

HEALTH CONDITIONS AT NORWAY HOUSE RESIDENTIAL
SCHOOL

HEALTH CONDITIONS AT NORWAY HOUSE
RESIDENTIAL SCHOOL, 1900 – 1946

By
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Abstract

The Norway House Residential School (NHRS), operated by the Methodist Church from 1900 to 1946, was located in Norway House, Manitoba. Like other Native Residential Schools at the time, the students suffered from poor health and a high mortality rate. Tuberculosis was the most common illness, although outbreaks of other infectious diseases, such as the common cold, influenza, and childhood diseases, occurred within the school. Health problems among the children can be linked to the numerous deficiencies of the Residential School system such as under funding, overcrowding, poor nutrition, little to no medical facilities, and poorly built and maintained buildings. The school environment was conducive to the spread of infectious diseases and increased the children's susceptibility to illness. However, the poor health of the children in the residential school can not be separated from the health conditions found in the children's home communities. The students of NHRS were not completely isolated from the residents of Norway House. They attended classes with the day school students and weekly church services. Thus infectious diseases circulating in the community and surrounding communities could easily spread to and from the school. Additionally, tuberculosis and the associated living conditions were a widespread problem in the home communities. Children were often exposed to the disease at home prior to enrolment at the school which lead to high rates within NHRS as well.

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Chapter 1: Introduction

The Native Residential School System in Canada operated from 1879 until the late 1970s. During that time, its sole purpose was to assimilate Native peoples into 'white' Canadian society. Along with problems of abuse (physical, emotional, and sexual), the poor quality of education, heavy work loads, and poor living conditions, the children also suffered from high morbidity and mortality rates. The health problems of the children have been linked to the numerous deficiencies of the schools such as overcrowding, poor ventilation, poor nutrition, the heavy work load of the students, little to no medical facilities, and chronic under funding (Bryce 1907; Kelm 1998; Lux 2001; Miller 1996; Milloy 1999). Tuberculosis, the chief cause of illness, and outbreaks of other infectious diseases easily spread within the schools due to the overcrowded conditions.

The best known report on the health of the children within residential schools is Dr Peter H Bryce's 1907 health report (Bryce 1907). Dr Bryce, the Chief Medical Officer of the Department of Indian Affairs (DIA), had been instructed by the department to conduct a medical inspection of the schools in the prairies (Sproule-Jones 1996). He inspected a total of 35 schools in Manitoba, Saskatchewan and Alberta and summarized the results from 15 boarding schools and 8 larger industrial schools¹. He found that an average of

¹ The boarding schools included in Bryce's 1907 report are Birtle, File Hills, Emmanuel College, Blood (Church of England), Peigan (Church of England), Sarcee, Onion Lake (Church of England), Blackfoot, Blood (Roman Catholic), Peigan (Roman Catholic), Ermine Skin, St Albert Orphanage, Onion Lake (Roman Catholic), Muscowequan, and Keeseekoose. The industrial schools include Brandon, Elkhorm, Qu'Appelle, Regina, Battleford, High River, Calgary, and Red Deer (Bryce 1907: 18, 20-21).

25% of all former students from the schools were known to be dead, with TB as the main cause of death. In File Hills Boarding School, which had the most complete records, the death rate was as high as 70%² (Bryce 1907, Bryce 1922). Bryce specifically blamed “the absence of a coherent federal health policy and standards for the schools, the inadequacy of government funding, the lack of medical knowledge and basic training among school officials, and the scarcity of physical exercises programs for native students” (Sproule-Jones 1996:211). Two years later, Bryce conducted another medical inspection of 243 Native school children with Dr James D Lafferty, also employed by the DIA. Similar results to the 1907 report were found. In Dr Bryce’s 1909 report, he estimated that the annual death rate of students in the residential school was roughly 80 per 1,000, again with TB as the main cause (Bryce 1909). However, it is hard to determine the exact number of children who died or suffered from poor health during their stay in the schools due to poor record keeping.

It is impossible to separate the poor health of the children within the schools from the health conditions on the reserves. Clearly the conditions within the schools contributed to the poor health of the children but similar conditions (i.e. overcrowded living quarters, poor sanitation, poor diet, inadequate clothing) and diseases, particularly tuberculosis, were found on both the reserves and in the schools (Lux 2001: 107). The children in the residential schools would not

² Bryce’s 1907 report and 1922 publication give different percentages for the number of former File Hills students known to be dead. In Bryce’s 1907 report, the percentages is reported as 69%; in the 1922 publication is it reported as 75% (Bryce 1907: 18; 1922: 4)

have been isolated from the health conditions on the reserves. Infectious diseases, both acute and chronic, could spread from the reserves to the schools when the children entered the school for the first time or returned from holidays. Diseases could also spread from the schools back to the reserves if a child were sent home on sick leave, which often occurred when a child was too sick to be cared for at the school (Kelm 1998: 68). In addition, some of the residential schools were located near or on a reserve which would have allowed for regular contact between members of the community and the school. This would have facilitated the spread of an outbreak between the school or the community. The Norway House Residential School serves as a prime example of this type of interaction and is the focus of this study.

The Norway House Residential School (NHRS), located in Norway House, Manitoba (Figure 1.1), was operated by the Methodist Church from 1900 until 1946. The school primarily enrolled children from the Norway House Agency which included Norway House and the surrounding communities of Cross Lake, God's Lake, Oxford House, and Island Lake. Occasionally children from more distant communities, such as Berens River, were enrolled (refer to Figure 4.2 for location of communities). The school was technically located in Rossville, the Methodist mission, which was a short distance from Norway House. The school had two features that allowed for regular contact with the residents of Norway House. The boarding school students regularly attended classes with the Rossville day school students; this was due in part to lack of classroom space in

the residential school and to the scarcity of teachers. Also, since the school was a religious affiliate, the children attended weekly church services at the Methodist church. Consequently, its presence would have created a social network by which infectious diseases could spread between the school and Norway House, as well as to the other communities from which the children came.

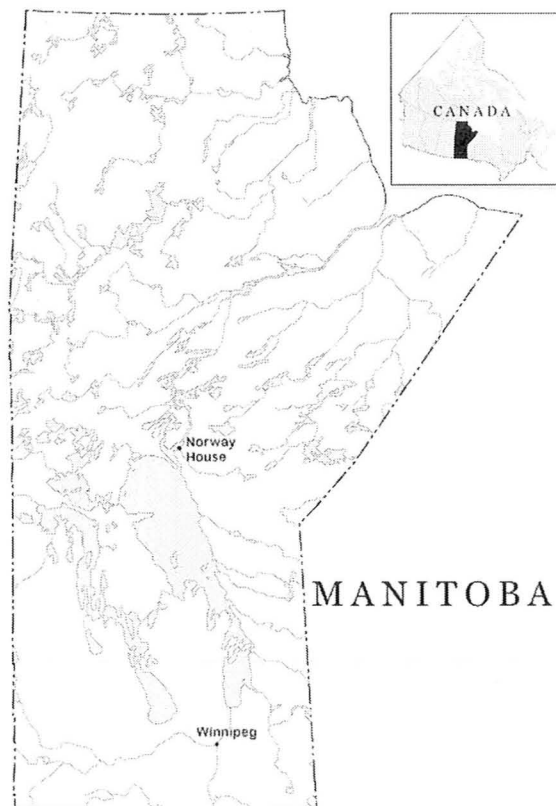


Figure 1.1: Map of Manitoba showing Norway House in relation to Winnipeg.

The purpose of this study is to develop a health history of the children attending NHRS. It specifically examines: 1) the general health of the children attending the Norway House Residential School from its opening in 1900 until it closed in 1946 due to a fire, 2) the living conditions of the school and their impact

on the children's health, and 3) the relationship between health conditions in the home communities of the children and those at the school.

Chapter 2 lays out the theoretical frameworks used to understand and describe the interaction between the children's health and the school environment experienced at NHRS. These include a biocultural perspective and a consideration of the effects of institutionalization on children's health and on the spread of diseases. As part of the biocultural perspective, I also discuss of the impact that colonization and a changing economy had on the health of the residents in the Norway House Agency during the first half of the 20th century. One of the main arguments of this study is that the health problems within the residential schools are linked to the health problems found in the communities.

Several different sources of archival material were consulted and used to examine the health and living conditions at the Norway House Residential School. These include official documents pertaining to the school from the Department of Indian Affairs (DIA) and from church officials in the National Archives of Canada (NAC) RG 10 School Files and the published *DIA Annual Reports*, which are available on-line. The unpublished memoirs of Reverends JA Lousley (1948) and Roscoe Chapin (1972), both former principals of the school, were also consulted. The Hudson's Bay Company post journals for the communities and parish records, specifically the burial records (ACCA, God's Lake Burial Records, 1900-1940; Norway House Burial Records, 1902-1937; UCCA, Oxford House Burial Records, 1918-1951) were also examined.

Together, these are useful for determining the health conditions of the communities and for finding links between the communities and the school.

Chapter 3 of the thesis discusses the details of the materials used in the study as well as the methods used to sketch the health profile of the NHRS pupils from 1900 to 1946.

Chapter 4 discusses the history of the Norway House Residential School. The chapter begins with a brief discussion of the Native Residential School System, its purpose, administration, and funding. This is followed by the history of the Norway House Residential School, the demographic profile of the children attending the school and the physical conditions of the school in comparison to what is known about other residential schools.

Chapter 5 examines the health conditions of the Norway House Residential School. It charts all the available information on outbreaks of acute infectious diseases, evaluates the impact of tuberculosis, estimates mortality rates, and considers the health of children when admitted and discharged from the school. Possible links between outbreaks of infectious diseases in the school and in the communities are examined as well.

This research contributes to studies of the health impact of the colonization process and policies on Aboriginal peoples in Canada as exemplified by the Residential School system. This in-depth case study of the Norway House Residential School explores the health conditions within the school and the relationship between infectious diseases in the school and those

in the home communities of the children. The major health issues and the living conditions of the Norway House Residential School were similar to those found in other residential schools.

Chapter 2: Biocultural Approach to Residential School Health and Disease Transmission

Introduction

This research project combines several approaches for understanding and describing the interaction between health and the residential school experience at Norway House. The first problem involves assessing the impact of the school environment on the health of the children. Like many other institutions, the residential school had several characteristics, such as close contact between a large number of individuals within a closed environment, that facilitate the spread of infectious diseases. However, this alone is not sufficient to explain the health patterns seen within the Native Residential School setting. There are other factors specific to the residential school experience that must be taken into account. This makes a biocultural approach pertinent to this study. A biocultural approach examines human biology within the “broader historical, political-economic, ideological and sociocultural contexts” (Goodman and Leatherman 1998:5). The health of the children must be understood within the context of the Native Residential School system as well as the broader colonization processes that were operating at the time, and historically.

This project focuses on a specific part of the colonization process: the Native Residential School system and the impact that the school experience had on the health of the children. However, other aspects of colonization such as the formation of reserves and the changed lifestyle and economy of Aboriginal

groups had a large impact on the health of Aboriginal people (Bryce 1907; Kelm 1998; Lux 2001; Maundrell 1941; Stone 1925; Waldram et al 1995). Such consequences need to be considered in relation to the residential school experience and its influence on the children's health. This is an important aspect of the project in that to understand the health within the residential school one can not look only at the school. The health histories of the communities themselves must also be examined. The high prevalence of tuberculosis in both the communities and the school is an excellent example of a health consequence of the colonization process. This will be discussed in more detail later in this chapter.

Finally, the spread of infectious diseases between the Norway House Residential School and the home communities of the children must also be considered. Outbreaks of infectious diseases that are present in the children's home communities have the potential to spread to the school and vice versa.

Health within an Institution

Institutions in which a large number of people are gathered within a closed environment are prime places for the spread of many infectious diseases, particularly ones that are spread through airborne transmission (Musher 2003; Stead 1996). This is due to the close contact, typically for an extended period of time, between susceptible individuals and at least one infectious individual. The size of the room and poor ventilation can increase the risk of infection (Musher

2003; Stead 1996). For instance, the risk of infection from tuberculosis or influenza is very high in rooms with restricted airflow due to the pathogens ability to remain in the air for extended periods of time (Musher 2003). Conditions that nurture infectious disease outbreaks have been seen and reported in institutions such as hospitals, nursing homes, prisons, homeless shelters, military barracks, day care centers, schools (both day and boarding) and dormitories (Bates et al 1965; Farmer 2003; Klein 1986; Musher 2003; Page 1882; Rushdy et al 1995; Stead 1996).

The Native Residential School at Norway House would obviously fall within this category. The children were in close contact with one another for the nine month period of the school year (September to June). Over-crowding and poor ventilation within the residential schools were commonly reported problems that were directly related to the spread of diseases within them (Bryce 1907: 17). Commonly reported diseases within the schools included colds, influenza, chickenpox, diphtheria, measles, mumps, rubella or German measles, scarlet fever, whooping cough, trachoma, tuberculosis, scabies, and lice (Keller 2002; Kelm 1998:67; Miller 1996: 304-305). Crowded, closed environments and household transmission are known to be the most common risk factors for transmission of the majority of these diseases (Dale 2005; Dambro and Griffith 2005; Musher 2003; Rudolph et al 2003).

Biocultural perspective on the Native Residential School setting

As previously stated, additional factors must be taken into account when examining the health profile of the children at NHRS which makes a biocultural perspective relevant to this study. A biocultural approach studies human biology within the context of the broader historical, political-economic and sociocultural processes that shape the local situation (Goodman and Leatherman 1998). It is not adequate solely to examine biology; one must understand the underlying socio-political factors that shape the biological consequences that are observed. In the case of the Native Residential School, it is necessary to understand the administration and funding of the system which in turn influenced the living conditions of the schools (Lux 2001: 109).

The funding system of the residential schools, which was inadequate and based on numbers of pupils in attendance, has been linked to numerous factors such as the overcrowding of the schools, admission of sick children, a diet that consisted of food that was cheap and nutrient poor, excessive work load of the children and the poor conditions of the buildings. These conditions in turn compromised the pupils' health (Lux 2001: 109). A more detailed discussion of funding as well as administration of the NHRS will be discussed in Chapter 4.

The admission of children with tubercular infections had a large influence on the health conditions seen in the school. According to DIA regulations, the admission of children with TB was prohibited; however, this was generally ignored by school officials. They were often more concerned about keeping the enrolment high in order to obtain the full grant amount. Infectious individuals

combined with crowded conditions facilitated the spread of tuberculosis within the school. Other factors in the school, such as an inadequate diet or other infectious diseases that spread easily, would have further compromised the health of tubercular children.

The diet in most Native Residential Schools was considered sub-par and contributed to the children's susceptibility to disease, particularly tuberculosis (Miller 1996). The food was usually of poor quality, inadequate quantity, and lacked the variety needed to provide all the necessary nutrients. It was not uncommon for doctors to report to the DIA on the relationship that they observed between the poor diet in the schools and tuberculosis (RCAP 1996). In fact, malnutrition is an important risk factor for activating a TB infection (Cegielski and McMurray 2004). The synergistic relationship between poor nutrition, lowered immunity, and infection is well established. Nutritional deficiencies are known to impair the immune system which is needed to control an infection. In fact, a deficiency of a single nutrient is known to have some effect on the immune response (Chandra 2002: S73). Cell-mediated immunity, which is severely impaired by malnutrition, is the main host defence against TB (Cegielski and McMurray 2004). However, the relative risk of TB due to specific protein-energy and micronutrient malnutrition is not entirely clear (Cegielski and McMurray 2004: 295). The TB infection, in turn, can further contribute to malnutrition, which makes it difficult to determine the exact causal relationship between malnutrition

and the increased risk of TB (e.g. Cegielski and McMurray 2004; Chandra 1972; 1988; Shell-Duncan 1997).

Infections from other diseases that were present in the school can also increase the chance of activating a latent TB infection. Infections can also have a negative impact on the immune system. Death from tuberculosis after contracting another disease was known to have occurred at residential schools (Kelm 1998: 67, 75). Data from the Norway House Residential School suggests similar occurrence. This will be discussed in more detail in Chapters 5 and 6.

Colonization and Aboriginal Health

As part of the biocultural approach, the broader impact that European colonization had on Aboriginal health should be considered as well. Several researchers have examined the impact of the colonization process on Aboriginal health (i.e. Kelm 1998; Lux 2001; Maundrall 1941; Waldram et al 1995). European contact is associated with the introduction of numerous infectious diseases that caused high morbidity and mortality rates among Aboriginal peoples as well as extensive social, political, and economic changes to Aboriginal life (Waldram et al 1995: 43). The extent of the depopulation caused by the introduced disease is a widely debated issue (for example see Dobyns 1966, 1983; Thornton 1987) and is beyond the scope of this project.

In central Canada, where the Hudson's Bay and Northwest Companies established fur trading posts, trade routes became a common means for

diseases to spread among Aboriginal populations (Waldram et al 1995: 56).

Epidemics often followed the trade routes with the major trading centers acting as the central point of dissemination. Additionally, the fur trade led to major changes in the Aboriginal economy and settlement patterns. It was common for Aboriginal groups to settle close to the trade centers which provided the high population density needed for diseases to spread quickly from person to person (Waldram et al 1995: 55-56). This was the common disease pattern seen in Central Canada during the fur trade.

York Factory and Norway House are examples of fur trading posts that became centers for the spread of infectious diseases within their region. York Factory, located on the mouth of the Hayes River on Hudson Bay, was the main port of entry in Western Canada. Norway House was closely linked to York Factory due to its key location. All trade goods travelling between York Factory and Lake Winnipeg and beyond passed through Norway House (Ray 1974). Due to continual contact with a wide region, Norway House and York Factory experienced frequent outbreaks, "more than other, less central posts" (Waldram et al 1995: 58).

By the end of the 19th century, tuberculosis had become the major health problem among Aboriginal populations and continued to be so well into the 20th century. Mortality rates among Aboriginal populations from tuberculosis were ten to twenty times greater than the general population (Waldram et al 1995: 61). The high incidence rate of tuberculosis has been linked to the relocation of

Aboriginal populations on reserves, the poor living conditions, and loss of traditional subsistence methods.

Tuberculosis was prevalent in the Norway House region by the late 1800's. According to an 1887 report from Indian Agent MacKay, tuberculosis was a common infection at Norway House (Maundrell 1941). The health problem was exacerbated by the declining economy and resulting poverty. By the last half of the nineteenth century, the fur trade, the main economy of the study region, was in decline. The development of the railroad re-oriented the main direction of the flow of trade goods south toward Red River instead of north toward Hudson Bay. The shipment of trade goods through Norway House began to decrease as York Factory lost its importance as a trading post (Maundrell 1941; Stone 1925). Additionally, the introduction of the steam boats on Lake Winnipeg in the 1870s decreased the need for trippers to move goods, which had been an alternative job to trapping the already depleted game in the region. As a result, many families from Norway House moved south to Fisher River in 1876 for access to better fishing and farming resources (Donaldson and Abel 1985).

Many of the families that remained at Norway House still relied on the fur trade. However, with the greatly depleted game, trappers were forced to travel further out to manage adequate amounts of game but this increased the initial expenses needed for travel. There were few individuals who had the financial means to do so, which left many families living in poverty (Stone 1925). Reports of scarcity and hunger also become very common during this period (Waldram et

al 1995: 61). This situation was made worse when the head of the household was sick, typically with tuberculosis, and was unable to work (Stone 1925).

Tuberculosis continued to be problematic in the area well into the 20th century. In Dr EL Stone's 1925 report on the health in the Norway House Agency, he stated that "disease here means one malady, and one only, for all practical purposes. That is tuberculosis. Practically nobody dies of anything else" (Stone 1925:246).

Disease Transmission between Residential Schools and Communities

It has been suggested that the Native Residential Schools acted as a focal point for the spread of diseases to the reserves when the children went home either on holiday break or when they were sent home on sick leave, as well as for the spread of diseases from the reserves to schools (Kelm 1998). Kelm (1998:68) specifically refers to outbreaks of typhoid, measles, diphtheria, whooping cough, and influenza within British Columbia's residential schools that spread from the reserves to the schools when the children returned to the schools from their homes. Tuberculosis was another disease believed to have entered the residential schools in this manner. Children who were infected with the disease were enrolled into the schools despite policies that barred their admission (Kelm 1998: 68).

Schools in general have long been recognized as potential centers for the spread of infection (Page 1882). Klein's (1986: 523) study of day care centers briefly illustrates how infections can spread from schools back to the families and

to the larger community. Each child or adult in the day care center, or school, can be a potential source of infection. They bring the infection to the school where it is transmitted to the other children, who in turn take the infection back home. Diseases that are transmitted from person-to-person by airborne transmission, fecal-oral or direct contact have the potential to spread in this manner (Klein 1986).

For example, tuberculosis is one of the many diseases that has been known to spread in a community through a school. One study which examined community-based outbreaks of tuberculosis over a thirty year period found that schools were the most common site for the dissemination of the disease (Raffalli et al 1996). Contributing factors to the initial spread of TB within the schools included sustained contact, inadequate ventilation and overcrowding (Raffalli et al 1996). In addition to tuberculosis, schools have often been reported as the site of dissemination for various other infectious diseases such as chickenpox, influenza, measles, mumps, scarlet fever, and whooping cough (Danis et al 2004; Donaghy et al 2006; Feeney et al 2005; Ma and Fontaine 2006; Siedler et al 2006). Even though these studies examined day schools, in which the children went home every day, the same principals can be applied to Norway House Residential School.

There are several important features of the Norway House Residential School that are important in this regard. The school was located on the Norway House reserve and the children were not isolated from the residents. Children

from both the Rossville day school and NHRS attended classes together during the week and on Sundays, the children attended church services at the Methodist Church. Thus, there was regular contact between Norway House residents and NHRS students. This increased the chances of infectious outbreaks within the school spreading to the community and vice versa. In addition, it would have also been possible for children to bring an illness from their home communities when returning from holiday. By studying the Norway House Residential School in depth, I hope to determine to what extent infectious diseases spread back and forth between the school and the communities in which the children resided.

Conclusions

In summary, in order to fully understand the health of the children attending the Norway House Residential School, there are several aspects must be explored: 1) the conditions within the school, 2) their impact on the children's health, 3) the health conditions in the children's home communities, and 4) the relationship between the health conditions in the communities and the school. Conditions existing in the school would facilitate the spread of diseases and also affect the susceptibility of the children to those diseases. The health conditions in the communities are also important since the children's health would be affected by the health of their families. The children were not completely isolated from outside contact once they entered the school. Diseases circulating in any

given community had the potential to spread to the school and vice versa. This would include both chronic infections such as tuberculosis as well as outbreaks of acute infections.

Chapter 3: Materials and Methods

Materials

Archival material has been used by various anthropologists to recover the health of historical populations (cf. Herring and Swedlund 2003). Often times the materials used were written and collected for very different purposes than for the analytic purposes of researchers, but they still provide valuable information on past populations. For this study, there were several main questions addressed when consulting the archival material. First, what was the general health pattern of the children attending the Norway House Residential School from 1900 to 1946? Second, what were the living conditions within the school and what impact would they have on the children's health? And lastly, what was the relationship between health conditions in the home communities of the children and those at the school?

To answer these questions, several different sources of archival material were consulted and used to reconstruct the children's health and the conditions at Norway House Residential School. The bulk of the material came from official documents of the DIA and church officials in the RG 10 School Files and the *DIA Annual Reports*; memoirs from Reverends JA Lousley (1948) and R Chapin (1972), both former principals; Hudson's Bay Company post journals; and, to a lesser extent, the parish records, specifically the burial records for the communities whose children attended NHRS (ACCA, God's Lake Burial Records,

1900-1940; Norway House Burial Records, 1902-1937; UCCA, Oxford House Burial Records, 1918-1951). The most important primary documents consulted for this project will be discussed, followed by an assessment of the potential biases within them.

National Archives of Canada RG 10 School Files

The NAC RG 10 School Files are a collection of Native Residential School administration documents compiled from the founding of the school system in 1879 until 1953. Documents in this collection are organized by individual schools and by headquarters. Consequently, there are DIA documents that pertain to the entire school system and others kept by individual churches that pertain to the schools under their authority. For this study, the files pertaining to the Norway House Residential School were consulted for the study period (1900-1946). These files consisted of correspondences between officials at the DIA and Methodist Church, admission and discharge records for 1933 to 1941 only, and various records pertaining to the maintenance and management of the school, such as account records and inventories (NAC 1898-1946).

The admission and discharge records are of special interest; unfortunately they are only available for a very limited period of eight years from 1933 to 1941. They include the admission form and health evaluation required for each child admitted during that period and the quarterly returns which listed, again, the children admitted to school and those discharged. For the children discharged,

information is provided on their age, amount of time enrolled in the school, and reason for discharge. In some cases, children were discharged due to health reasons or because of their death (NAC, Admissions and Discharges, 1933-1941).

Department of Indian Affairs Annual Reports

The *DIA Annual Reports* (1864 – 1990) are the published annual reports for the department. Only the annual reports for 1899 to 1946 were consulted for this study. The sections of the reports used in this study included the reports of Indian Agents pertaining to the school and to the home communities of the children, the School Principal's Annual Report, and the Statement of Boarding Schools in the Dominion. The Principal's Annual Report summarizes the following information about the school: the location, the land belonging to the school, a description of the school buildings, the total accommodations for students and staff, attendance figures, classroom work, the industries taught to boys and girls, religious training, school gardens, health and sanitation, water supply, fire protection, heating, recreation for the children, and general remarks from the principal. These reports were found to be very informative; however they are only available for 1901 to 1913 (DIA, Hardiman 1901; 1902; Lousley 1903 – 1913). The Statement of Boarding Schools is a table which summarizes information for all the residential schools in Canada. The information listed includes the location of the schools, the affiliated church, the school principal, the

total enrollment, the total number of boys and girls enrolled, and the average attendance for each school (DIA 1902-1906; 1914-1946; DMR 1937-1940). This information was essential for determining the demographic composition of the school.

The Indian Agents' reports for the home communities of the children (Norway House, Cross Lake, Oxford House, God's Lake and Island Lake) were also consulted. Similar to the Principal's Annual Report, the Indian agents reported on various aspects of the communities, including health and sanitation. They provided background information from which I compiled a yearly summary of the health conditions and outbreaks that occurred in each of the communities. Reports for Norway House and Cross Lake are available from 1900 to 1916 (DIA, Calverly 1907-1912; Fleetham 1904; Gilmour 1905-1906; Jackson 1903b-1904; Jones 1916; McColl 1989-1901; Semmens 1903; Short 1900; Stewart 1913-1915). The communities of Oxford House, God's Lake, and Island Lake were added to Treaty No 5 in the summer of 1909 (DIA, Semmens, 1909:114). Prior to their adhesion to Treaty No 5, there are no reports available for these communities in the DIA Annual Report. Reports for these communities appear in the DIA Annual from 1912 until 1916 (DIA, Calverly 1912; Jones 1916; Stewart 1913-1915)

Hudson's Bay Company Archives

The HBC kept daily journals of business transactions and other notable activities at each trading post. Despite the fact that these journals focused on mostly business-related activities, they still provide useful information on the communities where the posts were located. Daily entries include information on the weather, the daily work-related activities, arrivals and departures of people within the post, and most importantly for this project, events such as disease outbreaks occurring at the post and surrounding community. Post journals are available for Norway House (HBCA, Norway House Post Journal, 1904-1929), Cross Lake (HBCA, Cross Lake Post Journal, 1900-1940), Oxford House (HBCA, Oxford House Post Journal, 1900-1941), God's Lake (HBCA, God's Lake Post Journal, 1900-1940), and Island Lake (HBCA, Island Lake Post Journal, 1900-1940) for most of the study period. As the research progressed, the post journal for Norway House was found to be the most useful since this was the community in which the school was located. The journal was used primarily to determine the exact time of year when outbreaks occurred at NHRS and in the Norway House community.

Memoirs from former Principals

Unpublished memoirs were located for two of the school principals, the Reverends JA Lousley (1948) and R Chapin (1972). These memoirs cover their entire lives and missionary work, not just their years as principals of NHRS. Rev Lousley, who was principal for 14 years (1902-1916), provided a more extensive

description of his years as principal than Rev Chapin, who was principal for 7 years (1934-1941). Both of these documents are biased toward the perspective of the Methodist Church and the benefits of their missionary and educational work. However, they do provide a more candid view of the activities in the school than the “official reports” which were submitted to the DIA, especially Rev Lousley’s recollections. For example, Lousley recalls that while many of the staff were “anxious and willing to serve the best interest of the school...[they] were not so well qualified for that type of work” (Lousley 1948: 9). He describes two incidents with staff members that illustrate this claim. One involved the sewing teacher who complained that the machines were “worn out and unusable.” Lousley inspected the machines himself to discover that they only needed to be cleaned and oiled. The teacher did not know that sewing machines needed oiling. Another incident involved the woman in charge of the kitchen. She complained that the stoves and ovens were not working properly. Upon inspection, Lousley found the “front draughts wide open, the feed door at the end of the firebox wide open and the fire box one-third full of ashes, packed hard.” To fix the problem, he “poked the ashes out, cleaned off the top of the oven, put in wood, closed the door and regulated the front draughts.” The ovens worked fine afterwards (Lousley 1948: 7-8).

Parish Records

The Methodist, Anglican and Roman Catholic missions in the communities kept a record of the vital events (births/baptisms, marriages, and deaths). Not all of the community records from the various denominations survived. For instance, only the Anglican parish records are available for Norway House. The parish records for the Methodist Church which operated the Norway House Residential School are not available. The death records, in particular, would have been especially useful for identifying outbreaks.

However, there are several limitations to parish records. Parish records often differ in their completeness and accuracy. The church records, unlike civil registration, were “contingent on the commitment of the parishioners and the diligence of the parish minister” to record vital events (Moffat 1992: 43).

Additionally, parish records would only include individuals who were members of the specific denomination. Given that the Methodist, Anglican, and Roman Catholic churches were active in the various communities pertinent to this study, the records from one church would only include a portion of the entire community. Complicating this issue, not all of the parish records survived. For instance, in Norway House, the Methodist Church, to which the students belonged, did not survive. Thus there is a portion of the community, in which few to no vital events are known.

Despite these limitations, parish records, specifically the death records, are useful for identifying outbreaks though there are problems inherent with this as well. Deaths must have occurred during the given outbreak and the cause of

death must be listed so that it can be attributed to that specific outbreak.

However, the accuracy of the reported cause of death in parish records is often questionable. The clergyman, who had little to no experience in medicine, was responsible for determining and recording the cause of death. Thus, the reported cause of death was sometimes inaccurate or over-represented the causes that the clergyman was more familiar with (Herring and Hoppa 1999).

As research progressed, the parish records were used as 'a last resort' to identify co-occurring outbreaks between the school and the home communities after the previously mentioned sources were exhausted. It was only necessary to use the parish records to identify three co-occurring outbreaks: an outbreak of the common cold and pneumonia in Norway House (ACCA, Norway House Burial Records, 1902-1940), a whooping cough outbreak in Oxford House (UCCA, Oxford House Records, 1918-1951) and a typhoid fever outbreak in God's Lake (ACCA, God's Lake Burial Records, 1900-1940). Yearly deaths and causes tallied by Claire Young³ were examined.

Potential Bias in the Material

With any source, one must be aware of who the author was, who the target audience was and how this would influence what was said or not said. As Axel (2002: 14) states, many archival "documents were generated through complex interactions between different agents of colonialism and colonized

³ Claire Young compiled the death records as part of her undergraduate honors thesis at McMaster University.

subjects – various categories of official and non-official individuals or bureaucrats interacting with 'local assistants,' each of whom had their own interests and agendas". This would have been true for documents pertaining to the residential schools.

Most of the correspondence and reports examined for this study reflect the relationship between the DIA, Church officials associated with the school, and Aboriginal community members. They also reflect the main interest of the DIA and the Church officials running the schools, which was to assimilate the Aboriginal population into white Christian society. For this reason, it would have been to the benefit of the churches and DIA to ignore certain problems or place the blame elsewhere in order to justify the existence of the schools. For example, the principals' reports and the Indian Agent reports were not always accurate depictions of what occurred in the schools (Sproule-Jones 1996). For instance, it was not uncommon for school officials to improve the conditions for the period of time that the inspectors were present. In his book *Indian School Days*, Basil Johnson (1988: 139-144) recalls an improvement in the food when inspectors were visiting for the purpose of examining the diet.

Another common problem with school reports is that some inspectors were disinterested in the schools and disregarded complaints (Sproule-Jones 1996). For example, following a series of complaints about the food at Norway House Residential School, one Indian Agent investigated the issue and concluded that the food was "good and substantial." In his opinion, the

complaints were only “a general topic with the Indians” so that they had “something to talk about” (NAC, Report on Complaints, Jan 6 1915).

Additionally, some inspectors feared retaliation from the churches if they submitted a poor report (Sproule-Jones 1996). For instance, a Methodist church official argued to the DIA that “the policy of receiving reports from Government officials who have absolutely no experience in managing [the] schools, and putting reliance upon them, [was] absurd” (NAC, Ferrier to McLean, July 24 1915). Church officials did not wish to have their authority in running the schools questioned. These are all issues that must be taken into account when using these documents to develop a picture of the conditions that existed within the Norway House Residential School.

Methods

The main method used in this study involved locating, reading through the available archival materials, collecting and interpreting the relevant information in order to address the research questions. The relevant archival materials were located at the National Archives of Canada (NAC), the Archives of Manitoba, and the Hudson’s Bay Company Archives (HBCA). Microfilm of the RG 10 Schools was requested by mail from the NAC and examined using microfilm equipment available at McMaster University. During the summer of 2005, I spent a week in Winnipeg, Manitoba where the Archives of Manitoba and HBCA are located. While there, I examined the HBC post journals for Norway House, made an

electronic copy of the previously examined RG 10 School files for Norway House, and searched for other relevant material. Post journals for the other communities were later requested by mail and examined at McMaster University due to time constraints while in Winnipeg. The methods used to piece together the history of the school and health conditions will be discussed in detail.

Historical Context

There is no known previous study of the Norway House Residential School thus it became necessary to piece together the history of the school from the surviving records. While studying the various materials available, salient themes were identified; the relevant information from letters and reports was then collected and organized by related topics. This included commentary on, for example, the founding of the school, the administration and funding of the school, and any significant changes or events that occurred, such as school fires, construction of a new school building, increases in the size of the school.

In addition, all statistical information regarding the demographic composition of the school was collected in order to do a basic analysis of age and sex structure of the children who attended the school. The information gathered included the total number of students enrolled, the number of girls vs. boys when available, where the children were from, their ages, and how long they attended the school. Ideally, complete records of the children enrolled for the whole study period would give an accurate picture of the demography of the

school. Unfortunately, only scattered records and fragments of information are available but the information that was gleaned from a variety of documents made it possible to derive a rough estimate. Attendance records, broken down by male and female, is available in the yearly 'Statement of Boarding Schools in the Dominion,' which was included in the *DIA Annual Reports*, for almost every year from 1900 to 1940 (DIA 1902-1906, 1914-1936; DMR 1937-1940). Information regarding the children's home reserves is scattered throughout the records. No exact breakdown is available on how many children came from each reserve; however, the home reserve for children enrolled between 1933 and 1941 is included in their admission record. Using these same records, the average ages of the children when admitted, discharged, and the average time spent in school were determined. The main limitation of these data is that it only covers the children admitted or discharged between 1933 and 1941 (NAC, Admissions and Discharges, 1933-1941). This nevertheless is assumed to give a general picture of the children who attended the school.

Lastly, the general conditions in school were investigated. Again, this involved a close and detailed study of the various reports and letters available in the archives, then gathering and sorting the material by related themes. Special attention was paid to the diet, overcrowding in the school, general complaints and concerns about the condition of the school building, to name a few issues, to get a sense of the quality of the environment in which the children lived. I wanted to know whether NHRS fit into the picture of institutions and disease pattern

described by other researchers (Keller 2002, Kelm 1998; Lux 2001; Miller 1996; RCAP 1996).

Health Conditions

The main focus of this project is on the health of the children. This again involved searching through the records and extracting the relevant commentary. Due to the limitations of the sources, the majority of the analysis is necessarily descriptive in nature. For example, tuberculosis and scrofula are continually mentioned as problematic at NHRS but at no time is the total number of children affected given. As a result, the prevalence rate of TB in the NHRS cannot be determined for this study.

The majority of the information on health came from the *DIA Annual Reports* and the RG 10 School Files. The Principal's Annual Report published in the *DIA Annual Reports* always gave a summary of the general health of the children for the year and indicated whether or not there were any illnesses or deaths (DIA, Hardiman 1901; 1902; Lousley 1903 – 1913). However, there are several limitations to this source. First, it only presented an annual summary and often lacked the complete details of illnesses that occurred. For example, if an outbreak occurred in the school during the year, there normally was no mention of exactly when it occurred, for how long, or in most cases how many children were affected. However, since the annual report was intended to give the DIA an

overview of the entire school year, and focused on all aspects of the school, this is to be expected.

The second limitation of the Principal's Annual Reports for NHRS is that the reports were only published in the *DIA Annual Reports* from 1901 until 1913. After 1913, the Principal's Annual Reports were no longer included. For the rest of the study period, information on health and illness is sketchy and scattered among various other records. For some years, there is no information on the health, although it is very likely that illnesses did occur among the students. One notable example is the 1918-19 Spanish influenza pandemic which was known to have affected the Norway House community (Herring 1994), but about which no mention is made in the school records. Given that many previous outbreaks which affected Norway House also affected the school, and the known severity of the 1918-19 influenza epidemic, it seems unlikely that the school would have been spared from the outbreak. Further research on this specific outbreak, however, did find one mention of the 1918 influenza within the school in a published collection of stories from Norway House elders (Apetagon 1991). According to the elders, children were in fact sick from the flu but the school fared better than the community in terms of the number of deaths (Apetagon 1991). There must have been other illnesses and epidemics less remarkable than the 1918 influenza pandemic that were not reported in the documents available for the study.

Bearing this in mind, an epidemic/illness chronology was developed from the information gathered on illnesses and epidemics from all the sources. In most instances, only the presence of the disease was noted since the total number of cases is not available. As the research progressed, it was discovered that the majority of the outbreaks that occurred in the school also affected the surrounding community of Norway House. With this knowledge, the Norway House post journals became a useful tool to determine the time of year that the outbreaks occurred. This involved cross-checking the daily entries in the post journals during the years in which outbreaks were known to have occurred in the school in order to find any mention of it by the HBC official. In the majority of cases, this proved successful. In instances where an outbreak only affected NHRS and not the Norway House community, the presence of a similar outbreak in the other home communities (Cross Lake, God's Lake, Oxford House, and Island Lake) was investigated by cross-checking the Indian Agents' reports for the given communities, the HBC post journals for each community, and the parish records. This was only required in two instances: a whooping cough epidemic in 1933 and a typhoid fever outbreak in 1940. The whooping cough epidemic was known to have arrived in the school after the children returned from summer holidays (NAC, Shoup to MacKenzie, Jan 16 1934). Investigation of parish records, specifically the death records, found a co-occurring outbreak of whooping cough at Oxford House. This was likely the source of the outbreak in the school (UCCA, Oxford House Burial Register, 1933-1934). The typhoid fever

outbreak was reported both in the NHRS and at God's Lake (DMR Indian Health Services 1940). It is highly probable that these two outbreaks are linked but further evidence was not found to corroborate this suspicion.

In addition to the epidemic/illness chronology, I developed rough estimated death rates for the school children. Adequate numerical data for this purpose was available for two periods: 1900 to 1913 and 1933 to 1941. From 1900 to 1913, the total number of deaths and causes were located in the Principal's Annual Reports (DIA, Hardiman 1901; 1902; Lousley 1903 – 1913). Between 1933 and 1941, any child who died while in school was listed as "discharged" in the Admission and Discharge records; in some cases the cause of death was listed (NAC, Admissions and Discharges 1933-1941). For the twenty year gap between these two periods, deaths were occasionally reported; however, I suspect that some went unreported. Again, the 1918-19 Spanish influenza epidemic is a prime example. During the outbreak, two children died at the school but this was not reported in the official documents (Apetagon 1991).

The NHRS death rate per 1000 was estimated by dividing the total recorded deaths for each year by the total recorded attendance times 1000. There are two problems with this approach. First, there likely were cases of unreported deaths. Second, any child who died after returning home on sick leave would not be recorded as a death in school. Instead, the child would be listed as a discharge due to sick leave. This means that the estimated death rate is undoubtedly an underestimate and likely represents the minimum. Dr Peter

Bryce (1907) noted this problem in his 1907 report on the health conditions of the residential schools in Manitoba and the Northwest Territories. The Norway House Residential School was not included in his report; most likely due to the extra time and money that would be needed to travel there.

Another useful source of information on the children's health came from admission and discharge records for the school (NAC, Admissions and Discharges, 1933 – 1941). The admission records, which include the required medical evaluation prior to admission, described the general health and any pre-existing health problems of the children at the time that they were admitted to the school. The health report indicated, for example, whether they were malnourished, had a skin infection (scabies, lice), any contagious eye infections, or any previous history of tuberculosis. I consolidated this information into a data-base, calculated the proportion of children with pre-existing health problems, and then organized the file by the respective health condition. The proportion of children who were discharged for health reasons during this period was also calculated and when possible sorted by illness or condition. This analysis offers a general idea of how many children had health problems that were serious enough to require discharge; however, in most cases specific medical conditions were not listed.

Another gap in the records arises when children were sent home on sick leave. These children were away from the school for extended periods of time due to illness but were still enrolled in the school. The fact that they were being

counted as present (and therefore included in the denominator of any rate estimates) further underestimates calculations of the illness and death toll at NHRS. In 1934, the DIA informed school officials that:

It is inadvisable to retain on the quarterly return the names of any pupils who will be absent from the school for a considerable period of time due to illness. In the case of such pupils, application should be made for their discharges in order that their names may be removed...If their health improves and it is again considered desirable to place them at school, application can be made for their re-admission (NAC, Sutherland to Gordon, Jan 29 1934).

After this time, children who would have previously been sent home on sick leave were instead discharged from the school with the cause listed as “sick leave” (NAC, Admissions and Discharges, 1933-1941).

To supplement this analysis of the health of children attending the NHRS, a general overview of the health history of the home reserves of children was developed. These communities include Norway House, Cross Lake, Oxford House, God's Lake, Island Lake, Berens River, Nelson House, and Trout Lake, Ontario (refer to Figure 4.3 for location of communities). The last three had very few children who attended the school and required less scrutiny. More detailed descriptions of health conditions at Norway House were necessary because the school was located there and this would lead to more interaction between the school children and the residents of Norway House. Additionally, Norway House tended to have the largest proportion of children enrolled at the school⁴.

⁴ A year to year breakdown on the number of children from each reserve is not available. However, Norway House children tended to be in the majority (NAC, Blackford to Scott, Jan 9 1928). In addition, admission records for 1933 to 1941 showed that 43% of 130 children enrolled for that period were from Norway House.

Information on each of the children's home communities was gathered from the Agents' Reports submitted to the *DIA Annual Reports* and from the HBC post journals for each community. Another useful source is Dr EL Stone's 1925 report on the health of the Norway House Agency which discusses most of the reserves from which the children came. His analysis is important because the general health of the children's families and home communities would influence their own health, especially tuberculosis. Having a sense of the conditions in the children's home communities would help to determine whether health issues found in the school were unique to their experience at NHRS or whether they were more properly linked to the health of their communities.

Conclusions

In summary, several documentary sources offering perspectives on NHRS from a number of positions, such as the DIA, Church/school officials and the HBC, were used to describe and analyze the conditions at the Norway House Residential School from 1900 to 1946. While the description of the conditions at the Norway House Residential School is necessarily sketchy owing to the limitations of the sources, it provides a reasonable framework for making inferences about the processes and circumstances that affected the health of the school children during the study period addressed in this thesis.

Chapter 4: Historical Context of the Norway House Residential School

Introduction

The Norway House Residential School was part of the Canadian government's Native Residential School System. In this chapter, a brief history of the creation of the system, its purpose, as well as the administration and funding of the system are discussed. For a comprehensive discussion of this topic see Miller's (1996) *Shingwauk's Vision*. This background information is intended to place the Norway House School in its broader historical context. Next, the history of the Norway House Residential School and the demographic profile of the pupils are outlined. Lastly, the conditions in the school are presented, focusing on the various problems that existed there as well as at other locations in the residential school system. This discussion is crucial for it lays the foundations for understanding the school environment in which the children lived.

Creation of the Native Residential School System in Canada

The Native Residential School System, in addition to the reserves, was one of the mechanisms used by the Canadian government and Churches to colonize and assimilate the Aboriginal peoples into 'white society'. The basis for the creation of the school system was the seven numbered treaties signed between 1871 to 1877 with the Aboriginal peoples of north-western Ontario and the prairies (Miller 1996). The treaties were part of Canada's effort to expand

and develop into further territories by forcing the 'Indian' people onto reserves and opening up new land for 'white' Canadian settlement (Brown and Maguire 1979). The secondary purpose of the treaties, as explained by Indian Commissioner J.A.N. Provencher in 1873, was to help the Aboriginal people adjust to a new style of living. Below is his statement regarding the development of Residential Schools in response to the newly signed treaties:

There are two modes wherein the Government may treat the Indian nations who inhabit this territory. Treaties may be made with them simply with a view to the extinction of their rights, by agreeing to pay them a sum, and afterwards abandon them to themselves. On the other side, they may be instructed, civilized and led to a mode of life more conforming with the new position of this country, and accordingly make them good, industrious and useful citizens.

Under the first system the Indians will remain in their condition of ignorance and inferiority, and as soon as the facilities for hunting and fishing disappear, they will become mendicants, or be obliged to seek refuge in localities inaccessible to immigration or cultivation. Under the second system, on the contrary, they will learn sufficient for themselves, and to enable them to pass from a state of tutelage, and to do without the assistance from the Government (cited in Brown and Maguire 1979: 34)

In order to help the 'Indian nations' progress from their state of 'ignorance and inferiority,' each of the treaties included a clause to provide day schools on each of the reserves, at the expense of the Canadian government, to teach Aboriginal people 'the proper way to live'. In short, the purpose was to assimilate Aboriginal people into a non-Aboriginal, Christian community and to eliminate any legal or financial responsibility of the government to the Aboriginal people (RCAP 1996).

However, by 1879, the day schools had lost favour as an effective means for complete assimilation of the Indian people. Existing day schools often had

poor attendance which was viewed by officials as the result of parents' indifference and refusal to allow their children to attend school (Miller 1996:101). In reality, the poor attendance was likely due to difficulties children faced trying to travel to school everyday. The best way to educate Indian children, as viewed by government representatives, was to remove them from their homes and place them in residential schools. Residential schools were expected to "dissociate [the child] from the prejudicial influence by which he is surrounded on the reserve of his band" (Miller 1996: 103). Consequently in 1879, the Canadian government initiated a plan to start a residential school system. The Canadian Government appointed Nicholas Flood Davin to investigate the Native Residential School System in the United States and recommend steps to create a similar one in Canada. Davin recommended the use of existing church boarding schools and promoting a policy under which the Churches would establish more schools on the Government's behalf. This would ensure that the children would receive a secular education and religious training and put the responsibility on the churches to find teachers (Miller 1996).

Administration and Funding of Residential Schools

The administration and funding of the Residential Schools has been considered problematic and had enormous implications for the conditions in the schools (Miller 1996; RCAP 1996). The administration and management of the schools was an "ambiguous partnership between church and state" (Sproule-

Jones 1996: 201). The churches owned and operated the schools while the Department of Indian Affairs (DIA) provided funding. The DIA established regulations for the schools and employed Indian agents to conduct inspections of the schools. However, the agents responsible for the inspections often avoided their duties due to “lack of interest in native education, or from a fear of retaliation by the churches that managed the schools” (Sproule-Jones 1996: 210). School (church) officials often took offence at any government criticism of their school management. For example, in response to criticism at Norway House Residential School, a church official sent a letter to the DIA stating that “the policy of receiving reports from Government officials who have absolutely no experience in managing these schools, and putting reliance upon them, is absurd” (NAC, Ferrier to McLean, July 24 1915). In addition, at some schools, such as the Norway House Residential School, government inspections were infrequent due to the lack of a designated inspector (NAC, Hall-Jones to Ferrier, Jan 26 1926). This made it difficult for the DIA to enforce regulations and to ensure that the schools were up to par.

The school system was chronically under funded by both the Federal Government and the Churches. In the early years of the Residential School System, the government covered all the costs but it became difficult to control the spending of the school principals and, as more schools were opened, the system became too expensive to sustain. In 1892, the DIA began to provide only the initial building cost and then paid for major repairs and yearly funding in the form

of Per Capita Grants (PCG) based on attendance levels. The schools were expected to use the money for daily operations which included feeding and clothing the children, supplies, salary for the staff, and minor repairs. However, this method of funding had major implications for the conditions found in the schools. A funding system based on attendance figures forced school principals to maintain the maximum attendance so that the full grant amount could be obtained. This strategy often contributed to overcrowding in the schools and to a reduction in attention to the health status of potential pupils. In addition, principals had less funding for major expenditures, such as food, and had to increase the school's revenue from products produced on the schools' farms. The children were often used to provide farm labour which was designated as vocational training (Miller 1996).

Norway House Residential School

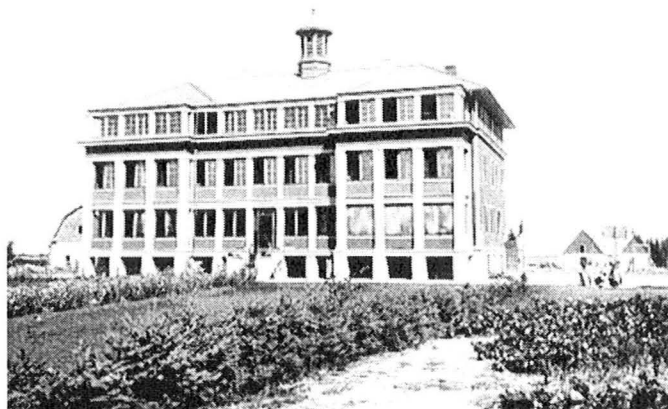


Figure 4.1: Norway House Residential School, 1921.
Source: Provincial Archives of Manitoba, Still Images
Section. Norway House Collection. Item Number 21.

History of the Norway House Residential School Building

The Norway House Residential School, located in the Rossville Village of the Norway House Reserve, was owned and operated by the Methodist Church. The Methodists had a long standing presence at Norway House. In 1840, the Methodist Church, with the encouragement of the Hudson's Bay Company, established a mission near Norway House, which soon became known as Rossville Village (Stephenson 1925).

The Methodist Church opened the Brandon Institute in 1895, a residential school located in southern Manitoba. However, many Aboriginal families living in Norway House and in communities further north who wished to send their children to school thought that Brandon was too far away (Stephenson 1925). In response to this concern, three years later, the Methodist Church sent a request to the Department of Indian Affairs to provide funding for the construction of a boarding school near the Norway House Reserve⁵. Norway House was considered an ideal location for a school because it was "a centre from which quite a number of bands [could] be reached" (NAC, Sutherland to DIA, June 22 1898: 1). The DIA approved the sum of \$3,000 toward the building and agreed to provide a yearly per capita grant of \$72 for 50 pupils (NAC, McLean to Sutherland, April 19 1898).

⁵ In addition to the Norway House boarding school, the Methodist Church also wished to establish medical and hospital work in Norway House. They requested money for the 'necessary building and outfit' of the hospital and stated that they could provide a doctor and nurse (NAC, Sutherland to DIA, June 28 1898). However, these requests were denied by the DIA (NAC, Branson to McKenna, April 25, 1899).

Construction did not begin until almost a year after the approval of the school due to disagreements between the Methodist Church and the DIA on construction costs and on who would pay (NAC, Branson to McKenna, April 25 1899). Proposed plans for the building were sent to the DIA and initial cost estimates by an architect amounted to \$12,000, well above the initial grant of \$3,000 from the DIA. Reverend Alexander Sutherland, the General Secretary of the Methodist Church Home Mission, requested a larger grant to cover the building cost (NAC, Sutherland to Smart, April 1 1899: 2). The DIA responded that it would be necessary for the Church to cover the difference or make adjustments to the plans (NAC, Smart to Sutherland, April 12 1899). In response, Sutherland claimed that the Methodist Church had been continually discriminated against by the DIA and had not received the same funding for residential schools as other denominations. At the time, the Methodist Church operated fewer residential schools than other denominations (NAC, Sutherland to Smart, April 15 1899). However, the DIA placed the blame on the Methodist Church, claiming that they had been "slow to take the initiative" in establishing boarding schools (NAC, Branson to McKenna, April 25 1899: 2). The rivalry between the churches for mission work was likely the cause of the perceived discrimination. The DIA continued to refuse to contribute any more than the initial grant of \$3,000 toward the building at Norway House so the Church had to cover the difference. Construction of the school building began in 1899 and was

completed by 1900. The boarding school, the first located on Lake Winnipeg, opened in the fall of 1900 with 58 students enrolled (DIA, Hardiman 1901).

In February of 1913, the first school building was destroyed in a fire that started from one of the wood burning stoves. No one was hurt and most everything was saved from the building. The vacant hospital building and the old Hudson Bay Company store were used as temporary accommodations. For a few days until the HBC store was prepared, the boys stayed in a number of the surrounding homes. The hospital building was used as the dining room, kitchen, laundry, sewing-room, girls' dormitory and bedrooms for the female staff while the HBC store was used for an office, boys' dormitory and bedrooms for the male staff. Within three days after the fire, classes resumed at the school (NAC, Lousley to Ferrier, Feb 26 1913; Feb 27 1913; DIA, Lousley 1913). Oddly, no mention of the fire appears in the Hudson's Bay Company Post Journal for Norway House (HBCA, Norway House Post Journal, February 1913).

Following the school fire, Rev Ferrier wrote to the DIA asking permission to dismiss the pupils until a new school building could be completed without losing the per capita grant for the enrolled students (NAC, Ferrier to McLean, June 21 1913). J D McLean replied that they would only pay the grant during the time that the school was in operation (NAC, McLean to Ferrier, June 27 1913). Rev Ferrier wrote back stating that he and the principal, Rev Lousley, "agreed that it would be a mistake to allow these children, especially those who are from such places as Oxford House, God's Lake, and Island Lake, to return to their

homes for a year, so we have arranged for them to be kept in the homes of the people" (NAC, Ferrier to McLean, Aug 15 1913: 1). The school would still be in operation this way and would receive the yearly per capita grant.

A new school building, much larger than the original, was completed in October of 1914 (DIA, Jones 1916). The new school building was also destroyed in a fire on May 29, 1946 (NAC, Goodman to Hoey, May 29 1946). Ironically, in 1930, visiting Methodist Church Officials from the Home Mission Board commented on the high risk of fire in the frame building of the school (NAC, MacKenzie to Gordon, Nov 21 1930). The following is an account of the 1946 school fire:

The fire started at 2:30 during the night. Donald [Beardy] was awakened by a burning sensation in his nose. When he opened his eyes, the dormitory was filled with smoke. Donald jumped out of his bed and ran towards the window which had been partially open. He pushed the screen out and looked down onto the ground. He could see flames gushing out from the wood bin in the furnace room. Instinctively, he woke up his friend, Oliver Sinclair, who was sleeping in the bed next to his. Oliver leaped up and obediently followed Donald's orders. The two young boys quickly woke up everyone, telling each one to make much noise. All the boys began to bang and hit the beds. They did this to wake up the little girls who were sleeping in another dormitory just below their floor. Donald ran out of the dormitory to wake up the boys' supervisor, Mr Organ, who then went and rang the fire alarm. Mr Organ told Donald to go outside and catch the girls as they came flying down the fire escape pillars. Meanwhile, Oliver was catching the boys at their fire escape. Less than a half hour later, all the children were out of the building and secure in the care of local people who had ran to the burning building to help. The matron of the school lined up all the children and head-counted each one. All were saved, including the staff members. Most of the children were wearing only their night clothes and socks...Within an hour after Donald and Oliver had awakened everyone in the school, it was completely demolished by the raging flames. (Apetagon 1991: 51)

At the time, there were about 105 students at the school. The majority were from Norway House and Cross Lake, with a few students from Oxford House, God's Lake, Island Lake, Grand Rapids, and Poplar River. After the fire, the children stayed at various homes until they were able to return home (Apetagon 1991).

The boarding school was not replaced until 1952 (Apetagon 1991). However, by this time major reviews and reforms had occurred to the federal government's Native education policy due to the growing opposition to residential schools from Aboriginal communities. During the 1950s, there was a shift away from the Residential School System to federally run day schools on the reserves as well as a change in the curriculum (Miller 1996; Shkilnky 1985). More emphasis was placed on the children's education and less on vocational training, and stricter regulations regarding health issues were enforced (Miller 1996). The half-day system, in which the children worked for half the day and spent the other half in the classroom, was abandoned. Instead, the children only did classroom work (Apetagon 1991).

Funding of the Norway House Residential School

The Department of Indian Affairs initially provided a yearly grant of \$72 per capita for a maximum of 50 students to attend the Norway House Residential School. However, within a few years of the school's opening this amount was found to be inadequate to pay for the total management and maintenance of the school. Over a five year period, 1899-1905, the expenses of the school totalled

\$24,049. For that period, grants from the DIA totalled \$14,263 leaving \$9,786 to be covered by the Church (NAC, Sutherland to McLean, Aug 8 1905). In fact, for most schools, the churches requested additional money from the DIA to cover the deficit between the total expenses and the received grant acquired every year and claimed that their per capita amount was too low (NAC, Benson to Pedley, Aug 21 1905; RCAP 1996). In this case, Rev Sutherland, the General Secretary of the Methodist Church, requested that the DIA cover half of the deficit accumulated from the Norway House Boarding School as well as from two other boarding schools managed by the Methodist Church. Without this subsidy, the Church would rather close the schools than continue accumulating a deficit (NAC, Sutherland to McLean, Aug 8 1905: 3-4). In response, Benson wrote to the Deputy Superintendent General of the DIA suggesting that the per capita grant amount be reconsidered and raised instead of paying off the annual deficits of the Churches (NAC, Benson to Pedley, Aug 21 1905). However, Duncan Campbell Scott, at that time the accountant of the DIA, claimed that there was no money available to pay off the debt or to raise the per capita grant (NAC, Scott to Pedley, Oct 4 1905).

The school did not receive an increase in its per capita grant until January of 1915. Shortly before that, the number of funded pupils was raised from the initial 50 to 80. This is because a larger building had been built after the fire in 1913. Church officials had requested that the school be placed in the Northern class of residential schools, which received a higher per capita grant to offset the

higher living expenses in the north (NAC, Ferrier to Scott, Aug 18 1914). The request was approved and the per capita grant was increased from the initial \$72 per capita to \$125 per capita (NAC, Scott to Ferrier, Jan 19 1915). The grant remained unchanged for the rest of the school's time of operation but in 1922 the number of pupils increased once more from 80 to 105, which resulted in further overcrowding of the school. The original capacity of the school building was 80 students; however, enrolment often exceeded the per capita grant limit to ensure payment of the full amount.

Principals of the School

A series of principals ran the school during its almost 50 years of existence (see Table 4.1). It is important to note the changes in principals because of the changes in school management that each brought. The priorities of each principal often differed, especially regarding attention to the health of the children.

PRINCIPAL	TERM
Rev M Hardiman	1900 – 1902
Rev J A Lousley	1902 – 1916
Rev G F Denyes	1916 – 1921
J T Blackford	1921 – 1930
Rev W W Shoup	1930 – 1934
Rev R T Chapin	1934 – 1941
Rev Caldwell	1941 – 1944
Rev J James	1944 – 1946

Table 4.1: Norway House Residential School principals and years served

Rev M. Hardiman was the first principal of the school when it opened in 1900. By his second year at the school, there was some opposition toward the school; however, later Lousley clarified that the opposition was along denominational lines (DIA, Hardiman 1901; Lousley 1902). Hardiman was reported to have been on poor terms with some of the parents and was unsuccessful in his dealings with them. As a result, he was replaced by Rev J A Lousley in 1902 (NAC, Laird to McLean, Oct 27 1902).

Rev Lousley was the longest serving principal for 14 years but he also was a controversial figure. Following an extensive investigation in 1907 of the case of a child who ran away from school after being continually punished by the staff and suffered from severe frostbite, the wisdom of Rev Lousley's position as principal was questioned by DIA officials. He was criticized for often being away from the school and for failing to provide adequate supervision over the actions of his staff. That same year (1907), a recommendation was made by M Benson, who was in charge of the School Branch of the DIA, to close the school for a year due to concerns about the health of the children. Tuberculosis was a major concern at the school and resulted in 9 deaths during the 1906-07 school year. Benson suggested that Lousley should be replaced when the school reopened (NAC, Benson to Pedley, Sept 28 1907: 4). Neither of the recommendations were carried out. Rev Lousley stayed on as principal until 1916. He was replaced at that time by Rev G F Denyes, apparently after a dispute between Rev Lousley and the Chief at Berens River regarding the attendance of some

children from Berens River (NAC, Carter to Scott, March 11 1916; Ferrier to McLean, July 17, 1916)

Rev G.F. Denyes stayed on as Principal for five years until 1921. He was replaced by the school's fourth principal, J.T. Blackford, the only principal of the school who was not a Reverend. The Methodist Church appointed him as principal of the school following his retirement from Superintendent of the Forestry Branch (Chapin 1972: 37). In 1924, Blackford's fitness for the position was questioned after his handling of a situation in which two local men were found drunk near the school (NAC, Graham to McLean, July 30 1924). The men were arrested by Indian Agent Gordon and charged with public intoxication, assault, and disturbing a religious meeting, the last two charges filed by Principal Blackford. In addition to the charges, Blackford contacted the Forestry Superintendent and demanded that the men be discharged from their position in the Forestry Branch. The men were consequently discharged. According to Agent Gordon, Principal Blackford's reaction was "unwarranted" (NAC, Gordon to Graham, July 21 1924).

Blackford nevertheless stayed on as principal until 1930, after which he was replaced by Rev W.W. Shoup (NAC, Ferrier to Scott, April 29 1921; NAC, Young to Scott, March 27 1930). Shortly after his arrival, Rev Shoup was charged by the RCMP with assaulting one of the pupils. However, the charges were dropped and Shoup was warned only to punish students with a strap. The investigating officer remarked that he had heard previous stories of Shoup's

harsh treatment of the students but only this particular incident resulted in charges (NAC, RCMP report, Dec 29 1931). When Shoup was given notice that he would be replaced as Principal in 1934, Dr Trupel, the Medical Superintendent at Norway House Hospital, wrote to say that he regretted the decision.

According to Dr Trupel, Principal Shoup had paid particular attention to the health of the children which, according to the doctor, had improved under his care. Dr Trupel had worked with the school as a Medical Attendant since 1927. He praised the principal for co-operating with the doctor on health matters which had not always been the case with previous principals. The diet had improved with his effort to build up a garden at the school and the children were better clothed than before, according to Dr Trupel (NAC, Trupel to DIA, Feb 9 1934).

Rev Roscoe T. Chapin served as the next principal from 1934 to 1941 (NAC, Beaton to McLean, April 24 1934). Rev Chapin was replaced by Rev Caldwell in 1941 after the former took over as Principal at Brandon Industrial School. Caldwell stayed on as principal until 1944. He was replaced by Rev J. James in 1944 (NAC, Cochrane to Hoey, Dec 29 1940; Phelan to Lazenby, July 7, 1944). Rev James served as principal until the school burned in 1946. There is very little known about the last three principals' activities at the school. Even Rev Chapin (1972) whose memoir is available had little to say about his term as principal at Norway House.

Demographic Profile of the Children

The official records provide surprisingly little information on the children who attended NHRS and the residential schools in general. Sadly, the children seem to be overshadowed in the records by disputes between school and government officials, money issues and other various problems in the school. Some information is available on the home communities; the total number of children in the school, and the age and sex distribution (DIA, 1902-1936; Hardiman 1901; 1902; Lousley 1903-1913; DMR, 1937-1940) but it is sparse and incomplete. The following is a rough estimate of the demographic profile of the children based on best available data.

Home communities of the children

The children attending the Norway House Residential School were mostly from the communities in the Norway House Agency: Norway House, Cross Lake, Oxford House, God's Lake and Island Lake (see Figure 4.2). Most of the children came from Norway House and Cross Lake; the number of children from the other communities was typically smaller (Apetagon 1991; NAC, Blackford to Scott, Jan 9 1928). A few children came from Trout Lake, Nelson House, and Berens River but it is difficult to determine the exact number from the records (DIA, Lousley 1911).

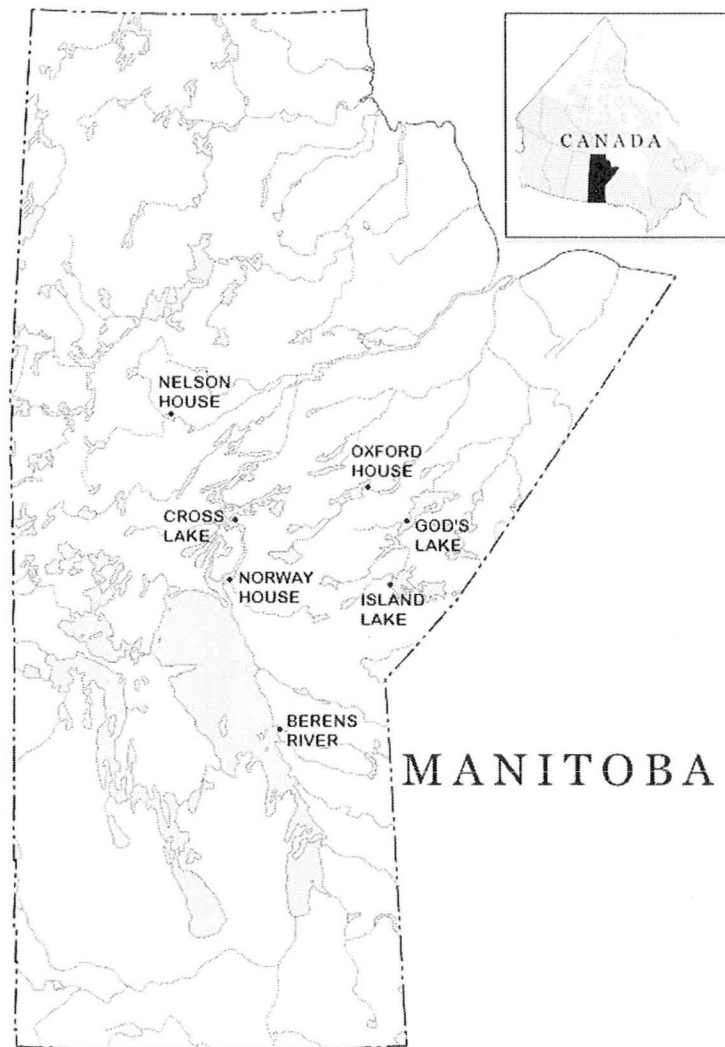


Figure 4.2: Map of the home communities of children attending NHRS
 Map adapted from National Atlas of Canada (<http://atlas.gc.ca>)

Admission and discharge records are only available for 1933 to 1941 (NAC, Admissions and Discharges, 1933-1941). The home communities of the children are only given in the admission records. From 1933-1941, 130 children were admitted to the school (see Figure 4.3). Norway House accounted for 43% of the students ($n=56$), followed by Cross Lake (31% or 40 children), God's Lake (10%

or 13 children), Island Lake (9% or 12 children), Oxford House (5% or 7 children) and Berens River (1.5% or 2 children).

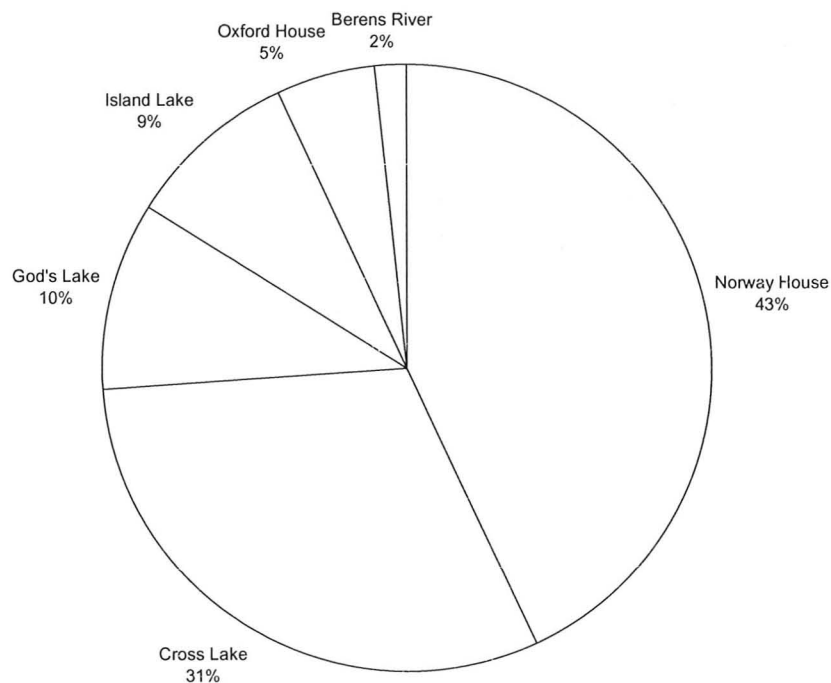


Figure 4.3: Home Communities of 130 Children admitted to NHRS from 1933 to 1941
(Source: NAC, Admissions and Discharges, 1933 to 1941)

This type of distribution in which the majority of the children came from Norway House and Cross Lake with fewer from other reserves appears to have been constant throughout the school's history. In 1928, Principal J T Blackford mentioned in a letter that the enrolment of children from the more distant reserves has always been lower (NAC, Blackford to Scott, Jan 9 1928). With the school located at Norway House, it was easier for school officials to recruit children from that reserve. In addition, Cross Lake is the closest to Norway

House of the other reserves and its proximity would have facilitated the recruitment of children.

Attendance figures

The number of children attending the school varied slightly from year to year (DIA, 1902-1936 Hardiman 1901; 1902; Lousley 1903-1913; DMR, 1937-1940). There are three types of attendance figures (or statistics) that should be noted: the total number of enrolled pupils, the average attendance for the year, and the total number of pupils provided for by the per capita grant. The total number of enrolled pupils is the total number of children listed on the school record for the school year. The average attendance is the average number of children who attended classes every day. Children occasionally were sick or away from the school for a period of time but were still listed as enrolled. In addition, it was often difficult for school officials to maintain enrolment because parents would sometimes keep them at home after returning for the summer break; some were sent home on sick leave and didn't return (NAC, Lousley to Pedley, April 7 1910). The total number of children provided for by the per capita grant is the maximum number of pupils funded by the DIA. Technically, this was also the maximum number of children allowed to attend the school set by the DIA. This is important to keep in mind when overcrowding in the school is discussed later in this chapter and in Chapter 6.

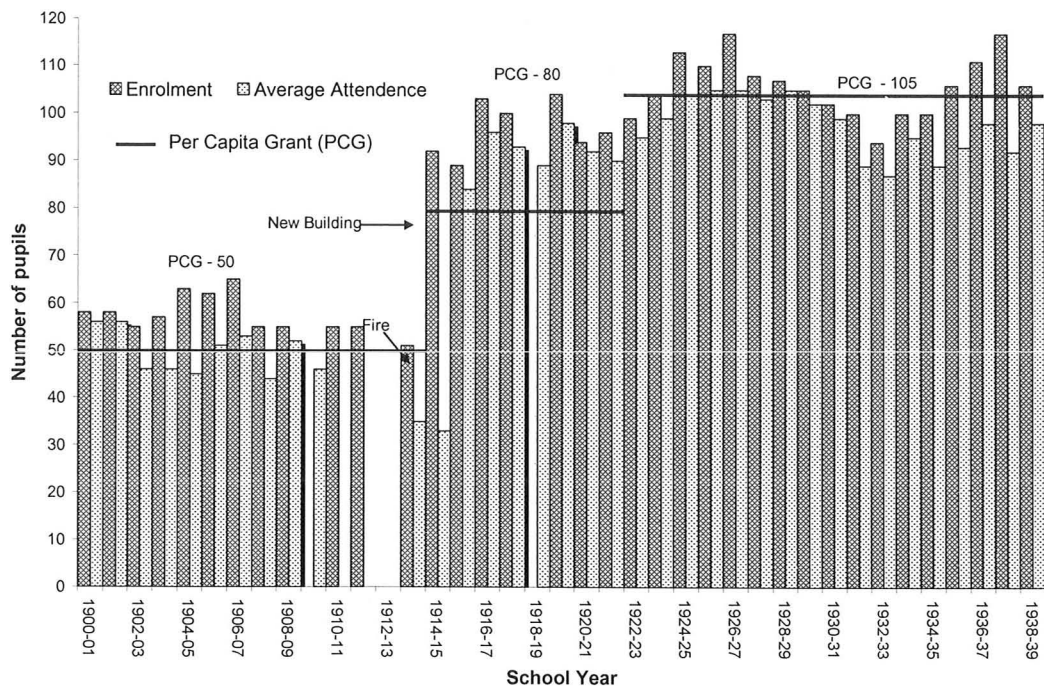


Figure 4.4: Yearly Enrolment and Average Attendance.
Attendance figures were not available for 1912-1913 and after 1939. (Source: DIA 1900-1936; DMR 1937-1939).

The maximum attendance for 1900-1913, based on the per capita grant, was 50 pupils (NAC, Branson to McKenna, April 25 1899). However, the school often exceeded this limit, as illustrated in Figure 4.4. From 1900 to 1913, the average enrolment (not including the 1912-1913 school year which is not available) was 57. The average yearly attendance was 50. The enrolment ranged from 46 to 65 pupils while the average attendance ranged from 44 to 56. In 1904, the Principal's Annual Report submitted to the Department of Indian Affairs noted that the attendance was 46, "four below the number for which a grant is allowed by the government." This was due to "detention of pupils by parents" after children were sent home on sick leave or on break (DIA Lousley

1904: 314). However, from the records, it is difficult to determine whether this number is only the average attendance or the total enrolment for the year. The highest enrolment figure during this period was reported in 1906 at 65 pupils which was noted as “probably more [children] than should have been in the dormitories considering the lack of ventilation” (NAC, Report of NHBS, 1907). The number of students in attendance decreased throughout the year due to discharges and deaths. A total of 10 deaths, the highest number in one year, occurred in 1906-07 (DIA, Lousley 1906).

The original school building was destroyed by fire in the winter of 1913 and a larger building was completed in the fall of 1914 (NAC, Lousley to Ferrier, Feb 26 1913; DIA, Jones, 1916). With a large building to house more children, the DIA raised the number of funded children from 50 to 80 (NAC, McLean to Ferrier, June 5 1915). The per capita grant was again raised in 1922 from 80 to 105 (NAC, Ferrier to McLean, Oct 4 1922; McLean to Ferrier, Oct 10 1922). Notice in Figure 4.4 that prior to the increase in 1922, both the total enrolment numbers and the average attendance exceeded the per capita grant of 80, with the exception of 1914-1915 when the average attendance was 33 students. However, the total enrolment for 1922 was 92 students. After the increase in 1922, the average attendance was equal to or below the maximum of 105 students. Total enrolment only exceeded this from 1924 to 1929 and from 1936 to 1938. Between 1914 and 1939, the total enrolment ranged from 89 to 117, with an average of 96 students (the enrolment for 1918-1919 was not available

so is not included in the average). The average attendance from 1914 to 1939 ranged from 33 to 105 children with an average of 91 students. Attendance figures are not available from 1939 to 1946. However, based on enrolment figures for previous years, the total enrolment for those years was probably around 100.

Age and sex distribution

Adequate information to determine the average age of the children attending the school during the study period is not available; however, according to the school records, the average age of the children in 1915 was 10.22 years (NAC, Menu from Norway House Boarding School, 1915). Information on the ages of the children at the time of admission and at discharge can be derived from the school records for 1934 to 1941 (NAC, Admissions and Discharges 1933-1941). The age at admission for 124 children and age at discharge for 120 children is available. Children admitted from 1934 to 1941 ranged in age from 5 to 16, with an average of 9.98 years.

In addition, an estimated age of admission can be calculated based on the discharge records. In the records, both the age at discharge and total time enrolled (listed as years, months, and days) are listed. With this information an estimated age at admission can be calculated. The term 'estimated age' is used because the children's birthdays are unknown. Two estimated averages were calculated. The first assumes that all the children had reached their next birthday

and the other assumes that none had done so. The actual average age is assumed to fall somewhere between the two values. This was done using the records for 80 individuals who were admitted between 1923 and 1933. The two values are 9.35 years and 10.23 years. The values are less than 1 year apart because 10 individuals were listed as spending an exact number of years in school so it would not matter whether or not they had reached their birthday. Since the average age of admission for 1934 to 1941 falls in between the two estimated age values, it seems safe to assume that children were usually around 9 or 10 years when they were admitted to the school. The time in school ranged from 9 months to 12 years 2 months with an average of 5 years 9 months. At discharge, the students' ages ranged from 8 to 18 with an average of 16 years.

Information needed to determine the sex distribution of the children for school years 1900-01 to 1912-13 is not available. However the sex distribution is available for school years 1913-14 to 1938-39 in the DIA Sessional Papers (DIA 1914-1936; DMR 1937-1939). (see Figure 4.5) Overall, 53% of the enrolled children were girls and 47% were boys. The higher percentage of girls than boys agrees with a statement by Principal Blackford in a letter to D C Scott that the number of girls was generally greater than the number of boys recruited (NAC, Blackford to Scott, Jan 9 1928). In addition, of the 130 children admitted between 1934 and 1941, 80 (61.5%) were girls while only 50 (38.5%) were boys. The greater number of girls than boys enrolled is likely due to gender differences in labour. The main subsistence base for most of the communities was hunting

which was primarily done by men (Flannery 1995; Stone 1925). Boys were likely kept at home to assist with trapping and to learn the skills needed to hunt. Of the boys already enrolled at the school, several were discharged early because they were needed to help at home (NAC, Admissions and Discharges 1933-1941).

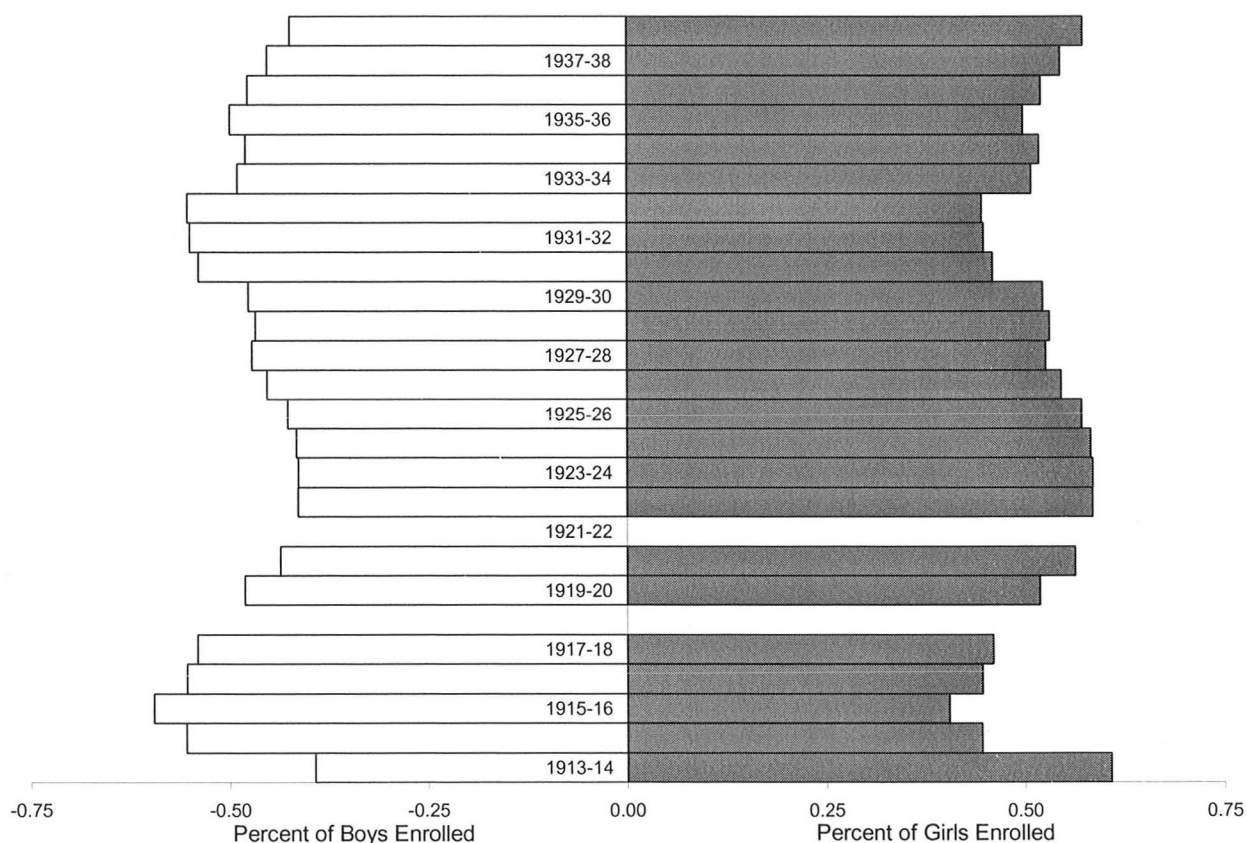


Figure 4.5: Sex Distribution for School years 1913-14 to 1938-39.
On average, more girls were enrolled than boys over the study period.

Conditions at Norway House Residential School

Like many Residential Schools, Norway House Residential School had its share of problems and complaints regarding living conditions and treatment of

the children. Within a few years of the school's opening, there were numerous complaints from parents regarding the workload, clothing, food and sanitary conditions of the school (i.e. NAC, Report on Complaints, Jan 6 1915). The majority of the complaints were made with good reason; however, some government and church officials disregarded many of the complaints and often blamed the children instead. For example, when lice and scabies infections were found among the children, the Indian agent did not consider this to be the result of poor sanitary conditions at the school but rather due to the "terrible condition" from which they came (NAC, Report on Complaints, Jan 6 1915: 2-3).

Despite such responses and, at times, complete disregard of these problems by the DIA and school officials, it is important to note that the poor conditions at NHRS were often conducive to the spread of infectious disease and had a negative influence on the children's health. Not all of the conditions that will be discussed have a direct link to health but they are still important to note as they were common issues with many other residential schools. In this sense, Norway House was very much like the other schools in the system.

Abuse

Abuse of the children in the care of the churches is a commonly identified problem within the Residential School system. There are two reports of abuse recorded at Norway House Residential School. One comes from 1907 and concerns a boy who had been hit with a strap several times as punishment for

continually wetting his bed. After the beating by the assistant principal, Mr Bell, the child ran away from the school and was badly frostbitten on his hands and feet, losing several toes (NAC, Sinclair to Laird, Feb 14 1907; NAC, Calverley to McKenna, April 9 1907). While the DIA thought that some form of punishment was necessary, they were disturbed that it resulted in the child running away and requested an investigation of the incident (NAC, Laird to Semmens, July 3 1907). Correspondence regarding the incident continued well into the fall of 1907.

Another instance of abuse is mentioned in a RCMP report from 1930. The report accuses the recently appointed principle Rev Shoup of assaulting a student by hitting him with a strap. According to the report, the investigating officer was aware of other accounts of Rev Shoup's harsh treatment of the student but in only this one incident were charges laid (NAC, RCMP report Dec 29 1930). The charges against the principal were dropped.

Work load

In 1907, Chief Sinclair, wrote a letter to David Laird, the Indian Commissioner, regarding the child who was badly frostbitten after running away from NHRS. In the letter, he briefly remarked on the heavy work load of the children. While he believed that children should learn to work, he did not think they should be worked as hard as they were at the school (NAC, Sinclair to Laird, Feb 14 1907). In this letter, he was echoing many complaints from parents about how over worked the children were. In their view, they sent the children to school

to learn. In the view of the DIA, the school did not have the children working hard enough (NAC, Lousley to Carter, Aug 11 1915). The children were expected to do most of the general work around the school. The boys were responsible for cutting the wood, carrying all the water that was needed, and attending the gardens and livestock. The girls did all the sewing, mending, ironing, washing, and assisted in the kitchen (DIA, Hardiman 1901; Lousley 1903). In 1923, Indian Agent W Gordon remarked that many of the older boys spent less time in class due to their labour spent clearing land (NAC, Gordon to McLean, July 2 1923). In a published collection of stories from Norway House elders, one commented that the boarding school students had cleared most of the land in a good part of Rossville (Apetagon 1991). The amount of time the children spent doing labour was one of the most common complaints against the residential system. It left little time for the children to spend in the classroom, which in the view of the parents was the main purpose of the schools (Miller 1997:251-252).

Diet

Like many other residential schools, complaints about the diet of the children were common (Miller 1996). Due to the number of complaints, in 1915 the school submitted a summary of the weekly menu (Table 4.2) to the DIA (NAC, Menu for NHRS, 1915) and two different Indian agents investigated the issue. The first agent, Indian Agent Stewart, downplayed the complaints, stating that the children tended to have “great expectations as to the amount of different

foods that they should be fed,” and further said that the school provides “good and substantial food” to the children and was “as good as can be expected.” He goes on to say that “complaints of the bad food are not personal complaints but seem to be a general topic with the Indians. They must have something to talk about and that is the way [he] look[ed] at it.” (NAC, Report on complaints, Jan 6 1915).

If Indian Agent Stewart’s report were accepted at face value, it would appear that there was no problem with the food. However, due to continuing complaints about the diet, John R Bunn, the Inspector of Indian Agencies, conducted a second investigation. His results differed greatly from the original report. He concluded that there were solid grounds for the complaints. The local doctor, Dr Norquay, informed Bunn that he (Dr Norquay) had treated several children from the school. Their conditions were described as “low physical conditions” that generally improved and disappeared after “proper nourishing food” at the hospital was received. Dr Norquay noted that the primary cause for these illnesses was the “lack of proper nourishing food, implemented also by a physical pre-disposition to tubercular troubles⁶” (NAC, Bunn to Scott, Sept 24 1915).

⁶ Tuberculosis was highly prevalent in home communities of the children. As a result, many of the children would be exposed at home and infected with TB (Stone 1925). The conditions in the school, in this case the diet, would aggravate their illness.

Day	Morning Breakfast	Noon Dinner	Night Supper
Sunday	Granules Porridge, Bread & Tea	Pork & Beans, Pie, Bread & Water	Bread & Jam, Tea
Monday	Baked Beans, Bread & Tea	Fish or Meat, Bread & Water	Fish, Bread & Tea
Tuesday	Oatmeal Porridge, Bread & Tea	Fish or Meat & Rice, Bread & Water	Prunes, Bread & Tea
Wednesday	Granules Porridge, Bread & Tea	Fish or Meat, Split Peas, Bread & Water	Fish, Bread & Tea
Thursday	Oatmeal Porridge, Bread & Tea	Fish or Meat, Pot Barley Bread & Water	Apples, Bread & Tea
Friday	Oatmeal Porridge, Bread & Tea	Fish or Meat, Bread & Water	Fish, Bread & Tea
Saturday	Oatmeal Porridge, Bread & Tea	Fish, Bread & Water	Bread, Butter & Tea
<p>The Fish or Meat is to be boiled with some of the dried vegetables mentioned above Pies are made once a week, 1 1/2 lb Lard to a making, pie cuts in 6 pieces For a change the Fish or Meat may be fried or roasted Yellow sugar to be used in tea, night and morning, also in stewing apples or making pies Yellow sugar, with syrup every alternate morning, served on Porridge When fish or meat is not in stock, dried vegetables, as the Principal may direct, may be used</p> <p>Fish: These are White [Fish], Pickerel, Pike, Gold Eyes, Sturgeon, Red and Grey Suckers Meat: This is Beef, Moose Meat, Venison Vegetables: Beans, Split Peas (dried) Cereals: Rolled Oats, Granules, Pot Barley, Rice</p>			

Table 4.2: Menu of the NHRS for 1915
(Source: NAC, RG 10 Vol 6268, file 581-1, part 1)

The Agent concluded that the prime cause for these children's illnesses was the lack of proper nourishing food in the school. There was an absence of fatty food, the quality of bread was "open to criticism," the quality of fish was not always the best and there was a limited quantity of vegetables. In January of 1915, there were only two meals of potatoes, one each in February and March and none after that. The only available vegetables were turnips, beets, cabbage, and carrots. Bunn suggested that the doctor supervise the diet of the school and

inspect it on a regular basis. He also recommended that the weekly supply of lard be increased from 5lb to 10 lb. In addition, he suggested that more bacon be added to the Boston Baked Beans and that it should be served more often than twice a week. One last change was to stop feeding the children red and grey suckers (*Catostomus catostomus*, *C. commersoni*) since they are considered a poor quality food (NAC, Bunn to Scott, Sept 24 1915). The Department approved of Dr Norquay's medical supervision of the diet at the school and instructed Indian Agent Jones to deal with the matter in monthly reports (NAC, Scott to Bunn, Sept 30 1915). By 1922, a school nurse looked after the food and was in charge of the kitchen (NAC, Graham to McLean, Feb 23 1922).

Lack of classroom space

Shortly after the school's opening in 1900, it was deemed too small to accommodate all of the students and still have space for classrooms. According to the understanding of the Methodist Church officials, the day school, which had been built a few years earlier, was to serve as classroom space for both the day and boarding school students, while the boarding school building would serve as living space for the boarding school students and the staff. However, with students from both the day school and boarding school in the day school, it was overcrowded and only one teacher was available to teach between 60 to 90 pupils (NAC, Sutherland to DIA, Dec 6 1900). During the school's first year, the

teacher, Mr Lowes, reported daily attendance of well over 60 students in class; sometimes the attendance exceeded 70 children. The teacher reported having 58 boarding school students and 42 day school students enrolled (NAC, Sutherland and McLean, Dec 6 1900). The day school building was only meant to accommodate 50 pupils (NAC, Branson to McLean, Dec 13 1900).

That same year, a request for funding for an addition to the boarding school was sent to the DIA but was denied (NAC, McLean to Sutherland, Dec 26 1900). Sutherland again claimed that the denial of the request was another example of discrimination against the Methodist Church. He stated that Church officials were “unable to see why [they] should accept this as a final decision” and that “while [they] are doing the work that the Department is bound to do in the matter of education.... [they saw] no reason why [the Methodist Church] should be put off with grants very much inferior....to other parties” (NAC, Sutherland to McLean, Jan 9 1901). The school building was not expanded until 1904. Paid for by the Methodist Church, it included three isolation rooms for the sick and additional space for the school (DIA, Jackson 1903a; Lousley 1904). The day school and boarding school continued to share classroom space after the addition to the school building and even after a larger building was erected in 1914 when the original building was destroyed by fire.

The lack of classroom space was continually problematic and suggestions were frequently made to separate the day and boarding schools because of understaffing. An Indian Agent Report in 1915 stated that there were 40 children

in the day school, half of which came from the boarding school, supervised by only one teacher. The Agent suggested that they discontinue the practice of boarding school students attending the same classes as the day school students. However, at the same time the boarding school was short on qualified teachers so this was not possible (NAC, Agent Stewart's Monthly Report, March 31 1915). Later in 1920, Agent Taylor also suggested discontinuing the practice. There was not enough room in the day school due to the presence of the boarding school students. A room in the boarding school could have become a classroom but it was being used for the girls' play room (NAC, Report of Agent Taylor, June 18 1920). However a few years later in 1926, the reverse happened. Classrooms in the boarding school were overcrowded while there was plenty of room in the day school. As a result more students from the boarding school were sent to the day school for schooling (NAC, Report of Agent Gordon, Jan 1926). No changes to this policy ever occurred.

Overcrowding

In addition to the lack of classroom space, the school had too many children enrolled. Between 1900 and 1913, the maximum number of allowed children in the school was 50. As discussed earlier in this chapter, the enrolment often exceeded the maximum and ranged from 46 to 65 students. Even after the construction of a larger school building, overcrowding continued to be a problem. Within a year of its completion, 87 children attended the school. This was,

according to Agent Stewart, “too many children...from a health point of view” (NAC, McLean to Ferrier, June 5 1915). The building was only meant to accommodate 80 children; this was the number the DIA funded with the school’s per capita grant (NAC, McLean to Ferrier, June 5 1915). Principal Lousley, on the other hand, disagreed and wished to increase the attendance to 100 (NAC, Report of Agent Stewart, April 30 1915: 1). According to the Principal, there was plenty of room for at least 100 students (NAC, Ferrier to McLean, July 24 1915). In addition to this, Principal Lousley wished to build an addition on to the school in order to bring the total attendance up to 160 (NAC, Ferrier to McLean, June 11 1915). The addition was never built.

Despite the claims by the Principal that he had enough room and accommodations for all the children, there were not enough beds in the girls’ dormitory for all the children. Most were sleeping two per bed, which was not allowed by the DIA (NAC, Report of Agent Jones June 30 1916; McLean to Denyes, July 31 1916). The requested addition to the school never materialized; however in 1922 the per capita grant was increased to accommodate 105 students. Church officials requested this enrolment and funding increase to help cover expenses for the school (NAC, Ferrier to McLean, Oct 4 1922; McLean to Ferrier, Oct 10 1922). At that time, the per capita grant was set at 80 students; however the enrolment always exceeded this. As a result, the school had to support more students than were funded.

Another request for an increase in the number of pupils occurred in 1925. A request was sent to the DIA by Rev Ferrier on behalf of Principal Blackford to increase the number of pupils from 105 to 110 (NAC, Ferrier to McLean, Sept 3 1925). Before “intelligent consideration [could] be given” to the request, the DIA asked Agent Gordon to send them the exact sizes of the dormitories (NAC, MacKenzie to Gordon, 1925). The purpose of the request was to determine the ideal number of children that could be housed in the available space. When he sent the dimensions, Agent Gordon “protested against any further increase to the pupilage.” The dormitories were already overcrowded, and Agent Gordon suggested that a reduction in the number of pupils should be made instead (NAC, Gordon to MacKenzie, Oct 7 1925). In light of this the Department denied the requested increase and stated that the current “number of pupils [was] in excess of the accommodation as to air space in the school.” However, instead of reducing the obvious overcrowding the Department only stated that the current number of 105 was “not to be exceeded” (NAC, McLean to Ferrier, Nov 3 1925). In response to the Department’s denial, Principal Blackford sent a personal letter to the DIA stating that they had plenty of sleeping accommodations due to the fact that several of the girls slept on the balcony (NAC, Blackford to McLean, Jan 5 1926). Agent Gordon had acknowledged this fact but said that it was only done during the summer months (NAC, Gordon to MacKenzie, Oct 7 1925). However, according to Principal Blackford, the girls were still sleeping there even during the winter month. There was also another room that would be used as sleeping

quarters but was “not very convenient,” according to the Principal (NAC, Blackford to McLean, Jan 5 1926). The response of the Department was the same as before: “...the present pupilage of 105 must not under any circumstances be exceeded, until funds can be found for an addition. Serious danger to the health of the pupils would be the result of overcrowding the dormitories” (NAC, McLean to Blackford, Jan 20 1926). The total number of allowed pupils by the DIA remained at 105 for the remainder of the school’s existence.

A few years later, in 1930, Dr Turpel wrote to the DIA stating that “the Norway House Residential School is over-crowded” (NAC, Turpel to DIA, May 20 1930). He suggested that something should be done to fix the problem, either through “additional accommodation or reduction in the number of pupils.” The doctor noted that the dormitories for the younger children were too small and many children were still sleeping two to a bed (NAC, Turpel to DIA, May 20 1930). Even Principal Shoup, after he took over in 1930, remarked that the school was overcrowded. Consequently, he did decrease the number of children enrolled at the school during his term as principal. He was the only principal to have the enrolment level less than the per capita grant amount (refer to Figure 4.4). As a result, the sanitary conditions in the school did improve according to Principal Shoup (NAC, Shoup to MacKenzie, Jan 5 1932). After his term as principal, the enrolment of the school went back up. The residential schools were linked to the mission work of the churches and as such the attendance level

of the school was often used as a measure for the success of the school and, consequently the principal. This would have motivated the principals to enrol more students and send requests to the DIA for an increase in the per capita grant.

Problems with the building

Inadequate and poorly constructed buildings were common problems among the Residential Schools. The majority of the schools reported ineffective heating systems, poor drainage and inadequate ventilation (RCAP 1996). The Norway House Residential School shared these problems. Several *Annual Reports* noted the inadequate heating system in the school. The school was heated by two wood furnaces; however, some rooms did not receive enough heat due to poor placement of furnace pipes which left parts of the school cold (DIA, Lousley 1903; Lousley 1905; Semmens 1907). Inadequate heating would be a problem on its own; however, this would have been compounded by the extremely long cold winters at Norway House. The average daily temperature is below freezing from November until April with the lowest average in January of -23°C (-10 °F) (WorldClimate 2005). In 1907, Agent Semmens informed the DIA that the school's foundation was insecure (DIA, Semmens 1907). In the same report, problems with the water supply and pumps were noted; however the exact nature of the problem was not stated (DIA Semmens 1907: 317).

Conclusions

The Norway House Residential School, operated by the Methodist Church on behalf of the DIA from 1900 to 1946, exhibited many problems typical of other Native Residential Schools of the period. As a school, its purpose was to educate the children; however, like other residential schools, its main focus was on vocational training with little time actually spent learning in the classroom. The children spent a great deal of their time doing manual labour and the general chores around the school which was one of the most common complaints of the parents. Additionally, the school was badly under funded due to the inadequate per capita grants from the DIA, again a common issue among the schools. The funding system based on attendance combined with the Church's missionary zeal to expand their work contributed to the over crowding of the schools. The poor diet of the children at the Norway House Residential School was also another common problem. Overall, the conditions at Norway House mirrored what was found in numerous other schools of the Native Residential School system.

Chapter 5: Health Conditions in Norway House Residential School

Introduction

Outbreaks of various infectious diseases periodically affected Native Residential Schools, but tuberculosis was the most prevalent disease (Miller 1996). Constant exposure to disease combined with overcrowding, poor diet, heavy work load, and little to no medical care at the schools led to high morbidity and mortality rates among the children (Bryce 1907, 1909; 1922; Kelm 1998; Lux 2001; Miller 1996; RCAP 1996). Norway House Residential School fits this general pattern. Epidemics occasionally hit the school and, as was the case for other residential schools, tuberculosis was a constant problem.

This chapter examines the general health of the children at Norway House Residential School. The first section is a yearly account of health related issues in the school. This includes a discussion of outbreaks of diseases, the presence of tuberculosis, and any resulting deaths. Additionally, since the school was not isolated from the rest of the community, I attempt to link outbreaks in the schools to outbreaks in the surrounding communities. The extent of medical care in the school is also addressed. The lack of medical care in many residential schools has been cited as a contributing factor to high morbidity and mortality rates (Kelm 1998; Lux 2001; Miller 1996; RCAP 1996).

Yearly Health Summary

During the school's history there were outbreaks of bronchitis, chickenpox, common colds, diphtheria, erysipelas, influenza, measles, mumps, German measles, pneumonia, scarlet fever, typhoid fever, and whooping cough. Table 5.1 is a chronology of the recorded outbreaks that occurred in the school. Tuberculosis is not included in the table since it was an ever-present issue in the school.

Disease Outbreak	Year
Whooping cough, bronchitis, pneumonia	1902/1903
Chickenpox	1902/1903
Scarlet Fever	Fall/winter 1904/1905
Measles	Fall/winter 1904/1905
Mumps	Fall/Winter 1904/1905
German measles	1906/1907
Diphtheria	1906/1907
Diphtheria	Winter 1908/09
Erysipelas	1911/1912
Spanish Influenza	Winter 1918/1919
Diphtheria	Fall 1923
Influenza	Winter 1928/1929
Whooping cough	1933/1934
Chickenpox	Fall 1935
Colds/pneumonia	1937/1938
Typhoid Fever	Spring/Summer 1940

Table 5.1: Chronology of recorded outbreaks in NHRS

During the first two school years that Norway House Residential School was in operation, 1900-01 and 1901-02, Principal Hardiman described the children's health as 'wonderfully good' and 'fairly good' respectively (DIA, Hardiman 1901; 1902). Principal Hardiman attributed the reported good health of

the children to the care of the school's doctor, Dr Lilian Yeomans, and nurse, Miss A Yeomans (DIA, Hardiman 1902). One child died during the first school year but the cause of death was not mentioned in the report (DIA, Hardiman 1901). During the school's third year (1902-03), there was an epidemic of whooping cough, bronchitis, and pneumonia at the school as well as in the Norway House community. Nearly all the children in the school were sick and many suffered with all three diseases simultaneously. Four children at the school died as a result of the outbreak, three girls and one boy. Principal Lousley, the new principal that year, was quick to point out that the deaths should not be "taken to indicate unhealthy conditions in or around the school, as there were about sixty-five deaths on the reserve from the same cause" (DIA, Lousley 1903: 337). In addition, there was an outbreak of chickenpox in the school and in Norway House and one girl died from eating poisonous berries (DIA, Lousley 1903; Semmens 1903). There are no records of the number of cases of chickenpox or when they occurred during the year.

No outbreaks occurred during the following year (1903-04), however, the "Great White Plague," tuberculosis, was noted as problematic in the school (DIA, Lousley 1904). This was the first year that the presence of tuberculosis was specifically mentioned within the Norway House Residential School, though it was likely present during the previous years. Several children had to be sent home on sick leave and five deaths occurred as the result of TB (DIA, Lousley 1904). During the fall and winter of 1904-05, outbreaks of measles, mumps,

scarlet fever and diphtheria were circulating around the communities in the Norway House Agency and resulted in a large number of deaths. In September 1904, measles and mumps affected both Norway House and the residential school. An epidemic of scarlet fever and diphtheria soon followed (DIA, Gilmour 1905; Lousley 1905). Due to the extent of the diphtheria outbreak in Norway House, the DIA sent a doctor and two nurses to tend to the sick at the beginning of November 1904 (HBCA, Norway House Post Journal, Nov 8 1904). However, even though diphtheria was widespread in Norway House, no cases were identified within the school. Three deaths occurred in the spring of 1905 as a result of the “after effects of [scarlet] fever and measles” (DIA, Lousley 1905). The 1905-06 school year fared better with only one serious case of sickness, a few minor cases, and no deaths (DIA, Lousley 1906).

The 1906-07 school year was regarded as particularly bad in terms of health. In the fall of 1906, the pupils were struck with an epidemic of German measles, also known as rubella. In addition, there was a ‘sore throat epidemic’ in the early winter in both the school and the community which was thought to be diphtheria (DIA, Calverley 1907; Lousley 1907). Scrofula and consumption were again reported as problems in the school. In an effort to limit the spread of TB within the school, the children with active cases were isolated within the sick room and the buildings were fumigated during holidays (DIA, Lousley 1907). However, with the constant presence of children with tubercular infections, these efforts likely had little effect. A total of nine children died from consumption and

one from spinal meningitis during the school year. Only two of the children were originally from the Norway House Reserve (DIA, Lousley 1907; NAC, Report of NHBS 1907). The ill health of the children that year was specifically attributed to the poor conditions at the school. Enrolment that year consisted of sixty-five students, which was “probably more than should have been in the dormitories considering the lack of ventilation” (NAC, Report of NHBS, 1907). In addition, Rev John Semmens reported to the DIA that the school was “poor and cold.” He suggested that the health of the children should improve when “the changes under contemplation are carried into effect.” It is not clear from the report what changes he had in mind (DIA, Semmens 1907: 317).

At the beginning of the next school year, Semmens again reported that the building was “scarcely fit for use” and was concerned that the children would suffer from “ill-health as was the case last year.” He recommended that school be suspended for a year; however, this did not occur (NAC, Semmens to Laird, Sept 7 1907). Had the school closed for a year, the Methodist Church would not have received the per capita grant from the DIA. Fortunately no deaths occurred during the year but there was “quite a lot of sickness” according to the Principal (DIA, Lousley, 1908). In January of 1908, the local doctor for Norway House, Dr W J Grant, found two or three cases of diphtheria in the school and placed it under quarantine. Two months prior to this, a case of diphtheria was found in the day school, which shared classes with the boarding school. The quarantine of the boarding school was lifted in February of 1908 (HBCA, Norway House Post

Journal, Nov 26 1907; Jan 18 1908; Feb 16 1908). Principal Lousley attributed the fact that there were no deaths during the school year to the benefits of having a doctor and nurse on staff at the school (DIA, Lousley 1908). During the next school year, despite the efforts of the staff “to preserve the health of the school,” three deaths occurred due to TB (DIA, Lousley 1909: 303).

No serious outbreaks of infectious diseases were reported for the next two school years (1908-09, 1909-10), but scrofula and consumption were again reported as prevalent in the school. In October of 1909, a tent hospital was erected on the reserve (DIA, Calverly 1910). Principal Lousley remarked that the presence of a hospital in the community helped to prevent the spread of sickness within the school by serving as a place for ill students to recover. In addition, the hospital nurse attended many cases of sick children in school. Of 95 cases the nurse attended outside of the hospital in its first year, 30 were in the school (DIA, Lousley 1910). However, the hospital burned down in January of 1911 and was not replaced until August 1912 (DIA, Calverley 1911; Steward 1913). During the 1910-11 school year, four serious cases of consumption were reported by the Principal. At the time of the submission of the Annual Report, one of the children had died, two were recovering, and one was still in critical condition (DIA, Lousley 1911). No follow-up on the cases is available.

During the 1911-12 school year, there was “a great amount of sickness....among the people” on the reserve which in turn affected the school children. Adequate isolation of the sick was “impossible on account of the great

numbers sick... [T]he accommodation at the hospital and also in the school [were] totally inadequate to meet the needs." Erysipelas, a group A streptococcal skin infection, was epidemic on the reserve and several cases of it appeared in the school as well (DIA, Lousley, 1912). Consumption and scrofula again were the chief diseases present in the school during the year. Cases of peritonitis, an infection of the abdominal cavity, were also noted within the school (DIA, Lousley, 1912). Peritonitis can have many causes but the combination of peritonitis, erysipelas, and tuberculosis in the school narrows the range of possible causes. One of the common pathogens that cause peritonitis in children is group A streptococcus, the same organism responsible for erysipelas (Stein 1998). Peritonitis can also occur in individuals with an advanced case of disseminated tuberculosis (Rudolph et al 2003). However, given that many of the children were infected with tuberculosis, it would be impossible to determine which pathogen was responsible for the peritonitis.

Following the fire that occurred in January of 1913, the school was without a nurse or doctor on staff. In addition, the local hospital, which had been rebuilt in August 1912, was closed following the resignation of the doctor, Dr Dent and the nurse-in-charge, Mrs Dent. Instead, the hospital building served as housing for the children following the fire (DIA, Stewart, 1913). At that time, there were three children who were seriously ill, one with consumption, one with "bad hemorrhages from the lungs," and a third who was listed as "seriously sick." These children were sent to separate houses and arrangements were made to

have “native women to be with them constantly” (DIA, Lousley, 1913: 556). At the time of the report, the child with consumption was noted as getting weaker, the child with hemorrhages was slowly recovering, and the third was also recovering. The principal, Rev Lousley, remarked that overall the health of the children was good despite these circumstances (DIA Lousley 1913: 556). After 1913, the reports from the school principals were no longer included in the DIA Annual Reports so a year to year account of the children’s health is unavailable.

Since the school no longer had a doctor on staff, Dr H.C. Norquay, who had been appointed as Medical officer of the Norway House Agency in August 1913, attended any sick children at the school. A new hospital, which was a benefit to both the school and community, was built in 1914 (DIA, Stewart 1914). By 1915, Dr Norquay had already treated several children from the school. The doctor noted that the primary cause for the majority of the illnesses he treated at the school was a combination of the “lack of proper nourishing food” at the school and “a physical pre-disposition to tubercular troubles.” Most of the children treated had a “low physical condition” which general improved and disappeared after receiving “proper nourishing food at the hospital” (NAC, Bunn to Scott, Sept 24 1915). Due to the doctor’s account and numerous complaints regarding the diet (refer to Table 4.2), J R Bunn, the Inspector of Indian Agencies, investigated the diet at the school. Following the investigation, Bunn recommended that the local doctor supervise the diet and inspect it on a regular basis (NAC, Bunn to Scott, Sept 24 1915).

During the 1916-17 school year, there were a number of minor illnesses during the winter. Dr Norquay found it unusual that so many of the children were sick in bed for several days of each week. A possible reason for the number of illness, according to Dr Norquay, was that the beds in the dormitories were very close together which would have facilitated the spread of any infectious disease (NAC, Report of Agent Norquay, May 1917).

The next school year, the Spanish influenza affected the Norway House reserve along with the Residential School. In the school, most of the children were sick except for some of the older boys who, along with the Principal's wife, cooked and cared for the sick children. During the outbreak, the school fared much better than the surrounding community. Only two children died within the school (Apetagon 1991). Norway House was hit particularly hard during the outbreak and an estimated 18% of the population died (Herring 1994).

For the next few years until 1922, there were no reports on the health of the children in the school. In 1922, Indian Agent W Graham submitted a report to the DIA stating that the health of the children had been good with only a few exceptions. One child was under the care of the doctor due to an active case of tuberculosis (NAC, Graham to McLean, Feb 23 1922). In 1923, the health of the children was reported as "very good" by Indian Agent Gordon. No deaths had occurred in the school for over two years, the children were properly nourished, and very little sickness had occurred with the exception of "a few cases of glands," or scrofula (NAC, Gordon to McLean, July 9 1923). In October of the

same year, a few months after Agent Gordon's report, a few cases of diphtheria occurred in the school (HBCA, Norway House Post Journal, Oct 20 1923; Oct 23 1923). To combat the illness, Dr E L Stone, the doctor stationed at Norway House, sent word to Winnipeg via boat to send diphtheria antitoxin as soon as possible since he had none in stock. The medicine was sent to Norway House by plane. On the day that the plane arrived, the HBC employee reported in the daily journal that "fortunately for everybody concerned, the "Dip" does not seem to be spreading and only two cases are in the hospital so far" (HBCA, Norway House Post Journal, Oct 20 1923). Dr Stone was successful in keeping the disease contained and it "did not spread out of the building [i.e. the residential school] it appeared in" (Stone 1925: 246).

For the next five years, there is no mention of illness in the school. In the winter of 1928-29, an outbreak of influenza affected both the school and the Norway House community. During the outbreak the day schools were closed (HBCA, Norway House Post Journal, Jan 14 1929). In the boarding school, about 80 of the students and several of the staff were sick in bed. There were no reported deaths due to the illness (NAC, Gordon to Bunn, Jan 9 1929).

Two years later, CF MacKenzie wrote to Principal Rev Shoup stating that "the Department [of Indian Affairs had] been giving serious consideration to the health of the pupils at Norway House." Tuberculosis had continued to be a major problem (NAC, Shoup to MacKenzie, Jan 5 1931). In hopes of improving the situation, the DIA recommended increasing the time that the children spent in

outdoor work and play with only a half-day spent in the classroom (NAC, MacKenzie to Shoup, Aug 25 1931). This recommendation is odd because the school was already using the half-day system in which half the children were in the classroom during the morning while the other half worked; they switched in the afternoon. It appears that the DIA made the recommendation to give the impression that they were making an effort to address the issue without actually having to do anything about it.

The 1933-1934 school year started off with a whooping cough epidemic, which was brought to the school when the children returned after the summer holidays (NAC, Shoup to MacKenzie, Jan 16 1934). The mostly likely source of the outbreak was Oxford House which was affected by the outbreak in the fall (UCCA, Oxford House Burial Register, 1933-1934). The Norway House Reserve did not appear to be affected by the outbreak; there is no mention of it in any of the available records. At the peak of the epidemic, forty children at the school were sick. According to the Principal, the school fared much better than the affected reserves. No deaths occurred in the school, unlike the high mortality that was reported at Oxford House (NAC, Shoup to MacKenzie, Jan 16 1934). However, the majority of the deaths at Oxford House were in children under the age of one which follows the usual age-specific mortality pattern for whooping cough (UCCA, Oxford House Burial Register, 1933-1934). The most serious cases of whooping cough tend to occur in infants and tend to account for the majority of fatal cases (Cherry et al 1989; Greenberg et al 2005; Turkington and

Ashby 1999). School aged children tend to have a lower mortality rate than infants.

By January of 1934, the children were all reported to be well and healthy. Dr Turpel, the local Norway House doctor, claimed that he had never “seen the school so well fed, dressed or so healthy.” According to Rev Shoup, the monthly weight charts kept by the school indicated an “almost universal increase in weight” (NAC, Shoup to MacKenzie, Jan 16 1934).

In the fall of 1935, there were a few cases of chickenpox in the residential school. To prevent further spread, both the Residential school and Rossville Day school were closed and put under quarantine (NAC, Lazenby to McLean, Nov 26 1935). The next available report on health appears two years later in the fall of 1937. Many of the children suffered from severe colds and 3 cases of pneumonia occurred, all of which recovered well (NAC, Lazenby to McLean, Nov 13 1937). Pneumonia also affected residents of the Norway House community and resulted in several deaths (ACCA, Norway House Burial Records, 1937).

In 1940, a severe outbreak of typhoid fever occurred at the school. Typhoid fever, caused by *Salmonella typhi*, is spread fecal-orally through ingestion of contaminated food, water, and milk (Rudolph et al 2003). Typhoid fever also affected God’s Lake but no details of the outbreak were found among the available records. Four deaths occurred among the school children that year, but the exact cause of death was only given for one and the other three were listed as “died in hospital;” however they were likely linked to the typhoid fever

outbreak or complications following the illness. The first death occurred in May and was due to complications from TB following typhoid fever, the next three deaths followed in July, August, and September. In addition, one child had to be discharged from the school due to complications from TB following a typhoid fever infection (NAC, Admissions and Discharges, 1940). Following the typhoid fever outbreak, plans were made to install a chlorinator to disinfect the water supply (DMR 1940). Chlorinators are commonly used to prevent water-borne diseases, such as typhoid fever. An additional death occurred in 1941 but the cause was not given (NAC, Admissions and Discharges, 1940). Information on health for the last 5 years of the school's existence is not available.

Shared Outbreaks in NHRS and Home Communities of the Pupils

Not unexpectedly, the residential school often shared outbreaks with the Norway House community as is evident in Table 5.2. This is not surprising because the children in the school were not isolated from the residents of Norway House. They attended classes with the Rossville day school pupils and attended church services once a week at the Methodist Church (DIA, Lousley, 1903). With daily interaction with Norway House residents, infectious diseases could spread easily between the school and the community in which it was located. Based on the recorded epidemics, it appears that only four outbreaks in the school did not affect the Norway House community as well: German measles

in 1906-07, diphtheria in 1923, whooping cough in 1933-1934, and typhoid fever in 1940.

Disease Outbreak	Year	Shared outbreak in communities
Whooping cough, bronchitis, pneumonia	1902/1903	Norway House
Chickenpox	1902/1903	Norway House
Scarlet Fever	Fall/winter 1904/1905	Norway House, Cross Lake, Oxford House
Measles	Fall/winter 1904/1905	Norway House, Cross Lake
Mumps	Fall/Winter 1904/1905	Norway House
German measles	1906/1907	?
Diphtheria	1906/1907	Norway House, Cross Lake
Diphtheria	Winter 1908/09	Norway House
Erysipelas	1911/1912	Norway House
Spanish Influenza	Winter 1918/1919	Norway House
Diphtheria	Fall 1923	Norway House
Influenza	Winter 1928/1929	Norway House
Whooping cough	1933/1934	Oxford House
Chickenpox	Fall 1935	Norway House
Colds/pneumonia	1937/1938	Norway House
Typhoid Fever	Spring/Summer 1940	God's Lake

Table 5.2: Related outbreaks in NHRS and home communities

For the first two outbreaks, there is no evidence from the records of cases in Norway House or in the other home communities. In the case of the diphtheria outbreak in 1923, the sick children were isolated in the hospital and the disease did not seem to spread (HBCA, Norway House Post Journal, Oct 20 1923). The whooping cough epidemic in 1933-34 had been brought to the school when children returned from the summer holiday (NAC, Shoup to MacKenzie, Jan 16

1934). The most likely source was Oxford House which was also affected by the outbreak (UCCA, Oxford House Burial Register, 1933-1934). The last noted outbreak was typhoid fever in 1940. Typhoid fever was reported at both the Norway House Residential School and God's Lake (DMR 1940). However, not enough information is available regarding the God's Lake outbreak to determine the relationship between the two.

Deaths

There were 36 deaths reported at the school from 1900 to 1946 based on the available records. However, it is likely that this is an underestimate. For instance, the majority of the known deaths occurred prior to 1913, the last year that the principal's annual report was included in the DIA Annual Report (see Table 5.3). Within each report, the principal summarized the health of the children for the year and reported any deaths that occurred. So for the first 13 years of the school's existence there was a yearly record of whether or not any deaths occurred. After that time, reports on deaths in the school and the children's general health were sporadic. The death records from 1933 to 1941, however, appear to be relatively complete. If a child died while at school, their death was listed in the discharge records, although children who were discharged on sick leave and shortly afterwards died would be omitted in the death count.

Between the two time periods in which the records are relatively complete, it seems that there was a large decrease in the average death rate (Table 5.3).

Year	Deaths	Cause	Death rate per 1000
1900-01	1	Unknown	17.24
1902-03	5	4 whooping cough; 1 poison berries	90.91
1903-04	5	TB	87.72
1904-05	3	Scarlet fever & measles	47.62
1906-07	10	9 TB, 1 spinal meningitis	153.85
1908-09	3	TB	54.55
1910-11	1	TB	18.18
1918-19	2	Influenza	20.00
1933-34	1	Unknown	10.00
1940-41	5	1 TB; 4 unknown*	47.62
Total	36	Average for 1900-1946.	13.36

*Three of these deaths are possibly related to typhoid fever.

Table 5.3: Known deaths and causes that occurred at NHRS
The fourth column contains the death rate per 1000 for the corresponding year.

The yearly death rate per 1000 was calculated by dividing the total deaths in a given year by the enrolment and then multiplying by 1000. From 1900 to 1913, the average death rate was 36 per 1000. For the later period (1933-1941) the rate dropped to 7 per 1000. The decrease could be the result of improvements, particularly in the diet and the presence of a hospital, or it could be the result of children being sent home when they became very ill. Children who died at home would not have been recorded as a death at the school. The common cause, tuberculosis, was still prevalent in the school. Consequently, the apparent decrease in the death rate at NHRS may simply be an artifact of unrecorded deaths in the later period.

Of the deaths of students that occurred following 1913, the two known to have occurred during the 1918-19 influenza epidemic did not appear in any of the

official documents from school or DIA officials. The remaining 6 deaths, one during the 1933-34 school year and 5 during the 1940-41 school year, were recorded in the Discharge Records which only include the 8-year period from 1933 until 1941 (NAC, Admissions and Discharges, 1933-1941). So with the exception of a letter in 1923 which states that no deaths had occurred in the school for over two years, the official documents are silent on any deaths that occurred from 1914 to 1932 and from 1941 to 1946 (NAC, Gordon to McLean, July 9 1923). It is possible that additional deaths were in fact reported but the records did not survive. However, records were not always complete and would have omitted children who died shortly after leaving the school on sick leave.

Of the reported deaths, tuberculosis was the most common cause. Nineteen deaths (53%) were attributed to the disease. This is not surprising since tuberculosis was prevalent among the school children and was commonly reported as problematic during the entire time the school was open. The majority of the TB deaths occurred prior to 1911, with nine occurring within a single school year. One death attributed to TB occurred in 1940, which was due to TB complications following an infection of typhoid fever.

The cause of death is not available for 6 of the recorded deaths (17%). However, it is likely that the three deaths that occurred in 1940 were related to the typhoid fever outbreak in the school. These children were listed as “died in the hospital” in the discharge records and occurred within four months of the death from TB following a typhoid fever infection (NAC, Admissions and

Discharges, 1933-1941). Nine of the deaths occurred during outbreaks of various diseases in the school: 4 occurred during a whooping cough epidemic in 1902-03, 3 occurred following co-occurring outbreaks of scarlet fever and measles in 1904-05, and 2 children died during the 1918-19 Spanish flu outbreak. Of the remaining two deaths, one was due to spinal meningitis and the other was a child who died from eating poisonous berries.

Medical Care

The lack of medical care at residential schools has been one of the factors linked to the high morbidity and mortality rates among students (RCAP 1996). However, this was one area in which the Norway House Residential School does not fit the general pattern. During the majority of the time that the school was in operation, there was either a doctor or nurse on staff at the school or there was a resident doctor and hospital that could care for any sick child. The school principals often remarked on the benefit of having medical care so close for any sick child (Chapin 1972; Lousley 1948).

Along with opening the Norway House Residential School in 1898, the Methodist Church wanted to establish medical and hospital work in Norway House. At that time there were no hospital or medical personnel in the community. In addition to the request for the school building, church representatives requested money from the DIA for the “necessary building and outfit” of a hospital and stated that they could provide a doctor and nurse (NAC,

Sutherland to DIA, June 22 1898). The request for the school was obviously accepted; however the request for the hospital was denied by the DIA (NAC, Branson to McKenna, April 25, 1899). The reason for this was not given.

It appears that the doctor, Dr Lillian Yeomans, and the nurse, Miss A Yeomans, who were available had the hospital been built, instead became part of the school staff and remained on staff until 1913 when the first school fire occurred (DIA, Hardiman, 1902; Lousley 1913). The benefits of having a doctor and nurse at the school were often remarked on by the principals in the Annual Reports to the DIA. For instance, during the second school year when no deaths occurred, Principal Hardiman claimed that “this alone speaks volumes for the care the children are receiving. On staff we have an experienced trained nurse and also a medical man” (sic) (DIA, Hardiman, 1902: 305). The second school principal, Rev Lousley, also made a similar remark in 1908: “There has been quite a lot of sickness this year, though no deaths. This is no doubt due to the fact that there has been a good doctor here and a trained nurse on the school staff” (DIA, Lousley, 1908:309).

Despite having a doctor and nurse on staff, deaths did occur at the school. In fact the majority of the known deaths (28 of 36) occurred during a period of time when medical personnel were on staff. However, it is possible that the presence of the doctor and nurse decreased the number of deaths that otherwise would have occurred. For instance, in 1902-03, there was an outbreak of whooping cough, bronchitis and pneumonia within the school and at Norway

House. Most of the children were sick with all three ailments at the same time (DIA, Lousley, 1903). Principal Lousley remarked that Dr Lillian Yeoman and Miss A Yeomans, the nurse, “did all in their power to check and cure the troubles” (DIA, Lousley, 1903:337). Three children died during the outbreak in the school. However, compared to the 65 deaths that occurred in Norway House from the same cause, it appears that the school fared better (DIA, Jackson, 1903a; Lousley, 1903). At that time, there was no hospital or doctor in Norway House.

When a government hospital was opened at Norway House in October of 1909. It was viewed as a great benefit to the school (DIA, Calverley, 1910). Following its opening, Principal Lousley remarked that the presence of a hospital in the community helped to prevent the spread of sickness within the school by serving as a place for ill students to recover (DIA, Lousley 1910: 443). In addition, the hospital nurse would sometimes visit the school and treat the children there. Of 95 cases attended by the nurse outside of the hospital in its first year, 30 were within the residential school (DIA, Calverley 1910). There is no indication of the types of illnesses treated at the school or whether each of the 30 cases were individual children. But since the total enrolment during that time was 55 children, at most, 54% of the children needed medical care during the hospital's first year of operation.

The hospital burned down in January of 1911 and was not replaced until August 1912 (DIA, Calverley 1911; Steward 1913). It was soon closed in the

winter of 1912 following the resignation of the doctor and nurse. The hospital building served as temporary accommodations for the school children after the school burned down in February of 1913 (DIA, Steward, 1913), at which time the school no longer had any medical personnel on staff (DIA, Lousley, 1913).

It was not long until a permanent doctor was sent to Norway House. In August 1913, Dr HC Norquay was appointed as the Medical officer of the Norway House Agency. A new hospital was also built in 1914 (DIA, Steward, 1914). Dr Norquay served as both the local doctor and also as the Indian Agent (Apetagon 1991). As the local doctor, he often treated children from the school and, as the Indian Agent he was responsible for periodically inspecting the school and sending reports to the DIA. Dr Norquay left Norway House to join the army during WW I; he was not replaced until around 1919-1920 by Dr Stone (Apetagon 1991). Following Dr Stone's departure, Dr Turpel became the local Norway House doctor in 1927 (NAC, Turpel to DIA, Feb 9 1934). He was replaced around 1939 by Dr Cameron Corrigan (NAC, Admissions and Discharges, 1933-1941).

As stated previously, the almost continuous presence of a local doctor was viewed as a great benefit by school officials. Rev Chapin, principal from 1934 to 1941, made the following statement in his memoirs:

"...it meant a great deal to us to have a resident doctor, hospital and nurses on the Indian Agency grounds so close to us. It was seldom we had any serious illness, but it was a comfort to know that if the doctor took a boy or girl to the hospital he was receiving the best care possible. Of course there were times when the doctor was not very popular—e.g. when he would clamp a quarantine on the

school for measles or something. But we were usually on pretty good terms" (Chapin, 1972: 74).

The local doctors did play a large role in the health of children attending the residential school. In addition to providing medical care and enforcing the occasional quarantine, they were responsible for conducting the children's medical examinations prior to enrollment.

In 1915, the local doctor was given the responsibility for supervising the school diet. As discussed previously, there had been numerous complaints regarding the food and a report from the local doctor, Dr Norquay, stated that the majority of the children he treated were suffering from a combination of poor nutrition and tuberculosis. Following an investigation into the matter, it was recommended that the doctor supervise and inspect the diet on a regular basis (NAC, Bunn to Scott, Sept 24 1915). The resident doctor was responsible for this task until 1922. Thereafter, the school had a nurse on staff who looked after the food and was in charge of the kitchen (NAC, Graham to McLean, Feb 23 1922).

The responsibility of the doctors to conduct a medical examination as a requirement for admissions would have had a large impact on the health of children within the school. If a child had a pre-existing health condition that was contagious, then the child could potentially spread the disease to others or the conditions within the school could worsen their ill-health. As will be discussed in the next section, scabies and tuberculosis were two ailments that children often had prior to admission. Scabies, a skin infection caused by mites (*Sarcoptes*

scabiei var. *hominis*), was the more common of the two and would not bar a child from admission. However, scabies is highly contagious and could spread readily due to the overcrowded conditions in the school. Unlike scabies, tuberculosis could bar a child from admission but as will be evident later; this was not always the case.

Health of children when admitted and discharged

Admission and discharge records for the Norway House Residential School are available for 1933 to 1941. Admission records are available for 130 children and discharge records for 130 children as well. These records contain information regarding the children's health at the time of admission and, occasionally, when discharged. As a requirement for admission, a medical examination by a doctor was necessary. The discharge records contain less detail regarding the children's health than admission records. However, if the child were discharged due to health reasons or died while in attendance at the school this was noted as the reason for discharge (NAC, Admissions and Discharges 1933-1941).

The available medical examinations required for admission were conducted by Dr Trupel and later by Dr C Corrigan, the local doctors for Norway House. The form included identifying information such as the child's name, band, and age; the child's height, weight, pulse rate, and temperature. If the child had a fever at the time, the cause was recorded. Any cutaneous (skin)

disease or eruption, trachoma or other communicable eye disease, or syphilis was noted, and whether, in the opinion of the doctor, the child had active tuberculosis. If TB were present in either active or inactive form, the location and stage of the disease was noted. The doctor also noted whether the child was undernourished or had any defects of the “body or limb,” vision, or hearing or any mental deficiencies (NAC, Admissions and Discharges 1933-1941).

Of the 130 admission records, 57 of children or 44% had one or more health conditions at the time of admission. The most common ailment was scabies and lice: 22% of the applicants were diagnosed with this infestation (n = 29). Scabies and lice are an infestation of the skin by mites (*Sarcoptes scabiei*) and head or body louse (*Pediculus humanus var. capitis* and *P. humanus var corporis*) respectively. Both are spread by direct contact and crowded conditions; poor hygiene and poverty can increase the risk of spread (Dambro and Griffith 2005; Rudolph et al 2003). The presence of children with scabies and lice had been a continual issue and was a common complaint about the school made by parents. In 1915, Indian Agent Stewart investigated this issue along with several other complaints. He concluded that the presence of scabies and lice was not the result of the conditions in the school but rather due to the “terrible conditions” from which the children came (NAC, Report on Complaints, Jan 6 1915). However, with a large proportion of children arriving at the school with the parasites, combined with the crowded conditions which would facilitate their spread, it would have been difficult to keep them under control. Malnutrition

and fever due to a cold were the next two common ailments, 13% (n=17) of the applicants were diagnosed with malnutrition and 12% (n= 16) had a cold at the time of examination.

Despite admission regulations that required the refusal of admission of any child who was considered tubercular, TB was prevalent in the school. This had been a long standing regulation but was rarely, if ever, enforced. As Miller puts it, "the regulations often were more honoured in the breach than in observance" (Miller 1996: 301). Dr E L Stone, who was the attending physician in Norway House in the 1920s and was responsible for conducting the medical examination of children prior to admission, had the following to say regarding admission requirements and tuberculosis:

I cannot recall any child, from any Reserve except Island Lake, whom I should not have rejected for tuberculosis if the regulation had been strictly adhered to. Those who appear to have active tuberculosis are rejected. Those whose infection appears dormant are passed. They have to be. Otherwise there would be no pupils in the schools. There are no better to be had. They do quite as well in schools as they would do outside, but, at that, there are too many deaths of pupils during their education (Stone 1925: 247-248)

Of the 130 children admitted between 1933 and 1941, 8% (11) of the applicants had some form of TB. Three of the children with TB were not approved for admission due to their condition, two had active cases of TB of the lungs and the other had an inactive case of TB of the lungs. The afflicted children came from several communities: 6 were from Norway House, 2 from Cross Lake, 2 from Island Lake, and 1 from Berens River, this is not surprising.

Dr Stone had reported in 1925 that the residents of the Norway House Agency communities were “heavily affected with tuberculosis” (Stone 1925: 241).

Of the eight children admitted, three had inactive cases of TB of the lungs, three had scrofula, one had TB of both the lungs and glands, and one had TB of the hip. One of the children with inactive TB of the lungs had previously been discharged at the age of 8. He had only been in the school for a year. At that time he was not considered “tubercular” but was discharged so that he could “become a little more robust.” (NAC, Shoup to McKenzie, Jan 16 1934). He was 12 at the time of readmission. It is very likely that he was infected with TB when he was first discharged but did not have an active case.

In addition, despite the presence of children in the school already infected with TB, officials believed that the school environment was still “healthier” than the homes of the children and in some cases would be a better place for a child to live. There is some evidence for this from the admission records of two children. In 1937, a child with a TB infection in both the lungs and glands applied for admission. Along with his admission and medical forms, the school principal, Rev Chapin, included a letter stating that:

Any TB he has had has been arrested and he is in apparently good health at the present time. This being so he is no menace to the other children. The home he comes from is terribly poor and he ought to stand a much better chance in the school of getting built up against further reinfection (NAC, Chapin to Lazenby, Dec 24 1937)

Another example is from 1940, where a girl, age 16, applied for admission. She was not infected with tuberculosis; however, it was prevalent in her family.

Again, Rev Chapin included a letter along with her admission forms in order to justify her admission to the school. An excerpt of the letter follows:

The parents now have two younger children in the school. The home is not a healthy home. They lost one child from tuberculosis this winter. The father is now himself in poor condition. And so the parents are anxious to get this girl in the school for a couple of years, both to get a bit of training and be cared for physically. The Doctor too is anxious to get her out of her home where she is so liable to infection. Before letting her into the school however he x-rayed her chest to make sure there was no disease (NAC, Chapin to Lazenby, May 2 1940).

Her admission to the school was denied due to her age. Regulations required that the children be discharged at the age of 16 (NAC, Philip to Lazenby, May 21 1940).

The majority of the children were discharged from the school because they had attained graduation age and were considered healthy at the time. Of the 130 children discharged between 1933 and 1941, 19% (25 children) were discharged due to health reasons. The most common reason was listed as "sick leave" or "ill health." Eleven children (8%) were discharged for this reason all of which occurred in the years after 1934. In January of 1934, officials at the DIA sent a letter to Indian Agent Gordon stating that:

It is inadvisable to retain on the quarterly return the names of any pupils who will be absent from the school for a considerable period of time due to illness. In the case of such pupils, application should be made for their discharges in order that their names may be removed from the return (NAC, Sutherland to Gordon, Jan 29 1934)

Following this letter, children who were sent home on sick leave were also discharged from the school. Prior to this they were sent home but kept on the

roll. The nature of their illnesses was not stated, although tuberculosis is a possibility.

Tuberculosis followed by discharge due to death were the next two common reasons. Seven children (5%) were discharged due to tuberculosis and 6 (4%) were discharged following their death at the school. Of the seven children discharged due to TB, 4 cases were due to an active case of TB, one was due to TB of the knee, one was described as a “TB breakdown” and the last was due to “doctor’s order due to chest x-ray,” presumably an active case of TB of the lungs. The health issues for the other two children discharged were a mental breakdown and in order to “become more robust.” The child discharged in order to “become more robust” has already been discussed. This child was later readmitted to school and had an inactive case of TB of the lungs.

Conclusions

Norway House Residential School was not unique among Residential Schools in its experience with infectious diseases. A series of outbreaks affected the school during its 46 years of existence (refer to Table 5.1). The majority of the outbreaks in the school were linked to outbreaks at Norway House. There were only two instances in which outbreaks were specifically linked to other communities. In addition to periodic outbreaks, tuberculosis was a constant problem in the school. Scrofula and consumption continually appeared in the records as a health problem. Children were admitted to school despite infection.

It was the cause of over half the deaths in the school (see Figure 5.2) as well as a common health reason for discharge. Of the known deaths in the school, the majority occurred within the first 15 years of the school existence; however, it is likely that additional deaths did occur. It is known that deaths were often underreported in the residential schools and this was known to be case in one instance (1918 influenza epidemic) at Norway House. Unfortunately, due to lack of documentation, it is impossible estimate the extent the death rate at Norway House Residential School is underreported.

Chapter 6: Discussion and Conclusions

Introduction

The main objectives of this study were to describe and evaluate the general health and disease patterns of the children attending the Norway House Residential School from 1900 to 1946, determine how the conditions in the school affected the children's health, and lastly to examine the interaction between health conditions in the children's home communities and in the school. The previous chapter focused on the general health and disease patterns. In this chapter, I discuss the major patterns of health and disease at Norway House Residential School, consider the conditions at the school that would have influenced them, and discuss how these relate to the health patterns seen in the children's communities, as well as the Native Residential School System as a whole.

General Health Issues in the School

Like many other health studies of Aboriginal populations for the same time period, it proved difficult to adequately recover health and disease patterns due to incomplete and unreliable data (Young 1994: 52). For the first 13 years of the school's existence, the health data for the children is fairly complete because of the published Annual Reports from the principals (DIA, Hardiman 1901; 1902; Lousley 1903-1913). After 1913, information regarding the children's health is scattered among correspondence between school and DIA officials. What exists

is often very sketchy and in some cases, for example the 1918 influenza epidemic, completely absent. Other sources, such as the HBC post journal for Norway House, were needed to supplement these sources but there are still gaps in the records.

Aside from lack of documentation, the accuracy of some reports is questionable. For example, the reliability of the first two Principal's Annual Reports by Rev Hardiman is doubtful. The most obvious discrepancy within his reports relates to his accounts of the heating system and level of fire protection in the building. He gives very little detail on either topic but implies that both are fine. His assessment of the children's health is similar in both reports (DIA, Hardiman 1901; 1902). However, in the next year's Annual Report from Rev Lousley, the fire protection is reported as completely inadequate and the heating system was constructed improperly, leaving parts of the school cold (DIA, Lousley, 1903). Another obvious example of inaccurate reports is reflected in claims that the school diet was adequate. The details of the investigation are discussed in Chapter 4; however, as a reminder, the first report from Indian Agent Stewart stated that the food was "good and substantial" (NAC, Report on complaints, Jan 6 1915) while the second report by Inspector Bunn found serious problems with the food (NAC, Bunn to Scott, Sept 24 1915).

Despite these limitations, a general pattern of the children's health for the study period was developed (refer to Chapter 5) though, in many parts, it is not as detailed as would be desirable. For example, tuberculosis was known to have

been in the school but the full extent of the disease's impact on the children's health is not entirely known. It can also be assumed that there were other acute outbreaks in school for which there are no records. The same can be said regarding the number of deaths at the school. However, what is known about the health conditions of the children and the general conditions of the school is consistent with what is known in general about other Native Residential Schools.

The most commonly reported disease in the school (Table 6.1), as well as in other residential schools, was tuberculosis (Bryce 1907, 1909; Kelm 1998:66; Miller 1999: 304; Waldram et al 1995: 136). Tuberculosis was first mentioned in 1904, although it was likely present in the school prior to this (DIA, Lousley, 1904). Tuberculosis had been a problem in Norway House and the surrounding communities for some time and was reported as a common infection in Norway House by 1887 (Maundrell 1941). It continued to be a problem in northern communities well into the 20th century. When Dr Stone submitted a health report for the Norway House Agency in 1925, he reported that the chief cause of illness was tuberculosis (Stone 1925). As discussed in Chapter 2, the high rate of tuberculosis within the communities was linked to the poverty and poor living conditions found on the reserves. Thus the majority of the children who were enrolled in NHRS would have likely been exposed to the disease at home due to its high prevalence rate. In fact, Dr Stone reported that the majority of the children admitted to the school should not have passed the required medical examination due to their tubercular infection. Had the regulation barring children

with TB from admission been properly observed, the school would have been empty (Stone 1925). This breach in policy was a common occurrence among the residential schools (Bryce 1907, 1909, 1922; Miller 1996).

School year	
1903-1904	several children sent home on sick leave due to TB, 5 deaths due to TB
1906-1907	scrofula and consumption reported as problematic, 9 deaths due to TB
1908-1909	3 deaths due to TB
1909-1910	scrofula and consumption reported as problematic
1910-1911	4 serious cases of consumption resulting in one death
1911-1912	consumption and scrofula chief cause of illness
1912-1913	Three seriously ill children: one consumption, one "bad hemorrhages from the lungs"
1914-1915	several children treated at hospital due to poor diet and "physical pre-disposition to tubercular troubles"
1922-1923	One child under care doctor due to active case of TB of lungs
1923-1924	health good except for "a few cases of glands"
1930-1931	DIA concerned about the health of the pupils, tuberculosis prevalent, one child under doctor's care
1932-1933	One child discharged due to TB
1933-1934	One child discharged due to TB
1934-1935	two children discharged due to TB
1935-1936	One child with inactive TB of lungs admitted, 3 children not admitted due to active cases
1935-1937	One child admitted with "infected gland"
1937-1938	One child admitted with TB of lungs and glands, one child discharged due to TB
1938-1939	Three children admitted with inactive TB
1939-1940	One child admitted with infected glands
1940-1941	One child discharged due to TB and one died of TB following typhoid fever infection

Table 6.1: Years in which TB is mentioned in the NHRS records

Since children with TB were admitted (for instance 8% of the applicants between 1933 and 1941 were known to have some form of TB), children who were previously uninfected ran the risk of acquiring the infection while at school.

Generally tuberculosis among children is not considered contagious,⁷ although rare cases of childhood transmission are known to have occurred (Cardona *et al* 1999; Curtis *et al* 1999). In addition, children generally remained in the school until age 16, with some as old as 18. Older children, or adolescents, have been known to transmit TB (Raffalli *et al* 1996), so this does not rule out the possibility that children in the school could have been infected by others while in attendance, but it was likely the older children who transmitted the disease to the younger ones.

Another factor to keep in mind is that many children could have arrived at the school with an unknown latent case of TB which was acquired at home. The conditions at school, such as the inadequate diet and exposure to other infectious diseases, would have helped to activate a latent case of TB. For instance, following the typhoid fever outbreak in 1940, one child was discharged from the school and another died due to complications from TB following a typhoid fever infection. The relationship between the school diet and TB will be discussed in the next section.

In addition to tuberculosis, the students were periodically affected by other infectious diseases (refer to Table 5.1). Not surprisingly, most were the common childhood diseases: chickenpox, diphtheria, measles, mumps, rubella, scarlet fever, and whooping cough as well as infections common to all ages, such as the

⁷ Most children under the age of 10 with active tuberculosis are not contagious. They generally have little to no cough and when a cough is present it is usually not forceful enough to expel the bacilli (Cutris *et al* 1999: 1494).

common cold and influenza. For most of the outbreaks, it is difficult to determine how many of the children were affected due to inadequate data. Generally, the documentary sources only state that an outbreak occurred but give no indication of how many of the children were affected or even when and how long the outbreak lasted.

For the most part, the outbreaks within NHRS coincided with outbreaks in the Norway House community (refer to Table 5.2). As was previously discussed in Chapter 4 and 5, the children were not completely isolated from the residents of the community; they attended classes with the day school students and attended church services at the Methodist church. This continual contact provided a means for diseases to spread from the community into the school. Once a disease entered the school, it could readily spread among the children due to the overcrowded living conditions.

It appears that most of the outbreaks originated in the Norway House community and spread into the school, transmission in the other direction appears to be non-existent or very limited. For instance, there were a few cases of diphtheria that were isolated in the school in 1923. Dr Stone refers to this outbreak two years later in his 1925 health report and states that “did not spread out of the building [i.e. the residential school] it appeared in” (Stone 1925: 246). However, it is not known if the surrounding communities were affected by the outbreak. Two other outbreaks that were limited to the school and did not appear to affect the Norway House community were the whooping cough outbreak in

1933 and the typhoid fever outbreak in 1940, though it is very difficult to determine this with any certainty. Children were often sent home on sick leave but the records do not state what their illness was at the time. In all probability, it was tuberculosis which was already widespread in the home communities of the children, with the exception of Island Lake. This is not to say that the school children did not introduce infectious diseases into their home communities after leaving the school but this is difficult to determine. In whatever way an infectious disease entered the school, the living conditions contributed to its spread and increased the children's susceptibility to it and other diseases.

The Relationship between Conditions at NHRS and Health

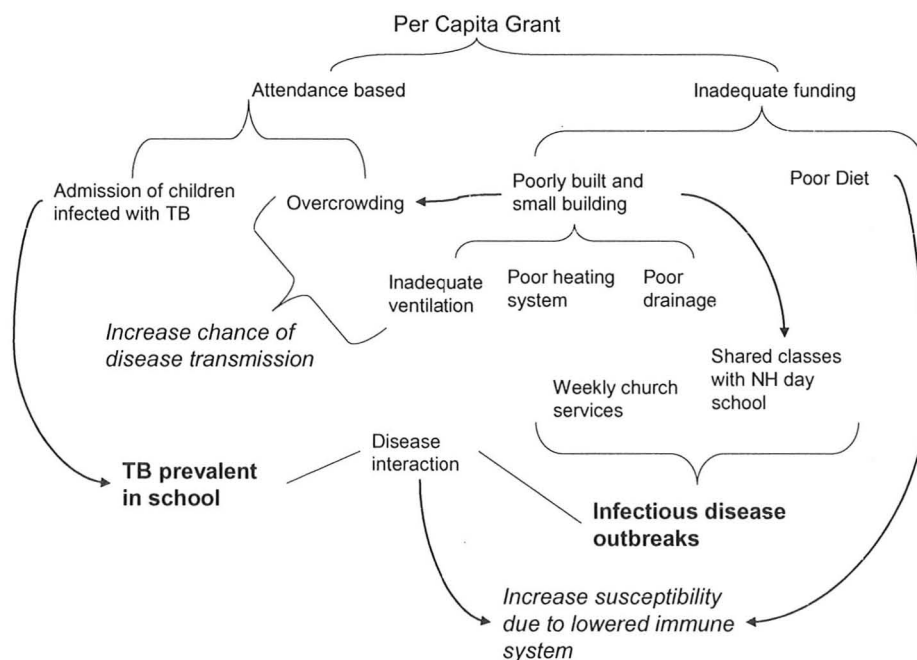


Figure 6.1 Diagram showing relationship between conditions at NHRS and infectious diseases

Norway House Residential School, like other institutions, had several characteristics that made it a prime environment for infectious diseases to spread (refer to Figure 6.1). In general, infectious diseases easily spread within an institution due to the fact that it is a closed environment in which a large number of people are gathered. This results in close contact between infected and non-infected individuals for an extended period of time. Additional factors such as overcrowding and poor ventilation, which were common problems at Norway House and other Native Residential Schools, would have increased the risk of disease transmission (Musher 2003; Stead 1996). The majority of diseases reported NHRS were spread person-to-person via a respiratory route and the most common risk factors for transmission are household transmission and crowded conditions (Table 6.2).

The overcrowding of Native Residential Schools, Norway House included, resulted from a funding system that was based on levels of attendance. It was common practice for principals to enroll more children, regardless of the prospective students' health status and the capacity limit of the school, in order to keep attendance figures high and the funding coming in (RCAP 1996). At Norway House Residential School, the original school building's capacity was 50 pupils and the second building's capacity was 80 but enrollment often exceeded the capacity (refer to Figure 4.4).

Disease	Transmission	Risk Factors
Chickenpox	Respiratory	highly contagious (~90% of close contacts), household transmission, crowded conditions
Diphtheria	Respiratory	crowded living conditions, household transmission
Erysipelas	direct contact	
Influenza	Respiratory	crowded, closed environments
Lice	direct contact	overcrowded conditions, close contact, poor personal hygiene
Measles	Respiratory	highly contagious, ~90% of close contacts
Mumps	Respiratory	highly contagious, ~90% of close contacts, household transmission common
Rubella (German measles)	Respiratory	crowded living conditions
Scabies	direct contact	crowded conditions, poverty
Scarlet Fever	respiratory or direct contact	crowded living conditions
Tuberculosis	Respiratory	household transmission, poor air circulation
Typhoid Fever	fecal-oral (contaminated food, water)	Poor sanitation
Whooping cough	Respiratory	highly contagious, ~90% of close contacts, household transmission common

Table 6.2: Transmission and risk factors for diseases present at NHRS
Sources: Dambro and Griffith 2005; Dale 2005; Rudolph 2003.

During the study period, there were numerous mentions of the health risks of overcrowding in the school. For instance, in 1906 the attendance rose to 65 students, 15 above the capacity. During the school year, 10 deaths occurred, mostly from TB, and several children were sent home on sick leave (DIA, Lousley 1907). After the fact, it was noted that the high enrolment was “probably more [children] than should have been in the dormitories considering the lack of ventilation” (NAC, Report of NHBS, 1907). It is not clear how long the children who died during the year or were sent home had been enrolled in the school. It was common for pre-existing health conditions, such as tuberculosis, to be ignored in order to fill the Native Residential Schools. With an increase in the

enrolment and an increase in the number of deaths in the same year, it is possible that some of additional children enrolled were already sick when they entered school and that the conditions in the school only worsened their ailment.

Another example of the health risk from overcrowding in the school was during the winter of 1916-1917. Many of the children were sick in bed with minor illnesses for several days each week. Dr Norquay attributed the high number of illnesses to the fact that the beds were very close together in the dormitories, which would have facilitated the spread of infectious diseases (NAC, Report of Agent Norquay, May 1917). During that time, there were 103 children enrolled in the school and the capacity of the school was only 80 students.

Despite the known risk to the children's health, the DIA did increase the per capita grant of the school from 80 to 105 in 1922 (NAC, Ferrier to McLean, Oct 4 1922; McLean to Ferrier, Oct 10 1922). This increase in the grant stemmed from requests from school officials for funding to help cover expenses from the additional students above the previous grant limit, rather than from additions to the size of the school in order to accommodate more students. Further requests for increases were denied due to strong opposition from Indian Agent Gordon (NAC, Gordon to MacKenzie, Oct 7 1925) and because the DIA recognized that the number of students was already in excess of what was allowed given the size of the dormitories (NAC, McLean to Ferrier, Nov 3 1925). The health risk of having too many children in the school was well recognized by DIA officials as well as school officials. Despite this understanding and the

numerous requests by the local Indian Agents and doctors to decrease enrolment levels, nothing was done to correct the problem (NAC, Report of Agent Steward, April 1915; Report of Agent Norquay, May 1917; Gordon to MacKenzie, Oct 7 1925; Turpel to DIA, May 20 1930).

Money appears to be the main reason for this. It was common for financial issues to take priority over the health of the children attending the residential schools. Had the DIA decreased the per capita grant limit, school officials would have greatly protested. The school principals seemed to have no qualms about filling the school well above the capacity of the building, even if doing so was known to be a health risk and in excess of the per capita grant. This was done to ensure that the full grant amount was received. However, this created a situation in which there were more children than were covered by the funding. In order to make ends meet, the school usually pursued one of two options: cutting expenses on items such as food, clothing, and minor repairs to the building or having the affiliated Church pay the additional expense. The Churches were unenthusiastic about making up the deficit and often requested that the DIA to cover the difference. However, the DIA was not always willing to cover the deficit either (NAC, Benson to Pedley, Aug 21 1905; RCAP 1996). Consequently, the DIA would occasionally agree to raise the per capita grant for schools. The schools themselves kept expenses to a minimum. This contributed to the poor quality of food and clothing, the heavy work load of the children, lack of medical facilities in the many of the residential schools, and poorly maintained

school buildings (RCAP 1996). Many of these conditions created an environment in which diseases could easily spread and increased the children's susceptibility to illness.

For instance, the poor diet of the school children has been linked to the high morbidity and mortality rates in the Native Residential Schools (Miller 1996; RCAP 1996). The synergistic relationship between poor diet and increased susceptibility to diseases is well known (e.g. Chandra 1972; 1988; Shell-Duncan 1997). In fact, it was not uncommon for doctors to send reports to the DIA commenting on the relationship they observed between the poor diet at the schools and tuberculosis (RCAP 1996). This fact was noted at the Norway House Residential School as well.

The majority of the data regarding the diet and its impact on health comes from 1915. During that year, two DIA officials investigated the diet because of a number of complaints from parents. The first investigating official, the local Indian Agent, downplayed the complaints and concluded that the diet was "as good as can be expected" (NAC, Report on Complaints, Jan 6 1915). The second investigation, conducted by the Inspector of Indian Agencies, came to a very different conclusion and without a doubt was a more accurate assessment of the diet. The menu was monotonous and lacked variety in the types of food (refer to Figure 4.7).

According to Dr Norquay, the Norway House doctor at the time, the school diet lacked the "proper nourishing food" needed for individuals who had "a

physical pre-disposition to tubercular troubles” (NAC, Bunn to Scott, Sept 24 1915). As discussed earlier, poor nutrition is a risk factor for a latent infection of tuberculosis to become active due an impaired immune system (Cegielski and McMurray 2004). It was common for children to be admitted to the Norway House hospital in “low physical conditions” that often improved after receiving proper food served at the hospital (NAC, Bunn to Scott, Sept 24 1915). Many of the children risked being infected with tuberculosis at home, given the high prevalence of TB in the home communities (Stone 1925). Due to the poor nutrition at school, a dormant infection could easily become active. It is also likely that the menu from 1915 had changed little from the time that the school opened in 1900. If, in fact, this was the general diet of the children for the first 15 years of the school’s existence, it could help to explain the high number of TB deaths during that time period (refer to Figure 5.2). But it should be noted that the clustering of deaths during those early years could have also occurred in later years, but is undocumented.

Following the investigation, there were some efforts to improve the diet at the school. Immediately afterward, Dr Norquay was instructed to supervise and conduct regular inspections of the food (NAC, Scott to Bunn, Sept 30 1915). By 1922, the school had a nurse who was in charge of the kitchen and looked after the food. Also, Principals such as Rev Shoup, who served from 1930 to 1934, were noted by the local doctor as having made improvements to the diet. Principal Shoup increased the gardens at the school in an effort to include more

vegetables in the diet (NAC, Trupel to DIA, Feb 9 1934). The extent of the changes to the diet and how much it would have improved the health of the children is difficult to determine. Nevertheless, the diet at the Native Residential Schools in general was continually considered substandard (RCAP 1996). It would be safe to assume that the quality of the diet at the Norway House Residential School was similar to that in other schools.

One advantage the Norway House Residential School did have over most other residential schools was an isolation room at the school, medical personnel on staff, and close proximity to the Norway House hospital. Many of the residential schools had little to no medical facilities (Miller 1996: 303). When the children did become ill, they at least received care. This did appear to be advantageous in some cases. For instance, during the 1918 influenza outbreak, the Norway House community was hit particularly hard and an estimated 18% of the population died as a result (Herring 1994). Within the school, most of the children were sick but they received care from the principal's wife and the older children who were not ill. Only 2 deaths occurred out of 89 students who were in attendance (Apetagon 1991). It could be argued that there were proportionally fewer deaths in the school (2% vs 18%) because of the care that the children received while sick. At other residential schools, the lack of medical care has often been linked to the high mortality among the children (Miller 1996:303; RCAP 1996). However, the presence of medical care at the school would only help children to recover when ill and not necessarily prevent them from becoming

ill in the first place. The previously mentioned living conditions, as well as the admission of children who were already ill would have negated that.

Conclusions

Overall, the health and poor living conditions at the Norway House Residential School were consistent with what was seen in other Native Residential Schools. Tuberculosis was the most common cause of illness and death among the school children. The high prevalence of the disease among the school children can be linked to the endemic conditions found on the reserves and the failure to enforce regulations barring the admission of infected children to NHRS. Outbreaks of other infectious diseases also periodically affected the school children. The continual interaction between the residential school children and the Norway House residents allowed infectious diseases that were circulating in the community to enter the residential school.

Once a disease entered the school, the living conditions facilitated its spread and increased the children's susceptibility to illness. The poor living conditions within the Norway House Residential School were directly linked to the chronic under funding of the school system and the inability of the DIA to enforce regulations, either due to lack of interest, effort, or authority. As was the case with other residential schools, financial matters usually took priority over the children's health and well being.

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