

**SANITARY LADIES AND FRIENDLY
VISITORS: WOMEN PUBLIC HEALTH
OFFICERS IN LONDON,**

1890-1930

SUBMITTED FOR THE DEGREE OF PHD BY
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DECLARATION

I hereby declare that, except where explicit attribution is made, the work presented in this thesis is entirely my own.

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Jennifer R Haynes

A handwritten signature in black ink, appearing to read "Jennifer R Haynes".

ABSTRACT

This thesis examines women sanitary inspectors, health visitors and tuberculosis visitors (referred to collectively as women public health officers) in London from the 1890s to the 1920s. It uncovers who these women were, what they did, and their views and attitudes in certain key areas.

Women employed in public health have often been implicated in historical accounts critical of the 'social control' of the state, and its failure to tackle structural social and economic reasons for poor health. This thesis challenges the assumption that these middle-class women were only, or merely, conduits through which an ideology of personal responsibility for health was imposed on the poor. Drawing on fresh source material about these particular women also provides new perspectives on the entry of women into the paid professions, and on the women's movement in general.

Introductory chapters analyse the historiography, and outline the nineteenth-century background: women's involvement in sanitary reform, voluntary visiting and elected local office; and the structures and male staffs of local health administration. An overview of patterns of employment and the gender division of labour follows. The required social and educational background, age, experience, and personal qualities of the women are explored. Their integration into existing structures, and the reaction of male colleagues, are examined through debates over 'official' titles, powers, attitudes and uniforms; and salaries and conditions of service. Systems of training and qualification are analysed, from the advent of women sanitary inspectors in the 1890s, to the gradual evolution of separate health-visitor training in the early twentieth-century. The organisational and campaigning activity of the women is placed within the context of the wider women's and labour movements. Finally, the thesis looks forward to the later inter-war period, confirming the continued complexity of middle-class female health activism in the 1920s and 1930s.

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LIST OF ABBREVIATIONS

AIWMC	Association of Infant Welfare and Maternity Centres
ATNPHW	Association of Trained Nurses in Public Health Work
BC	Bedford College
BCLM	<i>Bedford College London Magazine</i>
BJN	<i>British Journal of Nursing</i>
BMA	British Medical Association
BMJ	<i>British Medical Journal</i>
BP	Battersea Polytechnic
CAM	Committee Against Malnutrition
CBEW	Central Bureau for the Employment of Women
CMB	Central Midwives Board
CMC	Children's Minimum Committee
CON	College of Nursing
COS	Charity Organisation Society
CWHS	City of Westminster Health Society
DPH	Diploma in Public Health
ER	<i>Englishwoman's Review</i>
FWG	Fabian Women's Group
HVA	Health Visitors' Association
IDCPD	Inter-departmental Committee on Physical Deterioration
ILC	Industrial Law Committee
JBG	Board of Guardians for the Jewish Poor (commonly known as the Jewish Board of Guardians)
JCC	Joint Consultative Committee of Institutions Approved by the Minister of Health for the Training of Health Visitors and of Organisations of Health Visitors
J(R)SI	<i>Journal of the (Royal) Sanitary Institute</i>
KCHSS	King's College of Household and Social Science
KCL	King's College London
KCW	King's College for Women
LDC	London District Council (Whitley Council)
LGB	Local Government Board
LCC	London County Council
LNSWS	London and National Society for Women's Service

LSA	Ladies Sanitary Association (Ladies National Association for the Diffusion of Sanitary Knowledge)
LSWS	London Society for Women's Suffrage (later Service)
MAB	Metropolitan Asylum's Board
ME	<i>Municipal Engineering</i>
MMC	Maternal Mortality Committee
MO	<i>Medical Officer</i>
MOH	Medical Officer of Health
MSSA	Manchester and Salford Sanitary Association
MWF	Medical Women's Federation
NALGO	National Association of Local Government Officers
NAPC/T	National Association for the Prevention of Consumption / Tuberculosis
NATHS	National Health Society
NCIM	National Conference on Infantile Mortality
NCMCW	National Conference on Maternity and Child Welfare
NCW	National Council of Women
NCEC	National Council for Equal Citizenship
NH	<i>National Health</i>
NHWL	National Home Workers League
NM	<i>Nursing Mirror</i>
NT	<i>Nursing Times</i>
NUSEC	National Union of Societies for Equal Citizenship
NUWSS	National Union of Women's Suffrage Societies
NUWT	National Union of Women Teachers
NUWW	National Union of Women Workers
ODC	Open Door Council
PH	<i>Public Health</i>
PUTN	Professional Union of Trained Nurses
QVJIN	Queen Victoria's Jubilee Institute for Nurses
RAMC	Royal Army Medical Corps
(R)CN	(Royal) College of Nursing
RBNA	Royal British Nurses Association
(R)SI	(Royal) Sanitary Institute
SIA	Sanitary Inspectors Association
SIEB	Sanitary Inspectors Examination Board
S(I)J	<i>Sanitary (Inspectors) Journal</i>
SJCIWO	Standing Joint Committee of Industrial Women's Organisations

SMOH	Society of Medical Officers of Health
SPG	Six Point Group
SR	<i>Sanitary Record</i>
TSI	<i>Transactions of the Sanitary Institute</i>
TUC	Trades Union Congress
VFW	<i>Votes for Women</i>
WCG	Women's Co-operative Guild
WHEC	Women's Health Enquiry Committee
WHO	<i>Woman Health Officer</i>
WIC	Women's Industrial Council
WIN	<i>Women's Industrial News</i>
WLGS	Women's Local Government Society
WLL	Women's Labour League
WPHOA	Women Public Health Officers Association
WSIA	Women Sanitary Inspectors Association
WSI&HVA	Women Sanitary Inspectors and Health Visitors Association
WSPU	Women's Social and Political Union
WTUL	Women's Trade Union League

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There is a story in my family that, when I was a new baby, my father shut the front door in the face of the health visitor who was unlucky enough to call. He explained that he had already brought up three children and certainly didn't need any help with the fourth. Perhaps I wouldn't have turned out to be such a problem if he had listened to her advice. This thesis is dedicated to both my parents, with love and with thanks.

1: INTRODUCTION

FOCUS AND AIM

A firm in the City, which had on its staff a good linguist and an able accountant, would show little common sense if they selected the former as their book-keeper and relegated their foreign correspondence to the man of figures. Similarly, in public health work men and women have different aptitudes, and we are not making the best of our human material unless we recognise these aptitudes, and assign to each the task which they can do most efficiently and, therefore, with greatest ease to themselves and advantage to the community.¹

So spoke Croydon's Medical Officer of Health (MOH), H. Meredith Richards, at a meeting of the Royal Sanitary Institute (RSI) in 1907. He voiced the common assumption that women had 'special capabilities' in relation to public health, and that there were also duties for which they were 'by nature' unsuited. For Richards, women were particularly 'suitable for what one may call the educational side of public health work, such as the instruction of mothers in the care of their children and in personal hygiene'. It was 'a matter of common knowledge', he said, that women had 'little taste for mechanics', and were unfitted for undertaking 'the sanitary engineering side of public health work'.² According to one woman doctor in 1911,

For a woman to spend any portion of her time as an ordinary sanitary inspector is a waste of good material; a man can do that. A woman's province is *persons*, and above all *children*, and not *things*, and her place is as a helper and adviser and not as an inspector of nuisances, and if she acts ever so little in the latter capacity it weakens her power in the former.³

At the beginning of 1893 there were 115 sanitary inspectors working in London, all of them male. By 1930 their numbers had risen to 335, but there were also around 240 women officers working in the capital's local public health departments. Not only had local administration for public health expanded, but many of the new opportunities had gone to women. This thesis will explore this change, by examining those women who worked as sanitary inspectors, health visitors and tuberculosis visitors (referred to collectively as women public health officers) in London from the 1890s to the 1920s.

As will be seen later in this chapter, most accounts of the early twentieth-century public health services have dealt either with the policy-makers or with the recipients of care, or sometimes with the relationship between the two. This has

¹ Richards, 'Aim and scope of women's work in relation to public health', *JRSI* (XXVII, 1907), pp.193-4.

² *Ibid.*

³ *BMJ* (1 Apr 1911), p.787.

often been viewed simply in terms of class and gender divisions. The policy-makers have been seen as mostly middle-class and generally male, and the recipients of care as usually poor and often female. Middle-class women employed in the health professions have tended to be elided with the policy-makers in a historiography generally critical of the 'social control' and 'surveillance' of the state and its failure to tackle the structural social and economic reasons for poor health, living and working conditions. The aim of this thesis is to re-focus the picture, so that these women may be viewed in their own right. It will examine a wide range of key archival and printed sources, some new to the public domain, placing women public health officers at the centre of the analysis. For the very first time, it will establish who these women were, what they did, and how their work evolved. It will also uncover and examine their views and attitudes to their own status and role, to their male colleagues and superiors, to the poor families they visited, to public health policy, and to wider social and political issues.

In so doing it will make an original contribution to the understanding of the development and impact of the public health services, particularly to the debate over collective or personal responsibility for health. By placing middle-class women at the centre of the picture, significant new conclusions will be drawn about their role in the ideology and practice of health promotion. The complexity of the transition of women's involvement in public health, from voluntary charitable endeavour to paid municipal work, also provides an important new perspective on the entry of women into the paid professions. This is not a study of women entering a male-dominated occupation, but of two occupations: one male and one female, both subordinate to the male medical profession. It is, in addition, a study of tensions within, and between, female health occupations. Analysis of the relative distinctions between men and women sanitary inspectors, women sanitary inspectors and health visitors, and women public health officers and nurses, will highlight the complexity of the interplay between gender, class and occupational status that underlay the move of women into the paid professions. Despite a growing literature concerning the women's movement during this period, its full complexity is only just becoming apparent. An exploration of the involvement of women public health officers in both the women's and labour movements will also make an important new contribution to an evaluation of 'mainstream', middle-class women's social and political activism.

The overlapping roles of woman sanitary inspector, health visitor and tuberculosis visitor were performed alongside each other in local public health departments, often by the same women. Although they undertook a variety of work, the core duties of women sanitary inspectors concerned the working conditions of

women in small workshops and at home. Those of health visitors were in relation to maternity and child welfare, while tuberculosis visitors were concerned with the domestic circumstances of sufferers and their families. The three occupations demonstrate the broad spectrum of public health activity that was delegated to women. All included home visiting, and the involvement both of voluntary organisations, and of the state, in the private, domestic lives of the poor. All also exposed the tension between personal responsibility and environmental factors in public health.

There has, as yet, been no single study of women employed locally in public health across this period.⁴ Some analysis of the role of health visitors has been included in studies of maternity and child welfare, and tuberculosis visitors appear, less frequently, in studies of this disease. Often analysis has been of a depersonalised 'service', rather than of the women who formed it. Focus has been either on macro social policy, or on local service provision in one particular field. Historians of nursing have not generally examined health visiting in its own right, and have remarked that 'The process by which health visiting was captured as a branch of nursing is not well understood.'⁵ Women sanitary inspectors working locally have very rarely made an appearance in historical studies, generally being overlooked in favour of women factory inspectors employed by the Home Office. This study will, for the first time, attempt to overcome this fragmentation, and look at the full range of public health duties performed by women within local health departments.

While concentrating on salaried employees in the municipal sector, attention will be drawn to the diversity of women's involvement in public health. Although a national overview will be provided wherever possible, London has been chosen for particular attention because of the sheer range of services offered, and the variety of different local contexts, both voluntary and municipal, to be found. Work was more specialised within the capital, enabling a clearer analysis of changing patterns, whereas in many rural areas health visiting was combined with other duties, and women sanitary inspectors were not widely employed.

The chronological framework, from the 1890s to the 1920s, has been chosen to facilitate analysis of a broad spectrum of women's public health activity. Rather

⁴ Rare studies focusing on women in public health include work by Dowling, who has concentrated on the early nineteenth-century origins of health visiting – Dowling, *Ladies' Sanitary Association*; 'Health visiting, the beginning – the missing link', and 'Health visiting – expansion' *Health Visitor* (Oct-Nov 1973). Davies has discussed the relationship between health visiting and sanitary inspection in 'Health visitor as mother's friend'. Palmer has included health visitors in an analysis of several women's health professions in the inter-war period in *Women, Health and Politics*.

than concentrating solely on a few pioneers, the study will look at how the occupation changed over time. The main focus will be on the period from the first appointment of women to salaried posts as women sanitary inspectors in London in the 1890s, through the introduction of health visiting to the capital in the early twentieth century, to developments during, and immediately after, the First World War. Reference will be made to earlier and later periods whenever relevant. A short preliminary chapter will outline the nineteenth-century origins of women's public health work, and a chapter towards the end of the thesis will draw attention to some of the main themes of the inter-war period. Both these periods merit full studies in their own right.

School nursing, midwifery, and district nursing were closely related. Not only have these already received historiographical attention, but they sprang more directly from a tradition of curative medicine. Although boundaries were flexible, they generally took place in separate administrative contexts. Social work occupations, such as hospital almoning, care committee work and housing management, were also separate, with different patterns of training and recruitment. It is not possible within the confines of this thesis to examine the role of medical women in public health departments, particularly their involvement in maternity and child welfare and tuberculosis work, although this would provide an extremely fertile area for future research. It is the potent fusion of health and social work that makes women's public health work particularly significant and an important focus for study in its own right. Later sections of this chapter will show why this is so, through an examination of existing historiography, but first it is necessary to explain the key printed and archival sources for the study.

PRIMARY SOURCES

Because the aim of the thesis is to focus on those women who implemented policy, rather than on those who formulated it, their views have been more difficult to uncover than, for example, those of MOHs or central government officers. Official reports, especially those of the metropolitan MOHs and the LCC, have been useful in uncovering the patterns of work and range of duties of women public health workers. Local records have also provided information on the selection and recruitment of staff, and on salaries and conditions of work. The voices of the women themselves do occasionally appear in these sources, particularly if an individual MOH chose to quote at length from the reports of his female staff, but this was rare. More often, a statistical or tabulated summary of their 'achievements' was all that was noted. Even

⁵ Dingwall, Rafferty & Webster, *Introduction*, p.188.

if extracts from the reports of women officers were included, the editorial voice was that of the MOH.

The main medical and public health journals of the period had the same tendency, although some, notably that of the RSI, did include contributions by women. These have been useful, in addition, for prescriptive opinion about the 'ideal' woman officer and her role. Also predominantly aimed at a male readership were journals for sanitary inspectors, although contributions from women have been revealing. The nursing press, while reflecting the views of the nursing profession, has likewise been useful. The literature of the voluntary maternity and child welfare movement, both periodicals and conference proceedings, has helped to provide a corrective to the 'official' or 'professional' perspective. It has to be borne in mind that such sources reveal the attitudes and opinions of a few outspoken women public health officials – the leaders and opinion-formers of the profession, who had the time and inclination to put pen to paper to express their views.

A major source for the study has been the records and publications of the Women Sanitary Inspectors Association (WSIA – later the Women Sanitary Inspectors and Health Visitors Association, then the Women Public Health Officers Association, now the Community Practitioners and Health Visitors Association). These have provided rare direct access to the views, opinions and campaigns of women public health officers, although the WSIA did not represent all women working in the field. Its campaigns may sometimes have reflected more accurately the views and concerns of leading activists, rather than the rank and file. The WSIA operated at a time of great activism by a plethora of women's pressure groups of all shades of opinion. Women public health officers participated in these networks, and were drawn into more general campaigns. The records, reports and publications of these other organisations have also been useful.

The records of training institutions have revealed information about recruitment and selection, as well as details of the way in which women were prepared for their role. Those of institutions that are now part of the university sector, such as Bedford College, King's College of Household and Social Science, and Battersea Polytechnic, although variable in breadth and depth, have been easily available. The records of the RSI are still in private hands, unsorted and unlisted, so that it is by no means certain that all relevant material has been accessed. Those of the National Health Society are very partial for the period, and reliance on annual reports and other published sources has been necessary. The National Archives have helped to weld together all these sources, as well as providing the perspective of successive governments on the role of women in public health. They include files

relating to the regulation of training courses, correspondence with individual training institutions, and with professional organisations. Correspondence with individual local authorities, concerning the appointment, salaries and conditions of service of their staff, and the provision of public health services in general, has also been useful.

Very few personal papers of individual women public health officers have survived in the public domain.⁶ The exceptions are generally those of women who went on to have notable careers, or were important 'pioneers'. There are also occasional biographical or autobiographical accounts, although, once again, these generally relate to prominent figures. Very few women public health workers published monographs on professional questions, although there were a few notable exceptions. More commonly, they contributed textbooks aimed at other women in the field, and careers literature for intending inspectors and visitors. Both have provided a major source from which to counterbalance the more numerous publications of medical men and male inspectors, although in both cases it has been difficult to untangle the prescriptive from the descriptive.

If uncovering the voices of women in the public health professions has proved difficult, finding those of the women who were visited, mainly poor mothers, would be doubly so.⁷ Their views and opinions, when they were discussed, were filtered through middle-class perceptions, and were generally employed to substantiate the views and opinions of medical practitioners and social reformers. The aim of this thesis is to focus instead on the women public health workers themselves. It is recognised that this picture is necessarily one-sided, but it still makes a valuable contribution to an understanding of the impact of the public health services, and uncovering the complex relationship between public policy, visitor and visited.

SECONDARY SOURCES

The social and political framework within which women public health officers worked has been the subject of considerable historiographical interest. Public health in general, the maternity and child welfare and anti-tuberculosis movements, and protective labour legislation, have all provided rich sources for medical and women's historians, sociologists and historians of social policy. The remainder of this chapter will place the thesis in context, by drawing attention to where this large and diverse literature touches on women working in public health, and where a study of these

⁶ For similar problems in relation to the personal papers of nurses, and sources for nursing in general, see Hall, 'Archival sources', pp.266-267.

⁷ This has been widely recognized by women's historians. See, for example, Ross, 'Good and bad mothers', p.187.

women can, in turn, inform wider debates. Any study of the genesis of a 'new' female occupation, at a time of considerable campaigning activity by women, must also take into account the work of historians and sociologists of the women's movement, and of the professions.

From 'public' to 'private' health?

Although the details are often contested, many commentators, old and new, have agreed on the same broad chronology for developments in public health during the nineteenth and twentieth centuries.⁸ The first phase, lasting from 1840 to around 1880, was the heroic age of Chadwick, when England led the world in sanitary legislation and engineering, the environmental or miasmatic theory of disease causation reigned supreme, and there was a reluctance to intervene in private, domestic spaces. Next, there was an intermediate phase, dating from around 1880 to 1910, during which developments in bacteriology complicated thinking, and placed increased emphasis on infectious disease policies such as notification and isolation. This was when, according to Simon Szreter, 'the castle's drawbridge was hauled down', allowing municipal intervention in the private sphere.⁹ The third, which began in c.1910, was the era of the personal health services, with the accent on health education and individual hygiene, as characterised by the growth of maternity and child welfare, tuberculosis and similar services.¹⁰ Contemporaries, themselves involved in some of these developments, were convinced that a new emphasis on popular health education and personal hygiene was part of a pioneering brave new world, and that women workers were crucial to its success. Woolwich's woman sanitary inspector, for example, felt that

When sanitary science ceased to be wholly concerned with environment and began to consider the question of the individual, then came women's greatest opportunity in public health work. ...in the region of the home-life of the people, where personality is the central factor; where the individual was seen, both influenced by environment and helping to create environment.¹¹

The 'Whiggish' implications of such chronologies have been rejected by those who have seen the abandonment of earlier environmental issues by the public health profession, as not only a loss of its own identity, but as a retrograde step for the health of the British people. Historian of social policy, Jane Lewis, has suggested that

⁸ See, for example, Frazer, *History of Public Health*, pp.vii-viii; Brand, *Doctors and the State*, p.236; Lewis, *What Price?*, p.5; Marks, *Metropolitan Maternity*, p.25; Ashton & Seymour, *New Public Health*, pp.15-21; Smith, *People's Health*, p.417; Woodward, 'Medicine and the city', p.76; Worboys, *Spreading Germs*, p.110.

⁹ Szreter, 'The importance of social intervention', p.32.

¹⁰ See, for example, Woodward, 'Medicine and the city', p.76.

the broad vision for public health that had characterised much of the previous century was lost during the first decades of the twentieth.¹² For her, the narrowing of the focus onto the personal health services led to the abandonment by the medical profession of its traditional role as public health 'watchdog'. During the 1920s and 1930s, it failed to find a positive strategy to tackle health problems caused by structural socio-economic factors such as unemployment, malnutrition and poor housing. Instead, increasing responsibility was placed on the individual for the preservation of the nation's health.¹³

Others have noted the continuities that underlay apparently huge shifts in public health thinking and practice, particularly in the role of women. Several writers have highlighted the long-overlooked importance of femininity and domesticity within nineteenth-century sanitary reform, and the significant role that was played by women's philanthropic endeavour.¹⁴ They have revised the history of the public health movement, and placed the role of middle-class women at the centre of a picture once dominated by accounts of great male sanitarians, and great public projects such as sewerage and water supply.¹⁵ Instead, attention has been drawn to the application of the new sanitary science within domestic spaces. A middle-class 'cult of domesticity' has been identified, with the association of women with morality, godliness, purity and cleanliness. The influence of evangelical religion, and a conflation of moral and physical cleanliness with social class, has also been emphasised. The association of cleanliness with personal action and individual behaviour has been traced to the period before public services, such as water supplies and sanitation, had been established. It was the responsibility of the women of each middle-class family to make an island of physical cleanliness and moral purity for the members of their household.¹⁶

Annmarie Adams has argued that mid-nineteenth century sanitarians saw the body, the house, and the city as part of a single system, making women's role significant.¹⁷ Nancy Tomes has observed how nineteenth-century sanitary texts emphasised individual responsibility for the prevention of infectious disease by

¹¹ *JRSI* (Vol XXVII, 1907), p.197.

¹² Lewis, *What Price?* & 'The public's health'.

¹³ These views have been echoed by Webster in his analysis of health services provided during the inter-war economic depression. Webster, 'Health, welfare and unemployment' & 'Healthy or hungry thirties?'

¹⁴ Davidoff, 'Rationalization of housework'; Bashford, *Nursing Bodies*; Poovey, 'Domesticity and class formation'; Tomes, 'Private side'; Williams, 'Laws of health'.

¹⁵ Davidoff & Hall, *Family Fortunes*, pp.319-397.

¹⁶ *Ibid.*, p.382.

¹⁷ Adams, *Architecture*, p.76.

'scrupulous adherence to a detailed hygienic code of behaviour'.¹⁸ The public were already prepared for germ theory, the link between domestic hygiene and disease, and 'a powerful association between guilt and responsibility for infection', especially when it came to diseases of childhood and infant mortality.¹⁹ For Tomes and Adams, the nineteenth-century association between disease and housekeeping simultaneously gave women's work within the home a higher and nobler purpose, and made it more physically and emotionally burdensome, as any sickness or death became the result of personal failure.²⁰ Alison Bashford has questioned the traditional idea that there was a simple 'progress' from miasmatic and sanitarian theory of disease causation to one based on germ theory. She has concluded that the former was sustained in the area of women's work, notably in the field of nursing knowledge, where a moral imperative was retained.²¹ Tomes has questioned the traditional periodisation based around the advent of bacteriology, and has identified the persistence of sanitarian beliefs and practices and the importance of domestic hygiene up to 1920.²² For her, the idea that infective bacteria were commonly conveyed by house dust and insects, for example, led to a continued emphasis on basic domestic sanitary practices.²³ Bashford has noted a similar pattern in nursing textbooks published between 1860 and 1910.²⁴ Viewed from a female perspective, there were significant continuities in public health practice.

Another continuity was in middle-class attitudes to the poor.²⁵ For Dorothy Porter, the nineteenth-century view that the urban poor was a separate species, different in both physical appearance and social behaviour, was merely given renewed emphasis in the Edwardian period by vocabularies of degenerationism and eugenics.²⁶ Martin Gaskell has likewise noted the persistence of sensationalist images of the slum from the mid-nineteenth to the mid-twentieth century. Its unreality and sense of danger had an emotive power that endured. Slum dwellers were seen

¹⁸ Tomes, 'Private side', pp.528-529.

¹⁹ *Ibid.*

²⁰ Tomes, *Gospel*, pp.10, 64.

²¹ Bashford, *Nursing Bodies*, pp.12-15.

²² Tomes, 'Private side', p.513.

²³ Tomes, *Gospel*, pp.8-12.

²⁴ Bashford, *Nursing Bodies*, p.275.

²⁵ Throughout this thesis the concept of social class is used, as McKibbin suggests, only for the way in which it 'allows us to generalize while accepting that there are exceptions to every rule' - McKibbin, *Classes and Cultures*, p.vi. Recent studies have likewise emphasised enormous variations in income, status, religion and culture within the middle classes, which are further substantiated by the lives of the women who are the subject of this thesis – see, for example, Kidd and Nicholls, *Making of the British Middle Class*?

²⁶ Porter, "Enemies of the race", pp.147-148.

as undisciplined, thriftless, dangerous and intemperate.²⁷ Recent social historians, by contrast, have presented a much more positive view of life in the slums, and have described the orderly and creative responses of the poor to their living conditions.²⁸ Middle-class public health reformers have been criticised for their lack of sensitivity to cultural differences, for using theories of urban degeneration as an easy explanation, and for implementing a kind of 'cultural imperialism'.²⁹ Sanitary philanthropists and reformers have been accused of assuming the naturalness and superiority of middle-class domestic behaviour, and women's sanitary organisations and health societies of the elision of hygienic with moral and religious instruction and with the gospel of self-help.³⁰ For Bashford, 'sanitising' domestic space also meant 'moralising' it into middle-class values.

Through the imposition ... of fundamentally middle-class codes of morality, working-class suburbs, homes, families, lives and bodies were to be ordered and sanitised in both physical and cultural senses.³¹

Instead of tackling the structural economic problems at the heart of the housing problem, Gaskell has suggested, the government continually reverted to explanations that depended on the character of slum-dwellers.³²

'Reforming the mother': the maternity and child welfare movement

In her influential 1980 work, *The Politics of Motherhood*, Lewis has argued that early twentieth-century doctors and policy makers failed to take account of the structural causes of high levels of infant and maternal mortality. Instead, they emphasised the ignorance and feckless behaviour of individual mothers, who were to be educated and reformed, rather than given the material help that they needed.³³ Other historians, notably Anna Davin and Carol Dyhouse, have also criticised the ideology that lay behind the maternity and child welfare policies of the first decades of the twentieth century.³⁴ They have argued that the services provided were personal and individual, and reflected the close connection between social and moral reform, so that

²⁷ Gaskell, *Slums*, pp.3-4.

²⁸ Green & Parton, 'Slums', pp.25-6, 76; White, *Rothschild Buildings*, pp.96-100; Davis, 'Jennings buildings'.

²⁹ Jones, *Outcast London*, pp.151, 313.

³⁰ Poovey, 'Domesticity'; Williams, 'Laws of health', p.79.

³¹ Bashford, *Purity*, p.2.

³² Gaskell, *Slums*, p.10.

³³ Lewis, *Politics*.

³⁴ Davin, 'Imperialism and motherhood'; Dyhouse, 'Working class mothers'; Ross, *Love and Toil*. Working-class women were even blamed for their own maternal mortality and morbidity – see Oakley, *Captured Womb*, pp.72-79. She has drawn attention to the 'covert social control function of ante-natal care', pp.252-253.

Health visitors and infant welfare workers set out to reform the character of the working-class mother and to inculcate the requisite sense of moral responsibility.³⁵

Alongside the 'social control' aspect of this analysis, has been the politico-economic one that,

The focus on mothers provided an easy way out. It was cheaper to blame them ... than to expand social and medical services and it avoided the political problem of provoking rate and tax payers.³⁶

For Ellen Ross, far more resources, both public and private, were expended on 'regulating, correcting and policing working-class mothers' than on offering them food, clothing, medical services, housing or cash. Health visiting schemes put more energy and personnel into 'harassing mothers than into helping them'.³⁷ For Ann Oakley, the zeal with which the ideology was taken up 'probably had more to do with perceptions of women's social function, than with a strictly cost-benefit analysis of different strategies for preserving children's health'.³⁸ Whatever the cause, the result has been seen to have heaped yet more pressure on already overburdened working-class mothers, who were exhorted to live middle-class lives for the sake of the health of their children, and yet not given the resources with which to do so. The infant welfare movement 'had poor mothers coming and going, suggesting that they had powers that they actually lacked and holding them morally and sometimes legally responsible for deeds they could not do'.³⁹ Elizabeth Peretz has concluded that, while advice on modern child-care methods was freely and copiously available, material support, and the means to carry out the advice, was less forthcoming.⁴⁰ Even advice to wash kitchen utensils in hot water without the provision of better housing, more fuel and access to running water was asking the impossible, while medical examinations of infants uncovered health problems and prescribed treatment for them, but provided no easy or cheap access to medical care.⁴¹

These historians have themselves been writing during a period of neo-liberal developments in health policy, the rolling-back of the welfare state, and a renewed emphasis on health promotion, personal prevention and individual responsibility for health. These changes have spawned a number of influential and highly critical

³⁵ Lewis, *Politics*, pp.18-19.

³⁶ Davin, 'Imperialism and motherhood', p.26.

³⁷ Ross, 'Good and bad mothers', p.192.

³⁸ Oakley, *Captured Womb*, p.38.

³⁹ Ross, *Love and Toil*, pp.36, 203.

⁴⁰ Peretz, 'Costs of modern motherhood'

⁴¹ Ross, *Love and Toil*, p.211.

papers.⁴² The criticisms lodged against late twentieth-century policies bear a marked similarity to those of historians against a previous generation. One sociologist, for example, has pointed out how a 'victim-blaming ideology' has minimised the importance of evidence about the environmental assault on health:

The ideology of individual responsibility promotes a concept of wise living which views the individual as essentially independent of his or her surroundings, unconstrained by social events and processes.⁴³

For another, exhorting mothers to change their ways 'for the sake of the baby' has been at best misguided, since mothers already possess the sense of responsibility which the authorities have wished to instil, and at worst likely to exacerbate already heightened feelings of inadequacy and guilt.⁴⁴ The new health promotion has been accused of failing to take account of the material disadvantages of people's lives, of a narrow focus on the individual, and of associating 'lifestyle' diseases with individual self-control and responsibility. It has been in this climate of criticism of current trends in health policy that the revival of interest in the history of the maternity and child welfare movement has taken place, and this can be seen to have heavily influenced the historiography. Ross has even made an explicit connection between late twentieth-century 'government-sponsored AIDS campaigns and anticancer and anti-heart disease diets' and the early twentieth-century infant welfare movement.⁴⁵

As it has become available to an anglophone audience, the social philosophy of Michel Foucault has also been influential. David Armstrong has provided a Foucauldian analysis of the development of the maternity and child welfare movement in which, 'infant mortality became a problem of personal hygiene which demanded surveillance and intervention at a social level'. Moreover, 'the realignment of the conceptual space of infant mortality from a sanitary into a primarily social one meant that the infant ... became an essentially social object'.⁴⁶ Ross has, more recently, also drawn on the theories of Foucault and Donzelot to depict the period between 1870 and 1918 as an era when mothers fell under the scrutiny of the modern state.⁴⁷ This is the atmosphere in which scholarship from the 1970s to the 1990s has analysed the work of the health visitor.⁴⁸ She has been heavily implicated in a system that has been seen as, at best, failing poor mothers and, at worst, aimed

⁴² Stacey, 'Realities for change in child health care'; Crawford, 'You are dangerous to your health'; Graham, "Prevention and Health: Every Mother's business".

⁴³ Crawford, 'You are dangerous to your health'. For a similar criticism of present-day health visitors see Abbott & Sapsford, 'Health visiting: policing the family?'

⁴⁴ Graham, "Prevention and Health: Every Mother's business".

⁴⁵ Ross, *Love and Toil*, p.199.

⁴⁶ Armstrong, 'Invention of infant mortality', pp.217-219.

⁴⁷ Ross, *Love and Toil*, p.5.

⁴⁸ Lewis, *Politics*, p.105.

at their surveillance and control. For the authors of an overview of the history of nursing, for example, the relationship between the mother and the health visitor was one of 'social control' as the maternity and child welfare movement provided a rationale for 'the surveillance of families'.⁴⁹

Some historians, however, have written much more sympathetically of the efforts of middle-class activists to bring down infant and maternal mortality rates. Deborah Dwork has observed how,

Reading the analyses of Davin, Dyhouse and Lewis one begins to doubt the sincerity of official concern with the problem of infant mortality: everyone appears to have been more concerned with controlling women than saving babies.⁵⁰

For her, mothercraft, or the 'principle of pedagogy' as she has termed it, was not an early or inevitable solution. Neither was it particularly cheap. Education was time-consuming, labour-intensive and often expensive.⁵¹ She has noted that a number of other services were provided, in addition to instruction, and that some MOHs did recognise the influence of poverty and environmental conditions on infant health. Lara Marks has described how the services provided by Jewish charities seem to have been much valued by poor Jewish women in the East End.⁵² Her detailed local studies of London have shown that maternity and child welfare services were often much more responsive to the needs of poor mothers than writers, who have concentrated on macro-studies of social policy, have thought.⁵³ Whether it was in accordance with contemporary rhetoric or not, voluntary and municipal services often provided food, milk, fuel, cost-price clothing, home helps, birth control advice and free medical treatment. Marks has been less prone than other writers to view working-class women as victims, and has depicted them as 'not merely passive recipients of health and welfare provision' but as 'active choosers of the types of services most suiting their needs'.⁵⁴ Lewis has, however, argued that, although working-class women may have welcomed some of the services to be found at maternity and child welfare centres, the health visitor invading the home was a different matter.⁵⁵

One theme that has emerged from Marks's work is the importance of the attitude of those providing the services, particularly the degree to which they took into

⁴⁹ Dingwall, Rafferty & Webster, *Introduction*, pp.183-188.

⁵⁰ Dwork, *War is Good*, p.228.

⁵¹ *Ibid.*, p.220.

⁵² Marks, *Model Mothers*, pp.124-5.

⁵³ *Ibid.*, pp.227-8; Marks, *Metropolitan Maternity*.

⁵⁴ Marks, *Metropolitan Maternity*, p.273.

⁵⁵ Lewis, 'Working-class wife and mother', pp.111-112.

consideration the needs and desires of the mothers.⁵⁶ Davin has admitted that the attitude of at least some, 'though patronizing and class-bound, was at least relatively sympathetic and tactful' and that

those who saw themselves too much as representatives of authority, supervising and directing, would surely get on less well than those who made some effort, however self-conscious and clumsy, to develop understanding and sympathy.⁵⁷

Lewis has also suggested that, although some middle-class women social workers showed a real understanding of working-class women's problems, 'it is impossible to know how far the ideas of leading activists filtered down to the mass of women visitors'.⁵⁸ Health visiting has generally been analysed as a rather depersonalised 'service'. Despite their crucial role as the bridge between the policy-makers and the recipients of care, in none of the major accounts of the maternity and child welfare movement have health visitors themselves been much discussed. Who were they? What were their views and attitudes? These are two central questions that have yet to be answered. Given the sheer number and variety of organisations involved, and development over time, it is unlikely that the answers are either uniform or simple, yet they could be vital to an understanding of the true impact of the early twentieth-century maternity and child welfare movement. Likewise, exactly what health visitors did has been taken for granted. In most areas the visiting of mothers with babies under a year old was the keystone of their work, but educating mothers was not all that they did. Infant welfare was only one of the public health duties allocated to women. The maternity and child welfare movement cannot be studied in isolation if a truly rounded picture of the public health activity of women is to be established.

'Disciplining the patient': the anti-tuberculosis campaign

After Koch's isolation of the tuberculosis bacillus in 1882, soil dampness, a vitiated atmosphere and heredity gradually gave way as explanations of the disease. Bacteriology has been seen, not only to have identified individuals as agents of disease causation, but also to have placed an increased emphasis on their behaviour. According to Porter, it was no longer enough for the individual to take care of his own health. He was

sociologically redefined as the bearer of the relations of health and illness within a refashioned concept of the environment that included not only the physical milieu but also the world of social behaviour... This new perspective

⁵⁶ Marks, *Metropolitan Maternity*, pp.245-247, 268.

⁵⁷ Davin, 'Imperialism and motherhood', p.41.

⁵⁸ Lewis, 'Gender, the family and women's agency', p.53.

validated the Edwardian philosophy of preventive medicine as the panoptic overseer of communal life.⁵⁹

Armstrong has noted a similar pattern:

Under the new hygiene the natural environment was not of itself dangerous, but merely acted as a reservoir. The danger now arose from people and their points of contact. It was people who carried ill-health from the natural world into the social body and transmitted it.⁶⁰

He has applied a Foucauldian analysis to the phenomenon of the tuberculosis dispensary, claiming that it embodied 'an extension of the panoptic vision to a whole society'.⁶¹ The examination of tuberculosis contacts turned the 'medical gaze' on the healthy, on the transmission of disease between individuals, and on their social relationships. Other historians of tuberculosis, although not explicitly Foucauldian, have described the dispensary system in similar terms. For F.B. Smith, it was 'a sorting, isolating mechanism, rather than a curative resource', designed 'to regulate the family and contacts at least as much as the original sufferer'.⁶² Although some dispensaries did offer treatment, most, like maternity and child welfare clinics, emphasised diagnostic and educative functions.⁶³ Linda Bryder's study of the anti-tuberculosis movement has concentrated on a middle-class voluntary organisation, the National Association for the Prevention of Tuberculosis, founded in 1898. She has claimed that this exhibited all the baggage that usually went with such a pedigree: an unwillingness to tackle the root cause of poverty and ill health, a distrust of working-class lifestyles and a reliance on the education of the poor.⁶⁴ As with the maternity and child welfare movement, education has been viewed as a cheap option, and national efficiency seen as a cause of widespread public interest and support, as tuberculosis was primarily a disease of young adults, the nation's workforce.⁶⁵ For Bryder, tuberculosis was thought of as the result of moral weakness, and preventable by healthy living, while the realities of working-class life were misunderstood or ignored.

Crucial to the operation of the anti-tuberculosis campaign was its system of the home visiting of sufferers. Much as the maternity and child welfare centre provided a hub from which health visitors were dispatched to visit the homes of the poor, to instruct them on the proper care of their infants, so tuberculosis visitors were an integral part of the tuberculosis dispensary system. They gave instructions about

⁵⁹ Porter, "Enemies of the race", pp.170-171.

⁶⁰ Armstrong, *Political Anatomy*, p.10.

⁶¹ *Ibid.*, p.9; Lupton, *Medicine as Culture* (1994), pp.30-32.

⁶² Smith, *Retreat*, p.67.

⁶³ *Ibid.*, pp.72-4.

⁶⁴ Bryder, *Below the Magic Mountain*.

⁶⁵ *Ibid.*, p.30.

precautions to be taken to prevent the spread of infection. These included both the regulation of the patient's behaviour, and the re-ordering of household routines, such as the provision of separate sleeping arrangements, and exhaustive cleaning and hygienic practices. The tuberculosis visitor would also report on other members of the household who might be subject to the 'march past', an examination to see if they were infectious. This might have far-reaching implications, leading to the separation of families, economic ruin if a breadwinner was involved, and the social stigmatisation of the family.⁶⁶ Tuberculosis 'after-care' schemes have also generally been described as running on the principles of the Charity Organisation Society (COS), involving extensive investigations into financial and other circumstances, and aiming to make the families of tuberculosis sufferers self-sufficient and financially independent.⁶⁷

The tuberculosis dispensary was the point of dispatch of sufferers to the other wing of the anti-tuberculosis campaign, the sanatorium, which has also come in for much criticism from historians.⁶⁸ Neil McFarlane has argued that sanatorium treatment diverted attention and resources away from more radical solutions. He has called it 'a smokescreen behind which the social conditions which predisposed to infection were obscured'. Concentrating on the removal of infectious individuals from the rest of the population, or isolating them within their own homes, enabled policy makers to ignore the association between environment and pulmonary tuberculosis.⁶⁹ At the time it was recognised that bad housing, overcrowding, unemployment, a poor diet, and indeed poverty itself, were among the most important factors determining the development of tuberculosis.⁷⁰ Once again, medical opinion and practice have been implicated in a system that did nothing to tackle these socio-economic problems, but instead highlighted the behaviour of the individual in spreading infection. Tomes has seen the prevailing lack of official enthusiasm about more far-reaching preventive schemes as resulting from 'social resistance to confronting the problems of chronic disease among the poor'.⁷¹

She has also provided a corrective to the view that public health developed simply from a broad concern with environmental conditions to a narrow focus on the individual. She has observed that, although much effort was expended on the

⁶⁶ Smith, *Retreat*, p.73.

⁶⁷ Bryder, *Below the Magic Mountain*,

⁶⁸ See, for example, Worboys, 'Sanatorium treatment'.

⁶⁹ McFarlane, 'Hospitals, housing and tuberculosis', pp.59-85. Tuberculosis has held a key role in recent debates on the effectiveness of medical intervention in reducing mortality – see Szreter, 'Importance of social intervention'.

⁷⁰ Smith, *Retreat*, pp.169-174; Bryder, *Below the Magic Mountain*, p.97.

tuberculous individual, the gathering of data on patterns of susceptibility did produce hard evidence of the link between poverty and health.⁷² She has noted a distinct difference between public health workers and other social commentators, in that they were often willing to point to wide-ranging social causes of disease. Despite the important role that tuberculosis visitors played in the operation of such schemes, even less attention has been paid to these workers than to infant welfare workers. Indeed, virtually nothing is known about tuberculosis visitors themselves, or their relationship to the rest of the health visiting profession.

'Protecting' working women

As with the maternity and child welfare and anti-tuberculosis movements, factory and workshop legislation has been depicted as yet another means for the social control of working-class life and, in particular, of working-class women.⁷³ Commentators have pointed out how factory legislation from the 1830s onwards placed overwhelming emphasis on the protection of women and children. Barbara Harrison has argued that,

The protective stance effectively discriminated against women in the labour market; it increased the surveillance of women in the workplace and outside, and it reinforced the ideology and social relations which differentiated gender roles, and confined women's appropriate work to the domestic sphere and men's to the paid labour market.⁷⁴

The issue of girls becoming healthy and suitable wives and mothers, and the 'problem' of married women who worked, became particular targets for reformers.⁷⁵ Emphasis on dangerous processes and industrial diseases, such as lead and phosphorous poisoning, has been seen as detracting from serious consideration of more subtle and widespread socio-economic problems, such as long hours, low wages and poor home conditions.⁷⁶ Sweating was also attacked, it has been alleged, not because it damaged women's health, but because it lowered male wages, and affected motherhood.⁷⁷ The middle-classes have been depicted as viewing out-workers as a social, sanitary or eugenic problem, and a threat to organised labour, the gender division of labour within industry, the family wage, trade unionism, good mothering, the system of production, public order and even the very stability of the

⁷¹ Tomes, 'White plague revisited', p.476.

⁷² *Ibid.*, p.472; Robertson, "Terrible scourge".

⁷³ Harrison, 'Women's health?' & *Not Only*.

⁷⁴ Harrison, 'Suffer the working day', p.89.

⁷⁵ Gray, 'Languages of factory reform', pp.150-151; Harrison, *Not Only*, pp.59-63.

⁷⁶ Malone has observed the 'discourse of danger' that dominated discussion of women's work. Malone, *Women's Bodies*, p.1.

⁷⁷ Thom, 'Free from chains?', p.88; Lewis & Rose, "Let England Blush", p.113.

state itself.⁷⁸ Here, securing minimal alterations in the conditions in which out-workers laboured was also easier than wholesale reform of the labour market.⁷⁹ The general thrust of factory legislation, it has been suggested, was not to eliminate the root causes of ill health, but instead to provide protection for individual workers so that 'the answer to improving poor working conditions continued to be seen in personal rather than structural terms'.⁸⁰ If workers followed the prescribed rules and regulations, they would be protected.⁸¹

Very little has been written on women sanitary inspectors who were appointed by local authorities for the inspection of workshops where women were employed and the premises of out-workers. They were directly responsible only for general environmental and sanitary conditions, rather than with dangerous processes, hours of work or minimum wage legislation, as these were dealt with by the central factory inspectorate. Sanitary conditions were generally less controversial at the time, and have remained so for recent historians. While some, such as Harrison and Morris, have highlighted the social control aspects of the hours of work regulations, emphasis on the 'dangerous trades' and the Wages Boards, little attention has been paid to the regulation of general environmental conditions.⁸² Indeed, Harrison has argued that attention-grabbing headlines about the dramatic effects of lead and phosphorous-poisoning served to detract attention from the more subtle and all-pervading health problems from which many women workers suffered as a result of poor sanitary conditions. It was with these very problems that women sanitary inspectors were most intimately concerned.

More attention has been paid to those women who were employed as factory inspectors by the Home Office. Some of this is almost hagiographic in nature, and has chronicled how these early crusaders overcame considerable problems and suffered many hardships in the pursuit of their duties. It has also unquestioningly accepted the benefits of their endeavours, both for the health of working women, and for their own status as professional women.⁸³ This view has not gone unchallenged. Jones has seen the appointment of women factory inspectors as 'less a genuine change in class or gender relations and more a means of consolidating existing class and patriarchal relations'.⁸⁴ She has noted how, 'Women inspectors could be used as

⁷⁸ Rowbotham, 'Strategies against sweated work', p.179.

⁷⁹ Feldman, 'Importance of being English', p.58.

⁸⁰ Jones, 'Women health workers'.

⁸¹ Harrison, 'Women's health?', p.485.

⁸² Harrison, 'Suffer the working day', p.87; Morris, *Women Workers*, p.192.

⁸³ McFeely, *Lady Inspectors*.

⁸⁴ Jones, 'Women health workers', p.171.

a means of redressing a grievance without recourse to a "political" solution, such as a strike'.⁸⁵ They were a cheap response to the problems of occupational health, since much of their work was involved with individual behaviour, rather than tackling the structural root causes of the problems. The difference between the 'lady' inspectors and the 'women' workers, who had campaigned for inspection by ordinary working women, has also been noted.

However harshly the system is judged, most historians have agreed that the women inspectors were different, both from their male counterparts, and from contemporary policy-makers, in two crucial aspects. They were more likely to recognise those forces that gradually and incipiently undermined women's health, rather than to concentrate exclusively on the dangerous trades, and they also interpreted the concept of 'working conditions' more widely. They recognised and commented upon women's relative powerlessness in the labour market and how lack of nourishment, long walks to work, bad housing, unemployment, and cruelty in the workplace could all conspire to undermine health.⁸⁶ Many had personal links with the labour movement, and with women's organisations. An examination of the work of women sanitary inspectors at a local level may further illuminate the complex relationship between the middle-class professional women who were appointed to enforce protective legislation, and the working women they sought to help.

The women's movement

One of these complexities arose from the relationship between the views of organised working women, and those of the middle-class women's movement. Summers has noted how many historians have tended 'to present middle-class women's reforming campaigns as measures to control and repress the autonomy of working-class women'.⁸⁷ Attempts have been made, for example, to cast protective labour legislation primarily as a class issue. According to Olive Banks, the issue of protective legislation split asunder 'labour women' and 'feminist groups'.⁸⁸ She has argued that hostility between the two was exacerbated by a belief that the latter represented the interests of middle-class women, in opening up the professions and higher education. It has, however, proved particularly difficult to separate out strands of 'bourgeois' and 'social' feminism in the British context.⁸⁹ Many middle-class women were heavily involved in the trade union movement and socialist politics.

⁸⁵ *Ibid.*, p.180.

⁸⁶ *Ibid.*, pp.178-180, 192.

⁸⁷ Summers, *Female Lives*, p.30.

⁸⁸ Banks, *Politics of British Feminism*, p.30.

Some commentators have settled on a division, not between middle-class and working-class women, but between 'socialist women' and 'working women', the latter often taking the side of the 'bourgeois' opponents of protective legislation which threatened their jobs. Political belief may have been just as important as class.⁹⁰ Women sanitary inspectors entered the professional labour market, and joined 'middle-class' women's organisations that supported them in this. They also had close links with groups of labour women, who supported protective labour legislation. This was a complex position that demands further exploration.

Links between women's organisations and the maternity and child welfare movement were also significant. In *The Politics of Motherhood*, Lewis has argued that women's groups representing the views of poor mothers voiced demands that were consistently and significantly different from those of policy-makers. These were for medical treatment as well as advice, direct economic assistance in the form of cash, milk and meals, and free access to birth control information.⁹¹ As with protective labour legislation, it was not simply a division between working-class and middle-class women. Dyhouse, for example, has applauded women such as Maud Pember Reeves and Margery Spring-Rice for consistently emphasising, against a 'dominant middle-class ideology', that poverty and low wages were the real issue.⁹² For her, although social investigations undertaken by middle-class women were part of a philanthropic tradition, they were occasionally distinguished by an implicit or explicit 'feminism', in that they identified themselves with working-class women. Middle-class women were far from ignorant about the lives of working women, and their efforts cannot be dismissed as merely patronising or punitive.⁹³ Diana Palmer has suggested that, until the end of the 1920s, there was general agreement between middle-class reformers and working-class women's organisations about the importance of maternity and child welfare. There were tensions and 'class divisions', since services were class-specific, the instruction given to working-class women included an attempt to reform working-class lifestyles, and working women's organisations opposed reliance on charitable endeavour. On the whole, however, there was consensus. It was not until the 1930s, she has suggested, that several factors led to a fragmentation of this alliance. Working-class women became more overtly concerned with tackling health problems caused by poor housing and poverty,

⁸⁹ Levine, *Victorian Feminism*, pp.16-17.

⁹⁰ *Ibid.*

⁹¹ Lewis, *Politics*, p.14.

⁹² Dyhouse, *Feminism and the Family*, p.133.

⁹³ Collette, *For Labour*, pp.10-11

while middle-class women continued to rely on the accepted argument that poor diet was due to lack of knowledge of dietary requirements.⁹⁴

Much writing about women's groups in the inter-war period has, until recently, concentrated on those that grew out of the suffrage movement and campaigned for the further removal of political, social and economic inequalities.⁹⁵ Their stories have been told largely in terms of a failure either to attract a significant following, or to secure the reforms they sought, so that they became 'small and somewhat ineffectual pressure groups'.⁹⁶ In addition to this 'failure', historians have attempted to analyse the 'divisions' within the women's movement during this period. Much has been made of the supposed move of some towards a 'new feminist' philosophy based on 'difference' rather than 'equality', including the campaign for family allowances, the provision of birth control information and support for protective labour legislation.⁹⁷ According to Lewis, these 'new feminists' were keen to draw 'the feminist and labour causes together'.⁹⁸ For Harold Smith, 'new' feminists accused 'equality' feminists of adopting male values and priorities, while 'equality' feminists accused 'new' feminists of confining women to traditional roles, and of putting humanitarian interests before feminism.⁹⁹ Such divisions may have been over-stated. As Brian Harrison has observed, doubts about welfare regulations specific to women were voiced by a wide range of organisations and individuals.¹⁰⁰ Moreover, groups were willing to work together when they had common goals, individual members could hold views in opposition to the group, and programmes often overlapped.¹⁰¹ Despite their apparently small impact, overtly 'feminist' groups, have also received a disproportionate amount of historiographical interest. Attention has more recently been drawn to a wider range of women's organisations active in this period, especially what have been termed 'mainstream, conservative and mainly middle-class women's societies'. Caitriona Beaumont has argued that such organisations made a considerable contribution, through their use of the concept of active citizenship, which distanced them from the negative portrayal of 'feminism', and

⁹⁴ Palmer, *Women, Health and Politics*, pp.66, 70, 79, 181.

⁹⁵ Lewis, 'Beyond suffrage'.

⁹⁶ Beaumont, 'Citizens not Feminists', p.412; Harrison, *Prudent Revolutionaries*, p.314; Banks, *Politics of British Feminism*, p.118; Pugh, 'Domesticity and the decline of feminism'; Kent, 'The politics of sexual difference'.

⁹⁷ Harrison, *Prudent Revolutionaries*, pp.99-112.

⁹⁸ *Ibid.*, p.148; Lewis, 'Beyond suffrage', pp.12-13.

⁹⁹ Smith, 'British feminism in the 1920s', p.48; Lewis, 'Beyond suffrage', p.14.

¹⁰⁰ Harrison, *Prudent Revolutionaries*, p.148.

¹⁰¹ Banks, *Politics of British Feminism*, pp.14-15; Smith, 'British feminism in the 1920s', pp.48-49.

enabled them to attract mass support from a broad spectrum of women, the majority of whom were wives and mothers.¹⁰²

Because of their role in both administering factory legislation, and promoting maternity and child welfare, women public health officers were at the centre of many of the debates raised by the women's movement both before, and after, the First World War. Analysis of their relationship with other women's groups is revealing.

Professional power

The relationship between working-class women and those working in the public health professions was also influenced by the latter's status as 'professionals'. In the sociology of the professions, traditional thinking has been dominated by 'attribute' and 'process' models of professionalisation. These have attempted to produce a definitive list of traits by which professions might be differentiated from other occupations, and to outline the way in which occupations may 'score up' such traits on the road towards full professionalism. Several influential 'revisionist' works, produced during the 1960s and 1970s, have since been generally accepted as the 'new orthodoxy' and professionalism seen as an ideology, with the concepts of power, client-control and class at the centre of analysis.¹⁰³ There has also been a meeting between sociologists and historians of the professions (particularly of medicine which has dominated the literature), in an examination of the development of professional ideology within historical contexts. Analysis has, for example, moved away from seeing medicine as the paradigmatic case of a successful programme of professionalisation, and towards viewing it as the outcome of a particular Anglo-American historical context.¹⁰⁴

Ideas about class, and the way in which male-dominated professions have sought and used power, have been taken up by feminist commentators, whose views have meshed with those concerned with the 'politics of motherhood' debate as outlined above. For them, the rise of a new professional class of male experts – physicians, psychologists, nutritionists and child-care experts – spelled disaster for women. They have emphasised two areas: the snatching away by male doctors of

¹⁰² Beaumont, 'Citizens not Feminists'.

¹⁰³ Johnson, *Professions and Power*; Johnson, 'State and the professions'; Friedson, *Professional Powers*; Larson, *Rise of Professionalism*.

¹⁰⁴ For a plea for the closer integration of sociological and historical methods of studying the professions, see Friedson, 'Theory of professions', pp.19-32 and *Professionalism Reborn*, pp.4-7. For historical accounts of the development of professions see Perkin, *Rise of Professional Society*; Duman, 'Creation and diffusion'; Reader, *Professional Men*. For historical accounts of the medical profession, especially in relation to public health see Fee & Acheson *History of Education in Public Health*; Watkins, *English Revolution*.

women's traditional right to heal; and the appropriating by various professions of control over childbirth, domestic management and child-care knowledge.¹⁰⁵ For Davin,

The authority of state over individual, of professional over amateur, of science over tradition, of male over female, of ruling class over working class, were all involved in the redefining of motherhood and in ensuring that the mothers of the race would be carefully guided, not carried away by self-importance.¹⁰⁶

Rima Apple has argued that the ideology of scientific motherhood, 'presented women with a tension-laden contradiction: it made them responsible for the health and welfare of their families, but it denied them control over child-rearing.'¹⁰⁷ For Barbara Ehrenreich and Deirdre English, 'Women did not learn to look to an external "science" for guidance until after their old skills had been ripped away'.¹⁰⁸ The role of the health visitor in combating traditional wisdom, and in encouraging women's dependence on the male medical profession, has been emphasised. Ross has examined the central role of the mother to the culture and economics of the working-class household, and how this clashed with the new 'medical culture'. She has claimed that 'the reformers' ideas and demands were directed toward disrupting long-standing neighbourhood-based women's health-care and childbearing methods, practices that, for all their failings, were interwoven with wider survival strategies'.¹⁰⁹ There was a huge gulf between the 'strict schedules', 'regimentation' and 'austerity' that characterised 'professional' mothercraft, and working-class cultures, as well as between the advice given, and the practical circumstances of working-class homes.¹¹⁰ Moreover, welfare agencies were 'grossly insensitive' to the incongruity of sending young women, 'many of them just out of secondary school' to teach and 'monitor' mature women with large families.¹¹¹ The notion of professional power and expertise is yet another complicating factor in the relationship between women public health officers and working women that needs to be more fully explored.

Within the literature on professionalisation, gender divisions have, until comparatively recently, been explained in terms of 'attributes', such as women's 'natural' aptitude for the caring professions, in a way that echoes Richards' opinions of a hundred years earlier, as quoted at the beginning of this chapter. The

¹⁰⁵ Ehrenreich & English, *For Her Own Good*; Oakley, *Captured Womb*, p.1; Apple, 'Constructing mothers'; Porter, 'Professional-client relationships'.

¹⁰⁶ Davin, 'Imperialism and motherhood', p.13.

¹⁰⁷ Apple, 'Constructing mothers', p.162.

¹⁰⁸ Ehrenreich & English, *For Her Own Good*, p.29.

¹⁰⁹ Ross, *Love and Toil*, p.196.

¹¹⁰ Urwin & Sharland, 'From babies to minds', pp.176-178; Ross, *Love and Toil*, pp.79-80, 139-144.; Ross, 'Good and bad mothers', p.179.

¹¹¹ *Ibid.*, p.183.

controversial concept of the 'semi-profession' has traditionally been associated with female-dominated occupations, such as nursing, teaching and social work.¹¹² Women's 'naturally' caring attitude, and the 'emotional content' of the personal relationship which they establish with their clients, has been seen as sharply differentiating them from the objective detachment of male professionals, and leading to their inability to create and control an intellectual framework for their work. Women have also been depicted as not committed enough to the workplace to seek professional status, and as culturally more disposed to defer to men.¹¹³ Women teachers have, for example, been blamed for the supposedly low status of the profession, and for their own low status within it. This view has more recently been challenged by analysis of patriarchal domination within the professions.¹¹⁴ Emphasis has been on the occupational exclusion and demarcation strategies employed by men in order to maintain their domination of the labour market.¹¹⁵ In Jeff Hearn's analysis, for example, pioneer women social workers, including health visitors, posed a threat to male dominance by taking on 'the socialized work of emotionality in the interstices of capitalism'.¹¹⁶ According to Hearn, this was neutralised by placing health visiting under the control of male MOHs, thus making the profession subservient to one already male-dominated.

For Celia Davies, the very concept of a profession 'celebrates and sustains the masculine vision'. By its emphasis on the possession, mastery and control of knowledge, its impartiality, impersonality and the autonomy of the practitioner, it promotes an essentially gendered vision of the world that excludes women.¹¹⁷ Anne Marie Rafferty has argued that 'nurse leaders and policy-makers borrowed ideas and action plans developed by groups and institutions that they perceived as being already successful', i.e. medicine.¹¹⁸ According to Davies, this is hardly appropriate since 'Nursing aspires to be a profession when the concept expresses a gendered vision that is a denial of the feminine values of nurturing that nursing seeks to espouse'.¹¹⁹ Female occupations, it has been argued, have been forced to 'ape' male ones in a battle for opportunity and status, and to deny their 'feminine' attributes in so

¹¹² Etzioni, *Semi-Professions*; Simpson & Simpson, 'Women and bureaucracy', pp.199-235.

¹¹³ *Ibid.*

¹¹⁴ Acker, 'Women and teaching', pp.76-103.

¹¹⁵ See, for example, Witz, 'Patriarchy' & *Professions and Patriarchy*.

¹¹⁶ Hearn, 'Patriarchy', pp.196-8.

¹¹⁷ Davies, *Gender and the Professional Predicament*, p.59. See also, Acker, 'Caring as work for women', p.277.

¹¹⁸ Rafferty, *Politics of Nursing Knowledge*, p.182.

¹¹⁹ Davies, *Gender and the Professional Predicament*, pp.62, 134.

doing, while adherence to a supposedly feminine 'caring script' has continued to go unrewarded.¹²⁰

Middle-class women enter the labour market

Such themes have found echoes in the historiographical attention that has been directed towards the nineteenth-century entry of middle-class women into paid employment. According to recent literature, the prevailing idea that women had particular moral and spiritual qualities, personality traits, domestic and maternal skills, was used in an almost calculating way to justify their entry, first of all into voluntary and philanthropic work, and then into local government and the professions.¹²¹ Seth Koven and Sonya Michel have termed this the ideology of 'maternalism', a system of thought that idealised the role of the mother, and saw women as able to apply to society as a whole the values usually associated with that role, including care, nurture and morality.¹²²

Helen Jones has examined teaching, nursing, medicine and social work, and concluded that women were in a subordinate position to men in all four occupations. For her, 'Women both challenged and reinforced the sexual division of labour and domestic ideology, and, as a group, displayed a contradictory and ambivalent attitude towards employment.'¹²³ She has also noted how, despite superficial equalities such as a uniform entry requirement, and similar levels of responsibility and status, women factory inspectors remained inferior to their male counterparts. Because of the specialist nature of their work, their experience and promotion prospects were much more limited.¹²⁴ For her, the gendered division of labour was an inevitable consequence of the way in which the women argued for their own specialist capabilities, and one that they continued to fuel, even opposing full integration with the male inspectorate. For Palmer, the manner in which women entered the public domain, via philanthropy and by emphasising their special skills as wives and mothers, dictated both the focus of the maternity and child welfare campaign, and the way in which the health professions for women developed.¹²⁵ She has concluded that class divisions, deference to the medical profession and an inability to influence policy, marked the campaign for women's health, and this also affected women who were employed in the health services. According to Palmer, women health workers

¹²⁰ Acker, 'Caring as work for women'.

¹²¹ Prochaska, *Women and Philanthropy*; Hollis, *Ladies Elect*.

¹²² Koven & Michel, *Mothers of a New World*, pp.5-6.

¹²³ Jones, *Women in British Public Life*, p.47.

¹²⁴ Jones, 'Women health workers', pp.175-6.

¹²⁵ Palmer, *Women, Health and Politics*, p.26.

emphasised their ability to fulfil a caring role and their knowledge of home and children. This isolated them from their male colleagues and perpetuated an image of their inferiority.¹²⁶ The continuing involvement of voluntary organisations also affected the status of maternity and child welfare workers, and helped to reinforce a distinction between this and other branches of the health service.¹²⁷ Davies has likewise traced the origins of public health work for women to mid-Victorian philanthropy. She has concluded that the early volunteers did not make 'a bid to enter the world of work on the same terms as those of men'.¹²⁸ When women public health workers later became assimilated into the world of paid officialdom, this situation was perpetuated. The model of the woman sanitary inspector, appointed on the same terms as men, was, she has postulated, quickly rejected in favour of that of the 'health visitor as mother's friend'.¹²⁹

Not all commentators have, however, seen the emphasis on 'women's special capabilities' as unadulterated 'weakness'. For Lewis, women were able to act because 'contemporary social thought highlighted the importance of the particular kind of work – personal social work – that women did at a local level'.¹³⁰ In an article on the development of the social work profession, she has argued that nineteenth-century women's philanthropic activity took place in an age when personal social work was believed to be one of the central methods of achieving social progress, and women's work was consequently held in high esteem. Later, with the shift away from a voluntary ethic and towards state provision, women gained the status of paid workers, but were no longer able to exert their earlier influence. It was only as time passed that the nature of the personal relationship that women developed with their clients became a hindrance, rather than a help.¹³¹ This can be seen to pull against sociological analysis that such work has always, inevitably, been 'low status' in comparison to that of men. Examining tensions between male and female sanitary inspectors will, in particular, illuminate this issue. Divisions within, and between, female occupations have thus far received scant attention. Within public health work, the relative 'status' of the 'social work' and 'nursing' elements of the occupation demonstrates that the differences between types of female 'caring' work were also significant.

¹²⁶ *Ibid.*, pp.185-191.

¹²⁷ *Ibid.*

¹²⁸ Davies, 'Health visitor as mother's friend', p.44.

¹²⁹ *Ibid.*

¹³⁰ Lewis, 'Gender, the family and women's agency', p.40.

¹³¹ Lewis, 'Women, social work and social welfare'.

Lewis has also argued that the crucial boundary within which women's influence was contained was not that of the voluntary as opposed to statutory sector, but the local rather than central. 'Local government and the voluntary sector were conceptualized as extensions of family and neighbourhood, whereas national politics and policy-making were not.'¹³² As the balance between them shifted in favour of the latter, so the idea that personal social action was the key to social change faded along with women's influence. Thus, 'British women made the transition from unpaid voluntary visitor to paid health visitor and social worker in the employ of local government, but very rarely to paid policy-making positions in the civil service.'¹³³ The worlds of late-Victorian philanthropy and local government have often been depicted as closely bound together, with women moving freely between them.¹³⁴ For Anne Summers, however, while the difference between 'public' work in the voluntary and municipal sectors may not seem very great to us now, to contemporaries it was 'defining and tangible'.¹³⁵ A public sphere funded by ratepayers and administered by male officers was very different from one based on voluntary charitable endeavour, and the move from one to the other should not be underestimated.

Eschewing economic determinism, and turning instead to post-structuralism, Ellen Jordan has employed the theories of Pierre Bourdieu in relation to middle-class households and the entry of women into the labour market.¹³⁶ She has concluded that groups of female philanthropists, social reformers and intellectuals successfully altered the existing employment structure of society, by persuading employers that middle-class women were employable, and women and their families that they could work without sacrificing respectability or femininity.¹³⁷ Since the campaigners of the women's movement were often of a high social class, they possessed enough 'symbolic capital' as 'unimpeachable gentlewomen' to push the social rules to the limit, while also ensuring that they did not actually transgress the crucial concepts of gentility and femininity.¹³⁸ Victorian domestic ideology laid down stringent conditions under which work could be considered suitable for women. It should not involve contact with the grime of industry, be carried out in the company of men, involve hard physical labour, the baring of the body or the wearing of trousers.¹³⁹ Although her work applies to an earlier period, Jordan's analysis is relevant to the entry of women

¹³² Lewis, 'Gender, the family and women's agency', p.44.

¹³³ *Ibid.*

¹³⁴ Davidoff & Hall, *Family Fortunes*, p.436; Hollis, *Ladies Elect*, pp.10-20.

¹³⁵ Summers, *Female Lives*, pp.24-25.

¹³⁶ Jordan, *Women's Movement*, 'Lady clerks at the Prudential'.

¹³⁷ Jordan, *Women's Movement*, pp.220-1.

¹³⁸ *Ibid.*, pp.89, 198.

into public health work in the late nineteenth century, and to how middle-class women managed to undertake work that involved inspecting drains and lavatories, not only in houses, but in factories and workshops.

In addition to affecting the status of women working in the public health professions, voluntary origins have also been cited as one cause of difficulty between women health workers and working women. Criticism of the harshness of the self-help ethic and the judgmental attempt to reform behaviour according to middle-class views of respectability, traditionally aimed at the COS, has also been levelled at early twentieth-century health-visiting.¹⁴⁰ On the other hand, the stigma of pauperisation associated with state intervention in family life has also been identified as a problem, and some historians have depicted the voluntary worker as more understanding of the mothers' problems, when compared with the 'harsh or wooden administration' of local authority provision.¹⁴¹ Voluntary workers may have been part of the local community and more in tune with its needs than geographically-mobile and detached professional women. The picture is a far from straightforward one of patronising charitable endeavour. Looking closely at the origins and development of the health work professions will help to elucidate these themes.

CONCLUSION

Richards stated in 1907 that it was the educational side of public health work for which women were particularly suited, especially the instruction of poor mothers. This introduction has explained why this role has been seen as problematic by later commentators. Koven has observed that histories of maternity and child welfare published in the 1920s and 1930s chronicled the efforts of male doctors and public health officials on behalf of ignorant working-class mothers. Many later feminist historians, while highlighting the repressive nature of these efforts, have still emphasised male dominance of the movement.¹⁴² Jones, for example, has argued that any supposed power that middle-class women exerted over working-class

¹³⁹ *Ibid.*, pp.62-3.

¹⁴⁰ Lewis, *Politics*, p.105.

¹⁴¹ Lodge, 'Women and welfare', p.89; Marks, *Metropolitan Maternity*, pp.273-6; Bush, *Behind the Lines*, p.40.

¹⁴² Koven, 'Borderlands', pp.124-125.

women in the public arena was 'more a vicarious power of men operating through women than any real power among women'.¹⁴³ The aim of this thesis is to place women public health officers at the centre of analysis for the first time.

¹⁴³ Jones, *Women in British Public Life*, p.14.

2 : DOMESTIC TO MUNICIPAL HOUSEKEEPING

During the nineteenth century, middle-class women developed extensive experience in public health within their own households, as educators of the poor in domestic hygiene, and overseeing municipal sanitary enterprises as elected officers. This chapter will focus on these foundations for the appointment of women as salaried local government employees in the field of public health. It will also outline the structures and male staff of the local health departments into which the women were to be appointed.

WOMEN AND SANITARY REFORM

The middle-class home

It was the duty of middle-class women not only to keep their households clean, but also to keep them healthy. They performed the role of domestic sanitary inspectors within their own homes, and were bombarded with advice literature – manuals, books, magazines and newspaper articles – and also with consumer goods, offering them the means to carry out the advice.¹ The Ladies Sanitary Association (LSA) encouraged the formation of circulating libraries on hygiene since

some of the ablest professors of sanitary science have devoted themselves to popularising it by means of lectures and books, from which any woman of ordinary culture and intelligence may gain much of the knowledge she requires.²

Volumes such as Notter and Firth's *Practical Domestic Hygiene* were intended 'for those who, without any previous knowledge of the subject, desire to acquire a knowledge of Elementary Hygiene'.³ Reprinted from the 1890s to the 1930s with little alteration, it was aimed at middle-class householders, and contained advice on how to create a healthy home. Alongside technical descriptions of water closets, drains and different methods of ventilation, sections on domestic economy, care of the sick, and first aid indicate a female audience.⁴ Tracts published by the LSA included 'The

¹ For the division of labour between men and women householders, see Adams, *Architecture and Tomes*, 'The private side of public health'. For the importance of advertising and consumer goods see Forty, *Objects of Desire*, pp.160-161.

² LSA, *Report to the Seventh International Congress of Hygiene and Demography*, pp.5-6.

³ Notter & Firth, *Practical Domestic Hygiene*.

⁴ Other examples include Maguire's *Domestic Sanitary Drainage* and Corfield's *Dwelling Houses*.

inspector: how to get rid of bad smells without, and bad tempers within' and 'The bride's new home'.⁵ For the Association,

"The Health of Towns Act" may ensure good drainage and water-supply, pure air, and other important external sanitary requisites; but till every woman frames a Health of *Homes* Act, and becomes a domestic "officer of health", none can ensure that the pure air shall ever be breathed, the good water ever be sufficiently used, or other sanitary conditions ever be fulfilled in-doors.⁶

In addition to the publication of helpful texts, organisations began to provide training for women. In the 1880s, the Sanitary Institute began to hold 'Lenten Lectures for Ladies' on topics which 'no properly educated mistress of a household can afford to ignore', such as 'the chemistry of cleaning'.⁷ Alfred Schofield, the main lecturer, believed that it was important to concentrate on the hygienic instruction of women

because the man, poor ignorant creature, knows little of the health of his own children, and still less of the state of his own drains. It is the woman indeed who is the domestic guardian of the health of the nation.⁸

By the 1890s, women were making a significant contribution to the proceedings of the Sanitary Institute, and its congresses featured gatherings of 'ladies on domestic hygiene'.⁹ In a paper to the Institute on 'Sanitary house management', for example, one lady declared that, while 'ladies are not sanitary engineers', they 'have some special opportunities which they alone can make use of.' They 'can do more and must do more than merely call in masons and plumbers when drains and pipes go wrong'. For her, 'The want of proper drains, sinks and closets is a serious evil, but drains, sinks and closets, neglected and uncared for may, and do, produce far worse evils than their entire absence.' Although many of the duties of keeping the home clean and sanitary were 'not altogether pleasant', a woman should 'remember that by seeing them properly done she is helping, as only she can help, to preserve the blessing of a clean sweet house to her family'.¹⁰

Ladies Sanitary Association

Women's involvement in public health occurred simultaneously with the growth of the organised women's movement. It found its strongest voice in the female-dominated sanitary associations that were formed in the mid-nineteenth

⁵ LSA, 'For better for worse': the bride's new home' (185-).

⁶ LSA, 'Remarks on woman's work in sanitary reform' [1875], p.3

⁷ PH (I, 1888-1889), p.371; JSI (XV, 1894), p.45.

⁸ Schofield, *Behind the Brass Plate*, pp.134-5.

⁹ Hardy, *Epidemic Streets*, p.278.

¹⁰ Delorias, Countess de Viesca, 'Sanitary house management', *TSI* (VII, 1885-1886), pp.128-134.

century. The Ladies' National Association for the Diffusion of Sanitary Knowledge (also known as the LSA) was founded in 1857/8 and shared offices with the mid-Victorian feminists of the *English Woman's Journal*. It was supported by the Social Science Association, alongside other organisations that were campaigning to open up new areas of public activity for women, such as the Society for Promoting the Employment of Women.¹¹ The LSA wrote, published and distributed tracts through networks of 'bible-women', and explained them at cottage and mothers' meetings.¹² The religious tract, the staple of traditional missionary endeavour, was supplemented by the 'sanitary tract', lent to the poor and exchanged at each visit. Between its foundation in 1856 and 1881, the LSA distributed a million and a half of these tracts, with titles such as 'The massacre of the innocents', 'The influence of wholesome drink' and 'The worth of fresh air'.¹³ The sheer scale of its efforts has caused one historian to conclude that, 'In a sense it must be regarded as more influential than the other great tractarian movement of the day, the Oxford Movement'.¹⁴ Almost all the tracts produced by the LSA were authored by famous public health doctors, and the Association's editorial committee was composed entirely of men.¹⁵

Although the primary goal was to improve the physical condition of the poor, the members of such associations saw 'a natural relation' between 'the physical state and the moral condition'.¹⁶ It was their belief that the principal cause of ill-health was ignorance. The means to remedy this was personal influence. The distribution of tracts and treatises was insufficient since, 'the poor have rarely inclination or means to buy such books, or enough mental grasp to understand them', and 'the poorest of the people, especially the women, can only read very imperfectly, if at all'.¹⁷ Instead, oral and practical teaching and personal influence were recommended, through the employment of 'home missionaries'.¹⁸

¹¹ Goldman, *Science, Reform and Politics*, pp.117-121.

¹² Dowling, *Ladies' Sanitary Association*, pp.55-153.

¹³ Wohl, *Endangered Lives*, p.36; LSA Tracts.

¹⁴ Wohl, *Endangered Lives*, p.68.

¹⁵ Yeo, 'Social motherhood', p.72; Wohl, *Endangered Lives*, p.67. These included Parkes and Lankester, who were to go on to influence the training of women for public health work.

¹⁶ Baines, 'Ladies National Association for the Diffusion of Sanitary Knowledge', *Transactions of the NAPSS* (1858), p.531.

¹⁷ Powers, 'Diffusion of sanitary knowledge', *Transactions of the NAPSS* (1860), p.713.

¹⁸ For more on the work of bible-women and early sanitary missionaries see Dowling 'Health visiting the beginning – the missing link', *Health Visitor* (Oct 1973) and 'Health visiting – expansion', *Health Visitor* (Nov 1973).

Manchester and Salford Sanitary Association

It is to this movement, and, in particular, to the activities of the Ladies Auxiliary of the Manchester and Salford Sanitary Association (MSSA), founded in 1861, that the origins of modern health visiting have often been traced. Dingwall, for example, has claimed that

the origins of health visiting, in any recognizable form, clearly lie in Manchester and Salford in the eighteen-sixties. This was the first service which endured and which clearly exemplified the idea of a health visitor as someone who delivered advice and counsel rather than nursing care.¹⁹

The term 'health visitor' was, however, a much later introduction, and contemporary use of terms such as 'home missionary' reveal the religious and philanthropic framework within which such schemes operated.²⁰

Drawing on the example of district visiting, as practised by religious and missionary organisations, the MSSA divided the poorer parts of the area into districts, each of which was overseen by 'a lady superintendent'.²¹ In 1867 it began to employ working-class women to live and work in each area, and to carry out home visiting, under the supervision of the ladies.²² The visitors were 'intelligent women of the working classes, who should be properly trained, and then paid to devote their time to daily visiting the poor and giving them the practical instruction in domestic sanitary science'.²³ Not only would 'women' be better able to understand the difficulties of the poor than 'ladies', but they were 'less liable to be imposed on'.²⁴ The health visitor herself was usually

a superior woman of the class sought to be helped. She is in touch and sympathy with the people she visits; she understands them and they understand her.²⁵

It was also important that she live in her own district, 'in a small cottage or maybe a couple of rooms', both so that she was near at hand, and also so that her home could be 'an object lesson in cleanliness'.²⁶ The working-class visitors were able to carry out tasks that would not have been suitable for the lady supervisors.²⁷ They were

¹⁹ Dingwall, 'Collectivism, regionalism and feminism', p.293. See also views of an earlier commentator – McCleary, *Maternity and Child Welfare*, pp.25-26.

²⁰ It was in the 1890s that the term 'health visitor' was applied when, in 1891, the Ladies' Branch of the MSSA became known as the Ladies' Health Society.

²¹ For district visiting see Young & Ashton, *British Social Work*, pp.88-89 and Lewis, *Evangelical Mission*.

²² *Lancet* (26 Jan 1895), pp.256-257.

²³ Powers, 'Diffusion of sanitary knowledge', p.714.

²⁴ *Lancet* (4 May 1895), pp.1150-1151.

²⁵ Redford, 'Ladies' Health Society of Manchester and Salford', *JRSI* (XXI, 1900) p.178.

²⁶ *Ibid.*

²⁷ Dingwall, Rafferty & Webster, *Introduction*, p.176.

trained in simple nursing and carried ointment and a few bandages with them.²⁸ They could also render practical help with household tasks such as washing and dressing babies, making beds, tidying and cleaning rooms.²⁹ They dispensed carbolic powder, brushes and lime.³⁰ In addition, they urged thrift and temperance, encouraged the attendance of children at school, and of adults at places of worship.³¹

The role of the lady supervisor, by contrast, was to visit her district once a week, and to hold a meeting at which she might speak on various topics such as household cleanliness, child-care or thrift. She would sometimes be accompanied by one or two 'young friends', who might provide entertainment, music or singing.³² Other activities evolved, including savings clubs for the purchase of coal and blankets, intended to foster the habit of thrift. The visitor would receive training from the lady superintendent, who, 'from her larger knowledge, can direct the health visitor's work, help and encourage her in many ways, and assist in training her for her special duties'.³³

In 1894 the scheme was still flourishing, and consisted of 36 'ladies' and 20 health visitors 'taken from the class of working women'.³⁴ The MSSA gradually moved under the control of the local authority. Towards the end of the century its activities were partially directed by the MOH on behalf of the City Corporation which, in 1897, agreed to pay the wages of some of the visitors. In the course of their visits, the workers also began to distribute leaflets for the MOH on precautions against infectious disease, infant feeding and other subjects and, from time to time, helped him with special enquiries.³⁵ By 1906 the Society received a grant from the Corporation for the salaries of four out of the 23 visitors.³⁶

Early local authority schemes

The MSSA was a major influence on the development of local authority schemes. In 1874, women 'assistant sanitary inspectors' were appointed by Glasgow Public Health Department. Their duties were:

²⁸ Redford, 'Ladies' Health Society', p.178.

²⁹ *Ibid.*

³⁰ *Ibid.*

³¹ *Lancet* (3 Feb 1894), pp.288-289.

³² *Lancet* (4 May 1895), pp.1150-1151.

³³ Redford, 'Ladies' Health Society', p.178

³⁴ *Lancet* (3 Feb 1894), pp.288-289.

³⁵ Redford, 'Ladies' Health Society', p.178

³⁶ *BMJ* (20 Jan 1906), p.151.

To instruct the poorer classes as to cleanliness of person, cleanliness of beds, cleanliness of houses, and point out how they and their children may imitate and acquire in these respects the habits of the better classes.³⁷

In the 1890s this idea really took off. In 1893, a woman, certified and appointed as a sanitary inspector, was appointed in St. Helens to visit from house to house in the poorer parts of the town to give advice on child-care and household cleanliness. Similar posts were created in Liverpool, Leeds, Sheffield and Bradford.³⁸ In Liverpool they visited those who were 'habitually filthy' and 'paid no attention to their own cleanliness or that of their children'.³⁹ In Sheffield they visited to ascertain 'the standard of cleanliness and also the structural condition of the houses'.⁴⁰ In 1899 Birmingham Health Committee advertised for four women to work as health visitors in the city. Their duties involved house-to-house visiting, drawing attention to the need for cleanliness within the home, giving advice as to the rearing of children, infectious diseases and the nursing of the sick. They were 'to go into the worst parts of the city, and by friendly intercourse, exercise of womanly sympathy and tact, urge the poorer classes to a better and healthier appreciation of the rudiments of hygiene'.⁴¹ They carried with them disinfectant powder, and emphasised the importance, not only of cleanliness, but also of thrift and temperance. The example of the MSSA is evident, especially as the Birmingham visitors were required to reside in or near the districts in which they worked.⁴² There was one significant difference, however, in that they were 'well educated women'.⁴³

A health-visiting scheme was organised in Buckinghamshire in 1892, by the combined efforts of Florence Nightingale and Frederick Verney, Chairman of the Technical Education Committee. Here it was also 'ladies' who were sent out as 'missionaries' into the villages, 'to instruct the mothers and young women of the agricultural and labouring classes by means of cottage lectures and house-to-house visits'.⁴⁴ It was intended that they 'should make friends with the country people in their village homes, and make use of friendship for the purpose of distributing knowledge'.⁴⁵ George De'ath, the local MOH, gave a course of lectures to the ladies

³⁷ Quoted in Dowling, *Ladies' Sanitary Association*, p.168.

³⁸ Greenwood, 'Evolution of the health visitor', *NT* (10 Feb 1917), pp.160-163.

³⁹ *Lancet* (27 Feb 1897), p.627.

⁴⁰ 'Women workers in public health in Sheffield', *NH* (IV, 1913), pp.229-232.

⁴¹ Gardiner, 'Work of a health visitor', *JSI* (XXI, 1900), p.174.

⁴² *Lancet* (25 Feb 1899), pp.548-549; *PH* (XI, 1898-1899), p.721; Davies, 'Health visitor as mother's friend', pp.45-46.

⁴³ Gardiner, 'Work of a health visitor', p.175.

⁴⁴ *BMJ* (28 Jan 1893), p.176; *Lancet* (18 Aug 1894), p.386.

⁴⁵ Nightingale, *Reproduction of a Printed Report*, p.12

on 'health at home', supplemented by classes, written work, and practical visits.⁴⁶ Although it actually trained very few women (only four or five passed the examination), one woman sanitary inspector later remembered that Miss Nightingale's scheme 'had an undoubted influence in inducing many educated women to take up health work'.⁴⁷ The Society of Medical Officers of Health watched it with interest, and recommended that public money should be expended in 'health at home teaching', and that MOHs should train ladies for the work.⁴⁸ In the 1890s, the Liverpool Ladies' Sanitary Society also opened a 'school' for its health visitors, and offered a qualification for the work.⁴⁹ These were, however, both small, local experiments.

National Health Society

Meanwhile, one organisation began to play a national role in training ladies as educators of the poor in sanitary science. The National Health Society (NATHS) was founded in 1871 by a group of acquaintances that met at the house of Dr Elizabeth Blackwell, who also donated a large sum of money for its establishment. Blackwell, famous for being 'the first woman doctor', had long been interested in hygiene and preventive medicine.⁵⁰ She lectured on such subjects as 'How to keep a household in health', where she 'laid down rules of health for the guidance of poor women in the management of their households', and on 'The religion of health'.⁵¹ In this latter lecture she urged that sanitary knowledge should be more generally diffused and systematically applied, and that homes should be made 'the precious centres of ennobling influence that they are intended to be'.⁵²

From its headquarters in Berners Street, just off Oxford Street in London, in an area densely occupied by medical charities and in the same street as the LSA, the Society's affairs were managed by an array of figures from the capital's medical and social élite.⁵³ The Society advertised itself as being 'almost entirely under the management of women'.⁵⁴ They were well represented on the decision-making bodies – in 1889-1890, for example, comprising five out of 27 on the Council and

⁴⁶ *Ibid.*, pp.20-26.

⁴⁷ Greenwood, 'Evolution of the health visitor', *JRSI* (XXXIV, 1913), p.176.

⁴⁸ Wellcome: SMOH Council minutes, 5 Jun 1893 (SA/SMO/B.1/6).

⁴⁹ Smith, *People's Health*, p.115; Dowling, *Ladies Sanitary Association*, p.226

⁵⁰ Blake, *Charge of the Parasols*, pp.215-6.

⁵¹ Blackwell, *Pioneer Work*, pp.246-7.

⁵² Quoted in Chambers, *A Doctor Alone*, p.165.

⁵³ In 1889-1890, for example, the Society's forty vice-presidents included the Marquis of Salisbury, the Earl of Meath and Lady de Rothschild. At least eleven of its twenty-seven Council members were eminent doctors, seven being Fellows of the Royal Society.

⁵⁴ SR (XIV, 1892-1893), p.229.

eight out of 13 on the Committee of Management. Day-to-day administration of the Society's affairs rested in the hands of Fay Lankester, who became Secretary in 1873 at the invitation of Elizabeth Blackwell, and remained so until her death in 1924.⁵⁵ She was the daughter of the medical man, biologist and social reformer, Edwin Lankester and inherited his 'scientific predilections', taking an early interest in the study of hygiene.⁵⁶ She was also 'well known in London society', and a lady of 'quiet, gentle manners and appearance' and 'artistic taste'.⁵⁷ Fay was a supporter of women's suffrage, having

the strongest sympathy with my ill-used fellow women ... I have no doubt that until they have the position of voters many of them will continue to be down-trodden, badly-paid and ill-used.⁵⁸

Her father was already involved in the LSA (it was at his suggestion that it had appointed 'female sanitary missionaries') and in giving 'popular sanitary lectures'.⁵⁹

Although the Society initially operated very much within the framework set by other sanitary associations – distributing tracts and appealing to local clergymen to publicise its work – the training aspect of its activities became particularly important. Rather than employing bible- or mission-women, or undertaking district-visiting itself, it offered formal sanitary training to those already working amongst the poor. It began to train 'ladies' in elementary physiology and hygiene, by holding lecture series in areas like St John's Wood, Hampstead, and Kensington, for which a fee was charged and an examination set. Alfred Schofield, also active in training ladies at the Sanitary Institute, was a main lecturer.⁶⁰ It was hoped that the ladies, when suitably qualified, would go on to give lectures or 'homely talks' to working women and girls on 'health and daily life'. Lessons on hygiene were also given in the 'new' girls' schools, such as Queen's College and the North London Collegiate. In the 1890s, the Society's 'drawing-room lectures', which were intended for 'educated audiences', covered first aid, home nursing, elementary physiology and domestic and personal hygiene.⁶¹ Any lady willing to act as honorary secretary for such a class had to guarantee an attendance of 30 ladies, each paying ten shillings and sixpence, and a suitable room.

⁵⁵ NATHS, annual report, 1925, p.5.

⁵⁶ Fay was one of eight children. Whilst one of her brothers, Owen, went on to become a well-known Wimpole Street Physician, another, Forbes, became a London magistrate and a third, Ray, became one of the founders of modern British biology, she had to be content with her work for the NATHS. Her sister, Nina became one of the first women clerks of the Post Office, whilst Marion married a parson and lived in Stepney. NATHS, annual report, 1925, pp.5-6; English, *Victorian Values*.

⁵⁷ Schofield, *Behind the Glass Plate; Woman's Herald* (III, 1891), p.210.

⁵⁸ *Woman's Herald* (III, 1891), p.210.

⁵⁹ Powers, 'Diffusion of sanitary knowledge', p.714.

⁶⁰ SR (XII, 1890-1891), p.213.

⁶¹ *Ibid.*, p.594.

In return, the Society would provide a lecturer (usually a medical man), diagrams, books and other equipment, such as bandages. Examinations were held in each of the main subjects. Those passing three examinations could enter for the Society's medal and, if successful, were considered qualified to teach for the Society.⁶² These lectures were enormously popular. In 1890, 2,500 ladies attended. Of these, 450 received certificates, and ten the silver medal.⁶³

According to the NATHS, 'The great object of these ladies is to show the working class *how* to utilise to the uttermost the materials available in their own homes, and to make the *best* of surrounding circumstances.'⁶⁴ These 'homely talks', were 'simple practical addresses to the poor', and took place in halls around London and the suburbs often in conjunction with mothers' meetings, girls' clubs and district visiting societies. Subjects included the care and management of children, how to keep a home healthy and happy, the value of fresh air, and simple cookery.⁶⁵ Although it was hoped that the trained ladies would go on to spread the sanitary gospel on a voluntary basis, the Society recognised that there was 'very great scope' for the 'remunerative employment' of ladies in such teaching. The NATHS began to pay certain of its ladies to give the 'homely talks', by 1892 employing around 50 such lecturers.⁶⁶ One of these was Lucy Deane, later a woman sanitary inspector. She taught for the Society for a few months in 1893, travelling around London and North Kent to talk on a variety of different topics, altering the content and tone of her lectures to meet the needs of different audiences.⁶⁷ She lectured at the instigation of Chatham Corporation Technical Education Committee, where she spoke on 'healthy homes', and to 'mothers' at Holy Trinity Mission-room, Westminster, where the subject was infectious disease.

This aspect of the Society's work was given a boost by developments in schemes for technical education, and the ensuing demand from County Councils for 'lady teachers' to lecture to working class audiences.⁶⁸ Demand far outstripped supply, and the Society quickly expanded its training programme to meet this new need.⁶⁹ It set out entry requirements and developed a formal and coherent syllabus, separate from that offered to the 'drawing-room' audiences. In 1892, 'anyone wishing

⁶² NATHS, annual report, 1888, p.5. The medal was a silver heart with the head of the goddess Hygeia embossed on the obverse side.

⁶³ SR (XII, 1890-1891), p.641.

⁶⁴ NATHS, annual report, 1907, pp.18-19.

⁶⁵ SR (XII, 1890-1891), p.594.

⁶⁶ SR (XIII, 1891-1892), p.582.

⁶⁷ BLPES: Lucy Deane's diary, *passim*. (Streatfeild 1/1).

⁶⁸ SR (XIV, 1892-1893), p.229.

⁶⁹ NATHS, annual report, 1892, pp.9-11.

to enter on the course of training ... enabling her to go up for the Society's examination, and to qualify for the post of County Lecturer amongst the poor, must be an educated gentlewoman over twenty-five years of age.'⁷⁰ The Society claimed that, in order to influence 'mixed audiences', it was necessary that the lecturers should possess 'experience, intellectual culture and good general education'.⁷¹ Preference was given to those who had already trained as hospital nurses, deaconesses, or had done some sort of voluntary work amongst the poor. The lectures took place in the Society's rooms in Berners Street, and the fee was ten guineas, including the examination.⁷² There was a huge demand for the training. In 1892 the Society had around 500 applicants.⁷³

Schofield remained a prominent lecturer. He had published a series of 'Health at Home Tracts' for the Religious Tract Society with such titles as 'How to be healthy in one room'.⁷⁴ In his *Manual of Personal and Domestic Hygiene*, a basic text on the subject intended 'for all but medical students', he gave the three great principles of hygiene –self-reverence, self-knowledge and self-control.⁷⁵ Other medical men were involved. Owen Lankester was the brother of the Society's Secretary and taught 'accidents and disease'. In addition to his private practice in Wimpole Street, he was an honorary Associate of the Order of St. John of Jerusalem, and the training he gave in first aid was along lines laid down by the St John Ambulance Society.⁷⁶ Elementary anatomy and physiology were initially taught by John Gay, a surgeon with very general interests. J. Edward Squire replaced Gay. In addition to his practice in Harley Street, Squire was Physician to the North London Hospital for Consumption and Diseases of the Chest, and published a major work on the prevention of tuberculosis.⁷⁷ He was also the brother of Rose Squire, one of the NATHS's students and an early woman sanitary inspector. All these doctors were active in other aspects of the Society's work, including lecturing to the poor.

Elected women

In addition to philanthropic public health work and lecturing, women became active in nineteenth-century local government. Using the 'municipal housekeeping' or 'social mothering' argument, the wives or daughters of local business or professional

⁷⁰ *Ibid.*

⁷¹ NATHS, annual report, 1907, pp.18-19.

⁷² NATHS, annual report, 1892, pp.11-12.

⁷³ SR (XIII, 1891-1892), p.582.

⁷⁴ Schofield, *Health At Home Tracts*.

⁷⁵ Schofield, *Manual of Personal and Domestic Hygiene*, p.161.

⁷⁶ Ravenhill, *Memoirs*, pp.66-7; English, *Victorian Values*.

men, became involved in visiting workhouses, prisons and hospitals, and serving on Boards of Guardians and School Boards.⁷⁸ In addition, by 1899 there were 17 London Vestrywomen, many of whom served on sanitary and public health committees.⁷⁹ According to Hollis, they

refused to respect the traditional boundaries of what constituted women's and what men's public work. Many of them mastered the technical matters of sewage and sanitation, of drain-pipes and road surfaces, of finance and law.⁸⁰

After education, serving on public health and sanitary committees was the next most popular choice for women. Hollis has contended that women's entry into local government was hampered because so much business dealt with the built environment, and women were often 'confined' to the service committees of education, health and housing, at the 'periphery of power', while men ran finance, works, contracts and trading committees.⁸¹ This does not, perhaps, grant enough recognition to the importance of the work of such committees, or to the priorities of the women themselves. Hollis has also argued, however, that 'in their vestry work ... women came to appreciate the impact which the built environment, rather than any personal or moral qualities, had on family life.'⁸² In Camberwell, for example, one elected woman, Mrs Wright, brought to the notice of the Vestry instances of bad drainage and damp houses and 'after well substantiating her case ... induced the Vestry to consent to the ventilation of the main sewers.'⁸³

LONDON PUBLIC HEALTH ADMINISTRATION

The main public health responsibilities of London local authorities in the mid-nineteenth century were limited to what was termed 'nuisance' work. This involved the cleansing of houses, emptying and abolition of cesspools, removal of rubbish and animal dung, the inspection of slaughterhouses, the construction or improvement of water closets, and the provision of water supply.⁸⁴ Although a few women served on sanitary committees, public health departments were male institutions, with a male

⁷⁷ Squire, *Hygienic Prevention of Consumption*.

⁷⁸ For the role of women on the School Board for London see Martin, *Women and the Politics of Schooling*.

⁷⁹ For the shifting fortunes of women in elected office in London, see Hollis, *Ladies Elect*.

⁸⁰ Hollis, *Ladies Elect*, p.352.

⁸¹ *Ibid.*, p.423.

⁸² *Ibid.*, p.353.

⁸³ Kilgour, *Women as Members of Local Sanitary Authorities*, p.5.

⁸⁴ Roebuck, *Urban Development*, p.100.

staff. The work was overseen by local MOHs and undertaken by 'inspectors of nuisances', later renamed 'sanitary inspectors'.⁸⁵

Medical Officers of Health

Although MOHs had been appointed in Leicester and Liverpool in 1846-1847, it was not until the 1855 Metropolis Management Act that such appointments became compulsory in London, and from the 1860s-1870s that it became common elsewhere, particularly following the 1872 Public Health Act.⁸⁶ In the early decades many MOHs were part-time, lacked tenure, and were relatively poorly paid. Their influence was circumscribed by the fact that engineers, architects and others were heavily involved in sanitary science, although they had considerable local autonomy, and were able to follow their own ideas, practices and pet projects.⁸⁷ MOHs, however, grew in professional status and influence until, for one historian of public health, they 'stood out in administrations which were largely amateur'.⁸⁸ For Roebuck, the London MOH 'rapidly became an important, if not the most important, member of local government organisation'.⁸⁹ By the 1880s, elite medical men, clinical practitioners and research scientists had generally been replaced by 'middle-ranking' medical men with growing social and occupational cohesion.⁹⁰

Porter has identified the 'politics of expertise' that grew up around the public health profession in the last decade of the nineteenth century and the first decade of the twentieth.⁹¹ Medicine had, from the mid-Victorian period, already come to dominate public health in Britain as the 'sanitary idea' had been replaced by the rise of 'state medicine'.⁹² The victims were architects, plumbers and builders, as medical men consistently discredited their expertise and undermined their authority, openly blaming them for the ill health that arose from insanitary dwellings.⁹³ The second half of the nineteenth century was a period of the consolidation, expansion and 'professionalisation of preventive practice', and its demarcation from curative

⁸⁵ The 1875 Public Health Act had termed these officers 'inspectors of nuisances' and the 1891 Public Health Act (London) 'sanitary inspectors', although the two titles were used interchangeably. The Public Health (Officers) Act of 1921 finally standardised nomenclature by doing away with the term 'inspector of nuisances' in favour of 'sanitary inspector.'

⁸⁶ Wohl, *Endangered Lives*, p.181.

⁸⁷ Worboys, *Spreading Germs*, p.25.

⁸⁸ Wohl, *Endangered Lives*, p.193.

⁸⁹ Roebuck, *Urban Development*, pp.75-8.

⁹⁰ Watkins, *English Revolution*, p.79; Porter, 'Stratification', p.112.

⁹¹ Watkins, *English Revolution*, p.23; Porter, 'Stratification', pp.112-113.

⁹² Fee & Porter, 'Public health, preventive medicine and professionalization'.

⁹³ Adams, *Architecture*, p.42.

medicine.⁹⁴ The Diploma in Public Health developed as a specialist qualification, and a cluster of public health associations, special interest and pressure groups, all holding conferences and publishing journals, bolstered this burgeoning professional identity. These trends coincided with a new scientific awareness and the growth of knowledge in the fields of bacteriology and pathology, which underpinned the claims of public health doctors to a new expertise. MOHs not only used their specialist training and qualifications to differentiate themselves, on the one hand, from the main body of the medical profession and curative practice, and, on the other from general social reformers and sanitarians from non-medical backgrounds such as engineers or architects. They also gained control of the training and examination of the sanitary officers working under them, and defined the difference between the technical skill needed to execute the orders of the MOH, and the scientific knowledge and understanding on which the orders were based.

Inspectors of nuisances

According to Adams, the dominance of sanitarians was achieved partly through the appointment of inspectors who, under the watchful eye of medical men, policed the work of builders and architects.⁹⁵ The Inspector was 'the eyes, ears and nose' of the Sanitary Authority, while the MOH was 'the head'.⁹⁶ For historians he became 'the main agent of the local authorities in the lives of the mass of the people'.⁹⁷

The 1848 Public Health Act had empowered local Boards of Health to employ inspectors of nuisances, and the 1855 Metropolis Management Act granted similar powers in London. Under the 1866 Sanitary Act it was the duty of local authorities to undertake inspection for the active detection and abatement of 'nuisances', rather than merely responding to complaints. The 1872 Public Health Act further encouraged the appointment of inspectors, by allowing the Local Government Board (LGB) to pay half their salaries.⁹⁸ From 1875 every urban and district council outside London was required to appoint at least one full inspector, and, although some areas were restricted from appointing more than one, they appointed instead additional 'assistant' inspectors, with limited powers and without repayment of half their salaries.⁹⁹ Under the 1891 Public Health (London) Act, every metropolitan sanitary

⁹⁴ Watkins, *English Revolution*.

⁹⁵ Adams, *Architecture*, p.42.

⁹⁶ Taylor, *Sanitary Inspectors' Handbook* (1893), p.17.

⁹⁷ Roebuck, *Urban Development*, p.165; See also Wohl, *Endangered Lives*, p.198.

⁹⁸ Taylor, *Sanitary Inspector's Handbook* (1905), p.18.

⁹⁹ Bannington, *English Public Health*, p.83.

authority was to appoint an adequate number of 'fit and proper persons' as sanitary inspectors. The London County Council (LCC) was empowered to make representation to the LGB if an authority failed to appoint sufficient staff, and the Board might order the appointment of additional inspectors. A sanitary inspector was to hold a certificate approved by the LGB, so that 'he had by examination shown himself competent for such an office', or to have served for three consecutive years prior to 1895 as an inspector in a large urban area.¹⁰⁰ The initial appointment of inspectors in London was slow, but, in the 1880s and 1890s, staffs increased. By the end of the nineteenth century, there was an average of one inspector for every 20,000 inhabitants in London, and each MOH was in charge of an average staff of five inspectors.¹⁰¹ As public health administration expanded its role in the decades that followed, the employment of sanitary inspectors grew apace. In the ten years between 1893 and 1903, there was an increase of 60% in the number of sanitary inspectors in London.¹⁰²

Duties

The main emphasis in their role was on 'nuisance' detection and removal, including noxious or offensive businesses, trades and manufacturing, but unfit meat, food, drink or drugs suspected of adulteration, water supply, contagious, infectious or epidemic disease and overcrowding were added.¹⁰³ This range of duties remained relatively stable, and those prescribed by the 1926 Sanitary Officers Order were similar.¹⁰⁴ Routine house inspections were carried out according to a 'strictly uniform plan'.¹⁰⁵ First, the conditions of the street, roadway or footpath were noted – materials, surface, slant, state of repair, provision for drainage, the presence of standing water or accumulations of filth and rubbish. Next, the exterior of the house was examined - the state of repair of external areas, walls and roof, especially for signs of damp, the pointing and plastering, rain-water pipes and butts, gutters, ventilation, drains, etc. At the back, the inspector looked for accumulations of rubbish, the keeping of animals or poultry, evidence of rats, and noted the size, and state of the dust-bin or ash-pit. The WC was the subject of particular attention – its position in the house or yard, its ventilation, lighting, water-supply, flush mechanism, state of repair, the number of persons using it and its door and lock. Inside the house

¹⁰⁰ Holdsworth, *Public Health (London) Act, 1891*, p.142ff.

¹⁰¹ Wohl, *Endangered Lives*, p.195.

¹⁰² *BMJ* (6 Jun 1903), pp.1333-4.

¹⁰³ Taylor, *Sanitary Inspectors' Handbook* (1893), pp.7-10.

¹⁰⁴ Clay, *Sanitary Inspector's Handbook* (1933), pp.12-14.

¹⁰⁵ Willoughby, *Health Officer's Pocket Book*, pp.119-120.

the inspector would look for signs of dirt, damp and ill repair of floors, walls, ceilings and stairs. He would ask about the existence of rats or rat-holes, note the occupation of underground rooms, the size of sleeping rooms and the number of occupants, look at the means of ventilation, the state and size of windows and the condition of chimneys. Finally the sink and its drain would be examined. 'Nuisances' discovered during such an inspection might include foul or defective WCs; defective, foul, untrapped or unventilated drains, and soil pipes; accumulations of filth and overflowing dustbins; overcrowding of bedrooms, insufficient light or ventilation; defective roofs, rainwater pipes or gutters; or the absence of proper water supply.¹⁰⁶ Particular emphasis was placed on the rapid and complete removal of any 'foul matter' or 'vitiated air', the prevention of the return of 'foul gas', and the plentiful supply of pure air and water. A notice might be served on the person 'by whose act, default or sufferance, the nuisance arises or continues.' When the nuisance arose from defective construction, including of 'structural conveniences' such as privies, or where there was no occupier, the notice was served on the owner of the premises.

Background

Initially, there were no formal avenues for training or qualification, and it was customary to employ men who were 'of good personal character' and 'amenable to discipline'. Retired members of the police or armed forces were considered good candidates, and it seems that enforcement, rather than technical knowledge, was the main emphasis.¹⁰⁷ The typical early recruit has been described as 'an unskilled workman holding that which might almost be regarded as a sinecure office, an official recruited into the service of the vestry from the ranks of ex-sailors, ex-policemen, or army pensioners.'¹⁰⁸ Soon, however, it became recognised that a knowledge of building construction, plumbing and similar matters was an advantage. Wandsworth Board, for example, resolved that 'such Inspectors of Nuisances be skilled mechanics by trade either bricklayers, or masons, or accustomed to superintending building works – a preference to be given to sewer works'.¹⁰⁹ When Hackney advertised a vacancy in 1897, the candidates included a carpenter and joiner, a land surveyor and a foreman bricklayer, while in 1902 they included a carpenter, plumber, bricklayer and builder's foreman.¹¹⁰ By this date, such experience was supported by

¹⁰⁶ Taylor, *Sanitary Inspector's Handbook* (1893), p.21; (1897), pp.52-53.

¹⁰⁷ *SIJ* (II, 1896-7), pp.271-280

¹⁰⁸ Roebuck, *Urban Development*, p.78.

¹⁰⁹ Quoted in Roebuck, *Urban Development*, p.63.

¹¹⁰ HAD: St. John at Hackney, Vestry minutes, 9 Jun 1897, p.251 (J/V/12); Hackney Metropolitan Borough, Public Health Committee, 24 Apr 1902, p.358 (H/P/2).

a specialist technical training, and an obligatory qualification. The LGB regulated the appointment of sanitary inspectors in the capital, and this raised standards.¹¹¹

What might attract a young man into such an occupation? W.J. Brown remembered how his father, Joseph Brown of Battersea, had married young, probably at some time in the late 1880s or early 1890s, and initially kept himself and his family, 'by a variety of odd jobs, including the selling of hot potatoes'. He 'somehow qualified in his trade', which was plumbing.¹¹² He was

burdened with a large family. That family, throughout his life, acted as a brake on all his ambitions. He was sober, hard-headed and practical, with a great respect for, and desire for, education. But never could he afford to take risks. Always, the weekly two pounds or so had to be got in somehow.¹¹³

After moving from London to Margate, Joseph eventually became an Assistant Sanitary Inspector, probably as an attempt to gain some status and financial security. He seems to have been determined that his son should not be in the same position, and the family struggled to support him through his grammar school scholarship. After this, his father encouraged him to try for the civil service since, 'That, to my father, represented the Mecca of all earthly hopes' – a job for life with a pension at the end of it.¹¹⁴

Reputation and campaigns

Despite the fact that men like Joseph Brown (at least as portrayed by his son) seem to have been paragons of the sober, hardworking and aspirational classes, the office of sanitary inspector was the object of widespread mistrust. In the public's opinion, there were many influences that might induce sanitary inspectors to be less than zealous in the detection and remedying of problems, the main one being that they were under the control of Vestries, largely composed of property owners. This was a recurring theme in evidence to government inquiries into sweating.¹¹⁵ One male sanitary inspector, employed by the Jewish Board of Guardians to supplement the sluggish efforts of East End local authorities, felt that the vestry ought not to be 'the masters of the sanitary inspector', since 'a man should never have to be afraid of

¹¹¹ See, for example, HAD: Parish of St John at Hackney, Vestry minutes, 1894-1896, *passim* (J/V/8-9).

¹¹² Brown, *So Far*, p.11.

¹¹³ *Ibid.*, p.19.

¹¹⁴ *Ibid.*, p.37. For the 'new breed of professional local government officer', see Clifton, *Professionalism, Patronage and Public Service*. For local government clerks see Anderson, *Victorian Clerks*, pp.113-115. For lower middle class social marginality and ideology of personal improvement, see Crossick, 'The emergence of the lower middle class', pp.11-78. For school attendance officers see Williams, Ivin & Morse, *Children of London*.

doing his duty.¹¹⁶ Such problems persisted. Amy Sayle (a prominent woman public health officer and trade union activist) was a Housing Inspector between 1919 and 1921, and reported on the apathy of local authorities. She often found that the Chairman of the Housing Committee, the Clerk to the Council, or even the MOH, owned a large number of working-class houses in the area.¹¹⁷

Sanitary inspectors were growing not just in numbers, but also in occupational identity. The Sanitary Inspectors' Association (SIA) was founded in 1883, as the Association of Public Sanitary Inspectors. By 1899, membership stood at over 700. From its foundation to the inter-war period, its aims and aspirations show a remarkable degree of continuity. They were for raising the standard of qualification, increasing the powers of inspectors, and improving salaries and conditions of service, particularly superannuation. The battle most constantly fought was for security of tenure. The SIA emphasised the impossibility of an efficient and professional service when sanitary inspectors held temporary appointments under local authorities composed of property-owners. It argued that no sanitary inspector should be removed from office without the sanction of the LGB. Such campaigns centred on freeing the sanitary inspector from the taint of corruptibility, and raising his public reputation. It is no surprise to find that many sanitary inspectors were involved with the Fabian Society, since their agenda of professionalisation meshed with the Society's on the reform of local government.¹¹⁸ The Fabian tract 'From patronage to proficiency in the public service' singled out the SIA for comment, attributing

the existence of keen and progressive associations of municipal civil servants largely to the revolt of municipal officials against the disgraceful system of patronage which is one of the scandals of English Local Government at the present time.¹¹⁹

Sanitary inspectors repeatedly emphasised how they must master a wide variety of technical skills, and were particularly keen to point out their understanding of the knowledge of the professions such as law, architecture, engineering and medicine.¹²⁰

¹¹⁵ Select Committee of the House of Lords on the Sweating System, First Report (PP 1888 XX, Cd. 361), pp.115, 196, 491; Third Report (PP 1899 XII Cd. 165), p.11; Fourth Report (PP 1899 XIV, Cd. 331), p.472.

¹¹⁶ Select Committee of the House of Lords on the Sweating System. Third Report (PP 1899 XII Cd. 165), p.472-473. The JBG had employed its own sanitary inspector since 1866 because of the apathy of local bodies. See, for example, Southampton: JBG annual report, 1890, p.24 (MS 173 1/12/5).

¹¹⁷ Sayle, *Houses of the Workers*, pp.116-117.

¹¹⁸ Perkin, *Rise of Professional Society*, p.130.

¹¹⁹ Quoted in SJ (XXXVI, 1919-1920), p.165.

¹²⁰ SJ (I, 1895-1896), pp.10-11; Boobbyer, 'Training and duties of sanitary inspectors', JSI (XXVI, 1905) p.214

Unselfish service to the community was also emphasised. One even spoke in terms of knightly chivalry, saying,

Honesty, sympathy, courtesy, love of our fellows, indomitable patience, energy and courage, a love of work for work's sake, and a devotion to duty are the characteristics of a gentleman.... There is no reason why an inspector should not be a gentleman or a gentleman an inspector, and when such a combination occurs (and I am pleased to say I have known it occur pretty often) the advantage to the community in which he labours is great and lasting.¹²¹

These attempts at professionalisation did not help relations between medical men and sanitary inspectors. Many inspectors openly declared their resentment at being at the 'beck and call' of MOHs, and felt that they should not tolerate being their 'lackies or the servants'.¹²² These tensions remained throughout the period. In 1921 the tendency of some sanitary inspectors to deprecate the work of their superiors was condemned by one MOH. He wondered why the inspector could not recognise that the MOH was 'his superior officer, and is equivalent in rank to that of a captain, whilst the Inspector's rank is that of lieutenant?'.¹²³

CONCLUSION

This was the background to the appointment of the first women to London's local public health departments. Middle-class women had a long track record of acting as the custodians of the sanitary situation within their own homes, and as voluntary educators of the poor. They had extended this activity into the municipal sphere as elected officers of local authorities and paid hygiene lecturers and visitors, and a range of facilities had developed to train them for such roles. For Wohl, sanitary associations and health societies were significant because

they enabled the lady health visitors to develop considerable expertise in matters which were of vital concern to public health and thus provided a bridge to the professional employment of lady health visitors by local authorities.¹²⁴

He has linked the rise of the municipal woman sanitary inspector and health visitor to the decline of the voluntary sanitary associations: 'By 1900 women sanitary visitors were so much a part of local government that the Ladies' Sanitary Association had outlived its original purpose and was dissolved'.¹²⁵ There was, however, no

¹²¹ Boobyer, 'Training and duties', p.214

¹²² *SIJ* (I, 1895-1896), pp.260-1.

¹²³ *ME* (LXVII, 1921), p.589.

¹²⁴ Wohl, *Endangered Lives*, p.37.

¹²⁵ *Ibid.*, p.70.

straightforward linear development. The NATHS, for example, in many ways a successor to the LSA, survived until the 1940s.¹²⁶

Whether the health visitors of the MSSA may be seen as the direct antecedents of the London women public health professionals of the 1890s and 1900s may also be questioned. As Davies has observed, the scheme was widely acclaimed but nowhere imitated exactly.¹²⁷ Dowling has indicated how, while in Manchester there was a 'clear and well documented line of development' from the sanitary missionary to the municipal health visitor, this was not the case in London where a similar scheme, that of the Ranyard Bible-women, instead fed into the development of district nursing.¹²⁸ For both, it was the Factory and Workshops Act that gave 'a new and unexpected impetus' to women's sanitary endeavour in London. Both voluntary and municipal health visiting in the capital post-dated the employment of women as salaried local authority sanitary inspectors. This complicated its relationship with its Victorian philanthropic roots. Neither was it easy to see how, as salaried officers, middle-class women might fit into the well-structured municipal system of rank, based on social class, education and training, that determined the relationship between MOHs and sanitary inspectors.

¹²⁶ TNA: NATHS (BT 31/34230/20432).

¹²⁷ Davies, 'Health visitor as mother's friend'.

¹²⁸ Dowling, *Ladies' Sanitary Association*; For the work of the Ranyard nurses and similarities to the Manchester visitors see Platt, *Story of the Ranyard Mission*; 'L.N.R.', *Missing Link*; 'L.N.R.', *Nurses for the Needy*.

3: PATTERNS OF EMPLOYMENT

WORKSHOP INSPECTION

Early appointments

The first appointment of a woman to an official public health position in a London local authority was made in Kensington in 1893. Following the Factory and Workshops Act of 1891, responsibility for the sanitary inspection of workshops was transferred to local sanitary authorities.¹ In 1893 Kensington's MOH, T. Orme Dudfield, received complaints of overcrowding in dressmakers' establishments, and a male sanitary inspector investigated. He reported that he did not have enough time to keep them under the level of supervision that was required by the Acts, or that was in the best interest of the 'numerous and somewhat helpless class' of young women workers.² Dudfield argued that the 1891 Act could not be administered without the appointment of additional inspectors, and suggested the appointment of women.³ Dressmakers held a central place in Victorian public consciousness. Their burden on middle-class guilt may have made Vestry members more willing to listen to Dudfield's appeals.⁴ In July 1893 they decided to appoint two temporary women inspectors, specifically responsible for workplaces in which women were employed.⁵

Earlier in 1893, St. Marylebone's MOH had already recommended the appointment of women.⁶ An attempt by Paddington to appoint women inspectors failed in 1894. Islington was the next to make an appointment in 1895, followed by St. Pancras and Southwark in 1896.⁷ London MOHs may have been influenced by Nottingham, which had appointed the very first woman workshop inspector in 1892. There was also an influential lobby working to secure the appointment of women. Lucy Deane, one of the two women appointed in Kensington recorded in her diary

¹ The relationship between central and local government responsibility for factory and workshop legislation shifted over time. In general, it was the supervision of the sanitary conditions of factories and, in particular, of smaller workshops, rather than the safety of machinery, dangerous processes and hours of labour, that was devolved locally. In 1891 insanitary workplaces also became 'nuisances' under the Public Health (London) Act.

² K&C: St Mary Abbotts, Kensington, MOH report, May-Jun 1893, pp.84-5.

³ *Ibid.*, Nov-Dec 1892, pp.153-6.

⁴ Williams, *Rich Man*. For the image and reality of the Victorian dressmaker see Walkley, *Ghosts in the Looking Glass*.

⁵ K&C: St. Mary Abbott's, Kensington, Vestry minutes, 5 Jul 1893, p.30.

⁶ LMA: Printed reports by the LCC MOH on the sanitary staffs of the metropolitan boroughs (LCC/PH/1/245); *Kensington News* (26 Aug 1893); Kilgour, *Women as Sanitary Inspectors*.

⁷ RCN: Catto, 'Early women sanitary inspectors'.

how the National Health Society played a key role.⁸ When the possibility of the Kensington appointments first arose, Fay Lankester was 'in great excitement', and she lobbied influential people, including Vestry member John Braye.⁹ Braye moved the resolution, and remained a great supporter. He was 'angry and jealous' when Dudfield, as MOH, took public credit for the innovation.¹⁰ When asked whether many members had objected to the experiment, the Vestry Clerk replied, 'Far from it. A large majority were in favour.'¹¹ In other areas, such as Southwark and Paddington, women Vestry members were influential in arguing for the appointment of women.¹² In many districts, however, work under the Factories and Workshops Acts was absorbed into the routine duties of the general district sanitary inspectors. In others, male workshop inspectors were appointed.¹³ Elsewhere, both specialist male and female inspectors were at work, women concentrating on the inspection of premises where women were employed.¹⁴

Process of inspection

In 1903, a woman sanitary inspector described a typical visit to a tailor's workshop.¹⁵ First she noted the stale air. She then counted the number of occupants, say seven in number. From past experience she knew that the room was overcrowded, but she measured it, and calculated its legal occupancy rate, say of five persons. She then informed the employer that he was in contravention of the law, and must reduce the number of workers. Noting that there were no inlets for fresh air, or outlets for foul, other than windows and a fireplace, she 'figuratively speaking' waved 'our Factory and Workshop Act over his head', and announced that he must provide sufficient means of ventilation. She then drew his attention to the gas iron-heater, which was giving out noxious fumes, and pointed out that he was required to provide a special hood or canopy with a shaft to the open air. She then 'quietly' approached one of the females working in the room and asked where the sanitary conveniences were situated, and if there was one for the exclusive use of women workers. If not, she informed 'the now bewildered occupier' that he must provide an additional WC, and that she required the walls to be stripped of paper and to be lime-

⁸ LSE: Lucy Deane's diary, *passim* (Streatfeild 1/1).

⁹ *Ibid.*, 13-17 October 1893 (Streatfeild 1/1).

¹⁰ *Ibid.*, 21 Oct 1893 (Streatfeild 1/1).

¹¹ LSE: unidentified press cutting (Streatfeild 1/22)

¹² *Are women wanted on London Borough Councils* (WLGS, 1908); *SR* (XXVII, Jan-Jun 1901), p.316.

¹³ LCC MOH report, 1893, p.53.

¹⁴ *Ibid.*, 1903, p.63; See, for example, Finsbury MOH report, 1905, pp.161-163.

washed, the floor to be washed once a week and any rubbish lying about to be 'speedily dealt with'. Inspections such as these were carried on by women inspectors all over London. In 1902 in Hackney, for example, the woman sanitary inspector discovered nuisances on 246 premises. The largest number (80) related to dirty premises; next came insanitary WCs and drains (37); ventilation was a problem in 41 workrooms; and separate sanitary accommodation was lacking in six cases. The others were a mixture of damp walls and ceilings, defective conditions of yards, guttering, rain water pipes, floors, roofs and dustbins.¹⁶

Decency and delicacy

Dudfield recommended the appointment of women because 'some of the duties involved were of too special and delicate nature to be properly discharged by male inspectors'.¹⁷ From the late 1870s, working women's organisations urged the appointment of women factory inspectors on the grounds that there were certain issues, particularly relating to sanitary facilities, which could only be discussed between members of the same sex.¹⁸ The Lady Assistant Commissioners told the Royal Commission on Labour in 1894 about some factory women who heard their employer inform the male factory inspector that there was sufficient sanitary accommodation. They 'had not liked' to intervene to point out its 'objectionable situation', and that it was common to both sexes.¹⁹

Similar arguments were used to urge the appointment of women sanitary inspectors in London. In 1895, although there was already a male workshop inspector, Marylebone's MOH suggested appointing a woman, as there were 'several places in the parish which cannot properly be supervised by anyone of the male sex'.²⁰ The MOH for the City of London argued in 1901 that, 'There are many questions in connection with the sanitary surroundings of female workers in factories that can only be properly investigated by one of their own sex'.²¹ In 1897 St Pancras Vestry received a deputation from women's organisations, headed by Mrs Bertrand Russell, urging the replacement of the district's woman workshop inspector since, in many matters that affected a worker's 'health and comfort', she could not speak so

¹⁵ Franks, 'Provisions of the Factory and Workshop Act that concern women workshop inspectors', SR (XXII, 1903), pp.220-221.

¹⁶ HAD: Hackney Borough Public Health Committee, 7 May 1903 (H/P/3).

¹⁷ Kensington MOH report, 1904, p.66.

¹⁸ Jones, 'Women health workers', pp.167-168; Anderson, *Women in the Factory*, p.7; TNA: letter from the London Women's Trade Council to the Home Office, 14 Mar 1890, (HO 45/9818/B8031).

¹⁹ Royal Commission on Labour, Fifth Report (PP 1894 XXXV, Cd. 7540), pp.95, 512.

²⁰ LCC MOH report, 1895, p.60-61; 1899, pp.15-16.

freely to a man as to another woman.²² Male sanitary inspectors may also have felt uncomfortable interviewing women about such delicate matters as sanitary accommodation. Miss de Chaumont, a woman inspector in Kensington, was later to recall that her male colleagues

were all glad to hand over the inspection of women's workshops to a woman! As one of them said to me, "It's awful when you have to visit one of those Court Dressmaking establishments and have the eyes of dozens of girls fixed upon you."²³

An improving influence

In 1900 Dudfield also declared of one of Kensington's women inspectors that probably the most valuable service she renders to the Council and the community arises from the exercise of moral influence, leading to the due carrying out of the requirements of legislation.²⁴

Lucy Deane's first impression of the women workers was that they 'seemed scared and ignorant'.²⁵ It was the role of women inspectors to encourage them to follow the rules and regulations, and to participate in the system designed for their 'protection. They were to educate the workers in their rights under the law, and provide a confidante, neutral intermediary or 'friend' in whom they might trust. In 1909, a woman doctor wrote that 'A woman of tact and intelligence ... can do really good work in influencing women and girls with whom she comes into daily contact.'²⁶ It was this element of personal influence, of being able to educate and reform behaviour, which was valued in the woman inspector. Convincing working women to confide in the inspector, and to 'co-operate intelligently in transforming factory conditions from within', caused a growth in 'the spirit of self-help'.²⁷ Women inspectors were social workers as well as inspectors, and their appointment was encouraged by networks of social reformers and women's organisations.²⁸

INCREASING APPOINTMENTS

Whatever the reasons behind the appointment of women sanitary inspectors, they quickly won acceptance. The medical press, sanitary authorities, the LCC and

²¹ *Lancet* (5 Oct 1901), p.935

²² *SIJ* (III, 1897-1898), p.49.

²³ *WHO* (Oct 1942), p.5.

²⁴ Kensington MOH report, 1900, p.50.

²⁵ LSE: Lucy Deane's diary, 20 Nov 1893 (Streatfeild 1/1).

²⁶ Chesney, 'Sanitary inspectors and health visitors', *The Queen* (4 Dec 1909).

²⁷ Anderson, *Women in the Factory*, p.191.

²⁸ See Chapter 8.

the Royal Commission on Labour were all supportive.²⁹ By 1898 there were six female inspectors in London, working in Kensington, St. Pancras, Islington, Hackney, Southwark and Battersea.³⁰ Between 1898 and 1900 there was a small increase, with St. Marylebone and Poplar joining the other parishes. Although some districts opposed the idea of appointing women, this was not the case in the majority of areas.³¹ As can be seen in Fig. 1, after a gentle increase from 1893 to 1900, the number of women sanitary inspectors in the capital rose sharply from 1901 onwards, reaching a peak in 1910. By 1903, out of the 301 sanitary inspectors employed in London, 20 were women.³² In 1901 they had represented 11 out of a total of 275, and the LCC MOH reported that 'the increase in the total number of inspectors in London since the date of the last return is largely therefore due to the appointment of women.'³³ This pattern was repeated in subsequent years.³⁴

Figure 1: Number of full-time women sanitary inspectors on the staffs of London authorities, 1893-1912.³⁵



²⁹ *Lancet* (28 Oct 1893), p.1072 & (28 Apr 1894), p.1104; Royal Commission on Labour, Fifth Report (PP 1894 XXXV, Cd. 7421), p.138; LCC MOH report, 1898, p.73; Dudfield, *Woman's Place*, p.1.

³⁰ LMA: LCC, Clerk's Department, Return of Sanitary Officers, 1899, p.3 (LCC/PH/1/245).

³¹ See, for example, *SIJ* (III, 1897-1898), p.75; Bermondsey MOH report, 1905, p.40.

³² *BMJ* (6 Jun 1903), p.1333-4; LCC MOH report, 1902, Appendix VI, p.1.

³³ LCC MOH report, 1902, Appendix VI, p.1.

³⁴ *Ibid.*, 1903, p.76; *BMJ* (6 Jul 1904), p.141.

³⁵ Annual reports of the LCC on Public Health. These reports do not contain figures for each year. Neither are they consistent, either internally, or with separate printed reports on the sanitary staffs of the metropolitan boroughs (LMA: LCC/PH/1/245), differences perhaps being

Between 1904 and 1907 there was an overall increase in the number of sanitary inspectors to 319, 40 of whom were women.³⁶ By 1907, Southwark employed three women sanitary inspectors, a larger number than any other London borough. Fourteen boroughs employed two women; seven employed one; although there were still seven with no women on their staffs.³⁷

Sweated workers

The immediate reason for the increased employment of women can be found in public panic over the sweating system, and further legislative developments. The 1895 Factories and Workshops Act defined overcrowding, brought all but the smallest laundries under inspection, and increased the regulation of the sanitary conditions under which out-work was done. The 1901 Act, added further responsibilities. It extended coverage of the legislation from 'workshops', where manufacturing took place, to 'workplaces', including restaurant kitchens, offices and other premises in which large numbers of women were employed. It strengthened the powers of local authorities to enforce sanitary conditions in domestic laundries, and most importantly, in relation to out-work. Public concern about the sweating system gathered momentum during the 1890s and early 1900s. In addition to perceived threats to public health, sweated women workers were depicted as defenceless and in need of protection.³⁸ A broad alliance of women's and social reform groups pressed for the appointment of women inspectors for the registration and inspection of the homes of out-workers. They dealt with cases of overcrowding, sanitary defects, cleanliness, and prevented work from being brought in contact with infectious disease.³⁹

Range of duties

London's women sanitary inspectors, however, did not work exclusively on workshop and out-worker inspection. The same reasons of 'decency and delicacy' that made women suitable for the inspection of WCs in factories and workshops employing women, recommended them for the inspection of ladies' lavatories in

caused by different reporting times, and the inclusion or otherwise of figures for the Corporation of London and the City of Westminster. They do, however, show an overall trend.

³⁶ LCC MOH report, 1907, p.93.

³⁷ *Women as Inspectors* (CBEW, [1907]), p.12.

³⁸ Boston, *Women Workers*, p.64; Thom, 'Bundle of sticks', p.279; Thom, 'Free from Chains?', pp.90-7.

³⁹ Sharples, 'Inspection of home-workers', *JSI* (XXIV, 1903), pp.767-8

various public and institutional settings, such as schools and railway-stations.⁴⁰ Other areas of work also developed. When addressing an audience of women sanitary inspectors in 1904, Dudfield suggested that their duties with regard to workshops would, as time went by, become lighter as conditions improved, and hoped that more of their time would be devoted to work as 'missionaries of health'.⁴¹ One woman inspector remembered that,

It was then decided that certain additional duties such as tuberculosis and birth visiting could more readily be performed by ladies. It is hardly possible to say when or how this actually took place, for no two Sanitary Authorities determined that this or that duty should be carried out by the Lady Sanitary Inspectors at the same time.⁴²

Additional duties were most likely to concern the inspection of WCs and houses let in lodgings, work relating to tuberculosis and other infectious diseases, and 'special investigations' into infantile mortality or epidemic diarrhoea.

Houses 'let in lodgings'

Sanitary authorities had powers to deal with houses occupied by more than one family, or 'let in lodgings'.⁴³ Under bylaws, they might register premises, fix occupancy rates, order the separation of the sexes, enforce minimum sanitary provisions including privy accommodation, drainage, cleanliness and ventilation, and stipulate regular cleansing and lime-washing.⁴⁴ Misses Busk and Kenny served on the Public Health and Sewers Committee of the Vestry of St. George the Martyr in Southwark in the 1890s.⁴⁵ They 'laboured to get the overcrowded tenements of the parish into a more sanitary condition', and are credited with securing the appointment of women inspectors for this purpose.⁴⁶ In June 1896, the Vestry appointed Miss Elliott as 'Inspector of Tenement Houses', to administer the area's bylaws for houses let in lodgings, as well as to inspect workshops and workplaces in which women were employed, and the homes of out-workers.⁴⁷ In 1899 an additional woman inspector

⁴⁰ Leslie, 'Free lavatory accommodation for women', *JRSI* (XXXI, 1910), p.429; HAD: Hackney Metropolitan Borough, Public Health Committee, 20 Feb 1901 (H/P/1), 19 Jun 1911 (H/P/12; St. Marylebone MOH Report, 1900, p.17; St.Pancras MOH Report, 1901, p.71; LMA: LCC, Clerk's Department, Return of Sanitary Officers, 1899, p.3 (LCC/PH/1/245).

⁴¹ Dudfield, *Woman's Place*, p.14.

⁴² Gorniot, 'Sanitary lady', *SJ* (XIX, 1913-1914), p.145.

⁴³ LCC MOH report, 1892, p.34.

⁴⁴ Stockman, *Practical Guide* (1904), p.178.

⁴⁵ Hollis, *Ladies Elect*, pp.349-351.

⁴⁶ *Are Women Wanted on London Borough Councils?* (WLGS, Feb 1908).

⁴⁷ SLS: Vestry of St George the Martyr, annual report, 1896-7, p.16, 1898-9, p.7; minutes, 16 Jun 1896 and 22 Sep 1896.

was appointed, and the parish divided into two districts.⁴⁸ The *BMJ* was fearful for their safety –

The work will certainly be disagreeable and we fear may at times be not unattended with a certain amount of risk, for these lodgings constitute some of the foulest slums in London and are often inhabited by an unruly, lawless and drunken lot.⁴⁹

According to one woman inspector, houses let in lodgings were 'a favourite speculation of the slum landlord', who threw a 'few sticks of furniture' into a dilapidated property, and let it furnished.⁵⁰

Miss Elliott measured-up and registered the lodging houses, made sure that the landlords maintained them in a good condition, and abated overcrowding.⁵¹ She was instructed, however, to report to the chief male inspector any matters of 'a general sanitary character'.⁵² In addition she 'diligently instructed and overlooked the tenants'.⁵³ It appears to have been their talents in this latter direction that encouraged the employment of women inspectors for such work. Woolwich's MOH felt that the inspection of houses let in lodgings was best performed by a woman, as the by-laws dealt mainly with the 'habits of tenants', especially the habits of housewives.⁵⁴ One woman Inspector felt that the 'visits of educated women in an official capacity to the occupants of houses let in lodgings has a distinctly humanizing influence'.⁵⁵ For another,

In visiting the houses let in lodgings, not only is attention paid to the condition of the walls, ceilings, floors, roofs, window sash-frames, and other structural defects, but an endeavour is also made to educate the tenants to a higher standard of cleanliness and decency of living. Efforts are made to induce those housewives who are inclined to the slatternly to be orderly and methodical.⁵⁶

Some London authorities therefore used regulations relating to houses let in lodgings to employ women sanitary inspectors to 'educate' working-class women in domestic cleanliness and housekeeping.⁵⁷

⁴⁸ SLS: Vestry of St George the Martyr, annual report, 1898-9, p.30.

⁴⁹ *BMJ* (3 Oct 1896), p.963,

⁵⁰ *How to Become a Lady Sanitary Inspector*, p.25.

⁵¹ SLS: Vestry of St George the Martyr, annual report, 1898-9, p.42.

⁵² SLS: Vestry of St George the Martyr, minutes, 22 Sep 1896.

⁵³ *Are Women Wanted on London Borough Councils?* (WLGS, February 1908).

⁵⁴ TNA: extract from Woolwich MOH report, 1912 (MH 48/169).

⁵⁵ Maynard, *Women in the Public Health Service*, p.46.

⁵⁶ Quoted in LCC MOH report, 1907, p.69.

⁵⁷ LCC MOH report, 1910, p.80.

Infectious disease

By the 1890s, dealing with cases of notified infectious disease was part of the routine work of male sanitary inspectors. Although exact practice varied, an inspector would generally investigate the case, conduct a sanitary examination of the house and surroundings, enquire about the source of infection, follow-up contacts and possibly secure removal to a hospital, or arrange for disinfection.⁵⁸

Particular diseases were delegated to women inspectors. In official reports a distinction was often made between 'notifiable' and 'non-notifiable' diseases, women most commonly, but not exclusively, dealing with the latter. The boundaries between these two groups varied over time, and between different localities. Scarlet fever, typhoid, diphtheria and similar 'more dangerous' diseases were usually investigated by male sanitary inspectors, although women in some parts of London did perform this work.⁵⁹ These were acute diseases that were amenable to removal to an isolation hospital. Diseases most often visited by women were those that were not dealt with in this way –

those in which the infection is not easily carried, those which are regarded by mothers as of slight account, owing to their wide prevalence and those in which the practical advice of a trained and experienced woman may greatly increase the chances of recovery and diminish the spread of infection.⁶⁰

Visitation of 'non-notifiable' diseases, and childhood diseases that were nursed at home, such as measles, whooping-cough, chickenpox and mumps, was generally done by women, with the aim of 'helping the mother by giving her some idea as to the precautions to be taken.'⁶¹ In addition, although diseases associated with very young infants, such as ophthalmia neonatorum, and as a result of childbirth, like puerperal fever, were made notifiable, they also became the province of women.

The connection between childhood diseases like measles and whooping-cough was that MOHs tended to blame maternal ignorance and carelessness for mortality, attributing deaths to complications arising from improper home nursing or the application of folk remedies.⁶² Finsbury's MOH, for example, accused mothers of treating measles as if it were a minor ailment, and of deliberately exposing children to infection so that they might 'have done with it'. He claimed that improper nursing and feeding was widespread, and that children were 'allowed to go out of doors in all weathers, insufficiently and improperly clothed', with the danger of contracting

⁵⁸ Taylor, *Sanitary Inspector's Handbook* (1893), pp.125-127, (1897), pp.183-184, (1914), pp.312-313.

⁵⁹ Greenwood, 'Sanitary inspection', p.22.

⁶⁰ Eve, *Manual*, p.94.

⁶¹ Greenwood, 'Sanitary inspection', p.22.

pneumonia.⁶³ Maternal neglect was also considered to be a factor in ophthalmia neonatorum, since improper care resulted in blindness.⁶⁴ Visits of the women inspectors and visitors were therefore two-fold: to impress on parents the importance of taking precautions against the spread of the diseases, and to oversee the correct nursing of cases in poor homes. Both involved 'educating' mothers. For Woolwich's MOH, this was 'work which cannot be properly performed by male sanitary inspectors'.⁶⁵

Tuberculosis

Notification of tuberculosis gradually gained currency, although it had been designed for acute rather than chronic conditions, and swift removal of cases to an isolation hospital was not appropriate. Notification was first introduced in London in Finsbury in 1901. By 1911 it was in operation in 21 boroughs.⁶⁶ Women inspectors were brought into the resulting work. Every case in Finsbury was visited in the first instance by one of the district inspectors and re-visited by the lady sanitary inspector at one- to three-monthly intervals. During her visits, described as 'practical and educational', the patient would be shown how he should 'best order his life'.⁶⁷ Kensington made tuberculosis notifiable in 1901, and its women inspectors visited cases, both to gather statistical information on sufferers, their families and home circumstances, and also to instruct the patient and his family in 'rules' for the prevention of the spread of infection. In Hampstead, the duties of the woman inspector were to give the 'necessary instruction in the precautions that a consumptive patient should observe to prevent the spread of the disease'; to inquire into the source of infection; and 'to see to it that consumptive patients adopt a proper mode of life'.⁶⁸ She was assisted by a body of voluntary visitors, organised by the Hampstead Health Society.⁶⁹ Westminster Health Society also made tuberculosis an early aspect of its work. Each case was visited first by an officer of the Public Health Department, who made enquiries into the causes of the disease, remedied insanitary conditions, arranged disinfection and left an instruction card.⁷⁰ From then on, the Society's visitors took over the 'supervision' of the case. In 1903 the JBG replaced its

⁶² See, for example, Dudfield, 'Woman's place', p.9.

⁶³ Finsbury MOH report, 1910, p.69; see also SLS, Vestry of St. George the Martyr, Southwark, annual report, 1894, p. 32.

⁶⁴ *JRSI* (XXXIV, 1913), p.111.

⁶⁵ TNA: extract from Woolwich MOH report, 1912 (MH 48/169).

⁶⁶ MO (V, 1911), pp.117-118; *BMJ* (14 Feb 1903), p.387.

⁶⁷ *NH* (IV, 1913), pp.278-279.

⁶⁸ Hampstead MOH report, 1910, pp.58-59.

⁶⁹ *Ibid.*

male sanitary inspector with two salaried women health visitors, specifically to deal with cases of consumption amongst the Jewish poor.⁷¹

Regular visiting of tuberculosis cases for educational purposes, and to encourage the patient to alter his lifestyle, was 'not suitable work for a male sanitary inspector.'⁷² According to one woman inspector,

a woman can get access more easily to the consumptive patient's bedside and give him, or her, the necessary advice; and again, in a time of trouble and illness, and finally death, a woman's presence will be more easily tolerated than a man's.⁷³

Moreover, so much of the work in preventing the spread of the disease, and of caring for the patient, fell to women as housekeepers and home nurses. The home care of consumptives was widely recognised as 'essentially a woman's question' – 'the doctor could do much, the authority could make regulations, but after all the practical work was done by the women.'⁷⁴ For Miss Gardiner,

We have seen that lack of fresh air, of sunshine, of cleanliness, of proper food and clothing; and overcrowding ... are all important in the causation of consumption, and is it not perfectly evident that every one of these items lies well within the woman's province, and that it is in her power to remove them?⁷⁵

'Whoever heard of a *man* drawing down the blinds,' she asked, 'and thus shutting out the sunlight for fear that the curtains or carpets should fade', or guarding the best room for Sundays, causing overcrowding in the rest of the home? It was the woman who chose and cooked the food, and who sorted the clothes for the wash.

Infant mortality investigations

In 1902, Dudfield argued that 'the workshops in the Borough having become well-ordered and requiring less frequent inspection', the services of Kensington's women inspectors could be used elsewhere. He employed them on tuberculosis work, and also on enquiries into the circumstances of infant deaths in the borough.⁷⁶

Theirs was 'the delicate duty of interviewing bereaved mothers with a view to ascertaining to what extent the mortality might be regarded as due to causes of a more or less preventable character'.⁷⁷ Such work was undertaken in several

⁷⁰ Westminster: CWHS annual report, Jun 1906, p.10 (1352/17).

⁷¹ Southampton: JBG Executive, 1 Mar 1903, p.146.

⁷² Bermondsey MOH report, 1910, pp.15-16. See also the comments of the JBG's male inspector – Southampton: JBG annual report, 1899, p.80; 1900, p.87 (MS 173/1/12/6).

⁷³ Gardiner, 'The woman's part in the cause and prevention of pulmonary tuberculosis', *JSI* (XXV, 1904) pp.888-9

⁷⁴ *JRSI* (XXXV, 1914), p.510.

⁷⁵ Gardiner, 'Woman's part', p.887

⁷⁶ Kensington, MOH report, 1904, p.67.

⁷⁷ *Ibid.*, 1902.

boroughs.⁷⁸ Infant death inquiries were 'very depressing work', and required great sensitivity.⁷⁹

The emphasis was on deaths from diarrhoeal diseases, particularly summer or 'epidemic' diarrhoea. This was considered to be a 'filth' disease, governed by cleanliness in and around the home, and infant feeding practices, so that 'the mother was evidently the factor of paramount importance'.⁸⁰ The questions asked during investigations were influenced by these preconceptions. In cases where the death appeared to have been caused by improper feeding, or 'carelessness', the matter was explained to the mother, 'but she must not be censured except in a few isolated cases when it is apparent that the death was due to culpable negligence or even cruelty'.⁸¹ For one woman inspector,

It is a most delicate matter to point out to the bereaved mother that in all probability the unwise method of feeding the child brought about its death, but it has to be done for the sake of those who may follow.⁸²

There was no strict boundary between 'investigation', as might be carried out after any death from infectious disease, and 'education' in housekeeping and mothercraft. Indeed, the housekeeping practices of working-class women were a theme common to many areas of the work of early women inspectors.

Variety of duties

According to Miss Long, a woman sanitary inspector in Wandsworth, by 1906 there were seven major categories of work that might fall into the province of a woman inspector.⁸³ In addition to the inspection of laundries and workshops where women and girls were employed, and visiting the homes of out-workers, in a few boroughs the inspection of homes let in lodgings and of tenement houses fell to women. In some districts women sanitary inspectors had duties in connection with notifiable infectious disease, and in others they visited cases of measles and other non-notifiable childhood diseases. They had duties in relation to tuberculosis in many boroughs, especially where a system of voluntary notification was in place. The inspection of hotel and restaurant kitchens also fell to women inspectors, as did the

⁷⁸ See, for example, Finsbury MOH report, 1905, pp.157-174; Battersea MOH report (1905), pp.113-127; Lambeth MOH report 1905, p.122.

⁷⁹ Maynard, *Women in the Public Health Service*, pp.82-85.

⁸⁰ McCleary, *Early History*, pp.22-35. For more on the emphasis of the explanations for deaths from diarrhoeal disease see Dyhouse, 'Working-class mothers', pp.77-78 and Dwork, *War is Good*, pp.22-35.

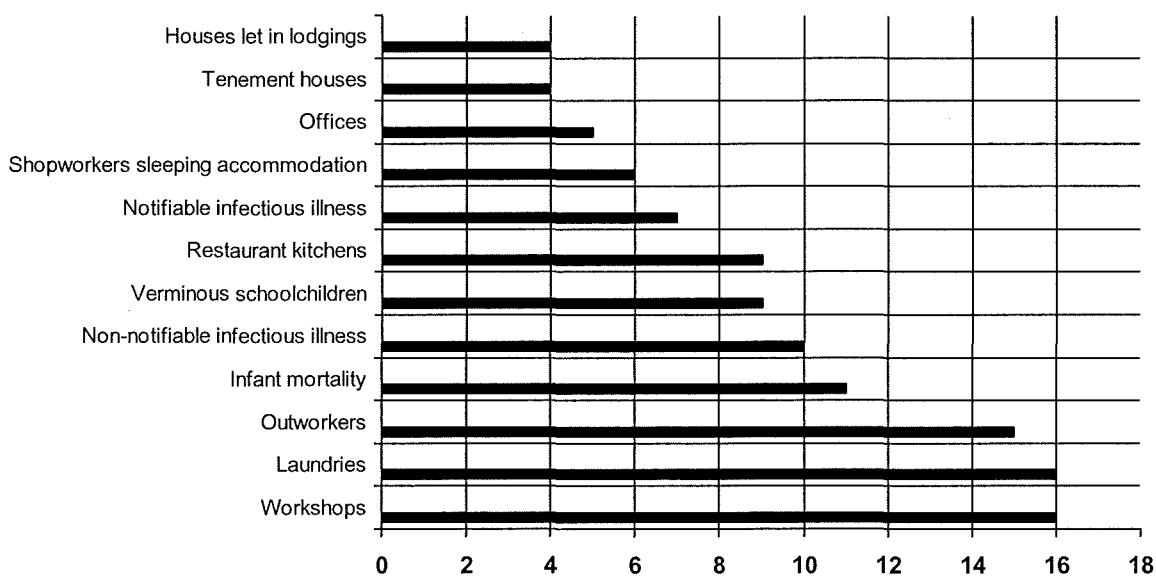
⁸¹ Maynard, *Women in the Public Health Service*, pp.82-85.

⁸² Long, 'Work of women as sanitary inspectors and health visitors', *JRSI* (XXVII, 1906), pp.737-739

⁸³ *Ibid.*

inspection of public lavatories for women. Finally, in most boroughs, deaths of infants under one year from diarrhoea were investigated by the women. Miss Long was at pains to point out, however, that the routine visiting of infants after birth was not recognised by the LGB as the work of a sanitary inspector. Another woman inspector declared that the duties varied in each district, 'in accordance with the individual opinions of the medical officer of health', and that no one woman did the full range of work.⁸⁴ In 1909 The National Union of Women Workers (NUWW) sent out a questionnaire about the work of women sanitary inspectors to all the London Boroughs. It received 16 replies, the results of which are tabulated in Fig 2. In all 16 areas women were employed to inspect workshops and laundries, and in 15 they also inspected out-workers. Eleven boroughs used their women inspectors for infantile mortality investigations. The inspection of cases of non-notifiable infectious disease was undertaken in ten.⁸⁵

Figure 2: Results of the NUWW Survey on the duties of women sanitary inspectors, 1909.⁸⁶



'UNSUITABLE' WORK FOR WOMEN

Despite the wide range of duties performed by London's women sanitary inspectors, there were some that were never considered suitable as women's work.

⁸⁴ Greenwood, 'Sanitary inspection', pp.21-22.

⁸⁵ *NH* (I, 1909), p.78.

⁸⁶ *Ibid.*

Slaughterhouses

Slaughterhouses were licensed by the local authority and subject to rules as to site, structure and sanitary provisions. Some sanitary inspectors also specialised in meat inspection, were required to seize any diseased or unfit meat and be present at the slaughtering and dressing process.⁸⁷ There is no evidence that women were ever considered suitable for such work.

In 1897, an application from a woman for the post of Slaughterhouse Inspector in the town of Colnbrook met with strong opposition. Not only was it questioned 'why any woman should want to undertake the repulsive and disgusting duties', but the commentator was amazed that she had 'sufficient conceit to persuade herself she can carry them out as efficiently as a man'.⁸⁸ One male inspector felt that slaughterhouse work was 'not in keeping with the delicate texture of a woman's nature and she has no right in it'.⁸⁹ Another thought that 'it would be neither decent nor prudent to ask a woman to do work which would take her into the atmosphere of the knacker's yard, pig breeding hovels, and many other objectionable places'.⁹⁰ For the *Sanitary Record*, women were not only 'constitutionally unfitted' to perform such duties, which should be left to 'the sterner sex', but

No one likes to think of woman, proverbially sensitive and by nature embued with tender sentiments, dabbling her skirts in the blood of the sacrifice.⁹¹

In an ironic response, one commentator stated that

No doubt, too, it would be gravely announced that the entrance of women into the ranks of slaughter-house inspectors would raise the tone of those engaged therein, and that, indeed, the main object of the lady was to raise the morals and manners of butchers.⁹²

He went on,

Happily there is still a large body of women who believe, and believe rightly, that an intimate acquaintanceship with what is ugly and evil is not in itself an advantage; and that if it must be made it had better be left to men, whose stronger constitutions and coarser sensibilities are fitted by nature to such tasks, and less likely to be demoralised in the process, than the more delicate ones which should characterise womanhood.⁹³

⁸⁷ Taylor, *Sanitary Inspector's Handbook* (1914), pp.368-370.

⁸⁸ SR (XIX, 1896-1897), p.569.

⁸⁹ Banks, 'Status of the sanitary inspector, past, present and future', SJ (XIX, 1913-1914), p.172.

⁹⁰ *Ibid.*

⁹¹ SR (XXXIII, 1904), p.254.

⁹² SR (XIX, 1896-1897), p.569.

⁹³ *Ibid.*

Deep cultural fears that women might somehow be polluted by their proximity to such 'degrading' spectacles as the slaughter of animals, and that their very femininity was in danger, pervaded the debate.⁹⁴

Drains

The association of women sanitary inspectors with drains and sewers was also contentious. For the *Sanitary Record*, their presence on drainage work was lacking in 'delicacy and the refinement we look for in woman'.⁹⁵ Women were 'not fitted to superintend the reconstruction of drainage works or the abatement of nuisances such as emptying cesspools, middens, etc.'⁹⁶ The difference from slaughterhouses was that background knowledge of drainage was considered to be an important foundation for other areas of work.⁹⁷ In Leeds, probationer women inspectors were

put on to house-to-house work under the direction of one of the more experienced men inspectors. They visited every house in the district assigned to them from top to bottom, and were required to know practically everything about drains and traps and sinks.⁹⁸

This was intended to avoid duplication of visits, and waste of effort, as the women could report directly to the chief inspector about any problems they found while doing other work. One of the Leeds inspectors expressed her gratitude for this 'somewhat severe training' in practical sanitation.⁹⁹ Miss Carey of Westminster felt that

It was most important that all women inspectors should have a knowledge of drainage and structural work, as it was preposterous that a sanitary inspector should be able to visit a house and come away without knowing whether that house was structurally sanitary or not.¹⁰⁰

She did not understand why women were supposed to be incapable of understanding drainage.¹⁰¹ There was a difference, however, between having technical knowledge, and actually performing the duties. She also thought that the woman inspector should not

supervise the laying of drains or the building of houses; that work I think is thoroughly well done by men, and I do not see that a woman would be likely to improve upon it.¹⁰²

⁹⁴ See, for example, SR (XL, 1907), p.444.

⁹⁵ SR (XLIX, 1912), p.63.

⁹⁶ Banks, 'Status of the sanitary inspector', p.172.

⁹⁷ SR (XXXV, 1905), p.489.

⁹⁸ JSI (XXIV, 1903), p.315.

⁹⁹ NCIM, *Proceedings* (1906), p.80.

¹⁰⁰ JRSI (XXVIII, 1907), pp.199-200.

¹⁰¹ SR (XXXIX, 1907), pp.338-339; NCIM, *Proceedings* (1906), p.81.

¹⁰² Carey, 'Whole work of a sanitary inspector', SJ (XII, 1905-1906), p.192.

While they considered that technical knowledge about such matters was essential to the accomplishment of their general duties, women inspectors did not claim the right to oversee the actual performance of the works. Once they had identified that a property required structural work, they most often passed the matter over to their male colleagues. Careers literature reassured those considering taking up the work that their acquaintance with drains would be minimal.¹⁰³ Women sanitary inspectors were continually battling against the perception of their work as unladylike. One woman inspector recalled that her friends had 'jeered' when she obtained her first appointment:

Their question (and it appeared to them a good joke) was "What will you do when you have to go down a drain?" This is a duty which neither I, nor any other "lady inspector" has ever been asked to perform.¹⁰⁴

Women entering the occupation had to 'rid themselves and their friends of the idea that their work is likely to consist chiefly of the obnoxious task of inspecting drains.'¹⁰⁵ Both the advice literature, and the women sanitary inspectors themselves, were always keen to remedy such misapprehensions. Drains were less taboo than slaughterhouses, but they were still 'unfeminine', and best avoided.

Structural sanitation

Aside from drains and sewers, there was debate over how far women should be involved in the structure of the dwelling, as opposed to the behaviour of its inmates. As one male sanitary inspector explained:

It would appear that the best arrangement is a complementary and reciprocal relationship, the inspector dealing with premises and informing the health visitor where her sympathy and advice are most needed, whilst the latter deal with persons and informs the inspector of any premises requiring his attention.¹⁰⁶

Another felt that women should 'control the purely domestic conditions' and men should deal with 'the sanitary and structural conditions of houses and their environment'.¹⁰⁷ In tuberculosis work the ideas of 'house' and 'home' should not be confused,

it is not only necessary to cleanse the dirty walls and floors of a house, it is necessary also to ensure that the home circle keeps them clean. A sanitary inspector can do the former, but unless his physical work is followed by the

¹⁰³ *Women as Inspectors* (CBEW, [1907]), pp.9-10.

¹⁰⁴ Armour, 'Sanitary inspecting', pp.330-331.

¹⁰⁵ Leng's *Careers for Girls*, p.41; Armour, 'Sanitary inspecting', pp.330-331.

¹⁰⁶ Bannington, *English Public Health*, p.94.

¹⁰⁷ Coombe, 'Women and public health work', SJ (XXII, 1916-1917), p.167.

moral work of the health visitor it is merely a case of wasted energy and expense.¹⁰⁸

For one MOH, the woman inspector should attend to 'what might be called the domestic part of hygiene as distinguished from that part of hygiene which is more connected with sanitary appliances.' She should 'advise the woman of the house as to the way to keep the trapped gullies about the premises clean and the importance of doing so' and 'exercise her influence in persuading the housewife not to throw large quantities of vegetable and animal garbage into the dustbin'.¹⁰⁹ Some MOHs felt that the duties of a sanitary inspector relating to structural sanitation presented physical difficulties for women.¹¹⁰ Dr Wynter Blyth, however, argued that the frequency with which inspectors were required to climb ladders or get on roofs was exaggerated. Moreover, 'with the pastime of cycling, ladies had adopted a more convenient form of dress which enables them to do now a good many things which their clothes would hitherto have prevented them doing'.¹¹¹ There was also a fine distinction between structural and domestic hygiene, and the latter was not necessarily confined to the behaviour of housewives. Women inspectors often dealt with the white-washing, papering and cleansing of premises.¹¹²

On the other hand, women were seen as particularly well suited to overseeing domestic hygiene. Their skills were useful 'in private dwelling places where the inspector usually has to deal with the woman of the house', and where she 'can give advice and criticisms more suitably than a man'.¹¹³ Dudfield claimed that women paid very little attention to criticism by men of the details of household work.¹¹⁴ One woman inspector commented that

At first the women seem astonished to see a lady, for, as a rule, they have only had inspection visits from men. Most of them hail the change with delight, as they can open their hearts – and cupboards – much more easily to one of their own sex.¹¹⁵

One journalist, who accompanied one of St. Pancras's women sanitary inspectors on her rounds, reported the view of one housewife that,

¹⁰⁸ Griffin, 'Value of the health visitor in the anti-tuberculosis scheme', MO (XIX, 1918), pp.107-108.

¹⁰⁹ *Lancet* (4 Aug 1906), p.289. See also Cameron, 'Appointment of qualified women with special reference to the hygiene and feeding of infants', pp.65-67 in NCIM, *Proceedings* (1906).

¹¹⁰ SR (XVI, 1894-1895), p.1711.

¹¹¹ SR (XIX, 1896-1897), pp.98-100.

¹¹² See, for example, Sheffield: IDCPD, Minutes of Evidence (Cd. 2210, PP 1904 XXXII), p.312.

¹¹³ TNA: Memorial to the Borough Council of Stepney, c.1909 (PRO 30/69/1369).

¹¹⁴ SR (XXXI, 1903), p.545.

¹¹⁵ Armour, 'Sanitary inspecting', p.336

If we must 'ave somebody a-ferreting in our dust-bins and back-yards, we'd rather 'ave a lady, and she's a nice young lady too.¹¹⁶

Arguments of 'decency and delicacy' were applied to the home, as they were to the workshop. A male inspector was not able to go upstairs or inquire into the interior sanitary arrangements, as a woman might.¹¹⁷ *The Lancet* claimed that women were best suited to visiting women or children ill in bed. Such inspection should take place 'under conditions which do not tend to diminish those feelings of propriety and self-respect which it should be our object to encourage amongst the wives and daughters of the labouring classes.'¹¹⁸ The moral welfare of the poor was not *The Lancet's* only concern. It went on to say that it was intolerable that such services 'should be performed otherwise than by medical practitioners or by those whose sex specially fits them for the work.'¹¹⁹ Female sanitary inspectors were seen as less of a threat to the authority of the general practitioner. Women were particularly appropriate at the bedside, and might be more readily welcomed than a man for advice on home-nursing

CHANGING PRIORITIES

By 1908, a particular range of duties had been allocated to London's women sanitary inspectors, and a division of labour between them and their male colleagues had been defined. The arrival of the official health visitor, and changing priorities within local health departments, altered the picture.

Regulatory framework

There was a complicated regulatory and financial situation in the capital, which led to a strict official demarcation between the duties of women sanitary inspectors and health visitors. The central problem was the refusal of the Local Government Board (LGB) to sanction the appointment of women when the duties of the post fell outside the terms of the Sanitary Officer's (London) Order of 1891. The issue was a constant problem for the London County Council (LCC) and the metropolitan boroughs. Giving advice about infant welfare and domestic cleanliness was excluded from the recognised duties of inspectors, and LGB auditors refused to sanction expenditure for this work, so that women sanitary inspectors were officially prevented from taking on such duties.

¹¹⁶ Quoted in Inglis, 'Sanitary inspectors', p.8.

¹¹⁷ TSI (XXIV, 1903), p.311.

¹¹⁸ *Lancet* (8 Jun 1895), p.1443.

¹¹⁹ *Ibid.*

Southwark, for example, wanted to appoint an additional woman inspector to improve the 'general habits and cleanliness' of its inhabitants, and the feeding and management of their children.¹²⁰ The LGB, although it sympathised with the Vestry's desire to reduce infant mortality, decided that, since these duties were not covered by the 1891 Order, part of the salary could not be repaid from government funds. Considering the matter to be 'of urgent necessity', the Vestry determined to make the appointment of a 'Lady Sanitary Officer and Health Inspector', and itself to pay the entire salary.¹²¹ As demand for health visitors increased, this complicated situation became an increasing problem, and authorities resorted to the 'subterfuge' of appointing woman sanitary inspectors in areas of work which, although recognised as falling within the remit of sanitary inspectors, might be made to involve domestic hygiene and infant welfare.¹²² The LCC and the LGB were constantly investigating cases in order to ascertain what proportion of the duties undertaken by individual women were 'sanitary inspection' as opposed to 'health visiting', and there were calls for the system to be simplified.¹²³

Meanwhile, outside London,

MOHs, backed by their enterprising local authorities, had a wonderful gift for interpreting the "sanitary" measures allowed under the [1875 Public Health] Act, cheerfully running the risk of a challenge by the auditors.¹²⁴

Here, women were more often openly engaged in visiting to promote cleanliness, and give advice to mothers.¹²⁵ Areas on the fringes of London also began such work. In 1900, for example, West Ham employed two 'Health Visitors' for 'instructing and aiding the poorer inhabitants in the care and management of their houses', and in the 'management of children'.¹²⁶ The Central Bureau for the Employment of Women reported that, compared with London,

in the provinces the idea of preaching cleanliness and sound living has taken even greater hold. Whether such a complete supervision of the working people's lives – of their houses, their children, their food, their dress and of themselves – will be a good thing in the long run is not for us to comment upon here, we have only to record what is being done and to note its particular connection with the employment of educated women.¹²⁷

¹²⁰ *SIJ* (VI, 1900-1901), p.139-141; *SLS*: Vestry of St George the Martyr, report, Mar-Nov 1900, pp.15-16.

¹²¹ *SLS*: Vestry of St George the Martyr, report, Mar-Nov 1900, pp.15-16.

¹²² *SJ* (XV, 1909-1910), p.199.

¹²³ See, for example, *LMA*: LCC Public Health Committee, 13 Dec 1906, p.533 (*LCC/MIN/10,00*).

¹²⁴ *Rooff, Voluntary Societies*, p.33.

¹²⁵ *Greenwood*, 'Evolution of the health visitor', *JRSI* (XXXIV, 1913), p.175. See Chapter 2.

¹²⁶ West Ham MOH report, 1900, pp.23-27.

¹²⁷ *Women Inspectors* (CBEW, [1907]), p.18. Outside London, the employment of health visitors was also encouraged by the introduction of the school medical service, and regulations for the inspection of midwives, leading to posts that combined these functions.

Early health visiting in London

Southwark was not the only London authority to side-step the regulations and appoint a health visitor. Dudfield, directly influenced by developments in Birmingham, first attempted to gain support for an appointment in Kensington in 1900.¹²⁸ Unsuccessful, he employed women sanitary inspectors on investigations into infantile mortality, and used the results as further ammunition. It was not until 1904 that he was authorised to appoint, temporarily to begin with, a 'properly qualified woman to act in the capacity of "Heath Visitor" to circulate leaflets for the guidance of mothers with regard to the feeding, clothing, etc. of young children, and the management of the home'.¹²⁹ The whole of her salary was met from the local rate, an option not open to poorer boroughs.¹³⁰ In 1900 Limehouse Board of Works decided to appoint a health visitor 'to visit and instruct mothers in the proper rearing of infants'. The LGB refused to sanction the appointment, and Limehouse could not proceed if it had to bear the entire financial burden. It was only 'through the kindness of a well-known nobleman', that a health visitor was appointed to work in Limehouse Fields in 1903.¹³¹

The purity of the milk supply was a focus for concern in this period.¹³² The first milk depot in London was founded in Battersea in 1902. In addition to her regular duties, one of the Borough's women sanitary inspectors visited children fed from the depot. She monitored their progress, urged mothers to bring them for regular weighing, gave instruction about correct feeding methods, and examined home conditions.¹³³ For this work, in addition to her salary as a sanitary inspector, she received a special payment from the Borough.¹³⁴ In Finsbury, however, each child was visited in its own home once a week by volunteer 'lady visitors' supervised by a representative of the COS.¹³⁵

In addition to milk depots, voluntary infant welfare schemes developed rapidly. From 1902, Westminster Health Society organised a scheme of home visiting to give advice on the care and feeding of infants, childhood diseases and

Within London, these were the responsibility of the LCC, which employed its own nurses. *PH* (XXII, 1908-1909), p.166.

¹²⁸ K&C: Kensington Vestry, Works and Sanitary Committee, 10 Jul 1900, pp.290-291.

¹²⁹ Kensington MOH report, 1904, p.48.

¹³⁰ Greenwood, 'Evolution of the health visitor', *JRSI* (XXXIV, 1913), p.177.

¹³¹ Stepney MOH report, 1905, p.24.

¹³² McCleary, *Infantile Mortality*, p.71; McCleary, *Early History*, p. 70; Heath, *Infant*, p.153.

¹³³ McCleary, *Infantile Mortality*, pp.81-82, 125.

¹³⁴ LMA: LCC, Clerk's Department, Return of Sanitary Officers, 1904, pp.2-3 (LCC/PH/1/245).

tuberculosis, but it was after 1906 that 'infant welfare became not only popular but fashionable'.¹³⁶ The most prominent pioneers were the infant consultation established by St Marylebone Health Society in 1906 and the St. Pancras School for Mothers founded in 1907.¹³⁷ By 1910 most boroughs could call on the help of a more or less well-organised volunteer work force, and some voluntary organisations also began to employ qualified women as visitors and superintendents.

Notification of Births and LCC (General Powers) Acts

The employment of women for infant welfare work was encouraged by the 1907 Notification of Births Act, which provided for the notification to the MOH of the birth of every child within 36 hours.¹³⁸ In 1908 it was adopted in 16 London authorities.¹³⁹ The LGB refused to sanction its adoption, unless some provision was made for home visiting to advise mothers on infant feeding and care.¹⁴⁰ This clashed with the inability of London authorities to appoint such visitors, and led to the 1908 LCC (General Powers) Act. This enabled any sanitary authority in London to appoint health visitors, and the Council to repay up to half their salaries. The LGB had to sanction each appointment and, in September 1909, issued an Order setting out qualifications, duties and terms of appointment. This created a separate class of official to undertake health-visiting work in London, with different qualifications and subject to different LGB regulations, than those applied to women sanitary inspectors. The women inspectors campaigned against this development. According to one, the effect of the 1908 Act was 'the almost complete cessation of the appointment of women sanitary inspectors', and the lapsing of existing appointments, their duties, such as workshop inspection reverting into the hands of male inspectors.¹⁴¹

Tuberculosis

Infant welfare was not the only area of growth. Between 1908 and 1913, successive regulations extended the system of tuberculosis notification, until all

¹³⁵ Newman, 'Special report on the Infants' Milk Depot' (Metropolitan Borough of Finsbury, 1905)

¹³⁶ McCleary, *Early History*, pp.112-134.

¹³⁷ *Ibid.*, pp.117-126; McCleary, *Maternity and Child Welfare*, pp.40-41; Rooff, *Voluntary Societies*, pp.37-39; Churchill, *Health Services*, p.22; Wellcome: Eric Pritchard, 'Harley Street Calling: some reminiscences of a medical man' (GC/49); Bunting et al, *School for Mothers*.

¹³⁸ McCleary, *Maternity and Child Welfare*, p.25

¹³⁹ *Lancet* (29 Jan 1910), p.326.

¹⁴⁰ Dundas, 'How to become a health visitor', *NH* (III, 1911), pp.120-121.

¹⁴¹ Greenwood, 'Evolution of the health visitor', *JRSI* (XXXIV, 1913), p.179.

cases of pulmonary tuberculosis became compulsorily notifiable, and local authorities were given powers for prevention and treatment. Efforts were centred around the establishment of tuberculosis dispensaries, modelled on R.W. Philip's famous enterprise in Edinburgh.¹⁴² The first tuberculosis dispensary in London was established as a voluntary undertaking in Paddington in 1909. Its main function was as a 'clearing house' for examining patients, selecting cases for treatment, supervising of home conditions and co-operating with charitable agencies.¹⁴³ By 1911, all but three of London's boroughs had use of a tuberculosis dispensary, or were on the way to doing so.¹⁴⁴ This caused a demand for women dispensary nurses and tuberculosis visitors in both the voluntary and municipal sectors.

A key role of dispensary staff was to carry out home visiting. At the Paddington Dispensary, for example, a nurse visited each patient and completed a 'careful register of its hygienic and economic conditions'. She also gave advice on the distribution of sleeping accommodation, and the best methods to prevent the disease.¹⁴⁵ She ascertained whether any other members of the household might be suspected cases and made arrangements for their examination. There was, reportedly, very little overlapping with the work of local health departments, although in many areas, patients were still supervised by the borough health visitors or sanitary inspectors.¹⁴⁶ Arrangements varied. Special nurses or visitors might visit dispensary cases, while a general health or tuberculosis visitor took cases not attending the dispensary, a male sanitary inspector sometimes dealing with male cases. A general health visitor might take tuberculosis cases for her district, or there might be a special tuberculosis visitor for the whole borough.¹⁴⁷

The dispensary also acted as a hub from which cases were referred to other agencies, something that was later elaborated into a system of tuberculosis care committees spanning the capital. Women officers, many with training and experience

¹⁴² Philip, 'Organization of the home treatment of pulmonary tuberculosis', *BMJ* (11 Jun 1904).

¹⁴³ *Lancet* (26 Mar 1910), p.880; *BMJ* (7 Oct 1011), p.866; Williamson, 'Dispensaries for the prevention and treatment of consumption', *JRSI* (XXXIII, 1912).

¹⁴⁴ MO (V, 1911), p.309. For an account of the foundation of the early dispensaries see LCC MOH report, 1919, p.10.

¹⁴⁵ *Lancet* (26 Mar 1910), p.867; Williamson, 'Complete anti-tuberculosis organization for London', *PH* (XXII, 1909-1910), pp.390-404.

¹⁴⁶ LCC MOH report, 1918, pp.18-19. In Kensington, for example, when a patient was placed on the visiting list of the dispensary nurses, they were removed from that of the borough's women sanitary inspectors – Kensington MOH report, 1920, p.21. See also Reid, 'The sanitary inspector and tuberculosis prevention', *SJ* (XIX, 1913-1914), p.273.

¹⁴⁷ Armitage, *Health Visiting*, p.280; Eve, *Manual*, pp.153-154.

in personal social work, were considered particularly suited to play a part in this work. The tuberculosis visitor was usually an ex-officio member of the care committee.¹⁴⁸

Effect on woman sanitary inspectors

Did these new priorities cause the 'demise of the woman sanitary inspector', as was feared? Responses varied. Some boroughs that had wished to appoint health visitors prior to 1908, and had been discouraged by the regulations, lost no time when the rules changed. Bethnal Green, for example, relieved its woman sanitary inspector of all her duties in connection with workshops and out-workers, and she was directed, instead, to concentrate her efforts upon visiting under the Notification of Births Act.¹⁴⁹ In some areas health visitors were the first women to be appointed to the staff. In many, however, health or tuberculosis visitors were appointed in addition to, and not at the expense of, woman sanitary inspectors, although the latter often relinquished their infant welfare work.

In 1910 the WLGS undertook an inquiry into health visiting in the capital. It found 56 women officials in total. Eighteen of these were qualified and appointed as sanitary inspectors, and worked solely on duties under the 1891 Order. Fourteen were qualified and appointed as sanitary inspectors, but were also employed part-time as health visitors. Ten were qualified as sanitary inspectors, held a dual appointment and were employed in mixed work. Six were qualified as sanitary inspectors, but were appointed and employed solely as health visitors. Only eight women employed as health visitors were not also qualified sanitary inspectors.¹⁵⁰ In 1912, the register of the WSIA revealed that only a quarter of its members, who were qualified as sanitary inspectors, were 'debarred from the nature of their appointment' from working as such. One third of women inspectors were employed inspecting workshops, laundries, out-workers' premises, public conveniences, restaurant kitchens, houses let in lodgings and similar duties, to the exclusion of all other work. The remainder carried out work in connection with the Notification of Births Act in addition to, but not in substitution for, these other duties.¹⁵¹ Thus, although there was considerable support for the idea of the new officer, there was not an immediate rush to replace all women sanitary inspectors with health visitors and, in 1912, there were 31 women sanitary inspectors, 16 health visitors, and ten women holding joint positions, in the capital, a small decline from the 1907-1910 peak (see Fig. 1).

¹⁴⁸ Meacher, *Tuberculosis*, p.66.

¹⁴⁹ Bethnal Green MOH report, 1910, p.27

¹⁵⁰ WLGS report, Mar 1911, p.22.

¹⁵¹ SR (L, 1912), p.414.

Rise of the health visitor

After a perusal of the 1910 MOH annual reports, the LGB concluded that 17 London boroughs had made 'more or less satisfactory appointments under the Health Visitor's Order'. In eight others, health visiting was being done by women sanitary inspectors.¹⁵² The appointment of health visitors remained optional, and the LGB did not have the same powers it possessed with regard to sanitary inspectors, in order to force a sufficient number of officers to be appointed. It did, however, throw its weight behind their appointment, concentrating its efforts on the handful of boroughs that remained opposed. These included Southwark, where Councillors in 1912 argued that the Borough's inhabitants were 'for the most part respectable citizens' and,

Married women objected to the visits of the health visitors, they knew how to bring up their children without the interference of young women ... they did not wish to be persecuted by this class of official.¹⁵³

'Recalcitrant Islington' was also taken to task.¹⁵⁴ Here, the Council thought that,

having regard to the moral and economic conditions which lie at the root of infantile mortality, the appointment of health visitors is an ineffective palliative and does not provide a remedy for the evil, which can best be dealt with by philanthropic effort rather than by administrative action.¹⁵⁵

Camberwell refused to appoint health visitors

on the ground that these would have no power to help in cases where insufficient and unsuitable food is due to poverty, and no power to punish parents who neglect the advice given.¹⁵⁶

Although the few lone voices that objected on political or ideological grounds were increasingly embattled, limitations on the financial support available for health visiting persisted. In theory, the 1908 regulations enabled authorities to reclaim half the cost of their health visitors from the LCC. In practice, in 1910, 'owing to the small and rapidly sinking surplus on the Exchequer Contribution Account', the Council attached certain conditions to such contributions.¹⁵⁷ They were to be for one year only, and dependent upon sufficient surplus after payments for the salaries of

¹⁵² *Ibid.*

¹⁵³ TNA: Conference with representatives of the Council to discuss unsatisfactory situation re female sanitary staff and health visitors in Southwark, 12 Mar 1912 (MH 48/165); Local Government Board, Local Authority Correspondence: Southwark (MH 48/165).

¹⁵⁴ MO (XVIII, 1917), p.183.

¹⁵⁵ MO (XVI, 1916), p.265; TNA: Letter from Islington Borough Council, 7 Sep 1916 (MH 48/163).

¹⁵⁶ TNA: Resolution of Camberwell Borough Council, 11 Oct 1911 (MH 48/161).

¹⁵⁷ SR (XLV, 1910), p.453.

sanitary inspectors.¹⁵⁸ Under these circumstances, grants were paid in 1909-1910 and 1913-1914.¹⁵⁹ No grants were paid in the intervening years. The irony of this situation was not lost on one woman sanitary inspector, who commented that

in the case of London, the question of the name and status of health visitor was largely determined by £ s. d., though, as a matter of a fact, the salaries of health visitors were very soon afterwards paid entirely out of the local rate, as the exchequer contribution account was completely depleted.¹⁶⁰

Despite these financial difficulties, by the First World War almost every London borough had appointed at least one health visitor. In 1916, Islington's MOH tried to shame his Council into action by declaring that 'Islington stands entirely alone in lack of health visitors' and 'that in the whole country there is only Camberwell that in any way touches it'.¹⁶¹ Indeed, among the 111 metropolitan and county boroughs in England and Wales there were less than ten in which the local authority had not appointed a staff of health visitors, and Islington was by far the largest of these in terms of population.¹⁶² By 1917, 'Camberwell's Non-conformity' was the subject of great attention. It was labelled as 'even more obdurate than Islington', and as having 'the unenviable distinction of being the only metropolitan borough which has not yet made such an appointment'.¹⁶³

Voluntary effort in relation to infantile welfare work also continued to grow apace. By 1912 there were 61 infant consultations or schools for mothers, 21 of these being in London. Between them they had the services of 389 visitors, of which around 300 were voluntary workers, although the professional staff did the most visiting.¹⁶⁴ As well as basic consultation and visiting work, such organisations had varied programmes of lectures, home helps, sewing and cookery classes, and mothercraft competitions. Out of 80 infant welfare centres in 1913, only 25% had no salaried officers, and 35% had more than one. 10% had less than five voluntary workers, and 30% had more than 20.¹⁶⁵ By the end of 1914 there were 155 'professional visitors' and 702 voluntary workers attached to infant consultations and schools for mothers.¹⁶⁶

¹⁵⁸ LCC MOH report, 1910, p.88.

¹⁵⁹ LCC annual report on public health, 1914, p.146.

¹⁶⁰ Greenwood, 'Evolution of the health visitor', *NT* (17 Feb 1917), pp.186-188.

¹⁶¹ TNA: LGB, Local Authority Correspondence: Islington (MH 48/163).

¹⁶² *Daily Telegraph* (17 Jun 1916).

¹⁶³ MO (XVII, 1917), p.26, 192 & (XVIII, 1917), p.183.

¹⁶⁴ NH (IV, 1913), p.183.

¹⁶⁵ Gibbon, *Infant Welfare*, pp.14, 28.

¹⁶⁶ NH (VI, 1915), p.198.

THE FIRST WORLD WAR

The Home Front

By July 1916, 53 of London's male sanitary inspectors, for whom no substitutes had been engaged, were on war service, causing a depletion of staff by 16%.¹⁶⁷ It remained theoretically possible for fully-qualified women to perform all the duties of male inspectors, causing Mrs Greenwood to comment in 1915 that she had seen 'the somewhat unusual advertisement for a "Sanitary Inspector, male or female".'¹⁶⁸ If male substitutes could not be found, rather than suggesting the appointment of women sanitary inspectors, however, the LCC recommended the appointment of additional health visitors. In four of the boroughs 'improvement was made', by such appointments and in Fulham a male sanitary inspector was replaced by a woman.¹⁶⁹ The matter was not, however, widely discussed. Whereas the journal of the Sanitary Inspectors Association debated the appointment of unqualified and volunteer workers being appointed during the War, there was no real discussion about the use of women as substitutes.¹⁷⁰ It seems that they were not viewed as a real threat or widely used to undertake work normally delegated to men. At one army recruiting tribunal, for example, the MOH applied for the exemption of an inspector on the grounds that his duties were 'urgent sanitary work'. He stated that

the inspector could not be replaced by a woman. The work was of a character that a woman could not undertake, and he would not permit a woman to do it, even if the man had to go.¹⁷¹

In 1915 the WSIA felt that a recent piece in *The Times*, suggesting public health as suitable war work for women, was misleading, as competition for posts remained keen.¹⁷² Although numbers of men coming forward for training fell, women candidates for the examinations increased.¹⁷³ The WSIA stated that 'more or less efficient substitutes had been found' for those on war work, but an increase in infant welfare work during the war caused shortages.¹⁷⁴ A measles epidemic in 1917 put pressure on public health departments, some of which appointed additional women specifically for this work. The burden of factory, workshop and out-worker inspection also increased in some districts. In October 1914, for example, Edmonton's MOH

¹⁶⁷ LCC MOH report 1915, p.1; 1916, pp.14-15.

¹⁶⁸ Greenwood, 'Women sanitary inspectors: their position and work', *Women's Employment* (XV, 1915), p.4.

¹⁶⁹ Fulham, MOH report, 1915, p.49.

¹⁷⁰ SJ (XX, 1914-1915), p.71 & (XXIII, 1917-1918), p.55.

¹⁷¹ MO (XVI, Jul-Dec 1916), p.257.

¹⁷² Wellcome: WSIA Executive, 25 Jan 1915 (SA/HVA/B.2/6).

¹⁷³ JRSI (XXXVIII, 1917), Supplement, p.21.

received lists of over 350 women who were receiving work at home from a Tottenham-based firm that held a government contract for the manufacture of kit-bags and bed-ticks for soldiers. Many of the out-workers had never undertaken this type of work before, and were not on any of the registers. This 'sudden and huge' increase of out-workers led to the appointment of an additional temporary woman inspector in that year.¹⁷⁵

Overseas

While the absence of male inspectors seems to have had little impact on perceptions of what was 'suitable' public health work for women at home, some women sanitary inspectors and health visitors themselves volunteered for nursing service overseas.¹⁷⁶ Although nursing was an option for both inspectors and visitors, some women sanitary inspectors undertook more unusual roles. Several found places with Mrs Sinclair Stobart's all-women medical units. Mrs Stobart was determined to demonstrate the 'capacity of women to take a useful share in national defence', and to suffer the hardships of war. She wrote of the need for 'proof of women's national worthiness' and of her 'secretly-held belief' that, in helping women to take a share in national defence, she was 'working none the less effectively for the goal of women's enfranchisement'.¹⁷⁷ Women sanitary inspectors who chose to serve in her units may have thought likewise.

In September 1914, a unit of women doctors, nurses, orderlies, interpreters and secretaries, organised by Mrs Stobart, arrived in Antwerp to convert a concert hall into a hospital.¹⁷⁸ Miss Dick, one of Westminster's sanitary inspectors, was attached to the hospital.¹⁷⁹ On her return she wrote that 'it fell to my lot to carry a small pioneer banner for my profession in the present war'.¹⁸⁰ She felt that

As women in war-time are generally tolerated solely in the capacity of nurses, the successful experiment of an all-woman hospital staff with women orderlies is particularly significant.¹⁸¹

¹⁷⁴ Wellcome: WSI&HVA Executive, 14 Sep 1917 (SA/HVA/B.2/7).

¹⁷⁵ Edmonton MOH report, 1914, pp.30, 85.

¹⁷⁶ See, for example, *NH* (VIII, 1916), pp.232-3, (IX, 1916), pp.30, 66; Wellcome: WSIA annual report, 1914-1915, pp.18-19 (SA/HVA/A.1/8); WSIA minutes, 3 Jan 1917, p.32 (SA/HVA/B.1/6); Kensington, MOH report, 1915.

¹⁷⁷ Stobart, *Miracles*, p.83. The anti-suffrage argument, that only those who physically defended the state should be entitled to vote, was often countered by the image of the military nurse. See Summers, 'Angels and citizens', p.26. The response of suffrage supporters to the concept of 'patriotic duty' was, however, not uniform, Rowbotham, *Century*, p.68.

¹⁷⁸ Stobart, *Miracles*, p.166.

¹⁷⁹ *NH* (VIII, 1916), p.232-3; Wellcome: WSIA annual report, 1914-1915, pp.18-19 (SA/HVA/A.1/8); Dick, 'Woman sanitary aide-de-camp', pp.142-145.

¹⁸⁰ Dick, 'Woman sanitary aide-de-camp', pp.142-145.

¹⁸¹ *Ibid.*

The hall was already fitted with baths, basins, sanitary accommodation and a water supply, although some rooms were infested with vermin. One of Miss Dick's first duties 'was to arrange for the efficient extermination of these undesirable tenants'.¹⁸² After this, she arranged for the disposal of kitchen waste and refuse, before turning to the more serious problem of the disposal of hospital dressings from the wards and operating theatres – 'The achievement of a suitable incinerator was a matter of some consideration.' An old iron stove was converted, 'with a little inventiveness and some wire netting for drying-grids'.¹⁸³ Miss Dick faced her most serious challenge when one of the pumping stations of the Antwerp waterworks was destroyed by enemy shelling. Many houses in Antwerp possessed deep wells and rainwater pumps 'so we were able to obtain water by dint of some enterprise and much exertion'.¹⁸⁴ When the bombardment of the city began in earnest, the patients were moved to the cellars.

The difficulties encountered in the endeavour to keep these unusual hospital wards in a proper sanitary condition may be better imagined than described. A very free use of disinfectants and deodorants was of course necessary.¹⁸⁵

At the end of three weeks the hospital was evacuated.

In November 1914 Mrs Stobart organised a similar unit, which went to Cherbourg, at the invitation of the French Red Cross, to convert a chateau into a hospital for French and Belgian wounded. This time, it was Miss Davies of Lambeth who served as Sanitary Officer.¹⁸⁶ Mrs Stobart was later to recall that the chateau was 'extremely picturesque in appearance' but 'any building less suitable for hospital purposes would have been hard to find'.¹⁸⁷ Sanitation posed a particular challenge, as water was laid on to the ground floor only, and the plumbing arrangements so primitive that Miss Davies decided to use the existing sanitary conveniences for liquids only. A pail system was introduced for other waste, which was then emptied into specially-dug trenches.¹⁸⁸ This hospital was also disbanded in April 1915.

Two women public health officers served with Mrs Stobart's hospital camp at Kragujevatz in Serbia. Miss Kerr of East Ham was Sanitary Officer.¹⁸⁹ Mrs Stobart

¹⁸² *Ibid.*

¹⁸³ *Ibid.*

¹⁸⁴ *Ibid.*

¹⁸⁵ *Ibid.*

¹⁸⁶ Mrs Stobart was later to write that Miss Kerr had been sanitary officer, but other evidence points to the presence of Miss Davies: *NH* (VIII, 1916), pp.232-3; Wellcome: WSIA annual report, 1914-1915, pp.18-19 (SA/HVA/A.1/8) and 'Note by M.F. Lucas Keene on her short visit to Mrs Sinclair-Stobart's Unit under the French Red Cross, 1914' (SA/MWF/C.169).

¹⁸⁷ Stobart, *Miracles*, p.179.

¹⁸⁸ *NH* (VIII, 1916), pp.232-3

¹⁸⁹ *NH* (VIII, 1916), pp.232-3, (IX, 1916), p.30; Wellcome: WSIA annual report, 1914-1915, p.18-19 (SA/HVA/A.1/8).

remembered how her sanitary schemes were 'the subject of interested and invariably of favourable criticism' –

the camp was said to be a model in outdoor sanitation, not only by the local authorities, who sent up men to make plans of the arrangements but by ... British and American experts who inspected it.¹⁹⁰

Miss Kerr reported that 'the air was delightfully fresh and the view charming, but the absence of a water supply, and the porous nature of the soil were serious disadvantages.'¹⁹¹ She contrived a system to cope with open-air sanitation on a fixed spot for more than 200 people. She organised a system of biscuit-tins with holes drilled in the bottom to strain water that could not soak into the ground, and had to be removed by pumping; secured a water supply in carts drawn by oxen; and devised elaborate precautions against typhus and typhoid.

Her colleague, Miss Newhall, left diaries of her experiences. She served at Kragujevatz in 1915 and then as a sanitary inspector with the Serbian Relief Fund, 1915-1919, in charge of the sanitary arrangements in one hospital camp after another, as she retreated with the Serbian army.¹⁹² In 1920 the Royal Sanitary Institute received a letter from the Fund in appreciation of her work. In one hospital she took over a building

which was in an unspeakable state of dirt and confusion after it had been in the hands of the enemy, and by her wonderful energy and great technical skill, in a short time Miss Newhall with her Serbian and Bulgarian orderlies was able to convert this disorder into a centre of cleanliness and comfort for her patients.¹⁹³

The Fund concluded that she had performed work that it was difficult to believe any woman could do, and praised her spirit, courage and professional knowledge. The work and conditions were gruelling and involved digging trenches, bucketing and sewage work, undertaking the drainage work for kitchens and bathrooms, and endless disinfection and incineration, amidst a background of appalling weather, endless shelling and outbreaks of disease. Entries in her diary give a flavour of her duties: 'Killed millions of bugs' (16 January 1919); 'Very heavy day, bucketing sewage' (3 November 1918); 'Someone put bullets in my incinerator. I nearly got shot' (3 March 1918); and 'Cleaned out filthy sewers and sprayed [with disinfectant] all day' (6 November 1918).¹⁹⁴

¹⁹⁰ Stobart, *Flaming Sword*, pp.26, 49; Stobart, *Miracles*, pp.188, 197.

¹⁹¹ NH (VIII, 1916), pp.232-3.

¹⁹² Wellcome: 'Diary of a Trekker in Serbia', Apr-Dec 1915 (GC/165/1); Manuscript diary 'year by year', while serving with Serbian Relief Fund units in Corfu, Salonika, Sorovic and Monastir, 1916-1919 (GC/165/1).

¹⁹³ RSPH: RSI Council minutes, Jan 1920, pp.118-119.

¹⁹⁴ Wellcome: 'Diary of a Trekker in Serbia', Apr-Dec 1915 (GC/165/1); Manuscript diary 'year by year', 1916-1919 (GC/165/1).

Leah Leneman has recently written that

During the First World War there really was nothing a woman doctor could not do in the war zone. They treated virtually every kind of wound and disease, they underwent the same hardships, privations and dangers as men, became prisoners of war, took part in devastating retreats, and worked under shells and bombs.¹⁹⁵

The same applied to women sanitary inspectors. Denied during peacetime the power to oversee sewage and drainage works, disinfection or incineration, they were able to demonstrate their skills and abilities for this type of work, as well as to suffer the hardships of life at the Front. After their return it was a rather different picture.

Post-war prospects

Enid Orange wrote in 1919 that

The present prospects of the woman sanitary inspector are not very hopeful. There are comparatively few appointments held in London or elsewhere by women sanitary inspectors who are not also health visitors ... It is, therefore, no longer practicable to consider taking up the work.¹⁹⁶

In the same year, the London Society for Women's Service (LSWS) observed that 'posts for Women Sanitary Inspectors *only* are few and far between'.¹⁹⁷ The immediate post-war period may not have been the most promising climate in which to extend the role of women. The supply of male sanitary inspectors exceeded demand, and ex-servicemen, who trained in large numbers in the early 1920s, complained of not being able to secure posts.¹⁹⁸

By contrast, there was a large increase in demand for health visitors. The impact of the First World War on the maternity and child welfare movement has been well chronicled, both by contemporaries and later historians.¹⁹⁹ A series of measures, notably the Notification of Births Extension Act (1915), which made notification compulsory, and the Maternity and Child Welfare Act (1918), focused attention on this area. In 1914 there were 600 health visitors in the country. By 1918 this had risen to 2,577 (including district nurses carrying out health visiting) and an additional 320 salaried health visitors employed by voluntary agencies. This amounted to a total of 1,355 full-time health visitors.²⁰⁰ The number of maternity and child welfare centres

¹⁹⁵ Leneman, 'Medical women at war', p.177.

¹⁹⁶ *Careers* (CBEW, 1919), p.90.

¹⁹⁷ TWL: LSWS memorandum on 'openings and trainings for women' (2/LSW/326).

¹⁹⁸ *ME* (LXX, 1922), p.250.

¹⁹⁹ See, for example, McCleary, *Maternity and Child Welfare*; Dwork, *War is Good*.

²⁰⁰ McCleary, *Maternity and Child Welfare*, pp.17-18.

also grew from 650 in 1915 to 1,278 in 1918.²⁰¹ By 1919 there were 195 maternity and child welfare centres in London alone, 154 of which were voluntary centres.²⁰²

CONCLUSION

By 1905 London local authorities employed women sanitary inspectors for a range of duties. They inspected places where women were employed, such as workshops, offices and restaurants. They also oversaw domestic hygiene and housekeeping practices in the homes of out-workers, tuberculosis sufferers, where there was the death of an infant from epidemic diarrhoea, or a case of common childhood disease, like measles or whooping-cough. There was increasing pressure for their work to be extended to routine visiting after birth. Initially, government funds could not be spent in this way, although voluntary activity in the area grew. In 1908 a separate class of official, the health visitor, was recognised for this purpose. From this date, the appointment of women sanitary inspectors fell away, as some of their duties relating to infant welfare, infectious disease and domestic hygiene, were taken up instead by health visitors.. The First World War saw an explosion in demand for maternity and child welfare workers, although duties relating both to tuberculosis, and childhood infectious diseases, remained important. It was not, however, simply a case of the replacement of inspectors by visitors. Many held joint appointments. Others continued as women sanitary inspectors, concentrating on workshop and out-worker inspection, and with other duties relating to tuberculosis and infectious disease overlapping with those of health visitors, patterns of work differing from borough to borough. By the 1920s, however, they were a small and specialised group, in departments that had vastly expanded their activities and their female staff.

²⁰¹ *Ibid.*

²⁰² NH (XII, 1919), p.143.

4: BACKGROUND AND CHARACTER

The 'ideal health visitor', it was argued, was 'to be found in *being* far more than in *doing*', and was 'born, not made'.¹ As one woman inspector put it, 'Although definite knowledge on certain subjects is of absolute importance, yet of far greater importance is that the women engaged upon the work should possess the right *personality*'.² This chapter will examine which women were considered to be of the 'right type' for public health work. It will begin by exploring the background of those entering the occupation, in terms of social status, education, age and experience. It will then examine some of the personal qualities that such women were assumed to possess, or encouraged to develop.

SOCIAL BACKGROUND

'Good social standing'

The first essential characteristic was possession of a certain social status. 'Lady health visitors' were to be drawn 'from the families of those who have a recognised professional or mercantile position in the town', but the best visitor was not necessarily from the highest social class.³ Woolwich's MOH thought that

by using the term lady they did not necessarily mean of a high rank in society, but they meant a person of ladylike manners and of some refinement.⁴

For another commentator, she should be

a woman sufficiently above those amongst whom she works as to be unconscious to a great extent of class difference and able to hold intercourse with the poorest classes without condescension, having that sort of easy dignity which permits a woman to talk to her fellow women simply from the womanly standpoint without regard to class, education, birth, or income.⁵

One woman inspector wrote that, 'public health work of whatever sort consists mainly in trying to make people do what, if left to themselves, they would not do; they have to be *dealt with*' (her emphasis).⁶ For her, this required characteristics most often found in 'a class which has always been accustomed to exercise a certain amount of authority over others', but without condescension. A woman official should be able to deal effectively, not only

¹ Skene, *Ideal Health Visitor*, p.14; Griffin, 'Value of the health visitor in the anti-tuberculosis scheme', MO (XIX, Jan-Jul 1918), p.157; Underwood, *Manual*, pp.252-253.

² Maynard, *Women in the Public Health Service*. p.6.

³ Evans, 'Essential qualifications of a lady health visitor', *JRSI* (XXIV, 1903) p.306.

⁴ NCIM, *Proceedings* (1906), p.80.

⁵ Evans, 'Essential qualifications', p.306

with the working classes, with tradesmen and with manufacturers, but also with voluntary workers of often high social standing, and she may find herself in frequent difficulties if she is wanting in that *savoir faire* which opportunities of social intercourse, of refinement, and of discipline alone can give.⁷

It was assumed that the natural recruiting ground for such women was the solid middle-classes.

By contrast, when working women's organisations first sought the appointment of women factory inspectors, they requested factory-women who 'from practical experience will know what sort of abuses are likely to exist and how to detect them'.⁸ Social reformers had different ideas. Lady Dilke complained that factory-women were 'utterly lacking in tact, discretion, power of self-control, knowledge of how to take the initiative or to organise or to grapple on their own responsibility with work – and no power of reporting or office work'.⁹ Such views won the day. When the first women factory inspectors were appointed, they were from the same class as the reformers themselves.¹⁰ The original health visitors appointed by the MSSA were working women. When they were brought under the control of the City Corporation, its Sanitary Committee was 'very critical as to the quality of the workers transferred'.¹¹ Manchester's MOH remarked that, since the Association employed visitors from the class whom they were to help, 'the work was therefore very unequal in character'.¹² Another commentator thought that, although good work was done in Manchester, 'experience goes generally to prove that the better qualified women do the best work and are more readily accepted by the poor'.¹³ Several witnesses to the Inter-departmental Committee on Physical Deterioration, although generally supportive of the MSSA, felt that it did not have 'quite the right kind' of visitor. Its lady supervisors were also accused of being untrained, 'over-charitable' and 'over fussy' by one of the Society's own officers.¹⁴ When the Corporation took over the activities of the MSSA, it felt that it would be 'ungracious' to dispense immediately with the services of the existing workers, but the character of the staff

⁶ Maynard, *Women in the Public Health Service*, p.6-7.

⁷ *Ibid.*

⁸ TNA: London Women's Trades Council to Home Office, 14 March 1890 (HO45/9818/B8031).

⁹ LSE: Lucy Deane's diary, 3 Jan 1894 (Streatfield 1/2).

¹⁰ Martindale, *Some Victorian Portraits*; McFeely, *Lady Inspectors*, p.47-48; Jones, 'Women health workers', p.173; Harrison, *Not Only*, p.187.

¹¹ Niven, *Observations*, p.185.

¹² *Ibid.*, p.183.

¹³ Evans, 'Some suggestions as to the better feeding of infants', *JSI* (XXXVII, 1906) p.732

¹⁴ IDCPD Minutes of Evidence (Cd. 2210, PP 1904 XXXII). See, for example, evidence of B Seebohm Rowntree, pp.201-209, Mrs Watt Smyth, pp.57-59 and Mrs B Worthington, p.285.

gradually changed, becoming 'more professional and skilled'.¹⁵ It had run up against both the medical profession and elected officials, whose opinions were similar to those voiced by Lady Dilke.

Warwickshire's MOH concluded that 'the Girton girl or educated woman was much better fitted for the work and gained easier entry into the houses ... than the type of woman trained from among themselves [the mothers]'.¹⁶ In Sheffield, the lady sanitary inspector had some assistants who were 'women of the lower middle class', several of whom had only a Board school education. She felt that they did not have the necessary 'weight and influence' with the mothers, who were quick to 'appreciate the difference', and took advice better from 'a lady'.¹⁷ Birmingham's MOH declared that 'the more of a lady the health visitor was in refinement and education, the more influence she would have among the people whom she visited'.¹⁸ Norwich's MOH felt that they had got just the right type of woman as an inspector, as she was 'well-bred' and 'whatever else she was she was a lady'.¹⁹

London's early women public health officers

Entry to salaried local authority posts was controlled by a number of factors. Officers were generally chosen by the sanitary committee, and then appeared before the full council, while MOHs had varying degrees of influence. If they were eligible for funding from the Exchequer, appointments were also subject to approval by the LGB, and the candidate had to be qualified according to the regulations. Some training institutions also selected by interview, where personality and social background were judged. What type of women made it through these selection procedures to become London's women sanitary inspectors and health visitors? It is difficult to establish the backgrounds of the women, other than of those who had noteworthy careers. They may not be typical, but there are some characteristics that were shared, to a greater or lesser degree, by other women entering public health work. London's first two women sanitary inspectors were Lucy Deane and Rose Squire, appointed in Kensington in 1893.

Lucy Deane was the daughter of Col. Bonar Millett Deane, son of the Rector of Brighton, and of Lucy Boscowan, whose father was Canon of Canterbury.²⁰ Lucy

¹⁵ Niven, *Observations*, p.187.

¹⁶ NCIM, *Proceedings* (1906), p.79.

¹⁷ IDCPD, Minutes of Evidence (Cd. 2210, PP 1904 XXXII), p.315.

¹⁸ JSI (XIV, 1903) p.311

¹⁹ *Ibid.* p.317

²⁰ LSE: Lucy Deane, biographical file (Streatfeild 4/1); TUC: Lucy Deane Streatfeild, ts biography (Gertrude Tuckwell Collection, Section G).

was born into a family with strong Church of England and philanthropic connections. Her father regularly visited the poor in East London, and Lucy spent time with the High Anglican Clewer Sisters in Westminster. Col Deane was killed in 1881, attacking a Boer position. When her mother died some years later, Lucy and her sister were left with only a small private income and faced the necessity of paid employment. Lucy's diaries reveal constant worries about eking out their 'allowance'.

²¹ Rose Squire was the daughter of William Squire, a Harley Street doctor. Her brother, J. Edward Squire, was also a medical man. We can learn much of Rose's childhood from the recollections of her sister, Agnes.²² The family lived in Orchard Street, went for twice daily walks in Hyde Park, and attended the Anglican Quebec Chapel. The girls watched London street life from behind the nursery windows, but were never allowed to go out unless they were accompanied. They sometimes visited their father's illustrious patients, including Lord Cardigan, from whom they heard stories about the Charge of the Light Brigade. More often, they attended functions at the College of Surgeons, and socialised with young doctors. The girls were educated at home by a governess, were taught how to curtsey, how to enter and leave a room properly, and not to slouch. Rose later remembered that

It was not in my girlhood expected that daughters of professional men would take up a career. Indeed there was very little opening for them if need to earn a living arose except teaching for the highly educated, and the dreadful dullness of a "companion's" lot for the incompetent. We took it for granted that while our brothers went to public school and University we had governesses in various subjects at home.²³

She rather elliptically referred to the reasons why she needed to seek paid work, saying, 'but changes come into the most secure and sheltered lives and at thirty-two I was seeking a career and livelihood.'²⁴ These women were both the daughters of professional men, and of a class that was thought to carry with it the 'easy authority' and social skills required. Had it not been for a family emergency, neither would have been required to seek her own living.

How typical were Deane and Squire of those that followed? Of those women sanitary inspectors who trained at Bedford College between 1895 and 1919, two were the daughters of doctors, and two of clergymen. The fathers of the others numbered a dyer, a high court judge, a farmer, a solicitor, the principal of a technical

²¹ See LSE: Lucy Deane's diary, *passim* (Streatfeild, 1/1-4). Lucy's sister, Hyacinthe, became an Inspector of Domestic Science and campaigned for better pay and conditions for domestic science teachers.

²² Brotherton: Agnes Mary Christy, 'Some recollections of my young days' (MS 973/11).

²³ Squire, *Thirty Years*, p.17.

²⁴ *Ibid.*, p.18. By the time that she sat the examination of the Sanitary Institute in 1894, she was living in Ealing, rather than Orchard Street. See, TNA: SIEB papers (MH26/2/214).

college, a journalist and a master at Rugby school.²⁵ Florence Lovibond, who later worked as a sanitary inspector in Holborn, was born into a famous brewing family. She had studied science at Bedford, before becoming a sanitary inspector.²⁶ The training at Bedford was available only to those with significant resources and a high level of previous education.²⁷ It seems, however, that even those who did not, or could not, afford this, were drawn from similar backgrounds. Nora de Chaumont, a sanitary inspector in Kensington from 1896, took the cheaper Sanitary Institute training, studying alongside Rose Squire. She was the daughter of a prominent army surgeon, who was also closely involved with the Institute.²⁸ Lizzie O'Kell was also the daughter of a medical man, and attended lectures at Queen's College. Although she won a scholarship, she was unable to take it up, due to her father's death, and instead accepted a clerical post, to support her mother and herself while she qualified as a sanitary inspector.²⁹ Family connections with medicine or social work are notable in all these early examples. Mrs Greenwood, who was a prominent woman sanitary inspector in Sheffield and then Finsbury, was married to a doctor.³⁰

Voluntary workers

The ideal voluntary worker was similar to the ideal salaried official. The advice to those embarking on voluntary schemes was that

One woman of good standing, education and method, with a high standard of work always before her, will accomplish honest, thorough, even brilliant work and will organize and lay plans for herself and future workers on lines which will not degenerate.³¹

The National League for Physical Education and Improvement noted in 1913 that a few centres had obtained the services of working-class women as volunteers. It recommended the representation of mothers in the management of maternity and child welfare centres, since they would 'know more clearly the difficulties to be faced and will be better able to render helpful services than women drawn from another rank of life'. It was also emphasised, however, that the superintendent, often a qualified health visitor, and almost always middle-class, should 'have charge of, and considerable control over, the work of the voluntary visitors', so that their work was 'thoroughly and tactfully supervised'.³²

²⁵ RHBNC: BC student entrance forms (AR203/1/1, AR200).

²⁶ RCN: Peter Catto, 'Early women sanitary inspectors', p.12

²⁷ See Chapter 6.

²⁸ Parkes, *Jubilee Retrospect*, p.17.

²⁹ WHO (Apr 1960), p.3.

³⁰ IDCPC Minutes of Evidence (Cd. 2210, PP 1904 XXXII), p.309.

³¹ Evans, 'Essential qualifications', p.310.

³² Gibbon, *Infant Welfare*, pp.11-17.

Almost all the managing committees of voluntary infant welfare centres were dominated by women.³³ As with salaried workers, medical connections drew them into the work. Emilia Kanthack, the driving-force behind the St. Pancras School for Mothers, was the sister of A.A. Kanthack, the eminent bacteriologist and pathologist.³⁴ Miss Broadbent, a key influence in the founding of the St. Marylebone Health Society, was the niece of Huddersfield's MOH, Benjamin Broadbent, who had pioneered health visiting there.³⁵ Some were drawn from the upper end of the social scale. Lady Cynthia Colville's involvement with Shoreditch Infant Welfare Centre is one example.³⁶ She chose Shoreditch by studying a map of London: 'it appeared to be rather like Chelsea, a well-knit, not too big district, easily accessible, geographically simple, and conveniently near my husband's office', and 'the name Shoreditch was somehow attractive'.³⁷ Although she did undertake some voluntary visiting, her main role was as Honorary Secretary, and she went on to be co-opted onto the Borough's Maternity and Child Welfare Committee, on which she served for over ten years as the only non-Labour member.³⁸

More typical was St. Marylebone Health Society which recruited its volunteers 'from the large contingent of retired nurses who were resident in the borough and many of whom had married members of the medical staff of the hospital where they had been trained'.³⁹ In St. Pancras, volunteers included both those with nursing and midwifery qualifications, and fully-qualified women sanitary inspectors.⁴⁰ The sheer number of women taking public health qualifications compared with the number of posts available points to the availability of trained voluntary labour, and training courses were advertised as suitable for both voluntary and salaried workers.⁴¹ When recruiting volunteer helpers in Westminster, the MOH was influenced by the MSSA scheme, but felt that the visitors 'should be better educated'. Through the establishment of the Westminster Health Society, he set up a network of 'trained local workers' to give 'practical instruction and advice in matters of health and sanitation to the people in their own homes'.⁴² In 1911 the volunteer visitors included certificated nurses and midwives, holders of the sanitary inspector's certificate, and of the National Health Society (NATHS) diploma. Many were just as well qualified as

³³ *Ibid.*

³⁴ Kanthack, *Preservation of Infant Life*.

³⁵ Wellcome: Mostyn Bird, 'St. Marylebone Health Society' (SA/HVA/F.3/5).

³⁶ *The Queen* (4 Jun 1930).

³⁷ Colville, *Crowded Life*, pp.95-96.

³⁸ *The Queen* (4 Jun 1930).

³⁹ Wellcome: Eric Pritchard, 'Some reminiscences of a medical man', p.7 (GC/49).

⁴⁰ St. Pancras, MOH report, 1907, p.27.

⁴¹ See Chapters 6 & 7.

salaried or 'official' health visitors. In addition, they had experience of a number of other charitable organisations, and included representatives of local branches of the Invalid Children's Aid Society, members of school care committees, and organisers of girls' clubs.⁴³ There were no formal qualifications required, but they had to satisfy the committee that they had received 'suitable training'.⁴⁴ This was often provided by the Society itself, which arranged for lectures.⁴⁵ In St. Marylebone, although a 'considerable number' of the volunteers 'were already experienced in the kind of work that was required of them', the MOH organised lectures on infant management, 'for uniformity and continuity'.⁴⁶

Rose Gamble, who came from a poor Chelsea family, and whose mother was employed as a cleaner at a voluntary baby clinic, remembered its workers as

real ladies who talked in clear cultured voices and knew exactly what they were going to say before they said it. Not that they were bossy or condescending, they simply had a distinct air of assurance about them that distinguished them from the dozens of ill-nourished and shabby women who flocked to the clinic with their young children.⁴⁷

For her,

The ladies at the clinic were kind but businesslike, and typical of the long tradition of upper-class British women who became aware of social needs and cared sufficiently to do something practical to help. It was no trifling part-time charity job for them. They worked hard, and some of them were there for years and years.⁴⁸

The salaried visitors employed by voluntary organisations closely resembled those employed by municipalities, although the pay was generally worse, and such posts were often used as stepping-stones to municipal appointments. Voluntary organisations might also specify particular qualifications to suit the local community. Some of the Jewish Board of Guardian's tuberculosis visitors were Jewish, and others were selected because of their knowledge of relevant languages, but all were otherwise similarly qualified to other women public health officers.⁴⁹ While there was certainly opportunity for the voluntary involvement of women from a wide range of backgrounds in public health work, the paid posts, whether in voluntary or municipal organisations, were dominated by a new breed of woman official. Such women

⁴² Allan, 'Value and scope of voluntary public health work', *JRSI* (XLV, 1924-1925), p.143.

⁴³ WAC: CWHS annual report, 1911, p.3 (1352/18).

⁴⁴ WAC: CWHS annual report, 1906, p.12 (1352/17).

⁴⁵ WAC: CWHS, St James's Soho and Strand, Committee Minutes, 20 Dec 1904 (1352/15).

⁴⁶ Pritchard, *Infant Education*, p.ix.

⁴⁷ Gamble, *Chelsea Child*, p.48.

⁴⁸ *Ibid.*

⁴⁹ Southampton: Letter from Hilda Joseph, 22 Sep 1904 and M.E.J. Blewitt, application and testimonials (MS 173/1/11/3).

formed the backbone of the work, supervising and training voluntary workers, and providing professional input to amateur managing committees.

'Educated gentlewomen'

Use of the word 'educated', when describing the ideal candidate for the work, was not intended to denote the quality, or even the quantity, of the candidate's actual educational achievements. When the NATHS advertised its training courses as suitable for 'educated gentlewomen', it never stipulated a minimum educational requirement. Indeed, the personal experiences of its earliest students reveal an almost total lack of previous formal education. Rather, it seems that it equated 'high intellectual' attainments with 'good social standing'.⁵⁰ In 1918, the Society claimed that, although 'women of education' were wanted, it was not essential for candidates to have passed 'any very stiff examinations', or to have had a college education. VADs, or those who had experience of 'parish and social work', were particularly suitable.⁵¹

After the first generation of Deane, Squire and their contemporaries, women public health officers benefited increasingly from the reform of middle-class girls' education. In c.1907, 'a University degree, although not in the least necessary, may occasionally help to decide the balance between two candidates'.⁵² In 1914, Finsbury's woman inspector observed that, 'Hitherto, the majority of women engaged in public health work have held a High School or College education and many have been University graduates'.⁵³ It is difficult to quantify these assertions, but evidence from local sources, does lend weight to their validity. Out of the six candidates selected for interview for a vacancy in Hackney in 1904, three also held Cambridge Senior and Junior (Local) certificates in subjects such as chemistry and physics. The successful candidate also had a London Intermediate BSc.⁵⁴ Her colleague, appointed in 1908, had Cambridge Senior and Junior (Local) certificates, and London matriculation.⁵⁵ Nellie Brocklehurst, a health visitor in Derbyshire and Poplar, 1912-1918, was educated at Portland High School, Manchester.⁵⁶ Battersea's woman inspector and visitor from 1912 to 1919 was educated at Wallasey High School for Girls in Cheshire and at University College of Wales, Aberystwyth, receiving her BA

⁵⁰ TNA: NATHS memorandum (MH26/1/383).

⁵¹ Wellcome: WSIA Executive, 16 Apr 1918 (SA/HVA/B.2/7).

⁵² *Women as Inspectors*, p.13.

⁵³ Greenwood, 'Women sanitary inspectors: training and examination', *Women's Employment* (XV, 1915), p.5.

⁵⁴ HAD: Hackney Public Health Committee, 7 Apr 1904 (H/P/3).

⁵⁵ HAD: Hackney Public Health Committee, 5 Mar 1908 (H/P/8).

from London in 1909. Mrs Fisher, who was sanitary inspector and health visitor at Hampstead for over 17 years, was educated at Clapham High School and Newnham College Cambridge, and also held an MA from Trinity College, Dublin.⁵⁷ Of the 17 women who trained as sanitary inspectors at Bedford College, all but five had attended, for varying periods of time, 'public' schools such as the North London Collegiate or a local Girls' High School. At least seven had already studied at Bedford College, either for Intermediate Science examinations or for a BSc degree. One had a London BA degree from elsewhere, and one had trained as a teacher at Bedford and worked at Kensington High School.⁵⁸ Most women sitting for the examination of the Sanitary Inspectors Examining Board (SIEB), wherever they trained, were educated to the ages of sixteen or eighteen and beyond, and held a variety of formal qualifications, including teaching qualifications, school certificates, polytechnic diplomas and university degrees.⁵⁹

As time passed, and educational opportunities increased, training courses began to insist on a secondary education. In 1919 the Ministry of Health stated that students should preferably have had a secondary school education up to the age of eighteen. Admission to courses was not limited to those who had passed certain prescribed examinations, but colleges were expected to satisfy themselves that 'the student's previous education has been such that she is likely to profit from the course'.⁶⁰ Students for the Battersea Polytechnic health visitors' course were initially required in 1910 to 'have had a good education'.⁶¹ By 1919, the Polytechnic preferred candidates to have attended 'a good secondary school', while, by 1923, it was suggested that 'younger students should endeavour to pass the London Matriculation or Senior Cambridge or Oxford Local or equivalent courses'.⁶²

By the time Rose Squire's niece, Hilda, came to train as a health visitor just after the First World War, her educational certificates were testimony, not only to her proficiency on the pianoforte, but to Oxford and Cambridge Schools Higher Certificate Examinations.⁶³ She was educated at Francis Holland School, Clarence Gate, where she was Head of the School, and received the education that had been

⁵⁶ *Lady's Who's Who* (1939).

⁵⁷ IOE: List of women nominated by the WSI&HVA for service in connection with the League of Nations Union (DC/UWT).

⁵⁸ RHBNC: BC, student record book (AR201/3/1); student records (AR200, AR203).

⁵⁹ RSPH: SIEB Register, Volume II.

⁶⁰ TNA: Health visitor training: regulations and grant in aid (MH53/101).

⁶¹ Surrey: BP Calendar, 1910-1911, pp.113-114 (I₁ 0500.003).

⁶² Surrey: BP Calendar, 1919-1920, p.68 (I₁ 0531.004) & 1923-1924, p.5 (I₁ 0531.008).

⁶³ Brotherton: Hilda Squire, educational certificates (MS 973/12-13).

denied to her aunt.⁶⁴ After working as a VAD from 1918-1919, Hilda went on to take the examinations of the NATHS and SIEB.⁶⁵ By the 1920s, the NATHS was able to say of its students that, 'There are few who have not had the advantage of a first-class secondary school training, and quite a number have passed through the higher schools.' The advantage was not just one of a trained mind, since 'This training has done much to mould character and give a standing which is very soon appreciated by the poorer and less favoured people among whom they work.'⁶⁶ These sentiments were echoed by Hilda Squire in a speech given at her school's Jubilee Dinner:

in this School we do not look on Education as a means of gaining knowledge merely to pass exams, but also to pass through life, holding on to one's highest ideals and being as helpful as possible to others.⁶⁷

Education was not viewed simply in terms of formal qualifications and intellectual attainments. For historians of women's education such as Pederson, Delamont and Dyhouse, educational reformers may have re-shaped Victorian concepts of femininity, but they did not reject them.⁶⁸ They have seen the new girls' schools as an attempt to educate girls to use their time constructively, and according to the ideals of service and duty, whether their labour was voluntarily given, or whether they entered a paid profession. Such schools promoted a publicly responsible, social service attitude. Character training and self-discipline were key, along with a combination of what Digby has termed 'plain living and high thinking', and an evangelical tone of duty and service.⁶⁹ Such schools helped to mould a new professional female class from which women public health officers might be drawn.

Male inspectors

By contrast, the tradesmen and sons of clerks, shopkeepers and minor officials, who might have sought a career as a sanitary inspector, would have been educated at elementary school. Although scholarships enabled a few to attend grammar school, the son of one male sanitary inspector who won such a scholarship never felt quite comfortable.⁷⁰ Most would have left school early and continued their education and training in a number of informal ways, through reading, membership of classes, or attendance at lectures. Taking the 46 women and 27 men who sat for the SIEB technical examination at sessions held in May 1901, May-June 1911 and June

⁶⁴ Brotherton: Hilda Squire, testimonial, Jul 1917 (MS 973/16).

⁶⁵ Brotherton: NATHS examination results (MS 973/17-18)

⁶⁶ ME (LXVIII, 1921), p.39.

⁶⁷ TWL: Hilda Squire, personal papers (7/HMS/1).

⁶⁸ Dyhouse, 'Storming the citadel?'; Pederson Reform; Delamont, 'Domestic ideology'.

⁶⁹ Purvis, *History*, p.79; Digby, 'New schools', pp.7-18; Delamont, 'Domestic ideology', p.1684.

1921, 30 of the women provided a previous educational certificate, compared with only four of the men.⁷¹

This was a feature observed by contemporaries. In 1893, one member of Kensington Vestry, remarking on the women sanitary inspectors newly employed in his district, said that,

They are ... a very much higher trained class than men inspectors could possibly be, because unfortunately owing to the competition of female labour at present, men could not be obtained at anything like the same salary, and the advantage of getting a trained educated lady is very great with regard to the amount of sanitary education that they give in those houses they visit, as well as merely perfunctorily pointing out what may be a nuisance.⁷²

Kensington's MOH commented that the work done by his women sanitary inspectors was not only as thorough and efficient, but also 'more educated', than that of any man he had had on his staff.⁷³ Although the *Sanitary Record* did not wish to be seen to set men and women inspectors against each other, it was 'bound to admit that as a body they [the women] are better educated and better prepared for the work than many of the men were when they started in the service.'⁷⁴ This was a common pattern at the end of the nineteenth century as middle-class women began to open up new spheres of paid work.⁷⁵ For women public health workers it had particular implications. Because of the importance of the personal influence of the women in influencing the behaviour of the urban poor, rather than just being able to recognise a blocked drain and cite the correct bye-law to remedy it, a 'suitable' education was considered a prerequisite in a way that it was not for the male inspector.

Working conditions and the 'right type of woman'

Arguments for improved working conditions, whether salaries, holidays or pensions, also reveal the preconceptions about the social background of women public health officers. That the women were supposed to come from 'good middle-class homes' was used to argue for sufficient remuneration to accompany such a lifestyle.⁷⁶ According to one commentator, 'She is a gentlewoman: enable her to live as one'.⁷⁷ For another, the £60 paid to Kensington's first two women inspectors was considered 'not a living wage to a cultivated and highly-educated woman'.⁷⁸ Women

⁷⁰ Searby, 'Schooling of Kipps', p.120; Brown, *So Far*, pp.28-29.

⁷¹ RSPH: SIEB Register, Volume II.

⁷² TNA: Letter to NATHS Secretary (MH26/1/246).

⁷³ LSE: Lucy Deane's diary, 14 Feb 1894, (Streatfeild 1/3)

⁷⁴ SR (XLIX, 1912), p.63.

⁷⁵ Jones, *Women in British Political Life*, pp.10-11.

⁷⁶ ME (LXV, 1920), p.455.

⁷⁷ Evans, 'Essential qualifications', p.310.

⁷⁸ LSE: Undated cutting from *The Star* (Streatfeild papers, 1/22).

inspectors campaigned for a salary 'suitable to the social condition of the woman chosen'.⁷⁹ Lewisham's MOH thought that women public health officers should be paid salaries allowing them to live in 'comfortable and refined surroundings'.⁸⁰

'Respectable' single women looking for housing had limited options in London.⁸¹ According to Mabel Brown, a badly-paid health visitor was compelled to live in 'the cheapest localities', either close to, or actually in, the neighbourhood of her work, so that she could never escape from 'its atmosphere':

After a hard day's work she must return home to her own housework, to mending and making, in short to further rush and hurry and managing, until she returns to bed too tired to sleep, still worrying about how to make both ends meet.⁸²

Women were not able to make as much use of their leisure time as their male colleagues since

housework, sewing, and home nursing are often the forms that their recreation has to take, which is not so entertaining as a man's recreation of golf, tennis, and other sports.⁸³

For Margaret Sharples, a Leeds inspector, 'The underpaid woman has no leisure because her spare time must be taken up in doing for herself what a more fortunate woman ... would pay others to do for her'.⁸⁴ All day the woman inspector was

almost entirely cut off by circumstances from intercourse with people of the same tastes and traditions as herself. She returns at night to lonely lodgings too tired to turn her mind from her day's work.⁸⁵

'Refined' home surroundings and sufficient leisure were needed because

The continual facing of those sordid problems which beset the lives of the very poor, the perpetual contemplation of the wrong side of the stuff of which our modern civilisation is made, the very dull unloveliness of the slum districts may mean weariness of body and mind, and a distorted view of life in which the ugly details of sin and suffering fill up too great a proportion of the foreground ... there may be, too, that arid dryness which comes from giving out to the more ignorant without any compensating contact with mental equals and superiors. The necessary daily dealing with matters which, rightly and by common consent, are not so much as mentioned in the ordinary interchange of social life, may lead, in a nature not strongly safeguarded, to a certain coarsening of fibre and the loss of something indefinable but very real, which, once lost, can never be regained.⁸⁶

⁷⁹ Wellcome: WSIA minutes, 3 Nov 1909 (SA/HVA/B/1/4).

⁸⁰ Wellcome: WSIA annual report, 1912-1913, pp.118-19 (SA/HVA/A.1/6).

⁸¹ Copelman, *London's Women Teachers*, p.153.

⁸² NH (XV, 1922), p.70.

⁸³ Gardiner, 'Varied nature of the work of women public health officials', *JRSI* (XXXV, 1914), p.514.

⁸⁴ Sharples, 'On the personality', p.19.

⁸⁵ *Ibid.*

⁸⁶ *Ibid.*, p.17.

To counterbalance the demands of the job, it was necessary to have 'a quiet and comfortable home', good food, strong and waterproof clothing, good holidays and the power to spend leisure time in 'surroundings that will relieve the depression of her work.'⁸⁷

Middle-class families also expected a decent return on their investment in the education and training of their daughters. In 1903, Miss Lovibond thought that parents who had financed training should not still have to support their daughters when they were working.⁸⁸ In 1915 one woman inspector concluded that it was simply not worthwhile for a woman with a university education to become a sanitary inspector unless she had 'considerable private means', since the financial return was too small.⁸⁹ While not committing itself to the demands of the women for equal pay, *Municipal Engineering* considered that they had a strong claim since

As a body the women are well-educated, many having received a High School training. They have come from good middle-class homes, and substantial sums of money have been spent upon their training.⁹⁰

If conditions were not good enough, 'the right type of woman' would not be recruited. Moreover, once recruited, she required special treatment, not only because she was entitled to be able to live in the style and surroundings appropriate to a woman of her class, but also because the very nature of her duties threatened her middle-class status and femininity.

AGE AND EXPERIENCE

In addition to social background, there were definite opinions about the preferred age and experience of candidates, and about their professed motivations for the work.

Age

It was commonly accepted that 'No one under twenty-five is of much value as a health visitor; the mothers will pay no attention to the very youthful.'⁹¹ As one experienced woman wrote, 'For a young official to give suggestions and warnings to a mother with six children may appear to be an impertinence.'⁹² Another reported that she constantly heard:

⁸⁷ *NH* (XV, 1922), p.70.

⁸⁸ *JSI* (XIV, 1903) pp.313-314.

⁸⁹ Maynard, *Women in the Public Health Service*, p.113.

⁹⁰ *ME* (LXV, Jan-Jun 1920), p.455.

⁹¹ Cassie, *Maternity and Child Welfare*, p.7.

⁹² Maynard, *Women in the Public Health Service*, p.92.

Well, Miss, I will try and do what you advise about baby, for you seem to know, and I don't mind you, for you are not one of those young creatures which come bouncing in a telling us mothers what we ought to do, it's not respectable like to be talked to by bits of girls.⁹³

Another issue was physical fitness. According to one text-book, outdoor work was a strain for those over 55 and, although some did manage to continue till 65, 'they are naturally rather slow.'⁹⁴ One commentator retorted that the implication that women over 32 could not climb stairs was 'opposed to all common sense', and suggested facetiously that, 'Doubtless in the near future stair-climbing will be included in the syllabus of the examinations and church towers will be requisitioned for the practical training.' For them, maturity had its advantages since,

Women are by nature more given to being influenced by impulse or personal prejudice than by judgement, and surely a woman has not had at 28 or even 32, the chance of acquiring that experience of human nature which, like several other qualities, is not obtainable even by certificates, but only by long contact with the world.⁹⁵

Moreover, mothers had a strong prejudice against being questioned by young girls. 'Though they are compelled to admit the youthful visitor, not one word will they utter which they can avoid speaking, or offer her any assistance; while to an older woman they will often volunteer much information.'⁹⁶ There was a minimum age, at which inexperience was considered too great, and a maximum, at which physical fitness became an issue. It was also assumed that the necessary personal qualities and social competence improved with age. The ability to work alone and unsupervised, and to use judgement and initiative, were also stressed.

When the very first two posts were advertised in Kensington, the Vestry asked for candidates aged between 30 and 40.⁹⁷ Lucy Deane later related how, as a young woman of under 21, she appeared before the members of the Vestry, expecting to be quizzed on the principles of sanitation and law. Instead, she was asked her age. Knowing full well that she was below the limit, she promptly answered, 'Oh, I prefer to leave that to the judgement of you gentlemen, who I know are such capable judges.' No further questions were asked, and she was appointed straight away.⁹⁸ She was lucky, since London sanitary authorities rarely appointed women younger than 25 as sanitary inspectors.⁹⁹ The three candidates that were

⁹³ SR (XLIV, 1909), p.505.

⁹⁴ Cassie, *Maternity and Child Welfare*, p.7.

⁹⁵ SR (XLIV, 1909), p.470.

⁹⁶ *Ibid.*

⁹⁷ LSE: unidentified press cutting (Streatfeild 1/22).

⁹⁸ SR (LIII, 1914), p.394.

⁹⁹ TUC: Newcastle Mail, 26 Mar 1909 (Gertrude Tuckwell Collection 30/5).

selected for interview to replace her were 34, 35 and 38.¹⁰⁰ Almost all those women appointed by Hackney between 1898 and 1927 were over 30, most over 35.¹⁰¹ Vestry members appear to have placed considerable store on age, as the youngest candidates received the least number of votes.¹⁰² One woman inspector pointed out that, to the members of borough councils, who were 'usually persons of mature age', candidates in their early twenties appeared 'extremely young', and they tended to prefer 'a nice motherly person' for the work. She herself had been turned down 'again and again' on the question of age.¹⁰³ In 1908, the best age to commence the career was considered to be between 28 and 35. After 35, 'only very exceptional candidates' were advised to risk the expense of the training, and the upper age-limit for appointments was 40.¹⁰⁴ In 1921, it was thought almost impossible for a woman over 35 to obtain a new appointment and health visitors were advised not to take up the work unless they had obtained all the necessary qualifications by the age of 30.¹⁰⁵

Marital status

Women teachers were criticised for not being wives and mothers, yet were subject to a marriage bar.¹⁰⁶ Much the same was true of women in the public health professions. The reason given by one male sanitary inspector for his opposition to the appointment of health visitors was that he would like to see the mother who would take advice from a young lady who had no practical experience of rearing babies. His statement, 'Fancy a single girl suggesting to mothers how to feed their infants!' was greeted by laughter at a meeting of the SIA.¹⁰⁷ The picture was, however, complex. When Hackney appointed its first woman sanitary inspector in 1898, despite some reservations from individual members, the Vestry informed Miss Teebay that her appointment would be rendered void in the event of her marriage.¹⁰⁸ Such arrangements seem to have been common, but not universal. In c.1907, a pamphlet produced by the Central Bureau for the Employment of Women stated that 'It is not often that married women ... obtain appointments.'¹⁰⁹ On the other hand, in

¹⁰⁰ K&C: Kensington Vestry, Works and Sanitary Committee, 5 Jun 1894.

¹⁰¹ HAD: Hackney Public Health Department: Staff Record Book (H/PD/1/1).

¹⁰² HAD: St. John Hackney, Vestry Minutes, 27 Apr 1898 (J/V/13).

¹⁰³ TNA: Transcript of meeting between Departmental Committee on Local Government Officers Superannuation and the WSI&HVA, 6 Nov 1925, p.9 (HLG 52/469).

¹⁰⁴ *How to Become a Lady Sanitary Inspector*, p.6

¹⁰⁵ Eve, *Manual*, pp.6-9.

¹⁰⁶ Oram, *Women Teachers*, pp.47-71.

¹⁰⁷ *SIJ* (III, 1897-1898), pp.189-192.

¹⁰⁸ HAD: St. John Hackney, Vestry Minutes, 27 Apr 1898 (J/V/13).

¹⁰⁹ *Women as Inspectors* (CBEW, [1907]), p.13.

1908, marriage was declared to be no bar to the profession.¹¹⁰ While, in 1914, one woman inspector wrote, 'Another unjust distinction frequently made between men and women is that the latter are generally compelled to retire upon marriage, thus enforcing celibacy on some of our most capable women.'¹¹¹

It was immediately after the First World War that the issue became particularly contentious, especially when some public health authorities dismissed married women doctors, nurses and charwomen, causing an outcry from women's groups.¹¹² In 1920 Edmonton's MOH wrote of the tension between his female staff advising mothers to 'let the care of the home, husband and children, take the first place in their life-work', when the medical officer of the Maternity and Child Welfare Centre was a married woman.¹¹³ Upon her marriage in the early 1920s Dr Gladys Miall Smith, Assistant Medical Officer in charge of maternity and child welfare, was requested by St. Pancras Borough Council to resign her appointment, although no clause to that effect had been included in her contract. She argued, not only on contractual grounds, but also because a married woman was especially suited to the work. Her case was taken up by the Medical Women's Federation, British Medical Association, Society of Medical Officers of Health, and the London Society for Women's Service.¹¹⁴ The health visitors and superintendents of the welfare centres in the Borough supported her. The Workers' Section of the Association of Infant Welfare and Maternity Centres was 'in complete sympathy' with the campaign against the dismissal from employment of any woman, solely on the grounds of marriage.¹¹⁵ Of Dr Miall Smith it said that

to deprive the mothers and babies of the borough of the services which she is so peculiarly fitted to render them shows a deplorable lack of vision and good judgement.¹¹⁶

The marriage bar was not a particular focus for women public health officers, as it was for women doctors and teachers. The Women Sanitary Inspectors and Health Visitors Association was not particularly outspoken on the matter, although it informed the LSWS that it supported the employment of married women, and attended conferences and meetings on the subject.¹¹⁷ Meanwhile, the ability of married women to work as public health officers remained variable.

¹¹⁰ *How to Become a Lady Sanitary Inspector*, p.6

¹¹¹ Greenwood, 'Women as sanitary inspectors and health visitors', pp.227-228.

¹¹² Dyhouse, *Feminism and the Family*, pp.78-9.

¹¹³ Edmonton MOH report, 1920, p.30.

¹¹⁴ *BMJ* (25 Mar 1922), p.481.

¹¹⁵ *NH* (XIV, 1921), p.101.

¹¹⁶ *Ibid.*

¹¹⁷ IOE: LSWS Joint Committee on Women Employed by Municipal Authorities minutes, 1 Dec 1921(DC/UWT, Box 57).

Experience and vocation

The narrow age range of the 'suitable' candidate, and debates over marital status were caused, in part, by the desired balance between experience and vocation. Careers literature noted that health visiting was not work 'for the immature woman', and recommended that school leavers should gain experience in hospital or infant welfare work before seeking an appointment.¹¹⁸ Under 1919 regulations on the training of health visitors, the minimum age for admission was fixed at 18, in order that girls might proceed straight to the course from school. The Ministry of Health realised that such girls, on completion of their training, would be only 20, and not 'sufficiently experienced or mature' to take up full posts. They were advised to take further training, such as that for the CMB certificate, or to take posts of 'limited responsibility' in maternity and child welfare centres.¹¹⁹ In this way girls straight from school might be secured for the profession, while obtaining the 'right' kind of experience, that would further develop their personal qualities.¹²⁰ On the other hand, it was stressed that health visiting should not be taken up when 'all other attempts to gain a livelihood have failed'.¹²¹ The balance between vocation and experience was a fine one.

Many women held other occupations prior to public health work. When Anne Smith was appointed to a post in Westminster in 1913, at the age of 30, she had been for seven years a mistress at Haberdashers Aske Girls School in Acton.¹²² Some of the Leeds inspectors were also trained teachers, and Annie Rothwell, a sanitary inspector in Oldham, was an elementary-school headmistress.¹²³ Other backgrounds were common. When Woolwich interviewed for a woman sanitary inspector in 1904, the successful candidate was 27 and had previously worked as a dispenser, only qualifying as a sanitary inspector the previous year. In 1906, a successful candidate was 34. She had previously worked in a savings bank and as a civil service clerk.¹²⁴ As time went on, extensive nursing experience became common. In 1908, women considering careers as sanitary inspectors were advised

¹¹⁸ Hughes, *Careers*, p.210.

¹¹⁹ TNA: Health visitor training: regulations and grant in aid (MH 53/101).

¹²⁰ Eve, *Manual*, pp.vi, 24.

¹²¹ ME (LXI, 1918), p.369.

¹²² TNA: Westminster sanitary inspectors (MH 48/168).

¹²³ JSI (XXIV, 1903) pp.316, 773.

¹²⁴ TNA: Woolwich sanitary inspectors (MH 48/169). Huddersfield was unusual in employing qualified medical women in the very early days of its health visiting scheme – see Marland, 'Pioneer in infant welfare', pp.35-36.

that most authorities preferred candidates with nursing qualifications.¹²⁵ By 1919 this custom was so widespread that there was a tendency 'to disparage the health visitor who is not a trained nurse.'¹²⁶ Indeed, by 1920, out of the 1879 health visitors employed by local authorities over half (986) were fully-trained nurses.¹²⁷

Possession of the 'right' social background, age and experience were not the only obstacles in front of the intending woman public health officer. It was necessary that she demonstrate a level of personal commitment. As with other female occupations, including nursing and teaching, the concept of vocation was important.¹²⁸ Some MOHs considered that 'work of this description is foredoomed to failure if taken up for the sole purpose of making a living.'¹²⁹ Missionary zeal remained a constant theme:

To us women who have been called into this glorious field of labour for our Empire, a field so brimming over with golden opportunities and unknown possibilities of usefulness, the words – Ideal Health Visitor – set our hearts on fire with enthusiasm and the desire that we may indeed be ideal helpers to the mothers of our future men and women.¹³⁰

In the language of religious conversion, the same author spoke of how, 'having seen the vision we shall hear the call to go forth and spend and be spent in supplying the needs we have seen around for social improvements.' To those who had not such vision, the work of a health visitor would be

drudgery, dull and depressing; her only reward being a good salary (and that not so good as she hopes), good social position, free evenings and weekends; after all such small rewards for a life's work and of a kind which could be gained elsewhere.¹³¹

This rhetoric of vocation, service and sacrifice survived the transition to the municipal age.

CHARACTER

Having the correct background and a vocation for the work were not the only prerequisites. Correct attitude and personality were also important, although these were often seen as arising naturally from background and vocation, and amplified by education and experience. Throughout the period there was consensus about the

¹²⁵ *How to Become a Lady Sanitary Inspector*, p.5.

¹²⁶ *NH* (XII, 1919), p.49.

¹²⁷ *ME* (LXVI, 1920), p.380.

¹²⁸ Abbott & Wallace *Sociology of the Caring Professions*, p.22; Rafferty, *Politics of Nursing Knowledge*, p.42; Holcombe, *Victorian Ladies*, p.36; Hannam, 'Rosalind Paget', p.142.

¹²⁹ Kerr, 'Modern educative methods for the prevention of infantile mortality', *PH* (XXII 1909-1910), pp.129-134.

¹³⁰ Skene, *Ideal Health Visitor*, p.1.

¹³¹ *Ibid.*, p.11.

personal characteristics that women sanitary inspectors and health visitors required. A range of traits was recommended, including patience, cheerfulness, humility and kindness, but it was 'tact' and 'sympathy' that were the most essential, and most often-repeated.

Tact

For the *Sanitary Record*, if tact was an essential quality of womanhood, there was wide scope for women in public health work.¹³² Various reasons were given for this. Health visitors had no legal right of entry, and were required to proceed through personal influence rather than legal authority. For one MOH, since the health visitor had to 'combat antagonism, gain confidence, arouse interest and to stir to action a woman whose house she has not a scrap of legal authority to enter', it was essential that she possess certain personal qualities that were not important for male inspectors.¹³³ According to one woman inspector, 'The faulty waste pipe ... may be drastically dealt with ... but the long-tubed feeding bottle must be approached with caution and the wiles of diplomacy'.¹³⁴ One MOH commented that tact was, fortunately, more plentiful in women than in men and, whilst 'a tactless Sanitary Inspector may do much good, a tactless health visitor would be a complete failure'.¹³⁵

According to *The Lancet*, it was the 'exhibition of tact, intelligence and firmness' that led to the success of Birmingham's health visitors.¹³⁶ When Southwark announced it was to appoint a 'Lady Sanitary Officer', the journal felt that 'the lady in question will require an immense amount of tact and perseverance'.¹³⁷ In Liverpool, it was thanks to 'the tact and kindness' of the women sanitary inspectors that their work was going well.¹³⁸ In 1921 'tact and good temper' were the most important requisites for the health visitor.¹³⁹ According to Dr Alfred Hill, 'there was more done by tact probably than by any other quality'.¹⁴⁰ For George Newman, a 'sympathetic and tactful bearing' were essential qualifications.¹⁴¹ One commentator went as far as to say that 'unless one possesses the grace of tactfulness, the greatest help one can be to Health Visiting and Welfare Work is to keep out of it altogether.' For her, 'A tactless word may be the last straw to an overburdened heart, and last straws can break

¹³² SR (XL, 1907), pp.32-33.

¹³³ NH (III, 1911), pp.120-121.

¹³⁴ Sharples, 'On the personality', p.14

¹³⁵ NH (XII, 1920), pp.208-9.

¹³⁶ *Lancet* (24 Jul 1899), p.243.

¹³⁷ *Lancet* (15 Dec 1900), p.1751.

¹³⁸ *Lancet* (2 Mar 1901), p.667.

¹³⁹ *Lancet* (26 Mar 1921), p.652.

¹⁴⁰ JSI (XXIV, 1903) p.310

women's hearts as well as camel's backs.'¹⁴² While women were considered likely to be more tactful than men, it was also observed that,

It is too often supposed that any woman merely because she is a woman will make a successful health visitor. Nothing could be further from the truth and in many districts the work of a capable visitor has been made difficult owing to the tactless action of someone who has preceded her.¹⁴³

According to the LGB representative sent to persuade Southwark to appoint health visitors in 1912,

A tactless woman appointed as health visitor is quite likely to offend respectable married women and to rapidly become known throughout a district as a nuisance – whereas if she had tact and judgement she would be regarded as a valuable friend. The choice of the individual health visitor rests primarily with the Borough Councils and it is their business to see that they get the right type of woman.¹⁴⁴

One woman inspector wrote that, 'Infinite tact, infinite patience, infinite sympathy are more necessary than other qualifications.'¹⁴⁵ According to another, 'the tactful official will quickly ascertain the frame of mind of those whom she visits, will know when to praise and when to blame, when to be firm and when to use persuasion only.' Tact was also essential since 'Many unpleasant truths will have to be told', and only the tactful would know 'how to take the sting out of them.'¹⁴⁶ Tact was something that went hand in hand with the professionalism of the health visitor, whilst tactlessness and an interfering and condemning manner was something displayed by voluntary visitors from a less-professional mould.

Sympathy

Closely linked with tact, sympathy involved the ability of the visitor to put herself in the shoes of the person she was visiting, to see things from their perspective, and to understand 'human weakness'. It was essential since the health visitor was 'to meet the mothers as a friend ..., and, understanding their difficulties to help them to make the best of their circumstances.'¹⁴⁷ One lecturer thought that it was vital that the mothers felt that the visitor was there to sympathise and not to condemn, to advise not to lecture. It was essential that she put herself in the mother's

¹⁴¹ Newman, *Infant Mortality*, p.264

¹⁴² Skene, *Ideal Health Visitor*, p.6.

¹⁴³ NH (IV, 1913), p.258.

¹⁴⁴ TNA: Southwark sanitary inspectors (MH 48/165).

¹⁴⁵ Long, 'Sanitary inspectors and health visitors', p.1

¹⁴⁶ Maynard, *Women in the Public Health Service*, p.7.

¹⁴⁷ Eve, *Manual*, p.26.

place and ask what she might have done in similar circumstances.¹⁴⁸ For another commentator,

If they [the mothers] feel that you try to put yourself in their position and endeavour to see their troubles from their point of view you will have done a great deal towards gaining their confidence... It is so easy to arrange other people's affairs and so difficult to arrange our own, and it is also difficult to understand why people cannot see things from our point of view.¹⁴⁹

The woman officer must thus 'possess that true sympathy which understands the great difficulties which are in the way of those who would endeavour to rise above their often debasing surroundings.'¹⁵⁰ As one woman sanitary inspector put it, she had not only to 'inspire lofty ideals of cleanliness and self control' into the mother of a starving family, but also to 'wonder if, under similar conditions, she would have the energy to kneel down and scrub the floors herself.'¹⁵¹ One commentator described a typical exchange between health visitor and housewife:

"Why, Mrs. Mentwell, have you had a busy day?" says the health visitor with a smile. ... "Busy? I should think so." Out it pours ... the usual complications of life in an inconvenient house, with only one pair of hands to do everything. The health visitor lets the torrent expend itself. She has heard it all before, not less than ten thousand times. And can still sympathise with a woman, not very clever, not very strong, struggling against heavy odds. Every good health visitor, confronted with a Mrs. Mentwell, asks herself one question, privately, It is – "Given the same circumstances, could I do as well?"¹⁵²

For the women inspectors themselves, sympathy was very different from an attitude of 'patronage or blame'. For them 'real sympathy with the mother' involved 'a determination to see her point of view and grasp her difficulties and love for the baby'.¹⁵³ As one wrote,

Whatever may be your opinion as to the true cause of the filthy state of Mrs. Brown's house and family, deal gently with the erring one; for the probability is that if we stood in Mrs Brown's shoes with an average income of 18s. per week, a not too steady husband, and ten children, including a baby at the breast, did not get a square meal once a week nor a new frock once a year, never had any holiday or pleasure, and nothing to look forward to except the comfortable certainty of ending our days in the workhouse, it is quite likely we might be as reckless and dirty as poor Mrs. Brown. Not, of course, that houses like Mrs. Brown's can be allowed to remain dirty, only season your lecture with sympathy.¹⁵⁴

In her lectures to the voluntary health visitors in St. Pancras, Emilia Kanthack advised them to cultivate imagination since, 'Tact and sympathy, after all, depend

¹⁴⁸ Lane-Claypon, *Child Welfare*, p.108.

¹⁴⁹ Macmillan, *Infant Health*, pp.96-97.

¹⁵⁰ Maynard, *Women in the Public Health Service*, p.7.

¹⁵¹ Gorniot, 'Sanitary Lady', *NH* (V, 1913), pp.170-173.

¹⁵² Prospice, 'Profession of health visiting', *Time and Tide* (Nov 1923), p.1129.

¹⁵³ Maynard, *Women in the Public Health Service*, p.88.

¹⁵⁴ *How to Become a Lady Sanitary Inspector*, p.29

entirely on imagination. Before you can sympathise with people, you must first be able to project yourself in imagination into their conditions.¹⁵⁵ The visitors would not be

a scrap of use to them [the mothers] or to their babies unless you understand them and they understand you. So you must do your level best to make yourself acquainted with their habits of mind and modes of speech and their code of manners, as well as with their physical and economic conditions.¹⁵⁶

Sympathy led, not only to understanding and respect, but also to flexibility and practicality. The tuberculosis visitor 'if possible, should never adopt a negative policy in her work and should not condemn without being able to suggest a practicable remedy'.¹⁵⁷ Visitors were 'not to deal with ideal circumstances, but to make the best of things as we find them, and at the same time by observation and kindly sympathy to do all in our power to improve those conditions.'¹⁵⁸ It seems as though many made a genuine attempt to understand the lives of poor mothers, and, moreover, that this might lead to a real and lasting sympathy for their hardships.

CONCLUSION

The ideal woman public health officer was drawn from the 'right' sector of the middle-classes and educated in such a way as to enhance her 'natural' aptitude for social service. She was young enough to be able to demonstrate her vocation for the work and to climb stairs, but old enough that she had been allowed time for her feminine character traits to mature through the 'right' type of experience. These traits were to include, above all, tact and sympathy, since it was through these that she was to build a successful personal relationship with the working women she encountered. By the early twentieth century, women public health officers firmly distanced themselves from the 'lady bountiful' image of the previous century, and from voluntary visitors such as the one who 'stirred the family soup with her umbrella and enquired what the boiling mixture might be'.¹⁵⁹ MOHs were also keen to point out that 'an ambition to do a little "slumming" for the sake of curiosity, novelty or excitement' was not 'any recommendation in the would-be health visitor' and 'all aspirants for fame must be warned at the outset.' Instead 'tact, patience, broadmindedness, evenness of temper and temperament, knowledge of the world and a sound training in her work' were all demanded.¹⁶⁰

¹⁵⁵ *Ibid.*, p.4.

¹⁵⁶ *Ibid.*, p.3.

¹⁵⁷ Burton, *Tuberculosis Handbook*, p.51.

¹⁵⁸ Macmillan, *Infant Health*, pp.1-2.

¹⁵⁹ NH (I, 1909), p.158, (III, 1911), p.117.

¹⁶⁰ NH (II, 1910), pp.120-121.

There was a wide gulf between the social background and circumstances of the women officials and the poverty and poor housing of those they visited to preach healthy living. Women officials were felt to 'deserve' a certain income and standard of living because of their social background, and also to maintain their health. That prolonged contact with the poor was seen as a threat to the mental and moral character of the women officers and to their physical strength is revealing. What is clear, however, is that, although their problems were of a totally different order, many women public health officers were used to tight budgets, to worrying about how to make ends meet, and to doing their own housework, cooking and mending. Clement Attlee's advice that it was 'a good corrective for the social worker to do his or her own domestic work for a few months, so as to learn what it is like', was unnecessary for most women public health officers.¹⁶¹

¹⁶¹ Attlee, *Social Worker*, pp.133-134

5: OFFICIAL, INSPECTOR, VISITOR OR FRIEND?

Contemporary commentators never suggested that male sanitary inspectors might better accomplish their work without the title of 'Inspector', the power to serve official notices, or by avoiding the appearance of being 'markedly official'. There was, however, considerable debate about what to call women public health officers, what statutory powers they should possess, and how they might hold official positions without the marks of 'officialism'. According to Kensington's MOH, the great qualification of a woman inspector was 'womanliness together with tact and her suppression of officialism'.¹ 'Officials are not loved by the people', observed *Municipal Engineering*, but 'if the health visitor possesses the one essential qualification of true womanliness, then she will prove a source of strength to the Health Department'.² The tuberculosis visitor should avoid 'with horror' becoming 'an official' of the dispensary, rather than 'a good friend to the family'.³ This chapter will explore these tensions between 'officialism' and 'womanliness'. The problem of integrating women into male structures will also be examined through the relationship between women officers, male sanitary inspectors and MOHs.

TITLE

When reflecting on early appointments in the regions, sanitary inspector Florence Greenwood remembered that women were generally certificated and appointed as 'inspectors', like their male colleagues, although their responsibilities and patterns of work differed.⁴ For her, it was Birmingham's MOH who caused a major departure, by objecting to the term 'inspector' as applied to his female staff, preferring the term 'health visitor'.⁵ He was convinced that the woman official 'must not be called an inspector', since inspectors were looked upon 'with something like dislike', and their duties were of an 'inquisitorial' rather than 'advisory' character, making them 'unpopular alike with tenants, property owners, and agents'.⁶ This view was inherited by his son, Alfred Bostock Hill, who, as MOH in Warwickshire, remained staunchly opposed to the title of 'lady inspector'. 'The lady I take for granted,' he considered, 'and to my mind and in my experience too, the inspectorial

¹ SR (XXXI, 1903), p.545.

² ME (LIX, 1917), p.265.

³ Griffin, 'Value of the health visitor in the anti-tuberculosis scheme', MO (XIX, 1918), p.157.

⁴ Greenwood, 'Evolution of the health visitor', JRSI (XXXIV, 1913), p.175; Greenwood, 'Evolution of the health visitor', NT (10 Feb 1917), pp.160-163.

⁵ Greenwood, 'Evolution of the health visitor', NT (10 Feb 1917), pp.160-163.

⁶ JSI (XXIV, 1903), p.311.

idea is bad, both for the official and for her work'. He considered that the health visitor 'is not an inspector in any sense of the word, her functions are those of a friend of the household.'⁷ For him, 'the less there is of an inspector about the woman the better'.⁸ Many agreed, but others held contrary views, so that, outside London, women were appointed to perform practically the same duties but with differing titles of sanitary inspector and health visitor, according to the individual opinions of MOHs.⁹

Miss Carey, Chairman of the Women Sanitary Inspectors Association (WSIA), thought that, while 'Dr Bostock Hill objects to the term "inspector" as applied to a woman; we object even more strongly to the term "visitor" as applied to officials. May we not leave that title to the voluntary worker?'¹⁰ Referring to the Manchester scheme, Mrs Greenwood thought that, 'Having regard to the fact that the term "Health Visitor" was originally used by a class of women of inferior education and standing ... it was felt by many that it lowered the standard of the Public Health Service'.¹¹ For another woman inspector, if women were designated 'visitors', men should have titles like 'Male Health Plumbing Visitor' and 'Milk Churn and Dairy Visitor'.¹² Another considered that, if a woman was called a 'health visitor', the misconception arose that she was working for a charitable institution. It was only when it was explained that she came with the authority of the MOH that difficulties of entry, inspection and enforcement vanished.¹³ Some MOHs agreed. One felt that the title 'lady health visitor' was 'not a happy one', since 'it leads to her being classed by the people with the vicar's district visitors. Therefore she is not expected to look over the dwelling, but to read the Bible, give a tract and a shilling, or an order for coals, blankets, or groceries, and then take her departure'.¹⁴ One woman inspector commented on 'the mistaken idea that the visits of inspection were offensive to the poor people'.¹⁵ She, and some of her colleagues, challenged the idea that 'visitors' were necessarily always more welcome than 'inspectors'. Voluntary visitors were reputed to find it difficult to refrain from 'advice and admonition' in matters well outside the scope of public health work, and to preach, condemn and generally interfere in the lives of the poor.¹⁶

⁷ Quoted in Bannington, *English Public Health*, pp.93-94.

⁸ *BMJ* (11 Mar 1911), p.598.

⁹ *Ibid.*

¹⁰ *BMJ* (1 Apr 1911), p.786.

¹¹ Greenwood, 'Evolution of the health visitor', *JRSI* (XXXIV, 1913), p.175.

¹² *SR* (XLVII, 1911), p.371.

¹³ *JSI* (XIV, 1903) p.313.

¹⁴ *BMJ* (4 Mar 1911), p.529.

¹⁵ *Careers* (CBEW, 1919), p.90.

¹⁶ Lane-Claypon, *Child Welfare*, p.26.

In distancing themselves from voluntary visitors, women health officers did not reject the idea that building a personal relationship was the basis of their work. They wanted it both ways - the status, power, and salary that went with the title of 'inspector', alongside characteristics commonly associated with the 'visitor'. Greenwood thought that 'health visitors do not possess a monopoly in tact and sympathy', and that these

qualities cannot be put on or taken off with a name and a uniform ... what about the women who are appointed in the dual capacity of sanitary inspector and health visitor? Are they for three days a week to be regarded as policemen who have come to find fault, and as health visitors with tact and sympathy during the other three?¹⁷

She concluded, 'that all officials in the public health service should be entitled health officers, thus doing away with the varying terms inspectors of nuisances, sanitary inspectors, and health visitors, leaving the latter title to voluntary workers'.¹⁸ Another woman argued that the title of inspector did not alienate her from those she visited. In her experience, relationships were so cordial that women inspectors were often called into houses as they were passing, in order to get some sanitary defect remedied, or to give advice about the baby.¹⁹ An inspector might be an ally against the landlord. For St. Pancras's women inspectors, 'any sanitary defects about a house where a birth had occurred ... would be especially pointed out to us by the mother, who, noticing from our visiting cards that we were Sanitary Inspectors, was anxious to get the evil remedied'.²⁰ Another stressed that the title 'inspector' had 'in no way proved an obstacle to successful health visiting' and that, on the contrary, it had 'enabled officials to obtain an entry into dirty and insanitary places, which might otherwise have remained undiscovered'.²¹ The WSIA argued that fears that the term 'inspector' conveyed the wrong impression about the object of a visit were 'groundless'.²² Indeed, it claimed that

It has been found in actual practice that the designation Sanitary Inspector bestows an infinite advantage upon the official, while in no way causing friction or detracting from the value of the work done, because it is a term well-known and held in high esteem among the poorer working classes.²³

¹⁷ Greenwood, 'Evolution of the health visitor', *JRSI* (XXIV, 1903), p.180.

¹⁸ *Ibid.*

¹⁹ Maynard, *Women in the Public Health Service*, p.100. See also Miss Sharples in NCIM *Proceedings* (1906), p.80.

²⁰ St. Pancras, MOH report, 1905, p.51.

²¹ Greenwood, 'Women as sanitary inspectors and health visitors', p.230.

²² WSIA, *Present Position of Women in the Public Health Service* (Jan 1911).

²³ Letter from the WSIA to Rt. Hon. John Burns MP on the Health Visitor's Bill, 5 Nov 1910 (reprinted by the WLGS).

The title of 'sanitary inspector' was, however, felt to denote 'a strange and unfeminine occupation'.²⁴ Willesden's woman sanitary inspector took exception, not to the term 'inspector', but to the term 'sanitary'. She felt that, from an aesthetic point of view, it would be much nicer to be called 'health lady', or 'health inspector', and to do away with the term 'sanitary' altogether.²⁵ Another commented that,

There are still a few people who connect the idea of a sanitary inspector mainly with the inspection of drains, and are therefore shocked that women should take up such work.²⁶

Women battled against

The general impression of outsiders ... that sanitary inspecting must be disagreeable work and everything connected with it must be disagreeable also, and above all that the woman sanitary inspector is the worst type of "New Woman".²⁷

Rose Squire remembered the disapproval of family and friends:

The distinction of being a pioneer may now be claimed with pardonable pride, but in 1893 the adoption of such a strange and "unladylike" occupation as that of inspector was a matter calling for explanation or apology – it was "not quite nice" and the eccentricity should preferably be ignored.²⁸

Miss O'Kell recollected that, 'our friends couldn't understand how we could do it. They always thought it had to do with drains and was not quite nice'.²⁹ The early women inspectors were keen to reassure friends and relatives that their work had nothing to do with drains and sewers, and did not break any taboos of 'ladylike behaviour'. On the other hand, they also wanted to avoid the title of 'health visitor', because of its philanthropic connotations.

STATUTORY POWERS

Willesden's woman sanitary inspector agreed with Bostock Hill that the term 'sanitary inspector' conveyed the idea of someone making complaints and investigating nuisances, while the poor were more ready to accept advice and suggestions from 'health visitor'. She also claimed, however, that, 'If only the Health Visitor had the same authority and the same legal powers as the Lady Sanitary Inspector she would be a happy woman.'³⁰ Along with the title of 'sanitary inspector' went a set of official powers. Throughout the period there was debate as to whether women should be vested with these in the same way as their male colleagues. Three

²⁴ Armour, 'Sanitary inspecting', p.330.

²⁵ Gorniot, 'Sanitary lady', *NH* (V, 1913), pp.170-173.

²⁶ *Fingerpost* (1906), p.1.

²⁷ *Progress in Women's Education*, p.235.

²⁸ Squire, *Thirty Years*, pp.17-18.

²⁹ *Women in the Trade Union Movement* (TUC, 1955), p.58.

³⁰ Gorniot, 'Sanitary lady', pp.170-173.

sets of powers were debated – right of entry, right to serve and enforce notices abating nuisances, and right to punish child neglect.

It was often argued that, if women were to succeed in befriending the poor, legal powers were more hindrance than help. One woman doctor explained that:

A doctor comes into a house or workshop because he is asked. A policeman comes with all the majesty of the law. A sanitary inspector, on the other hand, has to go where she is not asked, and succeeds best when she does not need to call in the majesty of the law.³¹

The balance between reforming behaviour through education and persuasion, and legal enforcement to remedy conditions that were outside the control of the individual, was difficult to negotiate. 'A woman of tact and character can exercise a refining and benevolent influence upon those with whom she has to deal. There is far more involved than the accurate interpretation of a by-law and its legal enforcement', wrote one commentator. However, while she watched over her district 'like some benevolent recording angel, notebook in hand, with persuasive tongue and convincing argument', she was 'always backed by the majesty of the law'.³² Although, for routine inspections, powers of entry were strictly limited, a sanitary inspector's legal authority did represent the means to issue notices and to ensure that all works were completed satisfactorily.³³ As such, it was a power for which women inspectors fought. It took on a symbolic value, representing equality with men, and a right to act in the public sphere of the law.

When Deane and Squire were appointed in Kensington in 1893, they did not have the appropriate status and powers. If they detected a breach of the legislation, they had to submit complaint sheets to a special committee, which met once every four weeks, and 'take instructions'. Their anomalous position with regard to the issue of legal notices was apparent to Kensington's MOH, who feared that, if an owner or occupier were to object to a notice, or refuse to implement the suggested improvements, the sanitary authority would be in a weak position.³⁴ The Sanitary Committee recommended that they be given the status of sanitary inspector, but was repeatedly overruled.³⁵ Finally, in April 1895, Rose Squire was vested with full status.³⁶ In the meantime, in 1894, Islington was the first London authority to appoint a woman with such status. St. Pancras, in 1895, and Southwark, in 1896, followed

³¹ Inglis, 'Sanitary inspectors', p.8.

³² Bird, *Woman At Work*, p.198.

³³ For the statutory powers of male inspectors see Taylor *Sanitary Inspectors Handbook* (1897), pp.38-40, (1905), p.52, (1914), pp.23, 69; *JRSI* (1908), p.750; *Lancet* (20 Jun 1903), pp.1751-2.

³⁴ *Lancet* (19 May 1894), pp.1263-4; Kilgour, *Women as Sanitary Inspectors*.

³⁵ K&C: Kensington Vestry, Works and Sanitary Committee 25 Jun 1895, p.7.

³⁶ *BMJ* (18 May 1895), p.1110.

suit.³⁷ It then became the pattern in other boroughs for women inspectors to hold the same powers as their male colleagues. Rose Squire remembered this as a significant landmark:

Even the Local Government Board had qualms about recognizing women as sanitary inspectors! It seemed that the whole structure of society was in jeopardy from such a departure from precedent! A period of anxiety ensued, during which a sense of injustice not unnaturally rankled in our minds, before the Board gave way. Thus another barrier in woman's path was down!³⁸

If women inspectors had to fight for legal powers, those appointed as health visitors did not have even this recourse. In 1911, the WSIA sought legal advice on the issue. It found that, although a sanitary authority might confer special right of entry, a health visitor could never be empowered to sign notices, or to take out a summons.³⁹ If a health visitor needed legal authority to gain entry to a home, it was argued, her advice was not likely to be heeded. It was 'preferable for her to obtain entrance by tact alone' and, 'a suitable visitor' rarely failed to obtain admission.⁴⁰ Miss Looker commented that, 'if an indignant British matron refuses to open the door of her castle, the "advice" must be thrown at the holder of the fortress from the doorstep'.⁴¹ Willesden's woman inspector felt that, since the poor seldom realised that health visitors did not have a right of entry, it was not often denied. Right of entry would give her 'a sense of security', although she may never need it, and also 'furnished the scrupulous mind with the feeling that they are not imposing upon the ignorance of their fellow creatures'.⁴² MOHs were also convinced that health visitors should never take any action of a punitive nature, since this would destroy their position as friendly advisers, and make people suspicious of their visits.⁴³ When it came to dealing with questions relating to infant welfare, most thought that, 'No legal enactments can aid in this; it is the friendly aid and counsel that they [the mothers] need, not the legal enforcement of penalties for neglect'.⁴⁴

Despite general consensus about the value of health visiting, there were some dissenting voices, especially from those of a libertarian and anti-statist persuasion. One such group was led by G.K. Chesterton's brother, Cecil, and Cecil's wife, Ada Jones. Ada remembered how they conducted 'a spirited campaign' against the suggestion that health visitors should be given right of entry, and thereby

³⁷ *Progress in Women's Education*, p.230; Kilgour, *Women as Sanitary Inspectors*.

³⁸ Squire, *Thirty Years*, p.24.

³⁹ Wellcome: WSIA Executive, 21 Feb 1911(SA/HVA/B.2/4).

⁴⁰ Lane-Claypon, *Child Welfare Movement*, p.18.

⁴¹ Looker, 'Passing of the woman sanitary inspector', *NH* (Dec 1908), p.11.

⁴² Gorniot, 'Sanitary lady', pp.170-173.

⁴³ See, for example, *PH* (XIX, 1906-1907), pp.415-416.

⁴⁴ MO (III, 1910), p.347.

checked the tendency 'in favour of the regimentation of the poor.'⁴⁵ She commented that

The number and variety of unauthorised inspectors are greatly on the increase. The trouble is that slum-dwellers and others take their assumption of authority for granted, while the wearing of a uniform denotes to them almost penal rights.⁴⁶

The campaign involved founding the 'Mothers' Defence League', with G.K. Chesterton as President. It offered legal advice and protection in cases where parental rights were infringed. A leaflet was issued, advising parents that no health visitor had the right to enter their home, or inspect their baby, without consent, and that the same applied to school attendance officers, school nurses, NSPCC and similar workers. It concluded with the slogan 'Britons never shall be slaves' and the warning that

Unless you safeguard your rights to the privacy of your homes you will become slaves to all kinds of cranks who don't know how to mind their own business.⁴⁷

It may seem extraordinary that Agnes Mott, one of London's women public health officers, was Honorary Secretary of the League. She was forced to resign from the WSI&HVA in 1919 because of her views, especially after she wrote to a nursing journal supporting the idea that working-class parents should 'know that they have a perfect legal right to refuse admission to a health visitor'. She agreed that

The over-inspection of the poor is a positive scandal, and would soon cease if the victims were made aware of their rights under common law.⁴⁸

It was either Agnes, or another woman sanitary inspector, who drew the attention of the League to the case of a mother who was prosecuted for cruelty because her children had lice. Ada remembered that

It was a local sanitary inspector who asked us to help, for the woman to her knowledge was a most devoted mother, the trouble being that the wretched place in which she lived had broken drains, through which rats passed freely.

Now rats are vermin carriers and in walking over the children at night deposited lice on the beds and clothing.

The League arranged for a solicitor to represent the mother, and the woman sanitary inspector gave evidence on her behalf. The case was dismissed, and a notice served on the landlord to repair the premises. There was so much adverse publicity that, when a similar case arose, the Chairman of the bench declared that, 'If Mr Chesterton likes lice, he must have them', and dismissed it.⁴⁹ Some women public

⁴⁵ Chesterton, *Chestertons*, pp.119-120.

⁴⁶ Chesterton, *I Lived in a Slum*, p.55.

⁴⁷ *Nursing Notes* (Nov 1919), p.95.

⁴⁸ *Ibid.*

⁴⁹ Chesterton, *Chestertons*, pp.120-121.

health workers were very aware of the impact of the use of legal powers and punitive measures on those who had very little control over their environment, and took action to help.

It was in improving the environment that was outside the control of the individual that health visitors most keenly felt the lack of powers. Miss Charlesworth of Shoreditch noticed many sanitary defects while on her rounds. Not being able to deal with them herself caused considerable waste of time and effort.⁵⁰ She agreed that 'the work of the health visitor was intensely personal, but it became less effective if the work were confined merely to visiting and giving advice.'⁵¹ For Miss Looker, powers of persuasion alone did not 'not go far with the class of landlords' she dealt with. She had to return to the office and report to the MOH, who instructed a sanitary inspector to visit and take appropriate action. It might be days, if not weeks, before the overworked man could attend to the matter. 'Think of the unnecessary multiplication of visits to the harassed householder,' she declared.⁵² West Ham's MOH reported that the health visitors on his staff, 'being without statutory office' were exposed 'to rudeness on the part of the tenant and obstruction on the part of the landlord.' In two cases landlords instructed their tenants not to admit the visitors.⁵³ For women inspectors, statutory powers were the only way to reach neglectful landlords. Denying them these unduly troubled the tenant, without reaching the root cause of the problem.

In 1910 Miss Carey of Westminster, in examining the steady growth of health visiting and the infrequent new appointment of women sanitary inspectors, was quite clear about the reasons for this. First, 'the health visitor did not come into collision with the slum landlord as the woman sanitary inspector did.' This meant that 'the anti-feminist councillor' had no objection to the appointment of a woman who only 'influences' mothers, and had no authority to serve a notice on the owner of an insanitary property. The slum landlord, 'had a very decided opinion about the woman sanitary inspector, which, although not flattering in its terms, was entirely honourable to the Women Inspectors.' Second, she blamed male sanitary inspectors who did not like to see women exercising the same powers as themselves. She was convinced that there was a plot afoot aimed at the 'ultimate annihilation' of the woman sanitary inspector and her replacement by the health visitor, 'whose charms they are constantly extolling'. She accused Bostock Hill of placing women officials on the

⁵⁰ SR (XLVI, 1910), p.232.

⁵¹ *Women Workers* (NUWW, 1911), pp.127-128.

⁵² Looker, 'Passing of the woman sanitary inspector', p.11.

⁵³ West Ham MOH report, 190, p.27.

same level as voluntary social workers, and of perpetuating 'the mistakes and prejudices of the unofficial worker', declaring that 'platitudes about women's mission being to women merely show that he does not know what he is talking about'.⁵⁴

The issue was an emotive one, but how did the women apply their powers? Between 1898 and 1914 women factory inspectors employed by the Home Office brought almost 5,000 cases to court and secured convictions in the vast majority.⁵⁵ Acting for themselves in court and arguing cases with well-known QCs, they felt that they were breaking new ground for women.⁵⁶ Indeed, as soon as they were able, several rushed to read for the Bar. The picture was very different for women sanitary inspectors at a local level. Of the 16 boroughs that replied to a questionnaire sent out by the National Union of Women Workers in 1908, in 13 women sanitary inspectors were allowed to sign their own notices (although in two of these they signed intimation notices only), and in 14 they saw their notices carried through (although often not for drainage or structural work). In only five boroughs did they actually undertake prosecutions.⁵⁷ It was a rare occurrence for a case actually to go before the magistrate, although it was not unknown.⁵⁸ In the two and a half years she worked inspecting common lodging houses in Southwark, Miss Elliott took 19 cases to court (ten relating to overcrowding and nine to cleansing) and obtained a conviction in every case.⁵⁹ Cases were often handed over to the male inspectors for remedy. In 1899 Miss Teebay of Hackney dealt with 258 nuisances herself, handing over 137 to the district sanitary inspectors, in a year in which she served 180 intimations, 43 final notices, nine statutory notices and applied for two summonses.⁶⁰ One woman inspector explained that the women generally only supervised to completion such work as whitewashing, the provision of additional ventilation, the repairing of floors, roofs, dustbins, etc. and left the supervision of drainage and construction work to the male inspectors.⁶¹ When Rose Squire took her first case before the bench, the magistrates 'made merry' over the idea that a 'dirty ceiling' might be injurious to health. Her colleague, Lucy Deane, recorded in her diary, 'Memo: a bench of JPs is a very ignorant thing', and noted the 'difficulty in obtaining a verdict from them in sanitary matters'.⁶² One senior woman said of the new inspector

⁵⁴ SR (XLVI, 1910), p.232; SR (XLVII, 1911), p.308.

⁵⁵ Anderson, *Women in the Factory*, pp.210-209.

⁵⁶ *Ibid.*

⁵⁷ NH (I, 1909), p.78.

⁵⁸ *Progress in Women's Education*, p.233.

⁵⁹ *Are women wanted on London Borough Councils?* (WLGS, 1908).

⁶⁰ HAD: Parish of St John at Hackney, Vestry, 14 Feb 1900, p.417 (J/V/15).

⁶¹ *Progress in Women's Education*.

⁶² LSE: Lucy Deane's diary, 10 Apr 1894 (Streatfeild 1/4).

that 'by bitter experience she will learn the difference between enacting laws and putting them into force'. She would eventually come to the conclusion that 'it is best to rely upon her own powers of persuasion and coercion instead'.⁶³ When powers were granted to the women, their use was limited, although not unimportant.

It was not unusual for male inspectors to be advised that, 'it is only in very exceptional instances that it is found necessary by a good sanitary inspector to requisition the stern arbitrament of the law'.⁶⁴ It was never suggested, however, that the male inspector should not be able to hold statutory powers, just that he should use them with discretion. For the woman inspector or visitor, the terms of the debate were rather different. In campaigning for equal status in the public sphere, in terms of both title and powers, they deliberately distanced themselves from the non-professional voluntary visitor. They did not wish merely to lecture and condemn, but to provide practical help. They argued that being a 'friend' was not enough, particularly when it came to the recalcitrant landlord or workshop proprietor. They were also keen not to be classed with those who used their power to punish mothers, rather than to help them.

UNIFORMS

In many districts it was common practice for male sanitary inspectors to wear a uniform. In Kensington, for example, uniforms had first been provided for sanitary inspectors in 1880 – a dark blue coat with an inscription 'KV Sanitary Inspector' on the collar in red letters, a waistcoat and trousers, and a cap with the words 'Kensington Vestry'. Some MOHs felt that uniforms were a way of ensuring that inspectors were not idle, and did not behave badly in public.⁶⁵ For those campaigning to raise the status of the inspector, uniforms were 'relics of the time when Inspectors were often drawn from policemen and soldiers'.⁶⁶ The Sanitary Inspectors Association (SIA) campaigned for their abolition, since they brought responsible public officials to the level of 'a railway porter'.⁶⁷ The chairman of the SIA Council felt that 'a livery' put the sanitary inspector 'on an equality with the beadle and lackeys'.⁶⁸

In the case of women officials there was debate over the type of uniform and, in particular, whether a nurse's uniform was the most suitable costume. In some areas an early decision was taken not to place them in uniform at all. In Norwich,

⁶³ Maynard, *Women in the Public Health Service*, p.59.

⁶⁴ Kenwood in Stockman, *Practical Guide for Sanitary Inspectors*, p.xiv-xv

⁶⁵ See, for example, St. Mary Islington, MOH report, 1893, pp.100-101.

⁶⁶ SR (XXXVI, 1905), p.8.

⁶⁷ SR (XXXIV, 1904), p.100.

⁶⁸ *SIJ* (II 1896-1897) pp.271-280.

whereas the male sanitary inspectors were provided with a uniform, the City's lady inspector was given an allowance with which she could dress as she chose. 'She did not have a band round her hat, in fact, she visited homes in the dress of a lady, and it was in that capacity that her work would be done most effectually'.⁶⁹ In London, early attempts to place women sanitary inspectors in nurses' uniform were fended off by the women, creating an atmosphere of solidarity with their male colleagues. The woman sanitary inspector in Southwark who, in 1897, refused to wear the uniform, was described by the *Sanitary Inspectors Journal* as a 'plucky' but 'recalcitrant damsel'.⁷⁰

In April 1903 the WSIA unanimously decided that 'the wearing of uniform by women sanitary inspectors is inadvisable as it is likely to hinder them in the discharge of their duties and would tend to lower their status'.⁷¹ According to Miss Gorniot of Willesden, 'The idea of inspecting factories and workshops in nurses attire is not a congenial one.' It also made the inspector more conspicuous, and this was a disadvantage, both to the inspector and to the person she was visiting, particularly in tuberculosis cases. She was aware, however, that 'more deference is shown to a person in uniform'.⁷² For health visitors it was common to insist on a nurse's uniform, both in the clinic, and for home visiting – a coat, skirt and plain hat, occasionally decorated with the label 'health visitor'.⁷³ Some MOHs felt that nurses' uniforms helped to differentiate health visitors from 'many other callers not always welcome', and because information was more likely to be willingly offered to a 'health nurse'.⁷⁴ Ross has recently argued that 'soberly uniformed' district nurses enjoyed much popularity and 'relative safety', as 'the costume transformed a lady into a civic institution'.⁷⁵ Kensington's health visitor commented in 1906 that, 'I have almost invariably been well received by the mothers, and especially since resuming the use of my nurse's uniform'.⁷⁶ Another visitor, who worked in an area of South London that included a street known locally as 'Little Hell', never 'met with any rebuff or rudeness in the worst slums. I soon found that as a nurse I could go anywhere'.⁷⁷ The experience of some did not bear out this view. In 1898 a Liverpool dock labourer was fined for assaulting a lady sanitary inspector who had called at his home in uniform.

⁶⁹ JSI (XXIV, 1903), p.318

⁷⁰ SJ (II, 1896-1897) p.308

⁷¹ Wellcome: WSIA minutes, 3 Apr 1903 (SA/HVA/B/1/1).

⁷² Gorniot, 'Sanitary lady', pp.170-3.

⁷³ *How to Become a Lady Sanitary Inspector*, p.20.

⁷⁴ PH (XXX, 1916-1917), p.135.

⁷⁵ Ross, *Love and Toil*, p.173.

⁷⁶ Kensington, MOH report, 1906, p.65.

⁷⁷ G.S.C., 'Health visiting in the early days', NM (13 Nov 1937), pp.157-158.

Perhaps mistaking her for an NSPCC worker, his wife assumed that the uniformed visitor was 'in some way going to interfere with the children'. Husband and wife became violent and abusive and proceeded to lock her up in a back room.⁷⁸

OFFICIAL MANNER

There was much advice forthcoming about how the women might be officials without behaving as such. One commentator argued that there was no reason why an official should not be as much of 'a friend of the family' as a voluntary visitor. 'The proper type of official health visitor does not thrust forward her authority, certificates or other attributes of officialism to the detriment of her true functions.'⁷⁹ For another, a health visitor must 'have the capability of being an official without appearing official'.⁸⁰

She 'must know and observe all the unwritten laws of etiquette and good manners'.⁸¹ After all, the mothers themselves usually had excellent manners.⁸² Visitors were reminded that 'one gains nothing by trying to force oneself on people', and that 'the politeness of everyday life must be scrupulously observed' since, 'by showing courtesy and interest in small matters we gradually establish a friendship with the mother'.⁸³ Tuberculosis visits should be 'in the nature of a first call to new comers of one's own social standing', and should be made as an 'invited guest' rather than an 'intruding official'.⁸⁴ Visitors in St. Pancras were advised that the mothers were 'very quick to respond to well-bred courtesy'.⁸⁵ The Superintendent of South Islington Infant Welfare Centre also thought that mothers should be extended the 'quiet courtesy that one would extend to guests in one's own house'. For her, 'the ideal infant welfare worker' was 'a perfect hostess', receiving each mother 'pleasantly and graciously'.⁸⁶ In home visits, the visitor was to set the mother at her ease and invite her to sit 'as it feels more friendly'.⁸⁷ Another tip was never to knock on the door with a 'double rat-tat', as this

strikes terror into their hearts; to them it sounds like a doctor, rent-collector or parson, and each may be an unwelcome visitor according to the condition of the circumstances; they do not like rat-tats.⁸⁸

⁷⁸ *BMJ* (14 May 1898), p.1304.

⁷⁹ *MO* (XVIII, 1917), p.183.

⁸⁰ Evans, 'Essential qualifications of a lady health visitor', *JRSI* 1903 p.306.

⁸¹ *Ibid.*, pp.12-14.

⁸² *Ibid.*, p.82.

⁸³ Macmillan, *Infant Health*, p.91.

⁸⁴ Eve, *Manual*, p.158,

⁸⁵ Kanthack, *Preservation of Infant Life*, p.4.

⁸⁶ Wise, 'Worker's view on an infant welfare centre', *NH* (XI, 1919), pp.225-226.

⁸⁷ Skene, *Ideal Health Visitor*, pp.8-9.

⁸⁸ *Ibid.*

There was one official habit that was to be particularly eschewed – being ‘inquisitorial’.⁸⁹ Avoidance of the taint of the COS enquiry agent seems to have lain behind much of the advice offered to health visitors.⁹⁰ A friendly visitor was to inspect the home ‘with a glance’, rather than ask a long list of official-sounding questions.⁹¹ A visit to a tuberculosis case was not intended to be ‘an inquisitive inspection’, but ‘a friendly call’.⁹² Questions should never ‘be hurled at the patient’ when ‘general conversation’ might reveal the necessary information.⁹³ Families had a perfectly justifiable dislike of ‘an intruder who asks questions apparently impertinent in both uses of the word, in a tone of voice which, if not actually supercilious or patronising, is at any rate offensively official’.⁹⁴ The obvious use of notebooks was not recommended. Instead the visitor was to take down sensitive details such as numbers of still-births, while appearing to note objective sanitary details, such as the condition of the sink or a leaking roof.⁹⁵ Visitors were advised not to fill in record cards during the actual visit. Instead, the information was to be memorised and written down outside the house, ‘preferably round the street corner’.⁹⁶ The tuberculosis visitor was ‘not a worse, but a better official’, if she carefully concealed her official notebook until safely out of sight of the house since

To produce a notebook in some quarters may even suggest the policeman’s formula: “Anything that you say now may be used in evidence against you”.⁹⁷

Not all women officers agreed with this stealthy gathering of information. There was tension between helping the mothers, and obtaining statistics for MOHs. One thought that the lengthy questionnaires with which MOHs burdened their women officials were problematic. Although statistics had their value, ‘numerous questions are frequently a sore trial’, since ‘the aim of these visits is, after all, not to obtain information, but to help the mother rear her baby’.⁹⁸ She feared that they were a temptation for the ‘bad worker’ to turn the visit into a series of questions and answers. There were similar tensions in tuberculosis work, where the lengthy reports required were particularly difficult to compile tactfully.⁹⁹ For one woman inspector, the

⁸⁹ Meacher, *Tuberculosis*, p.62.

⁹⁰ Eve, *Manual*, p.26.

⁹¹ Skene, *Ideal Health Visitor*, p.4.

⁹² Meacher, *Tuberculosis*, p.64.

⁹³ WHO (Oct 1930).

⁹⁴ Griffin, ‘Value of the health visitor’, p.157.

⁹⁵ Maynard, *Women in the Public Health Service*, p.84.

⁹⁶ Lane-Claypon, *Child Welfare Movement*, p.19.

⁹⁷ Eve, *Manual*, pp.158-159

⁹⁸ Maynard, *Women in the Public Health Service*, p.90.

⁹⁹ For the long list of questions that the tuberculosis nurse in Paddington was expected to ask see *Lancet* (26 Mar 1910), p.879.

Notification of Births Act led to the mother being 'subjected to an ordeal of clumsy questioning'.¹⁰⁰ She considered that

Another source of danger lies in the temptation to collect information on all social questions. Much that is of interest will be spontaneously given, and can be recorded and used, but we all need to remind ourselves nowadays that, in dealing with the intimate home-life of the people, however poor and however ignorant, we are dealing, not with inanimate things, but with living human minds and souls.¹⁰¹

For one infant welfare worker, it was wrong to

call at the homes and ask the mothers all sorts of questions as to their personal affairs such as "What rent do you pay?", "What wages does your husband earn?" and "Is he good to you?" I cannot see what good such questions do ... if any good is going to be done, the visitors will have to be friendly and not so officious, for the mothers are really frightened of them.¹⁰²

Women public health officers were aware of the tension in their role. While they valued official status, they rejected an official, inquisitorial or dictatorial manner.

RELATIONSHIP WITH MALE INSPECTORS

Local government offices in 1900 were male institutions. Women officers were 'rare and specialized', and women sanitary inspectors and health visitors the most numerous group.¹⁰³ As one woman warned, a female sanitary inspector 'may find herself in an office staffed entirely by men, with chief, committee, and council composed entirely of men – indeed everything looked at from the male standpoint'.¹⁰⁴ Issues of title, powers and uniform indicate significant difficulties in integrating women officials into existing structures. Their relationship with their male colleagues is also revealing.

Woman's sphere

Celia Davies has argued that the attitude of male sanitary inspectors to their female colleagues was determined by the fact that there were too many inspectors chasing too few jobs.¹⁰⁵ In 1899, 200 men competed for a single vacancy, and the Sanitary Institute certified at one single examination sufficient men to fill every vacancy that occurred that year.¹⁰⁶ It was a recurring problem and supply still greatly exceeded demand after the First World War.¹⁰⁷ When reflecting on the early years of

¹⁰⁰ Sharples, 'On the personality', p.16.

¹⁰¹ *Ibid.*

¹⁰² Letter from Nurse Cunliffe, *Workers Dreadnought* (22 Sep 1917), p.857.

¹⁰³ Spoor, *White-collar Union*, p.465.

¹⁰⁴ Greenwood, 'Women as sanitary inspectors and health visitors', pp.233-234.

¹⁰⁵ Davies, 'Health visitor as mother's friend', pp.50-51.

¹⁰⁶ SR (XXII, 1899), pp.41-42.

¹⁰⁷ SR (LXX, 1922), p.250.

the employment of women sanitary inspectors, commentators often hinted at the 'difficulties' that had initially arisen. They were keen to point out how any rivalry had quickly ceased, when 'women were found to be more suitable for the special duties for which they were employed.'¹⁰⁸

In general, male inspectors wished to see women confined to duties that did not overlap with their own. One asked,

Why should women overlap with the male sanitary inspector and deal with defective roofs, gutter, water-closets and nuisances? The male sanitary inspector is quite content to concentrate on these matters, and not open an inspection by inquiring "How's the baby?"¹⁰⁹

If they were to have women at all, one male inspector declared, it should be 'in their proper sphere' – 'as a lady nurse to the poorer classes' – while structural inspection was left to men.¹¹⁰ 'Properly trained as Health Visitors they would be a valuable adjunct to a Public Health Department ... but as Sanitary Inspectors they only bring ridicule upon the Public Health Service,' was a common view.¹¹¹ Even infant welfare work was resented by some. In 1905, one complained that men were forgotten in the annual reports of MOHs, while the praises of female inspectors 'were loudly sung'. For him, 'Acts of Parliament are distorted, Committees are over-persuaded, Councils are influenced in the support of fads and fancies which have little or no foundation under existing Public Health Acts.' This resulted in nothing less than 'magnifying a feeding bottle and neglecting insanitary areas; studying the infant and forgetting the multitude.' He stressed that any health visitor appointments should be in addition to, and not instead of, a full staff of sanitary inspectors.¹¹² Most, however, seem to have welcomed the arrival of the health visitor, and quickly seized on the opportunity of consigning women to their 'proper sphere' – one that complemented, rather than competed with, their own.¹¹³

'Fussiness' and 'superiority'

There was more than simple protectionism at work in the tensions between male and female public health officers. As has been seen above, the women came from rather different social backgrounds than their male colleagues.¹¹⁴ Some male

¹⁰⁸ Mrs Percy Boulnois, in Dudfield, *Woman's Place in Sanitary Administration* (WSIA, 1904), p.14.

¹⁰⁹ *ME* (LXVII, 1921), p.537.

¹¹⁰ *SJ* (III, 1897-1898), pp.189-192.

¹¹¹ *SJ* (XV, 1909-1910), p.185.

¹¹² *SR* (XXXV, 1905), p.433.

¹¹³ See, for example, *SJ* (XVIII, 1912-1913), p.110.

¹¹⁴ For similar tensions between male school attendance officers and women care committee workers, see Williams, Ivlin & Morse, *Children of London*, especially pp.14, 26, 49. Like

sanitary inspectors were critical of characteristics, such as a lack of common sense and practical judgement, which were felt to be typical of middle-class women. Male inspectors complained of the way in which the women laid a long list of trivial matters before the MOH, 'The idea appears to be that it is their special duty to show they are superior to the mere male Inspector.'¹¹⁵ One gave examples of some such complaints – 'handle off oven door', 'furnace will not draw well', 'kitchen door broken' – and failed to see what Act gave the local authority any power to demand such repairs. On the other hand, women inspectors were depicted as having 'the faculty of taking infinite pains, and would go into details more fully than men.'¹¹⁶ Debate raged in the columns of the trade press. One correspondent, terming himself 'Live and Let Live', praised women for their attention to detail, pointing out that only a woman would appreciate the inconvenience of having a broken kitchen door that would entail draughts and smoke. It was an accumulation of such details over time that created the slum dwelling.¹¹⁷ 'Justice', on the other hand, felt that women did not possess the same level of judgement as men, and did not agree that such trivial details constituted slums.¹¹⁸

One woman inspector reported that

On one of my first visits I made inquiries as to how often the stairs were washed and swept, as the dirt on them seemed quite thick enough to plant potatoes in. In answer the woman said, "Have you to do with that too? Why, the old sanitary gentleman who was here last never mentioned them." No wonder ladies get the name of being more particular than men.¹¹⁹

Another 'acknowledged that men pay less attention to detail than do women'. If a man ignored dirt but a woman treated it as a nuisance, 'bad feeling' resulted.¹²⁰ Miss Carey suggested, 'without desiring to give offence', that male inspectors 'were not always able to pay attention to the same small matters as women were able to do.'¹²¹ One medical man defended women inspectors against charges of 'fussiness' and 'over-education'. For him, it was not a problem of the 'over-education' of the women, but of the 'under-education' of health officers as a whole.¹²² Such statements must have rankled with male inspectors, attempting to improve their status and

sanitary inspectors, many school attendance officers were retired policemen or members of the armed forces, while care committee volunteers and workers were women from affluent families.

¹¹⁵ SR (XXXVI, 1905), p.8.

¹¹⁶ SR (LIII, 1914), p.346.

¹¹⁷ SR (XXXVI, 1905), p.52.

¹¹⁸ SR (XXXVI, Jul-Dec 1905), pp.74-75.

¹¹⁹ Armour, 'Sanitary inspecting', p.336.

¹²⁰ Maynard, *Women in the Public Health Service*, p.27.

¹²¹ NCIM, *Proceedings* (1906), p.81.

¹²² SR (XIX, 1896-1897), pp.98-100.

professional standing. Some historians have identified a 'celebration of their own moral superiority' in the attitudes of women entering the public sphere.¹²³ Women factory inspectors are renowned for the way in which they took a moral high ground and were critical of their male colleagues, who treated their work simply as a means to earn a livelihood.¹²⁴ Women sanitary inspectors stressed the importance of difficulty of their duties. Mrs Greenwood wrote that

The large demands thus made upon their powers of persuasion and teaching capacity, involve a considerable strain upon their nervous energy as well as their physical strength. The work of men inspectors, on the other hand, being of a more official character, does not involve the same strain.¹²⁵

It was a common perception of MOHs that the women on their staffs were 'greedy of work' and self-sacrificing'.¹²⁶ Miss O'Kell remembered,

We were all as keen as knives on our work ... We were determined to make it a success and we didn't care how hard we worked, or how long. It was all new – and new work for women.¹²⁷

One woman inspector passed on an anecdote relating to her first visit to some workrooms of a large shop. The supervisor said, "Well, I suppose I must let you in, for I can't offer you half-a-crown, and I can't ask you to have a drink" – 'a remark which let a flood of light upon some of the former visits of the male Inspector.'¹²⁸ Such stories appearing in print infuriated the men. At the Sanitary Congress in 1897, Miss Ravenhill said that women had more tact than men, and were also generally superior to other temptations, such as the offer of a 'drink', which assailed male inspectors, 'who were not always of as high culture' as the women.¹²⁹ One male inspector demanded an apology, declaring that the implication that male inspectors could be bribed in this way should never have been uttered in public, and that women did not have much tact if they made such speeches.¹³⁰ Tension between women inspectors and their male colleagues was exacerbated by the sensitivity of the men to anything that undermined their determination to free themselves from their nineteenth-century reputation of being poorly educated, untrained, and prone to corruption.

The idea that they were merely executive officers carrying out the orders of the MOH, whilst the women were undertaking, at their own initiative, duties which, as educational, fell into a higher category, added to the strain. One MOH recalled that,

¹²³ Levine, *Victorian Feminism*, p.19.

¹²⁴ Anderson in *Progress in Women's Education*, p.224; Harrison, *Not Only*, p.195.

¹²⁵ Greenwood, 'Women as sanitary inspectors and health visitors', p.227.

¹²⁶ *Lancet* (4 Aug 1906), p.291.

¹²⁷ *Women in the Trade Union Movement* (TUC, 1955), p.58.

¹²⁸ SR (XXXIII, 1904), p.163.

¹²⁹ *SIJ* (III, 1897-1898), pp.115-116.

¹³⁰ *Ibid.*, pp.173-174.

Formerly it was a statement quite commonly made by male members of health department staffs that the women were very much inclined to consider themselves quite definitely not part of the staff; in no sense colleagues of other workers, but on an entirely different plane.¹³¹

One commentator found himself wrong 'in thinking that there was a shoulder-to shoulder desire on the part of the women'.¹³² Instead, he was convinced that health visitors

do not consider themselves anything but purely independent officers; not even officers – this is an offensive word – but missionaries and teachers, free from all control, not liable to be directed to make inquiries for and report to anybody, but only to go about teaching ... just what they believe to be the right thing to teach. All this because they have had ... a secondary education and a term or two with a professor or two at or from a University Institution.¹³³

Salaries

In 1895, 'a qualified woman' wrote to the *Sanitary Record* about two advertisements, one for a male and one for a female inspector, pointing out that they were 'curiously alike in every point but one'.¹³⁴ The woman was to be paid £80-100, while the man was to receive £100-120. She asked, 'Will anyone behind the scenes kindly explain on what grounds such a difference is made?'¹³⁵ Before the First World War, in the 'lower professions', including nursing and teaching, women received on average 57% of male pay.¹³⁶ The difference between men's and women's wages was linked to the clear distinction between what was considered to be 'men's work' and what 'women's work'. Men sought to protect their jobs and their wages, by excluding women.¹³⁷

Although women sanitary inspectors were often appointed to posts with the same status and powers as their male colleagues, the duties they performed were generally different, and only rarely did they receive equal pay. Although at least one borough did treat its men and women equally, in general, London's early women inspectors were paid roughly 60% of the salaries offered to their male colleagues, and this situation persisted.¹³⁸ In 1908, a national survey found that, in four

¹³¹ *ME* (LXX, 1922), p.46.

¹³² *Ibid.*

¹³³ *Ibid.*

¹³⁴ *SR* (XVII, 1895-1896), p.441.

¹³⁵ *Ibid.*

¹³⁶ Routh, *Occupation and Pay*, p.123.

¹³⁷ Smith, 'Issue of "equal pay for equal work"', p.39.

¹³⁸ LMA: printed reports on the sanitary staffs of the metropolitan boroughs (LCC/PH/1/245). Salary figures are not always internally consistent. Neither do they always tally with other sources. Differences in exactly what was included in the final figure in terms of bonuses and allowances complicate the picture, and lack of information about relative length of service

authorities the maximum of the women's salaries equalled the minimum of the men's, and that women sanitary inspectors' pay was generally 'distinctly lower' than that offered to their male colleagues.¹³⁹ In 1918 it was the impression of members of the WSI&HVA that, where good salaries were offered, women were generally paid around three-quarters of the male wage.¹⁴⁰ The salaries of women sanitary inspectors were generally rather higher than those of health visitors.¹⁴¹ If women inspectors were 'cheap men', health visitors, an all-female occupation, were 'cheap women inspectors'. The First World War did little to alter this situation and, in 1920, only four London boroughs offered equal salaries to their male and female public health officials.¹⁴² In a few cases, women sanitary inspectors received the same as male inspectors, and health visitors the same as women sanitary inspectors, but it remained the general practice to pay lower salaries in both cases.¹⁴³ The Ministry of Health thought that, for sanitary inspectors, 'a proportion of one-third less for women's salaries might be accepted for general guidance.'¹⁴⁴ It rejected claims for equal treatment, since a woman 'discharges functions more analogous to those of an assistant sanitary inspector'.¹⁴⁵ When individual authorities did accept the principle of equal pay, they met with resistance from the Ministry.¹⁴⁶ The introduction of collective bargaining did not change matters. The London District Whitley Council placed health visitors on a lower grade than sanitary inspectors, but did not commit itself as to whether women inspectors should be graded with their male colleagues, or with health visitors.¹⁴⁷ It was left for local authorities to decide.

Clara Collet, then working at the Board of Trade, recorded in her diary in 1904 a conversation with Blanche Gardiner, who was working as a sanitary inspector at St. Pancras. She had asked for £2 a week instead of the 30 shillings she was currently paid. 'They haggled over it for a long time', and her appointment was renewed at 35 shillings:

She has since accepted it as she is too much interested in the work to be willing to refuse it on principle. It may be a stepping stone to a decent

makes direct comparisons between male and female inspectors difficult. Despite these problems, it is possible to construct a general picture.

¹³⁹ Sharples, 'On the personality of women in sanitary work', pp.9-20.

¹⁴⁰ Wellcome: WSI&HVA Executive, 29 Jan 1918 (SA/HVA/B.2/7).

¹⁴¹ Gardiner, 'Varied nature of the work of women public health officials', *JRSI* (Vol XXXV, 1914), p.514.

¹⁴² *BMJ* (12 Jun 1920), p.815.

¹⁴³ TNA: Memo by 'H.O.S.', Feb 1922 (MH 53/11).

¹⁴⁴ TNA: Public health staff, salaries in London, 1922-1923 (MH 53/11).

¹⁴⁵ TNA: Memo by 'H.O.S.', Jul 1920, (MH 53/61).

¹⁴⁶ Wellcome: WSI&HVA Executive, 20 Apr 1920 (SA/HVA/B.2/9); TNA: Letter to Lambeth Borough Council, Aug 1920 (MH 53/61).

¹⁴⁷ NH (Vol XV, 1922), p.22; TNA: Memo by 'B.C.H.S.', Mar 1924 (MH 53/13).

appointment later on. Of course she cannot live on it without assistance from her father.¹⁴⁸

Compromise in order to gain a foothold in a new field, and the lack of better paid opportunities elsewhere, were important factors. For one of the JBG's women inspectors, it was only because she was Jewish herself, 'anxious to work among the Jewish poor', and 'promote the health and general welfare of our poor co-religionists', that she was prepared to accept such a low salary.¹⁴⁹ Women sanitary inspectors were slow to campaign on the subject. Miss Teebay, a Hackney inspector, felt that they should bide their time until they had 'proved their worth'.¹⁵⁰ Miss Lovibond, noted that 'the enthusiasm of supporters of this movement does not in many places bring them proper salaries'.¹⁵¹ Margaret Sharples was

touched by the self-denial shown by women who remained at posts where they felt that their work was only beginning rather than accept appointments under better and easier conditions in another place. But is it fair to ask it of them? ... Surely the labourer is worthy of her hire.¹⁵²

Blanche Gardiner was later to write that, although the work of the women inspectors might differ in detail from that of the men, it was 'not generally regarded as *inferior* in either quality or quantity'.¹⁵³ She acknowledged that,

Some women may do health work for the mere love of it, that is, for the interest and understanding of social matters, but others (the majority) have to do it as a source of livelihood and support of, not only themselves, but also perhaps of a widowed mother or invalid relative.¹⁵⁴

Women sanitary inspectors urged their colleagues not to sell themselves short, not only for the sake of other women, but in order to defuse the antagonism of male inspectors. Miss Gray hoped that women inspectors were not 'cheap men'. She hated being accused of 'taking bread out of children's mouths'.¹⁵⁵ Miss Carey, a Westminster sanitary inspector, summed up the situation:

At present there is undoubtedly antagonism, more particularly on the part of the men who regard the women as their natural foes, entering into unfair competition with them, and underselling them in the labour market. And there is a great deal of justice in this view of the case. We do undoubtedly compete unfairly. We come into the labour market offering the same apparent qualifications, with less actual knowledge than you, of one branch of work, but often able to beat you in other branches, prepared to take the same risks, and

¹⁴⁸ MRC: Clara Collet, ms diary (MSS.29/8/1/73).

¹⁴⁹ Southampton: Letter from Hilda Joseph, 22 Sep 1904 (MS 173/1/11/3).

¹⁵⁰ Wellcome: WSIA minutes, 10 Oct 1907 (SA/HVA/B.1/3).

¹⁵¹ *Fingerpost* (1906), pp.13-14.

¹⁵² Sharples, 'On the personality', p.20.

¹⁵³ *JRSI* (XXVIII, 1907), p.198.

¹⁵⁴ Gardiner, 'Varied nature', p.514.

¹⁵⁵ *SR* (XIX, 1895-1896), pp.98-100.

to work the same hours; and then we accept lower salaries than you - thereby lowering the standard value.¹⁵⁶

For Miss Carey, the solution was for the women to obtain equal pay, since then there would be no temptation on the part of economically-inclined local authorities to appoint women, because they were cheaper than men, or health visitors, because they were cheaper than sanitary inspectors. It is occasionally possible to find male supporters for the principle of equal pay, 'to prevent any unfair competition with the male', but this was not common.¹⁵⁷

In 1909 Westminster's women inspectors complained to the City Council that their work was arduous, responsible and involved continuous mental strain, and that they were as entitled to earn a suitable living from it as were the men.¹⁵⁸ One Councillor thought that the tasks undertaken by the women inspectors were of 'a simple nature', and suggested that there were plenty of women who would undertake the work for even less. If they were unable to strand the strain, they should resign their posts.¹⁵⁹ Male sanitary inspectors were particularly sensitive to any suggestion that the work of the women was of a higher level. One, calling himself 'Fair play', wrote to the *Sanitary Record* that women were under no more 'mental strain' than the men. If women were treated equally, he argued, they would also be 'ten times better off', since 'one knows that the majority of inspectors are married men' who had to keep a wife and family, whilst the lady had only herself to maintain.¹⁶⁰ This debate illustrates the main issues that dogged attempts to raise the salaries of the women throughout the period: the idea that men should receive 'a family wage'; that there was a pool of women available to do the work for very little pay, or, indeed, for nothing; and that the work of the women was different.

Holidays and pensions

In 1910, Finsbury's woman inspector observed that 'there is no body of educated women workers who have such short holidays'. She argued that it was for this reason that many had to take sick leave and that there had been 'some serious break-downs'.¹⁶¹ It was difficult to campaign for shorter hours on the grounds of exhaustion, since a common argument against equal pay was that women were not

¹⁵⁶ SJ (XIII, 1907-1908), p.193.

¹⁵⁷ *Ibid.*, pp.166-167.

¹⁵⁸ TUC: *Hereford Times*, 5 Dec 1908 (Gertrude Tuckwell Collection 30/2).

¹⁵⁹ NH (I, 1909), p.54; SR (XLII, 1908), p.537.

¹⁶⁰ SR (XLII, 1908), p.546.

¹⁶¹ Greenwood, 'Sanitary inspection', pp.23-34.

as productive, having a higher sickness rate and less physical endurance.¹⁶² In 1898, one male sanitary inspector found that women were 'more susceptible to the ordinary wear and tear of such a life than men are, and are not unseldom absent from duty through ailments of one kind and another.'¹⁶³ One MOH felt that they required longer holidays, not only because they were 'physically unable to bear the strain of continuous official work', but also because 'their work was of an unquestionably more exhausting nature than that of men', since it was 'largely dependent on their persuasive and educational powers'.¹⁶⁴ It was this latter argument that was used by the women themselves.¹⁶⁵ The WSIA was initially cautious, considering it unwise to press for different holidays, as it would provide an excuse for lower pay.¹⁶⁶ However, by 1918, it argued that the three weeks offered by many local authorities was not enough because of the 'exceptional expenditure of nervous energy'.¹⁶⁷ The exercise of tact and persuasion by health visitors resulted in 'considerable strain on health and vitality'. For those visiting tuberculosis cases there was the additional risk of infection when an officer was over-tired and debilitated.¹⁶⁸

Campaigns over pension provision were fraught with similar tensions. The WSI&HVA argued for special treatment because of the 'exceptionally arduous' nature of their duties, necessitating an earlier retirement age, and because of their later age of entry.¹⁶⁹ The lower salaries paid to women meant that any amount of pension they received compared unfavourably with that of their male colleagues. This case for differentiation can be contrasted with the policy of the National Union of Women Teachers, which declared that, to ask for women to receive pensions earlier than men, was the same as saying that women grow older sooner than men.¹⁷⁰ In campaigns over salaries and conditions of work, finding a balance between equality and difference was problematic, and caused women to emphasise the arduous and draining nature of their work, fuelling tensions with male inspectors.

¹⁶² Banks, *Politics of British Feminism*, p.115.

¹⁶³ SR (XXI, 1898), p.91. See also Richards, 'Aim and scope of women's work in relation to public health', *JRSI* 1907 p.195.

¹⁶⁴ *JRSI* (XXXV, 1914), p.517.

¹⁶⁵ Greenwood, 'Women as sanitary inspectors and health visitors', p.234.

¹⁶⁶ Wellcome: WSI Executive, 8 Apr 1913 (SA/HVA/B.2/5), 13 Nov 1917 (SA/HVA/B.2/7).

¹⁶⁷ *ME* (LXII, 1918), p.398.

¹⁶⁸ TWL: WSI&HVA to the LGB, 21 Nov 1918 (2/LSW/326).

¹⁶⁹ Wellcome: WSI&HVA annual report, 1918-1919, p.7 (SA/HVA/A.1/12); *NH* (XI, 1919), pp.260-261.

¹⁷⁰ Copelman, *London's Women Teachers*, p.235.

Sanitary Inspectors Association

The attitude of the SIA to the arrival of women and debates over membership, adds to the picture of friction. The issue of women members was first raised in 1897, when a general meeting of the SIA decided against admitting London's women inspectors. When two women working for Manchester Corporation also applied, the issue was so contentious, that discussion was held over until it was felt that a large enough body of the membership was present to give a representative judgement.¹⁷¹ Such a meeting took place in November 1897.¹⁷² Some objected to the women on the grounds that they were incompetent, did not carry out the full duties of the office, were cheap labour and likely to injure the prospects and position of sanitary inspectors. Others argued that the best way to protect their own status was to admit women, and campaign to raise their salaries as well. A third group pointed out that, never in the history of the Association, had any candidate been refused who satisfied the articles, and that, unless there was anything against the ladies in terms of character, they should be elected. 39 voted for the admission of the Manchester women, and 49 against, although the Chairman pointed out that this decision did not apply to other nominations, and each case would rest on its own merits.¹⁷³ The debate was followed by objections to the attempt by a certain 'A. Elliott' to gain membership. It later transpired that the application had been submitted by Miss Annie Elliott, who declared that 'A. Elliott' was her usual signature, and she used it on her application form out of sheer force of habit. She emphatically denied attempting to join the Association by any other than legitimate means.¹⁷⁴

One male sanitary inspector could not understand why the Association had closed its doors to women, and thought that they might be admitted as associates. Although he did not consider that their place was in matters of structural sanitation, they had a role to play.¹⁷⁵ Another 'Sanitarian' did not agree and wrote that

The good ship Sanitation is manned by a manly fighting crew. It is a ship of war upon whose deck woman cannot ... find a place. If she attaches herself to the ship at all, it can only be as a figurehead.¹⁷⁶

The matter rested until 1901, when the first female member of the SIA, Margaret Sharples, a Leeds inspector, was elected.¹⁷⁷ At that year's AGM, there was animated discussion. One member took serious exception to her election, on the grounds that

¹⁷¹ *SIJ* (III 1897-8) p.30.

¹⁷² *SIJ* (III, 1897-1898), pp.141-144.

¹⁷³ *Ibid.*

¹⁷⁴ *Ibid.* p.174

¹⁷⁵ *SR* (XIX, 1896-1897), p.566

¹⁷⁶ *Ibid.*, p.592.

¹⁷⁷ *SIJ* (VII, 1901-1902), p.67.

the word 'Inspector' was a Latin noun of masculine gender.¹⁷⁸ Others were dismissive of taking the debate to such absurd lengths. It was agreed to settle the matter once and for all by seeking legal advice. Meanwhile, the AGM turned to the election of new members. Among the six candidates seeking election were Misses de Chaumont and Looker of Kensington. All the male candidates were unanimously elected, but opinion was still divided on the question of women. Miss de Chaumont was elected by 29 votes to 13, and the election of Miss Looker followed. Before the next meeting, at which Miss Teebay was also elected, the opinion came back from the solicitor confirming the eligibility of women for membership, provided they met the normal requirements. This appeared to settle the matter and, occasionally, from then onwards, female members were admitted.¹⁷⁹

Having secured the right to join the SIA, what use did the women make of it? There are remarkably few examples of their active involvement. They participated instead in the separate WSIA, founded in 1896.¹⁸⁰ Miss Carey was the first woman to address the South-Eastern Centre of the SIA in February 1908. She put the case forcibly that a sanitary inspector should not be merely a 'perambulating clerk' for the MOH, but a 'responsible officer' in his or her own right.¹⁸¹ Such arguments were perhaps intended to repair some of the damage that her less tactful colleagues had done, and, indeed, it was her bravura performance at this meeting that persuaded some of the men to suggest that the SIA should seek amalgamation with the WSIA.¹⁸² Carey also spoke on the campaign for security of tenure at another SIA meeting.¹⁸³ The WSIA likewise emphasised the urgent need 'felt by all sanitary inspectors, men and women alike', for security of tenure.¹⁸⁴ Despite these attempts to build bridges, the hostility towards women within the SIA was still apparent. In January 1910 Miss Carey felt compelled, after some particularly antagonistic letters to the *Sanitary Journal*, which had stated that women inspectors had been a complete failure and opened the profession up to ridicule, to submit a resolution condemning the action. She accused members of the SIA of using its official organ as a medium for making 'libellous attacks upon the professional reputation of other members.' She received the unanimous support of the meeting, although the very

¹⁷⁸ *Ibid.*, p.113.

¹⁷⁹ *Ibid.*, p.127.

¹⁸⁰ See Chapter 8.

¹⁸¹ SJ (XIII, 1907-1908), pp.191-193.

¹⁸² Letter from W.G. Kershaw, Hampstead sanitary inspector, SJ (XV, 1909-1910), p.200.

¹⁸³ SJ (XVI, 1910-1911), p.261.

¹⁸⁴ Wellcome: WSIA minutes, 27 Oct 1908 (SA/HVA/B/1/3).

need for the resolution reveals the continued strained relationship between men and women inspectors.¹⁸⁵

RELATIONSHIP WITH MEDICAL OFFICERS OF HEALTH

Independent workers

The relationship between women officers and their superior MOHs was also tense. In general, MOHs let them carry out their work with a fair degree of independence, requiring meetings at weekly or longer intervals.¹⁸⁶ They were still very much subordinate officers. 'He is the commanding officer and his orders must be carried out so long as they are lawful and reasonable', was the view of the author of one text-book.¹⁸⁷ 'A health visitor should always remember that it is her duty to carry out the instructions of her chief loyally whether his directions correspond precisely with her own views or not', was the view of another.¹⁸⁸ If a health visitor wished to lodge a complaint about her MOH, she was advised that

To appeal over his head to the committee would argue gross unsuitability of character in one of the two officials concerned and the health visitor will be wise to regard herself as the defaulter, and to patiently bear the supposed grievance.¹⁸⁹

It was not always easy for the women to defer to such authority. Miss Carey claimed that an inspector should have direct communication with his or her committee, and should be free to make reports to them and receive instructions.¹⁹⁰ In her early days inspecting in Kensington, Lucy Deane got into 'a terrible scrape' over a circular on outworkers that she wrote and distributed. Her MOH complained that she should have submitted it to him for approval first. She made a note in her diary 'never do anything in future or take any steps unless forced to any initiative.'¹⁹¹ She obviously resented the level of control exercised over her work, and could find her MOH 'harried by work and very cross'.¹⁹² By recruiting women of a certain background, MOHs may have found their authority questioned or, even worse, overlooked entirely, by women who were their social equals or superiors, and who prided themselves on their reforming zeal. Middlesborough's MOH complained that his first experience of a 'highly-trained lady' as a health visitor was 'unfortunate' since she

¹⁸⁵ *SJ* (XV, 1909-1910), p.196.

¹⁸⁶ Eve, *Manual*, pp.35-36.

¹⁸⁷ *Ibid.*

¹⁸⁸ Lane-Claypon, *Child Welfare*, p.20.

¹⁸⁹ *Ibid.*

¹⁹⁰ Carey, 'Whole work of a sanitary inspector', *SJ* (XII, 1905-1906), p.192.

¹⁹¹ LSE: Lucy Deane's diary, 30 Jan 1894 (Streatfeild 1/2).

was 'connected to so many movements' that she was unable to confine herself to the duties for which she was appointed. When she left, she was replaced by someone without such 'high qualifications'.¹⁹³

One member of the WSIA noted an important difference of perspective between MOHs and women health officers:

The health visitor coming into daily contact with actual people – adults and children – in their homes, and with the conditions obtaining there, has thus somewhat of an advantage over the MOH who has not this constant opportunity of seeing things for himself.¹⁹⁴

To this was added the fact that health visitors 'always have been and always must be' women whereas MOHs were generally men: 'Thus we have the public health problems viewed respectively from the woman's and from the man's point of view.'¹⁹⁵

Doctors and nurses

As nursing came to be a popular recruiting-ground for women public health officers, another layer was added to the relationship between MOHs and their female subordinates – that of doctor and nurse. Historians of nursing have argued that, within the confines of the hospital, a line had been established between these two roles.¹⁹⁶ The emphasis on self-control and character during training was perhaps seen as some guarantee that nurses might be trusted once they were outside the hospital.¹⁹⁷ According to an editorial in *National Health*, when questioned as to their preference for trained nurses, many MOHs replied, 'they do as they are told!'¹⁹⁸

The relationship between nursing and health visiting was not simple, and became entangled in the attempts of MOHs to increase the status and autonomy of public health medicine, which could mean underplaying the relevance of hospital experience. Many felt that three years spent in a hospital detracted from 'the preventive outlook', and that routine nursing in an institution did nothing to prepare the student for the social work aspects of the career, and the realities of working-class life.¹⁹⁹ One MOH thought that the woman who had 'gone through the mill' of three years nursing, 'inevitably gets more or less fixed'. She thought in terms of patients, whereas the 'ordinary people' the health visitor had to deal with were not sick and 'must be dealt with as observation or the inspiration of the moment

¹⁹² *Ibid.*, 9 Feb 1894 (Streatfeild 1/3).

¹⁹³ NCIM, *Proceedings* (1906), p.79.

¹⁹⁴ NH (XIII, 1921), p.239.

¹⁹⁵ *Ibid.*

¹⁹⁶ Gamminkow, 'Sexual division of labour', p.109.

¹⁹⁷ Rafferty, *Politics*, pp.54-55.

¹⁹⁸ NH (XV, 1922), pp.52-53.

¹⁹⁹ *Lancet* (16 Jan 1926), pp.147-8.

indicates.²⁰⁰ According to Eric Pritchard, the health visitor, in contrast to the nurse, had no 'clean-cut and easily defined duties to perform'. Technical knowledge was to be supplemented with an understanding of the difficulties of the poor, and the need to 'be tactful and resourceful'.²⁰¹ For Bostock Hill, 'the hospital trained nurse has autocratic ideas as to the control of patients invaluable in the sick room, but utterly out of place in the preventive atmosphere'.²⁰² In general, however, MOHs increasingly preferred trained nurses for the work.

CONCLUSION

It would be easy to construe the debate over title, powers and uniform simply as the opposition of 'public' and 'private', of 'male' and 'female' spheres. The 'inspector' was a public official acting in the public sphere of the law. The 'visitor' still operated in a private and unofficial capacity, her most appropriate uniform that of the nurse, associated with caring and domestic functions. The situation was far more complicated. Although the women wanted to distance themselves from the reputation of voluntary visitors, this was not just in order to increase their own standing, but so that they might better help those they visited. Being a friend and helper was not enough when unhealthy living and working conditions were the responsibility of landlords and workshop owners. Neither did the women wish to be mere inspectors. They saw themselves as social workers and reformers, with a different role from their male colleagues, and they used this, rather than equality, to argue for better working conditions.

²⁰⁰ *ME* (LIX, 1917), p.98.

²⁰¹ *NH* (XII, 1919), p.49.

²⁰² *JRSI* (XLII, 1922-1923), p.312.

6: TRAINING FOR WOMEN SANITARY INSPECTORS

Perceptions about the background and character of women public health officers, and the difficulties of integrating them into the structures of local administration came together in debates over training and qualification. The most appropriate method of preparing women for public health work was endlessly discussed, but never resolved. This chapter will outline the training of women sanitary inspectors. The gradual evolution of separate health-visitor training will be examined in Chapter 7, as will the impact of significant new regulations in 1919.

THE SANITARY INSTITUTE

The Institute was founded after the 1876 Social Science Congress, by a group of prominent sanitarians, including engineers, surveyors and architects.¹ Medical men, including MOHs and army doctors, played a leading role, and it was one of a cluster of organisations that supported the professionalisation of public health medicine.² One of the Institute's earliest activities was to establish examinations for Inspectors of Nuisances. There was no legislative requirement for them to be qualified until the 1890s, but MOHs encouraged local authorities to require the Institute's certificate. It was in their interest to have men on whom they could rely to perform their duties efficiently, but it would be 'calamitous' to give sanitary inspectors a 'quasi-medical knowledge', lest they become a cheaper alternative to medical men.³ Meanwhile, the Sanitary Inspectors Association (SIA) resented the control of the Institute over the training of its members, as it produced 'weak subordinates'.⁴

The Institute established a board of examiners from its own membership. The first examinations were set in London in 1877, were extended to the regions in the late 1880s, and to other parts of the Empire in 1901. By 1892 the certificate was required by 27 metropolitan, and 64 provincial, sanitary authorities.⁵ In 1879 the Institute established a 'School of Hygiene', and in 1886 began regular evening courses to prepare students for the examinations.⁶ Lectures were frequently, although not exclusively, given by members of the Institute's Council, mainly

¹ SI Congress report (Sep 1880), p.xvii; Louis C. Parkes, 'History of the Institute, 1876-1926', *JRSI* (XLVII, 1926-1927), p.1.

² Watkins, *English Revolution*, pp.291-293.

³ *Lancet* (4 Mar 1893), p.481.

⁴ TNA: SIEB correspondence (MH 26/1/146-149).

⁵ *TRSI* (XIII, 1892), pp.16-17, (XIV, 1893), p.245.

⁶ SI Congress report (Sep 1880), p.xii.

prominent public health doctors.⁷ The syllabus encompassed the legal and regulatory framework and technical details of inspection. By the 1890s the main elements were: the provisions of Public Health Acts and model by-laws; knowledge of what constitutes a nuisance; methods of inspection; the physical characteristics of good drinking water, pollution and water supply; drainage, sewerage and sanitary appliances; the characteristics of good and bad food and the Sale of Food and Drugs Act; infectious disease regulations; principles of ventilation and the measurement of cubic space; disinfectants and methods of disinfection; and clerical work.⁸ The examinations were practical – ‘models, plans and drawings are placed before the examinee; mortars, cements, pipes and sometimes specimens of healthy and diseased meat adorn the examination table, and strike no small feeling of dismay into the mere book learner.’⁹ It was accepted that a certain amount of book-study was necessary, particularly in the field of sanitary law, and the Institute’s Library was available to students. Textbooks began to appear, including Reid’s *Practical Sanitation* and Taylor’s *Sanitary Inspector’s Handbook*, both of which ran through several editions between the 1890s and 1930s.¹⁰ Although alterations were made to take into account legal and scientific developments, there was remarkable continuity in the subjects covered. Students also had the use of the Institute’s Parkes Museum.¹¹ Indeed, ‘The whole purpose of the Museum is to serve as a means of a practical demonstration and teaching for Sanitary Science, and is not designed as an attractive exhibition.’¹² The Museum’s chief section dealt with building construction and sanitary apparatus, including samples of various kinds of water closets, soil and drainage pipes, exhibits showing the results of faulty sanitation, and various ventilating appliances.¹³ Use of these exhibits illustrates the essentially practical and observational nature of a course that trained inspectors to be the ears, eyes and nose of the public health department. Visits to sewage and destructor works, dairy farms, disinfecting stations, model dwellings and other places of interest were also arranged.¹⁴ Every candidate was required to furnish a satisfactory testimonial as to

⁷ RSPH: SI Council Minutes Vol III (1893-1894), pp.21-22; *TSI* (X, 1888-1889), p.52.

⁸ TNA: SI, ‘Examinations in Sanitary Science for Local Surveyors and Inspectors of Nuisances’, Apr 1892 (MH26/1/81-82); *TSI* (XIV 1893), pp.247-8.

⁹ *JSI* (XVII, 1897), p.193.

¹⁰ Reid, *Practical Sanitation*; Taylor, *Sanitary Inspector’s Handbook*; Clarke, *Taylor’s Sanitary Inspector’s Handbook*; Clay, *Sanitary Inspector’s Handbook*.

¹¹ This had been founded in the same year as the Institute as a memorial to Dr Edmund Parkes, the first Professor of Hygiene at Netley, and was amalgamated into the SI on its incorporation in 1888 – see *JSI* (XV, 1894), pp.3; 45.

¹² RSPH: descriptive catalogue of the Parkes Museum (Jan 1904).

¹³ *Ibid.*

¹⁴ *JSI* (XV, 1894), pp.57-8.

age (no one under 21 was admitted to the examinations) and character.¹⁵ Examinations were held in various regional centres, and consisted of a three-hour written paper and a *viva voce* examination.¹⁶ It was stressed that 'no certificate will be granted to any candidate unless he can write legibly, spell correctly, and possess a fair knowledge of arithmetic'.¹⁷ Although the value of 'a sound preliminary education' was recognised, builders and plumbers were seen to have an advantage in the technical part of the training.¹⁸

Women and the Sanitary Institute

There was no limitation on women studying with, or sitting for, these examinations. By the end of 1898, there were over 120 women on the Institute's register.¹⁹ There was no guarantee that these women would obtain office, since 'the vacancies are utterly disproportionate to the candidates – many are called, few chosen'.²⁰ There was therefore a body of women studying for, and acquiring, formal sanitary qualifications without the hope of, or perhaps even the desire for, a paid appointment as an inspector. Many of these women held other certificates in hygiene, particularly from the National Health Society (NATHS).²¹

The very first woman to qualify was Margaret Scott, in 1891.²² She was born in Norwich in 1859, had trained as a teacher, studied at Cambridge, and was headmistress of All Soul's School in Hampstead. She applied to the Institute for permission to be examined and was told that

there was no precedent for such a request from a lady, but as there was no law against it the Council ... decided that I was at liberty to present myself if I liked. I did like, and when I entered the room and found all my fellow candidates were men, I felt a little uncomfortable. They seemed so surprised to see me.²³

She was not afraid of the examination, as she had spent a year following her own programme of rigorous preparation. She remembered how 'I resolutely gave up all society for a year and only lived for my work'.

¹⁵ TNA: SI, 'Examinations in Sanitary Science for Local Surveyors and Inspectors of Nuisances', Apr 1892 (MH 26/1/80).

¹⁶ *Ibid.*

¹⁷ *TSI* (XI, 1890), p.289.

¹⁸ *JSI* (XVIII, 1897), p.192.

¹⁹ Wellcome: SIEB Register: holders of certificates granted, after examination by the SI prior to 31 Dec 1898 (SA/SMO/T.1/1)

²⁰ *JSI* (XVIII, 1897), pp.196-197.

²¹ See Chapter 2.

²² I am indebted to Maxine Willett for 'finding' Margaret Pillow's papers and for drawing my attention to them. TWL: Papers of Margaret Eleanor Scott Pillow (7/MEP).

²³ TWL: interview with Miss Scott, *Woman's Herald*, 28 Mar 1891 (7/MEP/2/3).

I learnt as much of plumbers' work as possible ... I have spent hours over the practical laying of drains, water mains and connections. I examined cisterns, learned to draw plans of houses, ... etc.

After studying the relevant legislation, she visited dairies, slaughterhouses, bakeries, schools, hospitals, disinfecting rooms, and workshops. In every case she 'met with the greatest courtesy', and found 'common workmen willing to help me and anxious to explain and answer my questions.'

The plumbing work and building details were really very difficult. Then I had a natural dislike to getting wet and dirty ... I still have the liveliest recollections of my visit to examine the Hampstead dust destructor ... one very snowy Saturday...

Since she liked 'refinement, culture, and the artistic and pretty surroundings of life', this programme 'needed courage'. Scott did not think that many women would follow in her footsteps, since the difficulties were so great. She declared that

I have no intention of entering into competition by offering myself as sanitary inspector ... I studied sanitation because I think it is of vital importance that women should be equally acquainted with this subject as men, while as a lecturer I wished for the position which the certificate of the Institute bestows on its members.²⁴

With possession of her Associateship of the Sanitary Institute, she taught and lectured on hygiene for a wide range of organisations, including the NATHS, and wrote and published. Most notably, she co-wrote, with Arthur Newsholme, a volume on *Domestic Economy* 'comprising the laws of health in their application to home life and work', intended for use in schools.²⁵

The very first salaried appointments of women as sanitary inspectors took place before a formal qualification was required. On the appointment of the first women inspectors in Kensington in 1893, the *BMJ* emphasised that they were 'specially trained' for their work, by having attended the NATHS training course.²⁶ Kensington's MOH later suggested that it was at his instigation that they became qualified, but Lucy Deane had, before her appointment, recognised the need to supplement her NATHS diploma with the same qualification held by male inspectors. She was working as a paid lecturer for the NATHS, like Margaret Scott, when she began to prepare herself, continuing with the course at the Parkes Museum after her appointment in Kensington. She attended lectures and demonstrations in the evenings, while undertaking regular speaking engagements, and, later, working as an inspector. She teamed up with a NATHS colleague, who was also hoping to sit the exam, and her diary records how she 'went back and slept night with Miss

²⁴ *Ibid.*

²⁵ Newsholme & Scott, *Domestic Economy*.

²⁶ *BMJ* (28 Oct 1893), p.963.

Dunbar and read sanitary law with her till 12 p.m.' She declared that she was 'appalled at [the] small likelihood of my passing' and, together with her friend, approached Paddington's Chief Sanitary Inspector for coaching. He showed them his various report books, registers and notice forms, and took them on site visits.²⁷ On the day of the written papers there were five women (of whom four, including Deane and Dunbar, passed), and around 150 men in the examination halls. Miss de Chaumont, later also an inspector in Kensington, recalled how she was attending lectures for 'ladies' on domestic hygiene at the Sanitary Institute when she saw an article in *The Times* about the early appointments in Kensington.²⁸ Having met with the Kensington inspectors, she decided to study for the Sanitary Institute certificate. She was coached 'by an elderly inspector who took us round various interesting premises', and attended lectures at the Parkes Museum with Rose Squire.²⁹ De Chaumont was later to recall that,

In the early years one had to search for one's own instruction. I found that after the ground work had been laid by the lectures we attended, one learnt more by practical work and the kindness of one's male colleagues than could ever be accumulated by listening to any number of lectures.³⁰

From 1895, in accordance with the 1891 Public Health (London) Act, every sanitary inspector appointed in London was required to hold a certificate awarded by a body approved by the LGB. In order to wield the same powers as male inspectors, and in order for half of their salaries to be repaid by the LGB, it was necessary for London's women inspectors to hold the same qualifications as their male colleagues, and they became a regular feature at Sanitary Institute examinations.

SANITARY INSPECTORS EXAMINING BOARD

When the 1891 Act came into operation, organisations other than the Sanitary Institute possessed the theoretical power to hold examinations, but the Institute was the only body actually performing the function. According to the Society of Medical Officers of Health (SMOH), this was a 'very profitable privilege and monopoly'.³¹ Much wrangling followed, with the Institute jealously guarding its status and financial position, others challenging its monopoly, and the SMOH pressing for increased

²⁷ LSE: Lucy Deane's diary, Nov 1893 (Streatfeild 1/1-2).

²⁸ She was awarded a certificate in connection with the course at the Lent examination in 1894. See RSPH: SI Council Minutes, Vol IV, 1894-1895, p.6.

²⁹ WHO (Oct 1942), p.5.

³⁰ *Ibid.*

³¹ Wellcome: Report to the Council of the SMOH, by their Representatives on the Conjoint Committee, 1897 (SA/SMO/B.1/8).

representation for the public health profession.³² Universities, technical schools and colleges around the country began to offer courses of training, initially entering their candidates for the Institute's examinations.³³ In 1892, King's College London 'having considered the necessity which exists in London for systematic instruction in hygiene and in the duties of sanitary officers', instituted a course of evening classes followed by its own examination and certificate. Its syllabus was divided into three main elements: building construction; the general duties of the sanitary inspector; and physics and chemistry in relation to sanitary science. This last element was more theoretical than anything offered by the Sanitary Institute. Lecturers were College Professors in architecture and medicine. The course was specifically advertised as 'open to ladies'.³⁴ The College, along with other institutions, applied to the LGB for recognition under the 1891 Act.³⁵

The LGB wished to minimise competition between different examinations, and backed the idea of a new conjoint examining board for London.³⁶ After protracted wrangling, the scheme was eventually completed in 1899 with the incorporation of the Sanitary Inspectors Examination Board (SIEB). This consisted of twelve members, two appointed by the Sanitary Institute and three by the LGB, the remainder being one representative each from the other interested bodies, including the NATHS and the SMOH. The Board held its first examination in December 1899, although all those who had passed the examination of the Sanitary Institute before the end of 1898 were also eligible to be entered on the register. Meanwhile, the Sanitary Institute continued examining inspectors for posts outside London. It was only in the capital that a sanitary inspector was obliged to hold a certificate, although most authorities began to require a qualification, either of the SIEB, or of the Sanitary Institute.³⁷ The Institute trained those sitting for both examinations.

The SIEB examination consisted of two parts – a preliminary English and arithmetic test and a technical examination. The preliminary examination tested writing, spelling, composition, dictation, and mathematical skills. Examinations recognised in substitution included Junior Oxford and Cambridge Local

³² RSPH: SI Council Minutes Vol III (1893-1894), p.73 and *passim*; Minutes of the Committee on the Examination and Certification of Sanitary Inspectors under the Public Health (London) Act, 1894-1898. Wellcome: SMOH Council Minutes, 1894, *passim* (SA/SMO/B.1/7-8), 5 Aug 1891 (SA/SMO/B.1/5).

³³ *JRSI* (XXVII, 1906) Supplement pp.56-57.

³⁴ TNA: KCL correspondence with SIEB (MH 26/1/5-6); KCL calendar, 1892-1893, pp.358-361; *SIJ* (IV, 1898-1899), p.138.

³⁵ TNA: KCL correspondence with SIEB (MH 26/1/5-6).

³⁶ TNA: SIEB papers (MH 26/3/106-7).

³⁷ *JRSI* (XXI, 1900) pp.229-231; *Lancet* (15 Jun 1907), p.1684. Bannington, *English Public Health*.

examinations, the third class certificate of the College of Preceptors, or 'any equivalent or higher examination'.³⁸ The syllabus for the technical examination encompassed elementary physics and chemistry in relation to water, soil, air and ventilation; elementary statistical methods; municipal hygiene; and law and administration.³⁹ The technical examination was held over four days. As well as the written papers, on one afternoon the examiner would take the candidates round 'a selected slum area' and they were required to record their observations in notebooks provided. There was also an oral examination 'when the examiners can and do question candidates on almost every subject in the syllabus and several which are not'.⁴⁰

As with the Sanitary Institute, candidates had to be over 21, and provide a character reference.⁴¹ Each candidate was also required to have attended a course of instruction approved by the Board, or to provide evidence of having held a recognised post as a sanitary inspector for a period of three years.⁴² At the outset, only three teaching institutions were recognised by the Board: the Sanitary Institute, King's College and the NATHS.⁴³ In 1903 one woman sanitary inspector wrote of the difficulty of obtaining training in the provinces. One option was coaching by correspondence, 'but the result is not satisfactory', particularly as, even if she passed the examination, the woman inspector 'may feel sadly at sea when it comes to practical work'.⁴⁴ She herself

had the good fortune to get hold of a plumber, a man of wide general experience, who explained plumbing to me in every detail, and took me to see the drainage system of some new buildings he was at work on. My practical lesson in this particular branch was of more good to me than a dozen lessons from books, and I should advise all who intend to take up the work to follow my example.⁴⁵

By 1905, however, many of the universities and technical schools that were already training inspectors for the Sanitary Institute, had become recognised by the SIEB.⁴⁶ By 1915, it was 'possible to obtain, in most large centres of population, courses of study and practical demonstrations of the various sides of sanitary science and administration'.⁴⁷ One of Stockport's male sanitary inspectors praised the

³⁸ *How to Become a Lady Sanitary Inspector*, p.8.

³⁹ TNA: SIEB papers (MH 26/5).

⁴⁰ *How to Become a Lady Sanitary Inspector*, p.14.

⁴¹ TNA: SIEB papers (MH26/5).

⁴² *SIJ* (V, 1899-1900), p.238; *PH* (XII, 1899-1900), p.819.

⁴³ *BMJ* (28 Apr 1900), p.1068.

⁴⁴ Armour, 'Sanitary inspecting', pp.328-329.

⁴⁵ *Ibid.*

⁴⁶ *JRSI* (XXVII, 1906) Supplement pp.56-7

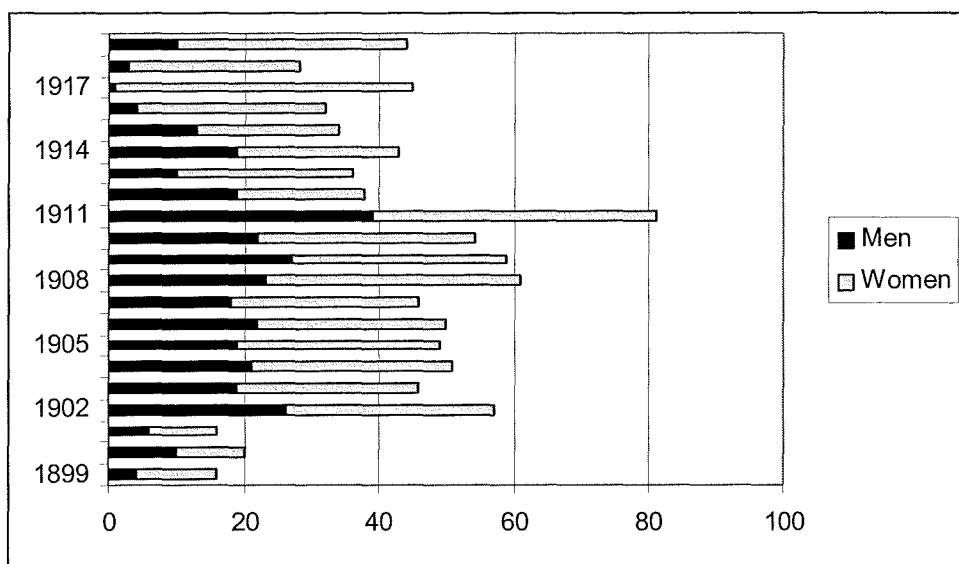
⁴⁷ Bannington, *English Public Health*, p.97.

earnestness and determination of one of his female colleagues who attended Manchester Technical School in the evenings, in order to learn the necessary skills.⁴⁸

Women and the SIEB

The striking feature of the first examination held by the SIEB in December 1899, was that over half the successful candidates were women. This pattern continued, as Fig. 3 illustrates.⁴⁹ By 1907 over 200 women held the qualification.⁵⁰ In all, 63% of certificates granted by the SIEB from 1899 to 1919 were awarded to women.

Figure 3: SIEB, certificates awarded, 1899-1919.⁵¹



Meanwhile, many women still took the Sanitary Institute qualification, despite being advised that unless they were 'without ambition' or 'merely desirous of obtaining some minor post in the provinces', the certificate of the SIEB was preferable.⁵² If time and money were no object, they should 'to go straight for the London Board', ignoring the RSI. However, 'for the ordinary candidate, not too well

⁴⁸ *SJ* (III, 1897-1898), pp.141-142.

⁴⁹ These figures rely on being able to identify 'female' first names in examination registers and published pass lists. There are some names that are 'ambiguous', although in many cases the training institute has helped to settle the question, leaving only a few uncertainties. These do not affect the overall trend. The 'official' examination registers of the SIEB and the RSI also often differ from lists of successful candidates published by the training institutions and in the medical press. In some cases this may have been because the granting of a certificate was 'held over' until evidence of some further qualification was provided. Whilst the precise figures differ, all the sources, however, confirm the same overall trends.

⁵⁰ *Lancet* (15 Jun 1907), p.1684.

⁵¹ RSPH: SIEB examination register, Vol II.

blessed with this world's goods', the RSI was 'a very good beginning', particularly as 'the examination is easier and the regulations not so difficult to fulfil.'⁵³ A major consideration was the SIEB preliminary examination, viewed with trepidation by many female candidates. One woman inspector wrote,

This is really an awful bugbear, as arithmetic, to the ordinary woman is most difficult. In the heartfelt words of many a student, "The prelim. Is a good thing to get out of". Happy are those who have, in the days of their youth, passed one of the recognised alternatives.⁵⁴

Women were encouraged to obtain private coaching, or attend evening classes in arithmetic. Other dodges were to sit for the College of Preceptors certificate instead, as this was considered to be much easier, or, failing this, to work for, and sit, the preliminary examination in January, before taking the technical examination the following May. This is an indictment of the standard of mathematics attained by middle-class girls during their schooling.

Even if the SIEB examination was the goal, women were advised that the course of lectures and demonstrations offered at the Sanitary Institute, while perhaps not so comprehensive as that on offer elsewhere, was short (lasting ten weeks), could be attended in the evenings, and was comparatively inexpensive (three guineas in 1915). There was also the advantage of a library, meaning less financial outlay on books, and of the Parkes Museum.⁵⁵ These were important considerations for many women, and meant that the Institute continued to have a steady flow of women students. As can be seen in Fig. 4, around 20% of women qualifying between 1899 and 1919 chose to train at the Sanitary Institute. Students at the NATHS were advised to make good the lack of facilities by joining Lewis's Library, and to visit the Parkes Museum in normal opening hours. Careers literature informed women that

The diploma of the National Health Society is the best all-round qualification. But to secure the diploma is a somewhat lengthy and expensive business. Practically it means giving up other work and living in London for about nine months. If the student has to board herself, in addition to the cost of books, fees, etc., her expenditure will be little short of £100.⁵⁶

By 1907 the fee for the whole diploma course was 15 guineas, while that just for sanitary inspectors was 12.⁵⁷ In either case, since the teaching was during the day, it could not be undertaken whilst in employment. The fee at Hackney Institute was described as 'extraordinarily low', being no more than five shillings in 1915, although

⁵² Maynard, *Women in the Public Health Service*, p.13.

⁵³ *How to Become a Lady Sanitary Inspector*, p.6.

⁵⁴ *Ibid.*, pp.11-13.

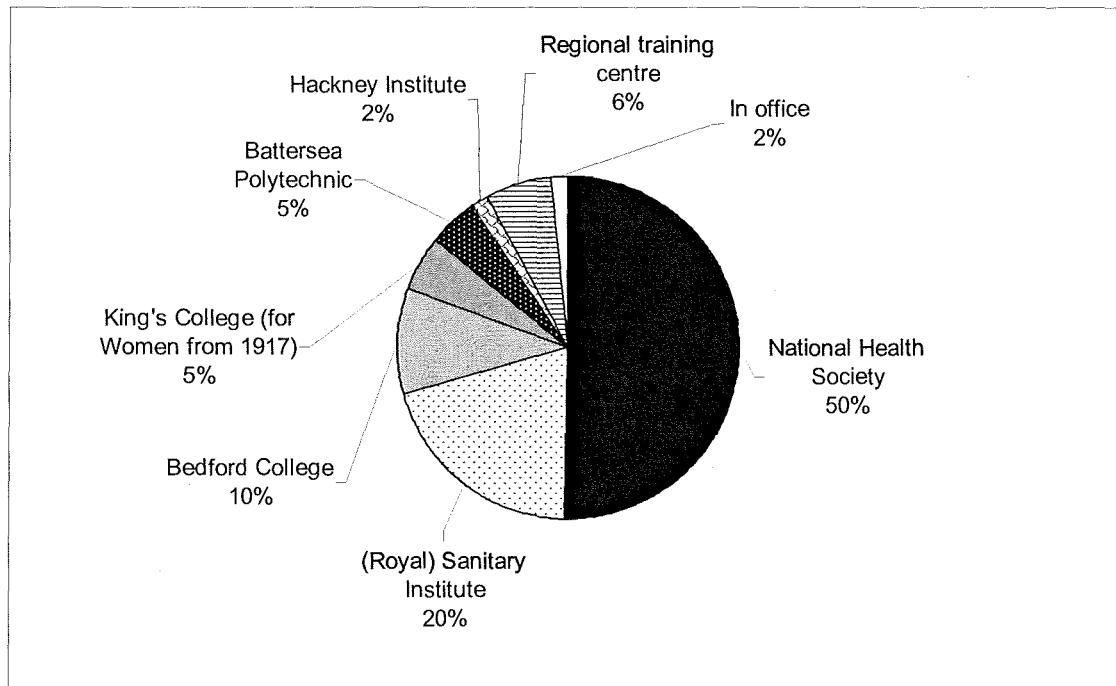
⁵⁵ *Ibid.*; Maynard, *Women in the Public Health Service*, pp.15-19.

⁵⁶ *How to Become A Lady Sanitary Inspector*, p.11.

⁵⁷ NATHS, annual report, 1908, p.19.

few women studied there, while that at King's College was comparable to the RSI, standing at three guineas.⁵⁸ The course at Bedford College was the most expensive by far, costing 30 guineas. Since the most popular training course, that of the NATHS, which by itself accounted for half of the women passing the SIEB examination between 1899 and 1919, was not the cheapest, expense was not the only consideration.

Figure 4: Training institutions of women gaining SIEB certificate, 1899-1919



THE NATIONAL HEALTH SOCIETY

Alongside equipping middle-class women for voluntary work amongst the poor, the NATHS had begun to train those in need of earning their own living as health lecturers and teachers. The Society also discovered that its certificates helped women to enter new branches of paid work, notably sanitary and factory inspection. When the very first posts for women sanitary inspectors in London were advertised, thanks to lobbying by Fay Lankester, it was stressed that candidates who held the certificate of the NATHS, would receive special consideration.⁵⁹ The Society made good use of the press interest in the Kensington appointments and, by 1896, it boasted that nearly every lady who held a public appointment connected with

⁵⁸ Maynard, *Women in the Public Health Service*, pp.15-19.

sanitation and hygiene had been trained by the NATHS.⁶⁰ By 1899, ten of London's women sanitary inspectors had trained with the Society. Three of these held the Society's diploma, as well as the certificate of the Sanitary Institute.⁶¹

The Society not only played a key role in the pioneering attempts of the very first local women sanitary inspectors to gain their posts.⁶² When they were plotting to go for factory inspectorships, it was the NATHS that put Deane and Squire forward, and it was on Miss Lankester's personal recommendation to Mr Tennant at the Home Office that the final decision to appoint Lucy Deane was made.⁶³ It was also through Miss Lankester that Lucy Deane was introduced to Mr Tennant, and through the connections of Miss de Pledge, who was Superintendent of Chelsea Poor Law Infirmary, at which the Society's students underwent their nursing training, that she went to tea with Lady Dilke.⁶⁴ The élite connections of the Society were put to a use other than attracting subscriptions. Elected members of local authorities felt that they could rely on an organisation with such a pedigree to supply ladies for sanitary work, not just suitably trained and qualified, but with the requisite personal characteristics and social status. This may have been a reason for the popularity of the course. It would have been easier to convince family and friends of the respectability of sanitary training provided by such an institution. The NATHS had the 'symbolic capital' to play a part in changing the employer's 'knowledge' of what constituted suitable work for women.⁶⁵

When Margaret Scott, Lucy Deane and their contemporaries entered for the Sanitary Institute examination, they felt that the NATHS course for health lecturers was not sufficient to prepare them, and attended lectures at the Parkes Museum, or studied, or were coached, independently. Soon afterwards, 'in consequence of the new opening for educated women inspectors as lately appointed by the Vestry of Kensington', the NATHS course was extended. It began to cover those subjects that were required by those wishing to qualify as sanitary inspectors 'without altering the range of subjects or lowering the high standard of instruction which has hitherto characterised the course for the Society's diploma.'⁶⁶ In order to gain recognition from

⁵⁹ LSE: Unidentified press cutting (Streatfeild 1/22).

⁶⁰ SR (XVII, 1896), p.902.

⁶¹ SR (XXIII, 1899), p.420.

⁶² LSE: Lucy Deane's diary, *passim* (Streatfeild 1/1).

⁶³ *Ibid.*, 5 Mar 1894 (Streatfeild 1/3). The choice was between Deane and Ravenhill. Miss Lankester reported that Deane had the most experience.

⁶⁴ *Ibid.*, Nov-Dec 1893 (Streatfeild 1/1-2).

⁶⁵ This is interesting in light of Jordan's recent work on the earlier impact of the 'unattached intellectuals' of the Society for Promoting the Employment of Women on opening up new areas of work for women. See Jordan, *Women's Movement*.

⁶⁶ NATHS, annual report, 1899, pp.12-13; SR (XV, 1893), p.351.

the LGB as a training centre, the Society was able to call on its élite connections.⁶⁷ Alfred Schofield, represented the Society in negotiations. He used statements from members of Kensington Vestry in order to argue for the usefulness of the work of women as inspectors, and secured representation for the NATHS on the SIEB.⁶⁸

The NATHS syllabus and examinations were intended 'to be of much benefit to every woman, whatever her position in life may be, as guardian of the health of her own household and family or in any public capacity she may aspire to'. It offered a complicated array of options.⁶⁹ The newly modified course, as instituted in 1894, took six months to complete. For the first part, there were lectures on elementary anatomy and physiology, first aid and nursing, followed by an examination. The second part consisted of lectures on domestic and personal hygiene and sanitation, on the principles of calculating cubic spaces, and interpreting plans and sections, again followed by an examination. Those attending the whole course, and passing in all subjects, were granted the Diploma of the Society. Those wishing to gain a certificate, qualifying them as a health lecturer, had, in addition, to attend a course on elocution and to pass a practical examination on the 'art and manner of imparting knowledge'. Students not requiring a full qualification were able to attend the lectures on any single subject and receive a certificate after the relevant examination. Those who wished to take the Sanitary Institute examination, might omit nursing, first aid and elocution.⁷⁰ Many women took the opportunity to keep their options open. Between 1899 and 1915, 39% of women trained by the Society took the diploma alone, 36% a professional qualification as a sanitary inspector, and almost exactly a quarter took both qualifications.⁷¹ For those qualifying as inspectors, there were around about forty lectures in total, supplemented by 'elementary demonstrations in the chemistry of air and water', and visits to the Parkes Museum, water and sewage works and disinfecting stations.⁷² All the lectures took place on weekday afternoons.⁷³

The Society also recruited new lecturers, notably Henry Kenwood, MOH for Stoke

⁶⁷ LSE: Lucy Deane's diary, 16 Nov 1893 (Streatfeild 1/1)

⁶⁸ TNA: SIEB correspondence (MH 26/1-2).

⁶⁹ NATHS, annual report, May 1896, pp.14-16.

⁷⁰ *Ibid.*

⁷¹ Each year the Society published lists of successful candidates for each qualification in its annual report. These figures have been compiled by comparing the names on the list for each year to see the degree to which they overlap. They do not take account of women who might have re-sat a failed examination in a following year, or who attempted to pass both examinations, but just passed one. Lists of successful candidates as published by the Society do not correspond exactly to the names appearing on the register of the SIEB, although the overall trend is the same.

⁷² Ravenhill, *Memoirs*, pp.66-7; SR (XXIV, 1899), p.220.

⁷³ SR (XXXII, 1903), pp.260-1.

Newington. He taught public health at University College London, holding a chair in the subject and co-authored the standard public health text for medical students.⁷⁴

Two early students have left accounts of their NATHS experiences. Alice Ravenhill was later to become an important figure in the domestic science movement.⁷⁵ Rachel McMillan, with her sister Margaret, was a labour activist, and pioneer of nursery education. Ravenhill, the daughter of a naval architect and marine engineer, begged her father to allow her to attend the local public day school for girls, but this was considered unsuitable, and she was taught at home by a governess, and at private schools. After this, she pursued her studies herself, interspersing these with a social whirl abroad, and social service work. She remembered:

I had but a slender allowance with which to buy books, and though I presently had courage to dissect snails, worms, or an ox's eye in my bedroom, I was in sore need of guidance. And I always worked in fear of being found out for already my people had expressed disapprobation of one or two books on elementary physiology and heredity which were found and traced to my ownership.⁷⁶

For Ravenhill, it was the disappointment of her parents calling off her wedding at three days' notice because her intended, a doctor, could not raise an appropriate 'settlement', that caused her to throw herself into these studies, and to plead for further training for a career.⁷⁷ Eventually, it was her father's declining financial circumstances, and a small annuity left by her grandfather that, after several years of her family refusing to allow her to study for an occupation, gave her the opportunity to study for the NATHS diploma. The importance of being able to undertake any sort of professional training after feeling trapped at home for so long cannot be overestimated.⁷⁸

Rachel McMillan, who had also been taught at home, and at Inverness High School, spent three years teaching at a school, run by two female relatives, before returning home to nurse her sick grandmother.⁷⁹ When her grandmother died, Rachel refused to be dependent on the financial support of her uncles, and decided that she 'must face the world alone'. She was not unduly 'dismayed ... by the fact that she had very small means, and no technical training for any trade or profession.'⁸⁰ After a period as a junior superintendent of a working girls' home in Bloomsbury, she

⁷⁴ Parkes & Kenwood, *Hygiene and Public Health*; Kenwood & Kerr, *Hygiene and Public Health*.

⁷⁵ Ravenhill, *Memoirs*; Ravenhill & Schiff, *Household Administration*.

⁷⁶ Ravenhill, *Memoirs*, p.53.

⁷⁷ *Ibid.*, p.52.

⁷⁸ *Ibid.*, pp.63-66.

⁷⁹ Steedman, *Childhood*, p.20.

⁸⁰ McMillan, *Life*, pp.31-2.

decided that, since her sister Margaret was not going to make a living out of her political activity, she must take up an occupation that could support them both. She decided to train as a sanitary inspector, using 'some of the small capital' that was left. Exactly why she chose this particular training is unclear, although, when caring for her grandmother, she had attended lectures on nursing.⁸¹ She returned to the home in Bloomsbury where she had once worked, since 'there were students and I can study there.'⁸²

For those without the benefit of any previous formal education, the work and examinations were hard. 'I felt paralyzed at first as I was confronted with the papers', Ravenhill later wrote, remembering the seeming confidence of her comrade, Lucy Deane, whose pen 'travelled swiftly and continuously over the ruled sheets'.⁸³ She was, however, much more assured in the *viva voce* examination. The intensity and loneliness of the course also took its toll. Ravenhill remembered that 'we were a decidedly tired group when we completed our 12 months of strenuous courses', and she was lucky to be able to take a holiday in Germany before taking up her post as a hygiene lecturer.⁸⁴ Likewise, Margaret McMillan visited her sister at the end of her course:

It was early morning, and I went suddenly into the desert drawing room where she sat alone with her books. She had passed her examinations brilliantly and was looking for work. Very pale and drooping she looked, sitting there in the big room.⁸⁵

Without the benefit of a holiday abroad, Rachel also took up a post as a hygiene lecturer.

The Society's students were bound together by their common circumstances and search for employment. Lucy Deane kept in touch with her colleagues during the few months after qualifying, visiting them for tea or going on outings to the theatre, during which they talked over their employment prospects and each scarce new post.⁸⁶ Miss Lankester, at the Society's offices, acted as an information bureau and lobbying service for new openings. In 1898, an 'Association of National Health Workers' was formed, for 'the improvement, instruction and mutual encouragement' of its members. Membership was open to all those holding the Society's certificate, and to its accredited lecturers. The first committee included Rose Squire; Miss Gray,

⁸¹ *Ibid.* p.24.

⁸² *Ibid.*, pp.79-80.

⁸³ Ravenhill, *Memoirs*, p.70.

⁸⁴ *Ibid.*, p.69.

⁸⁵ McMillan, *Life*, pp.90-1.

⁸⁶ LSE: Lucy Deane's diary, *passim* (Streatfeild 1/1-3).

Islington's woman sanitary inspector, was Honorary Secretary; and Alice Ravenhill was Honorary Treasurer.⁸⁷ By 1899 the Association had 51 members.⁸⁸

BEDFORD COLLEGE

The foundation of Bedford College in 1849 forms a milestone in what Dyhouse has described as the 'Whiggish' chronology of women's entry into higher education and it has been termed one of the 'academies of British feminism'.⁸⁹ It aimed for high academic standards, equality with male colleges and, in 1878, when the University of London opened its examinations to women, began to prepare its students for degrees. Bedford aimed to offer equal access for women to the full range of academic subjects, including science and, by the 1890s, had modern laboratory facilities.⁹⁰ From 1895 to 1919, Bedford College for Women offered a course in 'scientific hygiene', and prepared students to sit for the examinations of the RSI and the SIEB. It was the only organisation, other than the NATHS, that specifically prepared women for this career, but it produced far fewer candidates. Only 10% of women gaining the SIEB certificate between 1899 and 1919 studied at the College.

Initial discussions about the foundation of a hygiene course took place in 1894-1895. The College consulted Dr Louis Parkes, MOH for Chelsea, lecturer in hygiene at St. George's Hospital, and at the RSI. It was he who shaped the course, and became the first Head of the Hygiene Department.⁹¹ He advised that there was 'an opening for useful and remunerative employment for ladies who have been trained in sanitary science and who possess some diploma or certificate in hygiene'.⁹² Parkes suggested that the course would compete, not only with those offered by the Sanitary Institute and the NATHS, but also with other general hygiene qualifications. He seems to have had in mind attracting those women for whom a full medical education was out of the question at this date.⁹³ Bedford College's hygiene course was a hybrid, offering practical instruction for those wishing to enter paid posts as inspectors, combined with theoretical science for those taking elements of

⁸⁷ SR (XXII, 1898), p.107.

⁸⁸ SR (XIII, 1899), p.301.

⁸⁹ Dyhouse, 'Storming the citadel?', p.51; Purvis, *History of Women's Education*, p.107; Levine, *Victorian Feminism*, p.32.

⁹⁰ Bentley, *Educating Women*, pp.14-15.

⁹¹ RHBNC: BC Council minutes, May-Jul 1895 (GB110/1/5); Council report, 1894-1895, p.1 (GB113/1); File on Course in Public Hygiene, 1896-1908 (AL/334/1).

⁹² RHBNC: BC Council, 18 Jun 1895 (GB110/1/5).

⁹³ RHBNC: BC Council, May-Jul 1895 (GB110/1/5,); Council report, 1894-1895, p.1 (GB113/1); File on Course in Public Hygiene, 1896-1908 (AL/334/1).

the course as part of a general system of scientific or quasi-medical education, and who formed a large proportion of students.⁹⁴ Parkes' successor, Thomas Legge, emphasised the value of the course for those wishing to undertake social work, or for Boards of Guardians or School Boards, and stressed that 'the educational value of the course alone is high, and should appeal to those who are anxious to obtain a wide culture.'⁹⁵ The difficulty of running a course to meet the needs of such a varied body of students was to remain a constant problem.

The course appeared for the first time in the College prospectus for 1895-1896, as a 'Course of Scientific Instruction in Hygiene'. It was 'arranged with a view to provide systematic instruction in hygiene and also to give ample opportunity to women students for practical work in those branches of science which are essential to a thorough knowledge of Sanitation, Laws of Health, and Personal Hygiene.'⁹⁶ Requiring full-time study for an entire academic year, the course comprised hygiene lectures and demonstrations, and laboratory work in chemistry, physics, physiology and bacteriology. The fee for the complete course was 27 guineas. The examination consisted of written, practical and *viva voce* elements, and extended over four days. At the end of the first term, the College reported that

the students who have entered for this year's course seem very much interested in the work, and they believe that such a scientific course on sanitation, laws of health and personal hygiene is not to be obtained anywhere else, and especially with so much practical work which is carried on in our laboratories. In this as in many other ways our college shows itself a true pioneer.⁹⁷

The College offered its own examination and certificate on completion of the course, in addition to training women for external vocational qualifications.⁹⁸ In 1896 two students entered for the Sanitary Institute examination and were successful.⁹⁹

The heavy scientific bias of the course proved a problem for this latter role. The College did not secure representation on the SIEB, partly because the LGB did not wish to reopen the question of the admission of yet another body, the whole matter of the formation of the Board having been protracted enough. There were, however, more than administrative reasons since,

the scheme of instruction given at Bedford College is of a very different sort from that which is wanted for sanitary inspectors who, please remember are but inspectors of nuisances under a new name. We do not wish to know

⁹⁴ RHBNC: BC, Register of Hygiene students (AR220/2/2) gives details of those who took single course elements.

⁹⁵ *BCLM* (Jun 1898), pp.17-19.

⁹⁶ BC Prospectus, 1895-1896.

⁹⁷ *BCLM* (Dec 1895), p.15.

⁹⁸ RHBNC: BC Council, 3 Dec 1895, 11 Feb 1896 (GB110/1/5).

⁹⁹ *BCLM* (Jun 1896), pp.10-11.

anything about the classification of micro-organisms, pathogenesis, animal metabolism, pre-disposition, immunity, and things of a like nature, otherwise we should be creating a body which would prove utterly unfit to perform ordinary inspection of nuisances. I fear your course would be held to be largely foreign to the purpose.¹⁰⁰

The course challenged the strict delineation between the knowledge that was appropriate for a sanitary inspector, and that which was imparted to public health doctors during the training for the DPH. It may only have been the fact that it was available solely to women, and was thus seen as less of a threat to the control of the medical profession over its male subordinates, that saved it as a method of training for the sanitary inspectorship. In 1899 the SIEB finally agreed to include the College amongst those institutions whose certificate of instruction was recognised as evidence of training prior to sitting the Board's examinations.

Staff of the Hygiene Department had continually to justify the heavy scientific bias of the training. Legge wrote that,

Although sanitary inspectors are as a rule under the MOH ... their knowledge need not be a minus quality, and that they need not become mere machines to carry out the wishes of the superior officer, on the contrary, it is recognised by the Bedford College course that the more complete the training, the better and the more rationally ... inspectors will fulfil the duties of their office.¹⁰¹

For him, it was 'impossible to appreciate properly what is meant by "closeness of the air" without a knowledge of chemistry, or what is meant by "ventilation" without the knowledge of the elementary laws of physics'.¹⁰² In the first term there were four hours of practical physics a week, five hours of practical chemistry, and two hours of practical physiology, in addition to lectures and demonstrations in bacteriology.¹⁰³ The proportion of time given over to laboratory science is striking. The teaching of bacteriology could hardly have been by a more eminent authority. A.A. Kanthack was lecturer in pathology and bacteriology at St. Bartholomew's Medical School, and a fellow of King's College, Cambridge. He was at the cutting edge of the discipline, had been the first professional pathologist appointed to a London medical school, and had pioneered the development of bacteriology and pathology as part of the medical curriculum. He was followed by other bacteriologists and physiologists, including J.H. Drysdale and J.S. Edkins. Chemistry and physics were taught by College Professors Holland Crompton and Frederick Womack. The course seems to have had more in common with the DPH, combined with elements of the general medical curriculum,

¹⁰⁰ RHBNC: Thorne Thorne to BC Principal, Apr 1896 (AL/334/1).

¹⁰¹ BCLM (Jun 1898), pp.17-19.

¹⁰² Legge, 'Scientific instruction in hygiene for women at Bedford College, London', *BJN* (16 Aug 1902), pp.133-134.

¹⁰³ BCLM (Mar 1896), p.17.

than with the type of tuition offered by the Sanitary Institute or the NATHS. In designing the programme, Parkes was probably influenced by the hygiene teaching that he undertook at St. George's. Indeed, the course may be described as modern even in comparison with the tuition being offered in medical schools. Bacteriology, for example, had only just emerged as part of the medical curriculum in the 1890s.¹⁰⁴

By comparison with laboratory science, the most important part of the course from the point of view of anyone wishing to become a sanitary inspector, the hygiene lectures, occupied a fairly minor part of the students' time. Teaching was undertaken by a succession of distinguished public health doctors. Parkes himself was the author of an influential hygiene manual which became a classic text for those taking the DPH examinations.¹⁰⁵ He was replaced in 1896 by Thomas Legge, who wrote particularly on industrial medicine and bovine tuberculosis. W.C.C. Pakes, who was Head of the Department from 1899 to 1902, was the author of the first textbook to deal with the practical laboratory work required for the DPH, based upon his lectures at Guy's Hospital.¹⁰⁶ He was followed by William Henry Willcox, who was Lecturer in Chemistry and Practical Toxicology at St. Mary's Hospital Medical School. J.H. Brincker, an epidemiologist, led the department from 1907 until its demise in 1918. In addition to hygiene lectures, students visited the Parkes Museum to view 'the wonders of sanitary and insanitary science', and Legge introduced site visits to model dwellings, common lodging houses, schools, disinfecting stations, filter-beds, sewage farms, dairies and cowsheds.¹⁰⁷ The students reported that they had

spent many pleasant and instructive afternoons with Miss Baker, sanitary inspector for Marylebone, and to our great joy have discovered many prohibited forms of traps, as well as refuse accumulations on stairs and in yards. Two of us were fortunate enough to watch a smoke nuisance arising from the chimney of a fried fish shop. We are now living in hopes that something will happen to the College drains so that we may have a chance of inspecting them.¹⁰⁸

The following year they reported a 'delightful trip on the Sewage department's steamer down the river to Barking'.¹⁰⁹ Theoretical science, however, continued to remain important.

Parkes considered it necessary for students to have previously attended lectures, perhaps in the College, on chemistry, physics and biology as, 'without a knowledge of these subjects as groundwork, hygiene cannot usefully be taught', and

¹⁰⁴ Waddington, *Medical Education*, p.132.

¹⁰⁵ Parkes, *Hygiene and Public Health*.

¹⁰⁶ Pakes, *Science of Hygiene*.

¹⁰⁷ BC Prospectus, 1896-1897.

¹⁰⁸ BCLM (Dec 1902), pp.9-10.

¹⁰⁹ BCLM (Mar 1903), p.5.

the entry requirement was eventually set at a matriculation-standard qualification in chemistry and physics.¹¹⁰ In 1904 it was stated that 'it cannot be impressed too strongly that a previous knowledge of chemistry and physics is essential and that an elementary knowledge of hygiene and physiology is advisable to profit fully by the course'.¹¹¹ Later, the College offered a short preliminary course in science subjects for applicants, and students were required to sit a mathematics test early in the first term.¹¹² The students struggled with the theoretical elements of the course. As one student put it, 'when it is fifteen years since you last looked at an algebra, and Mr Womack will evaluate [alpha], and experiments that look perfectly innocent land you in quadratics, there is a good deal of home reading to be done'.¹¹³ In 1905 the Board of Education remarked that 'the weakness of the students at present in the Hygiene Class is due to poor general education, or lack of previous qualification'.¹¹⁴ Unfamiliarity with examination technique was also a problem.¹¹⁵

The students seem to have realised that there was an anomaly between their present studies and their future working lives. They imagined, with not a little irony, how, in the future, they would 'test infant foods for starch, according to the teaching of Kanthack and find the percentage of alcohol in ginger ale according to the methods of Womack'.¹¹⁶ The opportunity to study some practical science, which had been previously denied them, was, however, clearly prized by some, and may have been why they chose this particular course. One ('HM', probably Hilda Martindale, later a pioneering women factory inspector) wrote:

There is no doubt about it that the practical work of the hygiene department is charming in its novelty to those who have been taught this science before solely by speech. They, and they only, appreciate fully the work the Bedford College has done in giving this training so long desired, so long withheld. In the past it has been possible to attend lectures, to cram for examinations, but the laboratory work has never before been possible to the student of health, unless she took a complete medical course.¹¹⁷

The students likewise defended the scientific content of the course against its detractors: 'such benighted beings tell us that they think milk can be tested and dwelling-houses condemned without any knowledge of the laws of diffusion of gases

¹¹⁰ RHBNC: BC Council, 18 June 1895, 16 July 1895 (GB 110/1/5).

¹¹¹ *BCLM* (Mar 1904), pp.3-5.

¹¹² RHBNC: BC Calendar, 1915-1916, pp.77-8 (AR 243/7); Council, 29 Mar 1916 (GB110/1/11).

¹¹³ *BCLM* (Mar 1896), p.17.

¹¹⁴ RHBNC: Hygiene Committee, Board of Education, report [1905] (AL/334/1).

¹¹⁵ RHBNC: BC Council, 20 Jul 1910 (GB110/1/9).

¹¹⁶ *BCLM* (Mar 1896), p.18.

¹¹⁷ *BCLM* (Jun 1896), pp.10-11.

or of meteorological indications.¹¹⁸ After a period working as a sanitary inspector, Miss Lovibond wrote that, 'It cannot be too strongly laid down that an inspector should have a good foundation in scientific education in its highest sense.¹¹⁹

The hygiene students were 'somewhat older' than the others and were popularly known as 'the Antediluvian Class'.¹²⁰ Their relative maturity seems to have been respected by the College authorities. One student remembered of the College Principal that, 'she only told me the morning I left that smoking was not allowed in college though she must have known perfectly well I had smoked like a chimney the whole time having been accustomed so to do from my youth up!'¹²¹ Looking back on the course, Margaret Tuke wrote that,

though it did not attract a large inflow of students [it] added to the prestige of the College by taking an early part in a new and important movement and in sending out women thoroughly equipped for work in which they were to a great extent pioneers.¹²²

In 1910, a list of the 48 women who had taken the College Hygiene course and their subsequent occupations was compiled. Thirty-eight were in some form of employment. Eight were working as sanitary inspectors, eight as factory inspectors and four as health visitors. Four were hygiene or domestic science lecturers and one was teaching at Roedean. Six were doing social work (e.g. an almoner). Four were working in the new laboratory jobs that were opening up for women at this date (e.g. assistant in the pathological department of a hospital) and one was the head of a steam laundry.¹²³ In a recent history of Bedford College, Drewry and Brock have suggested that the hygiene course was 'intellectually' rigorous because of the demands of Bedford College staff, but it produced women over-qualified 'for the relatively mundane tasks open to them'.¹²⁴

The course was never popular. The number of students in the Hygiene Department never exceeded twelve, and was often very much less. The students joked in 1897 that, although their number had increased by 400% (from one to four),

¹¹⁸ BCLM (Dec 1896), pp.20-21.

¹¹⁹ BCLM (Dec 1903), pp.23-26.

¹²⁰ Tuke, *History*, p.159; BCLM (Mar 1896), p.17.

¹²¹ RHBNC: Adeline Montagu, student file.

¹²² Tuke, *History*, p.159.

¹²³ RHBNC: List of students who have taken the BC Hygiene course, May 1910 (AL/334/2). Some students went on to hold influential posts. Hilda Martindale was a pioneering factory inspector. Irene Whitworth became Assistant Director, Welfare and Health Department, Ministry of Munitions. Hilda Bideleux went on to shape the training of another generation of health visitors and sanitary inspectors as Head of the Hygiene Department at Battersea Polytechnic.

¹²⁴ Drewry & Brock, 'Social studies and social science', pp.313-317.

'the College need not be enlarged on our account just yet.'¹²⁵ Of these, 62% gained the College Hygiene certificate, 57% a sanitary inspector's certificate, and 40% achieved both qualifications. 1904 and 1905 were peak years for the College, when there were eight successful candidates for the SIEB. This may be compared with the NATHS, when a figure of between ten and twenty successful candidates per year was usual. Compared with other options, the training offered at Bedford was long, difficult and expensive, and required a high level of previous scientific education.

DEBATE

Some greeted the success of women in the examinations for sanitary inspectors with scepticism. The opinion of Meredith Richards, that women had 'little taste for mechanics' and were 'unfitted' for 'sanitary engineering', was a result of their poor performance in that portion of the RSI examination. He claimed that, if their weakness in this was not compensated for by superiority in other directions, it was unlikely that many would succeed in qualifying as sanitary inspectors.¹²⁶ Even those who had been educated in the best of the girls' high schools would not necessarily have had much of a grounding in practical science.¹²⁷ In the late nineteenth-century elementary schools attended by male sanitary inspectors, however, science was taught by practical observation and experiment.¹²⁸ One woman inspector admitted that women were generally weak in sanitary engineering, 'but this was due not necessarily to want of capability or interest, but to lack of proper instruction.'¹²⁹ She was supported by one gentleman, who felt that it was not surprising that women did not shine in their answers to questions about drainage, but it would be a mistake to attribute this to an innate inability on the part of women to understand mathematical and mechanical problems. Rather, 'hitherto the ordinary education for girls had been weak in this direction, and after making due allowance for this some women displayed quite exceptional mechanical aptitudes.' He considered that options should be allowed in the examinations, so that scientific knowledge of child life might be accepted in substitution for building construction. 'In the public interest', however, it would be a mistake to deny women facilities for the thorough study of all branches of sanitary science.¹³⁰ One woman inspector had 'for reasons of my own and because I

¹²⁵ BCLM (Dec 1897), pp.17-18.

¹²⁶ Richards, 'Aim and scope of women's work in relation to public health', *JRSI* 1907 pp.194-5.

¹²⁷ Delamont, *Knowledgeable Women*, pp.115-129.

¹²⁸ Hurt, *Elementary Schooling*, pp.181-182.

¹²⁹ *JRSI* (XXVII 1907), p.199.

¹³⁰ *JRSI* (XXVII 1907), p.200.

like it, pursued technical or practical work rather further than most women', but still felt that her 'very hard-learnt and hard-fought-for knowledge is a mere pinprick compared with the trained years of experience of a male inspector'. She observed that, while women had 'to cram their technical knowledge; to men it is, in the majority of cases, their life's work and experience.'¹³¹ Many male inspectors had training and experience in relevant practical trades, such as plumbing and building construction, before qualifying as inspectors.

One woman admitted that many of her female colleagues neither knew, nor wished to know, practical details about drainage. She reported that,

Most of them profess to consider drains "nasty" – "cannot bear smells" – and on one occasion I was present when a woman holding the certificate of the RSI ... was unable to say under what circumstances an upcast ventilating shaft might become a downcast one.¹³²

She had also overheard one woman about to enter the examination room remarking 'how can one be expected to answer all these stupid questions; if it were more interesting it would be different.' She did not, however, use this as an argument for a differentiation in qualifications, but as a rallying cry to her colleagues that, if they wished to be on equal terms with the men, 'they must prove that their practical knowledge is equal to that of the other sex.'¹³³

Some male inspectors resented the success of women in the examinations. One wrote in 1905 that

for them to be examined on the same papers as males for Inspectorship is more apparent than real, practically amounting to a farce. The examiners do not expect the same results from females as they do from males. Consequently 95 per cent of females are successful, while 60 per cent of males fail to satisfy the examiners. The extreme difference of these results has the tendency of holding the procedure up to ridicule.¹³⁴

He argued that the examination of women should be separate, and that subjects such as the principles of building construction and practical sanitation should not be taken. Some male inspectors seem to have been motivated to press for a separate training and qualification for the women in order to keep them from competing for the same posts.¹³⁵ 'Obviously hers should be the home, the hearth and the hospital, and to these she should be trained' wrote one, while another 'disgusted inspector' called on the Sanitary Institute to organise a separate training.¹³⁶

¹³¹ SR (L, 1912), p.414.

¹³² SR (XLVI, 1910), p.253.

¹³³ *Ibid.*

¹³⁴ SJ (XI, 1905-1906), p.9.

¹³⁵ SR (XXXVI, 1905), pp.74-75.

¹³⁶ *Ibid.*, pp.433, 475.

Some MOHs also thought that women were not offered an appropriate training since they had to go into detail about the construction of drains and sewers, and the inspection of slaughter-houses. For one, this was 'just as unreasonable as it would be to include such items as infant rearing in the training course for the male inspector'. He suggested that women should have a training of an equal standard, but specialise in those areas of work they most often undertook.¹³⁷ Some women sanitary inspectors themselves felt that the examining boards 'might well, without reducing the value of the certificate in any way, make the examination for women run more on the lines in which their work lies, including, for instance, the management and proper feeding of infants'.¹³⁸ There was also a general uproar caused by the presence of female students in slaughter-houses, and many commentators focused on this as an extreme and graphic image of the unsuitability of a general training. Encountering female students at a demonstration of the slaughter and disembowelment of a pony at a knackery upset one man. He declared that, 'The utility of the female sanitary inspector lies to a great extent on her femininity, and the attendance at such a demonstration and lecture tends in every way to abolish all sense of femininity and good taste'.¹³⁹ Part of the argument for the refusal by the LGB to sanction the appointment of women sanitary inspectors to undertake health-visiting work in London was that they were not properly qualified for it. The Board wrote to Southwark Vestry in 1900,

the work of visiting the homes of parents for the purpose of giving instruction to mothers in the feeding, care and nurture of infants is not only a work of a delicate nature, but it is one which requires special training of a high order if it is to be carried out with any advantage. Such a training does not come within the experience which a sanitary inspector is necessarily required to obtain.¹⁴⁰

Whatever the lack of aptitude and preferences of the women, and the protectionism of the male inspectors, many women were indeed undertaking different duties. The system of training and examination into which they had been squeezed by the 1891 Public Health (London) Act was straining at the seams.

CONCLUSION

Despite the varying fortunes of their courses for women sanitary inspectors, and the diversity of outlook and ethos, the differences between the NATHS, RSI and Bedford College were more apparent than real. Some historians of women's education have concentrated on the growth of formal schooling for middle-class

¹³⁷ *JRSI* (XXVII 1907), p.201.

¹³⁸ Dick, 'Work of women as sanitary inspectors', *JSI* (XXIV, 1904) p.879

¹³⁹ *SR* (XL, 1907), p.444.

women and their access to higher education. They have tended to overlook less 'formal' avenues, including voluntary societies, through which middle-class girls might obtain training for a career. At the same time, the game of 'double conformity' played by formal educational institutions emphasised the ethos of voluntarism, and the ideal of service.¹⁴¹ All the institutions declared that the training was useful for voluntary service, as much as for paid appointments, and very many more women qualified than there were vacancies. Women were prepared equally for careers in 'female' occupations, such as health teaching, alongside being encouraged to enter the 'male' occupation of sanitary inspection. The majority chose to train at 'respectable' single-sex institutions during the day, and not in the cheapest or quickest way. They can be contrasted with the typical male student who, having left school at fourteen, was working at a trade during the day and attending a cheap, short course in the evening, in order to break into a relatively secure occupation. Different experiences of training bolstered the differences between men and women public health workers in terms of the way in which they viewed themselves and their work.

¹⁴⁰ *SJ* (VI, 1900-1901), pp.139-141.

¹⁴¹ Delamont, 'Domestic ideology'.

7: HEALTH VISITOR TRAINING

A SEPARATE QUALIFICATION

In April 1907, Louis Parkes, Chairman of the Council of the Sanitary Institute, suggested that it should consider a special examination for women.¹ The following January, the Council, 'having regard to the large number of ladies holding appointments' as health visitors, and the likely rapid increase in their numbers, recommended the establishment of an appropriate examination.² It felt that, although

hitherto they have mostly prepared themselves for their duties by taking the Examinations for Inspectors of Nuisances, and although all the subjects of this Examination and the preparation for it are undoubtedly useful to them, the nature of their duties render it important that they should be more specially qualified in other matters relating to personal hygiene and the care of children, which do not come within the scope of the duties of an Inspector of Nuisances set out by the Local Government Board.³

A separate examination for health visitors was established. It was recommended not only for women who intended to take up paid posts, but also for 'those who are desirous of engaging in voluntary work amongst an industrial population'.⁴

The syllabus included the general structure of the body, personal hygiene, air, water, food, clothing, the dwelling, elements of home nursing, the care of infants and young children, the prevention of communicable disease, first aid, the treatment of injuries, ailments and accidents, and statistics.⁵ It differed in important respects from the syllabus for sanitary inspectors. The element on 'the dwelling', for example, contained not just the sanitary construction and engineering of the home, but a component on 'cleansing, sweeping and dusting'. As with the other examinations, every candidate was required to furnish the Board of Examiners with testimonials as to age and personal character, and no one under 21 was allowed to sit for the examination. The same standards for basic literacy and mathematics were required as for the Institute's own examinations for sanitary inspectors.⁶ That there was immediately a high demand for the training can be seen in Fig. 5. In only the second year of the examination in 1909, 92 women were granted certificates by the RSI as health visitors, compared with 66 women qualifying as sanitary inspectors under the RSI and SIEB schemes combined. By 1913, 350 candidates had received

¹ RSPH: SI Council minutes Vol X (1906-1907), pp.259-260, 309.

² *Ibid.* Vol XI (1907-1909), pp.48-49.

³ *JRSI* (XXIX, 1908), Supplement, p.77.

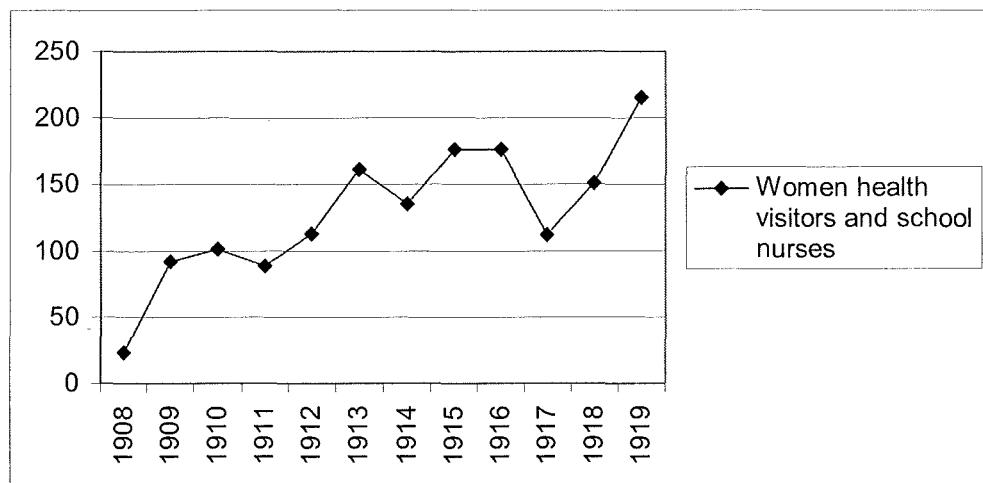
⁴ *NH* (IV, 1913), p.258.

⁵ *Lancet* (6 Jun 1908), p.1668; RSPH: SI Council minutes, Vol XI, 1907-1909, pp.108-111.

⁶ RSPH: SI Council minutes, Vol XI, 1907-1909, pp.108-111.

certificates.⁷ The high demand for the qualification was due, in part, to the adoption of the 1907 Notification of Births Act in many areas, the 1908 LCC (General Powers) Act, and consequent new regulations for the qualifications of health visitors in London.⁸

Figure 5: (Royal) Sanitary Institute: certificates granted, 1908-1919⁹



The London regulations, however, did not require any formal training in health visiting as such, while the labour market outside London remained unregulated. From 1909 a woman might be appointed as a health visitor in the capital if she was a qualified medical practitioner; a nurse with three-year training at a recognised hospital; or a certified midwife. Those not so qualified must have 'for a period of not less than six months, undergone in a hospital or infirmary ... a course of instruction including subjects relating to personal hygiene'. In addition, they were required to hold the certificate of the RSI for health visitors, or the certificate of the NATHS, or another body recognised by the LGB. Those who had, in the service of a local authority, discharged duties which, in the LGB's opinion were 'similar to those described in the Act', were also eligible. In certain circumstances, women who met none of these criteria, but who had a 'competent knowledge and experience', might also be appointed.¹⁰ According to one commentator, 'the good sense of the borough councils', acting on the advice of their MOHs and the LGB, prevented any misuse of this latter clause.¹¹ Women trained as nurses or midwives, or those who had relevant

⁷ *NH* (IV, 1913), p.258.

⁸ See Chapter 3.

⁹ RSPH: RSI examination registers.

¹⁰ *Lancet* (25 Sep 1909), pp.942-3; *JRSI* (XXXIV, 1913), p.178.

¹¹ Lane-Claypon, *Child Welfare*, p.101.

practical experience or specialist knowledge, might be appointed to posts without need for further training and qualification. Only those without such training or experience were required to obtain a specialist qualification, combined with a short period of nursing training. It was also emphasised that such qualifications did not allow a woman to act as a sanitary inspector.

The RSI followed the establishment of its examination by arranging a training course for health visitors and school nurses, and the Parkes Museum was expanded to include relevant material. By 1913, there was a new section devoted to 'infant hygiene', developed with the assistance of a woman sanitary inspector.¹²

An 'equal' qualification?

The issue of these regulations, and the introduction of the new RSI examination, did not stem an almost ceaseless tide of debate. Sidney Lawrence, Edmonton's MOH, claimed that it left him in the difficult position of whether to choose 'a woman with a man's training, or a woman only half-trained for her important duties.'¹³ He recognised that the duties of women inspectors meant that they need not study meat inspection or slaughterhouses, or have such a wide range of understanding of sanitary law as men, but felt that they required a different training of the same standard. Candidates were not required, as they were for the SIEB, to undertake any preliminary test of general education. Although they had to furnish evidence of practical knowledge, this could be by possession of the certificate of the CMB, or of general hospital training, not by actual experience in a public health department.¹⁴ Lawrence complained to the *BMJ* that,

the Institute has introduced ... into the public health service a great number of persons who, having passed an easier examination, now compete for appointments against those women who have (in the past) obtained the same Institute's certificate of "sanitary inspector" or that of the Sanitary Inspectors' Board. If ... my authority accepted such certificates, it must lead to a large competition for every vacancy, and therefore a lowering of the salaries paid, already (in my opinion) inadequate.¹⁵

In defending the decision of the RSI, Bostock Hill replied that it was an error to assume that the health visitor's certificate was easier: it was just, necessarily he felt, different.¹⁶ Parkes also claimed that 'the two examinations are for their respective

¹² RSPH: Parkes Museum, descriptive catalogue of sections: infant hygiene (Jun 1913).

¹³ *BMJ* (4 Mar 1911), p.529.

¹⁴ *BMJ* (25 Mar 1911), pp.727-8. The SIEB and RSI by this date required proof of practical experience, or attendance at a recognised training course, from candidates for sanitary inspectors' examinations.

¹⁵ *BMJ* (4 Mar 1911), p.529.

¹⁶ *BMJ* (11 Mar 1911), pp.597-8.

purposes of similar standard value.¹⁷ The main issue of debate, as so often with the education and training of women, was whether the qualification was 'different' but 'equal'.

For the women themselves this was a key issue. The Women Sanitary Inspectors Association (WSIA) was asked for its opinion on the advisability of differentiating between male and female candidates. Its response was that it 'strongly deprecates any suggestion or attempt to lower the standard of the examination in any way'.¹⁸ At a meeting of the WSIA in 1912, Dr Fremantle (MOH, Hertfordshire), put the case for a common preliminary sanitary training and examination for all officials followed by additional specialist qualifications.¹⁹ At a subsequent meeting, the WSIA passed a resolution in general support of these principles. It argued that there should be a uniform basic qualification of the same standard as the SIEB examinations but, 'that further certificates may be granted for special subjects... and should be recognised as qualifications in addition to, and not in substitution for the primary certificates'.²⁰ One of Finsbury's women sanitary inspectors suggested that specialisation in the supplementary examinations should be made 'on the basis of sex-capacity and individual bent':

If a man elects to make his outlook on public health so whole and rounded that he wants to know just how the infant mortality problem is partly of housing and general sanitation (and if he is a think to pass more examinations than he need!) then by all means let him take a course on the hygiene of infancy. So also with the woman: if she wants to know the bearing of slaughter-houses on the general well-being of the community let her pass an examination in the subject. She might emerge from the process a vegetarian!²¹

It remained the essential position of the WSIA in subsequent years that the qualifications should be different but of the same standard and that, rather than being sex-specific, men and women should be allowed to chose the area of their specialism according to personal preference.²² The Association acquired support from other women's organisations. Miss Kilgour, of the Women's Local Government Society, spoke in support of a single portal of entry for both sanitary inspectors and health visitors. She argued, quoting the arguments of Emily Davies in relation to equality in university education for women, that, 'if an inferior standard of knowledge is required, will it not be regarded as a standard accommodated to the inferior powers of

¹⁷ *BMJ* (18 Mar 1911), p.659.

¹⁸ Wellcome: WSIA annual report, 1906-1907, p.12 (SA/HVA/A.1/1).

¹⁹ *NH* (IV, 1912), p.149.

²⁰ Wellcome: WSIA annual report, 1912-1913, p.11 (SA/HVA/A.1/6); WSIA minutes, 5 Feb 1913 (SA/HVA/B.1/5).

²¹ Letter from Marion Fitzgerald, *SR* (L, 1912), p.193.

women?'²³ She stated that women sanitary inspectors, like their male colleagues, should pass an initial general examination, followed by suitable supplementary examinations. Her quotation of Emily Davies is significant, since it places the issue squarely in the centre of the debate that had been taking place over women's education as a whole.²⁴

The WSIA never won this battle and the separate system of qualification remained, although many women took a combined training. Meanwhile, the employment patterns of women were shifting, as demand for health visitors increased. One MOH, who championed the woman sanitary inspector and her equal training and qualification, was, by 1911, beginning to feel that the Sanitary Institute was taking advantage of women by allowing them to sit for the inspectors' examinations, since there were so few posts available. 'If they are unfitted for the work', he argued, 'why encourage them to go to the expense of employing coaches, of buying text-books, attending lectures and demonstrations, and the many other things necessary to compete?' If the only position open to them was that of health visitor, they should be putting their energies into that examination instead. It was simply not fair, he felt, to take their examination fees and, when they had passed, tell them that they were not wanted as inspectors, 'that their efforts have been wasted and there is another examination they must take before they can hope for work.'²⁵ The *Sanitary Record*, although seeing room for both officers, viewed the introduction of the separate examination as an underhand attempt to 'oust the woman inspector'. If health visiting was to be preferred as the public health occupation for 'women's special gifts', then further applications from women for the qualifications of an inspector should be discouraged. 'In fact, it should be boldly announced that the RSI does not think women fitted for the position of sanitary inspector'.²⁶ One female Associate of the Institute declared that, if all that the RSI considered necessary for a woman to undertake public health work was 'a mixture of a parish nurse and district visitor combined', then it would be more just to refuse to let her sit for an inspector's certificate.²⁷ The evolution of a separate training and qualification for health visitors had wide repercussions, and became enmeshed in the general debate over the perceived threat to status, pay and conditions which the arrival of the health visitor

²² Wellcome: WSIA annual report, 1914-1915, p.17 (SA/HVA/A.1/8).

²³ NUWW conference report, 1911, p.125.

²⁴ For more on this general debate see Delamont, *Knowledgeable Women*, p.105ff.

²⁵ SR (XLVII, 1911), p.254.

²⁶ *Ibid.*, p.277.

²⁷ *Ibid.*, p.392.

posed to the woman sanitary inspector.²⁸ While debate continued, training institutions began to formulate courses for health visitors. Some found it easier than others to adapt to the changes.

National Health Society

In 1907, the NATHS modified the syllabus of its diploma course and introduced two new subjects – ‘the care of infants and children’ and ‘simple cookery’.²⁹ In 1911 a course of lectures on tuberculosis was also added.³⁰ This new course, in addition to six months hospital training, was recognised by the LGB as a qualification for health visitors in London. Those completing the full diploma were also able to enter examinations for sanitary inspectors, and many chose to do so.

NATHS students had always been encouraged to gain some experience of nursing, and to take advantage of the special arrangements that the Society had made with the Chelsea Poor Law Infirmary. As early as the 1890s, the Infirmary was taking NATHS students for a period of six months training for an additional fee.³¹ Its Superintendent, Miss de Pledge, had trained at St Bartholomew’s Hospital and, as an active member of the Royal British Nurses Association, was part of the network of reformed nursing. Although it was stressed that, at the end of this training, students were ‘in no sense to be considered as nurses’, a general experience in the treatment of the sick was considered to be of the utmost benefit to them in their later posts.³² Alice Ravenhill remembered that, during her time in the Infirmary, she ‘acquired great dexterity’ in giving blanket baths, and the other manifold duties which attended work amongst the chronic cases in a poor law hospital.³³ She, and other students, including Rose Squire, were firmly convinced of the usefulness of their NATHS nursing training.³⁴ The Society was early in the field in providing a nursing background for women working in public health. The ‘rounded’ nature of the training that it offered may have been one of the reasons for its popularity, particularly after the requirement for nursing experience contained in the 1909 regulations.

²⁸ See Chapter 8.

²⁹ NATHS, annual report, Apr 1908, pp.8-9.

³⁰ NATHS, annual report, May 1912, pp.10-11.

³¹ LSE: Unidentified cutting, interview with Miss de Pledge (Streatfeild 1/22).

³² *Ibid.*

³³ Ravenhill, *Memoirs*, p.68.

³⁴ Squire, *Thirty Years*, p.21.

Battersea Polytechnic

New organisations also moved into the field, notably Battersea Polytechnic, which had been training male sanitary inspectors in its evening department since the late nineteenth century, and had also offered hygiene courses in its women's department.³⁵ In 1908, Battersea arranged a course to prepare students for the RSI health visitors examination and, its own certificate was subsequently recognised by the LGB as qualifying health visitors under the 1909 Order.³⁶ The training was designed to meet the requirements 'of well-educated women who wish to obtain posts as health visitors and school nurses, and of Church, District and Social Workers who feel the need of a training before undertaking voluntary work.'³⁷ In contrast to the training for male sanitary inspectors, the course took place in the afternoons. In May 1909, five students were successful.³⁸ From 1910, the Polytechnic strongly advised that students took the course for sanitary inspectors, alongside the health visitor training, and offered a reduction in fees for students taking both.³⁹ In 1915 one woman inspector commented that it offered 'a very thorough and practical course of training for women sanitary inspectors and health visitors at a most moderate fee' of nine guineas.⁴⁰

Following the NATHS example, students were 'strongly advised' to enter a Children's Hospital for 'a short period' of nursing training, and to attend the first aid and nursing classes held at the Polytechnic on Thursday evenings. They were warned that nursing experience would be 'a material advantage' when they came to seek posts.⁴¹ Arrangements were made with a district nursing association for those with no previous hospital or midwifery experience to work for one day a week for three or four months, for an additional fee.⁴² By 1913, the Polytechnic had made arrangements with several London hospitals for short courses of midwifery and hospital training.⁴³

³⁵ The LSA supported the Polytechnic movement and the opportunity it provided for education in hygiene. See Report of the LSA to the Seventh International Congress of Hygiene and Demography, p.10.

³⁶ Surrey: BP Prospectus, 1908-1909, p.82 (I₁ 0499.002).

³⁷ Surrey: BP Calendar, 1910-1911, p.p113-114 (I₁ 0500.003).

³⁸ Surrey: BP Principal's report, 1909-1910, p.25 (I₂ 0542 001).

³⁹ Surrey: BP Calendar, 1911-1912, p.115 (I₁ 0500.006) & 1913-1914, pp.74-75 (I₁ 0531.001).

⁴⁰ Greenwood, 'Women sanitary inspectors: training and examination', *Women's Employment* (XV, 1915), p.5

⁴¹ Surrey: BP Prospectus, 1908-1909, p.83 (I₁ 0499.002) and 1909-1910, p.104 (I₁ 0499 005).

⁴² Surrey: BP Calendar, 1909-1910, p.104 (I₁ 0499.005).

⁴³ Surrey: BP Calendar, 1913-1914, pp.74-75 (I₁ 0531.001).

Bedford College

Bedford College found it more difficult to adapt its hygiene course to the needs of health visitors. One student, who attended the course in 1908/09, and had a long career in infant welfare work, remembered that 'I thought then and still think after almost 20 years practical work that it was a rotten training they gave us! Of course, this generation of health visitors are trained on quite different lines.'⁴⁴ Those whose public health careers were to include maternity and child welfare, or tuberculosis visiting, were not adequately prepared. In 1904, when describing the hygiene course, the College magazine warned that

certain further qualifications are a great advantage to students who have the time and energy to spare for further training. A knowledge of hospital or district nursing helps to widen the experience and in many cases is essential for obtaining a post as a lecturer under the County Councils or as a health visitor or even as an inspector. Cottage or sick-room cookery may with advantage be added to the other requirements of training.⁴⁵

One student, who took the hygiene course in 1911/12, followed it with three months training at Great Ormond Street Hospital and a separate health visiting course, before going on to do infant welfare work.⁴⁶

The course was reviewed, the hygiene lectures increased at the expense of the third term's physics teaching, and a fourth term was offered, at an additional fee, for those wishing to study industrial legislation and economics.⁴⁷ Some lectures were devoted to the physiology and hygiene of infants and children, and opportunities provided for students to learn something of sick nursing and the care of children in the fourth term, either as an alternative to, or concurrently with, the economics course. The opportunity of one day per week being spent doing practical work in conjunction with Westminster Health Society was also offered during the fourth term. It was an important watershed when, in 1908, it was recognised that 'the duties of women sanitary inspectors differ in many details from those of men', and that this required a different type of training.⁴⁸ In addition to inspectors and hygiene teachers, by 1915/16 the course was aimed at 'health visitors under municipal councils, health and education committees and other organisations for promoting the public welfare'. It was considered useful also for those who wished 'to enter public life as, for

⁴⁴ RHBNC: Adeline Montagu, student file.

⁴⁵ BCLM (Mar 1904), pp.3-5.

⁴⁶ RHBNC: Nora Parker, student file.

⁴⁷ RHBNC: Sub-committee on the College Course in Hygiene, report (AL/330/1/1b).

⁴⁸ *Ibid.*

instance, members of County and Municipal Poor Law Authorities and agencies interested in infant care and women's employment.⁴⁹

Despite these reforms, student numbers continued to dwindle. Margaret Tuke stated that the reason for the downturn in applications was that

shorter, more purely utilitarian courses, preparing for various public health appointments, were being provided elsewhere. Women anxious to spend as little time and money on training as possible were not ready to give the two years demanded at Bedford for the Hygiene Course when the necessary qualification for a Health Visitor could be obtained in six months at other institutions.⁵⁰

She saw the College's two main rivals as the NATHS and Battersea Polytechnic. The College was not, however, prepared 'to lower the scientific standard which required the longer course', in order to compete with these other institutions. It continued to compromise, but was increasingly swimming against the tide.

1919 REGULATIONS

In its 1919/20 annual report, the Ministry of Health published figures giving the qualifications of the 1,879 health visitors then employed by local authorities. These showed that 986 (52%) were fully-trained nurses; 1,360 (72%) certificated midwives; 245 (13%) qualified sanitary inspectors; and only 147 (8%) qualified health visitors. 1,133 (60%) held more than one of these qualifications in a variety of combinations.⁵¹ The 1909 regulations governing appointments in London had been relatively permissive, and entry to the occupation outside the capital remained unregulated. The next ten years saw various attempts to bring order to the system of training health visitors, to raise standards, and to promote the possession of a specialist qualification, without creating a shortage of available workers. Behind all these initiatives lay continued controversy about the ideal health visitor: her age, social class, educational background and previous experience. No less contentious were debates on the philosophy that was to underpin her work. Was she to be a nurse trained in curative medicine, or a medical social worker grounded in the principles of social science and preventive medicine? Was she to be the product of a hospital, or of a university?

Prior to the First World War, the WSI&HVA outlined its preferred scheme of basic training as one that combined the main elements of a sanitary inspector's training with those of the health visitor courses that had been developing over the

⁴⁹ RHBNC: BC Calendar, 1915-1916, pp.77-8 (AR 243/7).

⁵⁰ Tuke, *History*, p.233.

⁵¹ ME (LXVI, 1920), p.380.

previous decade.⁵² The Association claimed that 'only the trained mind can grasp the real meaning of health visiting', and that training must provide 'the right class of worker'.⁵³ It pressed for the establishment of a Health Visitors' Examination Board, and one single recognised certificate.⁵⁴ It deprecated the wide variation in qualifications, and the fact that women might still be appointed at a lower salary 'than would be accepted by persons possessing high educational and technical qualifications'.⁵⁵ Although the details changed over subsequent years, the principles of WSI&HVA policy remained constant. A single statutory qualification that would regulate entry to the profession, and eliminate cheap competition, was fundamental to its policy, although this was sometimes attenuated by the need to protect the position of practising health visitors. A higher preliminary educational standard for new entrants, preferably not lower than that of the Senior Oxford or Cambridge Local Examinations, remained important. Sanitation and hygiene were key skills for the health visitor, and the Association used the benchmark of the sanitary inspectors' qualification as a minimum acceptable standard of competence. Most importantly, it was committed to equality of opportunity for those with a nursing background, and those who had expertise in social work or a university degree, although those without either, and who wished to enter the occupation, were also encouraged.

Prompted by the 1918 Maternity and Child Welfare Act, which encouraged the rapid development of services, one of the first steps of the new Ministry of Health was to examine the training of health visitors, and, in July 1919, it issued a circular on the matter. The Ministry was aware that 'a high standard of work' had not been uniformly secured, since, outside London, no qualifications had yet been prescribed.⁵⁶ Responsibility for setting a standard of qualification and training for health visitors was passed to the Board of Education, which issued draft regulations.⁵⁷ It acknowledged that, although nursing and midwifery training were useful, they did not cover many of the functions exercised by health visitors, and recognised two types of course. A full course of training lasting two years was intended for those with no prior experience. A one-year course for trained nurses, and for those possessing other relevant knowledge or experience, including those who had already been working as health visitors, and university graduates in certain

⁵² Wellcome: WSI&HVA minutes, 2 May 1917 (SA/HVA/B.1/6).

⁵³ ME (LXII, 1918), p.395.

⁵⁴ *Ibid.*, p.398.

⁵⁵ *Ibid.*; NH (XI, 1919), pp.284-285; Wellcome: WSI&HVA minutes, Apr 1919 (SA/HVA/B.1/6).

⁵⁶ TNA: Circular MCW 10/4, 4 Jul 1919 (MH/53/101).

⁵⁷ TNA: Board of Education, draft regulations for the training of health visitors, 10 Jul 1919 (MH/53/101).

subjects, was also to be available. Courses had to be recognised by the Board, and be conducted in close association with a university institution.⁵⁸ Grants of £20 per annum for each student attending such a course were made available.⁵⁹ The Ministry decided that, for salaried posts requiring government sanction and grant, it would, when enough students had qualified, set a date after which all women appointed for the first time as health visitors would be required to hold the new certificate.

The Board did not prescribe precise educational qualifications, but stated that candidates for the two-year course should have had a good secondary school education. A minimum age of eighteen was set, enabling girls to enter directly from school, although on qualifying they would only be suitable for posts 'of limited responsibility'. Any course of training was to provide both theoretical instruction and practical training. Visits of inspection to a wide range of institutions were recommended, along with continuous attendance for several months at maternity and child welfare clinics, tuberculosis dispensaries, and places where the student might gain practical work in social problems. The suggested syllabus shared many elements with courses previously developed by the RSI, NATHS and Battersea Polytechnic. Elementary physiology was required as a basis for instruction in other subjects, and was to include practical laboratory work. Methods of artisan cookery and household management were required as, although the health visitor 'need not be a skilled cook', she should be competent to provide advice on cookery, household economy and 'domestic arrangements'. It was recommended that the hygiene section of the syllabus should cover the duties performed by a sanitary inspector. Infectious and communicable diseases, and maternity, infant and child welfare were core subjects. Since health visitors could not adequately perform their duties unless they appreciated the 'conditions of life' of poor families, any course was to include instruction in elementary economics and social problems, as well as local government, modern social and industrial conditions, social legislation, voluntary institutions and agencies.

The Lancet was encouraged that, under the new regulations, 'the most successful health visiting is now found to be done by women of good education with some previous training in social science', rather than by trained nurses.⁶⁰ The WSI&HVA declared that it had seen 'one of its chief objects of desire realised, the establishment of a single qualification for health visitors'.⁶¹ It had some reservations,

⁵⁸ *BMJ* (9 Aug 1919), p.191.

⁵⁹ McCleary, *Maternity and Child Welfare*, p.32.

⁶⁰ *Lancet* (26 July 1919), p.161.

⁶¹ Wellcome: WSI&HVA annual report, 1919-1920, p.5 (SA/HVA/A.1/13).

but thought that it was 'distinctly satisfactory' that the Ministry should, 'so early in its career' have gone so far towards meeting its wishes.⁶² Not everyone was so satisfied.

Response of the Royal Sanitary Institute

The RSI was utterly opposed to the principles on which the 1919 regulations were based. It claimed that, through its members, it was closely in touch with the public health service throughout the country, and the new method of training did not meet practical requirements. According to the Institute, it had been framed with the needs and methods of university schools and technical colleges in mind. Vocational training for nurses, and other experienced officers, as had been successfully achieved by its own schemes, was overlooked.⁶³ The RSI declared that the Board of Education sought to produce 'an entirely new class of worker in the public health service', who would not be suitable to perform the ordinary duties of the health visitor.⁶⁴ It claimed that those who took the new 'educational certificate' were afterwards taking the RSI examination, so as to hold 'a vocational qualification' that was recognised by local authorities.⁶⁵ It did not feel that it could provide training under the new regulations, or 'an examination on university lines'.⁶⁶ Instead, it attempted, without success, to persuade the Ministry to accept its examination for health visitors as a qualifying examination under the new regulations.⁶⁷

During the First World War, the RSI had responded to LGB memoranda on infant welfare by modifying its scheme for training, and instituting a new advanced examination for infant welfare workers.⁶⁸ It felt that its own system of examinations had secured 'a good and uniform standard of qualification' that was known and trusted by local authorities and by government departments 'throughout the empire'. It argued that it would have been much better to develop this existing system rather than introduce a new one.⁶⁹ It held examinations in different centres around the country 'almost every week', and there were nearly thirty colleges that prepared students for these.⁷⁰ It claimed that the Board of Education under-estimated the problem of supplying the necessary number of qualified women from a handful of

⁶² *Ibid.*

⁶³ RSPH: RSI Council, Mar 1921, pp.302-303.

⁶⁴ *Ibid.*, pp.515-517.

⁶⁵ *Ibid.*

⁶⁶ *Ibid.*, pp.302-303.

⁶⁷ RSPH: RSI Council, Jul 1921, p.360.

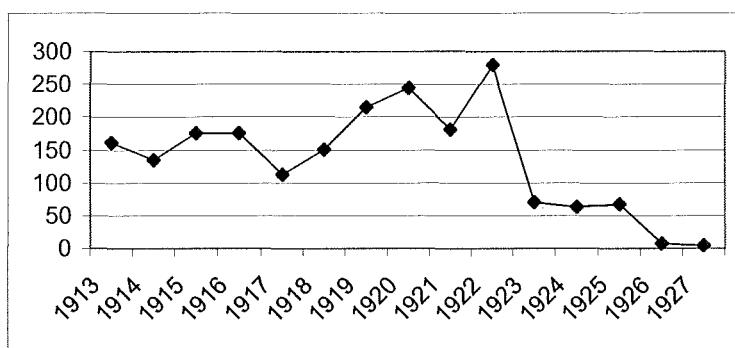
⁶⁸ *JRSI* (XXXVII, 1916), Supplement pp.23-24 & (XXXVIII, 1917), Supplement, p.13; RSPH: RSI Council, Oct 1916, pp.362-363 & Jul 1916, p.349; *ME* (LVII, 1916), p.91.

⁶⁹ RSPH: RSI Council, Mar 1921, pp.302-303.

courses. The RSI scheme also operated without cost to the country, whereas that of the Board involved the expenditure of public funds, and the cost to the individual candidate was nearly three times as much.⁷¹ The RSI had the support of many public health doctors and the Society of Medical Officers of Health (SMOH).⁷²

After the introduction of the new scheme in 1919, candidates continued to come forward to take the RSI examination, fuelling speculation that the new courses were doomed to failure (Fig. 6). The date when the new qualification was to become compulsory was to be fixed when a sufficient number of candidates had completed the new training. It was impossible to guess when this might be, which left the RSI, and health visitors, rather up in the air. The RSI felt that there would probably be an interval before there were enough women qualified under the new regulations. It decided to continue its existing course in order to fill this gap, despite discouragement from the Ministry of Health.⁷³

Figure 6: RSI: health visitors' certificates granted, 1913-1928⁷⁴



Meanwhile, individual institutions began to arrange courses under the new regulations. In 1919, the Board of Education recognised three centres connected with the University of London: Bedford College, Battersea Polytechnic, and King's College with the Ratan Tata. Each acted separately, and arranged its own examination.⁷⁵

Bedford College

In 1915, Bedford College Council was approached by the Training Committee of the Charity Organisation Society (COS) to provide a course of lectures for social

⁷⁰ RSPH: RSI Council, Mar 1921, pp.515-517.

⁷¹ *Ibid.*

⁷² RSPH: RSI Council, Dec 1921, p.415.

⁷³ RSPH: RSI Council, Oct 1919, pp.88-89, Dec 1921, p.416.

⁷⁴ RSPH: RSI examination registers.

⁷⁵ RHBNC: BC Principal to University of London, Nov 1919 (AL/330/1).

workers.⁷⁶ While demand for the Hygiene course continued to be 'disappointing', the new social work training was 'successful'.⁷⁷ This led to the arrangement of an 'independent and more comprehensive scheme' for the 1918/19 session, and the formation of a Department of Social Studies.⁷⁸ Helena Reid, previously a lecturer at the LSE, and with a background in school management and social work, became the first permanent Director of the new Department.⁷⁹ By contrast, the College Council finally resolved to discontinue the hygiene course, and the training of women sanitary inspectors, after the 1918/19 session, 'as so few students have presented themselves'. It reported that 'the course will partially be replaced by the hygiene teaching provided in connection with the new scheme of social studies'.⁸⁰ In 1919/20 compulsory subjects were general economics and social administration, followed by two to be chosen from industrial history, psychology of social conduct and social ethics, biological introduction to sociology, and 'conditions of health'.⁸¹ The latter two subjects were taught by Edkins and Brincker, of the old Hygiene Department. The new course was developed against a background of developments in the university teaching of social work and it met the requirements of the Diploma for Civic Workers of the University of London.⁸² One student wrote about the practical experience offered:

We help the Lady Almoner of a hospital to collect a weekly sixpence towards Tommy Tucker's surgical jacket in the guise of "The Lady from the Hospital" – as "The Lady from the School" we see that he has his hair cleansed and his tonsils removed, should he be ill we recommend that he should be sent to the sea to convalesce as "The Lady from the Society" (COS in disguise).⁸³

At Bedford College, health visiting became a branch of social work. Health visitors were 'ladies from somewhere', along with hospital almoners, school care committee workers and COS agents. The move from training women public health workers in a scientific hygiene department, to one of social studies was swift and significant.

In 1919/20, a specially modified version of the social studies course was recognised by the Board of Education for the training of health visitors, although the Board emphasised that practical experience should be for 'health purposes', rather

⁷⁶ Rooff, *Hundred Years*, p.239; Drewry & Brock, 'Social studies and social science', pp.317-8.

⁷⁷ RHBNC: BC, Council reports, 1915-1916, 1916-1917 (GB113/1).

⁷⁸ RHBNC: BC, Council report, 1917-1918 (GB113/1).

⁷⁹ RHBNC: BC, Social Studies, Director of course appointment (AR/330/7).

⁸⁰ RHBNC: BC, Council report, 1917-1918, pp.16 -17(GB113/1); Council, 27 March 1918 (GB110/1/12).

⁸¹ RHBNC: BC, course of training in social work, 1919/1920 (AR/330/2).

⁸² For the history of social work training see Smith, *Professional Education*; Macadam, *Equipment*.

⁸³ BCLM (Dec 1921), p.12.

than 'social investigation'.⁸⁴ Bedford offered both two- and one-year courses under the 1919 Regulations. The two-year course included the elementary physiology, economics and social problems, and hygiene lectures from the social work programme, supplemented by artisan cookery and household management, and additional lectures on personal hygiene, maternity and child welfare and tuberculosis. During the first year there was practical work in the College's physiology laboratories, and experience of 'general social conditions in connection with various social agencies'. During the second year, at least three months full-time was spent at an infant welfare centre.⁸⁵

As critics of the new training regulations had predicted, the course offered by Bedford College was expensive (20 guineas per session), long and academic. The number of students taking its health visitors diploma was very small. Between 1921 and 1924 Bedford trained only 13 women under the 1919 Regulations. This attempt to position health visitor training alongside a semi-academic training in social work, in a university environment, was not a success.

Battersea Polytechnic

In 1919, Battersea's Department of Hygiene and Public Health was recognised by the Board of Education as a training centre. It began to offer both one- and two-year courses, the latter also training women as sanitary inspectors.⁸⁶ The one-year course was arranged 'to meet the needs of individual students', depending on previous experience, knowledge, age and other circumstances.⁸⁷ The driving force behind the course was Hilda Bideleux, first head of the Hygiene and Public Health Department at the Polytechnic. She was herself a product of Bedford College's Hygiene course, as were several other lecturers.⁸⁸ Teaching was predominantly in the hands of women who had a university background in science or social work, or women public health doctors specialising in maternity and child welfare.

Compared with Bedford's failure, Battersea's initial success in recruiting students seems remarkable. At one point in 1920, it had 54 students in training, 41 of

⁸⁴ RHBNC: Letter from Board of Education, Sep 1919 (AI/330/1).

⁸⁵ RHBNC: BC, course of training in social work, 1920/21 session (AR/330/5).

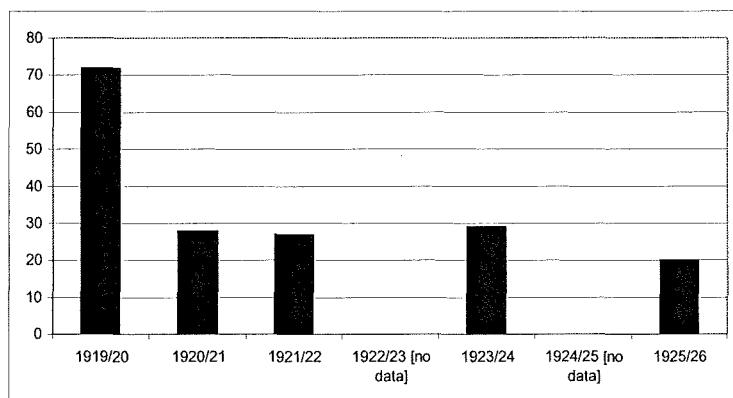
⁸⁶ Surrey: BP Calendar, 1919-1920, p.78 (I, 0531.004).

⁸⁷ TNA: BP, suggested scheme of training for health visitors in accordance with the regulations of the Board of Education, 1919 (MH 53/60).

⁸⁸ RHBNC: BC, Register of students who gained the Hygiene certificate (AR220/2/2); BC student entrance forms (AR203/1/1-6). For biographical details of Bideleux see Surrey: BP, 'Heads of Department of Hygiene' (P5 0397); *Battersea Polytechnic Magazine* (XIX, Jul 1927), p. 5; WHO (Sep 1960), p. 342.

whom were taking the two-year course.⁸⁹ The total number of women qualifying in the 1919/20 session was 72. Figures for the number of students gaining the Battersea qualification for the period 1919-1925 are incomplete (see Fig. 7), but, although numbers did drop off sharply after the 1919/20 session, the total was probably above 200. The course was cheaper (£14 per session, compared with Bedford's 20 guineas), but still extremely expensive and time-consuming when compared with that offered to sanitary inspectors who, in 1919, could expect to pay just two pounds for a full evening course at the Polytechnic.⁹⁰

Figure 7: Battersea Polytechnic: students gaining the Health Visitors diploma, 1919-1926⁹¹



Battersea's experience in one area of recruitment confirmed the predictions of the critics of the 1919 scheme – the lack of trained nurse recruits. The Principal of the Polytechnic felt that short courses not approved by the Board of Education were still attracting many nurses who were 'quite unsuitable as health visitors', and had previously been rejected by the Polytechnic.⁹² The chief reasons for their rejection were the absence of a good general education; that they were too old, many being over forty; or were perceived to lack 'any real interest' in the work. Meanwhile, even 'suitable' nurses were finding it difficult to afford the lengthy training. The Polytechnic also had difficulties in arranging the one-year course, on account of the varied backgrounds of the applicants. Bideleux thought that the difficulty was greatest in the case of nurses, who were often older women 'who did not take readily to theoretical work', had little scientific training, and were more interested in the curative side of

⁸⁹ TNA: Letter from Robert Pickard, 15 Oct 1920 (MH 53/101).

⁹⁰ *NH* (XII, 1919), p.48.

⁹¹ Surrey: BP, principal's reports.

⁹² TNA: Letter from Robert Pickard, 15 Oct 1920 (MH 53/101).

infant welfare.⁹³ Trained nurses were 'scornful' about the need for further training and thought that they had already 'done' physiology and other subjects.⁹⁴

Bideleux was also 'greatly disturbed' to see that nearly all local authorities advertising for health visitors demanded trained nurses, and knew of only two MOHs who did not 'prefer' them.⁹⁵ The Polytechnic was uneasy about whether students on the two-year course would be able to gain appointments.⁹⁶ Many of these women, or their parents, were making great sacrifices to pay for the training, and needed reassurance that they were not wasting their time and money. Bideleux also complained that non-nurse students were being discriminated against on their practical placements, since the superintendents of infant welfare centres who were trained nurses would give no useful teaching to these students, and 'kept them on mechanised tasks.' Battersea may have been more successful at recruiting students than Bedford, but there were still tensions.

King's College of Household and Social Science

Unlike other women's colleges, such as Bedford, King's College for Women had developed courses in 'women's subjects', and was slower at moving towards full degree-level work.⁹⁷ Its 'household and social science' course has been seen as the first attempt to forge a university subject based on women's traditional domestic roles and to provide 'an intellectual and scientific foundation for the pursuits of women as home-makers'.⁹⁸ In addition, the course was seen as a good preparation for a number of 'municipal housekeeping' roles, including voluntary work, local government, and social welfare. By 1918, its three-year diploma course included physics, chemistry, biology, physiology, hygiene, including infant hygiene, economics of the household, general economics, and household work.⁹⁹ At the end of their second year, students decided whether to specialise as 'teachers of household science', 'institutional administrators' or 'social and public health workers'. Those taking the third option studied economic history, central and local government, social movements, and social philosophy at the LSE, and underwent six weeks training at a recognised COS office. In addition, they were able to qualify as sanitary inspectors

⁹³ TNA: BP, visitation report, 19 Nov 1919 (MH 53/60).

⁹⁴ TNA: Visit by Miss Bideleux, Oct 1920 (MH 53/101).

⁹⁵ Ibid.; TNA: Visit by Miss Bideleux, Oct 1920 (MH 53/101).

⁹⁶ TNA: Letter from Robert Pickard, 15 Oct 1920 (MH 53/101).

⁹⁷ Sutherland, 'Plainest principles of justice', p.43; Oakley, 'Kings College for Women', p.489.

⁹⁸ Oakley, 'King's College for Women', p.502; Blakestad, *King's College of Household and Social Science*. Hall has also described how the 'domestic science' label masked a 'genuine engagement with laboratory science', Hall, 'Women in medicine', p.196.

⁹⁹ KCL: KCW, Household and Social Science Department prospectus, c.1918 (Q/EPH/SYL/8).

by taking sanitary law and building construction from the general King's course for inspectors.¹⁰⁰ In 1918 a two-year course for 'social and public' health workers' was also offered in conjunction with LSE. This two-year course was intended to give the same course of training to both public health and social workers during the first year, with students specialising in the second year.¹⁰¹

Janet Lane-Claypon, a physiologist and public health doctor, was Dean of King's College of Household and Social Science (KCHSS) from 1916 to 1923. She had previously taught health visitors at Battersea Polytechnic.¹⁰² Lane-Claypon believed that the particular combination of subjects taught in the College could readily be adapted to the needs of health visitor students. In 1919, the KCHSS two- and three-year courses were recognised for the training of health visitors under the Board of Education regulations, along with a one-year option for trained nurses and graduates.¹⁰³ Lane Claypon reported that, although the syllabuses had been worked out independently of the new regulations, they 'required altering only in the details of practical work and in the regulations for admission'.¹⁰⁴ She had high hopes for the course and thought that King's might become 'the main teaching body for the country'.¹⁰⁵

After only five months, however, there were significant problems.¹⁰⁶ Twenty students entered for the two-year course, all but two intending to specialise in public health, but, during the first term, a high proportion decided that they would prefer to train as social workers. Two left without completing the course to take up training for work in nursery or special schools, and several decided to return home and work in a voluntary capacity. The contribution to providing qualified health visitors was therefore 'negligible'. Lane-Claypon discovered that Bedford College and universities in Manchester, Bristol and Birmingham had encountered similar difficulties, leading her to conclude that 'there has been no demand whatever for the course', and that it could 'only be regarded as a failure'.¹⁰⁷ She wondered whether, since they were too young to take up full health-visiting posts, it was too discouraging to warn students of

¹⁰⁰ KCL: KCW, Household and Social Science Department, Diploma Course Prospectus, 1918 (Q/EPH/SYL/8); KCW Executive, 10 Nov 1914 (QA/C/M1a), 19 Jan 1915, (QA/C/M1) & 11 May 1915 (QA/C/M1).

¹⁰¹ TNA: Memo by Lane-Claypon, 13 May 1920 (MH 53/101).

¹⁰² Surrey: BP Calendar, 1910-1911, pp.113-114 (I, 0500.003). Hall, 'Women in medicine', p.196.

¹⁰³ KCL: KCW Executive, 14 Oct 1919 (QA/C/M1).

¹⁰⁴ KCL: Lane-Claypon to Richards, 10 Oct 1919 (QAP/GPF7/10)

¹⁰⁵ KCL: Lane-Claypon to Halford, 19 Feb 1919 (QAP/GPF7/11).

¹⁰⁶ KCL: KCW Executive, 10 Feb 1920 (QA/C/M2); TNA: Memo by Lane-Claypon, 13 May 1920 (MH 53/101).

19 and 20 that, 'The class of work chiefly available is in connection with homes for children, and the appointments are not, for the most part, well paid.' Such warnings may have been one reason why so many students abandoned training.¹⁰⁸ They may also have become discouraged when they saw 'the pick of the posts' going to trained nurses.¹⁰⁹ Many students who were able to afford to train at KCHSS did not need to earn their own living and, having begun the course at 18, 'hardly knowing what they want to do', they either changed their mind, or gave up the idea of paid work altogether.¹¹⁰ Lane-Claypon was not more hopeful about the one-year course. The Board of Education had given special permission for VADs to enter this course on the same terms as trained nurses and, in 1920, 23 students began training, 20 being ex-VADs and only three trained nurses. Lane-Claypon concluded that, once the supply of VADs had dried up, there would not be sufficient demand for this course either.¹¹¹ After 'extensive enquiries', she concluded that demand by nurses for training was high, but they were unable to afford either the fees, or to lose income for a year.

King's shared Battersea's difficulties in arranging practical work for non-nurses, and Lane-Claypon suggested that the nursing press had been making 'considerable propaganda' on the undesirability of non-nurses undertaking public health work.¹¹² In March 1920, Willesden's MOH forwarded a memorandum drawn up by the nurses on his staff, protesting against the training of non-nurse students. This was considered by King's to be 'the first official intimation of the organised opposition that was being attempted on the part of trained nurses to the Board of Education Scheme'.¹¹³ The views of MOHs were also significant, and training courses at universities in Leeds, Manchester and Birmingham were undermined by the refusal of local MOHs to arrange practical work for those who were non-nurses, let alone offer them appointments at the end of their training. Lane-Claypon concluded that

there will be a considerable consensus of opinion among the MOHs and among the nurses that the posts of health visitors should primarily be for the nursing profession. I am not myself prepared to subscribe fully to this doctrine, but I question whether it may not be necessary to do so on account of the marked lack of other material for training.¹¹⁴

¹⁰⁷ KCL: KCW Executive, 10 Feb 1920 (QA/C/M2); TNA: Memo by Lane-Claypon, 13 May 1920 (MH 53/101).

¹⁰⁸ KCL: Correspondence between Lane-Claypon and Halford, May 1920 (QAP/GPF7/11)

¹⁰⁹ TNA: Minute sheet, 1920 (MH 53/101).

¹¹⁰ *Ibid.*

¹¹¹ KCL: KCW Executive, 10 Feb 1920 (QA/C/M2); TNA: Memo by Lane-Claypon, 13 May 1920 (MH 53/101). This was probably also the reason for the sharp fall in the number of students training at Battersea Polytechnic at this date.

¹¹² KCL: KCW Executive, 10 Feb 1920 (QA/C/M2).

¹¹³ *Ibid.*, 9 Mar 1920 (QA/C/M2).

¹¹⁴ *Ibid.*, 10 Feb 1920 (QA/C/M2)

The two-year course was doomed because of lack of demand, and the one-year course because of the high cost. King's decided to carry on with the course for one more year, but it was discontinued in November 1920, due to lack of applications.¹¹⁵

Debates on the 1919 scheme

According to one MOH, after the issue of the 1919 regulations, only a 'small number' of women took advantage of the new training courses, and 'a very small proportion' of these succeeded in obtaining appointments. The expense and trouble of obtaining the qualification was 'out of all proportion to the results obtained'.¹¹⁶ It was his impression that many women 'openly flouted it' and, in defiance of the Ministry, persisted in taking certificates that were no longer recognised, such as that of the RSI. He was not alone in dismissing the 1919 regulations as unsuccessful and unable to provide a sufficient number of trained women.¹¹⁷ This is borne out by the experiences of the three London courses as described above. The Principal of Battersea Polytechnic pointed out that it was only natural that women would not spend money on the new training until the Ministry of Health took a 'firm stand', and set a date after which no other qualification would be recognised.¹¹⁸

In this, the training institutions agreed with those aiming to control entry and raise the status and salaries of health visitors. The London Society for Women's Service (LSWS) Joint Committee of Women Employed by Municipal Authorities, represented a wide range of women public health workers. In 1921, it pressed the Ministry to lay down a limit of two years from the date of the 1919 regulations, after which new entrants would not be eligible for local authority posts without the new qualification.¹¹⁹ It pointed out that training centres not recognised by the Board of Education were still offering shorter and cheaper courses, and that these certificates were still being accepted by local authorities. It considered that large numbers of students were hurrying through inadequate training with a view to obtaining appointments 'before it is too late', and that the standard of health visiting was thereby lowered. Students were attracted to such courses by 'flagrantly misleading

¹¹⁵ *Ibid.*, 11 May 1920 & 9 Nov 1920 (QA/C/M2).TNA: Memo by. Lane-Claypon, 13 May 1920 (MH 53/101).

¹¹⁶ *NH* (XIV, 1922), p.210.

¹¹⁷ See, for example, *JRSI* (XLIII, 1922-1923), p.311.

¹¹⁸ *NH* (XIV, 1922), pp.257-258.

¹¹⁹ TWL: LSWS Joint Committee of Women Employed by Municipal Authorities, memorandum, 12 Feb 1921 (2/LSW).

advertisements', and it was 'a very serious matter to women if the limited resources of time and money at their disposal for training are to be thrown away.'¹²⁰

The Ministry of Health agreed in principle, but so few nurses had trained since 1919 that insisting on the certificate would 'practically close the door' to them.¹²¹ Meanwhile, the number of non-nurses in training would simply not meet demand. Speculating about the origins of the dominance of nurses within health visiting, Dingwall, Rafferty and Webster have emphasised supply and demand. In addition to the preference of some MOHs for trained nurses, it was difficult to see, they argued, where else large numbers of women with a level of education intermediate between a board school and a degree might be found.¹²² The low level of recruitment to the two-year training courses for health visitors does imply that there were not enough suitably-educated women with sufficient resources and interest to meet the needs of growing public health departments.

Some MOHs and nursing organisations were quick to criticise the 1919 regulations for ignoring the needs of nurses. According to Joseph Cates, an MOH who was closely involved with the College of Nursing, the Ministry of Health had conceived the idea that 'quite a different type of person' was needed for public health work than the trained nurse who had proved herself so successful. Its scheme was 'calculated to produce a hybrid creature, without nursing training, too immature for a public appointment and quite unfitted for any branch of the health service.'¹²³ The work of the health visitor had expanded into areas where the trained nurse would be most useful, not only because of her technical skills, but also because she had 'learnt discipline in a manner and to a degree impossible in a non-residential course of instruction'.¹²⁴ Following the new regulations, a number of 'girls' who had been involved in war work 'flocked to the training centres', went 'through the mill' and emerged with the Board of Education certificate. A few, after difficulty, obtained positions, but others, 'wearied in their search for employment' entered hospitals to take a full nursing training.¹²⁵ He pointed to the abandonment of the course by King's as an indication of the failure of the experiment.¹²⁶ One nurse felt that it was partly because, during the war, trained nurses were 'occupied elsewhere', that the misguided regulations came into being. They were mistakenly founded on the idea

¹²⁰ *Ibid.*

¹²¹ RHBNC: Campbell to Tuke, 23 Nov 1921 (AR/330/2).

¹²² Dingwall, Rafferty & Webster, *Introduction*, p.188.

¹²³ Cates, 'Evolution of public health work for trained nurses', *JRSI* (XLIV, 1923-1924), p.377.

¹²⁴ *JRSI* (XLI, 1920), p.270.

¹²⁵ Cates, 'Evolution', p.377.

¹²⁶ *Ibid.*

that maternity and child welfare work was a 'branch apart from the medical profession, having its own type of education, its own functions, and officers.'¹²⁷ She claimed that the scheme had been a failure, and that not enough candidates had come forward. Another felt that

notwithstanding the fact that scores of trained nurses are out of work through having been advised to serve their country, the Ministry of Health propose to ignore the claims of such splendid women and waste public money on "flappers" and graduates.¹²⁸

She openly blamed the WSI&HVA, saying that the misguided regulations had been 'largely drawn up' by the Association, which had 'deliberately concealed' the preference for trained nurses. She foresaw

a hotch-potch of girls and graduates who will have to be dragged through by trained nurses and for whom trained nurses will have to take the responsibility.¹²⁹

The other most contentious issue arising from the new regulations was the age of students. One MOH thought that

a well-trained young woman is better than a less trained older one; and, generally speaking, the best results in training are obtained when a start is made early in life, and the gap between school training and special training becomes as small as possible.¹³⁰

Since a girl of 20 was 'too young for full duties', local authorities should pay 'a living wage' for a year of further experience of limited responsibility before she received the full responsibilities and salary of a health visitor.¹³¹ The London Federation of Infant Welfare Centres thought that the age of entry had been placed too low

as students should have a wider experience of life than is possible if they go directly from a general school to a specialised training course; on completing the course at 20 years of age, they would come into close contact with the mothers even though serving in a subordinate position at a welfare centre, and it was felt that employment if such young health visitors might discredit the whole movement in the eyes of those for whom the benefits are primarily intended.¹³²

Municipal Engineering saw the 1919 regulations as marked by the propensity of the government 'to hanker after the girl who as had a secondary school education up to the age of eighteen', and who would proceed from this directly to her training. It dismissed the Board's idea, that girls go on to further training and experience before taking up a post, as 'weak.' It had always been a problem for training institutions to

¹²⁷ Viney, 'Co-operation between the midwife and the health visitor', *JRSI* (XLVI, 1925-1926), pp.448-449.

¹²⁸ *BJN* (63, 1919), p.169.

¹²⁹ *Ibid.*, p.256.

¹³⁰ Kenwood, 'Qualifications and training of a health visitor', *JRSI* (XLI, 1920-1921), p.268.

¹³¹ *Ibid.*

deal with the 'tears and recriminations from those who thought that an appointment followed a certificate as night does day', and who resented being told to take further training or experience. The new regulations would only exacerbate this problem.¹³³ Another MOH felt that the new scheme was 'quite unsound, partly because it leaves the girl kicking her heels for an indefinite period after she has taken her certificate or sends her with it to take up other work.'¹³⁴ An inability to recruit straight from school exacerbated difficulties in attracting enough women to the occupation.

CONCLUSION

The women inspectors and visitors themselves initially argued for a training that was different from their male colleagues but of the same standard, and for one where specialisation was a matter of personal preference, not of gender. In the event, a separate system of training and qualification for health visitors was instituted. After 1919, the tendency for some of these to be longer than those for sanitary inspectors, more expensive, and run during the day, was crystallised in new regulations that situated them within educational institutions. Those organising college-based courses for health visitors, such as Hilda Bideleux, Helena Reid and Janet Lane-Claypon, shared many of the views of the leaders of the WSI&HVA. For these women, only well-educated girls should be recruited to the profession, their training should be based in educational institutions and have a relatively high academic content. The preferred recruiting grounds were girls' high schools. Health visiting was a branch of social service, not nursing. From the fate of the 1919 regulations, and the courses organised under them, it might appear that this philosophy failed. Although there were notable exceptions, it seems that the majority of MOHs were never convinced that health visiting should be based on anything other than a nursing training, or be seen as a social, rather than a medical, service. There was certainly a failure to recruit enough students from school, university, or social work who were prepared to finance a full two-year course in order to qualify as health visitors.

¹³² KCL: London Federation of Infant Welfare Centres, 'Observations in regard to the Board of Education's regulations for the training of health visitors' (QAP/GPF/7/11).

¹³³ *ME* (LXIV, 1919), p.88.

¹³⁴ *ME* (LXVI, 1920), p.312.

8: ORGANISATIONS AND CAMPAIGNS

As previous chapters have shown, women public health officers participated in debates over training, qualification, title, status and other issues affecting their conditions of work. One of the main ways in which they achieved this was through their own professional association. Another was through a network of women's organisations. This chapter will explore this organisational and campaigning activity.

WOMEN SANITARY INSPECTORS ASSOCIATION

In 1896 there were only a handful of women sanitary inspectors in London. They were often working alone, as the only women on the Vestry's staff. They contended with public scepticism about the appropriateness and value of their work, and the criticism of family and friends that it was unpleasant and unfeminine. They met with opposition and suspicion from their male colleagues, and were initially excluded from membership of the Sanitary Inspectors Association (SIA). It was under these circumstances, 'when women inspectors could be counted on the fingers of one hand and when health visitors were unknown it became the custom for the little band of pioneers to meet once a month'.¹

On each new appointment, the successful candidate was approached and invited to attend.² In 1902, by which time there were around 20 women working in London, the Association put itself on a more formal footing. Minutes of proceedings were kept, and a list of subjects for discussion, names of speakers and dates of meetings published.³ Two years later, it was decided to constitute the Association formally.⁴ The Women Sanitary Inspectors' Association (WSIA) came into being on 8th April 1904, 'for the promotion and intercourse among its members and others of such knowledge of sanitary science as falls within the department of a Woman Sanitary Inspector or Health Visitor'.⁵ Membership was open to those 'duly appointed by a Sanitary Authority', or who had previously held such appointments. Miss O'Kell, the Association's first Honorary Secretary, remembered how informal things remained, although 'we tried to do things properly':

¹ *NH* (I, 1908), p.16.

² Wellcome: WSIA minutes, 4 Apr 1902 (SA/HVA/B.1/1).

³ *Ibid.*

⁴ *Ibid.*, 8 Apr 1904 (SA/HVA/B.1/1).

⁵ The objects of the Association were lifted directly from those of the SIA, see *SIJ* (V, 1899-1900), p.49.

I remember one meeting of our Executive Committee – someone said there wasn't a quorum, so I got into a cab and went and fetched Miss Nicolas to make one. She was cross.⁶

The Association was initially a discussion group. Meetings were led by members, who took turns to give papers and introduce debates, although, from 1904, outside speakers were invited.⁷ In 1906 the Association expanded its remit to include 'sanitary and social subjects'.⁸ Issues included: 'The laws for restricting alien immigration' (March 1907); 'New methods of combating infantile mortality' (December 1907); 'Sweated industries and a minimum wage' (November 1907); 'Tuberculosis: conditions ideal or real' (March 1908); 'The undesirability of special legislation to limit the work of married women' (October 1908); and 'The work of women in local government' (December 1908).

Meanwhile, in 1901, at the instigation of Margaret Sharples, a Leeds inspector, and the first woman to be elected to membership of the male SIA, a meeting took place to discuss the formation of an Association of Women Sanitary Inspectors of the Midland and Northern Counties.⁹ There was disagreement about whether a separate women's organisation was needed, although the SIA had not made women inspectors particularly welcome. Mrs Greenwood, a Sheffield inspector, was Secretary. She thought that it was necessary for the women to form 'a little association of their own'. It would help them to educate themselves, and the public, about the work, campaign for better salaries and working conditions, combat isolation, and meet the 'social and intellectual needs of the educated woman.' The group was described as 'no formal association', but 'for mutual co-operation and sympathy'.¹⁰ Meetings appear to have come to an end when Mrs Greenwood took up a post in London in 1904.¹¹

At the outset, membership of the London-based WSIA was open only to those who worked in the capital. In 1903 an enquiry from a woman inspector in Leicester was forwarded to Mrs Greenwood, and members of her association were also welcome to attend London meetings as guests.¹² In 1906 some WSIA members suggested extending membership to those appointed by a voluntary committees, but the majority disagreed. It was decided, however, to open it to those outside London,

⁶ *Women in the Trade Union Movement* (TUC, 1955), p.58.

⁷ Wellcome: WSIA minutes, 25 Nov 1904, 28 Apr 1905 (SA/HVA/B.1/1).

⁸ *Ibid.*, 27 Apr 1906 (SA/HVA/B.1/2).

⁹ *SIJ* (VII, 1901-1902), pp.19-20.

¹⁰ *SR* (XXXII, 1903), pp.279-280.

¹¹ *NH* (XII, 1920), pp.271-272.

¹² Wellcome: WSIA minutes, 2 Oct 1903 (SA/HVA/B.1/1).

and several inspectors in Bradford and Leeds joined.¹³ Reports of each meeting were circulated, and Saturday afternoon social events organised for the benefit of those living too far away to attend evening meetings.¹⁴ Although refusing membership to those working in the voluntary sector, the WSIA initially made no distinction between the two offices of sanitary inspector and health visitor.

It gradually transformed itself from a discussion group into a campaigning organisation. In 1907 a Legal and Parliamentary Committee was appointed 'to watch for and discuss proposed legislation affecting public health and social conditions'. This was successful in getting the Association invited to give evidence before the Select Committee on Home Work.¹⁵ In the same year, an Infant Mortality Committee was established, which discussed issues to be raised at the National Conference on Infantile Mortality. Members were encouraged to collect information on the care and feeding of infants and to 'draw up some scheme for a common basis for future action'.¹⁶ The Association was also represented at a wide range of committees and conferences on issues related to its work. In 1909 it was also decided to 'safeguard the interests and improve the status of women sanitary inspectors and health visitors'.¹⁷ A Vigilance Committee was appointed.¹⁸ Its main functions were to 'inquire into all matters affecting the status and interests of women in the Public Health service' and 'to protest against unsatisfactory terms of appointments'.¹⁹ It sent letters of protest to local authorities that reduced their staffs, did not offer adequate salaries, or gave appointments to unqualified women.

WOMEN'S GROUPS

By 1908/9, the WSIA had almost 100 members, but was still a relatively small organisation. Women public health officers turned to other, larger or more influential, groups to further, both their own interests, and their social reform agenda. They saw themselves as pioneers in a movement to increase women's role in public administration and drew on the support of a network of women's groups supporting this.

¹³ *Ibid.*, 27 Apr 1906, 30 Nov 1906 (SA/HVA/B.1/2).

¹⁴ *Ibid.*, 26 Apr 1907 (SA/HVA/B.1/2).

¹⁵ *Ibid.*, 26 Apr 1907 (SA/HVA/B.1/2), 10 Oct 1907 (SA/HVA/B.1/3).

¹⁶ Wellcome: WSIA annual report, 1907-1908, pp.15-16 (SA/HVA/A.1/2).

¹⁷ Wellcome: WSIA minutes, 14 Jan 1909 (SA/HVA/B.1/4).

¹⁸ *Ibid.*, 4 May 1910 (SA/HVA/B.1/4).

¹⁹ *Ibid.*, 2 May 1914 (SA/HVA/B.1/5).

Women in public

Hollis has characterised the Women's Local Government Society (WLGS) as an upper middle class London group, functioning through a network of family, social, philanthropic and Liberal connections.²⁰ Although it concentrated on securing women's role as elected officers, it also campaigned for the opening to women of salaried positions within local government.²¹ WLGS pamphlets, designed to interest women in standing for local office, included accounts of the work of women sanitary inspectors and health visitors. One in 1894 concluded that 'women sanitary inspectors should be employed in all parishes'.²² Another in 1904 argued that they worked 'at a disadvantage unless there are women as members of the Public Health Committee to which they report'.²³ Women inspectors agreed. Mrs Greenwood, then Finsbury's lady sanitary inspector, wanted to see more women serving on borough councils who would

keep themselves in touch with the women officials and support them in the efforts they are making to infuse more common-sense and less red-tape into the work to be done. We also want women on the Councils to see that women sanitary inspectors are fairly treated. What chance has one woman in a borough against all the male forces, which, if not arrayed against her, still regard everything from the man's point of view?²⁴

Women inspectors supported the work of the WLGS. The names of prominent officers such as Misses de Chaumont, Dick and Looker appear in subscription lists and the WSIA participated in its campaigns.²⁵

The National Union of Women Workers (NUWW) also promoted the involvement of women in local public affairs, in both the philanthropic and local government sectors. Its affiliated organisations covered a wide field, and ranged from Diocesan Women's Leagues and temperance organisations, to women's colleges.²⁶ Louise Creighton, wife of the Bishop of London, was an early driving force, and the Fabian Beatrice Webb was a member, illustrating the diversity of membership. Webb attended its first conferences, which brought her into contact with 'the silent good and narrow women whom in one's secular and revolutionary set one never comes across'.²⁷ Despite conservative, philanthropic and religious origins, by the beginning of the twentieth century, the Union was active in campaigning for women's work on

²⁰ Hollis, *Ladies Elect*, p.318

²¹ WLGS annual reports, *passim*.

²² *Women's Work in London under the Local Government Act, 1894* (WLGS, c.1895).

²³ *Why Are Women wanted on the London Borough Councils* (WLGS, February 1904).

²⁴ Greenwood, 'Sanitary inspection', pp.22-4.

²⁵ See, for example, Wellcome: WSIA annual report, 1908-1909, p.10 (SA/HVA/A.1/3); WSIA minutes, 6 Dec 1911 (SA/HVA/B.1/5).

²⁶ Kelly, 'Sisterhood of service', p.167.

²⁷ *Diary of Beatrice Webb*, pp.102, 124-5.

public bodies and in local government, and worked closely with the WLGS.²⁸ Women sanitary inspectors were particularly active in the NUWW's Industrial Committee, where they had the 'opportunity of meeting and discussing their work, and the steps which can be taken to promote the appointment of women inspectors, and to train and prepare women for such posts.'²⁹ In 1902, Miss O'Kell wrote a leaflet for the NUWW for this very purpose, and links with the WSIA were strong.³⁰ In 1907 the Union undertook an enquiry into the duties of women sanitary inspectors, as part of the WSIA's campaign to illustrate the value of its members' work, and it also joined campaigns over salaries and conditions.³¹ In 1908 the WSIA formally affiliated to the Union, sent representatives to its Committee and Council meetings, and co-operated in campaigns.³²

It was through membership of NUWW committees that women sanitary inspectors were brought into contact with many prominent women reformers. The NUWW's Industrial Committee included Beatrice Webb, Labour activist Margaret Macdonald, trades union organisers Gertrude Tuckwell and Clementina Black, philanthropist Mrs George Cadbury, and social worker and proponent of the COS, Helen Bosanquet.³³ Since women prominent in local affairs were often involved in the Union, the WSIA drew on their influence, urging them to put pressure on authorities to raise salaries.³⁴ In 1910, for example, after a complaint about the pay and conditions of a post in Walsall, the WSIA's Secretary spoke to Mrs Cadbury, President of the Birmingham branch of the NUWW. She explained that, as an affiliated society, the WSIA looked to the NUWW for support on the wages of women workers. The poor rate of pay in towns like Birmingham 'was a scandal and it reflected greatly to the discredit of the NUWW Branch that they had done nothing to secure better terms of appointment.'³⁵

The Fabian Women's Group (FWG) was founded in 1908 to promote the equality of women as part of the Society's agenda.³⁶ In addition to issues of citizenship, such as the franchise, the Group decided to 'seek out and explain the conditions of economic independence for women under socialism'. This included

²⁸ Hollis, *Ladies Elect*, pp.25-27.

²⁹ NUWW, Annual Meeting of the General Committee, report, 1895, p. 21.

³⁰ Wellcome: WSIA minutes, 3 Oct 1902 (SA/HVA/B.1/1).

³¹ Wellcome: WSIA Executive, 25 Sep 1907, 30 Sep 1908 (SA/HVA/B.2/2).

³² Wellcome: WSIA annual report, 1908-1909, p.16 (SA/HVA/A.1/3); WSIA minutes, 8 Oct 1908 (SA/HVA/B.1/3).

³³ NCW, annual meeting report, 1902, p.82.

³⁴ Wellcome: WSIA minutes, 7 Dec 1910 (SA/HVA/B.1/4).

³⁵ *Ibid.*

³⁶ FWG, 'Three years work 1908-1911', reprinted in Alexander, *Women's Fabian Tracts*, p.145.

examining both motherhood and the workplace.³⁷ A 1911 survey of the c.220 members of the FWG revealed two women sanitary inspectors, alongside teachers, civil servants, typists, artists, musicians, and many more women 'engaged in unpaid and domestic work'.³⁸ The FWG requested that the WSIA send delegates to its meetings.³⁹ A 1910 conference was attended by the WSIA. Lucy Deane and Mrs Greenwood both made speeches.⁴⁰ The FWG book *Women Workers in Seven Professions* included an essay by Greenwood on women sanitary inspectors and health visitors.⁴¹

Protective labour legislation

For mid-Victorian women's groups, protective labour legislation was often seen as an infringement of civil liberties, but by the 1900s a broad spectrum, including labour women and 'social liberals', supported state intervention.⁴² Although women sanitary inspectors were not directly responsible for the most disputed aspects of legislation, such as working hours and dangerous processes, their duties brought them into close contact with groups campaigning on this issue.

The Women's Industrial Council (WIC) possessed close links with the Liberal Party, and also with the early Labour Party, especially with Margaret and Ramsay MacDonald. It was established in 1894 'to watch over the interests of women engaged in trades, and, over all industrial matters which concern women'. Instead of trade union organisation, it undertook investigative work, and organised petitions and deputations. According to one historian, this made it 'more socially acceptable' to its middle-class supporters.⁴³ It took a close interest in factory and workshop legislation and, feeling that the inspectors were 'continually hindered by the ignorance and timidity of the workers', WIC members themselves reported breaches of the Acts.⁴⁴ It campaigned for an increase in the number of women public health officers, observing that, in those districts where they had been appointed, there was an improvement in conditions.⁴⁵ In 1900, it sent circulars to MOHs, requesting particulars about the

³⁷ LSE: FWG, extracts from 1908 FWG report.

³⁸ LSE: FWG, 'Three years work, 1908-1911' (Fabian Society H35/2/3).

³⁹ Wellcome: WSIA Executive, 8 Jun 1910 (SA/HVA/B.2/3).

⁴⁰ *Ibid.*; FWG, *Three Years' Work 1908-1911*, reprinted in Alexander, *Women's Fabian Tracts*, pp.156-7.

⁴¹ Morley, *Women Workers*; LSE: advertising leaflet (Fabian Society E111/7).

⁴² Dyhouse, *Feminism and the Family*, pp.81-82; Malone, *Women's Bodies*, p.120; Harrison, 'Feminism and the health consequences of women's work', pp.78-79; Feurer, 'The meaning of "sisterhood"'; Rowbotham, 'Interpretations of welfare', pp.22, 30.

⁴³ Mappen, *Helping Women*, p.17.

⁴⁴ Reproduced in Mappen, *Helping Women*, p.46.

⁴⁵ Mappen, *Helping Women*, p.19; WIN (Mar 1902), p.299.

scope of women's work as inspectors.⁴⁶ In 1902 this was followed by a similar enquiry in the hope that it would encourage further appointments.⁴⁷ Margaret Macdonald's papers include correspondence with local authorities about the number of posts, salaries and duties of women sanitary inspectors, illustrating the way in which the WIC monitored appointments.⁴⁸ In return, women sanitary inspectors promoted the work of the Council. Several served on WIC Committees. Mrs Boyd Dawson, a qualified sanitary inspector, was Secretary of the Council for two years.⁴⁹

Women inspectors also forged close links with the Industrial Law Committee for the Enforcement of the Law and the Promotion of Further Reform (ILC). This was established in 1898, an alliance of women from the professional, voluntary and trades union sectors. Connections with the Women's Trade Union League (WTUL) were particularly close.⁵⁰ As well as promoting further legislation, it encouraged women involved in social work, such as district visitors, club leaders, deaconesses, and settlement workers, to play a role in reporting breaches of the Acts.⁵¹ At the RSI Congress in 1902, Miss de Chaumont, a Kensington inspector, gave a paper outlining its work.⁵² She argued that it was impossible for women inspectors to perform their duties, unless aided by the workers themselves, or by 'persons who are in constant and close relation with them'. The Committee's role was to place knowledge of factory legislation at the service of those who 'by their intimate intercourse with the industrial classes' were 'admirably qualified to use it for their benefit'. There was a close relationship between the ILC and the WSIA, which was granted free use of the Committee's offices for meetings.⁵³ These were in Mecklenburgh Square, 'the centre of many societies devoted to the interests of the most sweated forms of labour'.⁵⁴ A number of women sanitary inspectors held official posts on the Committee. These included Lucy Deane, Miss de Chaumont, and Edith Maynard, who was Secretary. Others gave their services as lecturers.⁵⁵ 1912, for example, saw Miss Portlock, woman sanitary inspector in Hackney, addressing Battersea Women's Diocesan Association on 'How our industrial laws help women and children' and the National Organisation of Girls Clubs on 'Health in the

⁴⁶ WIN (Mar 1900), pp.167-168.

⁴⁷ WIN (Mar 1902), p.299.

⁴⁸ TNA: Margaret Macdonald papers re homework and women sanitary inspectors (PRO 30/69/1369).

⁴⁹ WIN (Jun 1907), p.621.

⁵⁰ When the ILC wound up in 1920 it offered its funds to the WTUL.

⁵¹ ILC Report, 1912, p.11

⁵² De Chaumont, 'The work of the ILC', *JRSI* (XXIII, 1902) p.853

⁵³ Wellcome: WSIA annual report, 1906-1907, p.12 (SA/HVA/A.1/1).

⁵⁴ *Daily Citizen* (21 Aug 1913).

⁵⁵ Wellcome: WSIA annual report, 1913-1914, pp.31-32 (SA/HVA/ A.1/7).

workplace'. In all, over thirty lectures were given by women sanitary inspectors for the ILC in that year. For the women inspectors, participation in the activities of such social reform groups was a natural extension of their official duties.

Women inspectors also developed links with the Women's Trade Union League (WTUL). This was not a trade union itself, but promoted trade unionism amongst women workers.⁵⁶ For Olcott, by 1900, it had, under the patronage of Lady Dilke, developed into the 'recognised voice of women's labour', although its aims, along with those of many women's unions, still included social and welfare work, and it retained close links with Liberals.⁵⁷ Indeed, the trade unionist Ben Tillett criticised the 'goody-goody, preachy, patronising reformers' who ran the WTUL.⁵⁸ From the 1890s, the League spent an increasing amount of time campaigning for extensions to protective legislation in terms of hours, sanitary and safety arrangements and an increase in the number of women inspectors. Like the WIC, it worked closely with the early women inspectors, and passed on workers' complaints.⁵⁹ In 1903 the Union began a new campaign to recruit London's working women, not only those in industrial occupations, but also white-collar workers.⁶⁰ The WSIA was a target for recruitment, and from 1906-1909 Margaret Bondfield, Gertrude Tuckwell and Mary MacArthur all addressed the Association.⁶¹ At the annual business meeting in 1909, the WSIA debated affiliation to the League.⁶² Mrs Fisher pointed out how, by joining, the Association might be able to help other women workers. In the event, a special committee advised against affiliation, recommending instead an annual subscription to its funds.⁶³

Although some women's groups continued to oppose protective labour legislation, even some of these supported the work of women sanitary inspectors, arguing that basic health regulation, as opposed to restrictions to working hours, was necessary. The Freedom of Labour Defence Association (FOLD), founded in the 1890s, complimented the women inspectors

who do their work in a thorough manner, rendering needless such tyrannous enactments as the present day economists are never weary of commanding to the public legislature.⁶⁴

⁵⁶ Olcott, 'Dead centre', pp.34-35.

⁵⁷ *Ibid.*, p.44; Boston, *Women Workers*, p.61; Thom, 'The bundle of sticks', p.284.

⁵⁸ Quoted in Boston, *Women Workers*, p.55.

⁵⁹ TUC: WTUL annual report, 1893 & 1897, p.12.

⁶⁰ Olcott, 'Dead centre', p.46.

⁶¹ Wellcome: WSIA minutes, 30 Mar 1906 (SA/HVA/B.1/2), 14 Nov 1907 (SA/HVA/B.1/3), 1 Apr 1909 (SA/HVA/B.1/4).

⁶² *Ibid.*, 12 May 1909 (SA/HVA/B.1/4).

⁶³ *Ibid.*, 2-4 May 1910 (SA/HVA/B.1/4).

⁶⁴ *ER* (XXXII, 1901), p.23.

Malone has suggested that the woman inspector Florence Greenwood belonged to FOLD.⁶⁵ There is no evidence that Florence was actually a member, although a 'Mrs M. Greenwood', who was not a sanitary inspector, was.⁶⁶ Florence may, however, have been sympathetic to some of FOLD's views. In 1906 the WSIA debated the issue 'that the legislative restriction of hours of labour is beneficial to women'.⁶⁷ Greenwood argued that, although regulations relating to the health of the worker should be encouraged, restrictions to hours of work limited opportunities for women, confined them to certain trades, and lowered wages. Only two of those present supported her, while ten voted in favour of restriction. In 1901, she also wrote a series of articles that were reprinted by FOLD.⁶⁸ She aimed to show that 'sweeping statements' about high infantile mortality being due to the occupation of married women were 'not in accordance with the facts', and that a law forbidding them from working 'would cause far greater and more widespread suffering'.⁶⁹ For her, the answer was not restricting the worker, but improving living and working conditions, including through the work of women sanitary inspectors.⁷⁰ Although not all agreed, Greenwood was not the only woman public health worker to question the statistical evidence for a link between infantile mortality and married women's work.⁷¹ Even if they did feel that there was a connection, others did not consider that restricting women's ability to work was the solution. Blackburn's woman sanitary inspector, for example, argued that if mothers stayed at home, 'a great advance would be made in the diminution of the infantile mortality in industrial centres'. She realised, however, that it often resolved itself into the vexed question of 'work versus poverty'. Exclude the mother from work for only a few weeks and there might be insufficient food for mother and child. Thus, 'one has to consider whether the disadvantages to infant life, due to the industrial employment of the mother four weeks after child-birth outweigh the disadvantages which may accrue from poverty and its accompaniments'.⁷²

The debate over the regulation of home-workers raised similar issues. Some women inspectors were concerned that suppressing out-work altogether would be

⁶⁵ Malone, *Women's Bodies*, p.122.

⁶⁶ *ER* (Jul 1903), p.152.

⁶⁷ Wellcome: WSIA minutes, 23 Feb 1906 (SA/HVA/B.1/1).

⁶⁸ Greenwood, 'Is the high infantile death rate due to the occupation of married women?' *ER* (XXII, 1901).

⁶⁹ *Ibid.*, p.11.

⁷⁰ *Ibid.*, p.96.

⁷¹ For debate on this issue, see, for example, Thompson, 'Married women's labour and its influence upon infantile mortality,' *JRSI* (XXXII, 1911), pp.115-116; Le Boileau, 'Health visiting among infants', *JRSI* (XXVII, 1906), pp.600-601; *JRSI* (XXVI, 1905), pp.438-439; *Fingerpost* (1906), pp.13-14.

⁷² *SJ* (XVIII, 1912-1913), p.19.

hard on those women who supported themselves or a dependant.⁷³ Others agreed with trade unionists that it should be regulated out of existence.⁷⁴ The WSIA was cautious about sweeping regulation. The only types of out-work that it wished to see prohibited were certain 'unwholesome trades' such as fur work, or where glue was used. Neither did it wish to see it forbidden to work in rooms where people slept, because of widows and single women who lived in one room.⁷⁵ Under the influence of Margaret Macdonald, between 1899 and 1907 the WIC promoted a Bill for the licensing of home-workers. Under the scheme, an inspector would certify premises as fit and healthy before an employer might give out work, the certificate requiring renewal every six months. According to Macdonald, licensing would discourage out-work.⁷⁶ When questioned about its effect on the workers themselves, she admitted that 'every fresh thing is rather a trouble to these people', but, 'I do not think it would put them out very much.'⁷⁷ She was confident that landlords would remedy structural faults, that rents would not be raised as a consequence, and that tenants would be forced to adopt higher standards of domestic cleanliness.⁷⁸ She described an out-worker's dwelling which was dirty and untidy:

If she had got into the way of making her beds in the morning and cleaning up her floor, and so on, it would not have taken her much longer every day. I think if an Inspector coming could just have given her that little extra inducement to make her do these things, it would not have taken any appreciable amount of time off her work.⁷⁹

The attitude of the WSIA towards the WIC bill was 'one of uncompromising hostility'.⁸⁰ Miss Looker, one of the sanitary inspector members of the WIC's Legal Committee, emphasised the practical problems that licensing would entail, and the burden of extra work it would create. She was also keen to point out how the proposals would affect the workers,

because very often these nuisances are nothing at all to do with the outworker. They are simply to do with the owner of the property, and if the certificate was taken away from an outworker because of the unwholesome condition of the premises it would be very hard on the outworker, because the owner might not very easily be got at, and it might be some weeks before he would remedy the nuisance.⁸¹

⁷³ See, for example, evidence given by Miss Safford, Select Committee on Homework (PP 1907 VI, Cd. 290), p.158.

⁷⁴ See, for example, the views of Miss Brown in Islington, MOH report, 1905, pp.198-199.

⁷⁵ Select Committee on Homework (PP 1908 VIII, Cd.246), pp.152-153.

⁷⁶ *Ibid.* (PP 1907 VI, Cd. 290), p.214.

⁷⁷ *Ibid.*, p.215.

⁷⁸ *Ibid.*, p.226.

⁷⁹ *Ibid.*, p.226.

⁸⁰ WIN (Sep 1907), p.653.

⁸¹ Select Committee on Homework (PP 1907 VI, Cd. 290), p.151.

Mrs Greenwood stated that any scheme that demanded the total abolition of homework was cruel and unfair, and that the suggested licensing system would enormously hamper the worker, and annoy the employer.⁸² Miss Carey of Westminster declared that, although it purported to be a sanitary measure, it was really designed to further the interests of organised labour at the expense of women workers.⁸³ Women sanitary inspectors took particular issue with the WIC proposal that the inspector could refuse to give a licence, or revoke it at any time, thus depriving the worker of the means to earn a living. According to Margaret Macdonald, the inspectors would make some mistakes, 'and everybody must make some', but they should be able to shoulder the responsibility. In deference to the opinion of the WSIA, however, the WIC added the possibility of an appeal process.⁸⁴ This was not before women inspectors had disrupted the Council. Because of their strong representation on its Legal Committee, they carried a resolution in favour of withdrawing the Bill entirely, and this was duly forwarded to the Executive. It was claimed that the Executive had no power to rescind support for the Bill. Several women sanitary inspectors threatened to resign, either because of the issue itself, or because of the way in which the Council handled their resolution.⁸⁵

For women inspectors, the problem was often outside the control of the workers themselves. The domestic tidiness, or otherwise, of the women they visited, was not the main issue. Miss Looker emphasised that most of the premises she visited in Kensington were clean and tidy.⁸⁶ Miss Safford, who inspected out-workers for the City Corporation, found that most of the defects she encountered were structural, and a problem for the landlord. Generally speaking, the homes in which work was done were cleaner than others.⁸⁷ In this they agreed with organisations like the National Home Workers League (NHWL) and FOLD, which

While fully admitting that the sanitary conditions which prevail in the homes of many workers are defective, ... would recommend that these conditions should be remedied by the proper enforcement of laws already in existence, which place responsibility on the owners of the property and on the sanitary inspectors.⁸⁸

⁸² *Tribune* (9 Oct 1907).

⁸³ Wellcome: WSIA minutes, 7 Mar 1907 (SA/HVA/B.1/2).

⁸⁴ *Ibid.*, p.213.

⁸⁵ *WIN* (Jun 1907), p.621.

⁸⁶ Select Committee on Homework (PP 1907 VI, Cd. 290), p.154.

⁸⁷ *Ibid.*, p.157.

⁸⁸ *ER* (XXXI, 1900), pp.34-35.

The NHWL was a small and short-lived organisation, active mainly outside London, and with membership overlapping with that of FOLD.⁸⁹ It campaigned against legislation that would decrease out-work. Miss Vynne of the League

found everywhere the friendliest feeling between them [home-workers] and the sanitary inspector. The sanitary inspector's visit is not resented by anybody. In some cases he is welcomed because he has done good and has kept the landlord up to the mark.⁹⁰

Maternity and child welfare

The WSIA was also in close contact with the voluntary maternity and child welfare movement. Ten of the Association's members attended the National Conference on Infantile Mortality in 1906, and 30 attended the following year.⁹¹ It was represented on the committees of many voluntary maternity and child welfare organisations, such as the National Association for the Prevention of Infantile Mortality and the National Baby Week Council. Relationships, however, could be tense, since the Association was openly in favour of state-organised services, and women public health officers distanced themselves from characteristics associated with voluntarism. The WSIA tolerated the employment of trained voluntary workers who were directly responsible to an officer of a borough council, but disapproved of complete delegation to voluntary health societies.⁹² The reason the Association decided to affiliate to the National League for Physical Education was to prevent it from disseminating inaccurate information with regard to the work of women sanitary inspectors and health visitors, due to the 'ignorance' of its members.⁹³

The WSIA also co-operated with women's groups campaigning on maternity and child welfare. The Women's Co-operative Guild (WCG) is particularly well known for its campaigns around maternity, exemplified by the publication in 1915, of a collection of letters from members describing their experiences of motherhood.⁹⁴ Although with a middle-class leadership, the Guild was formed primarily from married women of the 'upper bracket of the manual wage earning group', and had close links with the Labour Party.⁹⁵ From a very early date, the WCG supported the appointment of more women sanitary inspectors and health visitors.⁹⁶ Its maternity campaign

⁸⁹ Bythell, *Sweated Trades*, p.237.

⁹⁰ Select Committee on Homework (PP 1908 VIII, Cd. 246), p.119.

⁹¹ Wellcome: WSIA annual report 1906-1907, p.10 (SA/HVA/A.1/1), 1907-1908, p.15 (SA/HVA/A.1/2).

⁹² Wellcome: WSIA Executive, 17 Feb 1913 (SA/HVA/B.2/5).

⁹³ *Ibid.*, 20 Sep 1911 (SA/HVA/B.2/4).

⁹⁴ *Maternity: Letters from Working Women*.

⁹⁵ Gaffin & Thomas, *Caring and Sharing*, pp.19, 54.

⁹⁶ *SIJ* (III, 1897-1898), pp.115-116.

began in 1911, and in 1913 Margaret Bondfield and Margaret Llewelyn Davies met with health visitors, as well as doctors and civil servants, to discuss municipal maternity and infant welfare schemes. A WCG deputation met with the President of the LGB in 1914 to urge reforms, including the compulsory notification of births, local authority maternity centres, and the appointment of municipal midwives.⁹⁷ The WSIA was represented on the deputation.⁹⁸

When the WCG opened a maternity and child welfare clinic in Coventry in 1915, many of its volunteers were 'experienced mothers' from the local community. Lodge has argued that this was a deliberate strategy to avoid the 'patronizing overtones' of middle-class workers.⁹⁹ The Guild, however, demanded the appointment of trained and salaried workers, experts who would give technical advice, rather than charitable visitors.¹⁰⁰ In outlining the Guild's maternity care scheme in 1914, Bondfield noted the changed atmosphere of the public health service. No longer did the homes of the poor come 'under the eye of chilly inspection'. No longer was a call from the inspector 'in some queer way a kind of reproach'. Instead, 'the woman from the Town Hall' was a 'wise friend and counsellor'.¹⁰¹ Although these Labour women resented the patronising attitude of many voluntary workers, they were keen that the women officials adopt a friendly, rather than official, tone. Such views chimed with the feelings of members of the WSIA. In 1915-1916, for example, the Association supported the Guild's protest against forms for the notification of pregnancy issued by certain local authorities. It agreed that 'the wording of these forms implies that the filling up of them is obligatory and the questions are of an impertinent and inquisitorial nature'.¹⁰²

Fabians Beatrice and Sidney Webb also came down clearly on the side of state-organised health visiting, as did the Minority Report of the Royal Commission on the Poor Laws.¹⁰³ The Webbs thought that the maternity and child welfare services provided by local public health departments, unlike the Poor Law medical service, had 'no pauperizing effect'.¹⁰⁴ A WSIA meeting in 1909 declared that it was 'certainly in sympathy with Dr. Dodd and his co-workers in their endeavour to break

⁹⁷ Gaffin, 'Women and co-operation', p.129.

⁹⁸ Wellcome: WSIA Executive, 7 Sep 1914 (SA/HVA/B.2/6).

⁹⁹ Lodge, 'Women and welfare', pp.91-92.

¹⁰⁰ Palmer, *Women, Health and Politics*, pp.79-81.

¹⁰¹ Bondfield, 'National care of maternity: the scheme of the WCG', *NH* (VI, 1914), pp.5-10.

¹⁰² Wellcome: WSIA annual report, 1915-1916, p.17 (SA/HVA/A.1/9).

¹⁰³ Webb & Webb, *State and the Doctor*, pp.179-185; Royal Commission on the Poor Laws, pp.796, 1221 (PP 1909 XXXVII, Cd. 4499).

¹⁰⁴ Mrs Sidney Webb, 'Relation of poor-law medical relief to the public health authorities', *PH* (XIX, 1906-1907), pp.129-138; Mrs Sidney Webb, 'Minority report in its relation to public health and the medical profession', *PH* (XXII, 1909-1910), pp.153-164.

up the Poor Law'.¹⁰⁵ Local Fabian Societies campaigned to extend maternity and child welfare services and the appointment of more health visitors.¹⁰⁶ When Maud Pember Reeves collected data for her FWG study, *Round About A Pound A Week*, it was with the co-operation of the staff of Lambeth's maternity and child welfare centres. The book has subsequently been seen as a statement that high infant mortality was due, not to the ignorance and carelessness of mothers, but to their poverty and poor housing, and that only the state could remedy the problem.¹⁰⁷ Reeves claimed that putting 'all the miseries and crying wants of the children of the poor to the ignorance and improvidence of their mothers' was 'merely to salve an uneasy conscience by blaming someone else'. It was, however 'always worth while' to 'teach an improvident and stupid woman to be careful and clever – if you can'. She supported the work of maternity and child welfare centres, and requested that they should be 'within the reach of every mother'. The problem was that they were 'fighting the results of bad housing, insufficient food and miserable clothing'.¹⁰⁸ These were sentiments shared by many women public health officers. In 1912 the FWG wrote to the WSIA asking it to advertise the book. The Committee ordered a dozen copies to be sold to members.¹⁰⁹

The WLL also campaigned on maternity and child welfare.¹¹⁰ Speaking of the League, Margaret MacDonald said that

We have among us many professional women, teachers, nurses, doctors, inspectors, post office clerks, etc. The facts of life have driven them to make common cause with the wage earners and they see in our movement the only hope for real social reform.¹¹¹

League members were active at a local level in the provision of voluntary and municipal maternity and child welfare services.¹¹² This is most famously exemplified by the fact that, when League women Mary Middleton and Margaret McDonald both died in 1911, the WLL chose to establish a baby clinic in Kensington as a fitting memorial.¹¹³ In lieu of positive state action, League women supported the idea of

¹⁰⁵ SR (XLIV, 1909), p.365

¹⁰⁶ See, for example, MO (XV, 1916), p.114.

¹⁰⁷ See, for example, Alexander, in her introduction to a re-issue of the book in 1979 reprinted as 'Fabian Women's Group 1908-1952', in *Becoming and Women*, pp.150-151.

¹⁰⁸ Reeves, *Round About*, pp.220, 228-229.

¹⁰⁹ Wellcome: WSIA Executive, 1 Mar 1912 (SA/HVA/B.2/4).

¹¹⁰ Collette, *For Labour*, p.66; Rowan, 'Women in the Labour Party', p.75.

¹¹¹ Quoted in Middleton, 'Women in Labour politics', p.28.

¹¹² Ferguson, 'Labour women and the social services', pp.39-40.

¹¹³ Middleton, 'Women in labour politics', p.29; Collette, *For Labour and For Women*, pp.112-

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voluntary effort, but in 1913 the WLL launched a national campaign for government-funded baby clinics.¹¹⁴ Representatives of the WSIA attended League conferences.¹¹⁵

Suffrage

Mrs Greenwood, observed that

From the nature of our work we have exceptional opportunities of seeing into the social conditions of the people and of realising the difficulties, and I may say, the deficiencies, of some of our present legislation; therefore as a body we women sanitary inspectors are specially qualified to influence legislation in the future in a practical direction, in a manner perhaps not possible to outsiders.¹¹⁶

Some women public health officers keenly felt the lack of the vote, and suffrage campaigners emphasised social reform issues in which they had a particular interest.¹¹⁷ Figs. 8 and 9, for example, show two typical illustrations from the front page of *Votes for Women*, drawing attention to high infant mortality rates, poor sanitation and lack of a professional health service.¹¹⁸

Many individual women sanitary inspectors and health visitors were active in the movement. Lucy Deane was a 'keen suffragist', and an active member of the National Union of Women's Suffrage Societies (NUWSS).¹¹⁹ Miss Wade, organising secretary of the International Women's Suffrage Society, was an experienced sanitary inspector and infant welfare worker, and later became part-time organising secretary for the WSIA.¹²⁰ Suffrage was, however, a controversial issue for the Association. In 1906 the WCG asked the WSIA to sign a manifesto in favour of women's suffrage, and send a representative to serve on a deputation to the Prime Minister. A resolution supporting this action was passed by a majority of ten (there were 40 members present), but was withdrawn when one member, Miss Long, threatened to resign if it were put into force.¹²¹ Later that same year, Mrs Pember Reeves was invited to speak about 'The suffrage for women', the best attended meeting of the whole season.¹²² At the end of her address, Miss Lovibond again

¹¹⁴ Thane, 'Women in the British Labour Party', p.362; Ferguson, 'Labour women and the social services', pp.45-46.

¹¹⁵ Wellcome: WSIA annual report, 1911-1912, p.9 (SA/HVA/A.1/5).

¹¹⁶ Greenwood, 'Sanitary inspection', pp.23-24.

¹¹⁷ The argument that votes for women were required to secure social reforms was supported by an alliance that cut across party lines, Rowbotham, *Century*, p.15.

¹¹⁸ VFW (13 Aug 1915), p.1 & (17 Sep 1915), p.1.

¹¹⁹ TUC: Ts biography of Lucy Deane Streatfeild (Gertrude Tuckwell papers, G/20).

¹²⁰ Wellcome: WSIA annual report, 1921-1922, p.12 (SA/HVA/A.1/14).

¹²¹ Wellcome: WSIA minutes, 27 Apr 1906 (SA/HVA/B.1/2).

¹²² Wellcome: WSIA annual report, 1906-1907, pp.8-9 (SA/HVA/A.1/1).

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



Figure 8: Votes for Women: 'a vote for the child's sake'.

IMAGE REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES

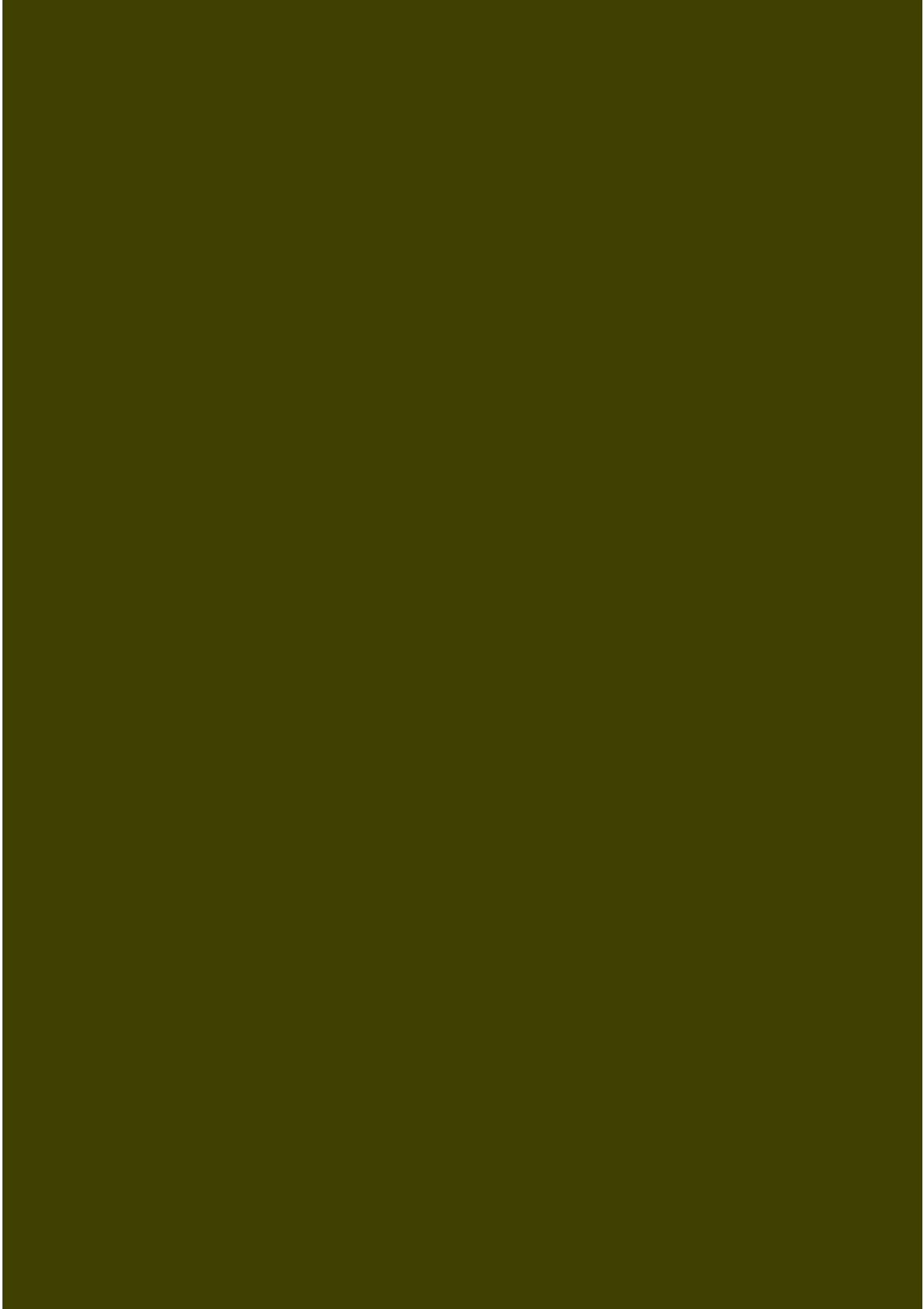


Figure 9: Votes for Women: 'where babies live'

proposed a motion in favour of suffrage.¹²³ Despite protest, the motion was not withdrawn, and 19 out of the 28 members present voted in favour, although at least two, including Miss Long, did tender their resignations as a result.¹²⁴

In November 1908 the WSIA was invited to participate in a 'professional and industrial' suffrage meeting. The Secretary replied that, although it was not possible for the WSIA to appear by name in the programme, if the organisers sent some tickets, she hoped to be able to sell enough to individual members. The name 'women sanitary inspectors' might then appear in the list of professional women supporting the meeting.¹²⁵ In April 1909 women inspectors took part in the Pageant of Women's Trades and Professions, organised by the London Society for Women's Suffrage (LSWS).¹²⁶ For suffrage historian Tickner, this pageant was intended to attract the support of both the labour movement, and of reformers who wished to see an end to sweated labour.¹²⁷ A thousand women from 90 different occupations took part in the rally. Each group contained ten or twelve women from the trade or profession, bearing appropriate emblems. That carried by women sanitary inspectors can be seen in Fig. 10. Women public health workers marched with those with whom they dealt in a professional capacity, such as dressmakers and laundresses. The pageant's programme stated that:

Sanitary Inspectors enforce the Sanitary Laws dealing with the home and workshop but have no voice in making or amending them. They are ever at the service of the public to ensure their health and comfort, but their hands are manacled; they share the work and responsibility with men inspectors but their politically unequal position as women is reflected in their smaller salaries. They uphold justice and ask no less.¹²⁸

As for trained nurses, including health visitors,

No class of workers realises more keenly the necessity for legislation in the direction of social reform. The housing of the working classes, unemployment, education, the feeding of schoolchildren, infant mortality, the conditions of women's labour, the mother's share in the control of her child, sweated industries, and many other matters confront trained nurses daily in the course of their work, and they desire the opportunity of giving effect to their views on these important subjects by the exercise of the Parliamentary Franchise.¹²⁹

¹²³ Wellcome: WSIA minutes, 30 Nov 1906 (SA/HVA/B.1/2).

¹²⁴ *Ibid.*, 14 Dec 1906 (SA/HVA/B.1/2).

¹²⁵ *Ibid.*, 12 Nov 1908 (SA/HVA/B.1/3).

¹²⁶ TWL: LSWS correspondence and papers relating to Albert Hall meeting, 27 Apr 1909 (2/LSW/296/1).

¹²⁷ Tickner, *Spectacle of Women*, p.100.

¹²⁸ TWL: LSWS correspondence and papers relating to Albert Hall meeting, 27 Apr 1909 (2/LSW/296/1).

¹²⁹ *Ibid.*

Figure 10: Design for sanitary inspectors' emblem used at the Procession of Women's Trades and Professions, 1909¹³⁰



In 1910, Miss Pankhurst invited the WSIA to support a WSPU procession. Nine voted for participation and 14 against, out of the 32 present.¹³¹ Once again, involvement was left to individual members. Shortly afterwards, Mabel Portlock, Honorary Secretary of the WSIA, wrote to the LSWS concerning another proposed meeting. Her letter illustrates the extent of the support for suffrage given by individual members (at a date when the total membership of the Association was only around 120), and her own personal commitment:

If you will send me 70 leaflets and defray cost of postage to our members, I will enclose them with a circular letter asking them to attend. About 60 marched in the WSPU demonstration a week or two back and possibly the same members would attend on Saturday. I will do my best, as a member of the London Society to induce members of the above Association to attend.¹³²

Some women public health officers also formed separate suffrage organisations. A Women Sanitary Inspectors and Health Visitors Suffrage Group existed, although it has been possible to discover details of only one meeting. This was held at the Emerson Club in November 1910 when Marion Phillips, then Secretary of the NUWSS, was the guest speaker. The Honorary Secretary of the

¹³⁰ Reproduced with permission of The Women's Library, London Metropolitan University (TWL: 2/ASL)

¹³¹ Wellcome: WSIA minutes, 4 May 1910 (SA/HVA/B.1/4).

¹³² TWL: LSWS correspondence, papers and press cuttings relating to Trafalgar Square meeting, 9 Jul 1910 (2/LSW/297/1).

Group was Theodora Fisher, Hampstead's woman inspector.¹³³ It participated in the Women's Coronation Procession, organised by the WSPU in June 1911. The programme for the procession stated that 'their knowledge of the homes of the poor makes them realise strongly the necessity of women having a hand in framing the laws which deal with housing, feeding of children, etc.'¹³⁴ There are also references to a 'Women Sanitary Inspectors' Suffrage Society', of which Miss Charlesworth was Secretary.¹³⁵

THE 'THREAT' OF THE HEALTH VISITOR

LCC (General Powers) Bill, 1908

The single most important campaign for the WSIA before the First World War was over the status of the health visitor. In 1908, the LCC backed a Bill that would enable London sanitary authorities to appoint a separate class of official to undertake health visiting, with different qualifications and subject to different LGB regulations, than those applied to women sanitary inspectors. The WSIA opposed the creation of a separate officer. It sought instead an addition to existing regulations governing the duties of sanitary inspectors, to allow the giving of advice in relation to domestic hygiene and infant care.¹³⁶ The Association emphasised that the nation's health could only be improved if 'the various conditions affecting health are considered and treated together', and that 'the sanitary condition of the houses and the personal and domestic habits of the inmates must be treated as one inseparable whole.'¹³⁷ Health visitors were described as 'unauthorised persons', whose employment would reduce the number of sanitary inspectors and 'lower the prestige of the statutory official'. The WSIA argued that men and women in the public health service should be appointed with equal salaries, opposed any differentiation in the qualifying examination, and emphasised 'the danger of a new class of official being appointed on a lower basis of status and salary'.¹³⁸ Miss Looker warned that the Bill might lead to 'the passing of the woman sanitary inspector', and that 'death knell' was sounding for her profession.¹³⁹ The WSIA claimed that, if health visitors were used to replace women

¹³³ VFW (1910-1911), p.77. I am grateful to Natalie Pollicutt for providing this reference.

¹³⁴ *Memento of Women's Coronation Procession to Demand Votes for Women: Order of March and Descriptive Programme* (The Women's Press, London, 1911), p.8.

¹³⁵ Wellcome: WSIA minutes, 6 Jan 1915 (SA/HVA/B.1/5); Crawford, *Women's Suffrage*, p.712.

¹³⁶ Wellcome: WSIA annual report, 1907-1908, p.14 (SA/HVA/A.1/2).

¹³⁷ *Ibid.*, pp.11-12 (SA/HVA/A.1/2).

¹³⁸ *Ibid.*

¹³⁹ Looker, 'Passing of the woman sanitary inspector', *NH* (1, 1908), pp.10-12.

sanitary inspectors, 'women would thereby be deprived of the valuable influence they are now able to exercise through their statutory powers in public health administration'.¹⁴⁰ It felt that

women as well as men should be able to speak with authority on sanitary matters both in the home and in the workshop. It would be a most regrettable thing if in the future women officials were deprived of the power of enforcing the Public Health Act and were obliged to leave entirely in the hands of men matters of which the woman is sometimes the better judge.¹⁴¹

Women inspectors felt constrained by the formal demarcation of their duties.

In 1908, Miss Carey made

a careful survey of all the things I was in the habit of talking about when paying official visits in order that I might rigidly exclude from my conversation any subject which I could not show positive authority for mentioning ... I found that I had to discard two topics of conversation - babies' bottles and the weather. There is no mention of these subjects in any of the Acts I know.¹⁴²

She reported that an LGB official, when asked whether offering advice on infant feeding was part of the proper duties of a woman sanitary inspector, had said that, 'Well, it is no part of the duties laid down for her, but at the same time you can't stop a woman's tongue, and she may say what she pleases.' Following this remark, Miss Carey had 'ventured again to make deprecatory remarks on the vexed question of feeding bottles' but that, 'of the weather I still never venture to speak unless I am spoken to, and even then I look behind the door before I reply to make sure that there is not a Councillor listening.'¹⁴³ For Leeds's chief woman inspector 'all sanitary conditions affect the baby most', and it was a mistake for infant welfare work to be separated from the other functions of the health department. If a public health worker visited the home, made inquiries about the baby, gave instruction as to its care and feeding, and yet did not consider its domestic environment, comparatively little good would be achieved.¹⁴⁴

The Chairman of the Public Health Committee of the LCC expressed his sympathy with the Association's views, but its Parliamentary Committee would not alter the Bill.¹⁴⁵ The attempt to persuade the LGB and LCC to weld the two offices together having failed, the WSIA wanted any new regulations to 'clearly differentiate' between the duties of sanitary inspectors and health visitors so that

¹⁴⁰ Wellcome: WSIA annual report, 1907-1908, p.14 (SA/HVA/A.1/2).

¹⁴¹ WSIA to LGB, Oct 1908. A draft of this letter was discussed at a special meeting of the WSIA in Oct 1908 (Wellcome: SA/HVA/B.1/3) and the final version was reproduced in the Association's annual report, 1908-1909 (Wellcome: SA/HVA/A.1/3).

¹⁴² SJ (XIII, 1907-1908), p.191.

¹⁴³ *Ibid*, pp.191-2.

¹⁴⁴ Maynard, *Women in the Public Health Service*, p.81.

¹⁴⁵ Wellcome: WSIA minutes, 12 Mar 1908 (SA/HVA/B.1/3).

nothing in these regulations will allow the work allocated to health visitors to encroach in any degree on those duties which it is now the privilege of the sanitary inspectors as responsible officers to perform.¹⁴⁶

The 1908 LCC (General Powers) Act came into effect in January 1909. It included a clause stipulating that health visitors were prohibited from discharging the duties of sanitary inspection and the WSIA seemed relatively satisfied.¹⁴⁷ It had not wanted the creation of a separate class of official but, once this became inevitable, it tried to protect the status of its members. The situation was far from ideal, however. Mrs Greenwood explained that,

there are two classes of women officials in connection with Public Health Departments, one on the same footing as the men, with equal powers and responsibilities, but remunerated at a much lower rate, and another with a lower status and a still lower rate of remuneration. The duties of the second class may be performed equally well by the first, but the duties of the first cannot be performed by the second. The introduction of the Health Visitor has therefore lowered the status of the Public Health Service.¹⁴⁸

Gertrude Tuckwell remembered how

The health visitors had no proper status, they had no proper pay. I frankly thought that these appointments were being used to further drag down the low salary received by the sanitary inspectors. It was so easy for an unenlightened council to try and make most of their appointments from health visitors, who had no legal status, no definitely defined duties, and whose cheap work could be utilised to do part of the work which must otherwise devolve on the sanitary inspector.¹⁴⁹

WSIA excludes health visitors

During the debate over the Bill, at least one member, a health visitor in Poplar, resigned because of 'the attitude of the Association to health visitors'. She may have felt that women sanitary inspectors were closing ranks, and attempting to exclude her and her colleagues.¹⁵⁰ If so, she was proved right. In 1909 the Association amended its membership rules. From that date, membership was open only to women sanitary inspectors, or health visitors also qualified as sanitary inspectors, who were duly appointed by a sanitary authority, or who had previously held such appointments.¹⁵¹ The Association thereby excluded from full membership all those who were qualified health visitors under the LGB regulations, but who did not also hold the sanitary inspectors' certificate. A concession was made to this class of officer in 1910, when it was decided that qualified women sanitary inspectors, not

¹⁴⁶ Wellcome: WSIA to LGB, Oct 1908.

¹⁴⁷ LMA: NUWW Industrial Sectional Committee, 23 Sep 1909 (ACC/3613/1/63).

¹⁴⁸ Greenwood, 'Women as sanitary inspectors and health visitors', p.232.

¹⁴⁹ JRSI (XLII, 1921-1922), p.298.

¹⁵⁰ Wellcome: WSIA minutes, 8 Apr 1908 (SA/HVA/B.1/3); Executive, Apr 1908 (SA/HVA/B.2/2).

holding official appointments, and health visitors holding official appointments, but unqualified as sanitary inspectors, should be eligible for associate membership.¹⁵² Eighteen women, most from outside London, took up this offer, including a contingent of five from Birmingham.¹⁵³ They were not entitled to any voting rights, or any say in Association policy.

In 1909 the Association considered a change of name. Only one member voted in favour of 'The Women Sanitary Officers Association', four supported 'The Women Sanitary Inspectors and Health Visitors Association', but the overwhelming majority of those present (23) voted to keep the title as 'The Women Sanitary Inspectors Association'.¹⁵⁴ The Association's reaction to the 1908 Act, and the increasing appointment of health visitors in London, was not to include them, but to remain devoted to defending the interests of women sanitary inspectors.

Health Visitors (Public Health) Bill, 1910

A further test came in 1910, when John Burns introduced the Health Visitors (Public Health) Bill, to allow authorities outside London to appoint 'suitable women' as health visitors to undertake duties with relation to the Notification of Births Act. Their qualifications were to be settled by the local authority, rather than regulated by the LGB.¹⁵⁵ The WSIA opposed the Bill, for much the same reasons as it had objected to the 1908 Act for London. It also argued that the legislation would achieve nothing, since over 200 women had already been appointed as health visitors in the regions. It would limit their duties to those under the Notification of Births Act, excluding other valuable services being performed, such as tuberculosis and infectious disease work.¹⁵⁶ Instead, the Association sought an extension of the recognised duties of sanitary inspectors, to include maternity and child welfare. It wanted all women officials in the public health service to be appointed with the status of sanitary inspector, and to be duly qualified as such, whatever their duties.¹⁵⁷ This view became known as the 'dual appointment' policy.

The WSIA was also concerned about the type of woman that might be recruited if the Bill came to pass. It stated that

We would desire to raise the profession by attracting the right type of women as at the commencement of the movement, when the work was sought by

¹⁵¹ Wellcome: WSIA minutes, 14 Jan 1909 (SA/HVA/B.1/4).

¹⁵² *Ibid.*

¹⁵³ Wellcome: WSIA annual report, 1909-1911 (SA/HVA/A.1/4).

¹⁵⁴ Wellcome: WSIA minutes, 14 Jan 1909 (SA/HVA/B.1/4).

¹⁵⁵ *BMJ* (25 Mar 1911), p.713; *Lancet* (25 Mar 1911), p.852.

¹⁵⁶ *The present position of women in the public health service* (WSIA, Jan 1911).

¹⁵⁷ Wellcome: WSIA annual report, 1911-1912, p.15. (SA/HVA/A.1/5).

women, both on humanitarian and economic grounds, as giving due scope to their abilities while aiding in the uplifting of the masses.¹⁵⁸

The early women sanitary inspectors considered themselves social reformers as well as salaried employees, and feared that the new health visitors would not necessarily share the same outlook. A very public campaign was undertaken to oppose the Bill, and the WSIA sent out over 1,000 copies of its statement of views to MPs and other 'influential persons', associations and newspapers.¹⁵⁹

Women's groups

In attempting to secure the downfall of both the 1908 and 1910 Bills, the Association drew on the support of other women's organisations. In this context, the issue became one in which wider debates about the status and role of women, and collective or individual responsibility for health, were aired.

Support for the WSIA was galvanised by the WLGS. It recognised 'the slender minimum of preparation' by which women might qualify as health visitors in London under the 1909 regulations, and the very much worse situation that might arise outside the capital should the Health Visitors' Bill be passed, because it left qualifications 'indeterminate'.¹⁶⁰ With the support of the WSIA, it commissioned Mrs Greenwood to enquire into health visiting in the capital.¹⁶¹ She reported that most was undertaken by women who were qualified as sanitary inspectors, and that their training and powers were required for the detection and remedying of insanitary conditions – 'such conditions being the greatest of all dangers to infant life'.¹⁶² According to Miss Kilgour of the WLGS, the prime cause for high infant mortality was poor sanitation. She argued that women employed in the public health service should be equipped to deal with this by being qualified and appointed as sanitary inspectors.¹⁶³ The Committee concluded that, 'if there are to be two types of women officials employed for health purposes, the health visitor should also be the sanitary inspector'. What was really needed was an amendment of the law that restricted some authorities from appointing more than one sanitary inspector, and defined too narrowly their duties.¹⁶⁴

¹⁵⁸ Letter from the WSIA to Rt. Hon. John Burns MP on the Health Visitor's Bill, 5 Nov 1910 (reprinted by the WLGS).

¹⁵⁹ Wellcome: WSIA Executive, 18 Nov 1910 (SA/HVA/B.2/3).

¹⁶⁰ LMA: WLGS Executive, 4 Dec 1910, pp.217-218 (A/WLG/9); WLGS report, 1910-1911, pp.21-23.

¹⁶¹ LMA: WLGS Executive, 11 Jan 1911, pp.230-231 (A/WLG/9).

¹⁶² WLGS report, 1910-1911, p.22

¹⁶³ NUWW, conference report, 1911, p.125.

¹⁶⁴ WLGS report, 1911-1912, p.12.

The WLGS lobbied the House of Commons and the LGB, communicated with other organisations, and reprinted and distributed a WSIA statement.¹⁶⁵ It organised two conferences, attended by individual MOHs and representatives of local government, as well as the WSIA, NATHS, WIC, NUWW, London Guilds of Help, Central Bureau for the Employment of Women, Women's Liberal Federation, National Women's Liberal Association, WCG, WLL and FWG.¹⁶⁶ This illustrates the general interest that the issue aroused among both labour and liberal women. The conference viewed

with grave apprehension the Health Visitors' Bill ... as it would tend to check the appointment of fully-qualified women as sanitary inspectors and to encourage the appointment of women under the name of health visitors, without adequate qualifications, without the necessary powers, with too narrow range of work and with practically no status.¹⁶⁷

In addition, the conference agreed

that any woman appointed in the future to carry out the work popularly known as health visiting should be qualified and appointed as sanitary inspector, and should hold additional qualifications for the special work of health visiting.¹⁶⁸

The NUWW had already supported the WSIA over the appointment of health visitors in London.¹⁶⁹ It

hoped that in any regulations issued by the LGB a clause may be inserted to the effect that all or any of the duties assigned to health visitors may ... be performed by any duly appointed sanitary inspector.

The Union feared that the tendency would be to appoint women as health visitors only, and men for all sanitary inspection work, whereas there was a great deal of sanitary inspection which could neither be given to health visitors, nor done properly by men.¹⁷⁰ The WIC's Legal Committee offered 'strenuous opposition' to the Health Visitors Bill. It argued against leaving the standard of qualification to be determined locally, stating that the women should have a high standard of training 'and be raised beyond possibility of doubt above the ignorance against which they have to contend.'¹⁷¹ As early as 1903 it had already pointed out that

¹⁶⁵ LMA: WLGS Executive, 29 Mar 1911 (A/WLG/9); WLGS report, 1910-1911, p. 35 & 1911-1912, p.12.

¹⁶⁶ WLGS report, 1911-1912, pp.9-11.

¹⁶⁷ *Ibid.*

¹⁶⁸ *Ibid.*

¹⁶⁹ Wellcome: WSIA annual report, 1908-1909, p.15 (SA/HVA/A.1/3); WSIA Executive, 18 Jun 1908 (SA/HVA/B.2/2).

¹⁷⁰ *NH* (I, 1909), p.78.

¹⁷¹ *WIN* (Jul 1911), pp.109-110; *BJN* (12 Oct 1910).

It is important that women should not be appointed merely as health visitors, with only part of the powers of inspectors; for unless they have full authority in visiting and reporting, their work is far more difficult and less effective.¹⁷²

The FWG protested

against the passing of the Health Visitor's Bill ... as its enactment will tend to limit the appointment of women as sanitary inspectors and will legalise the creation of a class of officers on a lower scale in respect to salary, status and responsibility and with possibly no sanitary training.¹⁷³

This resolution was sent to the Secretary of the Fabian Society and to all Fabian MPs. The WLL wrote to Mr Burns, and to the Labour Party, expressing disapproval of the Bill, and the Women's Liberal Federation passed a resolution in support of WSIA policy.¹⁷⁴ Gertrude Tuckwell of the WTUL, said that it was preferable to combine the two posts, as 'it must surely be a help when the visitor, who has the legal power of entry and is looking at the structural defects, is able at the same time to see what is wrong with the inhabitants.' For her, it was not just efficiency but 'you get rid of irritation on the part of the people you have to visit'. She claimed that she had heard the representatives of large women's associations voicing this point 'with dramatic intensity'.¹⁷⁵ The WCG also felt that health visitors should be qualified sanitary inspectors, in order to carry out all the duties at once, so that there would be 'less invasion of the home' and so that mothers would 'receive the most efficient officer'.¹⁷⁶ For reasons both of equality and the needs of working women, the WSIA's views chimed with those of other women's organisations, which agreed that the needs of working-class mothers could best be met by those who were qualified to remedy structural problems, as well as having expertise in infant welfare.

Women Sanitary Inspectors Council

Despite this very public campaign, it appears that the WSIA did not go far enough for some of its members. A breakaway group, called the Women Sanitary Inspectors Council, was formed, with the express purpose of fighting the Health Visitors' Bill. It is unclear how large this group was, but all members had previously belonged to the WSIA.¹⁷⁷ Miss de Chaumont, long-serving woman sanitary inspector

¹⁷² TNA: WIC, 'London Borough Councils and the Welfare of Women Workers', 1903 (PRO 30/69/1369).

¹⁷³ Wellcome: WSIA Executive, 23 Mar 1911 (SA/HVA/B.2/4). LSE: FWG report, Mar-Dec 1911, p.8 (Fabian Society, H35/2).

¹⁷⁴ LMA: WLGS Executive, 10 Apr 1911 (A/WLG/9).

¹⁷⁵ *JRSI* (XLII, 1921-1922), p.298.

¹⁷⁶ Bondfield, 'The national care of maternity: the scheme of the WCG', *NH* (V, 1914), pp.5-10; *SR* (LIII, 1914), p.320.

¹⁷⁷ LMA: WLGS Executive, 14 Jun 1911 (A/WLG/9).

in Kensington, and previous Committee member and Vice-President of the WSIA, was Secretary.¹⁷⁸

The WSIA objected to 'the assumption by a limited non-representative confederacy of the title Women Sanitary Inspectors Council' and attempted to deny any officer of the WSIA the right to be associated with it. Members of the Council felt that the Association was not doing enough to protect the interests of women sanitary inspectors. Miss de Chaumont stated that health-visitor members of the WSIA were openly opposed to working as sanitary inspectors, and referred to the difficulties of organising a large Association of both kinds of workers. The Council's publicly expressed views, however, were not particularly at variance with those of the WSIA. It emphasised that

the absurdity of sending a woman sanitary inspector into ... houses and forbidding her to look at the children, is surpassed by the folly of sending a health visitor to the children and telling her that the sanitary condition of the home is no concern of hers.¹⁷⁹

Aiming to bridge the rift, the WSIA's President sympathised with the Council for wishing to work unhampered by the large and unwieldy Association, but argued that it was unwise of them to cut themselves adrift. She also viewed the title of the Council as misleading. To avoid confusion, the Council changed its name to the Independent League of Women Sanitary Inspectors. In the event, the Health Visitors' Bill was withdrawn from the House without having reached a second reading. Both Council and Association claimed this as a victory.¹⁸⁰

Women Sanitary Inspectors and Health Visitors Association

Meanwhile, the number of WSIA associate members, predominantly health visitors, was growing (by 1914, there were 133 full members and 51 associates), and they resented exclusion from full membership. Agitation for change came initially from Birmingham, the first regional centre of the WSIA to be formed in 1912.¹⁸¹ In 1914, Miss Underwood of Warwickshire asked the Association to consider the formation of a 'Women Public Health Workers Association', including all salaried women officials, whether they held office as sanitary inspector, health visitor, school nurse or tuberculosis visitor.¹⁸² Opinion was divided. Those in favour of extending full membership to qualified health visitors argued that, only through including them

¹⁷⁸ The Annual Business Meeting of the WSIA, 3 May 1911, included much debate on the Women Sanitary Inspector's Council (Wellcome: SA/HVA/ B.1/5).

¹⁷⁹ *BMJ* (1 Apr 1911), p.786.

¹⁸⁰ *Lancet* (9 Dec 1911), p.1670.

¹⁸¹ Wellcome: WSIA Executive, 11 April 1912 (SA/HVA/B.2/4).

¹⁸² Wellcome: WSIA minutes, 2 May 1914 (SA/HVA/B.1/5).

could the Association help to raise their status and salaries. Others felt that acknowledging them as equals would jeopardise the 'dual appointment' policy. Feelings ran so high that, at the annual meeting in 1915, discussion of the matter was adjourned sine die.¹⁸³ At this same meeting, it was resolved (15 for, three against) that the name of the Association should in future be the Women Sanitary Inspectors and Health Visitors Association.¹⁸⁴ For members of the Birmingham Centre, acknowledging the increased importance of health visitors by this change of title, without giving them any real power, was adding insult to injury. In November 1915 several resigned from the Association, protesting that trained nurses, and others without the sanitary inspectors certificate, were excluded from full membership.¹⁸⁵

Meanwhile, the WSIA pressed ahead with its 'dual appointment' policy and responded to individual cases of the replacement of women sanitary inspectors by health visitors.¹⁸⁶ It sent a deputation to the LGB to press the advantage of dual appointments, and 'that all women officials appointed to carry out any of the duties affecting the administration of Public Health should be appointed with a legal status recognised under the Public Health Acts.'¹⁸⁷ It campaigned for a uniform basic qualification for all sanitary inspectors and health visitors, with further additional qualifications if an officer were to specialise in one branch of the work.¹⁸⁸

Despite continued debate, it became increasingly clear that, by alienating health visitors, the WSIA was endangering its very existence. Because of their exclusion, some staff of the Manchester Public Health Authority founded a union of their own, and others threatened the same.¹⁸⁹ At a special meeting in July 1917, the Association once again debated altering the basis of its membership.¹⁹⁰ It now proposed accepting as full members those who held official posts as women sanitary inspectors, health visitors, superintendents of maternity and child welfare centres or tuberculosis visitors, whether they were qualified or not. Associate membership was to be offered to qualified women sanitary inspectors and health visitors without official appointments. The Association's Executive was still determined to uphold the line

¹⁸³ *Ibid.*

¹⁸⁴ Wellcome: WSIA annual report, 1914-1915, p.16 (SA/HVA/A.1/8).

¹⁸⁵ Wellcome: WSIA minutes, 3 Nov 1915 (SA/HVA/B.1/5); WSIA Executive, 7 Sep 1914 (SA/HVA/B.2/6).

¹⁸⁶ See, for example, TNA: Letter from the WSIA, 10 Jan 1912 (MH 48/165); Westminster sanitary inspectors (MH 48/168).

¹⁸⁷ Wellcome: WSIA annual report, 1914-1915, p.17 (SA/HVA/A.1/8); Executive, 15 July 1914 (SA/HVA/B.2/6).

¹⁸⁸ Wellcome: WSIA annual report, 1912-1913, p.11 (SA/HVA/A.1/6).

¹⁸⁹ Wellcome: WSIA Executive, 9 Jul 1917 (SA/HVA/B.2/7).

¹⁹⁰ NH (X, 1917), pp.60-61.

between the voluntary and local government sectors, but was now prepared to abandon the distinction between the sanitary inspectors' and health visitors' training and qualification. Not all members agreed. One felt that, if the resolution were passed, the Association would be swamped by people 'who had not the public health outlook'. Another claimed that it would be a great mistake if the women sanitary inspectors, who had founded it, were to become a small minority. Others argued that the professional standard would be lowered.¹⁹¹ On the other hand, some health visitors expressed great bitterness about their position as associates, and stated that, if they were not accepted as full members, they were quite prepared to form their own separate association. Lucy Deane, the Association's President, took a pragmatic approach, realising that the Association's only hope of influencing the new Ministry of Health was by combining.¹⁹² When the vote was taken, the resolution was carried by only three votes more than the necessary two thirds majority and at least one member resigned, as she did not approve of the admission of 'all sorts of health workers' into the Association.¹⁹³

By the end of the First World War, the Association was still campaigning to raise the standard of the qualification required for health visiting, but no longer insisted that this had to be based around the sanitary inspectors' qualification, or that health visitors should be vested with the status and power of sanitary inspectors. It stated that 'developments in infant welfare work have shown that this is not always practicable or necessary'.¹⁹⁴ In 1919 it further broadened associate membership to include qualified health visitors not holding appointments and those employed by voluntary organisations.¹⁹⁵ It finally decided to treat women sanitary inspectors and health visitors as equal, although a distinction was still made between the voluntary and municipal sectors. An increasing range of services drew more trained nurses, without public health qualifications, into the field. In 1919, for example, Nottingham's VD clinic nurses were anxious to join the Association, but were unable to do so.¹⁹⁶ The Association was also under financial pressure. In 1920 it even considered dissolving, but decided instead to investigate the possibility of enlarging the membership.¹⁹⁷ In 1921 it voted to extend this to 'several additional branches of public health work', although in 1922 it decided not to admit district nurses working as

¹⁹¹ *Ibid.*; Wellcome: WSIA minutes, 11 Jul 1917 (SA/HVA/B.1/6).

¹⁹² *NH* (X, 1917), pp.60-61.

¹⁹³ Wellcome: WSIA Executive, 9 Jul 1917 (SA/HVA/B.2/7).

¹⁹⁴ *NH* (XIII, 1920), pp.46-47.

¹⁹⁵ *NH* (XII, 1919), pp.20-21; TNA: WSI&HVA application to register as a trade union, 1919 (FS 28/176).

¹⁹⁶ *NH* (XII, 1919), p.45.

health visitors.¹⁹⁸ It began to represent not only women sanitary inspectors, health visitors and tuberculosis visitors, but also superintendents of maternity and child welfare centres, municipal midwives, school nurses, infant life protection visitors and clinic nurses – ‘in other words all the women public health officers at present in existence.’¹⁹⁹

CONCLUSION

Women public health officers were part of social reform networks, both championing, and championed by, a range of women’s organisations. There was a broad coalition supporting the appointment of women sanitary inspectors, both in terms of opening-up a new area of employment for middle-class women, and because of their belief in the need for the better administration of protective labour legislation for women. The involvement of women public health officers in campaigns over protective labour legislation illustrates the complexity of the response of ‘liberal’ social reformers and ‘labour’ women to the issue, and to the debate over the balance between individual responsibility for health and environmental factors. Rather than blaming individual mothers for infantile mortality, labour women also drew attention to wider social, economic and environmental conditions, and campaigned for state-funded maternity and child welfare services, without the stigma, either of the Poor Law, or of philanthropy, views that were shared by many women public health officers. Frustrated that they had the expertise to contribute to social reforms, and yet were denied any legislative power, women public health officers also campaigned for the right to influence public policy through possession of the vote. They also fought for the official status and powers to enable them to ameliorate the living and working conditions of the poor through their professional work. The ‘dual capacity’ policy arose from a feeling that there was no logic in dividing the problems of structural and personal sanitation, nor any benefit to working-class women, and that women officials should be allowed to contribute to remedying both. Moreover, that they must be allowed to do so on the same basis as their male colleagues: with the same powers and responsibilities and the same right to act in the public sphere. By the

¹⁹⁷ Wellcome: WSI&HVA Executive, 5 Nov 1920, 19 Nov 1920 (SA/HVA/B.2/9).

¹⁹⁸ *Ibid.*, 26 Aug 1921, 19 Jan 1922 (SA/HVA/B.2/10); WSI&HVA annual report, 1921-1922, p.12 (SA/HVA/A.1/14)

1920s, however, women sanitary inspectors were a very small minority within the WSI&HVA.

¹⁹⁹ WSI&HVA news sheet, Oct 1925, p.1; WSI&HVA rules.

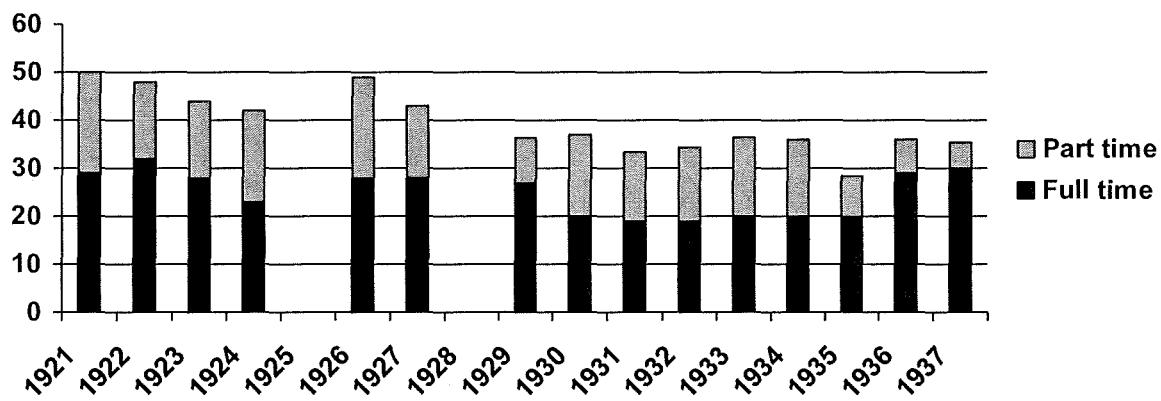
9: INTER-WAR DEVELOPMENTS

WOMEN SANITARY INSPECTORS

Prospects

Careers literature emphasised the limited opportunities for women sanitary inspectors throughout the inter-war period. A sanitary inspector's qualification was considered useful if held in addition to the health visitors' certificate but alone was 'of little value.'¹ By the late 1920s and 1930s, it was stressed that 'Openings for women sanitary inspectors are practically non-existent'.² At their peak in 1910 there were 41 full-time women sanitary inspectors working in the capital.³ Although by 1912 there had been a fall to 31, numbers remained relatively stable throughout the 1920s (Fig. 11). At their lowest ebb in the 1930s, there were around 20 full-time, and about half as many again working part-time. There was then an upturn, until in 1937 the number of full-time appointments almost regained the 1912 figure.

Figure 11: Number of women sanitary inspectors employed in London, 1921-1937.⁴



Numbers did not, however, increase in proportion to general population growth, or to the rise in the number of male inspectors (Fig. 12). In 1921 there were 304 male sanitary inspectors employed in the capital. By 1937 this had increased to 393, an increase of just under 30%. Numbers of health visitors were also rising. It seems that,

¹ *Careers and Vocational Training* (CBEW [1927]), pp.17-18.

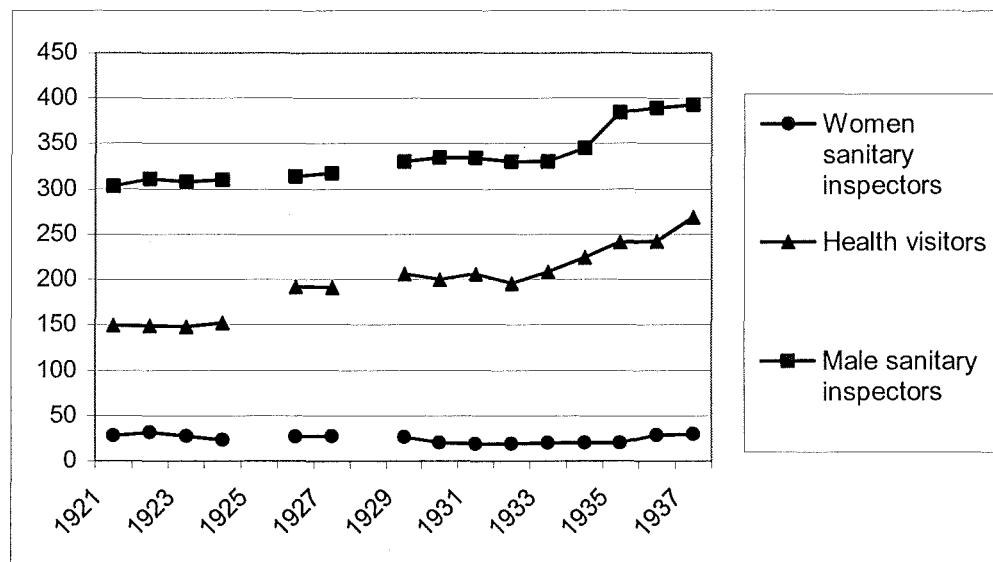
² LNSWS, 'Memorandum on Openings and Trainings for Women' (1927); Biscoe, 300 *Careers*, pp.193, 102; Strachey, *Careers*, p.237.

³ See Chapter 3.

⁴ LCC MOH reports.

while many metropolitan boroughs saw the need to have at least one woman inspector on their staff, they failed to find new areas of work, or to take on work traditionally given to men. Although they failed to develop and expand their role, women sanitary inspectors continued their duties throughout the inter-war period.⁵

Figure 12: Number of full-time sanitary inspectors and health visitors in London, 1921-1937⁶



Despite a widely-reported lack of appointments, women continued to qualify as sanitary inspectors. Until 1925 the SIEB remained the examining board for those wishing to work in London. Between 1920 and 1925, 191 women qualified, compared with 146 men.⁷ Numbers of both male and female candidates declined after an immediate post-war peak, but it was only in 1925 that, for the very first time, more men than women were successful in the examination (Fig. 13). This may have been because some training institutions continued to offer a combined training and women were advised that the possession of additional qualifications for 'very little extra outlay' was a great advantage, since dual appointments were still advertised.⁸ In 1925 the examination system was modified, and a new national board – the Royal Sanitary Institute and Sanitary Inspectors Examination Joint Board – was established.⁹ Figures for women qualifying in the late 1920s have proved difficult to

⁵ See, for example, Reid, 'Work of a woman sanitary inspector of workshops and bakehouses', *JRSI* (L, 1929-1930), pp.607-609; Whitbread, 'My work as a sanitary inspector in peace-time and in war', *WHO* (Feb 1940), p.8.

⁶ *Ibid.*

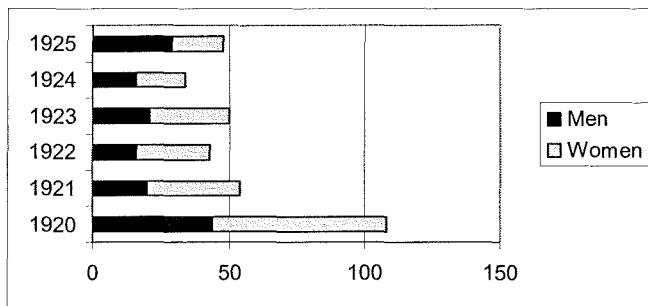
⁷ RSPH: SIEB Register, Volume II.

⁸ Eve, *Manual*, pp.23-24.

⁹ *JRSI* (XLVI, 1925-1926), p.141; Clay, *Sanitary Inspector's Handbook*, pp.10-12.

locate, but, by the 1930s, the number was very small. Between May 1931 and May 1935, 851 candidates qualified for posts nationwide, only 17 of them women.¹⁰ At the end of the 1930s, only a few women trained as sanitary inspectors, mainly as an additional qualification for another branch of public health work.¹¹

Figure 13: SIEB, successful candidates, 1919-1925



Women Sanitary Inspectors and Health Visitors Association

By the 1920s, women sanitary inspectors were a very small minority within the WSI&HVA, and they threatened to abandon it in favour of the male association.¹² Although there are occasional mentions of the election of women to the SIA, however, there remain only a few examples of their active involvement.¹³ Miss Davis of Greenwich, one of the SIA's 'most faithful conference attendants', and the only women to be elected as a Fellow, was exceptional.¹⁴

The WSI&HVA attempted to 'adopt some special system for safeguarding the interests of this important minority', and a special sub-committee was appointed.¹⁵ This made a case for their employment, by ascertaining what duties were best done by women, which of those performed by men had once been allocated to women, and which local authorities had relegated women to health visiting only.¹⁶ The WSI&HVA urged the appointment of at least one woman sanitary inspector in every authority.¹⁷ It drew up a memorandum outlining the work it saw as especially fitted to

¹⁰ *JRSI* (LI, 1930-1931), Supplement, pp.13, 21, 29, 46, 68, 76, 136, 142.

¹¹ Wellcome: Parnell, 'Need for more women sanitary inspectors in view of recent legislation', WPHOA conference report, 1938, p.20 (SA/HVA/D.1/8).

¹² Wellcome: WSI&HVA Executive, 15 Dec 1922 (SA/HVA/B.2/11).

¹³ *SJ* (XXXIII, 1927-1928), p.203; *Sanitarian* (VII, 1938-1939), p.178.

¹⁴ *SJ* (XXVI, 1920-1921), p.172, *SJ* (XXXII, 1926-1927), p.282; *Sanitarian* (VI, 1937-1938), p.93; *Sussex Daily News* (1 Sep 1937), p.12.

¹⁵ Wellcome: WSI&HVA annual report, 1923, p.18 (SA/HVA/A.1/15) & 1924, p.12 (SA/HVA/A.1/16).

¹⁶ Wellcome: WSI&HVA annual report, 1924, p.12 (SA/HVA/A.1/16).

¹⁷ *Ibid.*, 1925, p.8 (SA/HVA/A.1.17).

women.¹⁸ This included the inspection of workshops, laundries and outworkers; restaurant kitchens; and sanitary accommodation for women in factories, workshops, theatres, shops, restaurants, schools and other public places. Home visits on the notification of infectious disease, and reporting upon the condition of premises occupied by patients discharged from hospital, were also suggested. Housing work might include responding to complaints of insanitary conditions; inspection of common lodging houses, and those registered as let in lodgings; and 'friendly supervision' of council houses. In addition, visiting homes of the old and infirm was suggested. The Association felt that, 'in the absence of one or more women inspectors, many of these duties may not be performed frequently or regularly, if at all.' In response, the Minister of Health pointed out that very few authorities employed more than one inspector and that the Association's suggestion would mean that, either the staff would be doubled, or a man replaced by a woman. He also felt that several of the duties mentioned might be performed equally well by men.¹⁹ It seems that women sanitary inspectors were losing the argument that particular duties could, or should, be performed specifically by women.

With the support of the TUC, the WSI&HVA focussed attention on those London boroughs that did not employ a woman inspector.²⁰ Woolwich Health Committee had

long since come to the conclusion ... that there is no duty which a sanitary inspector is called upon to perform, which cannot be done as efficiently in every way by a man, and in many instances more so, than by a woman.²¹

Stepney was rather confused about the role of a woman sanitary inspector as opposed to a health visitor. It seems to have thought that the TUC was concerned because none of their general sanitary inspectors was female, rather than because they did not have a woman appointed to special duties.²² The campaign revealed that complicated patterns of dual appointment persisted, so that, even if they were not wholly, or even mainly, employed as sanitary inspectors, in several districts women still devoted a proportion of their time to these duties. Battersea, for example, employed nine women. Seven were health visitors. One was four-fifths a sanitary inspector and one-fifth a health visitor, and another was half a sanitary inspector and

¹⁸ MRC: WPHOA memorandum on the work of women sanitary inspectors (MSS.292/843.5/2).

¹⁹ Wellcome: WSI&HVA Executive, 6 Mar 1929 (SA/HVA/B.2/14).

²⁰ Wellcome: WSI&HVA annual report, 1924, p.12 (SA/HVA/A.1/16); MRC: Assistant Secretary of the TUC General Council to Morrison, 29 Nov 1928 (MSS.292/843.5/2).

²¹ MRC: Green to Morrison, 4 Dec 1928 (MSS.292/843.5/2).

²² MRC: Price to Morrison, 14 Dec 1928 (MSS.292/843.5/2).

half a health visitor.²³ In 1922 Kensington re-organised its staff and renamed its women sanitary inspectors, health visitors and tuberculosis nurses 'women health officers'. The borough was divided into seven districts, in each of which one woman performed the full range of duties.²⁴

The WSI&HVA used every new circumstance to press its case. In 1930 the prevalence of smallpox was used to urge the appointment of more women inspectors, since the examination of female contacts by male inspectors was 'not desirable'.²⁵ It promoted the appointment of women sanitary inspectors for duties under the 1934 Shops Act, since shops employed many women and girls. It also pressed for the appointment of women inspectors under the 1935 Housing Bill. For enquiries into overcrowding, it considered that 'a housewife will naturally more easily confide in a woman than a man.' During inspections of millinery and drapery establishments, restaurant kitchens, laundries, and other places, 'any reluctance on the part of women in discussing certain matters with men would be overcome if a woman inspector were making the enquiries'.²⁶ These were all arguments similar to those employed 30 years before. As new council housing estates proliferated, women were recommended for duties in this direction, although the traditional division of labour was maintained, with male sanitary inspectors responsible for structural upkeep, and women involved in 'preventive, social and "management" duties'.²⁷

HEALTH VISITORS

Prospects

By contrast, the number of health visitors in London continued to rise, from around 150 full-time posts in the early 1920s, to over 250 by the end of the 1930s (Fig. 14). By this date they generally spent less of their time in home visiting, and more in clinic work.²⁸ There were dental clinics, those offering artificial light treatment

²³ MRC: Winfield to Morrison, 5 Dec 1928 (MSS.292/843.5/2)

²⁴ Kensington, MOH report, 1922; MRC: Grinwood to Morrison, 4 Dec 1928 (MSS.292/843.5/2).

²⁵ Wellcome: WSI&HVA Executive, 4 Apr 1930 (SA/HVA/B.2/14); WHO (May 1930), p.2.

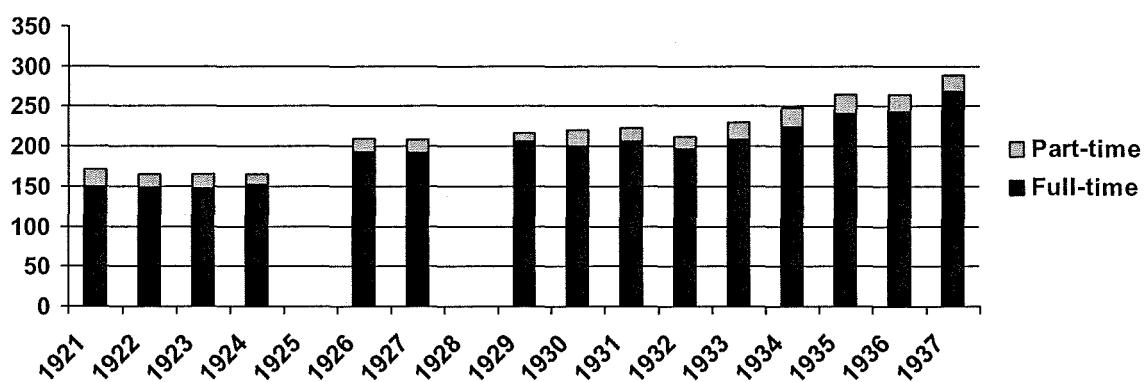
²⁶ WHO (Apr 1935), p.2 & (Aug 1935), p.2; Wellcome: WSI&HVA annual report 1935, p.16 (SA/HVA/A.1/27); comments by Mrs Reid, WPHOA conference report, 1938, p.20 (SA/HVA/D.1/8).

²⁷ Wellcome: comments by Miss Dick, WPHOA conference report, 1933, p.15 (SA/HVA/D.1/3); Poplar MOH report, 1925, pp.54-55.; Wellcome: Landray, 'Place of the trained woman in new housing schemes', WPHOA conference report, 1935, pp.26-30 (SA/HVA/D.1/5).

²⁸ See, for example, comments by Janet Campbell in *JRSI* (LIII, 1932-1933), pp.462-463.

for children suffering from rickets, orthopaedic and massage clinics, and those offering treatment for ear or eye problems.²⁹ The provision of ante-natal care was another major development.³⁰ Although specialist staff were often employed – clinics for ‘remedial exercise’ to cure flat feet and knock-knees, usually being under the charge of fully-trained ‘physical instructresses’, for example – health visitors often assisted.³¹ Indoor clinic work was seen as an option for older visitors.³² Volunteers were increasingly limited to helping to look after babies while the mothers attended classes, and to making teas, or selling foods and medicines. Even weighing babies often became confined to ‘trained’ workers.³³

Figure 14: Number of health visitors employed in London, 1921-1937³⁴



Tuberculosis work remained important. By 1935 there were 25 municipal tuberculosis dispensaries in the capital, and eight at voluntary hospitals or under voluntary management.³⁵ A variety of different staffing arrangements pertained. In Stepney, for example, in 1932 there were 11 health visitors for maternity and child welfare, and also five engaged entirely in tuberculosis.³⁶ In 1934 Woolwich employed three full-time tuberculosis visitors, two of whom also did a half-day a week at a maternity and child welfare centre, and the Tuberculosis Care Committee provided three further voluntary visitors.³⁷

²⁹ McCleary, *Maternity and Child Welfare*, pp.44-45; McCleary, *Development*, p.9; Cassie, *Maternity and Child Welfare*, p.44.

³⁰ McCleary, *Maternity and Child Welfare*, p.57.

³¹ Cassie, *Maternity and Child Welfare*, p.45.

³² TNA: Woolwich, Report on Maternity and Child Welfare Work, 1934, p.7(MH 66/404).

³³ NCMCW, *Proceedings* (1930), p.82; *Mother and Child* (VIII, 1938), pp.184-185; Deptford MOH report, 1919, p.30; Armitage, *Health Visiting*, pp.42-53.

³⁴ LCC MOH reports.

³⁵ LCC MOH report, 1935, p.53.

³⁶ TNA: Stepney, Public Health Survey report, May-Jul 1932, pp.8-9 (MH 66/391).

³⁷ TNA: Woolwich, Public Health Survey report, 1934, p.49 (MH 66/404).

Background

Initially, many of this later generation of health visitors were recruited from similar social backgrounds to their pre-war predecessors. For some, it was the First World War that drew them into public health. Miss Goodall, for example, had never planned to earn her own living, and took no interest in studying for exams. A year in France learning the language, was followed by a course at Pitman's in stenography, 'though not with any particular idea of using either of these accomplishments.' During the war, 'life became very serious', and she took up nursing, became attracted to preventive work, and qualified as a health visitor.³⁸ Dorothy Parnell, who was educated at home by a governess, and later at the local High School and in Paris, enjoyed a round of parties and social activities, with no thought of earning her own living. At the first 'rumblings of war' she joined Red Cross classes and then nursed as a VAD. As soon as the war was over she 'decided that she must find some suitable way to earn her living', and trained as a sanitary inspector and health visitor.³⁹

Many of the first generation came from backgrounds of 'genteel poverty'. Experience of financial stringency was repeated in the next. Cicely Hale was born in 1884, the youngest daughter of a GP. She was educated by a succession of governesses, attended dancing and French classes, and took piano lessons.⁴⁰ After schooling, her life was one of dances, shopping and the theatre, although she eventually trained and worked as a private secretary. Her 'life took an unexpected turn' when she heard Emmeline and Christabel Pankhurst speaking in Hyde Park. As office-worker and crowd-gatherer for the Women's Social and Political Union (WSPU), she was actively involved in the militant suffrage movement, dodging the police, and generally caught up in the excitement of the cause. After leaving the WSPU in 1916, she took a clerical post in a babies' home, 'but soon realised that after the six thrilling years of working for the suffrage I could not tolerate work without a human interest'.⁴¹ She consulted a society that advised ladies on careers. When they found that she had no qualifications 'they depressed me considerably by saying that there was nothing for me but to become a companion.' She had been frustrated by her lack of contact with the babies in her post at the home and, since 'quite suddenly I knew that I wanted to work with babies', the solution lay in health visiting. Using her savings, she gave up her job, and paid for the training. Until 1916 she had

³⁸ WHO (Apr 1948), pp.4-5.

³⁹ *Ibid.*

⁴⁰ Hale, *Good Long Time*, p.32.

⁴¹ *Ibid.*, p.63.

lived at home with an allowance of £30 a year, but when her father retired, her allowance was stopped, and she had to fend for herself. She remembered that, 'This put a considerable strain on my resources which were slender'. When, towards the end of her training, she found herself 'penniless and in rather a hole', a friend came to the rescue with a gift of £5, and she then found a job as a part-time secretary, which tided her over until she was qualified.⁴² She went on to be superintendent of an infant welfare clinic in Marylebone for sixteen years.

Jessy Kent Parsons, a prominent health visitor in Tottenham in the inter-war period, 'was on the threshold of a promising career in music', when the death of her husband in 1908 left her a widow with a young daughter. She qualified as a health visitor in 1915.⁴³ For Elizabeth Jackson, who was born in 1905, the daughter of a solicitor, it was her father's early death that meant that she had to earn her own living. She trained as a nurse before qualifying as a health visitor and working at Paddington School for Mothers.⁴⁴ For some, public health work was not their first choice of career. Helen Townsend was the daughter of an engraver.⁴⁵ She wanted to go to art school, but her father refused to countenance the idea, saying that she had no creative ability. She was determined not to live at home, and to be merely 'a young lady', so she trained as a nurse, and worked at an infant welfare centre in Islington in the 1930s. Kathleen Harrison wanted to train as a barrister,

but no day dreams and no willingness for hard work could bring such a career within the practical reach of a girl in 1925 who had no capital behind her and the urgent need to earn her living at a reasonably early age.⁴⁶

She qualified instead for public health work, satisfying her early ambitions by involvement in local Labour politics. Marjorie Dean, whose father was a headmaster, was intended for an academic or teaching career, and read English at King's College, London. It was illness that changed the direction of her life when, in 1918, she had a severe bout of influenza. The doctor advised that she should not follow an 'indoor' career, and she decided that, if she could not teach children, perhaps she could 'help to keep them fit'. She trained as a health visitor at Battersea Polytechnic, and worked in Poplar and Wandsworth.⁴⁷

As in the pre-war period, education remained not just a question of academic attainments, but of developing the character and skills required for social work. In the early 1930s, the Headmistress of Queen Mary School, Lytham, was asked to outline

⁴² *Ibid.*

⁴³ Wellcome: Jessy Kent Parsons, biographical material (SA/HVA/G.2/3).

⁴⁴ WHO (May 1949), pp.10-11.

⁴⁵ *Ibid.*

⁴⁶ WHO (Dec 1948), pp.6-7.

the preparation that a health visitor might make at school prior to her professional training. She spoke not only of the relevance of courses in biology, physiology, hygiene, cookery and needlework, but also of the role of prefect or house captain, through which a potential health visitor might acquire a sense of responsibility. The development of her muscles, posture and gait might be developed through work in the gymnasium, and open-air organised games. Opportunities for public speaking given by the school debating society were valuable. The most important part of her school education, however, was that,

She should learn ... to have a balanced and proper attitude towards social problems and the world around her and the people in it; she should understand how ... those with whom her work will bring her into contact need special sympathy and understanding.⁴⁸

The age and experience of the 'ideal' recruit remained the same. As one health visitor explained in 1936, 'In the profession of health visiting it is possible to be considered too old after 35 years of age, and too young before 25 years of age – so it's got to be snappy!'⁴⁹ The situation with regard to the marriage bar remained variable. According to a survey conducted by the LSWS in 1936, out of 28 London boroughs, nine operated a bar, three had no regulations but in practice did not employ married women, and 16 had no bar.⁵⁰ Some married women did work in public health. In 1937, for example, one woman sanitary inspector in Fulham worked under her maiden name while married to another sanitary inspector.⁵¹

Training

Janet Campbell of the Ministry of Health remembered that there were two schools of thought at the time of the 1919 regulations. One held that health visiting was primarily a social service, and could best be done by 'the educated woman', preferably with a university degree. The other considered that it was best done by the trained hospital nurse.⁵² Although there was constant debate, the latter opinion dominated in the 1920s and 1930s, as regulations allowed nurses to qualify after ever-shorter periods of training, and numbers of non-nurses entering the occupation dwindled.

In 1922 the Board of Education recognised that too few nurses were training because they could not afford a year of full-time study, and it approved whole- and

⁴⁷ WHO (Jul 1948), pp.4-5.

⁴⁸ Bailey, 'Preliminary education of health visitors', *JRSI* (LIV, 1933-1934), pp.415-417

⁴⁹ WHO (Mar 1936), p.5.

⁵⁰ LSWS annual report, 1936, p.16

⁵¹ *Sussex Daily News* (1 Sep 1937), p.12.

⁵² *JRSI* (LIII, 1932-1933), p.461.

part-time courses of less than a year for trained nurses, and those who had been working as health visitors under local authorities.⁵³ The 1909 London Order was finally rescinded, and the Ministry of Health issued new regulations. All health visitors were henceforth to be fully trained nurses holding *either* the CMB certificate or that of a sanitary inspector or health visitor, or, if they did not have a nursing qualification, to hold the new diploma.⁵⁴ A survey by the WSI&HVA of the 1,974 health visitors employed in England and Wales in 1925, revealed that they held between them 22 different certificates or varieties of experience in 88 combinations.⁵⁵ The combination held by the largest number (431) was a certificate of three years' general nursing training plus the certificate of the CMB. Next came a combination of these two certificates with one of the RSI qualifications (held by 206 women). The Board of Education Diploma, held either alone, or combined with other qualifications, was held by just 44.⁵⁶ By the mid-1920s the vast majority of health visitors were trained nurses.

'In deference to a generally expressed opinion', regulations were revised yet again in 1925, responsibility for them transferred from the Board of Education to the Ministry of Health, and the basis became a three-year hospital training, although the alternative longer course for non-nurses still remained possible.⁵⁷ A trained nurse with the CMB certificate might become a health visitor on completion of a six-month approved course of training. A non-nurse had to do six-months' hospital training and gain the CMB certificate, as well as undergo a two-year course of training. Janet Campbell admitted that the training remained 'ill-balanced', and that the amount of time given to nursing was out of all proportion to the study of public health.⁵⁸ In 1925 the Ministry of Health also decided that there should be a central examining board that was independent of the training institutions, and the RSI took on the role.⁵⁹ The great and the good of the public health profession dominated the new board.⁶⁰ Perhaps under the influence of its own female officials, there were repeated attempts by the Ministry to secure the appointment of more women, but the RSI was never convinced.⁶¹ Hull's Maternity and Child Welfare Officer, who organised a scheme of

⁵³ Board of Education Circular 1267, 9 Jun 1922.

⁵⁴ *BMJ* (22 July 1922), p.153.

⁵⁵ *Public Health and Health Visitors* (WSI&HVA, 1928), p.46; WSI&HVA, 'Memorandum on matters Connected with the Administration of the Maternity and Child Welfare and Other Acts', p.7.

⁵⁶ *Ibid.*, p.13.

⁵⁷ *JRSI* (LIII, 1932-1933), p.461.

⁵⁸ *Ibid.*

⁵⁹ RSPH: 'Scheme for conducting examinations for health visitors', May 1925.

⁶⁰ RSPH: RSI Council, Mar 1925, pp. 289-290 and Mar 1938, p.53.

⁶¹ RSPH: RSI Health Visitors Examination Committee, 5 Oct 1925, p.7, Jul 1929, p.80, Oct 1936, p.123; RSI Council, Oct 1925, p.371, May 1928, p.105.

training, thought that there were too many MOHs on the board, and that they did not appreciate 'the health visitor's point of view'.⁶² From April 1928, no new appointment as a full-time health visitor was sanctioned by the Ministry of Health unless the candidate had a qualification from the new central examining body. Under the Local Government Act of 1929, a health visitor was required to hold one of the following qualifications: the new RSI certificate; the old Board of Education diploma; or previous service as a health visitor under a local authority, if approved by the Ministry of Health.⁶³ Requirements for tuberculosis visitors were less strict. They were required to hold *either* one of these qualifications or nursing training together with at least three months experience at a tuberculosis sanatorium, hospital or dispensary.⁶⁴

Training institutions responded differently to these changes. From 1922 Battersea Polytechnic arranged shortened courses – both a full-time day-course of six months, and a part-time course involving six months' evening classes for theory and three months day classes for practical work.⁶⁵ The fee for the evening course was considerably cheaper than the full-time courses, making the training much more accessible.⁶⁶ The NATHS offered a full-time shortened course for trained nurses lasting two terms, and a part-time one, lasting for eight to nine months.⁶⁷ Bedford College, by contrast, never offered any training less than one academic year in length for trained nurses, as there was 'not sufficient educational value attached to a six month's course'.⁶⁸ Training at King's remained in abeyance.

It was the common experience of all the courses that numbers of one- and two-year students remained small. In 1930, Battersea Polytechnic was encouraged that a few two-year, non-nurse candidates were still training, although by the end of the decade they were 'disappointingly few', while the number taking the short course was limited only by the facilities for practical training.⁶⁹ The NATHS also had more applicants than it could accommodate for its six-month course, but discontinued its two-year course in 1933, since there were so few applications.⁷⁰ Between 1932 and 1938 only 18 non-nurses, taking a two-year training, passed the RSI examination, compared with 1228 nurses taking a six-month course (Fig. 15). Numbers of nurses opting for one-year courses were also small, and institutions relying on this route

⁶² PRO: Health visitors training centres, Hull University College (MH 53/121).

⁶³ WHO (Dec 1931), p.2.

⁶⁴ *Ibid.*

⁶⁵ NH (XV, 1922), p.14.

⁶⁶ Surrey: BP Calendar, 1924-1925, p.18 (I, 0531.009).

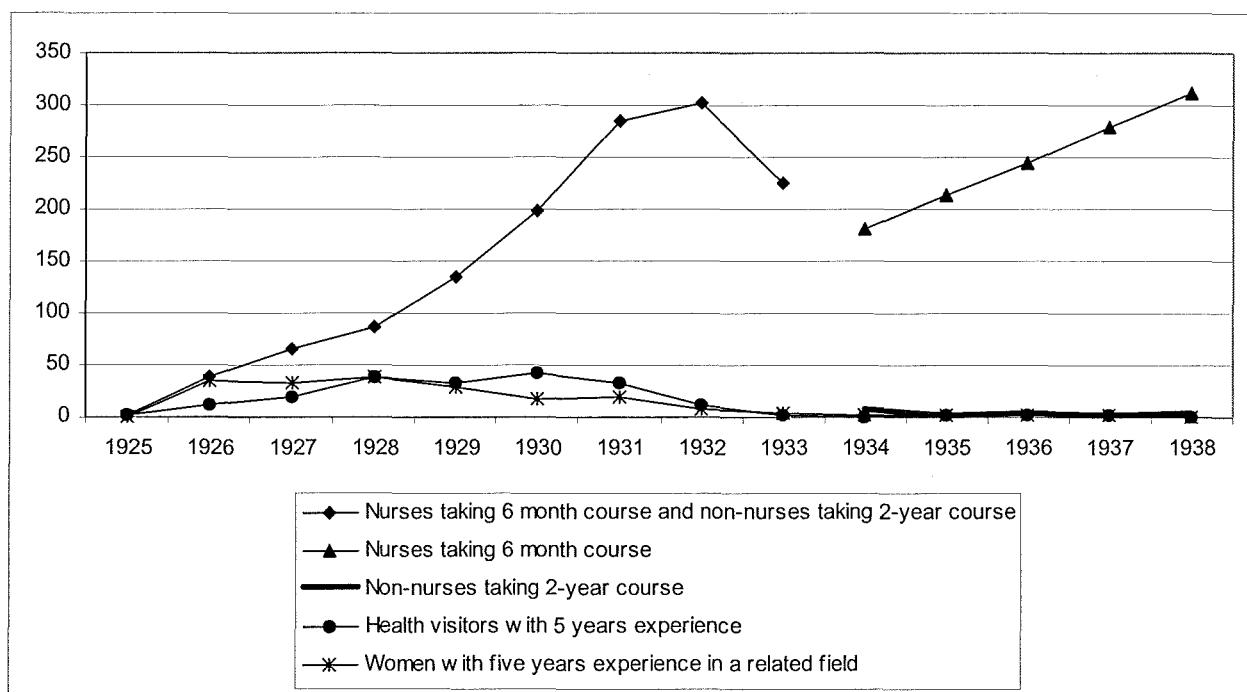
⁶⁷ NH (XV, 1922), p.71 & (XVI, 1923), p.99.

⁶⁸ RHBNC: BC Principal to Campbell, 1 Dec 1921, BC Principal to Board of Education, Apr 1925 (AL/330/2).

⁶⁹ Surrey: BP, Principal's report, 1929-1930, p.11; 1938-1939, p.10.

were unable to attract applicants. In 1928 KCHSS re-started a one-year course for trained nurses, but there were no entries in this, or subsequent, years.⁷¹ Between 1925 and 1931 only 15 women were awarded Bedford College's Public Health Workers certificate, and after 1931, although it was never officially withdrawn, there was not a single successful candidate. There was no advantage to a nurse in spending nine or twelve months training, when the same certificate might be obtained in six. Those who did follow this option had either obtained scholarships, or were living at home.⁷²

Figure 15: Successful candidates in the RSI health visitor examinations, 1925-1938⁷³



Despite these changes, in 1927 Janet Campbell was still concerned about the 'disappointingly small' number of nurses training, and thought that there was likely to be a serious shortage of health visitors when the certificate became compulsory in 1928. The primary reason was the expense of training. One solution was to encourage local authorities to employ part-time student health visitors.⁷⁴ In Liverpool, for example, a one-year course was offered, with nurses employed part-time as

⁷⁰ TNA: NATHS visitation report, Jun 1938 (MH 53/88).

⁷¹ KCL: KCW Household and Social Science Department annual reports/calendars.

⁷² TNA: JCC Survey of Syllabuses of courses for training for health visitors, revised 1938 (MH 53/114).

⁷³ RSPH: Committee on the Examination and Certification of Sanitary Inspectors under the Public Health (London) Act, minutes.

probationer health visitors, on a salary of around two thirds of the usual starting salary, their paid work serving as the required practical training. In Birmingham and Durham local authorities paid half the ordinary salary during a six-month course, and for six months subsequently.⁷⁵ All such schemes concentrated on training nurses. The College of Nursing (CON) was also approved by the Ministry of Health as a training centre under the 1925 scheme, and conducted a six-month course in conjunction with Bedford College.⁷⁶ It also developed evening refresher courses for those already working in public health, and a correspondence course.

The WSI&HVA, and the educational institutions disputed that heavy reliance on the nursing profession was healthy for the occupation. After the issue of the 1922 regulations, Battersea Polytechnic felt that shortened courses would 'lower the standard of training', and foresaw

a flow into the public health service of nurses, with very inadequate training in public health work, and the gradual disappearance of well-educated young women.⁷⁷

Lecturers at the Polytechnic were convinced that, unless the student was 'unusually bright', she was apt to feel overwhelmed, and that six months was insufficient for her to adjust to her 'new sphere'.⁷⁸ Those with a considerable amount of hospital experience were also 'difficult to convert' to the preventive outlook, and did not take readily to theoretical work.⁷⁹ The Head of the Hygiene Department did not consider that nursing training was 'educational enough'. It was outweighed by 'routine and technique', and teaching tended to be 'parrot fashion'. In the hospital, a nurse acted under orders, whereas a health visitor depended on her own initiative. There was also a lack of scientific background, which became evident when the pupils started courses in hygiene and physiology.⁸⁰ She felt that

The inadequacy of six months for a public health training will not need emphasising to anyone who has grasped the significance of maternity and child welfare work as essentially preventive and who has had some experience of social life in the poorer districts of our large towns.⁸¹

Other academic social workers also noted that, in view of the social and preventive work required from the health visitor, the amount of social training was inadequate. While

⁷⁴ Wellcome: WSI&HVA Executive, 24 Jan 1927 (SA/HVA/B.2/13).

⁷⁵ TNA: minute sheet, Feb 1928 (MH 53/112).

⁷⁶ CON: Education and Examination Committee, 24 Sep 1925 (RCN 7/1/1).

⁷⁷ Surrey: BP, Principal's report, 1922-1923, p.5.

⁷⁸ TNA: BP, visitation report, May 1938 (MH 53/87).

⁷⁹ TNA: BP, visitation reports, Nov 1919, (MH 53/60), May 1938 (MH 53/87).

⁸⁰ TNA: BP, visitation report, May 1938 (MH 53/87).

⁸¹ Wilkins, *Introduction*, p.47.

in the early days of the appointment of health visitors the work was regarded more from the "social" aspect, the tendency now is to place the medical side to the fore.⁸²

The WSI&HVA also deplored the insufficient stress placed on 'social training' after the 1922 regulations.⁸³ It recommended an equal balance between nursing and social science.⁸⁴ It considered the secondary school as 'the most satisfactory ground for recruitment', and the necessity for the universities to continue to arrange courses of training 'could not be too strongly urged'.⁸⁵ Like the CON, it provided a short, part-time course itself, in collaboration with both King's and the LSE, whereby those working in or near London, might study for the diploma, and also offered a correspondence course.⁸⁶ The Association considered that a third avenue of training should be available for those with a university social science certificate or diploma and, although it was not developed, discussed offering a part-time course for students with science degrees or social science training.⁸⁷

Although all the courses on offer differed widely in the amount of time allotted to practical and theoretical work, methods of instruction, and the number of hours allotted to each subject, the amount of time dedicated to social and economic questions was a matter of particular controversy.⁸⁸ The Ministry was concerned that the RSI Board did not include enough women with experience of economics, 'social subjects' and social work, and regularly suggested the names of suitable women.⁸⁹ The RSI did not see this as a priority.⁹⁰ One MOH examiner felt that, although the syllabus provided for a general knowledge of sociological work, recent examination questions indicated

a spirit which I think is abroad at present whereby the health visitor, it is implied, should be a sociological worker in a sense which is quite beyond her professional duties.⁹¹

Another MOH approved 'the practically complete reversal of the view' that the only proper preparation for health visiting was 'an academic one, and the most suitable people to give the courses and conduct the examinations are members of staff of the

⁸² Macadam, *Equipment*, p.130.

⁸³ NH (XV, 1922), p.101.

⁸⁴ Wellcome: WPHOA Executive, 2 May 1934 (SA/HVA/B.2/18).

⁸⁵ *Ibid.*, 26 Jun 1925 (SA/HVA/B.2/12), 9 Mar 1938 (SA/HVA/B.2/20).

⁸⁶ NH (XV, 1922), p.129; Wellcome: WSI&HVA annual report, 1927, pp.8-9 (SA/HVA/A.1/19); WSI&HVA annual report, 1921-1922, p.13 (SA/HVA/A.1/14); NH (XV, 1922), p.156.

⁸⁷ Wellcome: WSI&HVA annual report 1933, pp.12-13 (SA/HVA/A.1/24); WSI&HVA Executive, 9 Apr & 29 Aug 1924 (SA/HVA/B.2/12). WHO (Mar 1932), pp.6-8.

⁸⁸ WHO (Jan 1934), pp.1-2.

⁸⁹ RSPH: RSI Health Visitors Examination Committee, May 1933, p.105; Surrey: BP 'Heads of Department of Hygiene / Health / Human Biology, 1893-1983' (P5 0397).

⁹⁰ RSPH: RSI Health Visitors Examination Committee, Mar 1926, p.25, May 1926, p.31, Jun 1929, p.68, Mar 1933, p.103.

universities.' To him, that had been sheer 'folly'.⁹² A new emphasis on nursing and midwifery qualifications with a short period of specialist training was to be welcomed.

Recruitment

By the 1920s, when nursing had become the normal route into health visiting, the difficulty of attracting the 'right' type of woman to public health work had become a pressing issue. In 1921, the LSWS said that 'efficient workers would not to-day be attracted by the salaries at which these women had taken up their work ... in the spirit of pioneers opening up a new and interesting career for women'.⁹³ An editorial in *National Health* in 1919 claimed that educated women, who had to depend on their own earnings, were debarred from becoming health visitors, or quickly left the occupation for other work. Those that were left were of 'varying degrees of fitness' for the occupation.⁹⁴ According to Lady Sprigge, of the career information bureau of the LNSWS, by 1928 many fathers, when they were told of the salaries and conditions of service for health visitors, were 'very unwilling to allow them to adopt a profession where prospects were so bad'.⁹⁵ The cost of training compared with the potential return was considered to be a determining factor.⁹⁶ One commentator felt that, it was only due to 'the tradition of nominal salaries for hospital nurses' that it was possible to secure entrants to health visiting.⁹⁷ Many earned extremely low salaries in their hospital appointments, and felt that public health salaries were good, 'until they had had experience of living on it'.⁹⁸

The balance between age, experience and vocation was a particular problem when recruiting ex-nurses. One Ministry official was concerned that no nurse had entered the first CON course straight from her general training, perhaps because

health visiting, as an occupation, is not sufficiently attractive to encourage well trained young nurses to enter its ranks. It may be that the course is too costly for a nurse until she has had an opportunity of saving, or that at younger ages institutional life offers greater attractions.⁹⁹

Of the nurse candidates rejected by Battersea Polytechnic, some were considered too old, being over forty, whilst others were deemed to lack 'any real

⁹¹ RSPH: RSI Health Visitors Examination Committee, Oct 1933, p.107.

⁹² ME (LXXIV, 1924), p.200.

⁹³ TWL: LSWS Joint Committee of Women Employed by Municipal Authorities, minutes, 27 Oct 1921 (2/LSW).

⁹⁴ NH (XII, 1919), p.49.

⁹⁵ *Public Health and Health Visitors* (WSI&HVA, 1928), p.43.

⁹⁶ Hodgson, 'Health department', *Time and Tide* (Jun 1921), p.575.

⁹⁷ JRSI (LIV, 1933-1934), p.399.

⁹⁸ Wellcome: WPHOA Executive, 5 Dec 1930 (SA/HVA/B.2/16).

⁹⁹ TNA: Report by E.G. Creaser, 9 Nov 1926 (MH 53/120).

interest' in the work of a health visitor.¹⁰⁰ During interview, many nurses revealed that they were tired of institutional life, or believed that health visiting was an easy option.¹⁰¹ For one senior woman inspector, 'The successful and capable nurse is needed in her own profession, the unsuccessful one is certainly not wanted elsewhere'.¹⁰² For another commentator,

There is, I grieve to say it, the nurse who, almost worn out with years of arduous toil, imagined this form of employment might be a sort of remunerative rest cure.¹⁰³

High school girls were not entering nursing in sufficient numbers, and this affected the quality of recruits. Battersea Polytechnic rejected many nurses because they had only an elementary education.¹⁰⁴ The CON also turned away those who were 'lacking in general education'.¹⁰⁵ Each training institution placed its own interpretation on 'suitable previous education' and students rejected by one institution might be accepted by another.¹⁰⁶ The WPHOA and the educational institutions generally recommended that candidates should hold educational qualifications of the standard of the School Leaving Certificate or higher, but realised that, while some institutions made 'a very careful selection', others accepted 'almost all students who presented themselves'.¹⁰⁷ In 1934, a local scheme run in Manchester stated that, for the last three years, only one student had held a School Leaving Certificate. Many nurses did not possess it, and would be excluded if it were compulsory.¹⁰⁸ This suggests that there was a shortage of the type of woman that the educational institutions, the WPHOA and CON, wished to see enter the occupation.

ORGANISATIONS

Women Public Health Officers Association

All these changes meant that the WSI&HVA ended the 1920s a very different organisation from the 'little band of pioneers' who had met in the 1890s. By the middle of the decade, membership stood at over 400, and it reached 1,000 in

¹⁰⁰ TNA: Health visitor training: regulations and grant in aid (MH 53/101).

¹⁰¹ *Ibid.*

¹⁰² Maynard, *Women in the Public Health Service*, p.20.

¹⁰³ *BJN* (LXII, 1919), p.38.

¹⁰⁴ TNA: Health visitor training: regulations and grant in aid (MH 53/101).

¹⁰⁵ RCN: Education and Examination Committee, 1 Jul 1936, 4 May 1937, 2 Nov 1937 & 5 July 1938 (RCN 7/1/1).

¹⁰⁶ WHO (Jan 1934), pp.1-2.

¹⁰⁷ JCC, 'Survey of Syllabuses of Courses of Training for Health Visitors', p.16; Wellcome: JCC minutes, 27 Jan 1934 (SA/HVA/B.26/1).

¹⁰⁸ Wellcome: JCC minutes, 17 Nov 1934 (SA/HVA/B.26/1).

1931.¹⁰⁹ By the 1930s it accepted fully-qualified, municipally-employed women sanitary inspectors, health and tuberculosis visitors, superintendents of maternity and child welfare centres, midwives, school nurses, infant life protection visitors and clinic nurses, and also qualified and salaried superintendents of infant welfare centres and health visitors, who worked for voluntary committees. In addition, women might join as associates if they did not hold posts, but were qualified as sanitary inspectors or held the hygiene diploma of Bedford College, the King's College diploma in household and social science, or a recognised health visitors' qualification. In 1930 the Association changed its name to the Women Public Health Officers Association (WPHOA), to reflect its membership, although the great majority of members were health visitors.¹¹⁰ Major campaigns during the period were for the improvement and standardisation of salaries and conditions of service and on training, qualification and a preliminary educational standard for new entrants to the profession. Another was for the direct administration of the 1918 Maternity and Child Welfare Act by local authorities. The delegation of health visiting to district nursing associations was singled out for particular criticism. According to the Association, and some MOHs, a district nurse put her nursing work first, tended to regard her public health duties as 'of minor importance', and did not possess 'the Public Health outlook'.¹¹¹ The Association specifically excluded district nurses from membership.¹¹² It repeatedly insisted that all health visiting should be carried out by the officers of the local authority, rather than delegated to district nursing associations, and that all women who undertook health visiting should be fully qualified.¹¹³

Many of the Association's inter-war campaigns were led from the top. There was no more influential a figure in shaping Association policy during this period than Amy Sayle, who was Chairman for nearly 30 years (1921-1949). She exemplified many of the principles that the Association stood for. Born in 1886, the daughter of a solicitor, her childhood ambition was to become a medical missionary.¹¹⁴ It was while she was studying at Newnham College, Cambridge, that she heard Octavia Hill, for

¹⁰⁹ WHO (Oct 1931), p.1.

¹¹⁰ WHO (Mar 1930), p.3; (Jul 1930), pp.1-2.

¹¹¹ WSIA, 'Memorandum on matters Connected with the Administration of the Maternity and Child Welfare and Other Acts', p.2. See, for example, Eustace Hill in *Public Health and Health Visitors* (WSI&HVA, 1928), p.5-8; debates in the pages of *PH* (XXXV, 1921-1922), pp.235-236, 296.

¹¹² NH (XIV, 1922), p.178.

¹¹³ WHO (Mar 1929), pp.4-5. Wellcome: WSI&HVA annual report 1929, p.9 (SA/HVA/A.1/21).

¹¹⁴ Biographical details about Amy Sayle from WHO (May 1948 & Aug 1970); Hutchinson's *Woman's Who's Who* (1934); Newnham College Register (1905); LSE: Fabian Society membership cards; and Westminster: CWHS annual report, 1912, (1352/19). In 1918 she had

whom she was to have a life-long admiration, speak. As a result, she transferred her allegiance from foreign missionary service to domestic social work. She trained as a housing manager, and did care committee and almoners work, before studying for public health qualifications at the NATHS. After nursing as a VAD, in 1916 she became a tuberculosis visitor for Westminster City Council, and then a housing inspector under the Ministry of Health. This post resulted in the publication of a book on housing policy.¹¹⁵ Sayle was a member of South Kensington Labour Party and of the Fabian Society. She stood for Parliament as Labour candidate for Hemel Hempstead in 1924.¹¹⁶ In 1934 she was elected to the LCC, as representative of the Kennington division of Lambeth, and in 1946 she became an Alderman. She served on various LCC Committees, and acted as the governor of LCC schools, Avery Hill Training College and Battersea Polytechnic. Amy Sayle's personal vision of health visiting was that it was 'a branch of social work, the object of which is to palliate, to improve or to remove existing social conditions.'¹¹⁷ While health visitors bore a part in 'uplifting the whole standard of life of the community', there were four chief levers in this process – 'better wages, houses, health and education' – and all were so intimately connected that 'if wages fall below a certain value, healthy life is impossible.'¹¹⁸ Her background and values flavoured much of the work of the WSI&HVA in the inter-war period. She was a university-educated social worker, rather than a trained nurse, and also a committed socialist.

The WSI&HVA also drew leaders and figure-heads from outside the profession. Trade union activist Gertrude Tuckwell served as President twice (1921-1922 and 1928-1929) and at other times maintained close links as a Vice-President. Viscountess Rhondda was President in 1923. She had founded the 'equalitarian' women's pressure group, the Six Point Group (SPG), and was, less radically, Vice-Chairman of the National Baby Week Council.¹¹⁹ In 1924 Dame Maude Burnett stepped into her place. She was the first woman mayor of Tynemouth Borough Council, and was engaged in social work in connection with women and children.¹²⁰ She was followed, in 1926, by Conservative politician the Marquess of Salisbury, who was also a Vice-President for more than thirty years. Finally, in 1930, Cynthia Colville

applied to become social studies course director at Bedford College London. See RHBNC: Social Studies – Director of course appointment (AR/330/7).

¹¹⁵ Sayle, *Houses of the Workers*.

¹¹⁶ NH (XVI, 1924), p.160.

¹¹⁷ Sayle, 'Women as health and tuberculosis visitors', p.88.

¹¹⁸ *Ibid.*

¹¹⁹ Harrison, *Prudent Revolutionaries*, pp.4, 17; Eoff, Viscountess Rhondda, pp.69-70. Her father had been the first chairman of the Baby Week Council. NH (XVI, 1923), p.5.

took up the role, remaining President for the next thirty years. She was from an aristocratic background, and took a philanthropic interest in maternity and child welfare.¹²¹ Vice-Presidents were also a diverse group, and included figures from public health, local government and philanthropy, and an array of MPs of different parties, including Ellen Wilkinson and Nancy Astor. Amy Sayle remembered an annual dinner at which the Marquess of Salisbury

presided wearing the ribbon of the Garter; Miss Margaret Bondfield, as a vice-president, speaking at the same dinner, suggested humorously that Lord Salisbury and she might meet at the TUC ... That such a suggestion was even possible was surely a tribute both to Lord Salisbury, our President, and to "the English way of life".¹²²

With Presidents including the aristocratic Liberal philanthropist Cynthia Colville, the trade unionist Gertrude Tuckwell, and the militant suffragist and equality campaigner Lady Rhondda, the WSI&HVA was impossible to categorise by its choice of figure-heads and supporters.

Trades unionism

Some believed that the Association should become a trade union. Labour activist Susan Lawrence, as a Vice-President, was 'instrumental' in this movement.¹²³ Members in favour of the move highlighted the practical benefits. The Association would be able to draw on TUC expertise, have increased influence with central and local authorities, gain the backing of the Labour Party, and be able to increase parliamentary lobbying.¹²⁴ Others feared that it would lower the professional status of the WSI&HVA. Only one other women's 'professional' association had yet registered, and the SIA had recently decided, by a very slim majority, against this. They felt that the Association 'should remain distinctly professional' and 'had little in common with industrial organisations'.¹²⁵ Miss Dick claimed that 'ours is not a trade but a profession' and being in 'ones and twos' rather than the thousands, as were industrial workers, meant that it was impossible to act like a trade union. Another member felt that it would discourage many health visitors from joining.¹²⁶ In 1918, a vote was taken by postal ballot and it was a tight call. 46 members voted for trade union

¹²⁰ Hutchinson's *Woman's Who's Who*, (1934); *Lady's Who's Who* (1938-39); *Who's Who* (1939); *Who Was Who* (1941-1950).

¹²¹ *The Queen* (4 Jun 1930).

¹²² *WHO* (May 1947), p.19.

¹²³ MRC: Amy Sayle to Mrs McKay, 1 May 1952 (MSS.292/60.3/1); *NH* (XI, 1918), p.55. Amy Sayle was also at the forefront of this group.

¹²⁴ Wellcome: WSI&HVA minutes, 26 Jun 1918 (SA/HVA/B.1/6); *NH* (XI, 1918), p.132.

¹²⁵ Wellcome: WSI&HVA minutes, 2 Oct 1918 (SA/HVA/B.1/6).

¹²⁶ *NH* (XI, 1918), p.132.

registration, and 40 against.¹²⁷ Although the Association did register, there were still many members left to convince and, a year after registration, the WSI&HVA issued a leaflet justifying the decision.¹²⁸ The Association also affiliated to the WTUL, but its conversion to trade unionism came too late for it to play much of a role in the League, which presented its last report in 1921, when its functions were taken over by the TUC Parliamentary Committee.¹²⁹

The WSI&HVA debated affiliation to the TUC. In 1924 only 36 members returned ballot papers, 32 of which were in favour of affiliation.¹³⁰ Its initial application was, however, refused. It seems that, if it was difficult to persuade members of the Association that they should support trades unionism, it was equally difficult to persuade the TUC that women public health officers were suitable trade unionists. One TUC representative stated that the appearance of Lady Rhondda on the Association's headed paper had prejudiced the Committee, which was also not satisfied with the treatment of associate members, and the lack of a strike clause.¹³¹ The Association managed to iron out these difficulties, and was formally affiliated in September 1924. It was an unusual and bold step. Trades unionism was slow to take root in the health service. Elitism and concern for professional status have been suggested as possible reasons.¹³² In nursing, especially in the voluntary hospitals, it has been argued, the prevailing ideology of absolute obedience and making a virtue of bad conditions was responsible for trade unionism being particularly weak.¹³³ One nursing historian has suggested that

Many nurses were ladies and many others had become nurses in the hope they would be regarded as such. Association with working-class activities would have been in conflict with the social aspirations of many members of the profession.¹³⁴

According to another

with its members face to face with the reality of poverty, unemployment and social deprivation ... the Association [WSI&HVA] was far more radical than any of the other [health service] associations or even early nurses' unions.¹³⁵

Within the TUC, the WSI&HVA was not just isolated as a health service union. The 1920s and 1930s was a period of dramatic decline in the number of women in trade

¹²⁷ *Ibid.*

¹²⁸ *To All Women Sanitary Inspectors and Health Visitors* (WSI&HVA, [1920]).

¹²⁹ Wellcome: WSI&HVA minutes, 5 Mar 1919 (SA/HVA/B.1/6); *NH* (XI, 1919), pp.260-261, (XII, 1919), pp.20-21; TUC: WTUL report, Sep 1921.

¹³⁰ Wellcome: WSI&HVA annual report, 1924, p.8 (SA/HVA/A.1/16), Executive, 14 May 1924 (SA/HVA/B.2/12). *NH* (XVI, 1924), p.29.

¹³¹ Wellcome: WSI&HVA Executive, 4 July 1924 (SA/HVA/B.2/12).

¹³² Carpenter, *All for One*, p.29.

¹³³ Carpenter, *Working for Health*, p.169.

¹³⁴ Abel-Smith, *History*, p.132.

unions.¹³⁶ The first impression of the Association's delegate to the TUC in 1938 was, 'Men, men and yet more men'.¹³⁷ On its 90th anniversary in 1986, the then Health Visitors Association still remained one of the few trade unions affiliated to the TUC with a predominantly female membership, and a woman general secretary.¹³⁸

After affiliation, the Association used the lobbying machinery of the TUC. Resolutions in Congress were followed by deputations to the Ministry of Health. In addition, the TUC facilitated the Association's use of the local machinery of organised labour, particularly the local trades councils. These were sceptical about the status of the WSI&HVA, and asked for confirmation that it was a registered trade union, illustrating its unusual position.¹³⁹ Affiliation to the TUC remained controversial. In 1932 The Treasurer moved an emergency resolution on disaffiliation. She felt that certain economies should be made, and that the affiliation fee was one item that might be cut. She also felt that the TUC was 'a political organisation', and that it was 'unfortunate' that, as an organisation of local government officers, the Association was affiliated.¹⁴⁰ Several members strongly opposed the motion, arguing that the Association had gained a great benefit from its connection with the TUC. In a ballot only 60 papers were returned voting in favour of disaffiliation, out of a total membership of over 1,000, and so the Association remained part of the TUC.¹⁴¹ Because of the small number of ballot forms returned in this, and previous, votes on trade unionism, it is difficult to judge the views of the majority of women public health officers. A large number belonged to the CON, which eschewed trade unionism completely.

Nursing organisations

Since the Association based its membership regulations on the possession of specialist public health qualifications, there was a perception that it snubbed trained nurses. This attitude jarred with the ambitions of the nursing profession. Maggs has suggested that general nurse training became part of a strategy of 'occupational imperialism'. The fully-trained nurse saw herself as a member of an élite group, moving out of the hospital and into other fields in order to bring progress to

¹³⁵ Hart, *Behind the Mask*, pp.25-26.

¹³⁶ Boston, *Women Workers*, p.156.

¹³⁷ WHO (Oct 1938), p.5.

¹³⁸ *Morning Star* (26 Sep 1986), p.6.

¹³⁹ WHO (Apr 1932), pp.3-5. MRC: A.S. Firth to Hilda Gray, 8 Nov 1927 (MSS.292/843.5/1); circular letter from TUC General Council to the Secretaries of all Trades Councils, 8 Dec 1927 (MSS.292/843.5/1).

¹⁴⁰ WHO (Mar 1932), pp.6-8.

¹⁴¹ Wellcome: WPHOA Executive, 4 May 1932 (SA/HVA/B.2/16).

underdeveloped or backward areas.¹⁴² Changes in health visiting should be seen against the background of changes in nursing after the First World War, including the Nurses Registration Act and the establishment of the General Nursing Council. For one nurse in the 1920s

The nurses of to-day with their assured professional status, their standardised training, and the varied careers which lie before them, may well hope to take their full part in the work of preventive medicine.¹⁴³

The Royal British Nurses Association (RBNA) was the first nursing organisation to move into the public health arena. Founded in 1887 by Ethel Bedford Fenwick, suffragist, originator of the campaign for the state registration of nurses, and proponent of nursing as a high-status profession for educated women, it openly declared itself to represent nursing's élite.¹⁴⁴ Mrs Bedford Fenwick wanted nursing to be based on a standardised general training, employer-independent and with transferable basic skills followed by later specialisation.¹⁴⁵ The RBNA viewed public health work as just such a specialism, and in 1919 the Association of Trained Nurses in Public Health Work (ATNPHW) came into being under its auspices.¹⁴⁶ Organisation was necessary since

We must be prepared for competition in this vastly interesting field of work from women who consider other portals than those of the Nurse Training Schools will suffice to equip them for this work of national importance.¹⁴⁷

Membership was confined to fully-trained nurses who, in addition to their hospital certificate, held either a sanitary inspector's or health visitor's qualification.¹⁴⁸ Although its officers campaigned on training and salaries, the ATNPHW never became an effective pressure group, and was more of a forum for discussion and socialising.¹⁴⁹ Its activities dwindled during the 1920s. The Professional Union of Trained Nurses (PUTN), founded in 1919 as the only nursing association to be registered as a trade union, also formed a Public Health Section.¹⁵⁰ This passed resolutions in support of general nursing training as the basis of public health work, and in favour of higher salaries, which were its overriding concern.¹⁵¹

By contrast, the College of Nursing (CON), founded in 1916, was expressly prohibited by its articles from becoming a trade union and, unlike the RBNA, was

¹⁴² Maggs, *Origins*, pp.26-27.

¹⁴³ Viney, 'Trained nurse in public health', *JRSI* (XLV, 1924-1925), p.352.

¹⁴⁴ Maggs, 'Royal British Nurses Association', pp.29-32; Hart, *Behind the Mask*, p.38.

¹⁴⁵ Rafferty, 'Mrs Bedford Fenwick', p.2; Rafferty, *Politics of Nursing Knowledge*, p.66.

¹⁴⁶ *BJN* (62, 1919), pp.38-40; *NH* (XIII, 1921), pp.240-241.

¹⁴⁷ *BJN* (62, 1919), pp.169-170.

¹⁴⁸ *NH* (XIII, 1921), pp.240-241.

¹⁴⁹ *BJN* (68, 1922), pp.150-151.

¹⁵⁰ *BJN* (64, 1920), pp.260-261.

¹⁵¹ *BJN* (64, 1920), p.291; *BJN* (65, 1921), p.268.

closely associated with hospital management.¹⁵² It was condemned by the TUC as 'an organisation of Voluntary Hospital snobs'.¹⁵³ The College was insistent that trained nurses made the best public health workers, that the three-year general nursing training should be the common entry portal, and used the term 'public health nurse'. In 1921, the College's Council appointed a Public Health Advisory Committee, and in 1923 a Public Health Section was formed.¹⁵⁴ This does not seem to have set out any special qualifications for membership other than the general requirement of the College that members should be on the general nursing register.¹⁵⁵ By 1925 it had 376 members. As well as health visitors, school nurses and tuberculosis nurses, membership was gradually extended to district nurses, industrial nurses, midwives and school matrons.¹⁵⁶ Although competing for different categories of worker, the CON Public Health Section was a serious rival to the WPHOA. By 1936 it had a membership of 1,200, compared with the 1,600 members of the WPHOA.¹⁵⁷ The CON played on a perception that the WPHOA was anti-nurse. It was accused of advising health visitors not to join the WPHOA, because it 'took no interest in anyone with general nursing training', and of making other 'derogatory' statements – accusations which were strenuously denied.¹⁵⁸ The major issue dividing the nursing organisations from the WPHOA remained training, and the need for a register. The CON retorted that there was already a nursing register and that 'the small minority' of women public health officers who were not also trained nurses would soon 'cease to exist'.¹⁵⁹ Such differences limited co-operation, although joint action on salaries and conditions of service was occasionally undertaken.¹⁶⁰

Women's groups

Women public health officers continued to rely on the support of a variety of women's groups, although the prevailing climate and the map of organisations altered significantly after the First World War. There were five major organisations with which the WSI&HVA was involved in the 1920s and 1930s. It was affiliated to the supposedly 'equalitarian' SPG from 1921 to c.1933, and the supposedly 'new' feminist National Union of Societies for Equal Citizenship (NUSEC) from 1926 to

¹⁵² Hart, *Behind the Mask*, p.104; Abel-Smith, *History*, p.94.

¹⁵³ Quoted in Hart, *Behind the Mask*, p.60, Abel-Smith, *History*, p.143.

¹⁵⁴ CON, annual report, 1921, p.5.

¹⁵⁵ NH (XVI, 1923), p.121.

¹⁵⁶ CON, annual report, 1934, p.4 & 1935, p.9.

¹⁵⁷ Wellcome: WPHOA Executive, 4 Dec 1936 (SA/HVA/B.2/19).

¹⁵⁸ Wellcome: WSI&HVA Executive, 28 Mar 1928, 19 May 1928 (SA/HVA/B.2/13).

¹⁵⁹ TNA: Letter from the CON, 12 Jun 1924 (MH 53/112).

1932. Both the WSI&HVA and the nursing organisations worked closely with the London Society for Women's Service (LSWS), an organisation representing equality in the workplace for 'educated' professional women. Links with labour women were sustained through affiliation to the Standing Joint Committee of Industrial Women's Organisations (SJCWO). The Association also maintained its association with the National Council of Women (NCW), successor to the NUWW.

The WSI&HVA affiliated to the SPG in 1921, and representatives attended the Group's Executive Committee.¹⁶¹ It was represented on SPG deputations and demonstrations on the Sex Disqualification (Removal) Act, the equal franchise and political equality.¹⁶² The Association drew on the support of Lady Rhondda as President, and used the pages of the SPG's paper to publicise its views.¹⁶³ There were, however, major differences over protective labour legislation.¹⁶⁴ In 1930, the Association refused to support the SPG's 'Equal Rights Treaty', which included removal of some parts of the Factory Acts that applied to women only.¹⁶⁵ For the Association, 'if it was not possible to secure protection for men, it was better for the women to have it, than not to have any at all, and this was the view of the Trade Unions.'¹⁶⁶ Protective measures should be kept for women 'with a view to their being extended to men subsequently'.¹⁶⁷ The Association considered disaffiliation, but its representative on the SPG felt that, despite its opposition to protective legislation, it was 'doing useful work' in other directions.¹⁶⁸ By 1933, however, it was 'considered that little benefit could be derived from continuing affiliation', and the Association did not renew its subscription.¹⁶⁹

Relations with NUSEC were easier. Following earlier informal co-operation, the WSI&HVA formally affiliated in 1926.¹⁷⁰ NUSEC was of more practical support in

¹⁶⁰ See, for example, Wellcome: WSI&HVA Executive, 4 Dec 1929 (SA/HVA/B.2/14). RCN: Public Health Section, 3 Dec 1930 (RCN/6/1/2).

¹⁶¹ NH (XIII, 1921), pp.239-240, 265-266; Wellcome: WSI&HVA Executive, 1 Apr 1921, 29 Apr 1921 (SA/HVA/B.2/10).

¹⁶² WHO (Jun 1932), p.6; Wellcome: WSI&HVA Executive, 30 Jun 1922 (SA/HVA/B.2/10), 19 Jul 1923 (SA/HVA/B.2/11), 11 Nov 1925, 29 Jan 1926 (SA/HVA/B.2/12); WSI&HVA annual report, 1921-1922, p.6 (SA/HVA/A.1/14).

¹⁶³ See for example, *Time and Tide* (Oct 1923); Wellcome: WSI&HVA annual report, 1923, p.21 (SA/HVA/A.1/15).

¹⁶⁴ Wellcome: WSI&HVA Executive, 4 Feb 1927 (SA/HVA/B.2/13).

¹⁶⁵ *Ibid.*, 7 May 1930 (SA/HVA/B.2/14).

¹⁶⁶ *Ibid.*, 10 Apr 1931 (SA/HVA/B.2/15); WHO (Jun 1932), p.6.

¹⁶⁷ Wellcome: WSI&HVA Executive, 7 May 1930 (SA/HVA/B.2/14).

¹⁶⁸ *Ibid.*, 6 May 1931 (SA/HVA/B.2/15).

¹⁶⁹ *Ibid.*, 3 May 1933, 8 Nov 1933 (SA/HVA/B.2/17).

¹⁷⁰ Amy Sayle, 'Training of health visitors', *Woman's Leader* (XVII, May 1925), pp.141-142; TWL: NUSEC annual report 1925-1926, pp.68-70 (2/NSE/C/8)

passing resolutions and organising deputations.¹⁷¹ In return, the WSI&HVA supported NUSEC campaigns, including on family allowances.¹⁷² In 1927 NUSEC changed its outright opposition to any form of gender-based protective labour legislation. This was a controversial move. It led to the resignation of several prominent members, and the withdrawal of some affiliated societies.¹⁷³ The WSI&HVA, however, agreed with NUSEC's new stance.¹⁷⁴ Its decision to disaffiliate in 1933 was probably motivated less by matters of principle, than by the fact that the activities of the Council were starting to decline.

The LSWS formed a Joint Committee on Women Employed by Municipal Authorities in 1920. Women public health officers dominated the affairs of the committee through the combined efforts of the nursing organisations, voluntary associations, SIA, and WSI&HVA. The Committee publicised resolutions on public health salary scales, and wrote letters of protest to local authorities, women councillors and MOHs.¹⁷⁵ It attempted to provide a unified voice for women working in public health, but this was never easy. Defining the term 'fully-trained and qualified' was a particular problem.¹⁷⁶ It functioned by acknowledging that individual societies were not committed to resolutions carried by a majority, so that nursing organisations were able to withdraw support from resolutions on training.¹⁷⁷ The LSWS was a natural ally for women public health officers because of its emphasis on the opening up of new areas of work for professional women, and of improving their salaries. That it produced a pamphlet in the 1920s that argued that restrictive labour legislation was one of the main obstacles to women's emancipation, does not seem to have mattered.

Meanwhile, the WSI&HVA kept up links with labour women through the SJCIWO. This claimed to be 'the one body which can represent working women alike from the industrial, the political and the social point of view', its role becoming particularly important after the dissolution of the WLL in 1918, and the WTUL in 1921.¹⁷⁸ The SJCIWO sent a large number of letters of protest to individual

¹⁷¹ WHO (Mar 1932), p.2.

¹⁷² Wellcome: WSI&HVA Executive, 5 Jul 1926 (SA/HVA/B.2/13).

¹⁷³ Copelman, *London's Women Teachers*, p.235

¹⁷⁴ Wellcome: WSI&HVA Executive, 27 Nov 1925 (SA/HVA/B.2/12).

¹⁷⁵ LSWS annual report, 1921, p.13, 1922, pp.10-11, 1925, p.8, 1928, p.8, 1929, p.7. TWL: LSWS Joint Committee of Women Employed by Municipal Authorities, minutes, 16 Mar 1922 (2/LSW).

¹⁷⁶ TWL: LSWS Joint Committee of Women Employed by Municipal Authorities, memorandum, 12 Feb 1921 (2/LSW).

¹⁷⁷ TWL: LSWS Joint Committee of Women Employed by Municipal Authorities, minutes, 27 Feb 1921 (2/LSW).

¹⁷⁸ TWL: SJCIWO report, 1916-1917 (5/SJC); Collette, *For Labour*, pp.175-178.

authorities offering low salaries to women public health officers, and called the attention of the Labour Party and the TUC to the issue.¹⁷⁹ The WSI&HVA formally affiliated in 1924.¹⁸⁰ On the subject of protective labour legislation, the Association found a natural home here, and joined campaigns on factory regulation.¹⁸¹

The NCW maintained its role as an umbrella organisation for a very wide range of women's groups. The WSI&HVA was represented on NCW committees, and Secretaries of its Public Health Committee in the inter-war period included prominent women public health officials, such as Mrs Greenwood.¹⁸² In 1922, a Maternity and Child Welfare Committee was formed, which co-operated closely with the National Baby Week Council. The WSI&HVA used the NCW's support to argue for the appointment of more women sanitary inspectors, and on the issue of the low salaries of health visitors.¹⁸³

Health groups

The Association also participated in campaigns of pressure groups with an interest in health and welfare, such as the Maternal Mortality Committee (MMC), an alliance of Labour, Liberal and Conservative women led by Gertrude Tuckwell and May Tennant.¹⁸⁴ It put pressure on local authorities to implement the full range of services allowed by the 1918 Maternity and Child Welfare Act and, more controversially, drew attention to the general health of women, advocated birth control and considered poverty, low pay, unemployment and malnutrition as contributory factors in maternal mortality.¹⁸⁵ The WSI&HVA appointed representatives to attend the MMC, and backed its agenda in preference to that of the National Association for the Prevention of Infant Mortality.¹⁸⁶

Gertrude Tuckwell was also chairman of the Women's Health Enquiry Committee (WHEC). This included representatives from a wide range of women's

¹⁷⁹ TWL: SJCIWO report, 1917-1918, 1921-1922, p.4, Jan-Oct 1923, p.3, 1927-1928 (5/SJC); WHO (Jun 1932), pp.6-7.

¹⁸⁰ Wellcome: Executive, 8 Oct 1924 (SA/HVA/B.2/12).

¹⁸¹ Wellcome: WSI&HVA annual report, 1925, pp.7-8 (SA/HVA/A.1/17), WSI&HVA Executive, 28 Aug 1925 (SA/HVA/B.2/12); WHO (Jun 1932), pp.6-7.

¹⁸² BMJ (10 Jul 1909), pp.101-2; LMA: NCW Executive, 20 Jan 1922 (ACC/3613/1/5).

¹⁸³ LMA: NCW Executive, 17 Mar 1922 (ACC/3613/1/5), 12 Nov 1926, 29 Apr 1927 (ACC/3613/1/7).

¹⁸⁴ TUC: Gertrude Tuckwell, 'Reminiscences' (A/333-334).

¹⁸⁵ Palmer, *Women. Health and Politics*, pp.123-124; Lewis, 'In search of a real equality', pp.219-221; Williams, *Women and Childbirth*, pp.28-30;

¹⁸⁶ Wellcome: WSI&HVA Executive, 5 Oct 1927, 7 Mar 1928 (SA/HVA/B.2.13); WHO (Jul 1935), p.2. Palmer has observed how voluntary organisations were suspicious of the MMC's increasing emphasis on malnutrition. See Palmer, *Women. Health and Politics*, pp.144-145, *Mother and Child* (V, 1935), pp.397, 450-451.

groups. Amy Sayle was the WPHOA's official representative.¹⁸⁷ Its most famous product was a survey of maternal morbidity amongst working-class women, the result of poor nutrition in childhood and pregnancy. The results were published as Margery Spring Rice's *Working-class Wives*. As with the earlier *Round About A Pound A Week*, health visitors co-operated in the survey, and were particularly useful since they were used to interviewing mothers on personal matters.¹⁸⁸ Mrs Spring Rice stated that the work of collecting the histories contained in the book had lain mostly with health visitors 'and no words can express the admiration I have for these women officers'.¹⁸⁹ Alongside its more 'radical' demands such as family allowances, health insurance for all women and birth control, the WHEC supported the role of the health visitor, as a friendly counsellor, to whom a woman might talk more easily about her health, than to a doctor.¹⁹⁰ In 1939, the same year as the publication of *Working Class Wives*, the WPHOA formally adopted the principle of family allowances as part of its policy.¹⁹¹ One health visitor thought that Margery Spring Rice was 'in sympathy with the work of a health visitor' –

I can best describe it by comparing our work with the "bailing out of a boat". Unless someone will take up the far more urgent task of repairing the leak the value of the work is questionable.¹⁹²

She wanted to see the economic position of women appear more strongly in the conclusions to the book and, in particular, felt that

A personal allowance from the State to the wife would go a long way towards transforming her into a self-respecting, thinking individual. And if ever anyone earned their money these women and mothers would earn theirs.¹⁹³

Opinion was, however, divided. Another visitor held the view that

State aid by means of money allowances .. would rather tend to pauperise the wives ... the family should ... remain an independent unit, with personal pride..¹⁹⁴

Such differences point to the diversity of views that might be held by individual women public health officers. The latter opinion was voiced by a health visitor who was also a district nurse.

In the 1930s, the WPHOA supported groups that pointed to a link between unemployment, poverty and malnutrition, and campaigned for free milk, school meals

¹⁸⁷ Wellcome: WPHOA Executive, 1 Dec 1933 (SA/HVA/B.2/17).

¹⁸⁸ Wellcome: WPHOA Executive, 8 Nov 1933 (SA/HVA/B.2/17); Rice, *Working-class Wives*, p.26.

¹⁸⁹ WHO (Apr 1940), p.8.

¹⁹⁰ Rice, *Working-class Wives*, pp.47-48.

¹⁹¹ Wellcome: WPHOA Executive, 12 May 1939 (SA/HVA/B.2/20).

¹⁹² WHO (Feb 1940), p.3.

¹⁹³ *Ibid.*

¹⁹⁴ WHO (Mar 1940), p.8.

and increased allowances. It affiliated to the Committee Against Malnutrition in 1934, and to the Children's Minimum Council in 1936.¹⁹⁵ Many health visitors realised that mothercraft education was by no means an adequate solution to the results of severe poverty. In October 1933 London's public health workers were able to hear the controversial MOH, G.C.M. M'Gonigle, speak on the 'Nutritional dangers of a long period of economic depression.' The lecture was arranged 'as a result of numerous requests by health visitors'. Many worked in areas where a large proportion of families lived on benefits, and they noticed the 'gradual deterioration in the health of both mothers and children'.¹⁹⁶ According to the WPHOA's journal,

Workers for the welfare of mothers and young children have been growing increasingly uneasy about the question of adequate food and Dr. M'Gonigle's paper provided a centre around which these misgivings have crystallized and hardened.¹⁹⁷

It reported that there was a strong possibility that 'social or political action' would have to be taken to improve the nutrition of mothers and young children'. In 1934 the Association's resolution to the TUC was on 'the effects of the prolonged economic depression upon the nutrition of the people'. It called for extended provision of meals for schoolchildren, expectant and nursing mothers. The Association's delegate explained how it was impossible to provide an adequate diet for children on public assistance benefits, and that under-nourished children were likely to contract diseases. 'I am in daily contact with cases of anaemia, rickets and tuberculosis, much of which is due to malnutrition,' she said.¹⁹⁸ On the publication, in 1935, of the BMA's book *Family Meals and Catering*, the Association reported that the great bulk of the unemployed, and a large proportion of the employed, were not getting anything like enough to eat. Moreover, they 'could not get it even if they were miracles of virtue and economy and paragons among cooks into the bargain.' For these reasons, the BMA's book was a 'silent but glaring exposé of the scandal of underfeeding'.¹⁹⁹

CONCLUSION

It is dangerous to extrapolate, from the character of the WSI&HVA and its leadership in the inter-war period, the views, opinions and attitudes of individual women public health officers. It cannot, however, be insignificant that the Association was the first health service union to affiliate to the TUC, and that on some issues it was more comfortable with organisations of 'labour women' than with 'middle-class'

¹⁹⁵ Wellcome: WPHOA Executive, 7 Nov 1934 (SA/HVA/B.2/18), 8 Jul 1936 (SA/HVA/B.2/19).

¹⁹⁶ WHO (Oct 1933), p.9.

¹⁹⁷ WHO (Dec 1933), pp.1-2.

¹⁹⁸ WHO (Nov 1934), pp.6-7.

women's groups. Its simultaneous affiliation to the 'equalitarian' SPG and LSWS, the 'social feminist' NUSEC, the 'labour' SJCIWO and the 'mainstream' NCW, and the diversity of its Presidents should warn against too simplistic a use of such labels. All of these organisations provided valuable support for the Association's main aims of increasing the salaries and status of its members and providing a voice for women public health officers on social issues. In the 1930s these included malnutrition, as many women public health officers found that the education on domestic management and cookery that they provided was not an adequate response to grinding poverty. The WPHOA carried on its pre-war tradition of promoting public health as a form of social work and reform. By the end of the decade nursing dominated the profession and membership of the WPHOA was almost equalled by that of the Public Health Section of the College of Nursing, which eschewed trade unionism completely. The WPHOA feared that many nurses were not 'of the right type' and lacked 'the public health outlook'. Meanwhile, women sanitary inspectors had become a small minority within the public health profession.

¹⁹⁹ WHO (Oct 1935), pp.1-2.

10: CONCLUSION

This thesis answers important questions about who London's women public health officers were, what they did, and their views and attitudes. In so doing, it provides a significant new perspective on the development of the early twentieth-century public health services. It challenges the assumption that women public health workers were only, or merely, conduits through which an ideology of personal responsibility for health was imposed on the poor. It shows the importance of examining the complexity of middle-class female social activism in its own right, rather than as an adjunct to macro-studies of health policy or services. Women officers did not implement health services unthinkingly or uncritically. Indeed, the very ideology that underlay their work, that of 'the health visitor as mother's friend', meant that they were not only far from ignorant about working-class lifestyles and cultures, but in some cases became outspoken critics of the very policies and services that they represented.

The implications of this ideology of personal relationship for the status of women in professional life, is also important. Sociological models, in which the emotional and caring content of female-dominated occupations is seen as leading to their lower status, and to their 'aping' of male professional traits, cannot be applied here without modification. Male sanitary inspectors, and some MOHs, were threatened by the prominence given to women's social and educative public health work. It was accorded a higher prestige and greater independence than the closely supervised and delineated regulatory duties delegated to male inspectors. The integration of women into the existing professional hierarchy within local public health departments was a tense process. Although they fought for equal pay and legal authority, the women certainly did not wish to become 'mere inspectors', or even 'mere men'. They fought to maintain their higher status, challenged the loss of a wide 'humanitarian outlook', the downgrading of the social work element within health visiting, and the rise of nursing and routine clinic work that was perceived to be more amenable to medical control. This thesis shows that, when analysing the role of gender in relation to occupational status, the tensions between, and within, female 'caring' occupations were just as significant as those between male- and female-dominated occupations.

The thesis also examines the ways in which women public health officers participated in debates about the provision of health services, and campaigned, not only for their own professional status, but on behalf of the women they visited. It makes a contribution to an understanding of the complexity of the women's

movement, confirming that easy categorisation of either individual women, or of women's organisations, by class, political belief, or the relative adherence to 'equality' or 'social' feminism, is impossible. The sheer range of groups with which women public health officers were involved also demonstrates that an assessment of the women's movement as 'weak' in the inter-war period deserves re-evaluation.

In exploring these areas, three sets of relationships emerge as particularly significant: the female as opposed to the male sanitary inspector, the woman sanitary inspector as opposed to the health visitor, and the social worker as opposed to the nurse.

Men and women inspectors

London's women sanitary inspectors considered themselves to be different from their male colleagues. They were social reformers, part of a long tradition of female middle-class public service, drawn from backgrounds where medical or social work was important, and with an education and upbringing that promoted a publicly responsible, social service ethos. They were employed to influence the behaviour of the poor, rather than just to recognise sanitary problems and remedy them. In workshop inspection, for example, they were employed to educate and support the 'ignorant and timid' woman worker to make use of the legislation designed for her 'protection'. They did not, however, limit their work to this educative function, and saw close co-operation with groups aimed at wider social reforms as a natural extension of their official duties. Within and through their own organisation, the WSIA, they participated in debates on 'sanitary and social subjects'. Many also joined the suffrage movement because they wanted to influence legislation that dealt with working conditions, housing, health and welfare.

Women sanitary inspectors were aware of being pioneers, opening a new sphere of public work for women, and were anxious to prove their worth. Male sanitary inspectors, themselves from very different social and educational backgrounds, accused them of 'fussiness', a 'superior' attitude and of 'being on an entirely different plane'. Some MOHs also found them too independent, their reforming zeal interfering with their official work. Integrating them into local public health administrations, where a system of male rank and class determined the relationship between MOHs and male inspectors, was problematic. The women did not want to be 'mere' inspectors. They argued that the 'official' nature of the men's duties meant that they did not expend so much 'nervous energy', or suffer the same level of strain. They argued for higher pay on grounds, not of equality, but of difference.

Some received financial assistance from their families, or undertook the work from a sense of social service, but the majority did it to earn a living. Many were used to tight budgets, to worrying about how to make ends meet, and to doing their own housework. They did, however, have to be protected from the worst results of their daily contact with poverty, and from a 'coarsening of fibre'. Maintaining middle-class standards of femininity and respectability was important. Most trained at the National Health Society, with its elite connections and track record of philanthropic work among the poor. For some, being allowed any sort of practical training for a public role was enormously significant. The Bedford College hygiene course provided a rare opportunity to study laboratory science for those for whom a full medical education was out of the question at this date.

From the mid-nineteenth century, sanitary home management was a respectable role for middle-class women. Men were 'sanitary engineers', but women needed to understand the basic principles of drains, sinks and WCs, in order to oversee their correct domestic management. This division of labour was maintained once women became salaried public health officers. Knowledge of drainage was an important foundation for their duties, but they did not claim, or even desire, the right to oversee the performance of works. Some spent hours studying the laying of drains, and obtained coaching from male inspectors or local plumbers, but did not shine in their answers to examination questions on this. They recognised that, while they had to 'cram' this technical knowledge, for their male colleagues, many of whom were ex-plumbers, or had other related experience, it was 'their life's work'. Some resented having to understand technical details about drainage in order to qualify, and 'could not bear smells'. Others emphasised the importance of such knowledge, both in terms of their duties, and so that they could claim equality. All were agreed that their actual acquaintance with drains should be minimal.

Women inspectors performed different duties from their male colleagues, and their efforts were directed towards the housekeeping practices of poor mothers. They did not, however, deal solely with 'people' rather than 'things'. Although they left the supervision of drainage and construction work to male inspectors, they supervised whitewashing, ventilation, the repairing of floors and roofs, the adequate supply of dustbins, and similar matters. They also oversaw the correct maintenance and use of drains. Bad smells from choked and overflowing sink gullies were common complaints. One woman inspector felt that it was a mistake to organise the clearing of these, and instead attempted to 'persuade' the tenants themselves to keep them clear. To keep a yard gully clear, however, was not so simple, since it was common to several houses, and it was usually best for the sanitary authority to keep it in good

order.¹ There was a fine distinction between environment and behaviour. Women public health officers were realistic. Poor housewives were not always paragons of virtue, but there were conditions that were outside their control. Many, like Mrs Greenwood, attributed high infantile mortality equally to 'insanitary conditions' such as rubble sewers, privy midden systems, unpaved courts, back-to-back houses, lack of ventilation and overcrowding, and to 'conditions more or less within the control of the people themselves.'² For Leeds's Chief Woman Inspector,

there is always the danger of becoming too sympathetic with dirt – of telling oneself that "the poor souls can't help being dirty", cleanliness being well-nigh impossible in the working class quarters of a manufacturing city. But clean people, and there are many of them, particularly in the northern towns, teach one otherwise, for they are infinitely more condemnatory of their dirty neighbours than any inspector can be.³

This was a view shared by a broad range of women reformers. For the Fabian Maud Pember Reeves, cleanliness was closely related to income since it determined the type of accommodation and water supply and the amount of soap and cleaning materials. Given these constraints, personality was the next most important cause of order or disorder within the home.⁴

Inspectors and visitors

For this reason, women campaigned for statutory powers to oversee sanitary works, as well as to educate mothers. This was not simply a claim for equal status to act in the public sphere of the law, but so that they might better help the women they visited. The appointment of women as health visitors, without sufficient sanitary training, or the power to oversee works, was keenly fought. Women inspectors felt that being a friend and helper was not enough when it came to insanitary conditions and recalcitrant landlords. It was of little use to visit the home and give instruction about the care and feeding of the baby, and not consider the surrounding sanitary environment. The sanitary condition of homes, and the personal and domestic habits of their occupants were 'one inseparable whole'. They wanted both to give advice on infant feeding, and to remedy sanitary problems. In this they agreed with women's groups. The Women's Co-operative Guild felt that health visitors should also be qualified sanitary inspectors. Maud Pember Reeves argued that there was 'a great need for more qualified, authoritative women sanitary inspectors.'⁵ Such opinions led

¹ Maynard, *Women in the Public Health Service*, pp.58-59.

² IDCPCD, minutes of evidence (Cd. 2210, PP 1904 XXXII), p.311.

³ Maynard, *Women in the Public Health Service*, p.48.

⁴ Reeves, *Round About*, pp.18-19.

⁵ Reeves, *Round About*, p.37.

at least one woman inspector to co-operate with the Mothers' Defence League, to point out that lice might be due to broken drains and rats, rather than negligent housekeeping, and that poor mothers should not have to admit health visitors who could provide no practical help. By the 1930s,

Every experienced Health Visitor can recall families in which the chief thing needed by the mother was some personal interest and encouragement to stimulate her to go on persevering in making a poor and difficult home as clean and comfortable as possible – but she will also recall others in which her first step was to report a leaking roof or verminous walls to the MOH in order that he should require the landlord to remedy these conditions under the Public Health or Housing Acts.⁶

There was a difference of emphasis in the role of health visitor as opposed to sanitary inspector. Although the use of statutory powers by women inspectors was limited, they did serve notices and supervise the completion of works, whereas a health visitor could only report such conditions to an inspector for remedy, and they did this only rarely. During 3,185 visits to new births in 1910 Bermondsey's health visitor reported only 33 sanitary defects.⁷ In 1915, during the course of 2,836 visits, Hammersmith's health visitor referred only 40 conditions to the attention of the sanitary inspectors.⁸

Women inspectors claimed that property-owners on elected local bodies preferred health visitors because they did not challenge the slum landlord. They also suggested that their visits were welcomed more than those of health visitors because of their ability to rectify sanitary faults. They viewed themselves as the ally of tenant against landlord. This was undoubtedly a rose-tinted picture. Causing a landlord to make sanitary repairs to a property might backfire on the tenant. Hackney's MOH was 'constantly hearing of the rent of small properties being raised after the service of notice by the inspector for any necessary repairs.'⁹ One woman inspector complained that landlords often jumped to the conclusion that tenants had been complaining, and either turned them out, or raised the rent so much that they had to move anyway.¹⁰ Women workers also assisted in evasion of the acts, not only because of reprisals from employers blaming them for 'tipping off' the authorities, but because employers might dismiss their female staff rather than make the sometimes expensive adjustments required.¹¹

⁶ *Health Visiting as a Career* (JCC, 1939), p.4.

⁷ Bermondsey MOH report, 1910, p.17.

⁸ Hammersmith MOH report, 1915, pp.11-12.

⁹ J. King Warry, 'On the housing of the working classes in Hackney', *PH* (1901), p.678.

¹⁰ Armour, 'Sanitary inspecting', pp.338-9.

¹¹ See, for example, *Lancet* (5 Oct 1901), p.935.

Despite the 'rise' of the health visitor, women sanitary inspectors did not disappear overnight, and complicated patterns of dual appointment remained throughout the inter-war period. They did not, however, increase in proportion to the overall population, or to numbers of male inspectors. There was a practical problem limiting their growth, caused by their narrow specialisation. Many sanitary authorities employed very small staffs, and adding a woman inspector meant a large proportional increase, or the replacement of a man by a woman. The only way for women inspectors to have overcome this difficulty would have been to have shared the general duties of male inspectors, something that was never seriously considered, even during the First World War. By the inter-war period, women inspectors were losing the argument that their special duties could not either be performed equally well by men, or delegated to health visitors.

Although the resentment felt by many male sanitary inspectors towards their female colleagues was not motivated solely by protectionism, this was an important factor. There were too many men chasing too few jobs, and women attracted lower salaries. Confining them to health visiting was one solution, and male inspectors pressed for a separate system of training and qualification that might keep women from competing for posts. Women argued for a single system of qualifications for both men and women, followed by specialisation. This was not only to protect their status and salary, but reflected their view that the two sides of the work should not be artificially separated. Many took both qualifications.

In 1921, Enid Orange bemoaned the replacement of women sanitary inspectors with lower-paid health visitors, and the consequent loss of status, since 'the pioneer women sanitary inspectors were, for the most part, well educated women actuated by a love for social service.' For her, confining health visitors to duties that could not be undertaken by men lowered salary and status, and this in turn meant that prospects were so poor that many women of 'experience and ability' left the profession and suitable replacements were not attracted.¹² The pioneer women sanitary inspectors felt a gulf between them and the next generation of women public health workers, who were not always motivated by the same 'humanitarian' perspective. The WSIA initially excluded trained nurses and others without the sanitary inspectors' certificate, because it did not want to be swamped by those 'who had not the public health outlook'.

¹² Eve, *Manual*, pp.3-4.

Social workers and nurses

By the inter-war period, the majority of women public health officers were recruited from the nursing profession, and the disappearance of 'well-educated young women' was bemoaned. 'A change in quality' was thought to have come about during the First World War, when authorities were under pressure to increase staff at a time when the choice of candidates was restricted.¹³ From this date there was perceived to be an ever-increasing gap between the ideal recruit and the pool of available workers. The experience of the 'Mothers Arms' provided a useful corrective to the notion that all health visitors were perfect. It was a public house, converted during the First World War by the East London Federation of Suffragettes into a maternity and child welfare centre. One of its nurses was dismissed because of 'the way in which she treated the mothers', and for quarrelling with them about the price of milk, and another for pilfering.¹⁴

Female college lecturers like Helena Reid, Hilda Bideleux and Evelyn Wilkins, along with members of the WSI&HVA, attempted to position health visiting as a branch of social work, suitable for those with a good standard of education. It was seemingly impossible to persuade sufficient numbers of such women to undertake a long and expensive training. The special status accorded to VADs immediately after the war did encourage some to train, but there were simply not enough 'suitably educated' women with sufficient resources to train, to meet the growing needs of public health departments. The degree of maturity required was an additional problem, as it meant that public health workers could not be recruited straight from school, and suitable school-leavers were lost to other occupations. Other than ex-nurses, there was a 'marked lack of other material' for training. It is impossible to know what would have happened if training had been cheaper and easier for university graduates and trained social workers, as the WSI&HVA suggested, but the early university social work courses also experienced recruitment difficulties. Here, 'the uncertain prospects of a remunerative career' were blamed for the small numbers of women willing to risk training.¹⁵ Although some inter-war women public health officers did come from relatively comfortable backgrounds, most needed to earn their own living. The salaries offered to health visitors were not large, except, perhaps, in comparison with hospital nursing. Even within nursing there were large variations. Organisations of 'voluntary hospital snobs', like the College of Nursing,

¹³ Niven, *Observations*, p.193.

¹⁴ IISG: ELFS Finance Committee minutes, 19 Jan 1918 (212); minutes of general meetings, 19 Jan 1918 (208).

¹⁵ Macadam, *Equipment*, p.35.

joined with the WSI&HVA and the training institutions in wishing to attract 'the right type' of nurse to the work, but all faced similar problems.

Meanwhile, most MOHs favoured trained nurses, and were suspicious of attempts to turn health visitors into college-educated social workers. Hilda Bideleux knew of only two who did not prefer nurses. Although this may have been because of the reputation of nurses for 'doing what they were told', and not seeing themselves as wide-ranging social reformers with an independent agenda, there was also a more practical reason. An increasing amount of time was devoted to the type of clinic work where a nursing background was useful. Many also claimed that trained nurses were more welcomed by the poor because of the practical advice they could give in cases of illness. MOHs and nurses formed a powerful lobby to promote nursing as the most appropriate background. Between them they sabotaged attempts to provide practical training for non-nurses. The establishment of the RSI examination board in the mid-1920s might be construed as a return to power of the male public health establishment, after the brief and unsuccessful ascendancy of educational institutions, where women doctors, academics and social workers controlled training. All these factors came together to encourage the Ministry of Health to allow nurses to train after ever-shorter periods, while the supply of non-nurses undergoing a longer training dwindled.

Amy Sayle and the college lecturers fought the dominance of 'the medical side' in health visiting, and wished to see a return to earlier times when, they thought, it had been seen more from 'the social side'. They emphasised how a nurse acted under orders, whereas a health visitor had to depend on her own judgement and initiative. Even the wearing of a nurse's uniform was condemned for giving the impression that the work was 'curative not preventive'.¹⁶ A health visitor who donned a nursing uniform might at the same time put on her 'nurse's personality' and drop 'her character as a social worker'.¹⁷ One woman public health officer, a trained nurse herself, thought it

extremely important that the health visitor shall not fail to grasp and advise on social problems ... and if necessary be prepared to become vocal on them when occasion offers, for example in the case of new legislation.¹⁸

Such social problems included costs and standards of living, wages, unemployment and housing. She did not think that nurses were particularly likely to do this.

¹⁶ Armitage, *Health Visiting*, pp.6-7.

¹⁷ *Ibid.*

¹⁸ Wellcome: Bryant, 'Function of a health visitor is not that of a nurse', WPHOA conference report, 1938, p.12 (SA/HVA/D.1/8).

Poverty or behaviour

The primary duties of women public health officers lay with influencing personal behaviour, and 'educating housewives', although many not only recognised how the wider sanitary environment might undermine health, but also how unhealthy conditions might result from poverty. They felt that the advice that they gave would have limited effect unless these other problems were also tackled. Miss Lovibond thought that

the most careful instruction in house-cleaning will not make the slum tenement of one or two rooms a fit place in which to rear a family ... and the most detailed advice on cooking or diet will not make 18s a week a living wage.¹⁹

No real improvement was possible, she felt, unless other reforms went alongside health visiting. Having written at length about feeding, diet, clothing and the general care and management of the infant, one health visitor concluded that

In mentioning all these matters, it must be borne in mind that the environment of a great many children, chiefly owing to the present lack of sufficient accommodation, makes it almost impossible for them to be brought up well.²⁰

The duties of another brought her into contact with, 'A mass of people living under conditions in which to talk of hygiene is a farce.' She declared that

It is easy to try to explain away what is nothing short of a national disgrace by long words and to say that "economic circumstances" are the root of the trouble. It is poverty, gaunt poverty, coupled with ignorance, which in itself is definitely associated with environment.²¹

Another visited a mother who lived in what had been the drawing room of a house divided into tenements. She did all the cooking on an old-fashioned Victorian grate:

I was supposed to instruct her in the preparation of food for her year-old infant, but as her cooking utensils consisted of a kettle, a frying-pan and a fish kettle, I gave it up.²²

When discussing how a housewife might assist in public health, Amy Sayle put modification of her own behaviour at the bottom of the list. In connection with the use of dustbins, for example,

the first responsibility of the housewife ... is to use her municipal vote... for the candidates who will see, first, that landlords, who are required by byelaws ... to provide dustbins (with lids) really do provide them, and secondly, that household refuse is removed more than once a week from crowded districts.²³

¹⁹ *Fingerpost* (1906), pp.13-14.

²⁰ Armitage, *Health Visiting*, p.193.

²¹ Le Geyt, 'Housing from the health visitor's point of view', *NH* (XIV, 1922), p.245.

²² G.S.C., 'Health visiting in the early days', *NM* (13 Nov 1937), pp.157-158.

²³ Sayle, 'Co-operation of the housewife in public health measures', *JRSI* (XLVII, 1926-1927), p.273.

Having got a suitable bin, it was then up to the housewife to use it properly. Encouraging poor housewives to solve their problems by becoming active women citizens reveals Sayle's commitment to collective responsibility and solutions.

The view that there was a distinct difference between public health workers and other social commentators, in their willingness to point to wide-ranging social and economic causes of tuberculosis, is borne out by the views expressed by women public health officers.²⁴ They were keenly aware of the contrast between the advice they gave, and the realities of working-class life. Marion Fitzgerald was appalled at the 'wretched diet' upon which tuberculosis sufferers subsisted.²⁵ She felt that the poor could not afford a basic healthy diet, let alone the extra protein recommended for tuberculosis sufferers. She concluded that, 'No measures for the treatment of patients below the poverty line can be adequate unless accompanied by additional nourishment.'²⁶ Another woman described a typical visit to an advanced case, just returned from the sanatorium to live with his wife and eight children in two rooms. The visitor gave the usual advice about ventilation, sputum flasks and food values, while despairing that this would be of any use.

"Oh!" thinks the health visitor for the thousandth time. "What is the good of patching the poor thing up for a few months, just to spread more infection, and half-starving the family, so they may be more susceptible. Why can't 'they' build more houses to prevent this horror?"²⁷

When dealing with women workers, the inspectors also recognised that it was often a question of work versus poverty, and that working conditions lay outside the control of the women themselves. They were well aware of the wider social and economic conditions that might affect health. Edith Maynard declared that it was easy to blame poor ventilation on the workers who did not like fresh air, and refused to open the windows. She considered that they were well aware of the benefits of fresh air. It was cold and draughts that they objected to:

We need to bear in mind that the average factory or workshop worker is, in the first place, *badly clothed*..... The fact of being *poorly fed* further lowers her vitality and power of resistance to cold, so that she feels the open window much more keenly than would those who were well clothed and well fed.²⁸

She offered a solution that involved structural improvements to the workshop premises, rather than educating or altering behaviour.²⁹

²⁴ Tomes, 'White plague revisited', p.476.

²⁵ MO (Jul-Dec 1912), p.80.

²⁶ Marion Fitzgerald, 'Food problem in the home treatment of consumption', *JRSI* (XXXIII, 1912), p.638; Marion Fitzgerald, 'Food problem in the home treatment of consumption', *NH* (IV, 1912), p.53.

²⁷ Prospice, 'Profession of health visiting', *Time and Tide* (1 Nov 1923), p.1129.

²⁸ Maynard, 'Some aspects of health in the factory and workshop', pp.740-1

²⁹ *Ibid.*

For the most part, women public health officers exhibited a large degree of sympathy with the women that they visited, and did not place the entire burden for public health at their door. They were keen to distance themselves from any attitude of patronage or blame, whether this was the inquisitorial manner of the COS enquiry agent or the 'wooden administration' of the Poor Law. They objected to the title of 'health visitor' as it might give the impression that they worked for a charitable institution. The WSI&HVA tolerated the employment of trained voluntary workers who were directly responsible to an officer of a borough, but disapproved of complete delegation to voluntary health societies. In the inter-war period, it campaigned for the direct administration of the Maternity and Child Welfare Act, and singled out district nursing associations for particular criticism. This was partly a question of protecting status and pay. It was also a suspicion that those working for voluntary organisations did not always share the 'public health outlook' or a professional philosophy and manner, including the characteristics of tact and sympathy. Under the heading 'The lady was certainly not a Health Visitor', the following story appeared in the magazine of the WPHOA in 1934:

A little girl from a humble house was invited ... to a charity dinner given at a great house in the West End of London. In the course of the meal the little maiden startled her hostess by solemnly propounding the query "Does your husband drink?". "Why no", replied the astonished mistress of the house. After a pause the miniature querist proceeded with the equally bewildering questions: "How much coal do you burn? What is your husband's salary? Has your husband any bad habits? Does your son go to work?" By this time the presiding genius of the table felt called upon to ask her humble guest what made her put such questions. "Well," was the innocent reply, "mother told me to behave like a lady, and when ladies come to our house they always ask my mother those questions."³⁰

Mocking such stereotypes was one way in which women officers distanced themselves from them. They saw their visits as a way of helping mothers, not collecting all sorts of personal information for the MOH. They insisted on the importance of etiquette and good manners and the avoidance of a supercilious, patronising, or 'offensively official' manner. One health visitor wrote that

She must meet the people on their own ground, talk to them as equals, never patronise them in the slightest degree – why should she? – but give them credit for having as much brains as herself, even though they have not the same opportunities for proving it. There is no class, as there are no politics, involved in the work of the health visitor.³¹

Health visitors were encouraged not to lecture or condemn, nor to provide unrealistic textbook advice, but to ask themselves whether they could do as well in the same

³⁰ WHO (Nov 1934), p.12.

³¹ Armitage, *Health Visiting*, p.310.

circumstances, and to make the best of things as they found them. Because of this, and because of the natural resentment of mothers at being given advice by 'slips of girls', they were required to have a degree of maturity.

Conclusion

This thesis began with the assumption of Croydon's MOH in 1907 that women had 'special capabilities' in relation to public health, and that it was the educational side of the work for which they were particularly suited, especially the instruction of poor mothers.³² In cultivating precisely the type of personal relationship with the poor that was envisaged, however, women workers developed a fresh perspective on public health, based on a large degree of understanding of, and sympathy with, working-class life. They saw at first hand the inadequacy of any response to public health problems that was based purely on 'friendly visiting'. They rejected any artificial distinction between the 'personal' and 'sanitary' sides of the work, and advocated a broad social reform agenda. For Amy Sayle and her colleagues,

all *things* with which Public Health is concerned – drains and dustbins, for instance – are good only in so far as they are rightly used by *people*, and the measures concerning *people* in the first place – measures concerning the personal health of mothers, babies and school children, for instance – can be really effective only if there is a proper supply of the *things* necessary to health such as good houses, good air and good food.³³

London's women public health officers saw these twin aims as the true foundation of their work.

³² Richards, 'Aim and scope of women's work in relation to public health', *JRSI* (XXVII, 1907), pp.193-4.

³³ Sayle, *Housewife's Part in Public Health*, p.1.

BIBLIOGRAPHY

ARCHIVE SOURCES

British Medical Association (BMA)

Minutes of the Medico-political Committee

Minutes of the Public Health Committee

City of Westminster Archives Centre (WAC)

Records of the Westminster Children's Society (Acc. 1352)

Hackney Archives Department (HAD)

Parish of St John at Hackney, Vestry Minutes (J/V/6-15)

Hackney Metropolitan Borough, Public Health Committee Minutes (H/P/1-18)

Public Health Department Staff Record Book (H/PD/1/1)

King's College London Archives (KCL)

King's College London Calendars

Queen Elizabeth College publications (Q/EPH)

Records of Queen Elizabeth College (QA)

Institute of Education, University of London (IOE)

Records of the National Union of Women Teachers (DC/UWT)

International Instituut voor Sociale Geschiedenis, Amsterdam (IISG)

Papers of Sylvia Pankhurst, including records of the East London Federation of Suffragettes [consulted on microfilm: Adam Matthew publications, 1994]

Kensington and Chelsea Local Studies Library (K&C)

Minutes of the Vestry of St. Mary Abbott's, Kensington

Minutes of the Works and Sanitary Committee, St. Mary Abbott's, Kensington

Kensington Metropolitan Borough, Minutes of the Public Health Committee

Monthly Reports of the Medical Officer of Health

London Metropolitan Archives (LMA)

London County Council Clerk's Department: Committees Concerned with Public Health: Subject and Policy Files (LCC/PH)

London County Council Public Health Committee Minutes (LCC/MIN/9994)

London County Council Public Health Committee Presented Papers (LCC/MIN/10,025)

Records of the National Council of Women (ACC/3613)

Records of the Women's Local Government Society (A/WLG)

London Metropolitan University: TUC Collections (TUC)

Gertrude Tuckwell Collection

Records of the Women's Trade Union League

London Metropolitan University: The Women's Library (TWL)

Records of the Artists Suffrage League (2/ASL)

Records of the London Society for Women's Suffrage / Service (2/LSW)

Papers of Hilda M.L. Squire (7/HMS)

Records of the National Union of Societies for Equal Citizenship (2/NSE)

Records of the Six Point Group (5/SPG)

Records of the Standing Joint Committee of Industrial Women's Organisations (5/SJC)

Papers of Margaret Eleanor Scott Pillow (7/MEP)

London School of Economics: British Library of Political and Economic Science (LSE)

Streatfeild Papers

Fabian Society Records

Records of the Women's Industrial Council

The National Archives (TNA)

Board of Trade: Companies Registration Office: Files of Dissolved Companies (BT 31)

Board of Education, Technical Branch, and Ministry of Education, Further Education Branch: Technical Schools, Files (ED 82)

Registry of Friendly Societies: Intermediate Record Files of Trade Unions on the Register in 1971, Rules and Amendments etc. (FS 28)

Ministry of Housing and Local Government and predecessors: Legal and Parliamentary Branch and predecessors: Public Health and Local Government Legislation, Bill Papers (HLG 29)

Ministry of Health and successors: Local Government Administration and Finance, General Policy and Procedure, Registered Files (90,000 Series) (HLG 52)

Local Government Board: Sanitary Inspectors' Examination Board, Correspondence and Papers (MH 26)

Local Government Board: Local Government and Public Health Services, Correspondence with County Authorities (MH 30)

Local Government Board, and Ministry of Health, Health Divisions: Public Health and Poor Law Services, Local Authority Correspondence (Series I) (MH 48)

Ministry of Health: Poor Law Division and Health Divisions: Public Health and Poor Law Services, Local Authority Correspondence (Series II) (MH 52)

Ministry of Health: Health Divisions: Public Health and Poor Law Services, Local Government Administration and Finance, General Registered Files (91,000 and other Series) (MH 53)

Ministry of Health: Health Divisions: Public Health Services, Registered Files (93,000 Series) and Other Records (MH 55)

Ministry of Health: Local Government Act 1929, Public Health Survey (MH 66)

James Ramsay MacDonald and predecessors and successors: Papers (PRO 30/69)

Royal College of Nursing Archives (RCN)

Minutes of Council (2/1)

Records of the Public Health Section (6/1)

Minutes of the Education [and Examination] Committee (7/1/1)

Records of the Education Department (7/5)

Peter Catto, 'Early women sanitary inspectors' (unpublished manuscript, May 1979)

Royal Holloway and Bedford New College (RHBCN)

Bedford College Archives

Royal Society for the Promotion of Health (RSPH)

Records of the (Royal) Sanitary Institute

Minutes of the Committee on the Examination and Certification of Sanitary Inspectors under the Public Health (London) Act

Sanitary Inspectors Examination Board: Register, Volume II

Southwark Local Studies Library (SLS)

Vestry of St. George the Martyr, Southwark, minutes and annual reports

University of Leeds: Brotherton Library (Brotherton)

Papers of Hilda M.A. Squire (Ms. 973)

University of Southampton Library (Southampton)

Archives of Jewish Care (MS 173)

University of Surrey Library (Surrey)

Records of Battersea Polytechnic

University of Warwick: Modern Records Centre (MRC)

Clara Collet Papers (MSS.29)

Records of the TUC (MSS.292)

Records of the British Association of Social Workers (MSS.378)

Wellcome Library for the History and Understanding of Medicine (Wellcome)

Records of the Health Visitors Association (SA/HVA)

Papers of Jessy Kent Parsons (SA/HVA/G.2)

Papers of Rachel Barnes (SA/HVA/G.1)

Records of the Joint Committee of Institutions Recognised by the Minister of Health for the Training of Health Visitors and of Organisations of Health Visitors (SA/HVA/B.26)

Papers of Eric Pritchard (GC/49)

Papers of Dorothy Minnie Newhall (GC/165)

Records of the Queen's Nursing Institute (SA/QNI)
Records of the Society of Medical Officers of Health (SA/SMO)
Register of the Sanitary Inspectors' Examination Board, Volume 1
(SA/SMO/T.1)
Records of the Lister Institute (SA/LIS)
Records of the Medical Women's Federation (SA/MWF)

PRIMARY PRINTED SOURCES

Parliamentary Papers

Report to the Board of Trade on the Sweating System at the East End of London by the Labour Correspondent of the Board of Trade (PP 1887 LXXXIX, Cd. 331)

Select Committee of the House of Lords on the Sweating System

First Report (PP 1888 XX, Cd. 361)
Second Report (PP 1888 XXI, Cd. 448)
Third Report (PP 1889 XIII, Cd. 165)
Fourth Report (PP 1889 XIV, Cd. 331)
Fifth Report (PP 1890 XVII, Cd. 169)

Royal Commission on Labour on the Conditions of Work in Various Industries in England, Wales, Scotland and Ireland

Reports by the Lady Assistant Commissioners (PP 1893-4 XXXVII, Cd. 6894)
Fifth and Final Report (PP 1894 XXXV, Cd. 7540; PP 1894 XXXV, Cd. 7421)

Reports of the Select Committee on Homework

PP 1907 VI, Cd. 290
PP 1908 VIII, Cd. 246

Report of the Inter-Departmental Committee on Physical Deterioration

Vol I, Report & Appendix (PP 1904 XXXII, Cd. 2175)
Vol II List of Witnesses and Minutes of Evidence (PP 1904 XXXII Cd. 2210)

Reports of the Chief Inspector of Factories and Workshops

1893 (PP 1894 XXI, Cd. 7368)
1894 (PP 1895 XIX, Cd. 7745)
1895 (PP 1896 XIX, Cd. 8067)
1896 (PP 1897 XVII, Cd. 8561)
1897 (PP 1898 XIV, Cd. 8965)
1898 (PP 1899 XII, Cd. 9281; PP 1900 XI, Cd. 27)
1899 (PP 1900 XI, Cd. 223)
1900 (PP 1901 X, Cd. 668)
1901 (PP 1902 XII Cd. 1112)
1904 (PP 1905 X Cd. 2569)

Report of the Royal Commission on the Poor Laws

PP 1909 XXXVII Cd. 4499
PP 1909 XL Cd. 4684
PP 1909 XLI Cd. 4835

Reports and Pamphlets

Association of Infant Welfare and Maternity Centres
College of Nursing
Fabian Women's Group
Industrial Law Committee
Joint Consultative Committee of Institutions Approved by the Minister of Health for the Training of Health Visitors and of Organisations of Health Visitors
Ladies Sanitary Association
London Society for Women's Suffrage / Service
National Association for the Prevention of Infant Mortality
National Association for the Prevention of Tuberculosis
National Council for Maternity and Child Welfare
National Health Society
National League for Health, Maternity and Child Welfare
National League for Physical Education and Improvement
National Union of Women Workers / National Council of Women
National Union of Women's Suffrage Societies / National Union of Societies for Equal Citizenship
Parkes Museum

Queen's Institute of District Nursing

Six Point Group

Women's Local Government Society

Women Sanitary Inspectors Association / Women Sanitary Inspectors and Health
Visitors Association / Women Public Health Officers Association

Women's Labour League

Medical Officer of Health Reports for the vestries / metropolitan boroughs / urban
district councils of: Battersea; Bermondsey; Bethnal Green; Camberwell; Chelsea;
Deptford; Edmonton; Enfield; Finsbury; Fulham; Greenwich; Hackney; Hammersmith;
Hampstead; Holborn; Islington; Kensington; Lambeth; Lewisham; Paddington;
Poplar; St. Marylebone; St. Pancras; Shoreditch; Southwark; Stepney; Stoke
Newington; Wandsworth; Woolwich; and for the Corporation of London and the City
of Westminster

London County Council: Annual Reports on Public Health

Journals

Baby: The Mother's Magazine

Bedford College London Magazine

British Journal of Nursing

British Journal of Tuberculosis

British Medical Journal

Common Cause

Journal of the [Royal] Sanitary Institute

Lancet

Medical Officer

Mother and Child

Municipal Engineering

National Health

Nursing Mirror

Nursing Record

Nursing Times

Public Health

Sanitarian
Sanitary Inspector's Journal
Sanitary Journal
Sanitary Record
Suffragette
Time & Tide
Transactions of the National Association for the Promotion of Social Science
Transactions of the Sanitary Institute
Tubercle
Tuberculosis
Votes for Women
Woman's Herald
Women's Dreadnought
Women's Employment
Women's Industrial News
Woman's Leader and Common Cause
Worker's Dreadnought

Articles and Monographs Published Before 1940

Allan, Francis, J., *Aids to Sanitary Science for the Use of candidates for Public Health Qualifications* (Bailliere & Co., 1903).

Allen, Greta, *Practical Hints to Health Visitors* (London: Scientific Press, c.1905; c.1920)

Anderson, Adelaide, 'Historical sketch of the developments of legislation for injurious industries in England', in Thomas Oliver (ed.), *Dangerous Trades: The Historical, Social and Legal Aspects of Industrial Occupations as Affecting Health* (London: John Murray, 1902)

Anderson, Adelaide, *Women in the Factory: An Administrative Adventure, 1893 to 1921* (London: John Murray, 1922)

Armitage, C. Phyllis, *Health Visiting: The New Profession* (London: John Bale, 1927)

Armour, Mabyn, 'Sanitary inspecting' in *Education and the Professions* (London: Chapman & Hall, 1903)

Ashby Lucy E. and Earp, Kate *Health Visitors' Guide* (London: Scientific Press, 1926)

Attlee, Clement Richard, *The Social Worker* (London: Bell & Sons, 1920)

Bannington, B.G., *English Public Health Administration* (London: P.S. King, 1915)

Bardswell, Noel Dean, *Advice to Consumptives: Home Treatment, After-care and Prevention* (London: Adam & Charles Black, 1910)

Bardswell, Noel Dean (ed.), *The Tuberculosis Clinic* (London: John Bale, Sons & Danielsson, 1922)

Bird, M. Mostyn, *Woman At Work: A Study of the Different Ways of Earning a Living Open to Women* (London: Chapman & Hall, 1911)

Biscoe, Vyrnwy, *300 Careers for Women* (London: Lovat Dickson, 1932)

Black, Clementina (ed.), *Married Women's Work* (1915, republished by Virago, 1983)

Blackmore, Frederick J.C., *The Tuberculosis Patient's Guide* (London: Cassell, 1930)

Blackwell, Elizabeth, *How to Keep a Household in Health* (Ladies Sanitary Association, 1870)

Blackwell, Elizabeth, *Pioneer Work in Opening the Medical Profession to Women: Autobiographical Sketches* (London, Longmans, 1895)

Blyth, A. Wynter, *A Dictionary of Hygiene and Public Health* (London: Griffin, 1876)

Blyth, A. Wynter, *Lectures on Sanitary Law* (London: Macmillan, 1893)

Blyth, A. Wynter, *A Manual of Public Health* (London: Macmillan, 1890)

Boucherett, Jessie and Blackburn, Helen, *The Condition of Working Women and the Factory Acts* (London: Elliot Stock, 1896)

Bunting, Evelyn M. et al, *A School for Mothers* (London: Marshal & Sons, 1907)

Burton, A.H.G, *The Tuberculosis Handbook for Health Visitors and Nurses* (London: Scientific Press, 1914)

Busk, Alice E., 'Women's work on Vestries and Councils' in J.E. Hand (ed.), *Good Citizenship* (London, George Allen, 1899)

Cassie, Ethel, *Maternity and Child Welfare: A Text-book for Public Health Workers* (London: H.K. Lewis, 1929)

Chesterton, Mrs Cecil, *I Lived in Slum* (London: Gollancz, 1936)

Churchill, Stella, *Health Services and the Public* (London: Noel Douglas, 1928)

Clarke, Hilda, *The Dispensary Treatment of Pulmonary Tuberculosis* (London: Bailliere, Tindall & Cox, 1915)

Clarke, John H., *Taylor's Sanitary Inspector's Handbook: A Manual for Sanitary Inspectors, Inspectors of Meat and Other Foods* (London: H.K. Lewis, 1924)

Clay, Henry H., *The Sanitary Inspector's Handbook: A Manual for Sanitary Inspectors and Other Executive Public Health Officers* (London: H.K. Lewis, 1933, 1936, 1937 and 1939)

Collet, Clara E., *Educated Working Women: Essays on the Economic Position of Women Workers in the Middle Classes* (London: P.S. King & Sons, 1902)

Corfield, W.H., *Dwelling Houses: Their Sanitary Construction and Arrangements* (London: H.K. Lewis, 1894 and 1898)

Deane, Lucy A.E., 'Laundry workers', in Thomas Oliver (ed.), *Dangerous Trades: The Historical, Social and Legal Aspects of Industrial Occupations as Affecting Health* (London: John Murray, 1902)

Dick, A.M., 'A woman sanitary aide-de-camp in Antwerp', *The Englishwoman* (Vol XXV, Jan-Mar 1915)

Drake, Barbara, *Starvation in the Midst of Plenty: A New Plan for the State Feeding of School Children* (Fabian Tract No. 240, 1933), reprinted in Sally Alexander (ed.), *Women's Fabian Tracts* (London: Routledge, 1988)

T. Orme Dudfield, *Woman's Place in Sanitary Administration* (Women Sanitary Inspectors Association, 1904)

Education and the Professions (London: Chapman & Hall, 1903)

Evans, Dorothy, *Women and the Civil Service: A History of the Development of the Employment of Women in the Civil Service and a Guide to Present-day Opportunities* (London: Pitman, 1934)

Eve, Enid (ed.), *Manual for Health Visitors and Infant Welfare Workers* (London: John Bale, 1921)

Fabian Women's Group, 'A summary of six papers and discussions upon the disabilities of women as workers' (1909), reprinted in Sally Alexander (ed.), *Women's Fabian Tracts* (London: Routledge, 1988)

Fabian Women's Group, *Three Years' Work 1908-1911*, reprinted in Sally Alexander (ed.), *Women's Fabian Tracts* (London: Routledge, 1988)

The Fingerpost: A Guide to Professions for Educated Women (London: Central Bureau for the Employment of Women, 1906)

Gay, John, *A memoir on Indolent Ulcers* (London: Samuel Highley, 1855)

Gay, John, *On Haemorrhoidal Disorder* (London: Churchill, 1882)

Gay, John, *On Varicose Disease of the Lower Extremities and its Allied Disorders* (London: John Churchill, 1868)

Gibbon, I.G., *Infant Welfare Centres: The Work of Infant Consultations, Schools for Mothers, and Similar Institutions* (London: National League for Physical Education and Improvement, 1913)

Greenwood, F.J., 'Sanitary inspection' in *Speeches at the Local Government Section of the Women's Congress at the Japan-British Exhibition* (Women's Local Government Society, 1910)

Greenwood, F.J., 'Women as sanitary inspectors and health visitors', in Edith J. Morley (ed.), *Women Workers in Seven Professions: A Survey of Their Economic Conditions and Prospects* (London: Routledge, 1914)

Hall, O., *Manual for Health Visitors, School Nurses and Teachers of Hygiene* (Devonport: Swiss & Co, 1916)

Hamer, W.H., *Manual of Hygiene* (London: Churchill, 1902)

Hannington, W.A.L., *The Problem of Distressed Areas* (London: Gollancz, 1937)

Harman, N. Bishop, *Preventable Blindness: An Account of the Disease Known as Ophthalmia of the New-Born, and of its Effects* (London: Baillière, Tindall & Cox, 1907)

Hart, P. D'Arcy and Wright, G. Playling, *Tuberculosis and Social Conditions in England* (National Association for the Prevention of Tuberculosis, 1939)

Heaf, F. R. G., 'How far should the individual be considered in forming a tuberculosis scheme?', *Tubercle* (1939)

Heath, H. Llewellyn, *The Infant, the Parent and the State: A Social Study and Review* (London: P.S. King, 1907)

Holdsworth, W.A., *The Public Health (London) Act, 1891* (London: Routledge, 1891)

Hillier, Alfred, *The Prevention of Consumption* (London: Longmans, 1903)

Hillier, Alfred, *Tuberculosis: Its Nature, Prevention and Treatment* (London: Cassell & Co, 1900)

Holdsworth, W.A., *The Public Health (London) Act 1891* (London: Routledge, 1891)

Home Industries of Women in London, 1906 (London: Women's Industrial Council, 1906)

Hope, E.W., *Health at the Gateway: Problems and International Obligations of a Seaport City* (Cambridge University Press, 1931)

How to Become a Lady Sanitary Inspector (London: Scientific Press, 1908)

Hughes, D.W., *Careers for Our Daughters* (London: A&C Black, 1936)

Hutchins, B.L., *Home Work and Sweating: the Causes and the Remedies* (Fabian Tract No. 130, 1907), reprinted in Sally Alexander (ed.), *Women's Fabian Tracts* (London: Routledge, 1988)

Inglis, Elsie, 'Sanitary inspectors' in *The Fingerpost: A Guide to Professions for Educated Women* (London: Central Bureau for the Employment of Women, 1906)

Jex-Blake, A.J., *Tuberculosis: A General Account of the Disease, its Forms, Treatment and Prevention* (London: G. Bell & Sons, 1915)

Kanthack, Emilia, *The Preservation of Infant Life: A Guide for Health Visitors, Six Lectures to the Voluntary Health Visitors in the Borough of St. Pancras* (London: H.K. Lewis, 1907)

Kayne, G. Gregory, *The Control of Tuberculosis in England: Past and Present* (Oxford University Press, 1937)

Kenwood, Henry and Kerr, Harold, *Hygiene and Public Health* (London: H.K. Lewis, 1929)

Kilgour, Mary Stewart, *Women as Members of Local Sanitary Authorities* (1900)

Lane-Claypon, Janet E., *The Child Welfare Movement* (London: G. Bell & Sons, 1920)

Lane-Claypon, Janet E., *Hygiene of Women and Children* (London: Henry Frowde, 1921)

Latham, Arthur and Garland, Charles H., *The Conquest of Consumption* (London: Unwin, 1910)

Leng's *Careers for Girls* (Dundee: John Leng & Co, 1911)

Loane, M., *From Their Point of View* (London: Edward Arnold, 1908)

Loane, M., *The Next Street But One* (London: Edwrad Arnold, 1907)

Loane, M., *Simple Sanitation: The Practical Application of the Laws if Health To Small Dwellings* (London: Scientific Press, 1905)

Long, Kate L., 'Sanitary inspectors and health visitors' in *The Fingerpost: A Guide to Professions for Educated Women* (London: Central Bureau for the Employment of Women, 1906)

Lovibond, F.N.F., 'Health visitors' in *The Fingerpost: A Guide to Professions for Educated Women* (London: Central Bureau for the Employment of Women, 1906)

Macadam, Elizabeth, *The Equipment of the Social Worker* (London: George Allen & Unwin, 1925)

Macadam, Elizabeth, 'The universities and the training of the social worker', *The Hibbert Journal* (1914)

M'Gonigle, G.C.M. and Kirby, J., *Poverty and Public Health* (London: Gollancz, 1936)

McCleary, *The Early History of the Infant Welfare Movement* (London: H.K. Lewis, 1933)

McCleary, *Infantile Mortality and Infants Milk Depots* (London: P.S. King, 1905)

McCleary, G.F., *The Maternity and Child Welfare Movement* (London: P.S. King, 1935)

MacDonald, J. Ramsay, *Margaret Ethel MacDonald* (London: George, Allen & Unwin, 1912)

Macmillan, J. Shawnet Cameron, *Infant Health: A Manual for District Visitors, Nurses and Mothers* (London: Henry Frowde, 1915)

McMillan, Margaret, *The Life of Rachel McMillan* (London: J. M. Dent, 1927)

Maguire, William R., *Domestic Sanitary Drainage and Plumbing* (London: Kegan Paul, 1903)

Martin, Anna, *The Mother and Social Reform* (London: National Union of Women's Suffrage Societies, 1913)

Martin, Anna, *The Married Working Woman: A Study* (London: National Union of Women's Suffrage Societies, 1911)

Martindale, Hilda, *Women Servants of the State, 1870-1938: A History of Women in the Civil Service* (London: Allen & Unwin, 1938)

Maynard, Edith L., *Baby: Useful Hints for Busy Mothers* (Bristol: John Wright, 1906)

Maynard, Edith L., *Caring for Baby* (Leeds: E.J. Arnold, [1912])

Maynard, Edith L., *Children from Two to Five: Their Care and Management* (London: Scientific Press, [1915])

Maynard, Edith L., *Infant Care and Management: A Manual for Teachers* (Leeds: E.J. Arnold, [1913])

Maynard, Edith L., *Women in the Public Health Service* (London: Scientific Press, 1915)

Meacher, G. Norman, *Tuberculosis: A Manual for Tuberculosis Nurses, Health Visitors and Other Workers* (London: Scientific Press, c.1920)

Morley, Edith J. (ed.), *Women Workers in Seven Professions: A Survey of Their Economic Conditions and Prospects* (London: Routledge, 1914)

Murrell, William, *Clinical Lectures on the Prevention of Consumption* (London: Bailliere, Tindall & Cox, 1895)

New Careers for Women: The Best Positions and How to Obtain Them (London: George Newnes, 1917)

Newman, George, *Infant Mortality: A Social Problem* (London: Methuen, 1906)

Newsholme, Arthur, *Fifty Years in Public Health: A Personal Narrative With Comments* (London: George Allen & Unwin, 1935)

Newsholme, Arthur, *The Prevention of Tuberculosis* (London: Methuen, 1908)

Newsholme, Arthur and Scott, Margaret Eleanor, *Domestic Economy* (London: Swan Sonnenschein, 1899)

Nightingale, Florence, *Reproduction of a Printed Report Originally Submitted to the Buckinghamshire County Council in the Year 1892, Containing Letters from Miss Florence Nightingale on Health Visiting in Rural Districts* (National League for Physical Education, 1911)

Niven, James, *Observations on the History of Public Health Effort in Manchester* (Manchester: John Heywood, 1923)

Notter, J. Lane and Firth, R.H., *Practical Domestic Hygiene* (London, Longmans, 1897, 1902, 1911 and 1931)

Notter, J. Lane and Firth, R.H., *The Theory and Practice of Hygiene* (London: Churchill, 1896)

Oakley, Hilda D., 'Kings College for Women', in F.J.C. Hearnshaw, *The Centenary History of King's College London* (London: George Harrap, 1929)

Oliver, Thomas (ed.), *Dangerous Trades: The Historical, Social and Legal Aspects of Industrial Occupations as Affecting Health* (London: John Murray, 1902)

Pakes, W.C.C, *The Science of Hygiene: A Text-book of Laboratory Practice* (London: Methuen, 1900)

Pankhurst, E. Sylvia, *The Home Front: A Mirror to Life in England during the World War* (1932)

Parkes, Louis C., *Jubilee Retrospect of the Royal Sanitary Institute, 1876-1926* (1926)

Parkes, Louis and Kenwood, Henry, *Hygiene and Public Health* (London: H.K. Lewis, 1901)

Paterson, Marcus, *The Shibboleths of Tuberculosis* (London: John Murray, 1920)

Philip, R. W., *Pulmonary Tuberculosis: Etiological and Therapeutic* (Edinburgh: Pentland, 1891)

Philip, R. W., *A Thousand Cases of Pulmonary Tuberculosis with Etiological and Therapeutic Considerations* (Medico-Chirurgical Society of Edinburgh, 1892)

Platt, Elspeth, *The Story of the Ranyard Mission 1857-1937* (London: Hodder & Stoughton, 1937)

Powers, Susan R., 'The diffusion of sanitary knowledge', *Transactions of the National Association for the Promotion of Social Science* (1860)

Pritchard, Eric, *The Infant: Nutrition and Management* (London: Edward Arnold, 1914)

Pritchard, Eric, *Infant Education* (London: Henry Kimpton, 1907)

Progress in Women's Education in the British Empire; Being the Report of the Education Section, Victorian Era Exhibition 1897 (London: Longmans, 1898)

Ransome, Arthur, *A Campaign Against Consumption* (Cambridge University Press, 1915)

Ransome, Arthur, *Researches on Tuberculosis* (London: Smith, Elder & Co, 1898)

[Ranyard] 'L.N.R.', *The Missing Link; or Bible-women in the Homes of the London Poor* (London: James Nisbet, 1860)

[Ranyard] 'L.N.R.', *Nurses for the Needy or Bible-women Nurses in the Homes of the London Poor* (London: James Nisbet, 1875)

Ravenhill, Alice and Schiff, Catherine J., *Household Administration: Its Place in the Higher Education of Women* (London: Grant Richards, 1910)

Reeves, Mrs. Pember, *Family Life on a Pound Week* (Fabian Tract No. 162)
reprinted in Sally Alexander (ed.), *Women's Fabian Tracts* (London: Routledge, 1988)

Reid, Annie Hitchen, 'The work of a sanitary inspector', *British Soroptimist* (Dec 1930)

Reid, George, *Practical Sanitation: A Handbook for Sanitary Inspectors and Others Interested in Sanitation* (London: Griffin, 1892, 1893, 1895, 1897, 1921 & 1930)

Rhondda, Viscountess, *This Was My World* (London: Macmillan, 1933)

Rice, Margery Spring, *Working-class Wives: Their Health and Conditions* (1939, republished by Virago, 1981)

Riviere, Clive, *Tuberculosis and How to Avoid It* (London: Methuen, 1917)

Sayle, A. *The Houses of the Workers* (London: T. Fisher Unwin, 1924)

Sayle, A. *The Housewife's Part in Public Health* (London: Women Sanitary Inspectors and Health Visitors Association, 1926)

Scharlieb, Mary, *The Welfare of the Expectant Mother* (London: Cassell, 1919)

Schofield, Alfred T., *Behind the Brass Plate: Life's Little Stories* (London: Sampson Law, 1928)

Schofield, Alfred, T., *Health At Home Tracts* (London: Religious Tract Society, [1890])

Schofield, Alfred, T., *Manual of Personal and Domestic Hygiene* (London: Allman [1889])

Scott, Margaret Eleanor, 'Woman's work in promoting the cause of hygiene' (1891)

Sharples, Margaret L., 'On the personality of women in sanitary work', *Progress* (No 13, Jan 1909)

Skene, Lily, *The Ideal Health Visitor* (London: John Bale, 1923)

Social Services in North Lambeth and Kensington: A Study from Lady Margaret Hall (Oxford University Press, 1939)

Squire, J. Edward *The Hygienic Prevention of Consumption* (London: Griffin, 1893)

Squire, Rose E., *Thirty Years in the Public Service: An Industrial Retrospect* (London: Nisbet & Co, 1927)

Stephenson, Sydney, *Ophthalmia Neonatorum* (London: George Pulman & Sons, 1907)

Stobart, Mrs St Clair, *The Flaming Sword in Serbia and Elsewhere* (London: Hodder & Stoughton, 1916)

Stobart, M.A. St.Clair, *Miracles and Adventures: An Autobiography* (London: Rider & Co, 1935)

Stockman, Frank Charles, *A Practical Guide for Sanitary Inspectors* (London: Butterworth, 1900 & 1904)

Strachey, Ray, *Careers and Openings for Women: A Survey of Women's Employment and a Guide for Those Seeking Work* (London: Faber & Faber, 1935)

Sykes, John F.J., *Public Health Problems* (London: Walter Scott, 1892)

Taylor, Albert, *The Sanitary Inspector's Handbook* (London: H.K. Lewis, 1893, 1897, 1901, 1905 and 1914)

Thomson, H. Hyslop, *Tuberculosis and Public Health* (London: Longmans, 1920)

Thomson, H. Hyslop, *Tuberculosis: Its Prevention and Home Treatment* (Oxford University Press, 1928)

Thomson, H. Hyslop, *Tuberculosis and National Health* (London: Methuen, 1939)

Thorne, Richard Thorne, *The Administrative Control of Tuberculosis* (London: Bailliere, Tindall & Cox, 1899)

Townshend, Mrs, *The Case Against the Charity Organisation Society* (Fabian Tract No. 158, 1911), reprinted in Sally Alexander (ed.), *Women's Fabian Tracts* (London: Routledge, 1988)

Townshend, Mrs, *The Case for School Nurseries* (Fabian Tract No. 145, 1909), reprinted in Sally Alexander (ed.), *Women's Fabian Tracts* (London: Routledge, 1988)

Tuke, Margaret J., *A History of Bedford College for Women 1849-1937* (Oxford University Press, 1939)

Tuckwell, Gertrude, *Industrial Work and Industrial Laws* (London: Industrial Law Committee, 1902, 1903 & 1910)

Tuckwell, Gertrude, 'Sweating', in *Morality in Commercial and Social Life* (London: SPCK, 1908)

Underwood, E. Ashworth, *A Manual of Tuberculosis for Nurses* (Edinburgh: Livingstone, 1931)

Underwood, E. Ashworth *A Manual of Tuberculosis for Nurses and Public Health Workers* (Baltimore: William Woood & Co, 1938)

Vallow, Harold, *The Inevitable Complement: the Care and After-care of Consumptives* (London: John Bale, Sons & Danielsson, 1915)

Vynne, Nora and Blackburn, Helen, *Women Under the Factory Act* (London: Williams & Norgate, 1903)

Walters, F. Rufenacht, *Domiciliary Treatment of Pulmonary Tuberculosis* (London: Bailliere, Tindall & Cox, 1924)

Webb, Beatrice, *The Abolition of the Poor Law* (Fabian Tract No. 185, 1918), reprinted in Sally Alexander (ed.), *Women's Fabian Tracts* (London: Routledge, 1988)

Webb, Beatrice, *The Diary of Beatrice Webb Volume Two 1892-1905: 'All the Good Things of Life'* (ed. Norman and Jeanne Mackenzie, London: Virago, 1983)

Webb, Beatrice, *My Apprenticeship* (Penguin, 1938), p. 230.

Webb, Beatrice, *Women and the Factory Acts* (Fabian Tract No. 67, 1896), reprinted in Sally Alexander (ed.), *Women's Fabian Tracts* (London: Routledge, 1988)

Webb, Sidney, 'The London Polytechnic Institutes' in *Special Reports on Educational Subjects* (Vol II, 1898)

Webb, Sidney and Webb, Beatrice, *The State and the Doctor* (London: Longmans, 1910)

Wilkins, Evelyn, *An Introduction to Social Science for Health Visitors* (London: Edward Arnold, 1932)

Willoughby, Edward F., *The Health Officer's Pocket-Book* (London: Crosby, Lockwood & Son, 1893)

Wingfield, R. C., *Modern Methods in the Diagnosis and Treatment of Pulmonary Tuberculosis* (London: Constable & Co, 1924)

SECONDARY SOURCES

Abbott, Pamela and Sapsford, Roger, 'Health visiting: policing the family?' in Pamela Abbott and Claire Wallace (eds), *The Sociology of the Caring Professions* (London: Falmer Press, 1990)

Abbott, Pamela and Wallace, Claire (eds), *The Sociology of the Caring Professions* (London: Falmer Press, 1990)

Acheson, Roy, 'The British Diploma in Public Health: birth and adolescence', in Elizabeth Fee and Roy M. Acheson (eds), *A History of Education in Public Health: Health that Mocks the Doctors' Rules* (Oxford University Press, 1991)

Acker, Sandra, 'Caring as work for women educators', in Smyth et al (eds), *Challenging Professions: Historical and Contemporary Perspectives on Women's Professional Work* (University of Toronto Press, 1999)

Acker, Sandra, 'Women and teaching: a semi-detached sociology of a semi-profession', in Sandra Acker, *Gendered Education: Sociological Reflections on Women, Teaching and Feminism* (Open University Press, 1994)

Adams, Annmarie, *Architecture in the Family Way: Doctors, Houses and Women, 1870-1900* (Montreal: McGill-Queen's University Press, 1996)

Adams, Annmarie, *Corpus Sanum in Domo Sano: the Architecture of the Domestic Sanitation Movement 1870-1914* (Montreal: Centre Canadien d'Architecture, 1991)

Adams, Annmarie, 'The healthy Victorian city: the Old London Street at the International Health Exhibition of 1884' in Zeynep Celik, Diane Favro and Richard Ingersoll (eds), *Street: Critical Perspectives on Public Space* (Berkeley: University of California Press, 1994)

Alexander, Sally, 'Fabian socialism and the "sex-relation"', in Sally Alexander, *Becoming a Woman and Other Essays in Nineteenth and Twentieth Century Feminist History* (London: Virago, 1994)

Alexander, Sally, 'The Fabian Women's Group 1908-1952', in Sally Alexander, *Becoming and Woman and Other Essays in Nineteenth and Twentieth Century Feminist History* (London: Virago, 1994)

Alexander, Sally, *Women's Work in Nineteenth-century London: A Study of the Years 1820-50* (London: Journeyman Press, 1983)

Alford, M.E., *During Six Reigns: Landmarks in the History of the National Council of Women of Great Britain* (London: National Council of Women, 1953)

Allen, Sheila and Wolkowitz, Carol, *Homeworking: Myths and Realities* (Basingstoke: Macmillan, 1987)

Anderson, Gregory, *Victorian Clerks* (Manchester University Press, 1976)

Apple, Rima D., 'Constructing mothers: scientific motherhood in the nineteenth and twentieth centuries', *Social History of Medicine* (1995)

Apple, Rima D., 'Science gendered: nutrition in the United States, 1840-1940' in Harmke Kamminga and Andrew Cunningham (eds), *The Science and Culture of Nutrition 1840-1940* (Amsterdam: Rodopi, 1995)

Argles, Michael, *South Kensington to Robbins: An Account of English Technical and Scientific Education Since 1851* (London: Longmans, 1964)

Armstrong, David, 'The invention of infant mortality', *Sociology of Health and Illness* (1986)

Armstrong, David, *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century* (Cambridge University Press, 1983)

Ashton, John and Seymour, Howard, *The New Public Health: the Liverpool Experience* (Open University Press, 1988)

Atkinson, Paul and Delamont, Sara, 'Professions and powerlessness: female marginality in the learned occupations', *Sociological Review* (1990)

Banks, Olive, *Faces of Feminism* (Oxford: Blackwell, 1981)

Banks, Olive, *The Politics of British Feminism, 1918-1970* (Aldershot: Edward Elgar, 1993)

Banks, Olive, 'The role of religion in women's campaigns in the nineteenth century', *Bulletin of the History of Nursing Group at the Royal College of Nursing* (1986/87)

Barber, Bernard, 'Some problems in the sociology of the professions', *Daedalus* (1963)

Barry, Jonathan and Jones, Colin (eds), *Medicine and Charity Before the Welfare State* (London: Routledge, 1991)

Bashford, Alison, *Nursing Bodies: The Gendered Politics of Health in Australia and England, 1860-1910* (Unpublished PhD thesis, University of Sydney, 1994)

Bashford, Alison, *Purity and Pollution: Gender, Embodiment and Victorian Medicine* (Basingstoke: Macmillan, 1998)

Bayliss, Robert and Daniels, Christine, 'The physical deterioration report of 1904 and education in home economics', *History of Education Society Bulletin* (1988)

Beaumont, Caitriona, 'Citizens not Feminists: the boundary negotiated between citizenship and feminism by mainstream women's organisations in England, 1928-39', *Women's History Review* (200).

Bell, Liane, 'Shortages of nurses 1928-1935', *Royal College of Nursing History of Nursing Society Journal* (1991)

Benson, John (ed.), *The Working Class in England 1875-1914* (London: Croom Helm, 1985)

Bentley, Linna, *Educating Women: A Pictorial History of Bedford College, University of London, 1849-1985* (Surrey: Alma, 1991)

Bird, Elizabeth, "High class cookery": gender, status and domestic subjects, 1890-1930', *Gender and Education* (1998)

Blackburn, Clare, 'Building a poverty perspective into health visiting practice' in Paul Bywaters and Eileen McLeod (eds), *Working for Equality in Health* (London: Routledge, 1996)

Catriona Blake, *The Charge of the Parasols: Women's Entry To The Medical Profession* (London: The Women's Press, 1990)

Blakestad, Nancy L., *King's College of Household and Social Science and the Household Science Movement in English Higher Education, c.1908-1939* (Unpublished DPhil thesis, University of Oxford, 1994)

Bock, Gisela and Thane, Pat (eds), *Maternity and Gender Policies: Women and the Rise of European Welfare States 1880s-1950s* (Routledge, 1991)

Bonham, Valerie, *Sisters of the Raj: The Clewer Sisters in India* (London: Community of St. John Baptist, 1997)

Boris, Eileen and Daniels, Cynthia R., (ed), *Homework: Historical and Contemporary Perspectives on Paid Labour at Home* (Urbana: University of Illinois Press, 1989)

Boston, Sarah, *Women Workers and the Trade Union Movement* (London: Davis-Poynter Ltd, 1980)

Bradshaw, Ann, *The Nurse Apprentice, 1860-1977* (Aldershot: Ashgate, 2001)

Brand, Jeanne L., *Doctors and the State: The British Medical Profession and Government Action in Public Health* (Baltimore: Johns Hopkins Press, 1965)

Brasnett, Margaret, *Voluntary Social Action: A History of the National Council of Social Service 1919-1969* (London: National Council of Social Service, 1969)

Braybon, Gail, *Women Workers in the First World War: the British Experience* (London: Croom Helm, 1981)

Brion, Marion, *Women in the Housing Service* (London: Routledge, 1995)

Brockington, C. Fraser, *A Short History of Public Health* (London: J & A Churchill, 1956)

Brown, W.J., *So Far ...* (London: George, Allen & Unwin, 1943)

Bryder, Linda, *Below the Magic Mountain: a Social History of Tuberculosis in Twentieth-century Britain* (Oxford: Clarendon Press, 1988)

Bryder, Linda, "'Wonderland of buttercup, clover and daisies': tuberculosis and the open-air school movement in Britain, 1907-1939', in Roger Cooter (ed.), *In the Name of the Child: Health and welfare, 1880-1940* (London: Routledge, 1992)

Buchanan, Ian, 'Infant feeding, sanitation and diarrhoea in colliery communities 1880-1911' in Derek J. Oddy and Derek S. Miller (eds), *Diet and Health in Modern Britain* (London: Croom Helm, 1985)

Buchanan, Sheena H., *The Health Visitor and Tuberculosis* (London: NAPT, 1955)

Bullock, Ian and Pankhurst, Richard (eds), *Sylvia Pankhurst: From Artists to Anti-Fascist* (London: Macmillan, 1992)

Bulmer, Martin, Bales, Kevin and Sklar, Kathryn (eds), *The Social Survey in Historical Perspective, 1880-1940* (Cambridge University Press, 1991)

Bunton, Robin, Nettleton, Sarah and Burrows, Roger, *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk* (London: Routledge, 1995)

Burnett, John, *A Social History of Housing 1815-1985* (London: Methuen, 1980)

Burnham, John C., 'Why did the infants and toddlers die? Shifts in Americans ideas of responsibility for accidents – from blaming mom to engineering', *Journal of Social History* (1996)

Bush, Julia, *Behind the Lines: East London Labour, 1914-1919* (London: Merlin Press, 1984)

Bythell, Duncan, *The Sweated Trades: Outwork in Nineteenth-century Britain* (London: Batsford, 1978)

Caine, Barbara, 'Beatrice Webb and the "Woman Question"', *History Workshop Journal* (1982)

Cantor, David, 'The aches of industry: philanthropy and rheumatism in inter-war Britain', in Jonathan Barry and Colin Jones (eds), *Medicine and Charity Before the Welfare State* (London: Routledge, 1991)

Carpenter, Michael, 'The new managerialism and professionalism in nursing', in Stacey et al (eds), *Health and the Division of Labour* (London: Croom Helm, 1977)

Carpenter, Mick, *All for One: Campaigns and Pioneers in the Making of COHSE* (Confederation of Health Service Employees, 1980)

Carpenter, Mick, *Working for Health: the History of the Confederation of Health Service Employees* (London: Lawrence & Wishart, 1988)

Carter, K. Codell, 'The development of Pasteur's concept of disease causation and the emergence of specific causes in nineteenth-century medicine', *Bulletin of the History of Medicine* (1991)

Chambers, Peggy, *A Doctor Alone: A Biography of Elizabeth Blackwell: The First Woman Doctor, 1821-1910* (London: Bodley Head, 1956)

Chesterton, Mrs Cecil, *The Chestertons* (London: Chapman & Hall, 1941)

Cliff, Andrew, Haggett, Peter and Smallman-Raynor, Matthew, *Measles: An Historical Geography of a Major Human Viral Disease from Global Expansion to Local Retreat, 1840-1990* (Oxford: Blackwell, 1993)

Clifton, Gloria C., *Professionalism, Patronage and Public Service in Victorian London: the Staff of the Metropolitan Board of Works 1856-1889* (London: Athlone Press, 1992)

Cohen, Deborah A., 'Private lives in public spaces: Marie Stopes, the Mothers' Clinics and the practice of contraception', *History Workshop Journal* (1993)

Colville, Cynthia, *Crowded Life: the Autobiography of Lady Cynthia Colville* (London: Evans Brothers, 1963)

Collette, Christine, *For Labour and For Women: The Women's Labour League 1906-1918* (Manchester University Press, 1989)

Cook, J. Mordaunt (ed.), *Bedford College University of London: Memories of 150 Years* (London: Royal Holloway and Bedford New College, 2001)

Cooter, Roger, 'Anticontagionism and history's medical record', I, Peter Wright and Andrew Treacher (eds), *The Problem of Medical Knowledge: Examining the Social Construction of Medicine* (Edinburgh University Press, 1982)

Copelman, Dina M. *London's Women Teachers: Gender, Class and Feminism, 1870-1930* (London: Routledge, 1996)

Coppock, David A., 'Respectability as a prerequisite of moral character: the social and occupational mobility of pupil teachers in the late nineteenth and early twentieth century', *History of Education* (1997)

Corr, Helen, 'Sexual politics in the National Union of Teachers', in *Women, Education and the Professions* (History of Education Society, 1987)

Cotgrove, Stephen F., *Technical Education and Social Change* (London: George Allen & Unwin, 1958)

Crawford, Elizabeth, *The Women's Suffrage Movement: A Reference Guide 1866-1928* (London: UCL Press, 1999)

Crawford, Robert, 'You are dangerous to your health: the ideology and politics of victim-blaming', *International Journal of Health Services* (1977)

Cronjé, Gillian, 'Tuberculosis and mortality decline in England and Wales, 1851-1910', in Robert Woods and John Woodward (eds), *Urban Disease and Mortality in Nineteenth-century England* (London: Batsford, 1984)

Crossick, Geoffrey, 'The emergence of the lower middle class in Britain: a discussion', in Geoffrey Crossick (ed.), *The Lower Middle Class in Britain 1870-1914* (London: Croom Helm, 1977)

Dale, Jennifer and Foster, Peggy, *Feminists and State Welfare* (London: Routledge, 1986)

Currer, Caroline and Stacey, Meg (ed.), *Concepts of Health, Illness and Disease: A Comparative Perspective* (Leamington Spa: Berg, 1986)

Daniels, Christine E.J., and Bayliss, Robert A., 'Alice Ravenhill, home economist, 1859-1954', *Westminster Studies in Education* (1985)

Daunton, M.J., *House and Home in the Victorian City: Working-class Housing 1850-1914* (London: Edward Arnold, 1983)

Davidoff, Leonore, 'The rationalization of housework', in Diana Leonard Barker and Sheila Allen (eds), *Dependence and Exploitation in Work and Marriage* (London: Longman, 1976)

Davidoff, Leonore and Hall, Catherine, *Family Fortunes: Men and Women of the English Middle Class, 1780-1850* (London: Hutchinson, 1987)

Davidoff, Leonore and Westover, Belinda (eds), *Our Work, Our Lives, Our Words: Women's History and Women's Work* (London: Macmillan, 1986)

Davidson, Roger, "Searching for Mary, Glasgow": contract tracing for sexually transmitted diseases in twentieth-century Scotland', *Social History of Medicine* (1996)

Davies, Celia, *Gender and the Professional Predicament in Nursing* (Buckingham: Open University Press, 1995)

Davies, Celia, 'The health visitor as mother's friend: a woman's place in public health, 1900-14', *Social History of Medicine* (1988)

Davies, Celia, 'Professionalizing strategies as time-and-culture-bound: American and British nursing, circa 1893', in Ellen Condliffe Lagemann (ed.), *Nursing History: New Perspectives, New Possibilities* (New York: Teachers College Press, 1983)

Davies, Celia, 'Professionals in bureaucracies: the conflict thesis revisited', in Robert Dingwall and Philip Lewis (eds), *The Sociology and the Professions: Lawyers, Doctors and Others* (London: Macmillan, 1983)

Davies, Celia (ed.), *Rewriting Nursing History* (London: Croom Helm, 1980)

Davin, Anna, 'Imperialism and motherhood', *History Workshop* (1978)

Davis, Jennifer, 'Jennings' Buildings and the Royal Borough: the construction of the underclass in mid-victorian England', in David Feldman and Gareth Stedman Jones (eds), *Metropolis London: Histories and Representations since 1800* (London: Routledge, 1989)

Davy, Teresa, "A cissy job for man; a nice job for girls": women shorthand typists in London, 1900-1939', in Leonore Davidoff and Belinda Westover (eds), *Our Work, Our Lives, Our Words: Women's History and Women's Work* (London: Macmillan, 1986)

Delamont, Sara, 'The domestic ideology and women's education', in Sara Delamont and Lorna Duffin (eds), *The Nineteenth-Century Women: Her Cultural and Physical World* (London: Croom Helm, 1978)

Delamont, Sara, 'The contradictions in ladies' education', in Sara Delamont and Lorna Duffin (eds), *The Nineteenth-Century Women: Her Cultural and Physical World* (London: Croom Helm, 1978)

Delamont, Sara, 'Distant dangers and forgotten standards: pollution control strategies in the British girls' school, 1860-1920', *Women's History Review* (1993)

Delamont, Sara, *Knowledgeable Women: Structuralism and the Reproduction of Elites* (London: Routledge, 1989)

Delamont, Sara and Duffin, Lorna (eds), *The Nineteenth-Century Women: Her Cultural and Physical World* (London: Croom Helm, 1978)

Digby, Anne, 'New schools for the middle class girl', in Peter Searby (ed.), *Educating the Victorian Middle Class* (Leicester: History of Education Society, 1982)

Dingwall, Robert, 'Collectivism, regionalism and feminism: health visiting and British social policy 1850-1975', *Journal of Social Policy* (1977)

Dingwall, Robert, "In the beginning was the work ..." Reflections on the genesis of occupations', *Sociological Review* (1893)

Dingwall, Robert, 'Some sociological aspects of "nursing research"', *Sociological Review* (1974)

Dingwall, Robert, Rafferty, Anne Marie and Webster, Charles, *An Introduction to the Social History of Nursing* (London: Routledge, 1988)

Dingwall, Robert and Lewis, Philip (eds), *The Sociology and the Professions: Lawyers, Doctors and Others* (London: Macmillan, 1983)

Dingwall, R., Eekelaar, J.M and Murray, T., 'Childhood as a social problem: a survey of the history of legal regulation', *Journal of Law & Society* (1984)

Donajgrodski, A.P. (ed.), *Social Control in Nineteenth Century Britain* (London: Croom Helm, 1977)

Donzelot, Jacques, *The Policing of Families* (Baltimore: Johns Hopkins Press, 1997)

Dopson, Laurence, 'Nursing journals and the development of professional nursing', *Bulletin of the History of Nursing Group at the Royal College of Nursing* (1985/96)

Dowling, William, *The Ladies' Sanitary Association and the Origins of the Health Visiting Service* (Unpublished MA thesis, University of London, 1963)

Drewry, Gavin and Brock, Jenny, 'Social studies and social science', in J. Mordaunt Cook (ed.), *Bedford College University of London: Memories of 150 Years* (London: RHBNC, 2001)

Duffin, Lorna, 'The conspicuous consumptive: woman as an invalid', in Sara Delamont and Lorna Duffin (eds), *The Nineteenth-Century Women: Her Cultural and Physical World* (London: Croom Helm, 1978)

Duman, Daniel, 'The creation and diffusion of a professional ideology in nineteenth century England', *Sociological Review* (1979)

Dwork, Deborah, 'The milk option: an aspect of the history of the infant welfare movement in England 1898-1908' *Medical History* (1987)

Dwork, Deborah, *War is Good for Babies and Other Young Children: A History of the Infant and Child Welfare Movement in England 1898-1918* (London: Tavistock, 1987)

Dyhouse, Carol, *Feminism and the Family in England 1880-1939* (Oxford: Blackwell, 1989)

Dyhouse, Carol, 'Mothers and daughters in the middle-class home, c.1870-1914', in Jane Lewis (ed.) *Labour and Love: Women's Experience of Home and Family, 1850-1940* (Oxford: Blackwell, 1986)

Dyhouse, Carol, *No Distinction of Sex? Women in British Universities, 1870-1939* (UCL Press, 1995)

Dyhouse, Carol, 'Signing the pledge? Women's investment in university education and teacher training before 1939', *History of Education* (1997)

Dyhouse, Carol, 'Storming the citadel or storm in a tea cup? The entry of women into higher education 1860-1920', in Sandra Acker and David Warren Piper (eds), *Is Higher Education Fair to Women?* (Guildford: SRHE, 1984)

Dyhouse, Carol, 'Working-class mothers and infant mortality in England, 1895-1914', in Charles Webster (ed.) *Biology, Medicine and Society 1840-1940* (Cambridge University Press, 1981)

Ehrenreich, Barbara and English, Deirdre, *For Her Own Good: 150 Years of Experts' Advice to Women* (London: Pluto Press, 1979)

Elston, Mary Ann, 'Women in the medical profession: whose problem?', in Stacey et al (eds), *Health and the Division of Labour* (London: Croom Helm, 1977)

English, Mary P., *Victorian Values: The Life and Times of Dr. Edwin Lankester* (Bristol: Biopress, 1990)

Eoff, Shirley M., *Viscountess Rhondda, Equalitarian Feminist* (Columbus: Ohio State University Press, 1991)

Etzioni, Amitai (ed.), *The Semi-Professions and Their Organization: Teachers, Nurses, Social Workers* (New York: The Free Press, 1969)

Evans, David, 'Tackling the "Hideous Scourge": the creation of the venereal disease treatment centres in early twentieth-century Britain', *Social History of Medicine* (1992)

Eyre, Jessie G., *Tuberculosis Nursing* (London: H.K. Lewis, 1949)

Fee, Elizabeth and Acheson, Roy M. (eds), *A History of Education in Public Health: Health that Mocks the Doctors' Rules* (Oxford University Press, 1991)

Fee, Elizabeth and Porter, Dorothy, 'Public health, preventive medicine and professionalization: Britain and the US in the nineteenth century', in Elizabeth Fee and Roy M. Acheson (eds), *A History of Education in Public Health: Health that Mocks the Doctors' Rules* (Oxford University Press, 1991)

Feldman, David, 'The importance of being English: Jewish immigration and the decay of Liberal England', in David Feldman and Gareth Stedman Jones (eds) *Metropolis London: Histories and Representations Since 1800* (London: Routledge, 1989)

Feldman, David and Jones, Gareth Stedman (eds), *Metropolis London: Histories and Representations since 1800* (London: Routledge, 1989)

Feltes, N.N., 'Misery or the production of misery: defining sweated labour in 1890', *Social History* (1992)

Ferguson, Sheila, 'Labour women and the social services', in Lucy Middleton (ed.), *Women in the Labour Movement: the British Experience* (London: Croom Helm, 1977)

Feurer, Rosemary, 'The meaning of "sisterhood": the British women's movement and protective labor legislation, 1870-1900', *Victorian Studies* (1988)

Judith, Fido, 'The Charity Organization Society and social casework in London 1869-1900', in A.P. Donajgrodska (ed.), *Social Control in Nineteenth Century Britain* (London: Croom Helm, 1977)

Geoffrey Finlayson, *Citizen, State and Social Welfare in Britain 1830-1990* (Oxford, Clarendon Press, 1994)

Finlayson, Geoffrey, 'A moving frontier: voluntarism and the state in British social welfare 1911-1949', *Twentieth Century British History* (1990)

Floud, Roderick and Glynn, Sean (eds), *London Higher: The Establishment of Higher Education in London* (London: Athlone Press, 1998)

Ford, P. and Ford, G., *A Breviate of Parliamentary Papers 1900-1916: The Foundation of the Welfare State* (Oxford: Blackwell, 1957)

Forty, Adrian, *Objects of Desire: Design and Society Since 1950* (London: Thames & Hudson, 1986)

Fox, Enid, 'District nursing in England and Wales before the NHS: the neglected evidence', *Medical History* (1994)

Frazer, W.M., *A History of English Public Health, 1834-1939* (London: Baillière, Tindall & Cox, 1950)

Freidson, Eliot, 'The futures of professionalization', in Margaret Stacey et al (eds), *Health and the Division of Labour* (London: Croom Helm, 1977)

Freidson, Eliot, *Professionalism Reborn: Theory, Prophecy and Policy* (Oxford: Polity Press, 1994)

Friedson, Eliot, *Professional Powers: A Study of the Institutionalisation of Formal Knowledge* (University of Chicago Press, 1986)

Friedson, Eliot, 'The theory of professions: state of the art', in Robert Dingwall and Philip Lewis (eds), *The Sociology of the Professions: Lawyers, Doctors and Others* (London: Macmillan, 1983)

Gamarnikow, Eva, 'Nineteenth-century nursing reform and the sexual division of labour', *Bulletin of the History of Nursing Group at the Royal College of Nursing* (1984)

Gamarnikow, Eva, 'Nurse or woman: gender and professionalism in reformed nursing 1860-1923' in Pat Holden and Jenny Littlewood (eds), *Anthropology and Nursing* (London: Routledge, 1991)

Gamarnikow, Eva, 'Sexual division of labour: the case of nursing', in Annette Kuhn and Ann Marie Wolpe (eds), *Feminism and Materialism: Women and Modes of Production* (London: Routledge, 1978)

Gamble, Rose, *Chelsea Child* (BBC, 1979)

Gaskell, S. Martin, *Slums* (Leicester University Press, 1990)

Glick, Daphne, *The National Council of Women of Great Britain: The First One Hundred Years, 1895-1994* (NCW, 1994)

Goldman, Lawrence, 'The Social Science Association, 1857-1996: a context for mid-Victorian Liberalism', *English Historical Review* (1986)

Goldman, Lawrence, *Science, Reform and Politics in Victorian Britain: The Social Science Association 1857-1886* (Cambridge University Press, 2002)

Graham, Hilary, "Prevention and health: every mother's business: a comment on child health policies in the 1970s", in Chris Harris (ed.), *The Sociology of the Family: New Directions for Britain* (University of Keele, 1979)

Grant, Isabel, *National Council of Women: the First Sixty Years, 1895-1955* (London: National Council of Women, 1955)

Graves, Pamela M., *Labour Women: Women in British Working-class Politics 1918-1939* (Cambridge University Press, 1994)

Gray, Robert, 'Factory legislation and the gendering of jobs in the north of England, 1830-1860', *Gender and History* (1993)

Gray, Robert, 'Medical men, industrial labour and the state in Britain, 1830-50', *Social History* (1991)

Gray, Robert, 'The languages of factory reform in Britain c.1830-1860', in Patrick Joyce (ed.), *The Historical Meanings of Work* (Cambridge University Press, 1987)

Green, David R. and Parton, Alan G., 'Slums and slum life in Victorian England: London and Birmingham at mid-century', in S. Martin Gaskell, *Slums* (Leicester University Press, 1990)

Greenberg, Morris, 'Knowledge of the health hazard of asbestos prior to the Merewether and Price Report of 1930', *Social History of Medicine* (1994)

Guha, Sumit, 'The importance of social intervention in England's mortality decline: the evidence reviewed', *Social History of Medicine* (1994)

Gurney, Peter, 'The middle-class embrace: language, representation, and contest over co-operative forms in Britain, c.1860-1914', *Victorian Studies* (1994)

Hall, Lesley A., 'Chloe, Olivia, Isabel, Letitia, Harriette, Honor and many more: women in medicine and biomedical science in Britain, 1914-1939', in Sybil Oldfield (ed.), *This Working-Day World: Women's Lives and Culture(s) in Britain 1914-1945* (London: Taylor and Francis, 1994)

Hall, Lesley A., 'Nurses in the archives: archival sources for nursing history' in A. M. Rafferty, J. Robinson and R. Elkan (eds.), *Nursing History and the Politics of Welfare*, London: Routledge, 1996)

Hall, Lesley A., 'A suitable job for a woman: women, doctors and birth control to the inception of the NHS', in Lawrence Conrad and Anne Hardy (eds), *Women and Modern Medicine* (Amsterdam: Rodopi, 2001)

Hamlin, Christopher, 'Providence and putrefaction: Victorian sanitarians and the natural theology of health and disease', *Victorian Studies* (1985)

Hannam, June, 'The Leeds Women's Labour League and women's health', *Bulletin of the History of Nursing Group at the Royal College of Nursing* (1983)

Hannam, June, 'Rosalind Paget: class, gender and the Midwives' Institute c.1886-1914' *History of Nursing Society Journal* (1994/95)

Hardy, Anne, *The Epidemic Streets: Infectious Disease and the Rise of Preventive Medicine, 1856-1900* (Oxford: Clarendon Press, 1993)

Harrison, Barbara, 'Are accidents gender neutral? The case of women's industrial work in Britain, 1880-1914', *Women's History Review* (1993)

Harrison, Barbara, 'Feminism and the health consequences of women's work in the late nineteenth and early twentieth century Britain', in Platt et al (eds), *Locating Health: Sociological and Historical Explanations* (Aldershot: Avebury, 1993)

Harrison, Barbara, *Not Only the Dangerous Trades: Women's Work and Health in Britain, 1880-1914* (London: Taylor & Francis, 1996)

Harrison, Barbara, 'Suffer the working day: women in the "dangerous trades", 1880-1914', *Women's Studies International Forum* (1990)

Harrison, Barbara, 'Women's health or social control? The role of the medical profession in relation to factory legislation in late nineteenth century Britain', *Sociology of Health and Illness* (1991)

Harrison, Brian, 'Class and gender in modern British labour history', *Past and Present* (1989)

Harrison, Brian, *Prudent Revolutionaries: Portraits of British Feminists Between the Wars* (Oxford: Clarendon Press, 1987)

Harrison, Brian, 'Women's health and the women's movement in Britain, 1940-1940', in Charles Webster (ed.) *Biology, Medicine and Society 1840-1940* (Cambridge University Press, 1981)

Harrison, Nikki, *The First 80 Years (1903-1983): A Short History of the Westminster Health Society / Westminster Children's Society* (London: Westminster Children's Society, 1983)

Hart, Christopher, *Behind the Mask: Nurses, Their Unions and Nursing Policy* (London: Baillière Tindall, 1994)

Hart, J.S., *Elementary Schooling and the Working Classes 1860-1918* (London: Routledge, 1979)

Hearn, Jeff, 'Notes on patriarchy, professionalization and the semi-professions', *Sociology* (1982)

Hearn, Jeff, 'Patriarchy, professionalization and the semi-professions', in Clare Ungerson (ed.), *Women and Social Policy: A Reader* (London: Macmillan, 1985)

Hearnshaw, F.J.C., *The Centenary History of King's College London, 1828-1928* (London: George Harrap, 1929)

Hennock, E.P., *Fit and Proper Persons: Ideal and Reality in Nineteenth-century Urban Government* (London: Edward Arnold, 1973)

Hewitt, Margaret, *Wives and Mothers in Victorian Industry* (London: Rockliff, 1958)

Hobsbawm, E.J., 'The Fabians reconsidered', in E.J. Hobsbaum, *Labouring Men: Studies in the History of Labour* (London: Weidenfeld and Nicolson, 1964)

Holcombe, Lee, *Victorian Ladies at Work: Middle-class Working Women in England and Wales, 1850-1914* (1973)

Hollis, Patricia, *Ladies Elect: Women in English Local Government 1865-1914* (Oxford, Clarendon Press, 1987)

Howarth, Janet and Curthoys, Mark, 'Gender, curriculum and career: a case study of women university students in England before 1914', in *Women, Education and the Professions* (History of Education Society, 1987)

J.S. Hurt, *Elementary Schooling and the Working Classes 1860-1918* (London: Routledge, 1979)

Ineson, Antonia, 'Good advice and carbolic powder', *The Health Services* (1982)

Isard, Jacqueline, 'Nurse training in Fulham Infirmary 1910-1930', *Bulletin of the History of Nursing Group at the Royal College of Nursing* (1984)

Jackson, John A. (ed.), *Professions and Professionalization* (Cambridge University Press, 1970)

Jefferys, Margot, 'The uncertain health visitor', *New Society* (October 1965)

John, Angela V., *Unequal Opportunities, Women's Employment in England 1800-1918* (Oxford: Blackwell, 1986)

Johnson, Terence J., *Professions and Power* (London: Macmillan, 1972)

Johnson, Terry, 'The state and the professions: peculiarities of the British', in Anthony Giddens and Gavin Mackenzie (eds), *Social Class and the Division of Labour: Essays in Honour of Ilya Neustadt* (Cambridge University Press, 1982)

Jones, Colin and Porter, Roy (eds), *Reassessing Foucault: Power, Medicine and the Body* (London: Routledge, 1994)

Jones, Gareth Stedman, *Outcast London: A Study in the Relationship Between Classes in Victorian Society* (Harmondsworth, 1984)

Jones, Helen, 'Employers' welfare schemes and industrial relations in inter-war Britain', *Business History* (1983)

Jones, Helen, 'Women health workers: the case of the first women factory inspectors in Britain', *Social History of Medicine* (1988)

Jones, Helen, *Women in British Public Life, 1914-1950: Gender, Power and Social Policy* (Harlow: Pearson Education Ltd, 2000)

Jones, Jane, '90 years of caring', *Nursery World* (1986)

Jones, Jane, 'Women working for women: the growth of a trade union', *Morning Star* (1986)

Jordan, Ellen, 'The lady clerks at the prudential: the beginning of vertical segregation by sex in clerical work in nineteenth-century Britain', *Gender and History* (1996)

Jordan, Ellen, *The Women's Movement and Women's Employment in Nineteenth-century Britain* (London: Routledge, 1999)

Kaye, Elaine, *A History of Queen's College London, 1848-1972* (London: Chatto & Windus, 1972)

Kean, Hilda and Oram, Alison, "Men must be educated and women must do it": the National Federation (later Union) of Women Teachers and contemporary feminism', *Gender and Education* (1990)

Keep, Christopher, 'The cultural work of the type-writer girl', *Victorian studies* (1997)

Kelly, Serena, 'A sisterhood of service: the records and early history of the National Union of Women Workers', *Journal of the Society of Archivists* (1993)

Kent, Susan Kingsley, 'The politics of sexual difference: World War I and the demise of British feminism', *Journal of British Studies* (1988)

Kidd, Alan and Nicholls, David (eds), *The Making of the British Middle Class? Studies of Regional and Cultural Diversity since the Eighteenth Century* (Stroud: Sutton Publishing, 1998)

Koven, Seth and Michel, Sonya, *Mothers of a New World: Maternalist Politics and the Origins of Welfare States* (London: Routledge, 1993)

Koven, Seth, 'Borderlands: women, voluntary action and child welfare in Britain, 1840 to 1914' in Seth Koven and Sonya Michel, *Mother's of a New World: Maternalist Politics and the Origins of Welfare States* (London: Routledge, 1993)

Larson, Magali Sarfatti, *The Rise of Professionalism: A Sociological Analysis* (Berkeley: University of California Press, 1977)

Law, Cheryl, *Women: A Modern Political Dictionary* (London: I.B. Tauris, 2000)

Lee, Roger, 'Uneven zenith: towards a geography of the high period of municipal medicine in England and Wales', *Historical Geography* (1988)

Lee, W.R., 'Emergence of occupational medicine in Victorian times', *British Journal of Industrial Medicine* (1973)

Leneman, Leah, 'Medical women at war, 1914-1918', *Medical History* (1994)

Joseph Lester, *E. Ray Lankester and the Making of Modern British Biology* (British Society for the History of Science, 1995)

Levine, Philippa, *Feminist Lives in Victorian England: Private Roles and Public Commitment* (Oxford: Blackwell, 1990)

Levine, Philippa, *Victorian Feminism 1850-1900* (University Press of Florida: 1994)

Lewis, Donald Munro, *The Evangelical Mission to the British Working Class* (Unpublished DPhil thesis, University of Oxford, 1981)

Lewis, Jane, 'Beyond suffrage: English feminism in the 1920s', *Maryland Historian* (1984)

Lewis, Jane, 'Gender, the family and women's agency in the building of "welfare states": the British case', *Social History* (1994)

Lewis, Jane, 'In search of a real equality: women between the wars', in Frank Gloversmith (ed.), *Class, Culture and Social Change: A New View of the 1930s* (Brighton: Harvester, 1980)

Lewis, Jane and Rose, Sonya O. "Let England Blush": protective labour legislation, 1820-1914', in Wulla Wikander, Alice Kessler-Harris and Jane Lewis (eds),

Protecting Women: Labour Legislation in Europe, the United States and Australia, 1880-1920, (University of Illinois Press, 1995)

Lewis, Jane, 'Models of equality for women: the case of state support for children in twentieth-century Britain, in Gisela Bock and Pat Thane (eds), *Maternity and Gender Policies: Women and the Rise of European Welfare States 1880s-1950s* (Routledge, 1991)

Lewis, Jane, 'Mothers and maternity politics in the twentieth century', in Jo Garcia, Robert Kilpatrick and Martin Richards (eds), *The Politics of Maternity Care* (Oxford: Clarendon Press, 1990)

Jane Lewis, 'Myrdal, Klein, women's two roles and post-war feminism, 1945-1960', in Harold L. Smith (ed.), *British Feminism in the Twentieth Century* (Aldershot: Edward Elgar, 1990)

Lewis, Jane, 'The place of social investigation, social theory and social work in the approach to late Victorian and Edwardian social problems: the case of Beatrice Webb and Helen Bosanquet', in Martin Bulmer, Kevin Bales and Kathryn Sklar (eds), *The Social Survey in Historical Perspective, 1880-1940* (Cambridge University Press, 1991)

Lewis, Jane, *The Politics of Motherhood: Child and Maternal Welfare in England, 1900-1939* (London: Croom Helm, 1980)

Lewis, Jane, 'The public's health: philosophy and practice in Britain in the twentieth century', in Elizabeth Fee and Roy M. Acheson (eds), *A History of Education in Public Health: Health that Mocks the Doctors' Rules* (Oxford University Press, 1991)

Lewis, Jane, *What Price Community Medicine?* (Brighton: Wheatsheaf, 1986)

Lewis, Jane, *Women in England 1879-1950: Sexual Divisions and Social Change* (Hemel Hempstead: Harvester, 1984)

Lewis, Jane, 'Women, social work and social welfare in twentieth-century Britain: from (unpaid) influence to (paid) oblivion?', in Martin Daunton (ed.), *Charity, Self-interest and Welfare in the English Past* (London: UCL Press, 1996)

Lewis, Jane, 'The working-class wife and mother and state intervention, 1870-1918', in Jane Lewis(ed.), *Labour and Love: Women's Experience of Home and Family, 1850-1940* (Oxford: Blackwell, 1986)

Lodge, M., 'Women and welfare: an account of the development of infant welfare schemes in Coventry 1900-1940 with special reference to the work of the Coventry Women's Co-operative Guild' in Bill Lancaster and Tony Mason (eds), *Life and*

labour in a Twentieth-century City: The Experience of Coventry (Coventry: Cryfield Press, 1986)

Lupton, Deborah, *The Imperative of Health: Public Health and the Regulated Body* (London: Sage, 1995)

Lupton, Deborah, *Medicine as Culture: Illness, Disease and the Body in Western Societies* (London: Sage, 1994 & 2003)

Lupton, Deborah and Petersen, Alan, *The New Public Health: Health and Self in the Age of Risk* (London: Sage, 1996)

McBriar, A.M., *Fabian Socialism and English Politics 1884-1918* (Cambridge University Press, 1962)

McCleary, G.F., *The Development of British Maternity and Child Welfare Services* (National Association of Maternity and Child Welfare Centres and for the Prevention of Infant Mortality, 1945)

McFarlane, Neil, 'Hospitals, housing and tuberculosis in Glasgow, 1911-1951', *Social History of Medicine* (1989)

McFeely, Mary Drake, *Lady Inspectors: The Campaign for a Better Workplace 1893-1921* (Oxford: Blackwell, 1988)

McGann, Susan, *The Battle of the Nurses: A Study of Eight Women Who Influenced the Development of Professional Nursing, 1880-1930* (Scutari, 1992)

McKibbin, Ross, *Classes and Cultures: England 1918-1951* (Oxford University Press, 1998)

MacLeod, Roy, *Public Science and Public Policy in Victorian England* (Aldershot: Variorum, 1996)

MacLeod, Roy M., 'The frustration of state medicine, 1880-1899', *Medical History* (1967)

Madden, Claire, *Dorothy Evans and the Six Point Group* (London: Six Point Group [1945])

Maggs, Christopher, 'Nurse recruitment to four provincial hospitals 1881-1921', in Celia Davies (ed.), *Rewriting Nursing History* (London: Croom Helm, 1980)

Maggs, Christopher (ed.), *Nursing History: The State of the Art* (London: Croom Helm, 1987)

Maggs, Christopher, 'Nursing scandals and the public image of the nurse – the nineteenth century campaign', *Bulletin of the History of Nursing Group at the Royal College of Nursing* (1984)

Maggs, Christopher, *The Origins of General Nursing* (London: Croom Helm, 1983)

Maggs, Christopher, 'The Royal British Nurses Association 1887-1987', *Bulletin of the History of Nursing Group at the Royal College of Nursing* (1988)

Malcolmson, Patricia E., *English Laundresses: A Social History, 1850-1930* (University of Illinois Press, 1986)

Malcolmson, Patricia E., 'Getting a living in the slums of Victorian Kensington', *London Journal* (1975)

Malone, Carolyn, 'The gendering of dangerous trades: government regulation of women's work in the white lead trade in England, 1892-1989', *Journal of Women's History* (1996)

Malone, Carolyn, *Women's Bodies and Dangerous Trades in England, 1880-1914* (London: Boydell, 2003)

Mappen, Ellen, *Helping Women at Work: the Women's Industrial Council, 1889-1914* (London: Hutchinson, 1985)

Mappen, Ellen F., 'Strategists for change: social feminist approaches to the problems of women's work', in Angela V. John, *Unequal Opportunities, Women's Employment in England 1800-1918* (Oxford: Blackwell, 1986)

Marks, Lara, *Metropolitan Maternity: Maternal and Infant Welfare Services in Early Twentieth-century London* (Amsterdam: Rodopi, 1996)

Marks, Lara, *Model Mothers: Jewish Mothers and Maternity provision in east London 1870-1939* (Clarendon Press, 1994)

Marks, Lara, 'Mothers, babies and hospitals: "The London" and the provision of maternity care in East London, 1870-1939' in Valerie Fildes, Lara Marks and Hilary Marland (eds), *Women and Children First: International maternal and Infant Welfare 1870-1945* (London: Routledge, 1992)

Marks, Lara, 'The right to perfect health: maternal and infant welfare services in Kensington' (unpublished paper read at the Wellcome Institute for the History of Medicine, 9th February 1994)

Marland, Hilary, *Medicine and Society in Wakefield and Huddersfield 1780-1870* (Cambridge University Press, 1987)

Marland, Hilary, 'A pioneer in infant welfare: the Huddersfield Scheme 1903-1920' *Social History of Medicine* (1993)

Marsh, Neville, *The History of Queen Elizabeth College: One Hundred Years of University Education in Kensington* (London: King's College, 1986)

Martin, Jane, *Women and the Politics of Schooling in Victorian and Edwardian England* (Leicester University Press, 1999)

Martindale, Hilda, *Some Victorian Portraits and Others* (London: Allen & Unwin, 1948)

Melling, Josphah (ed.), *Housing, Social Policy and the State* (London: Croom Helm, 1980)

Melling, Joseph, 'Welfare capitalism and the origins of welfare states: British industry, workplace welfare and social reform c.1870-1914', *Social History* (1992)

Middleton, Lucy (ed.), *Women in the Labour Movement: the British Experience* (London: Croom Helm, 1977)

Mooney, Graham, 'Professionalization in public health and the measurement of sanitary progress in nineteenth-century England and Wales', *Social History of Medicine* (1997)

Mooney, Graham, 'Public health versus private practice: the contested development of compulsory infectious disease notification in late nineteenth-century Britain', *Bulletin of the History of Medicine* (1999)

Moore, Michael J., 'Social work and social welfare: the organization of philanthropic resources in Britain, 1900-1914', *Journal of British Studies* (1977)

Morris, Jenny, 'The characteristics of sweating: the late nineteenth century London and Leeds tailoring trade', in Angela V. John (ed.), *Unequal Opportunities: Women's Employment in England, 1880-1918* (Oxford: Blackwell, 1986)

Morris, Jenny, *Women Workers and the Sweated Trades: The Origins of Minimum Wage Legislation* (Aldershot: Gower, 1986)

Mowat, Charles Loch, *The Charity Organization Society: Its Ideas and Work* (London: Methuen, 1961)

Mumm, Susan, "Not worse than other girls": the convent-based rehabilitation of fallen women in Victorian Britain', *Journal of Social History* (1996)

Nolan, G.M., *Infant Mortality as an Indicator of Environmental and Social Change, 1890-1939* (Unpublished DPhil thesis, University of Nottingham, 1982)

Novak, Stephen J., 'Professionalism and bureaucracy: English doctors and the Victorian public health administration', *Journal of Social History* (1973)

Oakley, Ann, *The Captured Womb: A History of the Medical Care of Pregnant Women* (Oxford: Blackwell, 1984)

Olcott, Teresa, 'Dead centre: the women's trade union movement in London, 1874-1914', *The London Journal* (1976)

Olechnowicz, Andrezej, *Working-class Housing in England Between the Wars: the Becontree Estate* (Oxford: Clarendon Press, 1997)

Oram, Alison, *Women Teachers and Feminist Politics, 1900-39* (Manchester University Press, 1996)

Owen, Grace M. (ed.), *Health Visiting* (London: Bailliere Tindall, 1977)

Palmer, Diana, *Women, Health and Politics, 1919-1939: Professional and lay Involvement in the Women's Health Campaign* (unpublished PhD thesis, University of Warwick, 1986)

Parker, Julia, *Women and Welfare: Ten Victorian Women in Public Social Service* (Macmillan, 1988)

Pavalko, Ronald M., *Sociology of Occupations and Professions* (Illinois: Peacock, 1988)

Pederson, Joyce Sanders, *The Reform of Girls' Secondary and Higher Education in Victorian England: A Study of Elites and Educational Change* (New York: Garland, 1987)

Pellew, Jill, *The Home Office: From Clerks to Bureaucrats* (London: Heinemann, 1982)

Pennington, Shelley and Westover, Belinda, *A Hidden Workforce: Homeworkers in England, 1850-1985* (Basingstoke: Macmillan, 1989)

Peretz, Elizabeth, 'The costs of modern motherhood to low income families in interwar Britain' in Valerie Fildes, Lara Marks and Hilary Marland (eds), *Women and Children First: International Maternal and Infant Welfare* (London: Routledge, 1992)

Peretz, Elizabeth, 'A maternity service for England and Wales: local authority maternity care in the inter-war period in Oxfordshire and Tottenham', in Jo Garcia, Robert Kilpatrick and Martin Richards (eds), *The Politics of Maternity Care* (Oxford: Clarendon Press, 1990)

Perkin, Harold, *The Rise of Professional Society: England since 1880* (London: Routledge, 1989)

Phizacklea, Anne and Wolkowitz, Carol, *Homeworking Women: Gender, Racism and Class at Work* (London: Sage, 1995)

Pierotti, A.M., *The Story of the National Union of Women Teachers* (London: National Union of Women Teachers, 1963)

Poovey, Mary, 'Domesticity and class formation: Chadwick's 1842 Sanitary Report', in David Simpson (ed.), *Subject to History: Ideology, Class, Gender* (Ithaca: Cornell University Press, 1991)

Poovey, Mary, *Uneven Developments: The Ideological Work of Gender in Mid-Victorian England* (London: Virago, 1989)

Porter, Dorothy, "Enemies of the race": biologism, environmentalism, and public health in Edwardian England', *Victorian Studies* (1991)

Porter, Dorothy, 'How soon is now? Public health and the *BMJ*', *British Medical Journal* (1990)

Porter, Dorothy, 'Medicine and industrial society: reform, improvement and professionalization' *Victorian Studies* (1993)

Porter, Dorothy, 'Stratification and its discontents: professionalization and conflict in the British public health service, 1848-1914', in Elizabeth Fee and Roy M. Acheson (eds), *A History of Education in Public Health: Health that Mocks the Doctors' Rules* (Oxford University Press, 1991)

Porter, Maureen, 'Professional-client relationships and women's reproductive health care' in Sarah Cunningham-Burley and Neil P. McKeganey, *Readings in Medical Sociology* (London: Routledge, 1990)

Prochaska, F.K., *Women and Philanthropy in Nineteenth-century England* (Oxford: Clarendon Press, 1980)

Pugh, Martin, 'Domesticity and the decline of feminism, 1930-1950', in Harold L. Smith (ed.), *British Feminism in the Twentieth Century* (Aldershot: Edward Elgar, 1990)

Pugh, Patricia, *Educate, Agitate, Organize: One Hundred Years of Fabian Socialism* (London: Methuen, 1984)

Purvis, June, *Hard Lessons: The Lives and Education of Working-class Women in Nineteenth-century England* (Cambridge: Polity Press, 1989)

Purvis, June, *A History of Women's Education in England* (Open University Press, 1991)

Rafferty, Anne Marie, 'Nursing, medicine, quackery, and health care reform, 1844-1994', *Nursing Research* (1996)

Rafferty, Anne Marie, *The Politics of Nursing Knowledge* (London: Routledge, 1996)

Ravenhill, Alice, *The Memoirs of an Educational Pioneer* (Toronto: J. M. Dent, 1951)

Reader, W.J., *Professional Men: The Rise of the Professional Classes in Nineteenth-century England* (London: Weidenfeld & Nicolson, 1966)

Ready as Ever: An Historical Look at the Health Visitors Association (London: Health Visitors Association, 1990)

Rendall, Jane, *The Origins of Modern Feminism: Women in Britain, France and the United States 1780-1860* (London: Macmillan, 1985)

Rendel, Margherita, 'The contribution of the Womens Labour League to the winning of the franchise', in Lucy Middleton (ed.), *Women in the Labour Movement: the British Experience* (London: Croom Helm, 1977)

Roberts, Elizabeth A.M., 'Women's strategies, 1890-1940', in Jane Lewis (ed.), *Labour and Love Women's Experience of Home and Family 1850-1940* (Oxford: Blackwell, 1986)

Roberston, Stuart, "The terrible scourge of consumption is amongst us": The Guild of Help, voluntarism and the problem of tuberculosis in Edwardian Bolton', in Keith Laybourn (ed.), *Social Conditions, Status and Community 1860-c.1920* (Stroud: Sutton, 1997)

Roebuck, Janet, *Urban Development in Nineteenth-century London: Lambeth, Battersea and Wandsworth, 1838-1888* (London: Phillimore, 1979)

Romero, Patricia W., *E. Sylvia Pankhurst: Portrait of a Radical* (Yale University Press, 1987)

Rooff, Madeline, *A Hundred Years of Family Welfare: A Study of the Family Welfare Association, 1869-1969* (London: Michael Joseph, 1972)

Rooff, Madeline, *Voluntary Societies and Social Policy* (London: Routledge, 1957)

Rose, G.C., *Locality, Politics and Culture: Poplar in the 1920s* (unpublished PhD, University of London, 1989)

Ross, Ellen, 'Good and bad mothers: lady philanthropists and London housewives before the First World War', in Kathleen D. McCarthy (ed.), *Lady Bountiful Revisited: Women, Philanthropy and Power* (Rutgers University Press, 1990)

Ross, Ellen, 'Labour and love: rediscovering London's working-class mothers, 1870-1918', in Jane Lewis (ed.), *Labour and Love: Women's Experience of Home and family, 1850-1940* (Oxford: Blackwell, 1986)

Ross, Ellen, *Love and Toil: Motherhood in Outcast London 1870-1918* (Oxford University Press, 1993)

Rowan, Caroline, 'Women in the Labour Party, 1906-1920', *Feminist Review* (1982)

Routh, Guy, *Occupation and Pay in Great Britain 1906-1979* (London: Macmillan, 1980)

Rowbotham, Sheila, *A Century of Women* (London: Penguin, 1999)

Rowbotham, Sheila, 'Interpretations of welfare and approaches to the state, 1870-1920' in Ann Oakley and A. Susan Williams (eds), *The Politics of the Welfare State* (London: UCL Press, 1994)

Rowbotham, Sheila, 'Strategies against sweated work in Britain, 1820-1920', in Sheila Rowbotham and Swasti Mitter (eds), *Dignity and Daily Bread: New Forms of Economic Organising Among Poor Women in the Third World and the First* (London: Routledge, 1994)

David Rubinstein, *Before the Suffragettes: Women's Emancipation in the 1980s* (Brighton: Harvester, 1986)

St John, Diana E., 'Educate or domesticate?: early twentieth century pressures on older girls in elementary school', *Women's History Review* (1994)

Sanderson, Kay, "A pension to look forward to ...?": women civil service clerks in London, 1925-1929', in Leonore Davidoff and Belinda Westover (eds), *Our Work, Our Lives, Our Words: Women's History and Women's Work* (London: Macmillan, 1986)

Sanderson, Michael, *The Universities and British Industry 1850-1970* (London: Routledge, 1972)

Schmiechen, James A., *Sweated Industries and Sweated labour: The London Clothing Trades, 1860-1914* (London: Croom Helm, 1984)

Searby, Peter, 'The schooling of Kipps': the education of lower middle class boys in England, 1860-1918', in Peter Searby (ed.), *Educating the Victorian Middle Class* (Leicester: History of Education Society, 1982)

Searle, G.R., 'Eugenics and class', in Charles Webster (ed.) *Biology, Medicine and Society 1840-1940* (Cambridge University Press, 1981)

Seton, Rosemary, "Open doors for female labourers": women candidates of the London Missionary Society, 1875-1914" in Robert Bickers and Rosemary Seton (eds), *Missionary Encounters: Sources and Issues* (London: Curzon Press, 1996)

Sewell, Brocard, *Cecil Chesterton* (Faverhsam: St. Albert's Press, 1975)

Simpson, Richard L. and Simpson, Ida Harper, 'Women and bureaucracy in the semi-professions', in Amitai Etzioni (ed.), *The Semi-Professions and Their Organization: Teachers, Nurses, Social Workers* (New York: The Free Press, 1969)

Smith, David and Nicolson, Malcolm, 'Nutrition, education, ignorance and income: a twentieth-century debate', in Harmke Kammenga and Andrew Cunningham (eds), *The Science and Culture of Nutrition 1840-1940* (Amsterdam: Rodopi, 1995)

Smith, F.B., *The People's Health, 1830-1910* (New York: Holmes & Meier, 1979)

Smith, F.B., *The Retreat of Tuberculosis* (London: Croom Helm, 1988)

Smith, Harold L., 'British feminism and the equal pay issue in the 1930s', *Women's History Review* (1996)

Smith, Harold L., 'British feminism in the 1920s' in Harold L. Smith (ed.), *British Feminism in the Twentieth Century* (Aldershot: Edward Elgar, 1990)

Smith Harold L. (ed.), *British Feminism in the Twentieth Century* (Aldershot: Edward Elgar, 1990)

Smith, Harold, 'The issue of 'equal pay for equal work' in Great Britain, 1914-19', in *Societas* (1978)

Smith, Marjorie J., *Professional Education for Social Work in Britain: An Historical Account* (London: George, Allen & Unwin, 1965)

Sontag, Susan, *Illness as a metaphor* (New York: Vintage, 1979)

Spoor, Alec, *White-collar Union Sixty Years of NALGO* (London: Heinemann, 1967)

Stacey, Margaret, et al (eds), *Health and the Division of Labour* (London: Croom Helm, 1977)

Stacey, Margaret, 'Realities for change in child health care: existing patterns and future possibilities', *British Medical Journal* (1980)

Stacey, Margaret, *The Sociology of Health and Healing* (London: Routledge, 1988)

Steedman, Carolyn, 'Bodies, figures and physiology; Margaret McMillan and the late nineteenth-century remaking of working-class childhood', in Roger Cooter (ed.), *In the Name of the Child: Health and Welfare, 1880-1940* (London: Routledge, 1992)

Steedman, Carolyn, *Childhood, Culture and Class in Britain: Margaret McMillan, 1860-1931* (London: Virago, 1990)

Stevenson, Julie, "Among the qualifications of a good wife, a knowledge of cookery certainly is not the least desirable" (Quentin Hogg): Women and the curriculum at the Polytechnic at Regent Street, 1888-1913', *History of Education* (1997)

Stevenson, Julie, *A Neglected Issue in the History of Education and Training: Women Students of University College London and the Polytechnic at Regent Street, c. 1870-1930* (unpublished PhD thesis, Thames Valley University, 1996)

Summerfield, Penny, 'Women and the professional labour market 1900-1950: the case of the secondary schoolmistress', in *Women, Education and the Professions* (History of Education Society, 1987)

Anne Summers, 'Angels and citizens: symbols and realities in British Military Nursing 1854-1914', *Bulletin of the History of Nursing Group at the Royal College of Nursing* (1987)

Summers, Anne, 'The costs and benefits of caring: nursing charities c.1830-c.1860', in Jonathan Barry and Colin Jones (eds), *Medicine and Charity Before the Welfare State* (London: Routledge, 1991)

Summers, Anne, *Female Lives Moral States: Women, Religion and Public Life in Britain 1800-1930* (Newbury: Threshold Press, 2000)

Summers, Anne, 'Hidden from history? The home care of the sick in the nineteenth century'. *Royal College of Nursing History of Nursing Society Journal* (1992/93)

Sutherland, Gillian, 'The movement for higher education of women: its social and intellectual context in England c.1940-80', in P.J. Waller (ed.), *Politics and Social Change in Modern Britain* (Sussex: Harvester, 1987)

Sutherland, Gillian, 'The plainest principles of justice: the University of London and the higher education of women,' in F.M.L. Thompson (ed.), *The University of London and the World of Learning 1836-1986* (London: Hambledon, 1990)

Szreter, Simon, 'The importance of social intervention in Britain's mortality decline, c.1850-1914: a re-interpretation of the role of public health', *Social History of Medicine* (1988)

Thane, Pat, 'Women in the British Labour Party and the construction of state welfare, 1906-1939' in Seth Koven and Sonya Michel, *Mother's of a New World: Maternalist Politics and the Origins of Welfare States* (London: Routledge, 1993)

Thane, Pat, 'Women of the British Labour Party and feminism, 1906-1945', in Harold L. Smith (ed.), *British Feminism in the Twentieth Century* (Aldershot: Edward Elgar, 1990)

Thom, Deborah, 'The bundle of sticks: women, trade unionists and collective organization before 1918', in Angela V. John, *Unequal Opportunities, Women's Employment in England 1800-1918* (Oxford: Blackwell, 1986)

Thom, Deborah, 'Free from Chains? The image of women's labour in London, 1900-1920', in David Feldman and Gareth Stedman Jones (eds) *Metropolis London: Histories and Representations Since 1800* (London: Routledge, 1989)

Tickner, Lisa, *The Spectacle of Women: Imagery of the Suffrage Campaign, 1907-1914* (London: Chatto & Windus, 1987)

Tomes, Nancy, *The Gospel of Germs: Men, Women and the Microbe in American Life* (Harvard University Press, 1998)

Tomes, Nancy, 'The private side of public health: sanitary science, domestic hygiene, and the germ theory, 1870-1900', *Bulletin of the History of Medicine* (1990)

Tomes, Nancy, 'The white plague revisited', *Bulletin of the History of Medicine* (1989)

Toren, Nina, 'Semi-professionalism and social work: a theoretical perspective', in Amitai Etzioni (ed.), *The Semi-Professions and Their Organization: Teachers, Nurses, Social Workers* (New York: The Free Press, 1969)

Tuke, Margaret J., *A History of Bedford College for Women 1849-1937* (Oxford University Press, 1939)

Turnbull, Annemarie, 'An isolated missionary: the domestic subjects teacher in England, 1870-1914', *Women's History Review* (1994)

Urwin, Cathy and Sharland, Elaine 'From bodies to minds in childcare literature: advice to parents in inter-war Britain', in Roger Cooter (ed.), *In the Name of the Child: Health and Welfare, 1880-1940* (London: Routledge, 1992)

Venables, Peter, *Higher Education Developments: The Technological Universities 1956-1976* (London: Faber & Faber, 1978)

Vincent, A.W., 'The Poor Law Reports of 1909 and the Social Theory of the Charity Organization Society', *Victorian Studies* (1984)

Waddington, Keir, *Finance, Philanthropy and the Hospital: Metropolitan Hospitals, 1850-1898* (Unpublished PhD thesis, University of London, 1995)

Waddington, Keir, *Medical Education at St Bartholomew's Hospital, 1123-1995* (London: Boydell Press, 2003)

Wakeman-Reynolds, Beryl, 'The development of health visitor education and training in England', *Health Visitor* (1987)

Walby, Sylvia, *Patriarchy At Work: Patriarchal and Capitalist Relations in Employment* (Cambridge: Polity Press, 1986)

Waldron, F.C., 'The Association of Social Workers', *Case Conference* (1959)

Walkley, Christina, *The Ghost in the Looking Glass: The Victorian Seamstress* (London: Peter Owen, 1981)

Walton, Ronald G., *Women in Social Work* (London: Routledge, 1975)

Watkins, Dorothy E., *The English Revolution in Social Medicine, 1889-1911* (Unpublished PhD thesis, University of London, 1984)

Webster, Charles (ed.), *Biology, Medicine and Society 1840-1940* (Cambridge University Press, 1981)

Webster, Charles, 'Health, welfare and unemployment during the depression', *Past & Present* (1985)

Webster, Charles, 'Healthy or hungry thirties?' *History Workshop* (1982)

Weindling, Paul (ed.), *The Social History of Occupational Health* (London: Croom Helm, 1985)

Weiner, Deborah E.B., *Architecture and Social Reform in Late-Victorian London* (Manchester University Press, 1994)

Welshman, John, "Bringing beauty and brightness to the back streets": health education and public health in England and Wales, 1890-1940', *Health Education Journal* (1997)

Westover, Belinda, "To fill the kids' tummies": the lives and work of Colchester tailoresses, 1880-1918', in Leonore Davidoff and Belinda Westover (eds), *Our Work, Our Lives, Our Words: Women's History and Women's Work* (London: Macmillan, 1986)

White, Jerry, *Rothschild Buildings: Life in an East End Tenement Block, 1887-1920* (London: Routledge, 1980)

White, Rosemary, 'Health visitors: the willing horses', *Health Visitor* (1987)

White, Rosemary, *Social Change and the Development of the Nursing Profession: A Study of the Poor Law Nursing Service 1848-1948* (London: Henry Kimpton, 1978)

White, Rosemary, 'Some political influences surrounding the Nurses Registration Act 1919 in the United Kingdom', *Journal of Advanced Nursing* (1976)

Widdowson, Frances, "Educating teacher": women and elementary teaching in London, 1900-1914', in Leonore Davidoff and Belinda Westover (eds), *Our Work, Our Lives, Our Words: Women's History and Women's Work* (London: Macmillan, 1986)

Williams, A. Susan, *The Rich Man and the Diseased Poor in Early Victorian Literature* (Macmillan, 1987)

Williams, A. Susan, *Women and Childbirth in the Twentieth Century: A History of the National Birthday Trust Fund* (Stroud: Sutton Publishing, 1997)

Williams, A. Susan, Ivin, Patrick and Morse, Caroline, *The Children of London: Attendance and Welfare at School, 1870-1990* (London: Institute of Education, 2001)

Williams, Margaret Durrant, 'Kept well and working: the RCN and occupational health nursing', *Royal College of Nursing History of Nursing Society Journal* (1992/93)

Williams, Perry, 'The laws of health: women, medicine and sanitary reform, 1850-1890', in Marina Benjamin (ed.), *Science and sensibility: Gender and Scientific Enquiry 1790-1945* (Oxford: Blackwell, 1991)

Witz, Anne, 'Patriarchy and the labour market: occupational control strategies and the medical division of labour', in David Knights and Hugh Willmott (eds), *Gender and the Labour Process* (Aldershot: Gower, 1986)

Witz, Anne, *Professions and Patriarchy* (London: Routledge, 1992)

Wohl, Anthony S., *Endangered Lives: Public Health in Victorian Britain* (London: Methuen, 1983)

Woodward, John, 'Medicine and the city: the nineteenth-century experience, in Woods, Robert and Woodward, John (eds), *Urban Disease and Mortality in Nineteenth-century England* (London: Batsford, 1984)

Worboys, Michael, 'The sanatorium treatment for consumption in Britain, 1890-1914', in John V. Pickstone (ed.) *Medical Innovations in Historical Perspective* (Macmillan, 1992)

Worboys, Michael, *Spreading Germs: Disease Theories and Medical Practice in Britain, 1865-1900* (Cambridge University Press, 2000)

Yelling, J.A., *Slums and Slum Clearance in Victorian London* (London: Allen & Unwin, 1986)

Yelling, Jim, 'The metropolitan slum: London 1918-51' in S. Martin Gaskell, *Slums* (Leicester University Press, 1990)

Yeo, Eileen Janes 'Social motherhood and the sexual communion of labour in British social science, 1850-1950', *Women's History Review* (1992)

Yeo, Eileen Janes, 'The social survey in social perspective', in Martin Bulmer, Kevin Bales and Kathryn Sklar (eds), *The Social Survey in Historical Perspective, 1880-1940* (Cambridge University Press, 1991)

Young, A.F and Ashton, E.T, *British Social Work in the Nineteenth Century* (London: Routledge, 1956)

Zimmeck, Meta, 'Jobs for the girls: the expansion of clerical work for women, 1850-1914', in Angela V. John (ed.), *Unequal Opportunities: Women's Employment in England, 1880-1918* (Oxford: Blackwell, 1986)

Zimmeck, Meta, 'We are all professionals now: professionalisation, education and gender in the civil service, 1873-1939', in *Women, Education and the Professions* (History of Education Society, 1987)

