Body Work: Childhood, Gender and School Health Education in England, 1870 to 1977

Jane Pilcher
Department of Sociology
University Of Leicester
University Road
Leicester
LE1 7RH

Tel 0116 252 2731
Email: jlp3@le.ac.uk

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**Abstract**

In this paper, I focus on a neglected topic in the historical sociology of childhood, namely children’s health education, in order to explore a neglected theme, namely the gendered character of (re)constructions of childhood. Drawing on a series of government publications, and reports at the level of schools, I argue that whilst health education for children played an important role in a broader set of British national, political strategies to ensure the health and fitness of ‘the Nation’ during the twentieth century, it was girls who were the primary targets and recipients of health education in schools. Gender was thus central to the ‘body work’ in childhood that the official publications on health education sought to promote.

Body, gender, health education, historical constructions of childhood
The upsurge of sociological interest in bodies, and in particular, the development of embodiment perspectives, has encouraged an understanding of all bodies as unfinished, corporeal-cultural entities (for example, Grosz 1994; Shilling 1993). It is, though, especially the bodies of children that are constructed as bodies ‘in progress’. This makes childhood a life course stage of intensive ‘body work’, whether in a general sense of achieving a normatively ‘healthy’ rate of bodily growth during ‘growing up’ or, say, in relation to the (re)production of gendered bodies (James, Jenks and Prout 1998: 164). Thus conceptualised, ‘body work’ in childhood takes place within and through myriad settings, processes and practices, including law and social policy (see, for example, Pilcher and Wagg 1996, Author 1997, James and James 2004) and, as the new sociology of childhood reminds us, is undertaken not least by children themselves (Mayall 1996; James and Prout 1997).

In this paper, I consider one such arena of ‘body work’ within childhood: the formal education of children in bodily health. This is a set of knowledge, practices and policies articulated ‘in the name of the child’ (Cooter 1992) and in construction of childhood that has been overlooked within historical and sociological analyses. I argue for the importance of health education for school children in developing our understandings of the constructions and reconstructions of childhood during the modern period, and also point to the gendered character of these (re)constructions. Health education for children,
based upon a view of children’s bodies (and minds) as unfinished ‘works-in-progress’ was a key way in which children, and notably girls, were constructed as pivotal actors in the reproduction of the future social order in England and Wales during the twentieth century. I focus on the history of health education for school children from the inception of publicly funded education in England and Wales in 1870, through to the late 1970s when administrative restructuring shifted responsibility for the health of school children away from the government department of education to the department of health (Department of Education and Science 1977). My sources of evidence include a series of government publications on health education for children, including guidance on the curriculum in the various handbooks of health education (1928-1977) and official reports of health education provision at the level of schools contained within *The Health of the Schoolchild* (1907-1972). The various handbooks of health education, along with the discussions of health education policy and provision within the *Health of the Schoolchild* reports, were authored by senior civil servants and represented the ‘practical translation of government policy into prescriptions for educational practice’ (Hunt 1991: 74).

Clearly, as such, these official publications cannot tell the whole story of what was said about childhood and done to children (Hendrick 1992a) through the knowledge, practices and policies of health education in schools. The ‘new’ approach to the study of childhood (James and Prout 1997) requires an understanding of children as active, reactive and creative beings, and the official publications used in this article reveal very little about how children themselves actively experienced the health education curriculum. Yet, as argued by Pilcher and Wagg (1996: 2), recognising that children actively shape the social world must sit alongside an understanding of the ways their agency is framed and
conditioned by adult-dominated sets of knowledge, practices and policies (see also James and James 2004). Health education, including that for children, is inherently political in substance, despite its surface level neutrality and seemingly positive connotations (Lupton 1995; Green and Thorogood 1998). Health education in schools represents an important example of ‘how social policies…engage with particular discourses of childhood, respond to social events and embody specific ideological stances, combining to reproduce a particular form of childhood for children’ (James and James 2004: 9). In this article, I show that particular gendered constructions of childhood underlay the policy and practice of health education in schools during the period 1870-1977, which meant that it was girls and their bodies, rather than boys and their bodies, who were the primary targets and primary recipients of health education. Despite changes during the twentieth century, both in constructions of gendered childhoods and in the school health curriculum, including the gradual increase within it of the importance of sex education, official guidance on health education and local level provision in English and Welsh schools continued to construct feminine childhood as pivotal to securing the health of the nation.

The origin and early development of health education in schools

Education in health (or ‘hygiene’) has been part of the curricula of publicly funded schools in England and Wales since at least the late nineteenth century and continues in the present day (Board of Education 1930; Department For Education and Employment 2000; Mayall 1996). The longevity of health education as a subject in schools is suggestive of its importance, not least to successive British governments throughout the
twentieth century and beyond. Yet, histories of public health notwithstanding (for example, Armstrong 1983; 1993; Jones 1986; Lewis 1986), the history of health education in England and Wales has been virtually ignored, with a few exceptions (Amos 1993; Lupton 1995; Sutherland 1979; Welshman 1997); in particular, there is a lack of scholarly attention given to the history of health education in schools.

Historical analyses of child health, welfare and education do, however, provide a broad framework within which to understand the development of health education for children. The origin of social policy programmes related to children's health has generally been located by historians in the context of the widely held concerns about the poor living conditions, physical ill-health and doubtful morality of the large working-class population of nineteenth century urbanised, industrialised Britain (for example Fraser 1984; Laybourn 1995). Such concerns were encapsulated in the Boer War (1899-1902) era anxieties about the future of the British Empire and of the ‘race’, given revelations about its physically unfit male citizens, high rates of infant mortality, declining rates of fertility and incidence of venereal disease (see, for example, Bland 1982; Cooter 1992; Mort 1987). It was in such contexts that, between the last decades of the nineteenth century and the early decades of the twentieth century, environmental discourses of health and disease (exemplified in the public sanitation campaigns of Edwin Chadwick) were gradually replaced by discourses which targeted the individual as the key agent in the maintenance of bodily health and the prevention of disease (Armstrong 1983; Mort 1987; Welshman 1997). Although wide ranging in terms of its contributing elements (from bacteriology, to preventative medicine, to eugenicism), within these discourses
there was a common emphasis on education in hygiene or health as the most effective strategy through which to improve both the physical and sexual-moral health of ‘the Nation’ (Mort 1987). During the early years of the twentieth century, it was working-class children who emerged as a pre-eminent group of individuals through whose unfinished, and therefore malleable, bodies the future health and progress of the nation would be secured (Cooter 1992; Hendrick 1997).

The incorporation of the poorest children into the publicly funded schooling system, particularly from 1870 onwards, meant that the condition of their bodily health became a more pressing issue of political concern. As suggested by Mayall (1996), it became clear that the unhealthy and poorly nourished bodies of working class children inhibited the education of their minds. In the late nineteenth and early twentieth centuries, under the direction of central government policy, provision developed within schools aimed at improving the physical health of children, including school meals and programmes of medical inspection (Hendrick 1997). Schemes of physical exercise had been part of the school curriculum for boys and girls from the late nineteenth century onwards, in the form of ‘drill’ (military-style marching) and, by the early twentieth century, included more progressive forms such as dancing and gymnastics (Welshman 1998). As noted by Welshman (1998: 62), much of the appeal of physical education to the Board of Education and other commentators lay in the belief that it inculcated an improved form of disciplined physical citizenship, especially amongst boys.

Alongside these policy initiatives targeting children's bodies, there was also formal
instruction for children in schools on matters of hygiene, so that both their minds and bodies might be educated in the practice of healthy living. The topics taught to working class girls in the gendered curriculum of the late nineteenth and early twentieth centuries were focused around efficient housewifery and competent motherhood, and as such were concerned with the avoidance of malnutrition, ill-health and disease (Dyhouse 1981; Hunt 1991; Purvis 1991; Turnbull 1987). But it was not until the early twentieth century that health education was proposed as a compulsory subject in the curriculum for both trainee teachers and school children (Dyhouse 1976). In a clear depiction of children’s bodies as ‘works-in-progress’ toward a mature, adult, reproductive end-product, the Board of Education insisted that

’opportunity should be found in connection with the curriculum in elementary schools, for imparting to the children who are to become mothers and fathers of the race, the broad principles of healthy living’ (Board of Education 1905, cited in Dyhouse 1976: 49).

The establishment in 1908 of the School Medical Service marked a further key stage in policy directed both at children’s bodies and their minds, via its responsibilities for school meals, medical inspections of children’s bodies and physical and health education (Harris 1995). It also represented a consolidation and expansion of the power and occupational interests of those education and health professionals with a growing stake in the cultivation of ‘healthly’ children’s bodies within school settings (Cooter 1992: Hendrick 1992b; Turnbull 1987).
By the mid-1920s, the Board of Education no longer overtly prescribed the curriculum as it had done previously (Hunt 1991; Simon 1974). In place of the earlier mandatory regulations and codes, instead were published ‘suggestions’ as to what might be taught, according to the level of school, the age of pupils and on particular topics (for example, Board of Education 1927a). Such guidance publications have been described as being, at least during the period up until 1944, ‘bibles’ for teachers, and in circumscribing practice, as having for them all the significance of a mandatory syllabus (Hunt 1991: 21).

Examples include ‘suggestions’ on the teaching of patriotism, on classics and, most importantly for my purposes, the *Handbook of Suggestions on Health Education* (Board of Education 1928a). This was the most detailed official guidance on the teaching of health education in schools then published. In its preface, written by the then Chief Medical Officer to the Board of Education, George Newman, the handbook is described as part of the ‘necessary equipment of every teacher’ (Board of Education 1928a: 3). A 1929 survey of a sample of elementary schools found that 73% of junior mixed-sex departments or schools reported having at least one copy of the handbook of suggestions on health education, rising to 74% of senior boys, and 81% of senior girls departments/schools (Board of Education 1930). The distribution of the handbook was, then, relatively widespread amongst publicly funded schools. This is a finding which, together with the publication of subsequent editions and various reprints between 1928 and 1947, points to the importance of health education in schools during the first part of the twentieth century, in contrast to the view espoused by Sutherland (1979: 14).

In his account of health education and public health, Welshman (1997) attributes the
general expansion of health education to its cost effectiveness as a form of preventative medicine, in the context of the economic recession of the 1920s and 1930s and associated financial retrenchment on health expenditure. It is clear from Newman's preface to the 1928 handbook that part of the motivation for encouraging health education in schools was economic. He notes, for example, that the neglect of hygiene and health ‘costs a nation dear, in money and life’ (1928a: 6). It is, though, the longer term anxieties over national efficiency in the context of the decline of ‘the Nation’ in physical and moral terms that played the largest part in the development of health education in schools.

Moreover, the view of children’s bodies as unfinished entities made the life course stage of childhood the most worthy and effective one within which to invest health knowledge, practices and policy. In Newman's words, it is in childhood that ‘cure’ and ‘control’ are most practicable and it was through children that would be laid ‘the foundations of a health conscience in the minds of the English people of the next generation’ (1928a:12). School health education thus represents an important aspect of the reconstructions of childhood identified by Hendrick (1997) amongst others, whereby children through various social policies were attributed with a crucial status for the reproduction of the social order in late nineteenth and early-mid twentieth century Britain. However, as I go on to show below, this reconstruction of childhood was not an ungendered one. Indeed, we need to recognise not only reconstructions of childhood in terms of ‘Children of the Nation’ (Hendrick 1997), but more specifically, of ‘Girls of the Nation’.
Gendered childhoods in school health education up until the 1940s

As noted above, in the early editions of the handbooks of health education, hygiene education for children was emphasised as a key means of improving ‘national efficiency’, through raising levels of physical health amongst the future adult population. The suggested syllabus included (in the 1928 edition), cleanliness and care of the body, clothing, fresh air and sunlight, eating habits, communicable diseases, and science. In the two subsequent editions (1933 and 1939), the contents were expanded to include ‘the hygiene of food and drink’, ‘mothercraft and infant care’ and the ‘conditions of a healthy environment’. A significant element of health education proposed for children was predicated on the intense surveillance and regulation of their unfinished bodies.

Especially in the early editions of the handbooks, teachers were exhorted to scrutinise and regulate the bodies of their pupils, through for example, monitoring their bodily cleanliness, instructing them in the frequency of changing underclothes and of making bowel movements, and in the proper use of handkerchiefs (Board of Education 1928a: 9, 10, 14). Thus, although health education for children reflected the construction of them as adults of the future, this was predicated upon a close scrutiny of their childish bodies in the ‘here and now’ of their present.

The topic of mothercraft notwithstanding, the advisory discourses of the handbooks constructed the bodies of children as ‘unsexed’: there is a conspicuous absence of any discussion of the human sexual and reproductive body, despite virtually every other bodily system and function being suggested as potentially suitable topics for the health education curriculum within schools (Author 2004). Yet, within the early editions of the
handbook of health education, it is nonetheless evident that the sex of the child to be educated in health was most often assumed to be male. Generic use is made of the masculine pronoun throughout the handbooks. In itself, this might be argued to reflect the patriarchal linguistic practices of the era. However, the assumption of the health education pupil as a masculine adult-in-waiting is apparent in the following passage, where a link is made between health education and adult, masculine citizenship:

Any teaching of citizenship to older children resolves itself in a large degree into health education. The first duty of the citizen to the State is to make himself a strong, long-lived, capable citizen, able to work and produce, the guardian and maintainer of a home, an all-round man, loyal, patriotic, a “friend and helper of mankind” (Board of Education 1928a: 75-6; see also Board of Education 1933: 66).

Elsewhere in the handbooks, assumptions made about the ‘natural differences’ between girls and boys and their future differentiated roles in adulthood meant that both sexes were sometimes addressed. For example, in passages discussing the importance of a ‘healthy mind’, teachers are advised to encourage the interest of boys and girls separately through attending to the gender distinct ‘springs of action’ that each possess. In girls, these are said to be ‘the desire for happiness and usefulness’; in boys, the desire for ‘risk, adventure, fame and service’ (1933: 17; see also 1928a: 58). Gendered assumptions about the present and future interests of boys and girls are further reflected in suggestions about where in the curriculum health might be taught. Thus, in the 1928 edition of the handbook, it is suggested that teaching about nutrition should be undertaken for girls in
their ‘housecraft’ lessons, and for boys in science lessons (1928a: 28). Similarly, whilst aspects of health education could be covered under the history or geography curriculum, ‘in the case of girls much of the instruction will naturally form part of the teaching of domestic subjects and housecraft’ (1928a: 11), since as stated later in the handbook, ‘domestic training is essentially a form of health education’ (1928a: 76). These excerpts provide a clear illustration of the ways in which domestic training was regarded as virtually equivalent to health education, thus making girls and their bodies its ‘natural’ pupils.

In these ways, then, although the health education pupil was implicitly assumed to be male (through language and illustrative examples), the equation of health education with domestic training brought the practical focus of the health education curriculum very much on to girls. The Chief Medical Officer to the Board of Education included in his annual report of 1928 a chapter which, through emphasising the importance of instructing girls in the 'foundations of motherhood' as a key part of their education in health, shows the construction of feminine childhood in terms of future housewives and mothers. Thus, it was argued that the 'source and strength of a people depends primarily on motherhood. If the school girls of this generation are to become the wise mothers of the next, they must be taught the elements of Mothercraft'. Further, 'no schooling of a girl can be satisfactory which fails to aid in her equipment for this supreme task' (Board of Education 1928b: 82, 88). Thus, by the second edition of the handbook of health education, published in 1933, the contents had been amended to incorporate the 1910
memorandum on the teaching of mothercraft and infant care, along with a 1920 memorandum on the hygiene of food and drink.

For boys, a key part of health education was said to be physical training, games and team work in order that their bodies acquired 'strength and skill for manual labour' (1928b: 82), in preparation for their adult futures in paid employment as the mainstay of the nation’s workforce. Notably, however, the various editions of the handbook never incorporated a syllabus on physical training, published in 1919. Moreover, within the annual reports of the Chief Medical Officer to the Board of Education, physical education was invariably discussed under its own separate heading, rather than within sections or chapters on health education. Thus, physical education remained related to but separate from health education, unlike those aspects of the curriculum targeted especially at girls.

The closeness of the link between femininity and health education for children was apparently not a wholly desirable state of affairs, at least from the point of view of the Chief Medical Officer to the Board of Education. As early as 1925, George Newman was bemoaning the limited provision of health education for boys in schools:

'The teaching of hygiene to boys is on a much less satisfactory basis, owing to the fact that there is no practical school course corresponding to the domestic science work of the girls' (Board of Education 1925: 113).

Newman went on to extol the virtues of the 'spirit and methods' of the Boy Scout
movement (associated with Baden Powell), as a model of health education for boys via its emphasis on activities of one kind or another (1925: 114). The 'comparatively backward state' of health education for boys compared to girls (Board of Education 1925: 112) was not, however, resolved to Newman’s satisfaction some several years later (Board of Education 1930: 47). A survey of school health education undertaken by schools medical officers in 1929 showed the marked levels of gender disparity in the teaching of health education. Six per cent of the senior girls departments or schools in the survey were reported to offer no systematic course in hygiene, compared to 32 per cent of senior boys departments or schools. Provision for both genders was found to be much lower amongst the more middle-class, academically orientated secondary schools, but even here the proportion of girls departments or schools reported to offer no systematic course on hygiene (45 per cent) was significantly less than that for boys, at 85 per cent (Board of Education 1930). A further study, undertaken a decade later, suggested much the same gendered pattern of health education provision within schools. In 1943, a survey on the extent and character of sex education undertaken by His Majesty's Inspectors of Education reported that 'very much more attention is given to this subject in girls' schools than in boys' schools’, at the ratio of three to one (Ministry of Education 1943: 6, 12). Arguably, such a gendered disparity reflected a tendency within schools to equate both sex education and health education with instruction to girls about their present and future bodies, via topics such as menstruation and related personal hygiene, and mothercraft and infant care.
The annual reports of the Chief Medical Officer to the Board of Education (later the Ministry of Education, and Department of Education and Science), often referred to as the *Health of the Schoolchild* reports are an important source of evidence about the extent and character of health education for children within schools during the twentieth century and its contribution to the (re)construction of gendered childhoods. Published between 1907 and 1972, these reports include summaries of submissions made by county and city school medical officers to the government department of education, as well as policy statements emphasising the ongoing importance of health education in schools. Yet, despite the official rhetoric as to the central importance of health education for children per se, and concerns expressed at the highest level about the limitations of health education for boys, what the reports reveal is the extent to which local provision remained gendered throughout the period, with girls and their bodies as its primary recipients.

In the reports of local level programmes of health education within schools, more often than not, the examples given are of schemes within girls' schools or of schemes involving only girls within mixed sex schools. In the report for 1913, for example, an extended illustration is given of a scheme of health education as ‘practice rather than theory’. Operated by a girls’ school in Greenwich, London, this scheme included the topics of mothercraft and infant care, first aid and nursing, and household cleaning (Board of Education 1914: 237). Similarly, the example of the ‘Health Brigade’ within Birmingham’s elementary schools detailed in the report for 1922, appears not only to have been the initiative and responsibility of women science teachers but also to have had
only girl pupils as its members (Board of Education 1923: 28). The tendency for the examples of programmes of health education given in the official publications to be about girls’ schools, women teachers and girl pupils underlines the extent to which women and girls have been central to health education. This reflects both the gendered mapping of the mind/body dualism, within which girls and women are constructed as closer to ‘nature’ via their bodily functions, and relatedly, their status as ‘the socially constructed pivot of family health and welfare’ (Rodmell and Watt 1986: 10; see also Nettleton 1991; Welshman 1987). Important in this regard is the previously noted equation, especially at the local level of schools, of ‘health education’ with topics such as domestic science, mothercraft and infant care, and menstruation. Within the *Health of the Schoolchild* reports, there are over the years numerous examples given of house craft, first aid, and infant care orientated health education programmes for girls. These operated across the country, from Plymouth to Bradford (Board of Education 1924), from Birkenhead to Yorkshire (Ministry of Education 1947), from Leeds to Kidderminster, to Brighton (Ministry of Education 1960), from Devon to Croydon (Ministry of Education 1964). On occasion in the reports, the sex of the pupils involved in health education schemes described therein remains unclear and details of the syllabus of such schemes are provided only in general terms. It is therefore not always possible to interpret the extent of gendering of health education from the descriptions given. Even more rarely, though, are specific details provided about health education programmes targeted at boys. The case of a ‘Handyman’ course for boys in an Essex elementary school is an exception that rather proves the rule. Here the course centred around domestic repairs, included woodwork and the proper care of chimneys and was therefore compared with domestic
science courses for girls (Board of Education 1925: 114).

*Body work for boys? Bringing boys in to health education*

As Hunt (1987) reminds us, despite its longstanding place in the curriculum, it is important to note the wide variations between schools in the provision of domestic training for girls. There is also evidence of resistance to it being taught, from parents, pupils and teachers themselves (Dyhouse 1976; Turnbull 1987). Such resistance can also be interpreted as a reluctance to accept the (re)construction of feminine childhoods, and by implication, future adulthoods, that such gendered programmes of education represented. The contentious nature of domestic training was certainly alluded to in several editions of the handbooks of health education (for example, Ministry of Education 1956: 51-2; Department of Education and Science 1968: 94). Nevertheless, it was perhaps in response to the secure place of domestic science, mother craft and infant care in the school curriculum, relative to similarly orientated courses for boys, that official policy discourses increasingly began to encourage the inclusion of boys in this type of health education. Moreover, such courses were activity-based, and thus seen as more likely to secure the interest of boys. As early as 1925, the Chief Medical Officer to the Board of Education was referring to the ‘joint responsibility’ of boys as ‘homemakers of the future’ (Board of Education 1925: 115). This viewpoint was reiterated in the 1928 edition of the handbook of health education when, in a discussion of training in ‘Handwork and Domestic Subjects’, it was stated that ‘opportunities may…. be found for instruction in the carrying out of simple household occupations, in which boys also should take their part’ (Board of Education 1928a: 77). Likewise, in the Chief Medical
Officer’s (now Arthur MacNalty, appointed 1935) report for the years 1939-1945, it was argued that ‘boys and girls should be expected to take part in domestic work’ and that boys should be taught to expect to ‘share equally in the responsibility of home making’ (Ministry of Education 1947: 128). It was, though, especially in the post-Second World War period, in the context of emerging trends in adult ‘conjugal relationships’ documented in the 1950s by Bott (1971) and in the 1960s by Young and Willmott (1975), that official discourses on health education for schoolchildren began to be both more inclusive of girls, in terms of the use of language, and of boys, in terms of the need for their instruction in those health education topics traditionally seen as the preserve of girls arising from their anticipated future adult lives as wives and mothers.

**Gendered childhoods in school health education post-1945: the troublesome bodies of girls**

The first post-Second World War revised edition of the handbook of health education was published in 1956. One significant alteration to the content of the handbook was the omission of the chapter, present in the 1933 and 1939 editions, on ‘Mothercraft and Infant care’. The topic was now incorporated, in a much briefer form, within a new chapter (also present in the later 1968 edition) entitled ‘School and the Future Parent’. Here, the concern to encourage the instruction of boys as well as girls in the proper care of infants and children, in anticipation of their becoming fathers of the future, is clearly expressed through the use of the term ‘parentcraft’ (Ministry of Education 1956: 53; Department of Education and Science 1968: 94), alongside that of ‘mothercraft’ (Ministry of Education 1956: 51; Department of Education and Science 1968: 93) and
through frequent references to both sexes in this context. Earlier in the 1956 edition of the handbook, during a discussion of the range of subjects within secondary schools where health education could be taught, reference was made to ‘Housecraft’ and the need to include boys in it:

‘This is traditionally a subject for girls, yet boys too could benefit from some preliminary training in the domestic skills which a wife may now reasonably expect of her husband; efficiency, cleanliness (particularly in handling food), and proper standards of taste in domestic matters are as important for boys as girls’ (Ministry of Education 1956: 46).

In the 1968 edition of the handbook of health education, this section is re-titled ‘Home Economics’ and reference is again made to ‘home-making as a joint responsibility of the father and the mother’ so that ‘boys should have an opportunity to join in some of the home economics teaching’ (Department of Education and Science 1968: 88). Moreover, in a chapter on nutrition and food, the importance of teaching both boys and girls about nutrition is emphasised (Department of Education and Science 1968: 51). These examples suggest the ways in which official guidance discourses on health education in schools sought to encourage the inclusion of boys in the longer and more securely established elements of the health education curriculum, traditionally provided for girls, in reflection of a reconstruction of masculine childhood which incorporated future adult domestic and child care responsibilities. Nevertheless, within the chapter on school and the future parent, much of the discussion (within both the 1956 and 1968 editions) is actually about ‘mothercraft’ and the pros and cons of instructing girls in ‘body work’
related topics such as infant care, cookery, cleanliness, laundry and sewing along with household budgeting (Ministry of Education 1956: 51-53; Department of Education and Science 1968: 88-9). Moreover, there is still a notable tendency within the 1956 and 1968 editions of the handbook to rely upon the generic masculine pronoun. In illustrative examples, too, the ‘health-education-pupil-as-male’ assumption remains apparent. Thus, in a discussion of alcohol in relation to health, references are made to the need to ‘dispel the illusion that in the world outside school abstinence is somehow unmanly’ (Ministry of Education 1956: 112). Mention is made of athletes in training who avoid alcohol, and the examples given here are those masculine sports of boxing, mountaineering and football (Ministry of Education 1956: 112).

Yet, and in keeping with the tendency (noted earlier) within official discourses of health education to problematise girls' future embodied adult roles as wives and mothers, it was girls' bodies rather than boys' bodies that are given special mention within the 1956 chapter on sex education. Any discussion of the sexual and reproductive human body had been conspicuous by its absence in previous editions of the handbook (Author 2004). Yet, once the sexual and reproductive body had gained a place within official advisory discourses, it was the ‘special difficulties’ faced by girls at puberty that is specified as a topic about which girls should be instructed within health education (Ministry of Education 1956: 58). Those faced by boys at puberty do not gain mention at all. In an earlier advisory publication on sex education (Ministry of Education 1943), the bodies of girls were similarly problematised in a discussion of the growing ‘laxity of morals’ under wartime conditions and the consequent need for more sex education in schools. It was
noted that ‘young girls’ in ‘considerable numbers’ are the ‘victims of indiscriminate associations’, resulting in an increasing incidence among them of venereal disease (Ministry of Education 1943: 4). Likewise, in the 1968 edition of the handbook of health education the topic of alcohol is argued to be important because of the ‘occasions when girls whose knowledge of alcohol is inadequate become drunk at parties and allow sexual intercourse to take place’ (Department of Education and Science 1968: 139). In neither the 1943 nor the 1968 publication is boys’ sexuality problematised in such a manner. This construction of girls’ bodies as troublesome is in keeping with similar tendencies noted to be evident elsewhere, including in educational psychology where feminine puberty and adolescence more generally were regarded as handicapping girls’ physical and intellectual capacities (Dyhouse 1976; Hunt 1991; Mort 1987; see also Board of Education 1923a). It was not until the 1968 publication of the handbook of health education that boys’ experiences of puberty gain mention alongside those of girls. In addition to emphasising the importance of educating girls about the bodily changes of puberty (Ministry of Education 1956: 58), it was now proposed that ‘further information’ was also required by pubescent boys. Just as unprepared girls might be shocked by the onset of menstruation, for a boy to experience ‘seminal emission’ unprepared was a cause of ‘much distress’ (Department of Education and Science 1968: 99).

A sixth and last edition of the handbook of health education was published in 1977. Now entitled Health Education in Schools, the style of the publication was more academic and scientific than its predecessors, with references to learned journals and tables of statistical data. In fact, the 1977 edition bears very little resemblance, in content or style, to the
earlier editions: it had been almost wholly rewritten. At the outset of the 1977 edition of
the handbook, and indeed throughout, the language used is inclusive of girls, with a
limited reliance on the generic masculine pronoun and ‘boys and girls’ (although
invariably in that order) a phrase routinely employed. The long-present encouragement
within the handbooks for teachers to enact, in the name of health education, a culture of
surveillance of children’s bodily cleanliness, including the frequency of bowel
movements and so on, had now fully disappeared. Previously, health education
discourses had constructed the bodies of working class children as deficient in and of
themselves, and as such were regarded as a threat to the health of future adult
populations. A shift in concern away from ‘hygiene’ and toward the promotion of healthy
life-styles via the avoidance of ‘inadvisable’ behaviour (Green and Thorogood 1998;
Rodmell and Watt 1986) is indicated by new chapters on communicable diseases,
pollution, occupational health, accidents, drugs, alcohol and smoking, and most notably,
sex. For the first time in the handbooks, there was a specific chapter entitled ‘Sex
Education’ and the education of both sexes in each other’s experiences of puberty was
suggested as a topic for health education in schools:

‘Boys in particular should come to realise that for girls there are times connected with
menstrual periods or episodes in their emotional development when they may be
distressed or tired through no fault of their own and that both should realise that the
emission of semen is abundant, and sometimes uncontrollable’ (Department of Education
This passage clearly reflects a shift in the view of children and gives recognition to their need to know about their sexual and reproductive bodies in the ‘here and now’ of their present. Yet, the extract also shows the longstanding tendency within health education policy to especially problematise embodied femininity and to place upon it a burden of responsibility: here, for boys and men’s sexual behaviour. In a further example, it was said that girls

‘should also understand that they may quite inadvertently impose great stress on boys by arousing sexual reactions in them which they do not fully comprehend and may not be able to control’ (Department of Education and Science 1977: 117).

Later, during a discussion on the topic of contraception within the health education curriculum, it is claimed that girls ‘saying no’ is both by far the most widely used and most certain means of avoiding an unwanted pregnancy (Department of Education and Science 1977: 117). Clearly, then, although mothercraft and infant care no longer warranted discussion in the handbook as a suggested curriculum topic, the ‘troublesome bodies’ (Smart 1995) of girls remained a primary concern with official guidance discourses on health education within schools and, relatedly, within the construction and reconstruction of gendered childhoods.

The inclusion of sex as a suggested topic within the health education curriculum from the 1956 and onwards editions of the handbooks can, nonetheless, be interpreted as a progressive development, signalling the end of a long period of fence-sitting on the place
of sex within the health education curriculum (Author 2004). It suggests a reconstruction of childhood that, finally, incorporated a recognition of children’s bodies as being sexual and reproductive, both in their here and now and as adult works-in-progress. By the mid-1960s, in the context of changing post-war sexual cultures (Hall 2000; Porter and Teich 1994), sex had apparently secured such a firm place in the curriculum that concerns were expressed that health education for children was increasingly becoming largely about sex (Department of Education and Science 1966: 83). Yet, the dominant construction of sex education within the guidance on the health curriculum for children remained bodily-focused ‘education in preventative medicine’ (the avoidance of sexually transmitted diseases and pre-marital and extra-marital pregnancy), as well as gendered socialisation (into adult normative, embodied sexual identities and morality, specifically patriarchal heterosexuality in the context of marriage and parenthood). As shown above, the shifting content of the health education curriculum, and in particular, the increasing prominence within it of sex, did not mean the end of the tendency to construct girls and their problematic bodies as the primary recipients of health education in schools as a consequence of their status as female adults of the future. Indeed as studies of the modern history and contemporary politics of sex education in schools have suggested, the reproductive bias of much of what has been defined as ‘sex education’ has meant that it has been girls rather than boys who have been its main pupils (for example, Durham 1992; Lewis and Kijn 2002; Kehily 2002; Monk 2001; Author 2004; Author, forthcoming; Thomson 1994).
Conclusions

The sexual and reproductive human body may have been absent from official guidance discourses on school health education for much of the period 1870-1977, but as I have argued in this paper, embodied constructions of gendered childhoods were none the less central to their articulation. Through the handbooks of health education and through the publication of reports of local provision contained within the *Health of the Schoolchild*, central administrative government authorities promoted health education for children as a key means of gendering children's bodies and minds according to the perceived needs of twentieth-century capitalist, imperial and patriarchal English society. In the case of working class boys, the guidance publications on health education for school children promoted knowledge, culture and practices which sought to construct their bodies and minds through, for examples, programmes of physical education and instruction in technical, manual skills in reflection of their future adult roles in the paid workforce. In the case of girls, health education converged in important respects with the gendered curriculum as this had developed for girls from the late nineteenth century onwards, within which housewifery, mothercraft, infant care and menstruation-related personal hygiene were important. Girls were therefore an especially important focus of the ‘body work’, the finishing of children’s bodies (and minds), that health education in schools represented. At least up until the 1970s, the concept of health underlying the suggested health education curriculum for schools was, therefore, that of ‘functional-efficiency’ (Blaxter 2004). In other words, health as the ability to effectively perform social roles, especially, in the case of children, future, gendered, adult roles. Consequently, within the handbooks, guidance discourses were not ‘gender-neutral’ but instead reproduced
particular constructions of gendered childhoods, within which girls were attributed with an especial burden of responsibility for the health, welfare and later, also the sexual behaviour, of others, whether in their present or in their prescribed future roles as wives and mothers. Aspects of the construction of childhood within the handbooks may be regarded as ‘progressive’; for example, in relation to the promotion of the idea that boys too had some future household and parental responsibilities. Nonetheless, it was feminine childhood not masculine childhood that remained the socially constructed embodiment of responsibility for the present and future avoidance of dirt, disease, malnutrition, ill-health and immorality. Thus, gender was central to the ‘body work’ in childhood that the official guidance publications on health education in schools sought to promote.

The official publication sources drawn upon in this article show that gender was central to what was said about childhood and what was done to children (Hendrick 1992a) within early to mid-twentieth century health and welfare knowledges, practices and policies. Nevertheless, such sources have their limitations, not least the absence of children’s own voices and perspectives within them. Moreover, despite being published by successive government boards, ministries or departments of education, and with prefaces by Chief Medical Officers, and even though teachers may have placed great store by them as argued by Felicity Hunt and others, the handbooks of health education remained advisory rather than mandatory (Hunt 1991), and their distribution amongst schools was never by any means complete (for example Board of Education 1930). Further, individual head teachers continued to retain responsibility for and broad control over what got taught in their schools, right up until the 1980s (Flude and Hammer 1990). Within the Health of
the Schoolchild reports, some resistance to the provision of health education in schools was alluded to, via mention of crowded timetables, resource and staffing issues (for example, Board of Education 1925: 116; Board of Education 1927b: 75; Board of Education 1930: 39). Especially during the later period, other discourses of health education were available and had a presence in schools, for example, via the Health Education Council. More broadly, the role played by health education for children in achieving its objectives, both published and unpublished, should not be overstated. For example, improved standards of health characteristic of twentieth-century Britain were largely the consequence of structural changes, of increases in standards of living and relative levels of affluence for example, rather than solely the direct result of health education's efficacy in regulating children’s bodies, especially working class feminine bodies, to be less physically deficient and morally troublesome. Further, as I have argued elsewhere (Author 2004, 2005), shifts in the health education curriculum and in the construction of childhood it (re)produced were, in important ways, brought about by the agency (both presumed and actual) of children and young people themselves, for example, via their participation in the youth cultures of the post-war decades, their sexual morality and their consumption of drugs. In the light of these issues, further research is required on the interpretation, implementation and experiences at the local level of official guidance on the health education curriculum for children. Such research, in pointing to the ways social and educational policies, rather than being determinate structures, operate as powerful ideological resources, drawn upon and/or rejected in social interaction, would deepen understanding of the range of ways official guidance on health education contributed to the gendered construction and reconstruction of childhood
that was the experience of numerous cohorts of children during the modern era.

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