CONCLUSION

The Politics of Women’s Health and Work

The relationships between poor women’s work and health became central to public debate about the state of society in early Victorian Britain. Although poor women themselves lived their lives, making decisions in the immediate context of their own and their families’ economic needs, they were caught in a nexus of competing concerns that went well beyond their everyday experiences. Public health, the economy, the welfare system, and the strength of the population with regard to nation and empire building all framed the ways women’s health and work were understood and constructed. The discussions that so urgently considered their lives did not have a tremendous impact on the majority of working women, who were outside the bounds of the factories and mines that worried investigators. Yet conclusions regarding reproductive and able bodies did indeed guide laws that structured employment opportunities and the provision of welfare, often in contradictory ways. Poor women and the men who observed them were interested in maintaining women’s health in relation to work, but they assigned different and frequently incompatible meanings to “health” and “work”; their conflicting understandings led to very different solutions to the perceived problems experienced by women.

Most observers determined that women’s health and waged work were irreconcilable in an industrial society. Yet the interests of employers in women’s cheap labor and of the state in reducing the burden of poor relief created inconsistencies in official ideas about women’s bodies at work and produced contradictory prescriptions concerning the relationships between women’s health and work. Parliamentary investigators and their medical witnesses reduced women to their reproductive bodies and imagined that women’s wage labor endangered the public health, even if it supported the industrial economy. Those administering poor relief framed women both
as workers and as dependents, which complicated expectations regarding ablebodiedness, independence, and respectability. Working women themselves acknowledged their bodies’ reproductive aspects, yet perceived themselves as more than just would-be mothers, both in terms of their understandings of health and illness and in terms of the negotiations of their daily lives. Women stressed the ways their experiences of their bodies shaped an able-bodied identity in relation to work.

Medical men offering testimony to the parliamentary investigations into employment insisted that women should avoid working at industrial occupations—particularly in factories—because these occupations endangered women’s reproductive capacities and the health of society more generally. This suggests that these reformers could not see women as workers, but only as women. They were concerned with women’s ability to reproduce more workers rather than with women’s ability to produce as workers. Concentrating on reproductive issues served to downplay other work-related ailments that were gender neutral, shared by men and women alike, and which could have challenged industrial working conditions more broadly. Indeed, what emerged out of these investigations was a gendered binary opposition between the reproductive body and the able body. Legislation such as the Factory and Mines Acts that limited women’s hours or prohibited women from doing certain jobs aimed to protect the female reproductive body and to protect the social body from the moral and physical consequences of unchecked female labor. By contrast, the potential job-related harms to adult men were taken out of political view through the singular construction of men as able-bodied laborers. Thus the disadvantaging of women in this gender opposition was not accompanied by an advantaging of working-class men. It was women’s disabled bodies that in effect naturalized men as able-bodied, which handicapped male workers’ efforts to improve their own conditions of employment and poor men’s chances for welfare assistance.

We can see this gendering of ablebodiedness operating today in the construction of occupational health hazards. The “objective facts” of medicine still hold tremendous power over women’s work. Questions about women’s morality may be more subtle in present-day contexts, but scientific constructions that position all women as potentially pregnant, as Ruth Hubbard and Sally Kenney, among others, have pointed out, have been used to push women out of jobs (many of them “masculine” industrial positions working with chemicals) because of imagined dangers to potential fetuses. Women who fight restrictions based on potential reproductive hazards are additionally held up as morally irresponsible, selfishly choosing employment over their reproductive futures (the able body over the
reproductive body). Although reproductive health hazards are often equally present for men in the workplace—as they were in the Victorian context—medical ideas about women as reproductive bodies and men as able bodies continue to influence policy and cultural attitudes surrounding gender and work.1

The gendered early Victorian understanding of occupation that rested on the biology of women’s reproductive bodies was complicated and complemented by ideas about social reproduction. Medical evidence presented to the employment and sanitary inquiries of the 1830s and 1840s asserted that all working women (regardless of occupation) endangered the public health by neglecting social reproduction. Although this evidence supported reformers’ desires to limit women’s industrial labor, it contradicted investigators’ conclusions that saw women’s work in agriculture as healthy, indeed healthier than being at home. Reformers closely connected public health with the proper management of domestic economy, which was seen as the responsibility of women. By stressing a biological basis of female domesticity, medical theories could be used to justify a legal definition of womanhood as nonautonomous, and manhood as independent. The physician Edward Tilt, for example, in his 1851 On the Preservation of the Health of Women, argued that dependency was a defining characteristic of womanhood. He explained that “man was created independent because destined to govern the family, society, and nature; while woman was made dependent, tied to hearth and home by a long chain of never-ending infirmities, as if to point out the destined sphere where her activity could find more happiness, although a paler glory.”2 It is interesting that Tilt pointed to “natural” infirmities as justifying female domesticity. If working women did not naturally obey the dependency and domesticity supposedly dictated by their bodies, it was up to the government to impose labor restrictions that forced them to do so. Thus legislative limitations on female labor symbolically and practically curtailed the assertion of women’s independence, which was seen as damaging to the public health. Women, in effect, needed external pressures to protect them from their own tendency to go against their biology and “natural” gender roles.

The patients’ illness narratives suggest alternative explanations for the public health problems parliamentary investigators identified as rooted in female employment. Although investigators blamed women for the domestic disorder that supposedly led to the breakdown of families and laboring communities, women talked about their frustrations in dealing with the lack of sanitary provisions, unhealthy living conditions, and irresponsible husbands who refused to provide for their families, or even abused their families. Indeed, the patients’ emphasis on the health dangers
of home reversed the assumptions presented by the parliamentary investigators and medical witnesses. From the women's perspectives, it was often husbands and fathers who created the uncomfortable domestic environment through their abuse of alcohol and violence toward their families. The parliamentary evidence was more likely to point to the ways in which the ill health and “unnatural” behaviors of women caused the ill health and unsociable behaviors of men; if women managed the domestic economy, promoting their families’ well-being, their husbands would become healthier and more humane.

Although the parliamentary investigators and their medical witnesses blamed women’s independence through wage labor as a source of public health problems and a threat to national strength, those administering welfare assistance affirmed the need for gainful employment as a means for women to stay independent of the Poor Law. Poor Law authorities viewed poor women’s work as respectable and healthy if it assisted an individual or a family to survive. Able-bodied women who did not work to maintain their independence were often regarded as undeserving of relief. Yet, simultaneously, the Poor Law positioned women’s deservedness in relation to a male breadwinner norm that imagined women to be the dependents of their fathers and husbands. Poor Law authorities did not want to pay for women’s relief; they expected husbands and fathers to support them, but this did not mean that they exempted women from paid labor. Although men were neatly identified as able-bodied laborers or non-able-bodied persons in need of assistance, women’s roles were much more complicated. Women’s work for survival conflicted with a construction of health that insisted that women’s nondomestic work endangered the individual worker and her family by injuring her body and her ability to provide domestic care.

These tensions between women’s dual burdens of domestic labor and wage labor are still present today in several contexts. Working mothers continue to be castigated for neglecting their children at home or leaving them with nonmaternal caregivers in day-care centers. There is still very little critique of the association between women as reproducing bodies and their roles as the necessary primary caregivers. Yet few deny that most women have to work to contribute to family survival. These issues are constantly present in debates about welfare mothers. There is an obvious tension between the insistence that women work to stay off welfare and develop respectability through independence, and the insistence that there is really no replacement for the “natural” mother at home with her children. This resonates all too clearly with the contradictory expectations facing women in reference to the early Victorian Poor Law.
Poor women were caught between the able and the reproductive body, between production and reproduction, between the public and the private; yet these polarities broke down in a number of concrete ways. Although they existed in a cultural context that asserted the opposition between public and private, neither early Victorian women workers nor the men observing them really separated public and private in poor women’s lives. While declaring that the public realm of work should be separate from the private realm of the home, parliamentary investigators and medical witnesses actually blurred the distinctions between public and private by connecting work issues, health issues, and domestic issues. They insisted that women-as-workers could not separate themselves from their bodies or from their domestic responsibilities, and in many ways acknowledged the domestic as a site of productive labor. In this context, Emily Martin has written in her study of late-twentieth-century women’s experiences of reproduction that women “literally embody the opposition, or contradiction, between the worlds” of public and private.5 The early Victorian women’s health narratives also reveal how little these distinctions mattered in poor women’s lives. They did not detach their private bodily experiences from their experiences of work; their medical histories reveal that they were constantly negotiating between their bodies’ health and illness and their need to work for physical and emotional survival. Indeed they identified their health with their ability to work and perceived themselves as workers in terms of the healthiness of their bodies.

What comes through clearly in poor women’s words is that work was central to their experiences. It was not a question of how paid labor affected biological or social reproduction, but how to negotiate the relationships between their employment and the other elements of their lives. Jane Long has written that

working-class femininity was shaped and performed, in the context of both work and poverty, at the intersection of material conditions and cultural meanings. . . . [T]he women were never passive participants in the processes of forging working-class feminine identity. While middle-class conceptions of progress may have manifested themselves as a drive to fix female identity, the variety of material conditions and the individual responses of women illustrated that idealised visions of how women should behave and what their priorities should be, were subject to constant processes of negotiation.6

Nowhere is this negotiation clearer than in the context of poor women’s health and work, where a model of feminine strength predominated for the women themselves but was constantly challenged by ideological expecta-
tions and the material conditions of these women’s lives. Questioning the Victorian ideal of the female invalid, Laura Fasick argues that authors such as Charles Dickens and Elizabeth Gaskell wrote about female invalidism as a failure—for both middle- and working-class heroines. According to Fasick, “the ideal of work—and the strength necessary to perform that work—was an essential component of the Victorian heroine’s role.” Poor women’s voices certainly suggest that this ideal of work and of the body structured to perform that work shaped working-class women’s identities. Their choices regarding health and work reflect the centrality of this able-bodied norm.

Gender and class clearly informed understandings of health in the early Victorian period, and health as a category informed the ways people thought about masculinity and femininity and class differences. Although the parliamentary investigations reveal a clear concern with male health, the health of men and boys was not connected to reproductive processes. Investigators worried about the military ability of male industrial laborers, but they did not conceptualize the lack of healthy men as a problem of employment and public health, nor did empirical evidence challenge the construction of men as essentially able-bodied in contrast to women as essentially disabled. A critique of this nature would have been too great a challenge to the entire industrial system. Jobs that were considered healthy for men were not necessarily considered healthy for women. It was the body performing the job, not the job itself, that led medical men to alter their definitions of health. For men, ablebodiedness was simply a category pertaining to the healthy ability of the body to work. For women, by contrast, ablebodiedness both conflicted with theories about the capabilities of the female body and was complicated by the expectation that women had more pressing responsibilities for social reproduction. The patient narratives also suggest that men’s health issues were different from women’s, even beyond the context of reproduction. Male laborers suffered from more externally caused physical injuries—such as lacerations and fractures—related to work, and male patients had their ailments attributed to alcohol more frequently than did female patients. In these ways, gender and health influenced each other.

Female health itself was complicated by class. Victorian middle-class femininity was constructed around a perpetually diseased and weak body, based upon the assumed dominance of an unstable female reproductive apparatus. Working women and their medical practitioners, however, did not conceive of the female body only in terms of reproduction. Although they paid much attention to reproductive processes and especially menstruation, both patients and doctors noted other factors in determinations
of what made women sick. Additionally, reproductive complaints did not make up the majority of illnesses with which women came to the medical institutions under study here. Although the patients emphasized the significance of “normal” menstruation to their overall health, they did not attribute their ill health to the simple fact that they menstruated. They saw the regular functioning of their menstrual cycles as tenuous, but they also perceived their bodies to be naturally strong, rather than weak. Their home and work conditions could compromise that strength, and it was on these more social, economic, and environmental factors that women drew to explain their illnesses. This evidence suggests that the popular Victorian medical theory that their reproductive functions made women inherently weak and unstable in practice did not apply to perceptions of the female laboring classes—neither for the doctors nor for their patients. The female patients made it clear that they equated healthiness with strength and perceived delicacy and weakness to be signs of something abnormal rather than a preferred state of femininity.

Tensions also surrounded issues of female health within class. No labor in mines, trades, or factories, as represented in the parliamentary investigations, was thought healthy or suitable for women, whereas women’s work in agriculture was thought to produce healthy bodies. The parliamentary evidence speaks to the sharp contrast between the ways the labor of rural and urban women was imagined to affect their bodies and domestic skills. A woman engaged in field work in rural England was generally assumed by doctors and government officials to be healthy, but the same was not the case for a factory woman in urban England. Women’s voices also suggest a divergence in the ways agricultural women perceived their health in contrast to women working in industrial and in service employments. Although female agricultural workers did not connect heavy labor, fatigue, or exposure to wet and cold necessarily with ill health, the same cannot be said of industrial and service workers. This may have to do with the fact that women experienced agricultural work as agreeable, while they found work in factories, mines, and domestic service to be uncomfortable, dirty, and unpleasant.

In each case, poor women’s bodies could not be separated from their work. Public discourses mapped discussions of one onto discussions of the other, defining healthy work through assumptions about the female body and the healthy female body through the work it performed. For women themselves, their experiences of work shaped different understandings of the body and what made a woman healthy or sick. On the other hand, the ways women envisioned their bodies informed their employment choices and the types of occupations for which they understood themselves fit.
Women had to negotiate the contradictory expectations of public discourses and personal experiences.

In her analysis of people living with chronic illnesses in the late twentieth century, Kathy Charmaz writes that “having a chronic illness . . . means struggling to maintain control over the defining images of self and over one's life. This struggle is grounded in concrete experiences of managing daily life, grappling with illness, and making sense of it.” The struggles Charmaz describes are also evident in the lives of early Victorian working women. These were not women who could easily give in to their illnesses, because most of them lived on the edge of dependency. Although not all of them were suffering from chronic ailments, these women attempted both to understand what was making them sick and to negotiate their illnesses with the other aspects of their lives. In contrast to medical writers and parliamentary investigators who stressed that women’s health was circumscribed by their bodies’ responsibilities for biological and social reproduction, poor women went beyond the reproductive body, representing employment as a central element of their identities as healthy people.