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Excluded from Welfare: Colonial Ordinances and Women's Mental Illness in the Straits Settlements, 1875-1900

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Abstract

Mental illness among women in the Straits Settlements during the late nineteenth century emerged alongside the expansion of British colonial labour and welfare governance. Although colonial ordinances were introduced to regulate labour conditions and medical provision, these measures were primarily designed around male workers and failed to account for women's specific economic and social positions. From 1875 onwards, women were increasingly incorporated into mining, plantation, and auxiliary labour as economic demands intensified. Despite their growing participation, women remained marginal within labour and welfare policies, resulting in limited access to wages, food, housing, and medical care. This study examines how colonial ordinances specifically the Food Control Ordinance, the Workmen Salaries Ordinance, and the Mental Ordinance shaped women's vulnerability to mental illness between 1875 and 1900. Using a qualitative historical approach, the study analyses colonial ordinances, medical and asylum reports, government gazettes, and official correspondence from archives in Malaysia and Singapore. The findings demonstrate that welfare provision was selectively enforced through labour-based eligibility criteria that systematically excluded women, particularly those engaged in informal or auxiliary work. As a result, malnutrition, wage insecurity, and delayed medical treatment accumulated over time, contributing to physical decline and psychological distress. Mental institutions, rather than functioning primarily as spaces of care, operated as mechanisms for managing the visible consequences of prolonged deprivation. The study argues that women's mental illness in the Straits Settlements was not merely a medical phenomenon but a structural outcome of gendered colonial governance. By foregrounding women's experiences within colonial labour and medical regimes, this article contributes to scholarship on colonial welfare, gendered labour systems, and the social history of mental illness in Southeast Asia.

Keyword: Mental Illness; Women; British Colony; Colonial Ordinance; Straits Settlements

Introduction

Mental illness among women in the Straits Settlements during the late nineteenth century developed alongside the expansion of British colonial labour systems and welfare governance. As colonial administration intensified after the 1870s, a growing body of ordinances was introduced to regulate labour recruitment, wages, food supply, and medical treatment. These measures were presented as instruments of order, efficiency, and protection. Yet they were constructed around assumptions that positioned male labourers as the primary subjects of colonial concern. Women's participation in the colonial economy was recognised only marginally and rarely incorporated into formal systems of regulation or welfare. As a result, women experienced colonial governance not as protection but as

structured exclusion. From 1875 onwards, women were increasingly drawn into mining, plantation, and auxiliary labour as economic demands expanded. Their labour contributed directly to colonial production, yet it remained poorly defined within official categories of work. Colonial labour records from the Straits Settlements during the late nineteenth century consistently showed that women formed only a small proportion of the officially registered labour force, with the majority of registered workers recorded as male migrant labourers employed in mines and plantations.[1] Recruitment systems such as the Kangani system for Indian labourers and the credit ticket or special entry system for Chinese workers were designed to manage male mobility, discipline, and productivity. These systems shaped access not only to employment but also to food rations, housing, and medical services. Women entered this labour regime without being fully recognised by it. They worked within industries regulated for men while remaining outside the protections tied to male labour status. This contradiction formed the structural basis of their vulnerability.

Colonial policies governing labour and welfare did not simply overlook women; they actively produced hierarchies of value that placed male workers at the centre of administrative attention. Women were frequently classified as dependents, casual workers, or supplementary labour. Such classifications justified their exclusion from wage protection, food subsidies, and employer-provided housing. The assumption that women's earnings were secondary and their productivity unstable shaped how ordinances were implemented on the ground. Pregnancy, childcare, and domestic responsibility were treated as obstacles to efficiency rather than as realities requiring policy adaptation. The colonial state thus benefited from women's labour while avoiding responsibility for their welfare. Within this framework, women's health was governed indirectly through their labour status. Access to food, wages, and medical care depended less on physical need than on administrative recognition. Diseases associated with poverty and malnutrition, including beriberi, were widespread during this period and were known to produce both physical and psychological symptoms.[2] Yet colonial medical discourse tended to frame women's illness in cultural or moral terms rather than as outcomes of material deprivation. Poor health was attributed to dietary habits, ignorance, or domestic practices, deflecting attention from the structural constraints imposed by labour and welfare policies. This interpretive strategy allowed colonial governance to maintain an appearance of neutrality while tolerating unequal exposure to illness.[3]

Mental illness emerged within this context of cumulative deprivation. Women's psychological distress did not arise suddenly or independently of bodily hardship. It developed alongside chronic hunger, unstable income, exhausting labour, and delayed access to medical care. Hospitals and dispensaries prioritised registered workers whose treatment could be justified economically.[4] Women who lacked formal labour status were often expected to rely on family resources or private payment. Medical reports from the Straits Settlements also indicate that hospital patients in labour districts were overwhelmingly male migrant workers, reflecting the close relationship between labour registration and access to colonial medical services. As a result, treatment was frequently delayed until illness had reached an advanced stage. By the time women entered institutional care, their conditions had often deteriorated to the point of being classified as mental illness. The Mental Ordinance represented the final stage of colonial intervention. While presented as a humanitarian framework for care and protection, its implementation reflected the same economic and gendered priorities that shaped labour and medical governance.[5] Admission to asylums were influenced by ability to pay, labour registration, and perceived productivity. European and higher-paid patients were prioritised, while local women were frequently admitted as pauper cases under restrictive conditions.[6] The asylum thus became a space where the consequences of long-term exclusion were made visible, even as their causes were obscured. Women's prolonged confinement reinforced colonial narratives of weakness and incurability, while concealing the structural processes that had produced their condition.

Scholars work on colonial psychiatry has increasingly highlighted the relationship between imperial governance, medical knowledge, and social control. Studies by Anderson[7]and Vaughan,[8] for example, have demonstrated how colonial medicine functioned within broader structures of imperial power and racialised governance. In the context of Singapore and British Malaya, Loh[9] has shown how mental asylums operated as institutions embedded within colonial administrative systems. While these studies have provided valuable insights into the institutional history of psychiatry, much of the existing literature remains centred on the operation of asylums themselves. Less attention has been given to the structural conditions that preceded institutionalisation, particularly how labour regulations, food distribution policies, wage structures, access to medical care, and institutional confinement shaped women's mental health outcomes.

This study argues that women's mental illness in the Straits Settlements between 1875 and 1900 must be understood as a structural outcome of colonial governance rather than as an individual or cultural phenomenon. Labour regulation, food control, wage policy, medical access, and institutional confinement operated together to shape women's everyday lives. Each layer of exclusion intensified the next. Economic marginality limited access to food and housing; nutritional deprivation weakened the body; low wages generated chronic stress; delayed medical care allowed illness to worsen; and institutionalisation became the final response to accumulated hardship.[10] Mental illness was thus not an aberration within colonial society but a predictable consequence of policies that prioritised productivity over care. By foregrounding women's experiences within colonial labour and medical regimes, this article contributes to scholarship on colonial medicine, gendered labour systems, and the social history of mental illness in Southeast Asia. It shifts attention away from institutional spaces alone and toward the everyday policies that shaped vulnerability long before confinement occurred. In doing so, it challenges interpretations that locate women's distress in biology, culture, or morality and instead situates mental illness within the political economy of colonial rule.

Methodology

This study adopts a qualitative historical research design to examine how colonial ordinances shaped women's vulnerability to mental illness in the Straits Settlements between 1875 and 1900. Historical methodology is appropriate for analysing policy intent, institutional practice, and social conditions as reflected in official records and medical documentation.[11] The analysis focuses on three key ordinances: the Food Control Ordinance, the Workmen Salaries Ordinance, and the Mental Ordinance, which structured access to labour protection, nutrition, and institutional care.[12] Primary sources were drawn from colonial legislative proceedings, government gazettes, annual medical and asylum reports, and administrative correspondence held in archives in Malaysia and Singapore. These materials provide insight into how labour regulation, welfare provision, and mental health policy were implemented in practice. Particular attention was given to records relating to female labour, hospital admissions, and asylum populations in order to trace how women were positioned within these regulatory frameworks. Secondary sources on colonial labour systems, nutrition, and medical governance were consulted to contextualise these findings and to support interpretation.

Data were analysed using thematic analysis adapted for historical research. Documents were coded to identify recurring patterns related to labour status, food access, wage regulation, medical eligibility, and institutional admission.[13] These themes were then examined in relation to one another to demonstrate how different ordinances interacted to produce cumulative effects on women's health and well-being. Rather than treating mental illness as an isolated category, the analysis situates it within everyday material conditions shaped by colonial governance. Colonial archives were produced primarily by administrators and medical officials, and therefore reflect institutional perspectives rather

than women's own voices. This study addresses this limitation by reading official records critically and focusing on the structural conditions they reveal, rather than on individual diagnoses alone.[14] By analysing policy design and administrative practice, this methodology allows women's mental illness to be interpreted as a consequence of systemic exclusion embedded within colonial labour and welfare regimes.

Results and Discussion

This section analyses how colonial ordinances shaped women's vulnerability to mental illness in the Straits Settlements between 1875 to 1900. Rather than approaching mental illness as an isolated medical condition, the findings demonstrate that women's psychological distress developed through everyday material circumstances structured by colonial labour and welfare governance. Policies regulating labour recruitment, food supply, wages, medical access, and asylum admission formed an interconnected framework that governed women's lives from employment to institutional confinement. Each ordinance contributed to a cumulative process of deprivation that weakened women physically and psychologically over time. The discussion proceeds by examining six interrelated dimensions: gendered labour regulation and economic marginality; nutritional deprivation under the Food Control Ordinance; wage insecurity and housing under the Workmen Salaries Ordinance; restricted access to medical care; asylum practices under the Mental Ordinance; and finally, the cumulative and structural nature of women's mental illness. Together, these findings show that women's mental illness was not a sudden or individual outcome but a predictable consequence of gendered colonial governance.

Gendered Labour Regulation and Economic Marginality

The findings of this study indicate that women's mental illness in the Straits Settlements was deeply rooted in their economic marginality within colonial labour regulation. British labour ordinances were designed around assumptions that positioned male workers as the primary economic subjects of the colonial economy. Recruitment systems such as the Kangani system for Indian labourers and the credit ticket or special entry system for Chinese workers were structured to regulate male mobility, discipline, and productivity.[15] These systems shaped not only patterns of employment but also access to welfare provisions, including wages, housing, food rations, and medical care. Women entered the colonial labour force within frameworks that neither recognised their labour as central nor adapted regulatory mechanisms to their participation.

From the late nineteenth century onwards, women were increasingly employed in mining-related activities, plantation work, and auxiliary labour as economic demands intensified.[16] Despite their growing presence, women were frequently classified as casual, daily-paid, or supplementary workers. Such classifications excluded them from formal labour registration systems that determined eligibility for welfare benefits. As a result, women's labour was economically productive yet administratively invisible. This invisibility was based on the assumption that women's work was less valuable and easily dispensable.[17] Colonial correspondence and labour reports indicate that administrators were aware of women's participation in the workforce but did not revise labour policies accordingly. Instead, women's exclusion from labour protection was justified through notions of dependency and biological limitation. Pregnancy, childcare, and domestic responsibilities were framed as obstacles to productivity, reinforcing the view that women were unsuitable recipients of long-term investment. Colonial labour reports from the late nineteenth century indicate that women constituted a significantly smaller proportion of the formally registered workforce in the Straits Settlements. While male migrant labourers dominated official labour records, women frequently appeared only as

dependents or informal workers attached to male labourers. This administrative categorisation limited their access to wage protection, employer-provided housing, and regulated food provisions.

Economic marginality had cumulative effects on women's daily lives. Without access to regulated wages or employer-provided housing, many women lived in overcrowded and unsanitary environments near plantations and mining sites.[18] Low and irregular incomes restricted their ability to secure adequate food and medical treatment, increasing physical vulnerability and psychological strain. These conditions were not recognised as consequences of labour policy but were instead treated as individual or cultural failings. The absence of women from official labour categories thus translated into material deprivation that shaped both physical and mental health outcomes. This gendered structure of labour governance formed the foundation upon which subsequent exclusions were built. The denial of formal labour status restricted access to food subsidies, wage protection, and medical care, creating a chain of disadvantage that culminated in delayed treatment and institutionalisation. Women's mental illness must therefore be understood not as an isolated medical issue but as a predictable outcome of economic marginalisation produced by colonial labour regulation. By foregrounding labour status as a key determinant of vulnerability, this section establishes the structural context for examining how specific ordinances further intensified women's exposure to illness and psychological distress.

Nutritional Deprivation and the Food Control Ordinance

The Food Control Ordinance played a central role in shaping women's physical and mental vulnerability in the Straits Settlements. Although the ordinance was introduced to regulate food distribution and stabilise prices, its benefits were closely tied to labour registration and employment status. In practice, food rations and subsidies were extended primarily to registered workers, a category that excluded many women engaged in informal or auxiliary labour. As a result, women who contributed to mining and plantation work often lacked reliable access to adequate nutrition, despite performing physically demanding tasks. Colonial medical reports consistently linked poor nutrition to illness among the local population, particularly diseases such as beriberi, which was prevalent in the late nineteenth century and known to produce both physical weakness and psychological symptoms.[19] Women were especially vulnerable to nutritional deficiencies because their wages were lower and less stable, and because they were frequently responsible for supporting dependents. The Food Control Ordinance did not account for these realities. Instead, it reinforced existing inequalities by tying food security to formal labour status rather than to actual need or contribution.

Rather than recognising malnutrition as a consequence of structural exclusion, colonial officials often attributed women's poor health to cultural practices or ignorance. Medical and administrative reports described dietary habits as irrational or unhygienic, diverting attention from the economic constraints that limited women's access to nutritious food. This interpretation allowed the colonial administration to avoid responsibility for addressing food insecurity among women labourers while continuing to benefit from their work. The framing of malnutrition as a cultural problem thus obscured the role of colonial policy in shaping everyday survival. Nutritional deprivation had cumulative effects on women's physical and mental health. Chronic hunger weakened the body, reduced resistance to disease, and intensified fatigue.[20] Over time, these physical effects contributed to emotional distress, anxiety, and cognitive impairment. Women who were already burdened by long working hours and domestic responsibilities experienced heightened psychological strain as a result of food insecurity.[21] Yet these conditions were rarely recognised as contributing factors to mental illness within colonial medical discourse[22].

The exclusion of women from food subsidies also interacted with other forms of deprivation. Low wages limited women's ability to purchase food independently, while poor housing conditions exacerbated the effects of malnutrition. When illness developed, women's lack of formal labour status often delayed access to medical treatment, allowing conditions to worsen. In this way, the Food Control Ordinance did not operate in isolation but functioned as part of a broader system that compounded women's vulnerability. Nutritional deprivation was therefore not an accidental outcome of colonial administration but a predictable result of policy design. By linking food security to labour registration, the Food Control Ordinance reinforced gendered inequalities and contributed directly to women's physical decline and psychological distress.

Wages, Living Conditions, and the Workmen Salaries Ordinance

The Workmen Salaries Ordinance further shaped women's vulnerability to mental illness by reinforcing economic insecurity and poor living conditions. Although the ordinance was introduced to regulate wages and prevent exploitation, its protections were largely inaccessible to women because their work was commonly classified as informal, casual, or supplementary. Wage regulation was tied to recognised categories of labour, which prioritised male workers in mining, plantation, and industrial sectors. Women's labour, often described as auxiliary or temporary, fell outside these categories and therefore outside the scope of wage protection.[23] As a result, women's earnings were consistently lower and more unstable than those of male labourers. Their wages were often paid daily or irregularly and were easily reduced or withheld by employers. Low and unstable income reduced women's ability to obtain secure housing, forcing many to live in overcrowded and poorly maintained dwellings near plantations and mining sites.[24] Such living environments were marked by inadequate sanitation, limited ventilation, and high population density. These conditions increased exposure to infectious disease and produced persistent physical discomfort. For women, who frequently combined paid labour with domestic responsibilities, these conditions created sustained physical exhaustion and emotional strain.[25]

Colonial records rarely connected poor living conditions to wage insufficiency or labour policy. Instead, overcrowding and insanitary housing were commonly framed as problems of behaviour or custom rather than as consequences of economic marginalisation. This framing concealed the role of the Workmen Salaries Ordinance[26] in shaping everyday hardship. By failing to regulate women's wages effectively, the ordinance indirectly produced housing conditions that undermined physical health and psychological well-being. Poverty was thus treated as a moral or cultural condition rather than as a product of policy design. Economic insecurity also heightened women's exposure to stress and anxiety. Irregular income made it difficult to plan for illness, food shortages, or temporary unemployment. Women who supported children or elderly relatives faced additional pressure, as limited wages had to be stretched across household needs.[27] The constant uncertainty surrounding survival created a condition of chronic stress that was rarely acknowledged within colonial medical discourse. Emotional distress caused by financial instability was not recognised as a legitimate health concern, particularly for women whose labour was undervalued and weakly protected.

The relationship between wages and mental health became especially visible when illness interrupted women's ability to work. Without savings or wage guarantees, even short periods of illness could lead to rapid economic decline. In such circumstances, women delayed seeking medical care due to cost, allowing physical and psychological conditions to worsen. This delay increased the likelihood that illness would progress into severe mental distress requiring institutional intervention. The Workmen Salaries Ordinance therefore played a critical role in shaping the material conditions that preceded women's mental illness. By excluding women from wage protection, the ordinance

reinforced poverty, insecure housing, and chronic stress. These conditions interacted with nutritional deprivation and restricted medical access to produce a cumulative burden that weakened both physical and mental resilience. Women's mental illness must thus be understood as emerging from prolonged exposure to economic instability rooted in colonial wage regulation rather than as an isolated or sudden medical event.[28]

Access to Medical Care and Institutional Delay

Access to medical care represented a crucial point at which women's physical hardship and psychological distress might have been addressed. However, colonial medical provision in the Straits Settlements was structured in ways that systematically delayed treatment for women labourers. Eligibility for subsidised medical services was closely tied to labour registration, wage levels, and the ability to pay fees. Many women were employed informally or classified as casual workers. As a result, they were frequently excluded from free or subsidised hospital treatment.[29] Colonial medical reports indicate that hospitals and dispensaries prioritised registered workers whose treatment could be justified in economic terms. Medical expenditure was linked to labour productivity, and care was concentrated on those whose health was considered valuable to the colonial economy. Women who did not meet these criteria were expected to rely on family resources or private payment, which were often insufficient given their low and unstable incomes. This exclusion was not incidental but reflected a broader logic within colonial governance that linked welfare provision to economic usefulness. Women's health was treated as a private matter rather than as a responsibility of the state, despite their contribution to colonial production. Colonial hospitals frequently prioritised registered labourers whose recovery was tied to economic productivity. Women who lacked formal labour status were less likely to receive early medical attention and often sought treatment only when illness had significantly progressed. Medical department reports from the Straits Settlements indicate that the majority of hospital patients recorded in labour districts were male migrant workers, reflecting the strong connection between labour registration and access to treatment.

Delayed access to medical care had serious consequences for women's physical and mental health. Prolonged exposure to malnutrition, disease, and exhaustion weakened the body and reduced resistance to illness. Over time, untreated physical conditions produced emotional distress, anxiety, and cognitive impairment. Medical records frequently described female patients as arriving at hospitals or asylums in an advanced state of illness, reinforcing colonial perceptions of women as inherently weak or unstable. These descriptions concealed the structural factors that delayed treatment in the first place. Colonial administrators often explained women's failure to seek early treatment in cultural terms. Delayed admission was attributed to superstition, ignorance, or preference for domestic remedies. Such interpretations diverted attention from the financial and institutional barriers that prevented access to care. By framing delayed treatment as a cultural problem, the colonial medical system avoided addressing the labour-based eligibility criteria that restricted women's entry into hospitals. This interpretive strategy preserved the appearance of administrative neutrality while sustaining patterns of exclusion.[30]

The delay in medical intervention also increased the likelihood of institutionalisation under the Mental Ordinance. Women whose physical illnesses deteriorated due to lack of early treatment were more likely to be classified as mentally ill and transferred to asylums. In this way, exclusion from general medical care contributed directly to the growth of mental institutions. Rather than preventing mental illness, colonial medical policy often facilitated its progression by withholding care until crisis points were reached. Medical institutions thus functioned less as preventative services than as gatekeeping mechanisms that intervened only after significant deterioration had occurred. This

analysis shows that limited access to medical care was a key mechanism linking labour exclusion to mental illness. Women's mental breakdowns did not emerge suddenly but developed through prolonged neglect and delayed treatment. The medical system, shaped by colonial priorities and economic calculation, intervened too late to prevent deterioration. Women's mental illness must therefore be understood as the outcome of systematic delay embedded within colonial healthcare provision rather than as a failure of individual behaviour or cultural practice.[31]

The Mental Ordinance and Profit-Oriented Asylums

The Mental Ordinance regulated the admission, treatment, and confinement of individuals diagnosed as mentally ill in the Straits Settlements and represented the final stage of institutional intervention. While the ordinance was framed as a humanitarian legal instrument designed to protect both patients and society, its implementation reflected the same gendered and economic priorities that structured labour and medical governance. Admission to mental institutions was influenced by labour registration, wage level, and the ability to pay institutional fees. These criteria systematically disadvantaged women labourers, who were more likely to be classified as informal workers and therefore excluded from subsidised care.[32] Medical reports from the Straits Settlements during the late nineteenth century show that female patients represented a smaller proportion of total admissions compared with male labourers. However, the records frequently described women as being admitted at more advanced stages of illness, suggesting that intervention often occurred only after prolonged deterioration.

Colonial asylum records indicate that European patients and higher-paid, registered workers were prioritised for admission and treatment. These patients were more likely to receive earlier intervention, better accommodation, and closer medical supervision. In contrast, local women were frequently admitted as pauper patients under restrictive conditions. Their institutional experience was shaped by overcrowding, limited resources, and delayed diagnosis.[33] The asylum thus reproduced social hierarchies already embedded in colonial society. Rather than functioning as an equalising space of care, it mirrored the inequalities generated by labour and welfare policies.[34]

Financial considerations played a central role in shaping asylum practices. Colonial asylums were expected to operate efficiently and minimise public expenditure. This expectation encouraged administrators to favour patients whose treatment could be economically justified, either through their labour value or through private payment. Women, particularly those without formal labour status or family support, were viewed as unproductive and costly. This perception shaped both admission decisions and the duration of confinement. Women were often retained in institutions for extended periods, reinforcing colonial narratives of chronic illness and incurability. These narratives obscured the structural causes of women's mental distress and instead presented institutionalisation as a natural or necessary outcome. Colonial medical reports frequently described female patients in terms that emphasised emotional instability, passivity, and moral weakness. Such descriptions reinforced gendered stereotypes and framed women's mental illness as an inherent condition rather than as a response to prolonged hardship. By the time women entered asylums, their physical and psychological states had often deteriorated due to malnutrition, poverty, and delayed medical care. The asylum thus became a site where the consequences of earlier exclusion were made visible, even as their origins were concealed.

The Mental Ordinance also functioned as a mechanism of social control. Women who could no longer sustain labour or domestic responsibilities were removed from public view and confined within institutions.[35] This process served to manage non-productive bodies while preserving the appearance of order within colonial society. Rather than addressing the conditions that produced mental illness, the asylum system contained its visible effects. The ordinance therefore did not operate

independently but formed part of a broader regulatory framework that governed women's lives from labour participation to institutional confinement. Women's mental illness, as managed under the Mental Ordinance, must be understood as the cumulative outcome of gendered colonial governance rather than as a failure of individual resilience or cultural adaptation.[36]

Structural Production of Mental Illness under Colonial Governance

Mental illness among women did not emerge as an isolated medical condition but developed gradually through the accumulation of social and economic pressures embedded within colonial governance. The colonial labour system organised everyday life through rigid hierarchies of productivity and value.[37] Workers who were formally recognised within labour regulations gained access to certain forms of support such as wages, housing, food provisions, and medical services. Those who remained outside these categories faced far greater uncertainty. Women frequently occupied this marginal position. Their labour contributed to economic production but was rarely acknowledged within official administrative frameworks. As a result, their access to basic welfare provisions remained unstable. This structural marginalisation exposed women to prolonged nutritional insecurity, physical exhaustion, and economic dependency, conditions that intensified vulnerability to both physical and psychological illness. Colonial governance further reinforced these vulnerabilities through gendered assumptions about labour and social roles. Administrative policies frequently treated women as dependents attached to male labourers rather than as workers in their own right. This classification allowed colonial authorities to minimise responsibility for women's welfare while still benefiting from their economic contributions.[38] Women's domestic responsibilities, reproductive roles, and caregiving duties were interpreted as natural obligations rather than labour requiring protection or support.[39] Consequently, the everyday burdens placed upon women were largely invisible within official policy frameworks. The absence of institutional recognition meant that health problems experienced by women were often addressed only when they became severe enough to require institutional intervention. By the time medical authorities encountered these cases, the conditions that had produced them were already deeply entrenched.[40]

Understanding women's mental illness within this broader political economy challenges interpretations that locate psychiatric illness primarily within cultural or biological explanations.[41] Colonial medical discourse often described female patients in moral or behavioural terms, emphasising emotional instability, domestic conflict, or cultural practices. Such explanations obscured the structural conditions shaping women's lives. When viewed through the lens of labour regulation and welfare governance, however, mental illness appears less as an individual pathology and more as the outcome of prolonged social and economic strain.[42] This perspective expands the study of colonial psychiatry beyond institutional spaces such as hospitals and asylums, directing attention to the everyday policies that structured vulnerability long before patients entered medical institutions.

Rethinking Colonial Welfare, Gender, and Mental Health

The findings of this study require a reassessment of colonial welfare in the Straits Settlements, particularly in relation to gender and mental health. Colonial ordinances are often presented in administrative records as evidence of order, reform, and progress.[43] However, when examined through women's experiences, welfare provision appears highly selective and deeply structured by gendered assumptions about productivity and dependency. Access to food subsidies, wage protection, and medical care was consistently linked to formal labour registration and economic contribution. This framework positioned male workers as legitimate subjects of welfare while treating women as

peripheral participants whose needs fell outside the responsibility of the state.[44] Women's exclusion from labour protection and medical care was therefore not the result of bureaucratic oversight but reflected deliberate policy priorities. Colonial welfare systems were designed to preserve the efficiency of the workforce rather than to promote social well-being. Illness among women was tolerated as long as it did not disrupt labour productivity or public order.[45] Only when women became unable to work or care for dependants did their condition become a matter of institutional concern. At that point, asylum confinement replaced earlier forms of assistance. This pattern demonstrates that colonial welfare operated reactively rather than preventively, intervening only after prolonged hardship had produced visible breakdown.

Mental health institutions governed by the Mental Ordinance exemplified this logic. Rather than functioning as therapeutic or rehabilitative spaces, asylums served primarily to manage the social consequences of long-term neglect. Women were often admitted at advanced stages of illness, reinforcing colonial narratives of incurability and chronic weakness. These narratives obscured the structural causes of their distress and shifted attention away from labour exclusion, nutritional deprivation, and delayed medical access.[46] Colonial medicine explained women's illness in moral terms instead of material conditions, making inequality appear normal and unavoidable.

Family Responsibility, Informal Care, and the Shifting Burden of Welfare

Colonial welfare policy increasingly shifted responsibility for care away from state institutions and onto families, particularly in cases involving women. Rather than expanding access to medical or institutional support, colonial administrators promoted informal care within households as a cost-saving strategy. Women who displayed early signs of illness were often returned to relatives rather than admitted to hospitals or asylums, especially when they were classified as non-productive or unable to pay for treatment.[47] This approach reframed illness as a private matter rather than a public responsibility, reinforcing the idea that women's health fell outside the scope of state welfare. Family care, however, did not necessarily provide adequate support. Many women's families were themselves affected by poverty, unstable employment, and overcrowded living conditions. The expectation that relatives could absorb the burden of care ignored the material realities of working-class households. Women who were ill often remained in environments characterised by malnutrition, exhaustion, and limited medical supervision. Informal care thus functioned less as a form of protection than as a mechanism of delay. It postponed institutional treatment without addressing the conditions that had produced illness in the first place.[48] Colonial medical records suggest that women were frequently discharged from hospitals or refused admission on the grounds that their families could supervise them at home. This decision was framed as humane and economical, yet it relied on assumptions about women's domestic roles as carers rather than patients. When women failed to recover under family supervision, their deterioration was later used as justification for asylum confinement. In this way, informal care became part of a longer trajectory toward institutionalisation rather than an alternative to it.[49]

The shifting of responsibility to families also reinforced gendered expectations about care and dependency. Women were assumed to be naturally suited to domestic environments, even when those environments were materially deprived. Their suffering was rendered less visible within private spaces, delaying recognition and treatment. By the time women entered asylums, their conditions had often worsened significantly due to prolonged neglect. The promotion of family responsibility therefore did not prevent mental illness but contributed to its cumulative development. This pattern demonstrates that informal care was not a neutral or benevolent alternative to institutional medicine. Instead, it functioned as an extension of colonial welfare logic that prioritised cost reduction over

early intervention. Women's mental illness emerged not only from exclusion within labour and medical systems but also from policies that redirected care into spaces where adequate support was unlikely. Family responsibility thus became another layer in the chain of structural disadvantage, linking economic marginalisation to delayed treatment and eventual confinement.

Conclusion

This study has shown that women's mental illness in the Straits Settlements between 1875 and 1900 must be understood as a structural and cumulative outcome of colonial governance rather than as an isolated medical condition or cultural phenomenon. Through an examination of labour regulation, food control, wage policy, medical access, and institutional confinement, the analysis demonstrates how colonial ordinances systematically marginalised women by tying welfare to formal labour status and economic value. Women's participation in mining, plantation, and auxiliary work did not translate into recognition within regulatory frameworks. Instead, their labour remained administratively invisible, limiting access to wages, food subsidies, housing, and medical care. The findings reveal a consistent pattern across different domains of policy. Labour exclusion restricted women's access to regulated wages and welfare benefits. Nutritional deprivation weakened physical health and intensified emotional strain. Low and unstable income produced chronic stress and insecurity. Delayed access to medical care allowed illness to progress untreated. Finally, asylum admission under the Mental Ordinance occurred only after significant deterioration. Mental illness thus developed gradually through prolonged exposure to hardship rather than through sudden psychological rupture. Institutional confinement marked the endpoint of a process shaped by earlier exclusions rather than the beginning of care.

By foregrounding women's experiences, this study challenges interpretations that locate mental illness in biological weakness, moral failure, or cultural deficiency. Instead, it demonstrates that distress and breakdown were embedded within everyday material conditions shaped by colonial regulation. Gender was central to this process. Colonial welfare systems privileged male, registered workers as deserving subjects of protection while treating women as peripheral contributors whose suffering did not warrant intervention. Mental health institutions managed the visible effects of inequality without addressing its causes, transforming material deprivation into medical diagnosis. This analysis contributes to scholarship on colonial medicine and governance by showing how mental illness functioned as a social indicator of structural neglect. It reveals that colonial power operated not only through asylums and hospitals but through policies governing food, wages, housing, and labour registration. Women's mental illness in the Straits Settlements was therefore not merely a medical problem but a reflection of how colonial systems valued economic productivity over human well-being. Understanding this relationship allows mental illness to be read as a product of governance rather than as an individual failure, highlighting the need to situate medical history within broader histories of labour, welfare, and gender.

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