children had at the school in terms of their health as seen in the letters and documents which allowed me to follow the path of a few students from admission to discharge.

4.1 Sickness

Review of the **Physical Examination** forms reveal that the majority of children were assessed by physicians to be in good physical health upon admission to the Residential school. There were no major outbreaks of any specific illnesses evident among children being admitted to the school and overall, the majority of the children were free from illness at the time of their admission. This is interesting information because within the literature, Residential school survivors have often shared their experiences of being sick while in Residential school, or memories of fellow students being sick at the schools, and many Residential school survivors recall a high rate of illness in general (Milloy 1996, Foxcroft 1996, Graham 1996, Redman 2000, Deiter 1999, Jaine 1993). One former student remembers many children having boils, warts, and general malaise as well as regular lice infestations (Milloy 1999), while another student remembers a child having a tapeworm (Grant 1996). Another former student noted that 45 children died within the 48 years the Residential school he attended was in existence (Jaine 1993), and at some schools, "Children were forced to bury the bodies of other child residents who had died" (Chansonneuve 2005:37). Survivors also often discuss the lack of adequate healthcare for the sick children at the Residential schools. A former student remembers having to view her dead sister who had died from sickness while at the school. When their father complained about the lack of healthcare given to his child, all of the other children in the family were discharged from the school and not allowed to enroll again (Redman 2000). While some of these memories have been documented, Grant notes that there had been little formal documentation made available to the public

concerning illnesses children experienced in the Residential schools (Grant 1996). My research has contributed data concerning the health of children at the time of their admission into one Residential school.

One explanation for this major finding could be that the St. Joseph's (Cross Lake) Residential school did not have a high rate of sickness among the children either at the time of their admission to or after they had been living at the school. But sickness was indeed present at the school. Letters between the Department, the Indian Agent, and the school and various forms show numerous discharges due to sickness, as well as deaths of children at the Residential school or soon after being sent home as a result of sickness. For example, in April of 1943, there was a point where one child had died at the school and 16 others were discharged either to the school infirmary, the hospital, or home due to illness. Over the entire study period, there were 10 children who died either at the school, the hospital, or after being sent home, 6 children discharged because they had tuberculosis, 7 children discharged because they were sent to the sanatorium, and 21 children discharged due to unspecified illness. The documents used in my study do not contain information on the total number of children enrolled in the school at any time, and therefore I cannot comment on the percentages of children who became sick or died during their time as a Residential school student. However, the Admission/Discharge forms allow for a count to be taken of how many children were discharged from the school due to sickness or death during the study period, and therefore show that children did become sick while living at the school and it was not that children were simply unaffected by illnesses. Although the numbers of children who were sick upon admission or who became sick while at the school are not great, some of the illnesses were

transmissible and caused death, such as tuberculosis, and so still should be seen as a significant concern.

After contact, tuberculosis became a serious health concern among First Nations populations across Canada. In her summary report on the life and work of Dr. Peter Bryce, Chief Medical Officer for the Departments of the Interior and Indian Affairs, Sproule-Jones (1996) notes that around the beginning of the 20th century, the rate of tuberculosis deaths among the First Nations people of the prairies was estimated to be 42.6 per 1000 population, approximatley 20 times the rate for the non-Aboriginal population at this time. She also notes that Bryce estimated that the tuberculosis death rate among all Aboriginal peoples of Canada at this time was 34.7 per 1000 people compared to 1.8 per 1000 people for the non-Aboriginal population of Canada. As for Canadian residential schools, Kelm (1998) in her research into the system of Residential schools in British Columbia, notes that a 1939 Departmental survey estimated that approximately 5% of all Residential school students were suffering from active tuberculosis, and that another federal government conducted study done in 1940 showed that 70% of all children in Residential schools reacted positively to tuberculin tests. Kelm began her research as a history doctoral dissertation at the University of Toronto and has produced very informative research on the health of children in Residential schools and how the schools impacted the health and bodies of Aboriginal people across Canada, with a focus on the First Nations people of British Columbia. She made use of archived materials and documents from a number of resources including National Health and Welfare records, National Archives of Canada and British Columbia, Department of Indian Affairs records, the Union of British Columbia Chiefs Resource Center, the United

Church Archives, the Oblate Archives, and the Anglican Archives. As well she had conducted interviews with First Nations and non-First Nations teachers (Kelm 1998). She notes that in B.C. Residential schools, the number of children being discharged due to sickness were quite high. Between 1896 and 1904 one school had 25 children on sick leave each year out of an average of 58 children, another school showed that 55 out of 269 graduates were dead by 1905, and during the 1940's, Bishop Christie School discharged approximately 18% of children due to ill health (Kelm 1998).

Another explanation may be that the doctor did not fully complete the **Physical Examination** form or did not properly document illnesses on the form. Among the 400 applications, approximately 20% were either not filled out completely or were completely blank. For example, Dr. John Millar left 42 forms completely blank, 16 forms completely blank except for information about negative tuberculosis x-rays, and 11 forms blank except for height, weight, and x-ray information, for a total of 69 forms that were not filled out correctly. There is no indication in any of the letters why the doctor did not complete the forms, or any notice by the Department that this was not being done properly. There was also no evidence of any recommendations that policy should be more closely followed in terms of each child having a complete medical examination before being admitted to the Residential school. It is also possible that the doctor missed or misdiagnosed an illness in a child. In terms of tuberculosis, approximately 5% of newly infected individuals will develop tuberculosis within 1 to 2 years (Canadian Lung Association 2000). The disease may also exist in a dormant state for several years, known as latent tuberculosis infection, and either remains dormant indefinitely or become active at a later date, often when stress or illness creates a weak immune system. If the bacillus

becomes active immediately it can remain active for between 2 to 5 months (Keller 2002). Following a primary infection, there is an estimated 10% lifetime cumulative risk of developing tuberculosis and half of these cases will occur within the first 2 to 3 years after initial infection (Canadian Lung Association 2000). However most cases go undetected due to lack of specific symptoms in the early stages, and even in fairly advanced cases results of an examination can be normal and not detect infection (Canadian Lung Association 2000, Keller 2002). Second stage symptoms are more noticeable and include weight loss, fever, chronic fatigue, and sweating. Later stages usually involve a cough with sputum, chest pain, and breathing difficulties (Keller 2002). Therefore, children who were sick could have been admitted to the school without their illness being documented. Dr. Peter Bryce, in his 1907 report following the investigation of 35 industrial and boarding schools in Manitoba and the Northwest Territories during the months of March, April, and May 1907, found that even though the question on the Application for Admission which read, "Condition of the child on entry?" was always answered with the response "Good", 24% of the 1537 children included in his study had died, mainly of tuberculosis or its related effects, and this percentage increased when he included children who died after being discharged from the schools (Bryce 1907, Sproule-Jones 1996). Sproule-Jones (1996) notes that among students, the death rate from tuberculosis was more than 100 times higher than the general population. The story of Child No.132 is an example of this type of situation. This child was first admitted to the school by the Department after she had been living there for approximately 6 to 7 months without formal approval. Five months after her formal approval she was sent to home because she was sick. Approximately 3 months later she was re-admitted to the

school by the doctor, not the Indian Agent, nor the Department. Eight months later this child died at the hospital. In this case, the doctor who sent her back to the school either missed the presence of the illness in the child or else she became fatally ill during the months after she had returned to the school. If this child had an infectious disease her re-admission could have led to the spread of infection to other children residing at the school, especially if poor school conditions were conductive to the spread of illness, as it has been reported in much of the literature on Residential schools. Milloy (1999) notes that some children did come into the Residential schools already infected with certain illnesses "having contracted the disease in overcrowded and squalid living conditions in their reserve homes". While this type of comment might suggest that the schools provided healthier environments than the children's homes, it more importantly points out that it was the doctors and Indian Agents acts that led to the admission of sick children into the schools and in turn the spread of infection. Sproule-Jones (1996) discusses how Indian Agents may have feared disclosing sickness in children due to retaliation from the churches who would then be seen as not properly managing the schools and would not be able to receive the maximum amount of per capita funding. She notes "The threat of ostracism from the local church community prevented some agents form reporting cases of disease or death" (Sproule-Jones 1996:210). Through her examination of the Residential school system in British Columbia, Kelm (1998) saw that both church and government officials believed that the homes of First Nations people were unhealthy. It was also the view of the school staff and Department officials that the sickness and mortality rates were so high in the Residential schools because the children were mentally and physically weak (Kelm 1996, Sproule-Jones 1996). "As late at 1907,

residential school principals maintained that the high rate of tuberculosis among their students was inevitable given the weaker constitution of the native people" (Sproule-Jones 1996: 212). This idea was then passed on throughout society so that the collective narrative became one in which the blame for poor conditions of health was placed on First Nations people themselves. Many came to believe that contagious diseases were either punishments from god for lifestyle practices which did not fit their idea of a religiously structured life, or genetically determined and therefore hereditary and incurable. These ideas were solidified in the minds of dominant society through generations of teachings (Kelm 1998, Sproule-Jones 1996). Kelm (1998) discusses how the colonial powers felt that the answer to these perceived problems was to gain control over First Nations life and change their life practices to ones that were more like their own. Aboriginal mothers were thought to have poor skills and unsanitary practices, and Aboriginal homes were equated with disease and infection. She notes that those that advocated for Residential schools blamed the high infant and childhood mortality rates on these perceived aspects of Aboriginal life (Kelm 1998). "Because medical authorities, at the time, tended to blame the First Nations themselves for such conditions and for the ensuing state of ill-health, it was logical to them that ameliorating this situation would require not systemic changes in the relationship between the First Nations, the Canadian state, and settler populations, but deep seated changes in the nature of Aboriginal physicality itself" (Kelm 1998:80). Kelm (1998) describes the idea that First Nations people were to be blamed as the source of their own health conditions as "basic notions" that were held by the colonizing powers, as well as "racially charged and gendered messages" that were reinforced through the teachings children received at the school

(:57). However, she argues that the product of the residential schools was not healthier children but instead weakened bodies "which through no fault of their own, brought disease and death to their communities" (Kelm 1998:57).

Another explanation as to why there were sick children in the Residential school, is that children became ill after they were admitted. Even early on in the history of the Residential school system it was recognized that the children became ill after spending time at the school. In regards to tuberculosis, one Indian Agent commented that "[No one] responsible can get beyond the fact that those children catch the disease while at school… in a building whose every seam and crevice is, doubtless, burdened with Tuberculosis Bacilli" (Milloy 1999:78). With tuberculosis, there may have been difficulty in diagnosing the disease in children at the time of admission due to the characteristics of the infection. Children with a primary tuberculosis infection may be asymptomatic (Canadian Lung Association 2000:379). In research on residential schools in Ontario, Graham notes that parents and school staff disagreed on where a child became sick. Parent would say that the children contracted lice and scabies at the schools while the school staff said they got them at home (Graham 1996). A review of the Cross Lake Residential school documents, including letters and the **Admission/Discharge** forms, shows that children were sick while at the school and a total of 34 children were discharged due to poor health. Upon checking to see whether the child was ill upon their admission to the school using the **Admission for Application** and **Physical Examination** forms, it is possible to see that the majority of children were reported as healthy upon admission and therefore had become sick while they were a student at the school.

A fourth explanation as to why there were sick children at the Residential school may be that school authorities admitted children to the Residential school while they were sick but prior to having their medical examination. The dates on the **Application for Admission** and **Physical Examination** forms show that this occurred on many occasions. The documents indicate the dates the Indian Agent forwarded the forms, as well as the dates that approval of admission was given by the Department and in many cases, significant periods of time passed between when children were taken into the school and when they received their medical examination, the longest period of time being 26 weeks. The letters include discussions between the Indian Agent, the school Principal, and the Department on how this time lag was a common occurrence and how it was often attributed to the doctor not being able to travel to the school to perform the health exam. The Indian Agent also informed the Department that if policy was followed, each child would be waiting a long period of time before they could enter the school, so it was for good reason that the policies were relaxed for this school. As the records indicate, the majority of children were healthy at the time of their admission and so perhaps school staff saw the threat of illness as low and therefore did not follow policies set out by the Department of Indian Affairs. However, a minority of children were admitted to the school while ill, and these illnesses could have been spread to other students

Certainly there were some cases where children were sick at the time of their admission to the Residential school. Kelm (1996) in her investigation of the residential school system in British Columbia states that, "In some instances, children arrived at the schools ill with diseases they had either picked up during the summer or had had for some time prior to admission" (Kelm 1996:66). This may have been the case for

tuberculosis especially considering that the bacillus can remain dormant in the body for years with the possibility of reactivation. The **Physical Examination** forms note a number of different illnesses or health concerns among children making an application to the Residential school. However, it must be noted that many of these health exams occurred after the **Application for Admission** forms were filled out, in some cases months later. Letters indicate that it was common practice to take children into the Residential school from the date that their **Application for Admission** form was filled out, whether or not they had been seen by the doctor. Children could have already been residing at the Residential school for weeks or even months by the time their health exam was completed and their sickness documented on their **Physical Examination** form. Therefore, illnesses noted among the children on their **Physical Examination** forms at the time of their admission to the school may have been illnesses acquired after they had been living at the Residential school for a period of time awaiting their medical examination. Kelm notes that "...many of the children who went to the schools were healthy, but they entered environments that were ideal for the dissemination of disease" (1996:67). In a report on the state of Residential schools written in 1897 it states, "it is scarcely any wonder that our Indian pupils who have a hereditary tendency to phthisis (tuberculosis), should develop alarming symptoms of this disease after a short residence in some of our schools, brought on by exposure to draughts in school rooms and sleeping in overcrowded overheated and unventilated dormitories" (Sproule-Jones 1996:216). Within the schools, crowded sleeping areas, diets lacking proper nutrition, unsanitary conditions, and high stress created risks for latent tuberculosis to become reactivated, as well as for tuberculosis bacilli to be spread among the children (Keller 2002).

Therefore, even if the medical examination found some type of illness in a child, a closer examination of the records reveals that often the child's medical examination occurred some time after they left the care of their families.

- Of the 36 out of 400 children who are listed as "Undernourished" on their Physical Examination forms, only 8 children had their health exam within 10 days of the date of their Application form. All other children had between 2 weeks and 23 weeks between these dates.

- For children with scabies, 18 out of 26 had their health exam within 10 days of the date of their Application for Admission form. The other 8 children waited between 2 and 25 weeks.

- For children with head lice, 3 out of 5 of the children had their health exams within 10 days. The other 2 children waited 3 weeks and 6 weeks.

- For children who were listed as having a tuberculosis related illness, 1 out of 10 had their health exam within 10 days of the date of their Application for Admission form. The other children waited between 4 weeks and 18 weeks for their health exam.

- For children who were listed as having respiratory infections/conditions, 2 out of 6 had their health exam within 10 days of the date of their Application for Admission form. The other children waited between 2 weeks and 6 weeks for their health exam.

- For children who were listed as having swollen glands, 4 out of 9 had their health exam within 10 days of the date of their Application for Admission form. The other children waited between 2 weeks and 11 weeks for their health exam.

- For children who were listed as having an eye condition, 1 out of 3 had their health exam within 10 days of the date of their Application for Admission form. The other 2 children waited 3 weeks and 15 weeks for their health exam.

- The child who was listed as having ear condition waited 5 weeks for their health exam.

- For children who were listed as having dental concerns, 6 out of 12 had their health exam within 10 days of the date of their Application for Admission form. The other children waited between 2 weeks and 26 weeks for their health exam.

- For children who were listed as having cozyra or cold, 8 out of 22 had their health exam within 10 days of the date of their Application for Admission form. The other children waited between 2 weeks and 24 weeks for their health exam.

Within the documents there is no mention of any school staff being ill or what the policy was for staff who became ill. Other researchers have discussed how staff illnesses were often seen as unproblematic and the possibility of them being a source of infection was not considered. Miller (1996) discusses how in 1932 at the Anglican Residential School in The Pas Manitoba, the daughter of the Principal, who worked as supervisor of the girls, was found to have tuberculosis. However, they considered this unproblematic and so she continued to interact with the girls, possibly spreading the illness to the children. Therefore, contrary to the belief that Aboriginal people were the source of their own sickness, school staff may have often been the source of infection within the Residential schools.

Those who developed and managed the schools believed that the children would be better off living apart from their families. …"it was hoped that residential school attendance would save children's lives by isolating them from infectious homes" (Kelm 1996:58). However, the reality was that it was not a matter of the schools taking in sick children to be saved by the church and state in the Residential schools, or to be taught health, hygiene, and life skills so that they could increase their chances for survival and successful lives as adults. Instead, it was a matter of an institution into which children were forced, which due to poor conditions and problems with administration, has led to

lifelong and intergenerational negative impacts on health and well-being. Many children did not make it out of the Residential schools alive, but for those who survived, the illnesses they acquired or experienced as children, along with the lack of appropriate healthcare within the Residential schools, has left lasting negative effects on both physical and mental health.

Kelm (1996) discusses how the government created the belief that if Aboriginal people did not assimilate, they would remain inherently unhealthy and that morbidity and mortality rates would remain high. However, the data for the Residential school at Cross Lake, demonstrate that over three decades the majority of children were healthy upon admission. Kelm (1996) states that many parents fought against the idea that children would have better health at the Residential schools and instead wanted schools built within their communities so that children could be fed and cared for by their parents and families. She discusses how parents complained to the Department about the poor health of their children as a result of the school conditions and took action to try and help the children. "In petition after petition, Aboriginal parents asserted that it was not they who neglected their children, but the residential schools; it was not their homes that killed their children, but the domestic environment of the schools" (Kelm 1996:76).

In terms of these Residential school documents, there is evidence that the majority of children coming into the Residential school were not sick. The documents show that living with their own families was not destructive to their health, and that the statements made by the government and churches as justification for taking children away from their parents did not apply to the majority of cases. The **Physical Examination** forms show that overall, the children were healthy.

4.2 Body Mass Index

Body Mass Index (BMI) is a number which is calculated using the height and weight measurements of an individual. BMI is a measure of weight for height. For children, the interpretation of BMI is age and sex specific and is referred to as BMI-for-age (CDC 2009a). Once a BMI number is calculated for a child, it must then be plotted on a gender specific BMI-for-age growth chart in order to obtain a percentile ranking. The percentile ranking indicates where the child's BMI number is positioned among other children of the same age and sex. The percentile ranking is then used to place the child in a weight status category. The CDC (2009a) notes that BMI-for-age is an indirect means of measuring body fatness and can be used as a method of screening for weight categories that may lead to health problems. BMI can be used in conjunction with other methods of assessment such as evaluations of skin fold thickness, diet, physical activity, and family history in order to determine whether a child has or is at risk of a health problem (CDC 2009a). BMI is calculated in the same way for children as it is for adults, however, criteria used to interpret the meaning of BMI is different. BMI for adults is neither age nor sex specific and is therefore interpreted using different criteria than that for BMI-for-age. Age and sex are included in the interpretation of BMI for children because the amount of body fat changes with age, and the amount of body fat differs between girls and boys. There are also no healthy weight ranges for BMI-for-age as are found in the interpretation charts for BMI for adults. This is because healthy weight ranges change with each month of age for each sex, and also as height increases (CDC 2009a).

Growth Charts

The growth charts used to determine percentile rankings are those compiled by the CDC and released for use in 2000. They consist of a number of percentile curve charts which show the distribution of certain body measurements in children in the U.S. (CDC 2009b). In 2000, the CDC released a revised version of the 1977 NCHS growth charts. These revised charts are based on more recent and comprehensive national data and are created using improved statistical procedures. The BMI-for-age for girls and boys are included in this set of growth charts, replacing the 1977 weight-for-stature charts (CDC 2009b).

The Data

The weight status percentile scores indicate that the majority of children, 275 out of 310 (89%) fall into the "Healthy weight" category. Ninety of the **Physical Examination** forms did not have the sections for height and weight completed or filled out properly and so these children could not be included in the analysis.

Only 6 (2%) children fell into the "Overweight" category. There was nothing noted about their weight on their **Physical Examination** forms and none of these children were listed as having any other type of health concern or conditions upon their admission to the Residential school. Such a low rate of obesity in the children at the time of their admission to the Residential school is very interesting considering the recent findings on rates of overweight and obesity among First Nations children and youth in Canada (FNC 2005). While rates of obesity and overweight are increasing among all children in Canada, recent Canadian surveys of health show that the rate of obesity among Aboriginal children, including First Nations, Inuit and Metis, is even higher

(Willows 2005, Ng et al. 2006). In their study of children of the Cree Nation of Mistisssini in Quebec, researchers found that 71% of the children in the study sample were overweight or obese. Obesity among children in this population in four times that found in the general Canadian population (Ng et al. 2006). In Canada, pediatric obesity increased by nearly 0.1 kg/m^2 per year since 1981. Between 1981 and 1996, the prevalence of children who were overweight increased from 15% to 29% for boys and from 15% to 24% for girls. The prevalence of obesity over the same period of time has increased from 5% to 14% for boys and 5% to 12% for girls (FNC 2005). In the FNRLHS, a nation wide survey of all on-reserve First Nations people which collected data during 2002 and 2003, it was found that 41.5% of the children were considered to be normal or underweight, 22.3% of the children were considered to be overweight, and 36.2% of the children were considered to be obese (FNC 2005). The authors note that "the data reveal that Canadians of Aboriginal descent have consistently higher rates of being overweight and obese compared to the overall Canadian population" and that "First Nations children have a particularly high risk of obesity" (FNC 2005:256). Willows (2005) examined the issue of overweight in First Nations children by reviewing research conducted with four different groups of First Nations children in Canada: The James Bay Cree; the Mohawk of Kahnawake Quebec; the Oji-Cree of Sandy Lake, Ontario; and the Anishnabai Temagami First Nation in Ontario. Among each of the populations, children were found to be experiencing high rates of overweight and obesity. Within each of these communities, there have been drastic changes in diet and subsistence practices over a short time period and these populations rapidly transformed from societies based on traditional practices of hunting and gathering and agriculture, to societies that subsist on

store bought foods and practice a more sedentary lifestyle. In relation to the James Bay Cree, the author notes that only 2% of children in this population were obese sixty years ago (Willows 2005). This is similar to the findings concerning the body weights of the children being admitted to the residential school. During the years 1930 to 1953, only 2% of the children admitted to the Residential School were in the "Overweight" category.

Therefore, it is possible that this transition from healthy body weights to high prevalence of overweight and obesity among the children may have been happening uniformly across Canada as a result of the process of colonization. We may now be seeing the effects of this change. It appears that prior to the changes forced upon First Nations children in Residential schools, which in turn forced them into changing their diet, traditional practices, and even perceptions about foods, the majority of children were at healthy body weights. This may begin to establish the argument that indeed there is a link between the Residential school experience and the high rates of obesity among First Nations people. Allec (2005) noted that "A rapid transition from hunting and gathering to sedentary, reserve-based lifestyles, as well as a switch from a high-fiber, low-fat diet to one based on low-fiber, high-calorie foods, has exacerbated the prevalence of obesity and diabetes among Canada's Indigenous peoples" (:12). Children were forced to give up their diets of traditional foods for a diet lacking in substance and nutrition. One example of the types of change in diet that the children were forced to experience at the schools is noted by Milloy (1999) in his discussion of the lack of improvements in the care of the children at the schools. He writes that in 1969, a dietitian noted that macaroni or spaghetti was on the menu four times in one week and bologna five times (Milloy 1999). It would be interesting to compare the BMI numbers of the children at this school at this later date

in the history of the system to the BMI's of the children being admitted to the Cross Lake Residential School from 1930 to 1953. For many people, the forced change that occurred in Residential schools, marked the beginning of the transition to poor food habits or perceptions of food that have been linked to other health conditions including diabetes, coronary disease, hypertension, and overweight and obesity. The abrupt change in diet between life at home and life in the Residential schools caused many former students physical and emotional pain as children, and these effects have carried over into their adult lives. One former student recalled, "Weeks went by without a taste of meat or fish... A few times I would catch the smell of roasting meat coming from the nun's dining room and I couldn't help myself - I would follow that smell to the very door. Apart from the summers [at home] I believe I was hungry for all seven of the years I was at the school" (Kelm 1998:73). For one school it was noted that, "The speed with which the change of diet was carried out added to the list of traumas already suffered by Nuu-chah-nulth students" (Foxcroft 1996:32). It should also be considered that in the schools, the staff taught the children that their traditional diet was uncivilized. Children were taught to see the foods that they grew up on and which their families still cooked and ate at home as undesirable and the homes where their families prepared foods as unclean (Kelm 1998).

The experiences with poor quality and quantity of food in the residential schools have left some former students with lifelong issues related to food and eating. In her discussion of her own experiences in healing from the traumatic effects of colonization, Hill (2002) discusses the impact that Residential schools, and the food in the schools, have had on the "generational unwellness" among First Nations peoples. In discussing

food at the schools she states, "Boarding school residents know what it is like to be hungry. They know what it is like to eat spoiled food" (Hill 2002:22). She notes that in the early years, even though the nutrition content of the diet was poor, children would usually go back to eating a traditional diet once they were released from the schools. However, by the mid century, the diets of the parents had also changed to a less nutritious westernized diet, and so the home diet also became nutritionally poor. Traditional foods became a delicacy. Hill (2002) notes that contrary to many people's beliefs, bannock is not a traditional food, as flour, sugar, yeast, and dairy products were not part of a traditional diet. She states, "It is no wonder that many Natives are finding themselves with a high rate of obesity, heart disease, diabetes, and other diseases. The body is now consuming foods that it does not recognize" (Hill 2002:21). She goes on to discuss how the diets of Aboriginal people changed after contact with Europeans. Different Aboriginal groups had different diets based on the foods from the region in which they lived. She notes, "Our bodies are not able to digest properly and assimilate nutrients from foods in westernized diets". Hill (2002) feels that being deprived of food results in an obsession with food. She notes "Those raised in boarding schools may have an extreme need to fill the cupboards and refrigerator with food, even before they are low" (Hill 2002:22). She feels that these obsessive compulsive thoughts about food should be acknowledged and dealt with as they continue to affect people even as they are healing from the other traumas of the residential school system. Hill goes on to discuss how these feelings or memories about food can be passed down to the next generation where any feelings of anxiety, fear, loneliness or even happiness can unconsciously trigger the desire to eat. She notes that for some, eating creates a numbing of emotional pain in a similar way as

alcohol and drugs are used to deal with emotions (Hill 2002). Grant (1996) discusses how children learned to eat as fast as they could because where second helpings were available it was usually a "first come first served" situation. One former student recalls how her eating habits changed as a result of Residential school. "Alice French reports that her grandmother considered Alice's eating habits a disgrace when she came home after her years in the school at Aklavik because Alice could never break herself of the habit of eating too fast" (Grant 1996:128).

In Kelm's (1998) examination of the residential schools in B.C, she found that it among the dominant white society, it was assumed that First Nations parents were not taking proper care of their children, that they were negligent parents and that Aboriginal women made poor mothers. She found that many people working among First Nations communities "condemned the child-rearing practices of Aboriginal women and argued that Native children were best raised away from their biological mothers" Kelm 1998:62). However, the findings from my study may present evidence that the current issue of overweight and obesity among First Nations populations extends much deeper than parental control over diet and is highly connected to the lack of control that people have over choices such as diet, participation in physical activity, and cultural beliefs and perceptions about food and body type. The development of this health problem may have been set in motion years ago as one of the tragic effects of colonialism.

Only 12 (4%) children fell into the "Underweight" category. When the BMI values of children are compared to the listing of "Undernourished" from the **Physical Examination** forms it is apparent that these two descriptors do not always correspond. This means that a child who was listed as "Undernourished" on their **Physical**

Examination form does not have a BMI percentile score that categorizes them as "Underweight". Most of the children listed as "Undernourished" are actually in the "Healthy weight" category. Therefore, the decision to list a child as "Undernourished" must have been based on criteria other than just body weight as it does not appear that low body weight was used as the diagnostic criteria for this variable on the **Physical Examination** form. While some students reported weight loss while they were in the schools (Milloy 1999, Foxcroft 1996, Haig-Brown 1988), this was most likely a change that happened after they were admitted to the school and had been living in the school for some time. Of the 12 children who fall into the "Underweight" category based on their BMI percentile score, only 2 were listed as being "Undernourished". These two children were also listed as having fevers due to colds. This may have been the reason that the doctor listed them as "Undernourished". The **Physical Examination** forms for these children were completed approximately one month after the **Application for Admission** forms were completed. Therefore, it is possible that these children became ill while at the school awaiting their health exams. Another child who falls into the "Underweight" category is also listed as having a fever due to a cold. The **Physical Examination** form for this child is dated approximately four months after her **Application for Admission** form was filled out. If she was living at the school during this time, it is very likely that she became ill at the school while awaiting her health exam.

It is interesting that in 1922, Duncan Campbell Scott stated that "ninety-nine percent of the Indian children at these schools are too fat" after a child at the Onion Lake School in Saskatchewan complained that the children did not have enough to eat (RCAP 1996:371). Although the Department did set a scale of rations in terms of what types of

foods and how much was to be given to the children, when one school was investigated in 1894, it was found that most children there were underfed and the school had not followed the prescribed diet (Milloy 1999). Milloy (1999) further notes that this was the common practice in most schools and the situation did not improve until after WWII, and even then the improvement was minimal.

This research depicts the situation in this one Residential school. It would be interesting to see if the situation was similar at other Residential schools at this time. The majority of children were at healthy weights during the period 1930 to 1953 at this particular Residential School, and so it is possible that children were at healthy body weights in 1922 at other Residential schools. Revealing the accuracy of the influential remark made by Duncan Campbell Scott, an individual in such a position of power at the time, could tell a great deal about the collective narrative of the dominant white society at this time. It would show that the perceptions of Aboriginal life and people by those in power were created by those in power to support their own ideals and societal goals without understanding the meaning of life that exists within the Aboriginal cultures in Canada, or the impacts they would have on a whole nation of people.

When the BMI percentile scores of the children were compared across the 1930's, the 1940's and the 1950's, there were no statistically significant differences found between the three time periods. There were also no significant differences found in the BMI percentile scores when compared across the bands of origin of the children. The only notable finding from the statistical comparison of the BMI percentile scores was that the lowest mean score was found in children during the 1940s. Eleven out of the 12 children categorized as "Underweight" were admitted during the 1940s. There is no

stated reason for this trend in any of the documents, however, it could perhaps been a result of the economic situation during the time as a result of WWII and the Depression period. It is also interesting that only girls fell into the "Underweight" category. This could indicate that there were bodyweight issues occurring among the female children.

4.3 Admissions Policies

The letters written back and forth between the Indian Agents, the Department officials, and the Principle of the school provide an interesting glimpse into what was occurring at the school and in the community during this period of time.

4.3.1 Children Brought into the Residential School Before Having a Medical Examination.

One of the most interesting findings that came out of the analysis of the documents was the full acknowledgement that children were being accepted into the Residential school before they had been given a medical examination. A Departmental policy, created in 1894, stated that in order to ensure that only healthy children were admitted to the schools, all prospective students were to first receive a health certificate signed by a doctor prior to admission (Miller 1996, Milloy 1999, RCAP 1996). Disregard for the Department polices was demonstrated by the admission of ill children. In 1909, the Department even developed new application and health exam forms which were supposed to keep tubercular infected students from being admitted to schools (Milloy

1999). However, children with tuberculosis were still admitted to schools even if the infection was noted on the medical examination form, children who did not pass the exam for other health reasons continued to be admitted to the schools, and children were admitted to the school without formal approval by the Department (Milloy 1999, Kelm 1996). With the implementation of the per capita system, in which the government funded the school a set amount of money per student, the various church denominations were in competition to obtain the highest number of eligible children. Funding was a strong incentive for school officials to admit unhealthy children, who were then kept in living quarters with healthy children (Miller 1996). "Under these circumstances, many church officials admitted students without a proper medical examination. Though a threat to the student body, unhealthy children ensured the high enrollment levels necessary for adequate funding" (Sproule-Jones 1996:210).

The documents show that on numerous occasions, children were living at the school for some time before their admission was approved, or before the forms were even sent in to the Department. As a result, sick children may have been taken into the school without the school staff having any knowledge of their sickness and this could have led to the spread of sickness among the children living at the school. However, even in some cases the school staff knowingly brought in sick children without formal approval. Grant (1996) notes that in 1911, the Inspector of Indian Agencies in Saskatchewan complained that principals of schools were taking in sick children who were not medically examined for weeks or months because it was known that they would not pass the medical exam due to poor health. The inspector expressed his concern over how this would expose the

healthy children to disease and goes on to offer some advice on how to correct this situation.

> *"I think the Department should issue strict instructions to all Principals that they are not to allow children into the schools for a longer period of time than 2 days before having them examined by a doctor. I think it would be a good idea if doctors were specially instructed that they must be most particular in the examination of children applying for admission to schools and on no account admit those with diseases..." (Grant 1996:120-121).*

In 1925, Duncan Campbell Scott noted that there needed to be more care taken in checking the medical remarks for all applicants (Milloy 1999). It is apparent that these recommendations were not adhered to as the Department would send back approval of admission for children who were clearly shown to be ill on their **Physical Examination** form, or for those the doctor suggested should not be admitted until sickness was ruled out.

The records show numerous instances where the **Physical Examination** form was filled out long after the **Application for Admission** form was completed. There are a few possible explanations for this. One explanation was that **Application for Admission** forms were filled out during the summer months and children did not move into the school until the beginning of the school year in September. Filling out of school application forms may have occurred during Treaty time when people gathered together in one location, or when the Indian Agent could more easily travel to the surrounding communities to recruit children. This is discussed in one of the letters in which the Indian Agent notes that sometimes the doctor is able to examine children during the summer on the reserves before they come to the school the following September. Another explanation is that the **Application for Admission** forms were filled out on the day that the children were brought to the Residential school. In this case, many children were

taken into the school before they had their medical examination. From the letters, it is apparent that this second scenario occurred on a regular basis.

There were a number of letters sent between the Indian Agent and the Department explaining how children had to be first taken into the school and then after would have applications made and medical examinations taken. Explanations from the Indian Agent as to why children needed to be taken into the school before having medical examinations or before receiving approval from the Department included: the Principal having difficulties obtaining children's records from other Residential schools; parents who left the area for hunting or trapping and so could not sign the form; and parents who were sick or who had died and so could not sign the form. However, it appears that most of the time, school officials were waiting for the doctor to perform the medical examinations. In letters from the Indian Agent to the Department, the Indian Agent admits that most of the time, children were first admitted to the school and then at a later date when the doctor visited the school, they had their medical examinations. Therefore the letters provide insight into how often the doctor actually visited the school. In one particular letter, the Principal wrote that 6 months without a visit is too long. If the doctor could only visit the school a few times per year, this left the students with only the school staff as healthcare personnel. In the same letter, the Principal noted how the school nurse was overwhelmed with trying to care for all of the sick children at the school.

The documents show that the school staff felt it necessary to break policy in order the keep the schools functioning. They felt that it would take too long to get children into the schools if they had to first have each child medically examined and then receive approval of the admission from the Department, as policy stated. However, it is also

evident that the problem was not completely the fault of one party. Records show that children who were sick were admitted to the school with no question by the Department despite the doctor recording the presence of the sickness on the **Physical Examination** form. Also, the schools allowed the admissions without approval, but the Department did not supply enough doctors to examine the children year round. The winter conditions made it difficult for travel and the doctor, who was based at Norway House, could not always travel to the school to perform medical examinations. Within the letters there are discussions of how the schools often had to wait for months for the doctor to come to do the health examinations. Miller (1996) notes that at some remote schools, children were not able to have medical examinations before being admitted to the school. Milloy (1999) notes that one of the major problems was that the Department did not employ enough medical staff to properly take care of the children's health, and some schools had visits from the doctor only once per year (Grant 1999). Therefore this was occurring at other Residential schools as well. Perhaps if the Cross Lake Residential School would have been provided with its own doctor, only healthy children would have been admitted, children would have received their medical examinations before entering the school, and children who were sick, could have been directed to the hospital or sanatorium or home to their parents instead of being brought into the school to spread their infection to the other children. Therefore, policies that were put into place to protect the health of the children were seen as inconvenient to school and Department staff, and so were disregarded so that they could continue to bring children into the schools.

4.3.2 Admission of Underage Children.

In 1909 the Department of Indian Affairs created a policy which stated that children were to be at least seven years of age to be admitted to the Residential schools and were to be educated until age eighteen (Grant 1996). However, documents show that many times, the Department approved the admission of children younger than seven years with or without an explanation from the Indian Agent. There were 33 children under the age of seven admitted to the Cross Lake Residential School during the period of time covered in this study, the youngest being only three years of age. The literature shows that school and church staff though that children should be taken from their parents even earlier than seven years of age. Some church officials believed that the schools should be able to take in children at the age of three, while others complained that parents were used to having their children enter the schools at age six and so it should not be changed to age seven (Grant 1996). A group of St. Boniface priests explained that the earlier age is better, "for they must 'be caught young' to be saved from what is on the whole the degenerating influences of their home environment" (Grant 1996:75). This corresponds to the general colonialist attitude of this time period that the only way to successfully educate and assimilate First Nations people, would be to begin the process of assimilation among the youngest (Milloy 1999, Grant 1996), and hence, least powerful, members of the population. Residential schooling was to act as a "means to 'save' Aboriginal children from the insalubrious influences of home life on reserve" (Kelm 1998:57). This type of explanation shows the perceptions of First Nations life and family traditions by those in control of the education system. This colonial ideology

completely disregarded the concept that small children should be kept with their parents and lacked any consideration of how First Nations families raise their children and create family and community bonds. The colonial mentality was that it was crucial to remove the perceived savage elements of First Nations life by forcing children to give up their identities and culture. Colonial leaders were certain that this was the only way that First Nations people would become healthy and productive. Kelm (1998) discusses how those who proposed the system of residential schooling believed that assimilation was only possible for children who were physically separated from their parents and therefore removed from their influence and parenting practices. "Capturing minds meant capturing bodies first; indeed, residential schooling had, at its very core, the desire to physically supervise, contain, and control the population of First Nations youth" (Kelm 1998:59). Many First Nations parents fought for their children, even if they did not see much success in their attempts. Kelm (1998) in her research found that First Nations parents were angry that their children were not kept healthy at the schools. She notes that the schools tried to place the blame on the children for becoming sick so often but the parents argued against the idea that children were healthier when they lived apart from their families and community and argued it was the schools who neglected their children not the parents. In the end, taking the children from their parents at such young ages may have been one of the most damaging policies of the Residential school system.

Some of the most heart wrenching quotes in the literature in Residential schools are about how there were young babies living at the schools without the love and care of their parents. Research shows that this type of very early separation of child from their parent has negative impact on later health as adults. Sproule-Jones (1996) discusses the

connection between early separation of parent and child and the increased risk of illness. She states that the weakened psychological state of children when separated from their parent's increases their susceptibility to illnesses, and children who experience life-change stress are more susceptible to respiratory illnesses such as tuberculosis (Sproule-Jones 1996). She states, "...native residential school students would have been at even greater risk of contracting respiratory disease because of the changes in their family life and traditions, as well as the lengthy separation from their parents necessitated by government education policy (Sproule-Jones 1996:213). Perhaps if school authorities would not have allowed these very young children to be admitted to the Residential school, negative health outcomes they may have experienced could have been prevented.

4.3.3 Incomplete Physical Examination forms.

Out of the 400 applications reviewed for this study, approximately 20% of the **Physical Examination** forms were either left blank or not filled out completely. For instance, Dr. John Millar signed 71 of the **Physical Examination** forms; however, 69 of those forms were left either completely blank or incomplete. Dr. A.B. McPherson signed 18 of the **Physical Examination** forms but left 6 of these without height and weight information and 5 of them completely blank. Within the letters, there is no mention of any concern over blank or incomplete **Physical Examination** forms. The Department continued to approve the admission of these children without the required health information. In this case all parties involved hold blame; the doctor for not completing the form, the school staff for passing incomplete forms on to the Indian Agent, the Indian

Agent for accepting and forwarding incomplete forms to the Department, and the Department for approving the admission of children for whom there was little or no health information provided. By giving approval of admission, the Department was breaking their own policy of making certain that sick children were not brought into the Residential school. It is understandable that the school staff were not afraid to disregard the policies if the Department also followed the policies in such a relaxed fashion. The fact that the Department did not follow its own policy explains why there were very little reprimands on school staff for bringing children into the schools before they had received formal approval or before they had their medical examination.

If a child's **Physical Examination** for was blank or incomplete, there is no way to tell whether the child had even received the medical examination. These children could have been brought to the school with sicknesses which then spread to the other children.

4.3.4 Discharge of Students

Another interesting finding from the documents relates to the discharge of students from the school. Every September, December, March, and June the Principal filled out a form listing all children who had been discharged from the school during that quarter. The letters also document the discharges as the Indian Agent was required to inform the Department of the request for discharge of each student and the Department would have to approve of the discharge.

It is interesting that the **Admission/Discharge** form or letter would often note that the child had been discharged due to sickness. The majority of discharge requests

contained no information as to what type of sickness the child had, nor does the Department inquire as to what sickness caused the child to be discharged. In terms of deaths at the schools, the majority of **Admission/Discharge** forms or letters had no explanation as to the cause of death. There were additional reports that were supposed to be filled out in the event of a death of a student; however, it is questionable whether this was consistently followed. Within the archived documents there is a file containing information on the deaths of students, however I did not include this file in my study and cannot comment on how complete these files are in the archives. At the schools, deaths of children often went unreported. Grant (1996) notes that the death of children at the Residential school were often purposely hidden and never discussed and that while records of deaths were supposed to be filed, it was not policy to inform the parents if their child died at the Residential school. Within the documents from the Residential School reviewed as part of this research, there was one case where the Department wrote to the Indian Agent asking for the death report for a student who had died at the school a month and a half prior. The school had not yet sent the report on the inquiry into the death of this child. Therefore, it appears that policies such as performing inquiries into the death of students were not adhered to completely by school staff.

Survivors have discussed how those who were supposed to be caring for them in the Residential school, those who took the positions of pseudo-parents for the children, did not genuinely care for them. The forms show that child after child is discharged from the school due to sickness or death but there is very little written about the individual child or about what was wrong with the child, how this sickness and subsequent discharge affected the child, or how the sickness or death affected the family of the child.

For the children who were discharged and sent to other institutions such as hospitals, sanatoriums, convents, and other Residential schools, there may be a continuation of the history of these individuals as recorded in records from those institutions from which we can learn how the Residential schooling affected their lives. For those children who died at the schools or shortly after being discharged elsewhere, an examination of death reports, church records, or even actual cemeteries where they are buried may provide more information as to how the Residential schools may have contributed to their death. These types of connections between historical documents can assist people in piecing together parts of their lives or the lives of family members in order to continue the quest to understand the effects of the process of colonization and the system of Residential schools specifically.

Overall, this strategy of assimilation developed by the government and the churches created immense and long-lasting effects on the health of First Nations people who were forced to attend as well as the multiple generations who have followed and who have been left to live in the aftermath of this traumatic loss of culture, language, and Aboriginal identity. Many generations of lives have since become intimately connected with the legacy of the Residential school system.

4.4 Summary

The documents examined in this study have revealed a wealth of information concerning the health of the children at the time of their admission to the Residential school as well as some information on what happened to a few children during their time

as students in the school. The documents involved in this research provided the opportunity to study what was written on the pages in a direct form of analysis. However, review of these documents also allowed for a deeper type of analysis of the meaning behind what was occurring in the schools, such as missing in the data, or making connections between information to begin to piece together a more complete understanding of the Residential school system and its long-term effects. Numbers of children with certain health conditions were counted and organized, but at the same time, a deeper look into issues such as dates and signatures on the documents allows for a better understanding of why, where, and how a child may have become sick. What is most evident from this research is that policies which were put into place by the Department of Indian Affairs in order to protect the well-being of the children were not followed consistently by the authorities who held the responsibility to do so. For example, children were brought into the school when, for numerous different reasons, should have been denied admission at that time; medical examination forms were not filled out properly or not filled out at all; medical examinations were not given to children before they came into the school; doctors did not visit the schools frequently enough to provide adequate healthcare; and forms were not forwarded in an appropriate amount of time.

Therefore, the problem was not one that involved a stream of sick children being admitted to the Residential school. In fact, the majority of the children were healthy. The illnesses that children were found to have upon admission, when they received their medical examination at the same time, were conditions such as lice and scabies. Life threatening health issues such as tuberculosis and fevers were found among children who

were finally receiving their medical examinations weeks and months after they were brought to the Residential school.

Perhaps if school and Departmental officials would have followed policy more diligently, and taken more time and care to make sure that forms were filled out and forwarded on time, children may have had a better experience at the Residential school in terms of health and healthcare.

Chapter 5

Significance and Conclusion

Healing is term now commonly associated with the legacy of the Residential school system in Canada. Many Residential school survivors, their families, and communities are now in the process of disclosing information about their experiences in the Residential schools and by doing so are beginning a process of recovery and healing from the pain and trauma of those experiences. However, making connections between past experiences and current health issues is not an easy process. Many residential school survivors have identified that they cannot even begin to heal from the trauma of the Residential school experience until they are able to recognize how they have been affected. For those affected by intergenerational transmission of effects, this is even more difficult due to the lack of awareness of what actually happened to family and community members in Residential schools. For some people, identifying the issues that are creating negativity in their lives is a first step on a healing path. This can happen slowly over time, or as a result of some type of crisis such as illness, family breakdown, or crime (DeGagne 2007).

In addition to individual healing, there is also community healing. Community healing is characterized by four stages; a prevailing sense of crisis in the community, building the momentum of a healing movement, hitting the wall, and healthy people living in a vibrant community (DeGagne 2007). However, DeGagne (2007) notes that individuals and communities often face setbacks amongst their progress and there are joys and challenges that make the process difficult yet rewarding. The realization of the

connection between Residential schools and the poor health status of First Nations peoples is just beginning to be recognized among healthcare professionals as well. Providing education on the history and effects of the Residential school system in Canada to healthcare professionals working with First Nations patients is crucial in getting healthcare professionals to understand the origin of many of the health and social problems they see affecting their First Nations patients. In doing so, resentment can begin to be replaced by understanding and compassion, leading to better health outcomes and in turn, a healthier First Nations population.

In response to this movement towards healing, a number of organizations have been created in order to assist survivors and their families obtain the assistance and compensation they require in their path to healing. While it may seem that many of these organizations focus mainly on issues related to mental health, the holistic understanding of health found within First Nations culture, means that there are connections between each type of health concern be it physical, mental, emotional, or spiritual. The purpose of most of these survivor groups is to provide support to survivors through whatever type of healing they require.

The Aboriginal Healing Foundation (AHF) is a national Aboriginal-managed, non-profit private corporation. The AHF was established on March 31, 1998 with the purpose of managing the $350 million dollar grant provided by the Government of Canada. This funding came as part of Gathering Strength – Canada's Aboriginal Action Plan, to "support community-based healing of the legacy of physical and sexual abuse at residential schools" (AHF 2006). Therefore funding for the AHF was for the purpose of supporting the healing needs of residential school survivors who suffered physical and

sexual abuses in the schools, as well as the needs of families and communities who have also been affected by these abuses through intergenerational transmission of negative effects.

The AHF-funded programs can be used as entry points for the healing of many of the negative effects of the Residential school experience. In some cases, survivors must first recognize the need and ability to begin their healing before they can even connect other types of health problems to the trauma they suffered in Residential schools.

The AHF provides resources for holistic and community-based healing programs, promotes healing issues and needs of survivors, and works at creating a public environment that is supportive of the needs of survivors and their successive generations (AHF 2006). The vision of the AHF involves a future where survivors and their families have "addressed the effects of unresolved trauma in meaningful terms, have broken the cycle of abuse, and have enhanced their capacity as individuals, families, communities and nations to sustain their well-being and that of future generations" (AHF 2006:17). Prior to the establishment of the AHF, there were some publically and provincially funded healing activates in First Nations communities and while the effects of Residential schools were identified as stressors, they were not the focus of any particular programs. There were a few survivor groups but none of these were "equipped to generate systematic understanding of residential school healing and therapeutic responses" (AHF 2006:55). In 2006, as part of the Residential Schools Settlement Agreement, the federal government provided an additional $125 million to the AHF which it has committed to the continuation of already established programs for an additional five years. This extra funding will allow 141 projects and programs to continue on until March 31, 2010, and

10 healing centers to be funded until September 30, 2011. Since the creation of the AHF, the organization has approved funding for 1,345 community-based healing grants totaling $406 million (AHFa). The AHF is also very active in providing means for communities and initiatives to evaluate the progress and success of their programs so that this information can also be used contribute to healing efforts of all survivors.

As the healing process takes a long time, the AHF funded projects are only beginning to see results. Reports from funded programs show that many survivors are just starting on their path of healing and many are only beginning to feel ready to consider their personal healing (AHF 2006).

As a result of this research, perhaps other researchers and First Nations members will be motivated to examine other collections of Residential school documents. There is great potential and value to this type of research for impacting the lives of First Nations people in a positive manner. There were approximately 130 Residential schools in Canada, which means that there is most likely a very large collection of records in various archives and storage facilities across Canada. However, finding complete sets of records for each school may not be possible.

Researchers working on other Residential school records have found that some of the files assumed to be held by the government of Canada are missing. For example, researchers involved in work on the Shingwauk Residential School began to notice the missing files when they were assisting survivors locate their personal records in order to prove their attendance at the school for Settlement Agreement claims (Sadowski 2006). In looking through government files, they found evidence of instructions from the government to either destroy old Residential school records or recycle them during war

time paper shortages. "What we have found is that there was a general federal policy to destroy many government files and that there was a very high level of records destruction activity that occurred between 1936 and 1956" (Sadowski 2006:3). As a result, thousands of Residential school documents were destroyed. Unfortunately, it appears that important documents such as Quarterly Returns, Admission/Discharge forms, Student Lists, and Application for Admission forms were included in the list of documents to be destroyed. This means that valuable information on the health of children at the time of their admission to Residential schools may have been lost. Therefore, additional research into this issue of missing documents is needed. This group of researchers was eventually contacted by the Department of Indian Residential Schools Resolutions Canada with requests for information or file searches. This is evidence that even the government does not have complete listings of all children who attended the schools. The researchers found no consistent policy for creating and destroying records. There were different policies for headquarters and field offices and neither were very strict. As a result "many Indian Affairs documents did not survive because of the actions of individual Indian Affairs officials. ...Recognition of the potential for irregularities with unpredictable consequences seems to have been beyond the capacity or concern of many of those involved" (Sadowski 2006:6). It was not until 1973 that a moratorium on records destruction was agreed to between the Public Archives of Canada and Indian Affairs (Sadowski 2006). These researchers also feel that more needs to be done in order to determine whether or not these records have been destroyed. "Many documents and other materials associated with the Residential school era exist in collections other than those of the Government of Canada. If the legacy of the Residential schools is to be properly

addressed, a national project of Residential school resource identification and sharing needs to be established by all parties as soon as possible (Sadowski 2006:12).

For survivors and their families, being able to see and hold the documents that initiated the experiences that forever changed their lives might be a significant part of their healing journey. As the plans for the Truth and Reconciliation Commission, one of the most significant parts of the Residential Schools Settlement Agreement, are finally being developed, it will soon be a significant time of healing for a large segment of the First Nations population of Canada. These Residential school documents can be vital pieces of survivors' stories and may provide strength and courage to people during this very difficult time. For people to be able to hold documents that validate their claims of being in the school, or becoming sick in the school, or how their heath and well-being changed as a result of the schools, will be a very meaningful and useful development during this major truth telling event.

Discovering that they or their relatives and community members were healthy as children and that it was within the Residential schools that they became sick may provide answers to questions about why First Nations people experience such high rates of poor health. Research into Residential school documents is being done by the Government of Canada, yet there are very few available details on the specifics of the type and methods for this research. In order to verify a claimant's attendance at a Residential school, the Resolutions Sector performs a search for confirmation of attendance. The National Residential School Survivors Society notes on their website that the government has a computer assisted search system as well as a system for manual searches for documents. They also note that an advisory review panel which includes survivors and other

Aboriginal representatives is involved in the process of validating claimant attendance in Residential school (NRSSS).

The government states that it has collected extensive records for all Residential schools included in the list of schools recognized in the Settlement Agreement. However, they note that records may be incomplete due to reasons including "the destruction of schools by fire, archival issues and record keeping policy" (INACa). They note that they are continuing to build the collection of documents. They state, "IRS records were held by various organizations. We continue to work with various parties who may still have records in their possession including provincial and territorial governments, church entities, First Nations, and Band Councils in order to locate and obtain IRS records to ensure that all existing residential school records are included in our database" (INACa). They note that they have been in contact with churches and other organizations and that all parties are willing to assist in building the most complete set of Residential school records possible. As a result "Many new sources of documents have been identified and added to the collection of records" (INACa).

Therefore, although it seems that there are people working on creating a complete database of Residential school records as possible, it does not appear that there is an opportunity for survivors or their families to easily access these documents. Some may be available in various archives across Canada; however others may be going directly into the possession of the Government of Canada without first being made publically available. This signals the need for the creation of a position, whose job it would be to retrieve and send out copies of documents requested by former students and/or their families. Types of documents could include Admission/Discharge forms, Application for

Admission forms, Physical Examination forms, Reports of Deaths, etc. With such a system, if the person who requests the documents cannot visit the archives directly due to geographic location or other type of barrier, they could be provided with copies by mail, email, or fax. Many people do not even know that these types of documents exist and that copies can be obtained. It is time that First Nations people are notified of the existence and availability of these important pieces of their life history.

The creation of links between Residential school experiences and the health problems faced by so many First Nations people as adults is one of the main purposes for this type of research project. Documenting the health of the children upon their admission to the school is just the first step in the process. A further possibility for the usage of the information contained in the Residential school documents is to utilize the treaty numbers listed on the Application for Admission forms to create linkages to other health databases such as cancer or diabetes registries. Through this type of connection, links can begin to be made between Residential school attendance and later health outcomes by tracing the health of individuals after they were discharged from Residential schools. Using such linkages, it will become apparent whether Residential school survivors have continued to suffer poor health in their adolescence and adult lives, and what types of illnesses or health conditions are common among this population of First Nations people. Taking this further, the health of those who are intergenerationally affected by the legacy of the Residential schools can also be traced in order to better understand how the health and wellbeing of these multiple generations of family members have also been affected.
It would also be interesting to begin to make connections with other types of research projects such as investigation of sanatorium records, cemetery records, hospital records

etc. in order to see what happened to children after they were discharged from the Residential schools. Many children were discharged for reasons other than they had reached the maximum age, yet nothing more was recorded about these children. By examining these other sources, more information on the health and lives in general of these children, as well as children who were discharged at the maximum age, can be located and documented. Many First Nations people question what happened to themselves and family members in the Residential schools as the details have been kept covered for so many years. People have been left with unanswered questions as to why they suffer higher rates of health problems than other non-First Nation Canadians. Others who do understand have begun to tell of their experiences and how their lives have been affected by this colonial system. These stories and memories are very powerful and allow those who have been fortunate to be spared from this tragic legacy to better understand the damage that has been done to the lives and culture of a nation of people. By using the document to show connections between Residential school attendance and later poor health outcomes among adult survivors and their successive generations, more power will be added to the fight for validation of what happened to the children in the schools and the compensation that First Nations people are so entitled.

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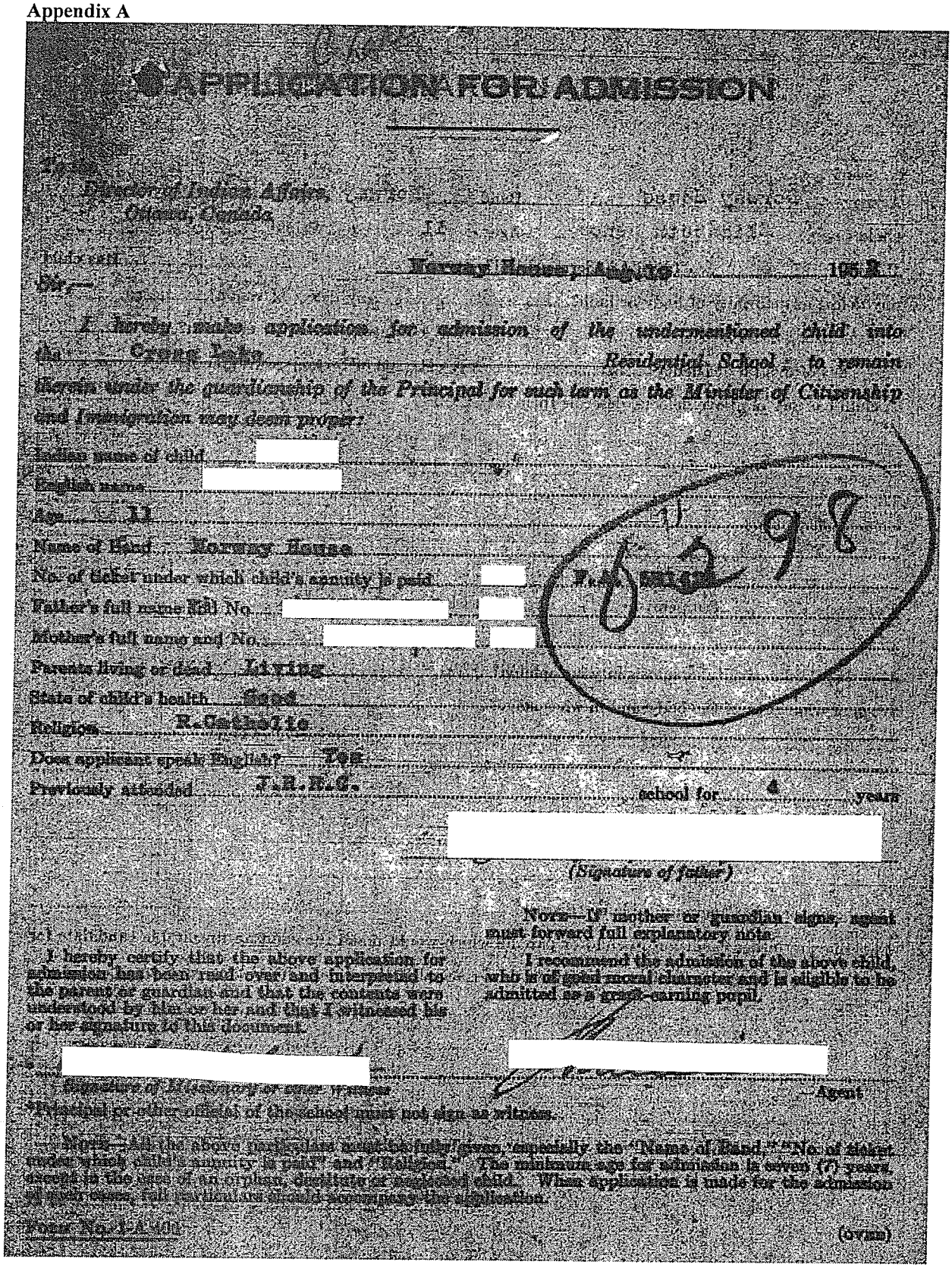
Appendix A



APPLICATION FOR ADMISSION

To
Director of Indian Affairs,
Ottawa, Canada.

Fort Vermilion, Alberta, 19th June, 1935

Sir,—

I hereby make application for admission of the undermentioned child into the Catholic Indian Residential School, to remain therein under the guardianship of the Principal for such term as the Minister of Citizenship and Immigration may deem proper:

Indian name of child [redacted]
English name [redacted]
Age 11
Name of Band Norway House
No. of ticket under which child's annuity is paid [redacted]
Father's full name and No. [redacted]
Mother's full name and No. [redacted]
Parents living or dead Living
State of child's health Good
Religion R.Catholic
Does applicant speak English? Yes
Previously attended I.R.B.S. school for 4 years

[redacted]
(Signature of father)

Note—If mother or guardian signs, agent must forward full explanatory note.

I hereby certify that the above application for admission was read over and interpreted to the parent or guardian and that the contents were understood by him or her and that I witnessed his or her signature to this document.

[redacted]
Signature of Missionary or other witness

I recommend the admission of the above child, who is of good moral character and is eligible to be admitted as a day-earning pupil.

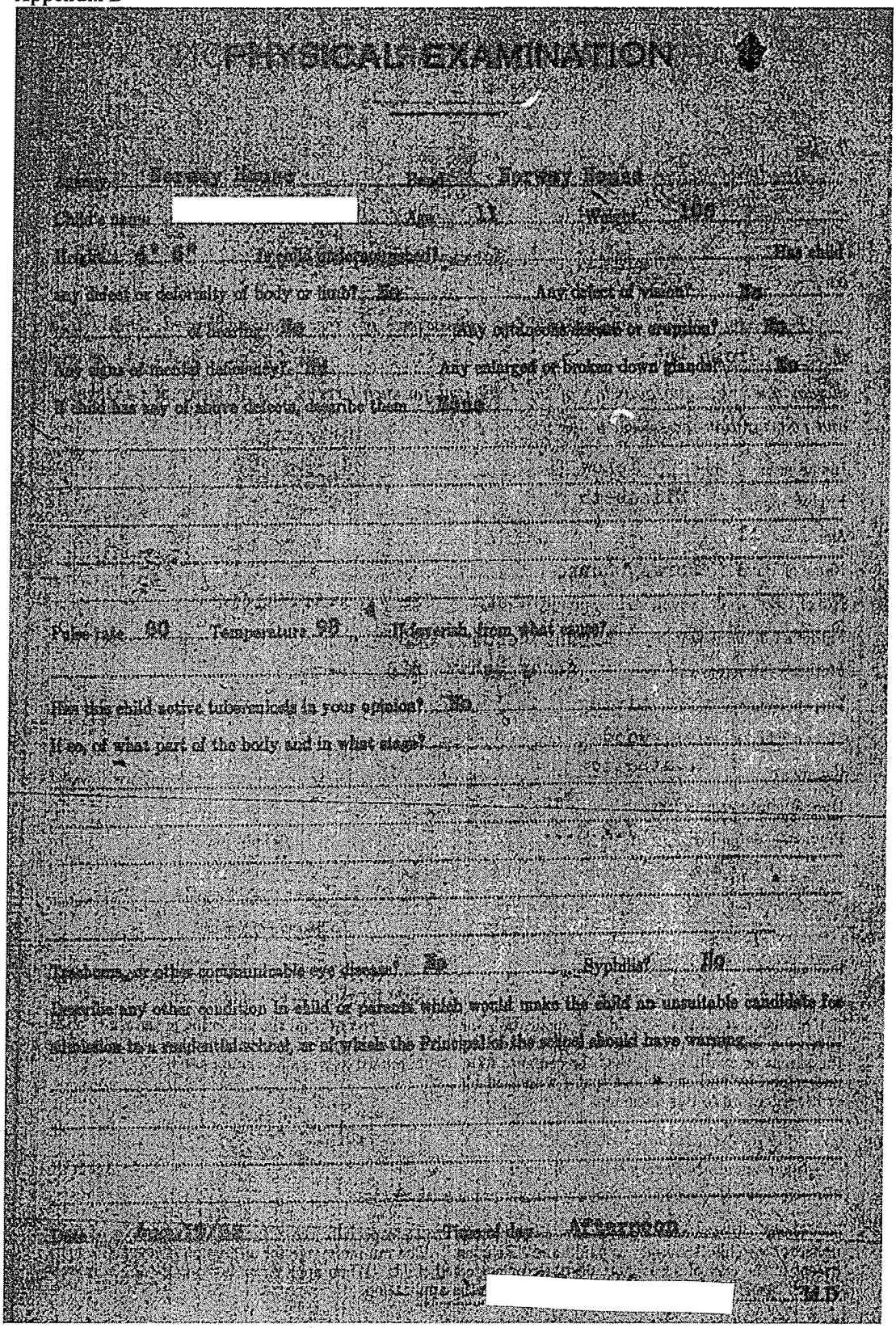
[redacted]
Agent

*Principal or other official of the school must not sign as witness.

Note.—All the above particulars must be fully given, especially the "Name of Band," "No. of ticket under which child's annuity is paid" and "Religion." The minimum age for admission is seven (7) years, except in the case of an orphan, destitute or neglected child. Where application is made for the admission of such cases, full particulars should accompany the application.

Form No. 1-A-(a) (over)

Appendix B



PHYSICAL EXAMINATION

Name [redacted] Boy Height 4' 8" Weight 106

Has child any defect or deformity of body or limb? No Any defect of vision? No

Any defect of hearing? No Any cutaneous disease or eruption? No

Any signs of mental deficiency? No Any enlarged or broken down glands? No

If child has any of above defects, describe them None

Pulse rate 80 Temperature 98 If present, from what cause?

Has this child active tuberculosis in your opinion? No

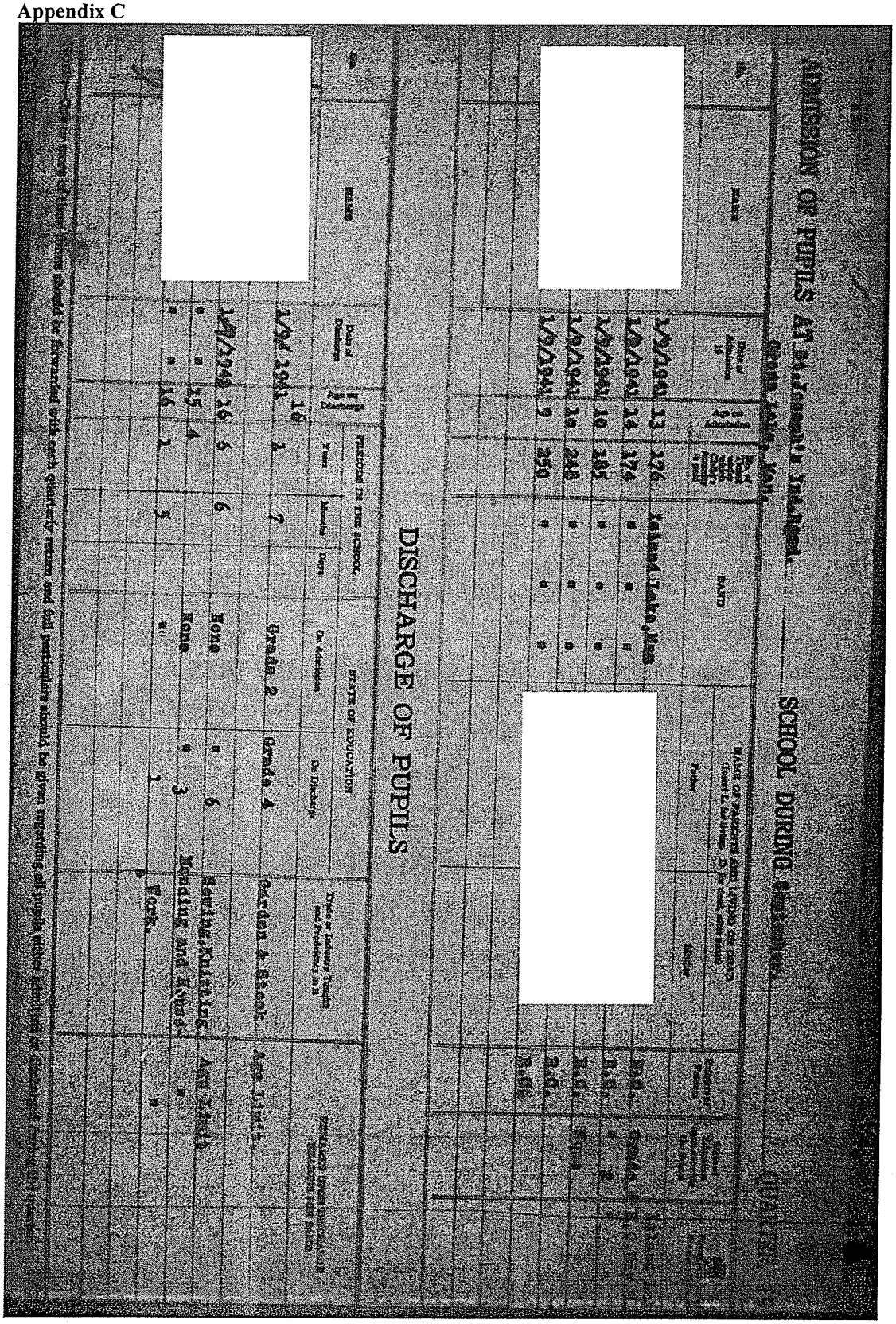
If so, of what part of the body and in what stage?

Trachoma or other communicable eye disease? No Syphilis? No

Describe any other condition in child or parents which would make the child an unsuitable candidate for admission to a residential school, or of which the Principal of the school should have warning

Date [redacted] Signature of doctor [redacted]

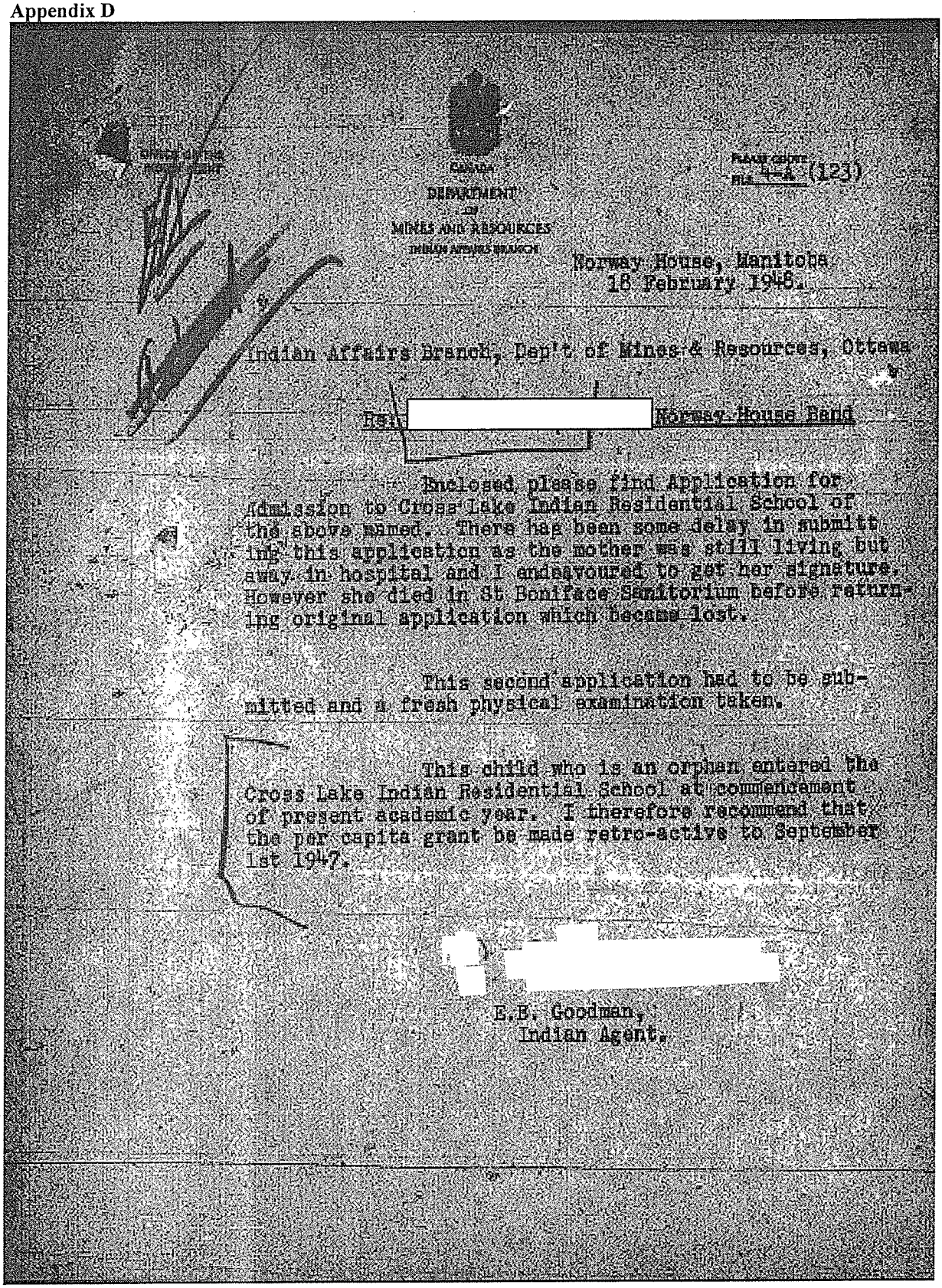
Appendix C



ADMISSION OF PUPILS AT Mazomanie, Wisconsin SCHOOL DURING Quarter

DISCHARGE OF PUPILS

Appendix D



CANADA
DEPARTMENT
OF
MINES AND RESOURCES
INDIAN AFFAIRS BRANCH

FILE No. 4-A (123)

Norway House, Manitoba
18 February 1948.

Indian Affairs Branch, Dep't of Mines & Resources, Ottawa

Re: [redacted] Norway House Band

Enclosed please find Application for admission to Cross Lake Indian Residential School of the above named. There has been some delay in submitting this application as the mother was still living but away in hospital and I endeavoured to get her signature. However she died in St Boniface Sanitorium before returning original application which became lost.

This second application had to be submitted and a fresh physical examination taken.

This child who is an orphan entered the Cross Lake Indian Residential School at commencement of present academic year. I therefore recommend that the per capita grant be made retro-active to September 1st 1947.

[redacted]

E.B. Goodman,
Indian Agent.

Appendix E - Application for Admission	
Fields	Notes on the Fields
1) Blank space for the address	Form is addressed to: Director of Indian Affairs, Ottawa, Canada -this is absent on the early version of the form -a form used in 1933 addressed: To the Deputy Superintendent general of Indian Affairs, Ottawa Canada -there are no names on these forms, just addressed to the title of Director of Indian Affairs, but no address at all on the early version of the form At the top of the form it is written: "I hereby make application for admission of the undermentioned child into the (blank) Residential School; to remain therein under the guardianship of the Principle for such term as the Minister of Citizenship and Immigration may deem proper:"
2) Blank space for a) location where the form was filled out b) date the form was filled out	-the community where the form was filled out -this is absent on the early version of the form -the date when the form was filled out
3) Space to fill in the name of the residential school	-the name of the school to which the application is being made
4) Indian name of child	-this space left blank on many of the application forms while some forms list the same name as the English name and some forms list the last name of the child in this space
5) English name	-first name or given name of the child
6) Age	-age of the child at the time of application -ages range from age 3 to age 14
7) Name of Band	-name of the band that the child has been registered with through the government Cross Lake, God's Lake, Island Lake, Nelson House, Norway House, Oxford House
8) No. of ticket under which child's annuity is paid	-treaty number for each child assigned by the government when registered as a First Nations person.
9) Father's name in full and No.	-the name of the birth father but in some cases the name of a stepfather or other male guardian
10) Mother's name in full and No.	-the name of the birth mother but in some cases the name of a stepmother or other guardian
11) Parent's living or dead	-will usually explain if the mother and/or father of the child are alive or deceased, but does not explain how the parent died if they are deceased
12) State of child's health	-short explanation of the general health of the child, usually in a one-word explanation such as good, fairly good, very good, good health, satisfactory, apparently satisfactory -the form does not indicate who determines the state of health as stated on this form – it could be the Indian Agent as he is the one who filled out the forms

13) Religion	-states the religion of the child, most likely from information about the child's parents/family
14) Does applicant speak English?	-explains the child's ability to speak English or the level or amount of English they can speak -version Form 64 has the question worded as Speaks English or not?
15) Previously attended (blank space for school name) school for (blank space) years	-provides information on other schools the child attended and the amount of formal education they had received prior to their application to the Residential school -sometimes just "day school" is written with no name of the school, could be assumed that it is the day school in the community from which the child comes
16) Blank space for signature of father	-if anyone other than the father of the child signs this space, there must be an explanation provided as to why the father did not sign.
17) Blank space for signature of Missionary or other Witness	-could be signed by anyone other than the school Principal
18) Blank space for signature of Indian Agent	-the Indian Agent who filled out the form
*At the bottom of the form there is a space for the signature of the child's father. Some forms have the father's signature in Cree with someone else having signed the name in English. Under this space it is written: "If mother or guardian signs, agent must forward full explanatory note."	
Above the space for the signature of the Missionary or other witness it is written: "I hereby certify that the above application for admission has been red over and been interpreted to the parent or guardian and that the contents were understood by him or her and that I witnessed his or her signature to this document." Below this space is written: "Principle or other official of the school must not sign as witness."	
Above the space for the signature of the Indian Agent it is written: "I recommend the admission of the above child, who is of good moral character and is eligible to be admitted as a grant-earning pupil."	
At the bottom of the application it is written: "Note- All the above particulars must be fully given, especially the "Name of Band," "No. of ticket under which child's annuity is paid" and "Religion". The minimum age for admission is seven (7) years, except in the case of an orphan, destitute or neglected child. When application is made for the admission of such a case, full particulars should accompany the application."	
Form has the number: Early forms: Form 61 Form No. 21 Form 64 Later Form No. 1-A 406	
*There is a space labeled Moral Character which appears on the early version of the form which does not	

appear on the later version of the form. -is absent from the application used in May 1933 - Form No. 21
*Form 64 also has the heading Present State of Education -this heading does not appear on the previous or later versions of the form

Appendix F - Certificate of Health (early)	
Fields	Notes on the Fields
1) Annuity ticket, Name and Number and Band of Parent or Guardian	treaty number, name, and band of parent or guardian to child
2) Candidate's Name	-first and last name of child
3) Age	-age of child at time of health examination
4) Height	-height of child at time of health examination
5) Weight	-weight of child at time of health examination
6) State defects of limb, if any?	-description of any problems with the child's limbs
7) State defects of eyesight, if any?	-description of any problems with eyes or eyesight
8) State defects of hearing, if any?	-description of any problems of the ears or hearing
9) State signs of scrofula or other forms of tubercular disease, if any?	-description of any problems relating to tuberculosis infection
10) Describe what cutaneous disease, if any?	-description of any problems with the skin
11) State whether subject to fits	-could possible mean seizures -no description of what is considered subject to fits, what a fit may be or how many
12) State whether child has had smallpox	-any history of smallpox infection
13) State whether vaccinated, and if so, in what year	-can assume that this means vaccinated for smallpox
14) Is this candidate generally of sound and health constitution and fitted to enter an Indian school?	-whether the child is generally healthy overall -no explanation of what is considered generally sound of health and constitution, or also what is considered fitted to enter an Indian school
15) There is a space for the doctor's signature _____M.D.	-signature of the doctor who performed the examination
* At the bottom of this form it is written: "I certify that I have made a personal examination of the above named applicant and that the answers set down by me are correct"	
*At the bottom of the form it is written "N.B.- No child suffering from scrofula or any form of tubercular disease is to be admitted to school; if in any special case it is thought that this rule should be relaxed, a report should be made to the Department setting forth the facts"	

Appendix G - Health Examination (later)	
Fields	Notes on Fields
1) Agency	-name of agency which oversees the band to which the child belongs
2) Band	-the band to which the child belongs
3) Child's Name	-the name of the child, usually contains the first and last name of the child
4) Age	-the age of the child at the time of application to the school
5) Weight	-the weight of the child at the time of application to the school, usually in pounds
6) Height	-the height of the child at the time of application to the school, inches or feet
7) Is child undernourished?	-opinion of the person conducting the health examination -yes or no answer
8) Has child any defect or deformity of body or limb?	-description of any physical effect on the body of the child
9) Any defect of vision?	-description of any problem with the child's eyes/vision
10) of hearing?	-description of any problem with the child's ears/hearing
11) Any cutaneous disease or eruption?	-description of any problem with the child's skin
12) Any sign of mental deficiency?	-description of any leaning disabilities or mental health issues of the child
13) Any enlarged or broken down glands?	-description of any problem of the child's glands -could be used to assess whether the child has tuberculosis as there are often related problems of the lymph glands
14) If child has any of above defects, describe them	-a larger space on the health examination form for the doctor to describe any health problems of the child that were described in the previous spaces on the form
15) Pulse rate	-the pulse rate of the child at the time of the health examination -could be used to assess the overall health of the child at the time
16) Temperature	-the temperature of the child at the time of the

	health examination -could be used to assess general health of the child as in whether the child had a fever and therefore a bacterial infection or virus at that time
17) If feverish, from what cause?	-more detailed description of health if child was found to have a fever -form does not provide a space to explain how the health examiner comes to a diagnosis of the health condition of the child
18) Has this child active tuberculosis in your opinion?	-a direct question about Tuberculosis -yes or no answer -an opinion of the health examiner, does not ask for test results or other diagnostic results
19) If so, of what part of the body and in what stage?	-description of how tuberculosis is affecting the child
20) Trachoma or other communicable eye disease?	-yes or no answer -no explanation of the diagnosis
21) Syphilis?	-yes or no answer
22) Describe any other condition in child or parents which would make the child an unsuitable candidate for admission to a residential school, or of which the Principle of the school should have warning	-a larger space for the health examiner to explain in greater detail any health issue of the child
23) Date	-date of the health examination
24) Time of Day 25) (Space for the signature of the doctor) _____M.D.	-time of day of the health examination -signature of the doctor who performed the health examination on the child -could also be just the signature of the doctor while someone else performed the actual health examination

Appendix H - Admission/Discharge Form	
Fields	Notes on Fields
Admission of Pupils	
(blank space for name of school) during (blank space for month) Quarter 19_	-name of the school -date, the quarter of the school year for which the report has been made
1) No.	-number assigned to the student by the school
2) Name	-name of student being admitted
3) Date of Admission	-date that the student began attending the school
4) Age on Admission	-age of the student at the time of admission
5) No if Ticket under which child's annuity is paid	-treaty number for the student assigned by the government when registered as First Nations person
6) Band	-name of the band that the student has been registered with through the government
7) Name of Parents and Living or Dead (L for living D for dead after names) Father/ Mother	-name of the students parents and whether they are living or dead -no explanation if they are listed as dead
8) Religion of Parents	-religious affiliation of the parents
9) State of Education upon entering the school	-the level of education that the student had prior to being admitted to the Residential school
Discharge of Pupils	
1) No.	-number assigned to the student by the school
2) Name	-name of the student being discharged from the school
3) Date of Discharge	-date that the student was discharged from the school
4) Age on Discharge	-age of the student at the time of discharge
5) Period in the school (Years/ Months/ Days)	-length of time for which the child was a student at the school
6) State of Education On Admission/ On Discharge	-student's level of education at admission to the school and at discharge from the school
7) Trade or Industry Taught and Proficiency to be 8) Remarks upon Discharge/ Reasons for Same	-skills that the student learned at the school -reason why the student was discharged from the school
9) Signature	-signature of the Principal of the school
*At the bottom of the page it is written: Note- One or more of these forms should be forwarded with each quarterly return and full particulars should be given regarding all pupils either admitted or discharged during the quarter.	