One of the main conclusions emerging from the early Victorian parliamentary inquiries into employment and sanitation was that families, communities, and the nation would be better off if women stayed at home tending to social reproduction. Recall William Raynor Wood’s dire pronouncement that “a fearful deterioration of the moral and physical condition of our working population is rapidly taking place” as a result of women’s work away from home.¹ Women of the laboring classes were faced with ideological and practical pressures not to go out to work. Prescriptions about women’s proper place and functional arguments concerning the better care of families combined to confirm the dangers of women working. Men had to earn the money with which to support social reproduction, while women were to devote their attention to educating children, keeping a clean and orderly house, and managing domestic comforts. Women were responsible for both biological and social reproduction through the management of family survival strategies, which could include their own paid domestic work.

As we saw in chapter 2, poor women presumably failed miserably in this context, for their economic circumstances necessitated that they work outside the home for wages. The solutions to the perceived social problems posed by women’s employment revolved around ways to get women to spend more time at home. In this chapter, I examine the material conditions poor women faced at home. The idealization of middle-class domesticity ignored the reality that for many of the laboring poor, a healthy, comfortable, stable home was often unattainable. Although women of the wealthier classes for the most part could assume that home was a relatively healthy place to be, poor women had to struggle against
unwholesome sanitary conditions and poverty even to create the environment in which health was possible.²

Sanitation and Domesticity

Many poor people could not meet the preconditions that would allow them even to imagine attaining a middle-class domestic ideal. At a basic level, these preconditions included rudimentary sanitation, a habitable dwelling, and a certain level of privacy. The medical attendants at University College Hospital (UCH) and the Chichester Infirmary often included notes concerning the sanitary condition of their patients’ homes. (The asylum cases do not contain as much information on this subject.) Some patients indicated that they lived in comfortable homes. Assessments of comfort were based primarily on whether the home was dry, and complaints abound concerning damp living spaces. The women who lived “in a dry and open situation” were better off than those who lived “in a close damp” situation.³ Ann Ward, for example, “always lived in open dry situations and enjoyed very good health.”⁴ These sanitary issues resonate with the more general environmental themes brought out by the patients discussed in chapter 5.

For many poor women, living spaces were far from healthy, and the patients’ comments reflect this situation. The general literature on rural and urban working-class housing stresses its overcrowding, lack of sanitary provision, and general unhealthiness.⁵ Enid Gauldie, describing the Cruel Habitations of rural dwellers, notes that many rural cottages were built “without floors or ceilings, with unlined walls, unsound foundations and no drainage.”⁶ Inadequate housing and economic hardship for a growing population, combined with the new promise of industrial towns, led rural dwellers to leave the countryside for the cities hoping to find better circumstances. According to Edwin Chadwick’s statistics, the population of Sussex grew 10 percent from 1831 to 1841, while during the same period, the population of the West Riding increased 18.2 percent, and that of Middlesex 16 percent.⁷ The search for better housing in towns, however, was futile. Migration along with substantial population growth caused a housing squeeze in Victorian cities. During the first half of the nineteenth century, the town population grew from one-third of the total population of England and Wales to more than one-half.⁸

London and the West Riding were among the regions most affected by this urbanization and population growth. The housing problems of the early Victorian period “tended to be concentrated in those towns which
had either experienced the first impact of industrialization [like those in the West Riding, especially Bradford and Leeds] . . . or, like London and Liverpool, were seaport magnets which attracted constant waves of migrants. The laboring poor turned to cellar dwellings, lodging houses, and the quickly erected tenements and back-to-back housing that have received much historical attention. Workers crowded into inner cities to be near their places of employment, creating a sanitation crisis. Poor drainage, lack of provision for sewage and running water, the proximity to such things as slaughterhouses, and the ubiquitous smoke from factories made cleanliness difficult for the poor.11

The evidence of the case histories illuminates some of the sanitary problems women had with their homes. Many of the patients at UCH came from the districts around Tottenham Court Road, in St. Pancras, which were characterized as particularly unhealthy. Sarah Budd, a woman who worked both as a laundress and as a charwoman, had moved six months before her illness to “a room over newly built stables at Bayswater, damp and unhealthy and to her residence there she partially attributes her illness.” Emma Roberts described her residence as in a “very close situation in which she is much exposed to smells from the drains.” These patients associated unpleasantness with unhealthiness. Additionally, smells were believed to be a central cause of illness in the prevalent miasma theory of disease. In this context, in his evidence before the 1844 Royal Commission on large towns, the physician J. Toynbee stated that the poor were often opposed to efforts to ventilate their dwellings, as ventilation would further expose them to bad smells: “One poor woman, laboring under extreme debility, and who attributed her illness to the bad smells in the place, told me to-day that she could not go out of her room (a kitchen cellar) without feeling sick from the smells arising from the cesspool and that it would make her still worse if any opening were made in the window.” Poor women also would have connected open windows with the cold and damp drafts that they so often blamed for their ill health.

Rural patients were not exempt from the sanitation problems that disrupted a comfortable domestic life. In some cases, rural patients at the Chichester Infirmary indicated that they lived “in a low malarious place,” or in “an aguish district,” revealing an association between environment and disease. The dwellings of the Sussex patients were also unhealthy. Mary Merrit related “that 7 months ago she went to live in a new damp cottage, and caught a severe cold.” Similarly, Martha Miller, a servant from Emsworth, told the clerk that she “had always enjoyed good health till soon after the commencement of her residence in a new and damp house about
12 months ago—when she with others who inhabited the damp house were attacked with violent colds.  

Although patients usually described colds in passive terms, in this case it is as if the house itself attacked its inhabitants with colds.

The sanitary movement aimed to address the unhealthy living conditions of the poor. Sanitary reformers looked to change both the habits of the poor and the environment in which the laboring classes lived. The domestic ideal and the sanitary ideal were, in fact, closely connected, as social reproduction was predicated on a healthy living environment and vice versa.  

The evidence from the parliamentary inquiries was sometimes contradictory in this context, as prescriptions for women to stay at home for health reasons were juxtaposed against detailed descriptions of the filth in which the laboring poor lived. In his report on Leeds to the 1842 Commission on the Sanitary Condition of the Laboring Population, for example, the physician Robert Baker blamed female labor, especially in factories, for the “utter inability of the wives of the operatives to obtain their requisite domestic acquirements by which the homes of future husbands may be made more attractive than society abroad.”

As women were “allotted in the order of Providence, the domestic duties of human kind,” it was necessary for women to expend their energies at home attending to social reproduction. Baker graphically described the living conditions of the laboring classes as abominable and unhealthy. The poor lived in houses “with broken panes in every window-frame, and filth and vermin in every nook. With the walls unwhitewashed for years, black with the smoke of foul chimneys, without water, with corded bed-stocks for beds, and sacking for bed-clothing, with floors unwashed from year to year, without out-offices.” Presumably, these were things that could be improved if women devoted all their time to their homes.

Yet the problems went further to things over which women had little control and which Baker hoped sanitary measures would be implemented to improve. In one neighborhood,

the surface of [the] streets is considerably elevated by accumulated ashes and filth, untouched by any scavenger; they form nuclei of disease exhaled by a thousand sources. Here and there stagnant water, and channels so offensive they have been declared to be unbearable, lie under the doorways of the uncomplaining poor: and privies so laden with ashes and excrementitious matter, as to be uneuseable, prevail till the streets themselves become offensive from deposits of this description: in short there is generally pervading these localities a want of the common conveniences of life.
Although he describes the poor as “uncomplaining,” two paragraphs later Baker refers to a “deputation of females” who came to him to “complain” about stagnant water in a particular neighborhood, “which they declared was not only offensive but deadly,” as it produced fever. Similarly, the patient records suggest that the poor were not “uncomplaining”; they were very much attuned to the damp, unsanitary nature of their dwellings, and indeed often attributed their illnesses to it.

In agricultural districts, the juxtaposition of parliamentary representations of women’s homes and occupations is somewhat more complicated. Although field labor was considered basically healthy for women, investigators were much less sanguine about rural dwellings. On the one hand, the filth surrounding rural homes could be just as bad as that in cities. Alfred Power, an assistant Poor Law commissioner who investigated Lancashire for the 1842 sanitary inquiry, indicated that many of the supposedly urban nuisances existed equally in rural regions: “want of external as well as internal cleanliness of the dwellings; want of internal ventilation, . . . accumulations of refuse; imperfections of drainage; the crowded state of the rooms; habits of intemperance; the progress of contagion for want of removal to hospitals; [and] undrained lands” were all present in the countryside. Commissioner Tufnell used evidence from a medical officer of Bromley Union in Kent to describe rural sanitation problems:

A total absence of all provision for an effectual drainage around cottages is the most prominent source of malaria; throughout the whole district there is scarcely an attempt at it. The refuse of vegetable and animal matters are also thrown by the cottagers in heaps near their dwellings to decompose. . . . Pigsties are generally near the dwellings, and are always surrounded by decomposing matters.

With these conclusions, it seems paradoxical to recommend that women should give up their healthy field labor to stay in unhealthy dwellings. Indeed, the supposed healthiness of agricultural labor could be seen as a balance to unhealthy homes. Yet, while using evidence to illustrate the existence of sanitary dangers in rural areas, Commissioner Tufnell concluded that “throughout the greater part of these counties [Kent and Sussex] comparatively few diseases are found to arise from the want of sanitary precautions.”

Sometimes the lack of support from sanitary measures made women’s efforts at cleanliness futile, revealing the tensions between the domestic ideal and the reality of life in poor neighborhoods. Evidence from the var-
ious sanitary inquiries of the 1830s and 1840s illuminates the difficulties poor people faced in meeting reformers’ expectations for cleanliness. The surgeon R. Bowie, for example, testified to the metropolitan sanitary commissioners that

however much the poor might have desired to increase the cleanliness of their houses, they had no control over the supply of water, and they had no means of procuring receptacles for holding it. Many of them, too, were quite unable from their large families, from weakness and disease, to clean their houses: neither had they any means of draining the surface of streets, courts, and alleys in which they reside, or cleaning the privies and cesspools in the neighbourhood, or of escaping the poisonous emanations given off from them.26

Bowie’s language in fact points to the helplessness of women confronted with the lack of sanitary measures. The care of large families could prevent women from satisfactorily keeping a clean house; thus it was not only employment that precluded women from accomplishing their domestic tasks. Family, disease, and filth itself stood in the way of proper domestic cleanliness. Going back to Leeds, Robert Baker acknowledged that the constant visual presence of filth “dulls the energies of even the most willing housewives, and weakens in time the most cleanly original determinations.”27 Women were supposed to keep their own homes and doorsteps clean, but reformers such as Baker argued that without sanitary reform, women would be confronted with the daunting uncleanliness of their surroundings, which would in turn stunt their senses. In this context, James Smith, reporting on Bradford for the 1845 Royal Commission on large towns, described the difficulties of domestic management without sanitary regulations:

In the perambulation of the lower districts, inhabited by the poorer classes, it was often very affecting to see how resolutely they strove for decency and cleanliness amidst the adverse circumstances; to see the floors of their houses and the steps washed clean . . . when the first persons coming into the house must spoil their labours, with the mud from the street kept filthy by neglect of proper scavenging; to see their clothes washed and hung out to dry, but befouled by soot from the neighbouring furnaces; and to see their children attempted to be kept clean, but made dirty from the like causes; and sometimes to see those children, notwithstanding all their care, pale, sickly and drooping, evidently from the pestilential miasma of a natural stream converted into sewer and dammed up for the sake of mill power.28
Here, Smith emphasizes families’ hopeless efforts to keep clean in the face of unsanitary conditions beyond their control.

Some people, however, believed that the poor were content to live in filth, a claim that the London surgeon R. Bowie dismissed in his testimony before the 1845 Royal Commission on the Improvement of the Health of the Metropolis. When Bowie was asked if he did “not coincide with the popular notion that [the working classes] love dirt, and that they cannot be trained to habits of cleanliness,” he responded that this was “a most erroneous opinion.” Edward White, a medical officer of Holborn Union, testified to the 1840 Select Committee on the Health of Towns that both the state and the poor themselves needed to take responsibility for sanitary improvements: “I think the health of the poor might be improved by increased draining and cleanliness and ventilation; and if you get the people more temperate and moral, they will become more cleanly.”

Many of the medical witnesses suggested this two-pronged approach to public health.

In reporting on the condition of the laboring classes, some writers pointed specifically to the relative dangers of home and work, claiming that home could often be less healthy or comfortable than the work environment. The Manchester correspondent for the Morning Chronicle, for example, wrote that “the people employed in factories breathe better air than at their own homes.” R. Bowie testified that filth “is fully as much owing to the dirty state of [working-class] rooms, courts and alleys, as to their occupations, as may be seen in the condition of the women and children.” Bowie assumed that women and children were at home and that they therefore provided the best measure of the sanitary condition of dwellings. In his evidence before the 1844 Royal Commission on Large Towns, the physician Thomas Southwood Smith discussed the prevalence of fever emerging from the lack of proper drainage and cleaning around the residences of the laboring population in East London. Producing a table showing “The Proportion of the Sexes Attacked with Fever” from 1825 to 1828, Southwood Smith pointed out that

in each of these four years a somewhat larger number of females than of males were attacked with fever; that is, a proportionately larger number of mothers were disabled from nursing their children and attending to their families, every such family being of course thereby placed in the greatest possible disorder and distress, the disease of the mother being in many cases the direct and immediate cause of her husband and her children being similarly affected.
Women in this analysis were more susceptible to fever because they spent a greater amount of time working in their dwellings than outside of the home. According to Southwood Smith, unsanitary conditions—not women’s work—led to disease and family breakdown. Similarly, James Ranald Martin concluded in a publication for the Health of Towns Association that the lack of sanitary regulations, rather than a lack of domestic rigor by women, was the source of filth and disease:

That certain trades and occupations are injurious to the health of artisans is not to be disputed; but the grand cause of the fearful ravages of disease in our manufacturing districts is unquestionably to be traced to the filth and wretchedness of their dwellings, the insufficient supply or the bad quality of their food, their want of cleanliness arising from a defective supply of water, and the vicious habits that so generally—we had almost said necessarily—accompany personal and domestic discomfort.35

Martin implies that it was home itself that created both disease and immorality. Depending on the context, middle-class observers positioned poor women either as victims of domestic misery or as responsible for that very misery.

**Poverty**

The lack of sanitary conditions in these women’s neighborhoods was directly connected to their poverty. As we saw in chapter 3, poverty was a serious impediment to the ability of women to stay healthy. It was also an obvious obstacle to domestic comfort. Commissioner Vaughan, in the investigation into women and children in agriculture, concluded that families lacking material necessities had more pressing things to worry about than cleanliness and refinement:

The urgency of grosser wants, which supplants the attention to comeliness and order,—the necessity for shifts and expedients, which poverty adopts to obtain its ends,—the scantiness of room, which hardly keeps apart the proprieties of life from its humiliating needs,—all concur to produce an apathy to outward order and purity, such as deprives the moral and social sensibilities in a great part of their natural nourishment.36

In addition to their sanitary environments, healthy homes were also
defined through the ability to meet material needs. The case histories indicate that getting the “necessaries of life,” including food, clothing, and shelter, was the scale by which doctors and their patients measured basic material comforts. In some of the casebooks for UCH, there are patterns of information that suggest that the clerks asked the patients whether they possessed the “necessaries of life.” Several patients reported that their subsistence needs were being met. Edith Best, for example, “says that she has always had enough food,” while Hannah Gordon and Margaret Holmes “had plenty of food and clothing”; both, however, also said that they had to work hard. Anne Horpwood, a seventy-seven-year-old woman, told the clerk that she “has always been in comfortable circumstances and has never known want.” In an unusual case, Sophia Simkins, a housemaid, stated that “she always had enough to eat; she thinks rather too much; she was accustomed to have meat twice a day.” Perhaps she measured her food intake against previous positions in service or what she had been used to as a child.

The overall sense gathered from the hospital and asylum records, however, is that obtaining the “necessaries of life” was a rather precarious business, and “want of the necessaries of life” was all too common. Financial crises were easily precipitated by illness or the unemployment of one member of the family, and women were even more vulnerable based upon their assumed dependence on men to provide for them. Like the poor relief letters and petitions, the case histories illustrate the economic worries of poor women. The asylum patient Ann Reynard, for example, “rave[de] chiefly on the fear of poverty and destitution, not being able to pay for the necessaries of life.” Historical debates over the standard of living of the working classes in England, as John Belchem has pointed out, “obscure much of the diversity and harshness of working-class experience.” Whether statistics show that industrialization improved or degraded the living standards for English workers, they do not illuminate quality of life issues. The patient narratives, by contrast, highlight the individual experiences of workers and the interrelationships among economics, health, and self-worth. The case histories suggest that many of the patients admitted to the hospitals and the asylum lived on the edge of dependency. Their ability to stay out of pauperism was often determined by seasonal or trade cycles. One patient in the asylum specifically attributed her mental depression to “lowness of Spirits brought on by hardness of [the] Times.” The “Times” in the late 1830s and 1840s could be particularly hard for working people in all three regions I examined.

Poverty and general difficulty with financial circumstances are listed as recurrent causes for illness and insanity in both the hospital and the
asylum records. Mary Ann Steel, a maidservant from Chichester, had been an outpatient for two years before being admitted to the infirmary. Her illness, the clerk noted, “appeared to have arisen rather from mental distress and destitution than from any original organic disease.” This comment is interesting because it reveals a tension within the clerk’s own conceptualization of disease. When no source could be found in specific organs, he looked further to the whole body and the social circumstances of the patient. In another case, Jemima Taylor, a forty-two-year-old London woman who was “laboriously engaged in domestic occupations,” described herself as “of regular habits but has experienced at times a scarcity of both food and clothing, this was especially the case last winter (43–44) when she often had not fire in her room and often scarcely any thing to eat for days together.” The situation was similar for Catherine Wright, who came to the Chichester Infirmary in 1838 “in a bad state of health. . . . She has a variety of complaints which probably have been produced by adverse circumstances.” Likewise, a clerk recorded that Mary Anne Jenkins, a patient of Mr. Duke’s in 1846, “has been frequently an I.P. [inpatient] with various complaints the principal cause of which appears to be the want of proper food.” These were hardly circumstances that facilitated living the domestic ideal.

In Victorian understandings of physical and mental health, poverty played a central role. John Conolly, a major figure in mid-Victorian asylum work, lectured that

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a neglected infancy, an uninstructed childhood, scanty food, thin clothing, and all the pinching wants of those who depend on the labour of the day for the food of the day, prevent the healthy development of the body, of the brain, and of the mind . . . [and] bring numerous victims to an asylum—for them the only worldly refuge from want and care.
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William Ellis, the first director of the West Riding Asylum, wrote in 1838, “as the [asylum was] established solely for the reception of the poor, it will not be a matter of surprise that a greater number of its inmates, both male and female, are sent thither through distressed circumstances, than from any other moral cause.” Poverty, according to Ellis, was both a “source from which [insanity] first originates . . . [and] the cause of relapses.” Financial distress was noted as the cause of insanity in 101 of the asylum cases I examined. Many of these cases are contained in a single casebook, covering November 1841 to May 1845. This volume corresponds to a certain extent with a severe economic slump in 1841–42, but also with a trade recovery after 1842. Many patients expressed a fear of poverty and a constant worry
about money, even when these were not recorded as the primary cause of their illnesses.54

Despite the claims of some women that they were well fed, patients in each of the institutions commented on their inability to maintain an adequate diet. There were a number of women who, like Elizabeth Plumridge, “felt very weak and low in spirits for want of food.”55 The patients and their doctors believed a healthy diet—one that supported the necessaries of life—was a diet that included “animal food,” preferably fresh meat of some kind.56 Elizabeth Hepburn, a married woman with ten children, related that she “has suffered great privation and [was] obliged to subsist in great measure upon vegetable diet” for the last year.57 Mary Meggs was seen under Mr. Duke in 1840 and noted that she lately “has lived very badly not having any animal food oftener than once a fortnight or even longer.”58 These two examples suggest that patients equated severe poverty with the fact that they ate little or no meat. Similarly, Elizabeth Morris, a married woman with seven children, indicated that she was “accustomed to live chiefly on bread rarely tasting either salt or fresh meat.”59 Anne Steel told the clerk that her pain “is relieved by food but being destitute of means she is unable to take what is proper for her—bacon and salt-pork being the chief diet.”60 In this case, hunger itself was most likely making Steel ill. Testifying before the Select Committee on the Health of Towns in 1840, the physician Neil Arnott emphasized the importance of good food to maintaining health. He claimed that “want of food would weaken the health of the parties, and render them more susceptible of injurious impressions.”61 He went on to say that while most male workers had an adequate amount of meat, “perhaps the wives and children have but a small allowance, but the man takes care of himself.”62 In most cases, it was poverty and gender hierarchies in the family—not women’s inattention to the domestic tasks of cooking—that caused women and their families to suffer from a shortage of food.63 In connection, it is unlikely that malnourished women could live out the ideal domestic existence expected of them.

Many, if not most, members of the laboring classes in the early Victorian years had to rely on the combined earnings of families to survive. The threat of poverty necessitated a financial contribution from men, women, and often children. This family economy precluded the formation of a middle-class domesticity that assumed women and children remained at home. As Sonya Rose has written about the later nineteenth century, “the members of Parliament and social reformers who were concerned with infant mortality and the ‘working mother problem’ did not acknowledge that most working-class women had to bring cash into their households at some time during their married lives.”64 Although middle- and working-class men alike
aimed for a male breadwinner wage as a sign of independent manliness, the reality in laboring communities was that most households functioned as “family wage economies,” in which “the wages of family members formed a common fund which paid for expenses and supported the group.”65 Women’s and children’s earnings had to supplement the insufficient wages (or unemployment) of the primary breadwinner.

For married women, staying out of pauperism was most often dependent upon the employment of the husband, and even if a husband was not the primary breadwinner in reality, the ideology was powerful enough that the emotional consequences of a man out of work could be significant. Many married patients noted that their general circumstances, and their health in particular, declined when husbands were unemployed. Sarah Budd’s husband, for example, was a carman. Since he had “been out of work . . . she has lived badly, getting meat seldom.”66 Similarly, Charlotte Jordan’s husband’s illness prevented him from working and the family from getting enough food.67 In these cases, poor living is again associated with diet. Other women expressed that they were emotionally affected by their husbands’ unemployment. Catherine McGrill had “always enjoyed good health until lately, when her husband lost his employment and she experienced great depression of spirits.”68 These cases suggest that the women could not earn enough by themselves to support their families.

A husband’s death, like his unemployment, could also be financially devastating and damaging to a patient’s well-being. Susannah Spence, a charwoman whose husband had killed himself a month before her admission to the asylum, was suffering “distress from pecuniary circumstances and want of Food.”69 Similarly, a fifty-year-old widow with four children was admitted to Chichester Infirmary suffering from “various nervous feelings” that produced “an incipient desire to talk and especially so concerning her pecuniary matters—formerly having been in very good circumstances but now dependent on herself for support.”70 We can speculate that her good circumstances were connected to her husband’s employment; when he died, she was no longer sufficiently able to maintain herself and her children.

The case histories offer ample evidence that the patients’ households often functioned as family wage economies. Widowed women, especially, relied on combined earnings to avoid pauperism and to maintain their own and their families’ health. Ellen Livesey was having difficulties as her three “children have lately been out of work; she has also had little work herself and has been in straitened circumstances.”71 Elizabeth Ann Thornton, a charwoman from Leeds, “has depression of spirits owing to her children being out of work. . . . Want of employment for the family” was the
cause assigned for her illness.72 This evidence demonstrates the vulnerability of widows whose survival was very much tied to a family economy and reliance upon the earnings of children.

From their narratives, it appears that the majority of patients in my samples struggled to maintain their health in the face of poverty, which led some of the patients to express a sense of the general hardship of their lives. A dressmaker whose husband had deserted her stressed the instability of her life; she “has not had sufficient to eat during the last 3 years....Has no place of abode, but has resided first with one acquaintance and then with another during the last 3 years.”73 Elizabeth Packwood, a widow in service since the death of her husband, “describe[d] her life as having been one of great trouble and anxiety.”74 Poor living conditions and scanty food led to illness; illness kept these women from earning their livelihoods and precluded them from fulfilling the expectations of domesticity.

Political and social reformers positioned home as the ideal space for women, but they simultaneously recognized that home—as a physical entity and as an ideological construct—was far from ideal for many of the laboring classes. In contexts where investigators focused on the absence of women from home, their solutions to the domestic discomfort of the poor rested on strategies to get women to spend more time at home in the interest of their families’ health and their own well-being. In contexts where investigators were interested in the sanitary condition of home, however, women often were positioned as victims of the filth neglected by sanitary reform. There was little economic analysis of women’s abilities to maintain a healthy home, even though women’s own stories stress the financial obstacles standing in the way of their own and their families’ health.