MALTA, MOTHERHOOD, AND INFANT MORTALITY:
INTEGRATING BIOLOGICAL AND SOCIO-CULTURAL INSIGHTS

by

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Abstract

Because infants are the most vulnerable members of a community, their deaths – and the resulting infant mortality rate (IMR) – are said to signal more fundamental problems that are likely to affect the general health of a community. However, a focus on proximate- and intermediate-level risk factors in epidemiological analyses presents a decontextualized picture and ignores the role of larger forces on health, disease, and illness. In response to this trend, this project will contribute to a revitalization of the use of infant mortality as an index of larger social problems by tempering statistical analyses with critical reflection regarding the effects of the liminal position of Malta within the British imperial system, prior to the Second World War. In addition, by bringing together several analytic approaches which often proceed in parallel, rather than in dialogue – historical epidemiology, social history, and the analysis of colonial discourse – this dissertation highlights the problematics of knowledge production at both the theoretical and methodological level. As a result, my work is not just about Malta, one moment in history, the calculation of infant mortality rates, or the disentanglement of various determinants of infant mortality in this context; it is about the dynamics and repercussions of power differentials and of social, economic, and political inequalities, as they define and structure health outcomes and experiences. Specifically, I will show that fluctuations in international tensions affected Malta’s population on a number of levels because of the island’s importance as a British military and naval base and its location in
the middle of the Mediterranean. I will demonstrate how Malta’s “strategic position” restricted political and economic development in the island and articulated with colonial perceptions of the Maltese as “Other” and Malta as “overpopulated.” Finally, I will argue that international tensions, Malta’s location within Empire, and perceptions of the island and its inhabitants in the early twentieth century affected the ways in which infant deaths were explained and understood and the strategies of intervention initiated in the island to curtail infant mortality – all of which had a tremendous impact on the rates at which infants in Malta died.
Acknowledgments

Writing a dissertation is something of a paradox: it can be a lonely and isolating process, but it cannot be done alone or in isolation. Despite the hours I spent by myself, typing away at my desk, with not even a window to remind me that there was a world beyond the screen before me, the influence of those who were involved in my life and work during this period was monumental. First of all, I must thank my supervisor, Dr. L.A. Sawchuk. When I applied to the University of Toronto, I had no idea what I wanted to do, and unfortunately – so he tells me – my letter of application made that abundantly clear. Yet Larry fought to have me accepted into the PhD program, he was a friend to me when I knew next to no one, and he gave me the freedom to embark on a project that I found stimulating, despite his reservations about me being “seduced by the dark side”. If Larry had not decided to bring me along to London, Gibraltar, and Malta to assist him in his research, if he had not introduced me to the joys of archival research, and if he had not given me unfettered access to the astonishing amount of data and materials that he had collected over the years, I would never had been able to write the dissertation that follows. And for that I will always be grateful.

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Chapter 1 – The Meaning of Infant Mortality

Today, reducing infant mortality worldwide is an international public health priority, and mothering is overwhelmingly implicated in debates surrounding infant and child health. The primacy of this concern, and the role of mothers, is evidenced by the World Health Organization’s world health report of 2005, subtitled ‘Make every mother and child count’, in which they wrote:

Why is it still necessary for this report to emphasize the importance of focusing on the health of mothers and children, after decades of priority status, and more than 10 years after the United Nations International Conference on Population and Development? (World Health Organization 2005).

However, in this report, when the World Health Organization acknowledges that more should be done to address still staggering rates of infant, child, and maternal mortality among many of the world’s populations, despite the fact that the health of mothers and children has been of priority status for decades, they are perhaps under-stating the case. International attention to the health of infants, children, and their mothers is not a new phenomenon, and it has been a “priority” for more than a few decades. Klaus (1993) and Davin (1978) have shown that concern over infant and child mortality, and the practices of mothering, initially appeared in France and Britain in the late nineteenth and early twentieth centuries. Increased attention to infant and child health also characterized the twentieth century as a whole. In 1919, Eglantyne Jebb, a British social reformer, founded Save the Children to raise money to send emergency aid to children suffering from

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1 The World Health Report was first published in 1995, and in addition to including health statistics relating to all countries, it focuses on a specific subject each year, thereby signalling the priority status of that issue. For example, World health Reports in other years have focused on such crucial and timely issues as infectious disease (World Health Organization 1996), mental health (2001), HIV/AIDS (2004), the crisis in the global health workforce (2006), and the title of the most recent world health report is “A safer future: global public health security in the 21st century” (2007).
shortages of food and supplies partially engendered by the Allied blockade of Germany and Austria-Hungary following the First World War (Yates 2007). Subsequently, Jebb drafted a Declaration of the Rights of the Child, which was endorsed by the League of Nations General Assembly (the body which was formed following World War I and was replaced by the United Nations following World War II) in 1924. In 1946, this declaration was revised, and in the same year the United Nations Children’s Fund (UNICEF) was created to provide humanitarian and developmental assistance to children and mothers in developing countries. An expanded version of the declaration was adopted by the General Assembly of the United Nations in 1959, and in 1979 the drafting of the Convention on the Rights of the Child was begun. Unanimously adopted by the General Assembly of the United Nations in 1990, one of the four main principles of the Convention is to promote the right to life, survival, and development of infants and children.

A flurry of activity followed, as the health of infants, children, and their mothers was brought to the forefront of international health policy with the 1990 World Summit for Children, the 1993 World Conference on Human Rights, the 1994 International Conference on Population and Development (mentioned above, by the WHO), and the 1995 Fourth World Conference on Women in Beijing, among others (Black et al. 2003; Rutstein 2000; United Nations 2007). Significantly, by 1995 the Convention on the Rights of the Child had been ratified by 185 countries, and it later informed the formulation of the Millennium Development Goals adopted in the United Nations Millennium Declaration of 2000, signed by 189 countries. Goal 4 of the Millennium

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2 At this point the United Nations itself had only existed for one year, and its coordinating agency regarding international health, the World Health Organization (WHO), would not be formed until 1958, replacing The Health Organization, which had been a part of the League of Nations.
Development Goals is to reduce child mortality, with its target to reduce by two-thirds the under-five mortality rate between 1990 and 2015, which has as its indicators the under-five mortality rate, the infant mortality rate, and the proportion of 1 year-old children immunized against measles. In addition, Goal 5 to improve maternal health has as its target the reduction of the maternal mortality rate by three-quarters during the same period, with its indicators the maternal mortality rate and the proportion of births attended by skilled health personnel (United Nations 2007). In 2002, the Save the Children Alliance began releasing a yearly report entitled State of the World’s Mothers whose mandate was to address factors affecting the health of mothers and their infants and children (Save the Children 2002). In addition, in 2005 the United Nations Children’s Fund (UNICEF) turned its focus to achieving the Millennium Development Goals.

I would like to draw the reader’s attention to the years in which international attention was directed at issues of infant and child well-being; the impact of international conflict should not be overlooked. Klaus (1993) argues that the Franco-Prussian War of 1870-1871 sparked concern over infant mortality in France, and Davin (1978) contends that in Britain such concern began at the turn of the twentieth century, in part due to the Boer War of 1899-1902. Moreover, the rights-based discourses on child health, detailed above, seem to have followed or coincided with the First World War (1914-1918), the

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3 Indicators in the context of the Millennium Development Goals include quantitative measures: proportions, averages, rates (mortality, prevalence), and total numbers, all of which are quantifiable and comparative.

4 Branches of Save the Children were subsequently opened in a number of other countries with the 1946 International Save the Children conference hosting representatives from 34 countries, and in 1977 the Save the Children Alliance was founded, later renamed the International Save the Children Alliance in 1997 with chapters in 28 countries, including Canada, the United States, Jordan, Japan, Norway, Italy, Honduras, and many others. The subtitle of the 2002 report was ‘Mothers and Children in War and Conflict’ (Save the Children 2002), and in subsequent years it was ‘Protecting Women and Children in War and Conflict (2003), ‘Children Having Children’ (2004), ‘The Power and Promise of Girls’ Education’ (2005), ‘Saving the Lives of Mothers and Newborns’ (2006), and ‘Saving the Lives of Children Under Age 5’ (2007).
Second World War (1939-1945), the Vietnam War (1959-1975), the Persian Gulf (1990-1991), the Cold War (1947-1992) and the events of September 11, 2001 and the subsequent wars in Iraq and Afghanistan. In line with this pattern, in this dissertation I will explain how the Boer War brought attention to the problem of infant mortality in early twentieth century British colony of Malta. In addition, I will show that fluctuations in international tensions affected Malta’s population on a number of levels because of the island’s importance as a British military and naval base and its location in the middle of the Mediterranean. I will demonstrate how Malta’s “strategic position” restricted political and economic development in the island and articulated with colonial perceptions of the Maltese as “Other” and Malta as “overpopulated.” Finally, I will argue that international tensions, Malta’s location within Empire, and perceptions of the island and its inhabitants in the early twentieth century affected the ways in which infant deaths were explained and understood and the strategies of intervention initiated in the island to curtail infant mortality – all of which had a tremendous impact on the rates at which infants in Malta died.

The Importance of Infant Mortality

As stated above, one of the indicators employed to measure international progress in regards to the Millennium Development Goal to reduce childhood mortality is the infant mortality rate (IMR), the number of deaths under 1 year of age per 1000 live births. Today, the IMR is a commonly calculated statistic that is employed not only as a measure of infant health and well-being, but as a general barometer of health, a sensitive indicator of fundamental problems in a community that disproportionately affect infants. The importance of the infant mortality rate is said to lie in the “apparent association between
the causes of infant mortality and other factors that are likely to influence the health status of whole populations”, including economic development, general living conditions, social well being, rates of illness, and the quality of the environment (Reidpath and Allotey 2003:344). The ability of the IMR to capture rapid changes in these structural determinants of population health as well as the effects of disease epidemics are seen as some of its strengths (Reidpath and Allotey 2003). Traditionally regarded as one of the most reliable comparative indicators of health, the health statistic is therefore internationally regarded as a delicate index, a highly sensitive indicator, a proxy measure, or a good predictor of: population or community health, the overall life expectancy of a population, the effects of malnutrition, the overall level of health care, the social and sanitary state of a community, general and local unhealthy conditions, general social or demographic well-being, a group’s ability to manage its social and physical environment, as well as social, economic and health conditions in a community (Caldwell 1996; Gesler et al. 1997; Hargraves and Thomas 1993; Lerer 1996; Loudon 1991; Moffat and Herring 1999; Reidpath and Allotey 2003; Sawchuk et al. 2002a; Sawchuk and Burke 2000; Scott and Duncan 2000; Swedlund and Ball 1998; Swenson et al. 1993). It has also, at times, been used as an index of “civilization” (Berger 2001; McElhinny 2005; Save the Children 2007).

There are, of course, problems with the infant mortality statistic, as it is employed and calculated. For example, the period of one year does not correspond precisely to any infantile development process, and differing interpretations of what constitutes a “live birth” have rendered questionable the comparability of IMRs across time and place (Galley and Shelton 2001). For example, while the WHO guidelines stipulate that all births showing any signs of life be counted as a “live birth”, regardless of the duration of the pregnancy or the size of the newborn, in Switzerland an infant must be at least thirty centimetres long to be considered “living”. In Italy there are at least three different definitions in use in different regions, and the proportion of infant deaths which occur within the first twenty-four hours of birth in Sweden, Japan, France, and Hong Kong are suspiciously low, suggesting that a disproportionate number of infants are not classified as “live births” (Eberstadt 1991).
While IMR is supposed to be a sensitive indicator of fundamental problems in a community that disproportionately affect infants – a notion that is given lip service in most studies – the value of IMR as an index can be lost, as Reidpath and Allotey (2003:344) explain:

Despite starting as indicators of a whole population’s health, measures like IMR often, it is reasoned, become the principle focus of health policy such that health strategies and health priorities are formulated with the proxy outcome measure in mind… health policies begin to target the chosen outcome measure, while ignoring the rest of the population for which the outcome measure was supposed to be an indicator.

This appears to be the case with the Millennium Development Goals. For example, the infant mortality rate is not employed as an indicator of population health, but as a component of child mortality, which the United Nations hopes to dramatically reduce by 2015. Thus, while the IMR is purported to be an index of, even more than overall health, a population’s social and economic environment, and its role as an index of general social conditions is widely recognized, the ideas of child mortality and of infant mortality carry tremendous symbolic clout. The image of dying children and infants is a potent one, and the international community has mobilized to combat the tragic deaths of our youngest global citizens.

As a consequence, many studies are aimed at determining the causes of infant mortality, foregrounding the importance placed on infant deaths in and of themselves, rather than their role as an indicator of a population’s well-being. In some of these analyses, it is acknowledged that the aetiology of infant mortality is complex, that a large number of factors have been implicated, and that it is difficult to disentangle the diverse influences that may have the most important effects on infant health (Frisch et al. 1992; Gesler et al 1997; Scott and Duncan 2000). However, most studies of infant mortality are nonetheless oriented towards determining the risk factors (typically conceived of as
variables or individual characteristics associated with the development of a ‘disease’ in epidemiological analyses) that are associated with varying rates of infant death.

In effect, the range of risk factors under investigation is vast, and there are a number of competing and interrelated explanations for infant death, including four large clusters of factors investigated: First, **general characteristics of the child** include: inadequate weight gain, small size, underweight status, poor infant nutrition, micronutrient deficiencies, and the sex of the child (See Appendix 1 for an overview of factors, reasoning, and references). Second, **general characteristics of the mother or the family** into which the child has been born, include: age of the mother; parity or birth order; birth interval or spacing; family size; the family’s religion; the effect of consanguineous marriage; and the death of an older sibling. Third, **parental behaviours** have been associated with infant mortality rates: infant feeding practices, such as breastfeeding and the age of supplementary feeding; health seeking behaviour; and parental underinvestment – a situation where children receive differential treatment from their parents who selectively invest time, resources, care, love, nurturance and attention on their children. Finally, a variety of studies have examined the effect of **disadvantage** on infant mortality, variously finding general associations between poverty, social disadvantage, socioeconomic conditions, and economic position and rates of infant mortality as well as more specific correlations between infant death and the following factors: low status of women; poor maternal nutrition; employment, unemployment, and income; maternal and paternal education and illiteracy; divorce or marital disruption; water supply and sanitation; access to health services such as prenatal and antenatal care; year or period of birth; and region, area or location of birth or residence.
The scope of these risk factors is extremely broad, and a number of scholars have suggested ways of organizing them into categories. For example, Mosley and Chen (1984) argue for the separation of sociobiological variables, which they see as having direct effects on infant death, from socio-economic determinants, which provide a backdrop of contextual constraints indirectly influencing the extent and distribution of infant and child mortality. Millard (1994) put forth a model with three tiers of variables: (1) proximate biomedical variables, (2) intermediate influences, such as childcare and individual behaviours, and (3) ultimate variables, including social and economic conditions. While Millard’s division appears to be an attempt to lend weight to the importance of socio-economic conditions (particularly with their description as ‘ultimate’ influences), in practice, within investigations into infant mortality the common focus is on proximate and intermediate variables, perhaps because they are more easily studied (Gesler et al. 1997). At this level of determination, the risk factors most emphasized and, in some cases, widely recognized as associated with infant mortality include breastfeeding and weaning behaviours and a lack of maternal education. This results in what Wise (1993:9) has labelled the “tyranny of the ‘P’ value”, whereby statistically significant risk associations frame scholarly and popular understandings of infant mortality as the product of deviant maternal behaviour. Consequently, instead of taking an elevated infant mortality rate as a sign of larger problems in the conditions of life that are leading to infant death, such as an insufficient socio-sanitary and/or medical infrastructure, infant mortality is depicted in both historical and contemporary populations as a product of the circumstances and behaviours of individuals.
In addition, this focus on proximate- and intermediate-level risk factors presents a decontextualized picture and ignores the role of larger forces on health, disease, and illness. Moreover, such an assessment of individual risks and benefits is particularly problematic when social patterns operating within this larger context are ultimately relevant, as I argue in this dissertation is the case with infant mortality (Rapp 1991). Thus, following Morsy (1995:172) I contend that

the project that poses a greater challenge as an object of intellectual discourse, not to mention as a framework for political activism, transcends the disentanglement of primary determinants from webs of epidemiological variables. It is the investigation of the historical and social factors that produce (and reproduce) risk – factors that then are constructed as medicalized risk categories.

This investigation of infant mortality, located in early twentieth century Malta, is an attempt to do just this. As a result, my work is not just about Malta, one moment in history, the calculation of infant mortality rates, or the disentanglement of various determinants of infant mortality in this context; it is about the dynamics and repercussions of power differentials and of social, economic, and political inequalities, as they define and structure health outcomes and experiences. I see looking at patterns of infant mortality, and its attendant discourses in Malta as a platform to address these broader issues.

This dissertation is also more than a description and investigation of infant mortality in early twentieth century Malta because it represents an attempt to bring together several analytic approaches which often proceed in parallel, rather than in dialogue – historical epidemiology, social history, and the analysis of colonial discourse – to allow for a richer analysis of social conditions and structural relations of power that underlie infant mortality. The work herein is therefore grounded in the assertion that
anthropology, since it is situated at the nexus of the biological and the social (Levins and Lewontin 1998) is well positioned to incorporate various levels of determination. Moreover, as a medical anthropology project, this work follows from the contention that in any attempt to better understand the causes of health and illness in societies, it is paramount to take a broad view that acknowledges the role of individual choices, social and cultural patterns of behaviour, and political and socio-economic circumstances, and how these factors interact and are interrelated (Brown 1998). Such an approach can incorporate the diverse ways knowledge is produced in anthropology and provide an effective framework to consider the complexities and contradictions of social life and how they influence biologies (Goodman and Leatherman 1998). This serves to enlarge the sphere of knowledge, but could sharpen and enrich the relevance of anthropology for understanding and combating human suffering (Goodman and Leatherman 1998; Lee 1999).

The patterning of infant mortality in early twentieth century Malta is also important in its own right: not only were real people facing real problems, but the Maltese example represents a significant and weighty case-study of infant mortality running parallel (and at odds) with other locations at this moment in history, and its echoes resound in contemporary writings on the subject. Infant mortality is a subject of international attention and the reduction of infant and childhood illness and death globally is undoubtedly important; therefore, in this dissertation, I have undertaken analyses which aim to reveal correlations between levels of infant mortality and a variety of factors at the proximate, intermediate, and ultimate levels, over time and across Malta’s localities and families. However, my analyses do not extend to the period
following the onset of World War II, and I have not attempted to quantitatively assess the factors that led to the rapid decline in infant mortality rates in Malta following the Second World War. While some data is presented for subsequent years, due to the spike in infant mortality which accompanied the Second World War, the extent of the damage the islands suffered as a result of massive bombings, the dearth of information regarding the myriad of factors at play during the War years, and the impossibility of disentangling all of the factors which contributed to the declines in infant mortality following Armistice (as this constituted a period of massive rebuilding and the initiation of a large number of social programs), I chose to concentrate my attentions on the factors which may have been responsible for elevated rates and disparities in infant mortality within Malta prior to World War II. I believe that by revealing the factors which were correlated with higher rates of infant mortality prior to the Second World War, I can help to illuminate which of the changes and interventions that were initiated following the War are likely to have had the greatest impact on improving the health status of Malta’s infants and population in general.

I am also attempting to analyze a variety of factors at the proximate, intermediate, and ultimate levels because I contend that some of the ways in which risk factors and determinants of infant mortality in contemporary studies are conceptualized, measured, and understood, can individualize risk and end up replicating – in a way remarkably similar to blunter discourses from the early twentieth century (which are discussed throughout this dissertation) – the focus on poor parenting decisions as an explanation for infant and child death. Nevertheless, following Morsy (1995), I am attentive to the suggestion that consideration of these determinants of infant mortality should not distract
from attention to the historical and social factors that produced the infant mortality rate as a statistic and the varying degrees of risk experienced by Malta’s populations and populations worldwide. Therefore, I aim to interpret my results cautiously and with due consideration for additional factors which were, or could not be, measured and assessed, and I foreground colonial discourses and explanations of infant mortality in order to evaluate their origins, validity, and consequences with regards to the health and well-being of Maltese infants, women, and men.

A Study of Infant Mortality in Malta

During the course of my archival research in the National Library of Malta, I uncovered a pamphlet written by Dr. Joseph Morana, a general physician of Maltese descent who worked in the islands in the 1940s, titled An Investigation On Infant Mortality In Malta (1946). On the front cover of this small volume, he stated: “this is the first attempt at an enquiry of our infant mortality in the history of Social Medicine” (Morana 1946; emphasis added), thereby signalling his commitment to understanding how social and economic conditions impact health, disease and the practice of medicine. Thus, while according to today’s standards Morana’s work might be considered unsophisticated and empirically suspect, I would argue that there are many parallels between his work and my own. Of a total of 717 infant deaths, in 17 localities throughout Malta, Morana selected 225 to investigate. While no rationale was provided for the selection of these deaths for investigation, Morana’s study incorporated various

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6 This pamphlet contained no additional information on its author. Nor was there any indication of why, or for whom, this study was prepared. This illustrates one of the major drawbacks of archival research: that there are frequently gaps, omissions, inconsistencies, and contradictions that the investigator is forced to reconstruct, reconcile, or simply accept.

7 His quantitative analyses consist of the calculation of basic percentages and their comparison.
levels of determination in his subsequent quantitative analyses; for each of these deaths, he collected information on the following: mother’s education (illiterate vs. primary education), multiparity, other infant deaths in the family, bad sanitation, rural residence, artificial feeding, and income of less than 3 pounds per week (See Table 1.1). His selection of these factors for analysis, along with his discussion of the reasons for their selection and the results of his investigation, suggest that Morana sought to empirically evaluate, and in some cases argue against, prevailing explanations for elevated rates of infant mortality in Malta. Specifically, he highlights the following preoccupations: (1) the extent and meaning of elevated infant mortality rates, (2) the role of medicine and medical personnel in the reduction of infant mortality in the islands, (3) the ‘problem’ of overpopulation in Malta and its Malthusian and eugenic connotations, (4) the role of family-level factors such as multiple births, infant feeding practices, and maternal capacities on risk of infant death within Maltese families, (5) the salience of one’s place of residence and economic position within the Maltese context, and (6) the importance of attention to sanitary infrastructure. Importantly, each of these preoccupations will be variously addressed in the chapters of this dissertation; therefore, select quotations from Morana’s paper will appear at the top of each chapter, signalling for the reader some of the themes that will emerge therein.

8 None of these factors were clearly defined; for example, it is unclear what he considered to be ‘bad sanitation’.
Table 1.1 – Factors Investigated by Dr. Joseph Morana in *An Investigation On Infant Mortality In Malta*

<table>
<thead>
<tr>
<th>Town or Village</th>
<th>No. of deaths recorded</th>
<th>No. of deaths investigated</th>
<th>Mother's Education - illiterates</th>
<th>Mother's Education - Primary Education</th>
<th>Multiparity</th>
<th>Families with other Death</th>
<th>Bad Sanitation</th>
<th>No. of rural families</th>
<th>Artificial feeding</th>
<th>Family income less than £3 per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cospicua</td>
<td>28</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Vittoriosa &amp; Kalkara</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Senglea</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Zebug</td>
<td>54</td>
<td>35</td>
<td>17</td>
<td>18</td>
<td>33</td>
<td>26</td>
<td>16</td>
<td>2</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td>Siggiewi</td>
<td>30</td>
<td>9</td>
<td>5</td>
<td>4</td>
<td>8</td>
<td>7</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Qormi</td>
<td>115</td>
<td>40</td>
<td>17</td>
<td>23</td>
<td>30</td>
<td>21</td>
<td>1</td>
<td>1</td>
<td>13</td>
<td>19</td>
</tr>
<tr>
<td>Luqa</td>
<td>22</td>
<td>17</td>
<td>7</td>
<td>10</td>
<td>16</td>
<td>7</td>
<td>8</td>
<td>4</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Tarxien &amp; Pawla</td>
<td>107</td>
<td>23</td>
<td>13</td>
<td>10</td>
<td>19</td>
<td>12</td>
<td>1</td>
<td>1</td>
<td>16</td>
<td>12</td>
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<tr>
<td>Zurrieq</td>
<td>48</td>
<td>16</td>
<td>8</td>
<td>8</td>
<td>14</td>
<td>12</td>
<td>16</td>
<td>3</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Safi</td>
<td>5</td>
<td>3</td>
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<td>1</td>
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<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Qrendi</td>
<td>16</td>
<td>6</td>
<td>2</td>
<td>4</td>
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<td>4</td>
<td>3</td>
<td>0</td>
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<td>Mqabba</td>
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<td>0</td>
<td>1</td>
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<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
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<tr>
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<td>4</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Zejtun &amp; Marsaxlokk</td>
<td>110</td>
<td>25</td>
<td>16</td>
<td>9</td>
<td>23</td>
<td>17</td>
<td>2</td>
<td>2</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>Zabbar &amp; Marsaskala</td>
<td>60</td>
<td>21</td>
<td>12</td>
<td>9</td>
<td>17</td>
<td>15</td>
<td>1</td>
<td>1</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Ghaxaq &amp; Birzebuggia</td>
<td>78</td>
<td>12</td>
<td>7</td>
<td>5</td>
<td>9</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Gudja</td>
<td>18</td>
<td>8</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>7</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>717</strong></td>
<td><strong>225</strong></td>
<td><strong>115</strong></td>
<td><strong>192</strong></td>
<td><strong>143</strong></td>
<td><strong>68</strong></td>
<td><strong>25</strong></td>
<td><strong>119</strong></td>
<td><strong>135</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Percentages</strong></td>
<td></td>
<td></td>
<td><strong>51.11</strong></td>
<td><strong>48.89</strong></td>
<td><strong>85.33</strong></td>
<td><strong>63.56</strong></td>
<td><strong>30.22</strong></td>
<td><strong>11.11</strong></td>
<td><strong>52.89</strong></td>
<td><strong>60</strong></td>
</tr>
</tbody>
</table>

(Morana 1946)
Ultimately, Morana concluded that “multiparity emerges as the chief cause of our high infant death rate”; although he also stipulated that it is a “characteristic of our race and an index of our virility [which] shows us to be a nation in progress and as such full of vigour and stamina” (1946:6). This is significant because some of the analyses in this dissertation similarly reveal a correlation between higher levels of infant mortality and families with greater numbers of births (see Chapter 7). While I consider this to be an important finding, much like Morana I am cautious in my conclusions, in part because, in the Maltese context, colonial administrators often cited “overpopulation” and “excess” fertility as the chief causes of elevated rates of infant mortality in the island (see Chapter 6). I argue, moreover, that giving undue weight to the proximate and intermediate relationships – such as the correlation between family size and infant mortality – serves to obfuscate the ultimate causes of elevated rates of infant mortality in Malta overall and the ultimate causes of disparities in infant mortality between Malta’s inhabitants: the overall and varying degree of social, political, and economic marginalization of the Maltese, as reflected in an insufficient level of economic opportunity and an inadequate socio-sanitary infrastructure. Given the purported utility of the infant mortality rate as an index of larger problems in a community that disproportionately affect children, this is perhaps an unsurprising conclusion. However, in light of the increasing tendency to address infant deaths in relative isolation, as in the case of the Millennium Development Goals, I seek to foreground the importance of structural determinants of infant mortality in Malta, while giving due attention to the problems inherent to the statistic and its historical and social construction. It is my intention that by doing so this dissertation can argue against the prominent contemporary discourses of infant mortality which tend to
individualize risk and associate infant death with the poor parenting – or “mothering” – of individuals, and at the same time contribute to a revitalization of the use of the infant mortality rate as general barometer of the health and living conditions of a community.
Chapter 2 – Materials, Methods, and Theoretical Orientation

It is with some trepidation that an opinion is expressed from the results obtained, as the error is great when dealing with comparatively small numbers; but the correlation of certain factors is so forceful that conclusion can be reached with some certainty; thus after a great deal of obloquy, a line of action has been reached which makes this vexed question of our infantile mortality emerge from the realms of speculation into those of concrete facts.

- Dr. Joseph Morana, An Investigation on Infant Mortality in Malta (1946)

Within the epidemiological or biomedical literature infant mortality is often framed by quantitative analyses of identified risk factors, factors which are posited to contribute to (an increase or decrease) in one’s risk of disease or mortality if statistically significant results are found. Moreover, because of the problems inherent in the definition and measurement of risk factors, there is a tendency to focus on proximate or intermediate variables, which leads to the individualization of risk and obscures the value of the infant mortality rate as an index. Nevertheless, I operate from within this paradigm, and I do so in order to introduce another facet of the composite that is infant mortality: how it has been defined, socially constructed, and influenced by political and economic forces. This represents an attempt to do analytic justice to the “intricacies of reality” by thinking about the multiple and overlapping levels of determination and how they interact in the case of infant mortality (Silverblatt 1991). As such, this project will explore how biomedically- and culturally-oriented approaches, seemingly disparate, can work together in productive relation.

Specifically, the guiding principle of this thesis is in line with the position held by contributors to Goodman and Leatherman’s (1998) Building a Biocultural Synthesis: that the future of biological anthropology lies in bringing biological anthropology into closer touch with contemporary trends in cultural anthropology, including a consideration of
political economy and critical theory (Moran 1998). This follows Lee’s (1999) assertion that what is urgently needed is more projects that see science, humanism, and critical reflection as three components of a problematic, each of which, alone, is inadequate to account for all anthropological subjects. Particularly with regard to understanding health, illness, and disease, no single approach can generate all the questions, or provide the complete or only answers (Wiley 1992). Unfortunately, in my eyes, one of anthropology’s greatest strengths, its broadly holistic and biocultural approach, is threatened by the deepening chasm dividing biological and cultural anthropology (Goodman and Leatherman 1998; Singer 1998b). Moreover, while it has been argued that medical anthropology could serve as a bridge between the two subdisciplines, a meeting place which would facilitate the reintegration of anthropology and the re-emergence of a biocultural synthesis (Goodman and Leatherman 1998; Johnson and Sargent 1990; Singer 1998b), this is not a simple or straightforward process. Specifically, I am attentive to Segal and Yanagisako’s (2005) argument that the integration of diverse anthropologies within a single dominant paradigm can actually limit critical dialogue and close down the problematizing of knowledge and its production. However, these authors state “our point is not… to suggest that it is never useful to bring cultural and biological knowledges into cooperative dialogue” (Segal and Yanagisako 2005:12), and I argue that the investigation of infant mortality would benefit greatly from such a dialogue. Therefore, this research includes a targeted focus on the biological elements of infant mortality, while simultaneously highlighting the cultural with a recognition of the extent to which health status, and the infant mortality rate, is defined and shaped according to sociocultural ideas and practices (Singer 1998b).
Despite the chasm between biological and cultural anthropology – or perhaps because of it – this work is an attempt to demonstrate the increasing need for projects that explore interpenetrations rather than upholding the existing rigid dichotomies (Levins and Lewontin 1998), and is in keeping with the argument that unwillingness to explore the strengths of the ‘other’ subdiscipline “perpetuates the false dichotomies that poststructuralism tells us are ubiquitous and falsifying Western tropes” (di Leonardo 1991). This dissertation represents more than an analytic exercise, then; the integration of various levels of determination through the combination of biological and socio-cultural perspectives is undertaken under the auspices that such an endeavour should, as Goodman and Leatherman (1998:6) argue, “sharpen and enrich the relevance of anthropology for understanding a wide variety of struggles to cope with and combat persistent human suffering.”

However, even this dichotomizing discussion of the subdisciplines of anthropology, their separate designation as ‘biological’ and ‘socio-cultural’, and the chasm which divides them, risks reinscribing a binary distinction rather than demonstrating the ways in which they are complementary. Further, their integration in this dissertation, and the danger of foregrounding one type of analysis through the organization of chapters, within chapters, and even within individual sections, and hence privileging one mode of interpretation over the other, is an ever-present concern, and one which has not been entirely reconciled. In part, this is the result of the varying and conflicting demands of each: what constitutes ‘good’ scholarship, ‘reliable’ sources, ‘significant’ findings, or ‘convincing’ arguments is rarely consistent across genres, and no less so across subdisciplinary boundaries within anthropology. This dissertation, then,
is about the problematics of knowledge production at both the theoretical and methodological level. Not only do I seek to demonstrate how knowledge about infant mortality has been historically and socially constructed, but my work also challenges the ways in which knowledge is typically produced within anthropology.

**Historical Demography and Epidemiology**

One of the aims of this dissertation is to use existing aggregate statistics, archival, and parish records to trace the infant mortality rate over time and space, and to determine the effects some of the fundamental factors that may influence infant mortality in Malta, such as regional differences in social conditions and family-level variations. Specifically, using SPSS 14.0, I have plotted secular trends in infant mortality rates for the island as a whole and its individual communities and the seasonality of Malta’s infant deaths, and I have employed simple linear regression analyses, multiple linear regression analyses, Pearson’s and Spearman’s chi-square tests, t-tests, and analysis of variance tests to track disparities in infant mortality and to assess the relationship between aggregate and family-level infant mortality rates and a variety of variables.\(^9\) In this endeavour, this dissertation is most obviously a work of historical demography or epidemiology.

There are a number of historical studies of infant health of this nature from researcher in fields such as Demography, Public Health, Biological Sciences, and Geography (e.g. Galley and Shelton 2001; Hart 1993; Loudon 1991; Millward and Bell 2001; Scott and Duncan 2000; Van Poppel et al. 2002, 2005; Williams 1992; Wolleswinkel-van den Bosch et al. 1998, 2001), as well as Anthropology itself (e.g.

\(^9\) More detailed descriptions of the specific analyses run and the variables included in the analyses will be discussed in subsequent chapters. See Appendix 2 for a description of the statistical procedures employed and their respective assumptions.
Kemkes 2006; Kertzer et al. 1999; Moffat and Herring 1999; Sawchuk and Burke 2000; Sawchuk et al. 1985, 2002; Swedlund and Ball 1998). Importantly, within these works, the terms historical demography and historical epidemiology are often used interchangeably, although the two areas of study do have different priorities. While historical demography represents an attempt to reconstruct demographic characteristics of past populations, and to explain the causes and consequences of these characteristics (Willigan and Lynch 1982), historical epidemiology is more specifically concerned with the description and analysis of health and diseases in given areas and past periods of time (Saracci 2001:2). Both demography and epidemiology originated in the nineteenth century, and whereas the discipline of demography was brought into existence by changes in mortality, fertility, and population numbers and its subject matter has subsequently been largely focused on demographic transitions (Caldwell 1998), epidemiology had its roots in the work of John Snow, who traced London’s cholera epidemics of 1849 and 1854 to polluted water sources in particular districts (Saracci 2001) and the discipline is largely concerned with patterns of (epidemic) disease occurrence and the factors that influence these patterns (Lilienfeld and Stolley 1994). Because issues surrounding fertility and mortality are relevant both in terms of the demographic characteristics and health profiles of past populations, historical investigations of infant mortality are sometimes considered both demographic and epidemiological; however, most studies fall under the umbrella of historical demography.

Although demography may have a long history, historical demography itself is a relatively young branch of academic research, dating from the 1950s (Saito 1996). Demographers and other ‘population experts’ began to turn their attention to
understanding past demographic phenomena at this point, in part because the unexpected baby boom following World War II exposed the fallibility of forecasting and extrapolating existing trends into the future, and “the demography of the past was regarded as an observatory whose findings could be applied immediately to decipher contemporary situations” (Rosental 2003:117). Since then, according to Kertzer (1997), the largest and most significant projects in European historical demography, as practiced in France, Italy, Britain, and the United States, have emphasized large-scale and quantitative analyses, and have come primarily from demographers such as Wrigley (1966) and the Princeton European Fertility Project, begun in 1963. In recent years, however, there have been calls for the linkage of structural or macro-level studies, which are larger in scale and attend to regions or nations over time through the analysis of aggregate data, to micro-level studies, which focus more on concrete, local settings, and assess individual, nominative information (e.g. Kertzer 1997; Saito 1996; Willigan and Lynch 1982).

This focus on the micro-level has led to the increased use of the techniques of family reconstitution and, in studies of infant mortality, the biometric method, both of which I utilized in my investigation of infant mortality in Malta. In family reconstitution, a researcher employs nominal information typically in the form of parish registers detailing marriages, baptisms, and burials in order to reconstitute families (Wrigley 1966; Willigan and Lynch 1982). Baptisms and burials serve as proxies for births and deaths, and these are linked with individual marriages to allow for the analysis of patterns of fertility and mortality at the level of the family. While this procedure is relatively straightforward, it is very time-consuming, which effectively limits the size of
community that can be included in this type of analysis (Galley and Shelton 2001; Scott and Duncan 2000). The typical parish reconstitution study therefore covers a village of approximately one thousand inhabitants (Willigan and Lynch 1982). It is further complicated if undertaken in areas where population turnover is high; therefore, areas with low levels of immigration and emigration are typically selected (Galley and Shelton 2001). In order to be included in a data pool derived from family reconstitution, information must be available regarding an individual’s date of death; therefore, all of the demographic measures derived from reconstitution relate only to the population of ‘stayers’, those born locally who continued to live in their native community, and this is recognized as one of the limitations inherent to the method (Saito 1996).

In addition to family reconstitution, and specific to studies of infant mortality such as my investigation of infant mortality in early twentieth century Malta, micro-level investigations often employ the biometric method, a technique originally designed by Bourgeois-Pichat (1951) to separate exogenous and endogenous mortality, that is, deaths attributable to the post-natal environment as opposed to those attributable to causes preceding or associated with birth. However, as refined by Knodel and Kinter (1977), it is also a demographic method for distinguishing breast-feeding from non-breastfeeding populations and for inferring weaning patterns from the age distribution of documented infant deaths derived from sources such as parish or civil registers (Herring et al. 1998). Age-at-death for the infants who die in a community (only sporadically reported in the burial records) are typically calculated by linking baptismal and burial records, and are operationalized as months-of-age at death. Thereafter, cumulative mortality is plotted on the y-axis, with age expressed as a function $[\log(n+1)]^3$ on the x-axis.
Knodel and Kintner, who applied Bourgeois-Pichat’s biometric technique to populations with known patterns of infant-feeding, found that by plotting cumulative infant mortality, and comparing the slope of the line for the first six months with that of the second six months, the method of infant feeding could be determined. That is, if the slope of the line connecting months one to six is steeper than the slope connecting months six to twelve – if infant mortality rises particularly steeply during the early months of the first year of life – this suggests breast-feeding is less common in the population and that a high percentage of infants are fed by other means (Sawchuk et al. 1985; Sawchuk et al. 2002a; Sawchuk and Burke 2000). Thus, a comparison of the slope of the line from 1-6 months to that of 6-12 months is employed to determine the presence or absence of breast-feeding: where the slope of the line from 6-12 months is steeper than that of 1-6 months (with a ratio of the slopes of the lines marking cumulative mortality exhibiting a value greater than one), this indicates that the population was breastfeeding; whereas, where the slope of the line from 1-6 months is steeper than that of 6-12 months (with a ratio below one), this indicates an absence of breastfeeding (or, alternately, very early weaning) (see Table 2.1).

Table 2.1 – Biometric Results for Populations with Known Patterns of Breastfeeding

<table>
<thead>
<tr>
<th>Study Area</th>
<th>Date</th>
<th>Type of Feeding</th>
<th>Breast</th>
<th>Artificial</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>All Infants</td>
<td>Since Birth</td>
<td></td>
</tr>
<tr>
<td>U.S. Cities</td>
<td>1911-1916</td>
<td>1.6345</td>
<td>.825</td>
<td>.823</td>
</tr>
<tr>
<td>Berlin</td>
<td>1895-1896</td>
<td>1.253</td>
<td>.719</td>
<td>--</td>
</tr>
<tr>
<td>Barmen</td>
<td>1905</td>
<td>1.275</td>
<td>.370</td>
<td>--</td>
</tr>
<tr>
<td>Cologne</td>
<td>1908-1909</td>
<td>1.182</td>
<td>--</td>
<td>.733</td>
</tr>
<tr>
<td>Hannover</td>
<td>1912</td>
<td>1.368</td>
<td>.474</td>
<td>--</td>
</tr>
</tbody>
</table>

(adapted from Knodel and Kinter 1977:398)
In addition, further scrutiny of the plotted values allows for some insight into the timing of weaning; whereas an absence of abrupt changes indicates a varied or extended period of weaning, significant breaks in the slope are indicative of the start of weaning (Sawchuk et al. 2002a; Sawchuk and Burke 2000; Scott and Duncan 2000). With regards to the timing of weaning, if a straight line is not observed, a break in the relationship, usually occurring at age 2, 3, or 4 months, is interpreted to be the result of “excess mortality” attributable to digestive impairments associated with weaning and artificial feeding (Bourgeois-Pichat 1952; Knodel and Kinter 1977; Pressat 1972). The argument rests on the assumption that any spikes in infant mortality are likely resulting from the introduction of non-breast milk foods to such an extent that cumulative infant mortality increased in association with the process (Herring et al. 1998). Importantly, this is not an exact point but rather a general threshold effect, the point at which enough foods other than breast-milk are being fed to the infant such that cumulative infant mortality increased (Herring et al. 1998). Infant deaths are therefore presumed to be the result of the classic weanling diarrhoea syndrome: where gastrointestinal disease associated with contaminated water and food combines with other contagious diseases to take a heavy toll on infants (Herring et al. 1998).

Anthropologists working in the area of historical demography have greatly contributed to the increasing prominence of micro-level studies employing family reconstitution and the biometric method (e.g. Moffat and Herring 1999; Sawchuk and Burke 2000). However, there is an increasing recognition that while micro-level approaches to statistical analysis offer clear benefits, such quantitative analyses of demographic trends need to be complemented by qualitative methods and data sources in
order to fully explain the causes and consequences of demographic characteristics of past population (Kertzer 1997). Kertzer (1997:4) draws particular attention to the question of infant and child mortality, an area which he argues “the wealth of quantitative materials is greatest”, and he contends that the most interesting and productive of these studies complement statistical analyses with qualitative archival materials and methods more familiar to the historian than the traditional demographer. Gesler and colleagues (1997) have similarly argued for the integration of positivist and non-positivist approaches in studies of infant mortality, with positivist approaches such as disease ecology important for the investigation of variables associated with patterns of infant mortality, and non-positivist approaches valuable for the formulation of theory and the selection of variables for study and to help explain the results of the project. Moreover, as Kertzer (1997:1) argues:

How and why people acted as they did, how they came to change their behaviour, and of course the impact of these changed demographic behaviours on other aspects of their lives and on larger social institutions and social interactions – these can only be understood in terms of a complex web of relationships involving cultural norms, social structure, political power, and economic relations.

Consequently, Saito (1996) warns against any tendency to study past populations in isolation from economic, social, and cultural aspects of these groups, and contends that the most important set of issues to be explored in future research in historical demography is concerned with social and economic history.

The relationship between demographic and economic factors has been of primary importance to historical demographers since the Second World War (Saito 1996);
however, this is an area to which anthropologists are contributing greatly. For example, Swedlund and Ball (1998) examined the effects of low wages and employment on rates of childhood mortality in Massachusetts from 1830 through 1920, and Sawchuk and colleagues (2002) examined disparities in rates of infant mortality in Gibraltar’s military and non-military populations from 1870-1899. As Kertzer (1997) has argued, in contrast to the more macro-level studies such as the Princeton European Fertility Project, these types of micro-level studies have placed great emphasis on differentiation within local populations, especially by kind of family economy, as well the role of political context and ecological factors. Moreover, as Swedlund (2000) argues, most of the observed mortality increases and declines can be accounted for largely by political-economic and environmental-historical factors. In addition, anthropological investigations of infant mortality in past populations have attended to the effects of social, political, and economic marginalization, and have contrasted their findings with the explanations put forth by experts of the period in question (e.g. Kertzer 1997; Moffat and Herring 1998; Swedlund and Ball 1998).

My investigation of infant mortality in early twentieth century Malta draws most directly from the anthropological work of Swedlund and Ball (1998). These authors locate themselves as empiricist and as employing a biomedical perspective with their attention to measurable states of health (morbidity and mortality), yet their innovative approach simultaneously considers current statistical models to explain mortality while investigating a number of questions pertinent to critical and political-economic

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10 Saito (1996) argues that Wrigley and Schofield’s (1989[1981]) The Population History of England 1541–1871, in which they examine demographic measures in relation to a time series of prices and wages is in the “Malthusian tradition”, in that it represents an explicit attempt to examine the interdependence of demographic and economic systems. Malthusianism itself will be discussed in more detail in Chapter 6.
approaches to biological anthropology. This includes reflection on how experts of the period framed problems and “a fresh consideration of categories of analysis that are generally thought to be straightforward and unambiguous in their social science and epidemiological etymologies but that may be legitimately contested and problematized” (Swedlund and Ball 1998:192). As such, they acknowledge that the study of infant mortality is socially and historically embedded, that scientific approaches are informed and influenced by the cultural milieu and political economy; therefore recognition of social milieu and historical contingency are fundamental to the research problem. What I consider most laudable about Swedlund and Ball’s (1998:216) analysis is their attempt to present both positivist and interpretive perspectives, without purporting to reconcile them, but to “recognize the tension that may exist between them and then to exploit their respective strengths for enlightenment on a complex historical question.” As such, it is not only the specific strategies that Swedlund and Ball (1998) employ that I seek to mirror, but also the spirit in which they conduct their research, with considerations of social, cultural, and historical influences as not merely addenda in an examination of infant mortality but as providing a deeper understanding of the research problem.

However, it is my contention that previous scholars have not gone far enough in their attempts to incorporate – and interrogate – qualitative archival materials in their studies and explanations of infant mortality in historical populations. In this vein, my work is also inspired by Scheper-Hughes comments in her contribution to *Anthropological Demography*; she argues that we must remain attentive to the following:

What is being hidden from view in the official statistics? Whose economic or political interests are reflected in the kinds of records kept? How are the records kept? What events are tracked? What is thought hardly worth counting at all? And what can this tell us about the collective
invisibility of certain groups and classes of people – women and children in particular? Only a paradigm shift toward a theoretically-driven and critically interpretive and analytical work can open up new areas of knowledge about the relationship between the way people live and the way they die (Scheper-Hughes 1997:220).

As such, in this dissertation, in addition to contributing to the body of work linking micro-level and macro-level analyses within historical demography, I am interrogating the ways in which infant mortality was tracked and understood, and I seek to problematize and contextualize the demographic and epidemiological portrait of Malta during this time period by placing the statistical findings within the larger structure of colonial domination – in part, by analyzing colonial representations of, and discourses about, the Maltese, overpopulation, and mothering – and how this mediated colonial responses to infant death (e.g. Manderson 1996; Jolly 1998).

**Grounding in Qualitative Analyses**

Following Swedlund and Ball (1998), a body of work that has greatly influenced the streams of analyses and discussion within this dissertation is Critical Medical Anthropology (CMA). According to Brown, Barrett and Padilla (1998), CMA has put forth two main critiques of conventional medical anthropology projects. The first critique is of medical anthropology which attributes regional disparities in health to local sociocultural differences without attention to the effects of global political economic inequalities, and the second critique represents a challenge to the (formerly more common) presumption that Western biomedicine is an empirical, law governed science, unbiased by its own cultural premises (Brown, Barrett and Padilla 1998). As a result of the first critique, fine-grained local-level analyses have been increasingly complemented by strategies that incorporate transnational inequalities and explore the impact of global
processes (Ginsburg and Rapp 1995). In essence, whereas conventional demographic work has been criticized for its overemphasis on the aggregate and large-scale processes, CMA argues that anthropological work often focuses too narrowly on the micro-level and has similarly called for an integration of micro- and macro-level analyses. The second critique put forth by CMA, informed by the work of Michel Foucault (1990) most notably, eliminates the privileged position of biomedicine as exempt from cultural analyses, and contributed to the examination of the ways in which the Western scientific endeavour, and knowledge related to the body, health and illness, was historically, socially, and culturally constructed, negotiated, and renegotiated across time, space, and context (Lock and Scheper-Hughes 1996).

An additional body of literature that informs this project is rooted in the work of Anna Davin (1978), “Imperialism and Motherhood.” In this work, Davin explores the context of the preoccupation with infant mortality and domestic management in nineteenth and twentieth century England, a study which laid the foundation for a number of historical studies of infant care in colonial settings including British Malaya (Manderson 1984, 1987, 1996, 1998), Belgian Congo (Hunt 1988, 1999), Australia and New Zealand (Mein Smith 1997), Ceylon (Jones 2002), Latin America (Birn 2002), the Philippines (McElhinny 2005), Sudan (Boddy 1998), and Fiji and Vanuatu (Jolly 1998a, 1998b). It is anticipated that this investigation of infant mortality in Malta will uncover a number of convergences as well as divergences when placed alongside the situation in the United Kingdom and colonies of the period. The comparative element of this dissertation is therefore overt, and while it is typical of all subdisciplines in anthropology (Brown 1998), I would like to stress that this attempt at a sensitively drawn comparison is
not employed to generate abstractions but to open new lines of investigation (Silverblatt 1991) and to note striking commonalities even in the face of differing nuances and timings of events (Jolly 1998a). Moreover, through a consideration of parallel processes, this work attends to Briggs’ (2002:21) assertion that “colonialism was not a series of isolated incidents”; rather it was an “international, economic, political and cultural system that shared assumptions, strategies, and rules.” In addition, this will help to interrogate the similar and disparate patterns of infant mortality in Malta, as compared to other sites, revealed by the statistical analyses.

Much like many of the studies of infant care in colonial settings, listed above, this project is feminist, as it constitutes feminist anthropology in its original formulation, as an anthropology of women dedicated to understanding the lives of women across cultures, as well as more recent feminist attentions to the social and political ramifications of gender, of women as the second sex, and the simultaneous, not sequential, experience of forms of difference engendered by the articulated categories of race, class, culture, modernity history, and so on (Behar 1995; Jolly 1998b; McClintock 1995; Moore 1988).11

This dissertation also models the work of Davin and the authors listed above in tracing the parallel and divergent trajectories of discourses on infant mortality and mothering in two sites – the colony and the colonizing country, in this case Malta and the United Kingdom. In examining the available texts on Malta, I have teased out recurring themes, terms, phrases, and metaphors; how and where discourses emerged; the historical, political, and economic conditions which created the possibility for their

11 Although as a feminist project, this endeavour fails, at least partially, as the voices of Maltese women are largely absent from this dissertation, such that I fear that I am ending up in the undesirable position of “speaking for” rather that “speaking to” colonized women (Briggs 2002; Spivak 1988).
emergence and re-emergence; and the ways in which social power, dominance, and inequality were enacted and reproduced by discourses in the Maltese Islands (Heller 2001; Parker 1992; Terre Blanche and Durrheim 1999; van Dijk 2001). Moreover, following Hunt (1988:410), my aim is to show how discourse was translated into colonial practice in Malta, to “shed light on the actual veracity of colonial generalizations and the impact of and response to colonial programs, interventions and prescriptions within particular rural and urban contexts.” As such, in this dissertation I am attending to circulating discourses, their context, as well as their effects, and this work is informed by critical discourse analysis as I examine how power relationships are structured and maintained through discourse (Fairclough 1995).

This project is also influenced by post-colonial theory and scholarship, drawing a great deal of inspiration from the edited volumes by Ram and Jolly (1998) and Cooper and Stoler (1997), among other works. Specifically, this dissertation is attentive to the postcolonial project’s rejections of colonial categories and scholarship that takes them for granted (Stoler 2001). Postcolonial studies was arguably inaugurated by Edward Said’s (1978) *Orientalism*, in which Said argued that Europeans produced “the East”, “the Orient”, “the Other”, via literature and scholarship, as inferior and in need of civilizing and colonization, and thereby constructed themselves, and Europe. Moreover, because Malta was a British colony during the period under investigation, my work is also informed by colonial discourse analysis, as I seek to critically examine the effects of representations of colonialism and constructions of the Maltese (Said 1978; Young 1994). Importantly, Orientalist discourse does not simply exist on a continental scale, it has been observed within “Europe” as demonstrated by Herzfeld’s (1984) discussion of
Mediterraneanism and the ways in which inhabitants of areas surrounding the Mediterranean have been homogenized and constructed as culturally and genetically inferior compared to their more northern neighbours who are more likely to be considered truly “European.” It has also been noted by Schneider (1998) in the Orientalist discourse which she labels the ‘Southern Question’, whereby more southern Italians are depicted as less civilized and modern than their more northern counterparts, particularly among Italy’s political and cultural elite.

Each of the approaches outlined above – critical medical anthropology, feminist anthropology, critical discourse analysis, and postcolonial theory – emphasize the indispensability of history as a component of analysis, the ways in which contemporary understandings have historical origins, and the manner in which the past has been constructed in light of the conditions of the present. Each is also attentive to all forms of patterned inequality and recognizes the need to address multiple layers of stratification and the varying ways in which the people embedded within these hierarchies are both complicit and impacted. In addition, each school is cognizant of the power-laden encounter between those producing knowledge and those about whom knowledge is being produced, and of the socially constructed nature of ‘gathering data’ (di Leonardo 1991:34). As a consequence, these theoretical influences do not make uneasy bedfellows; instead, each contributes to a broadening of the lens through which infant mortality is viewed.

**Materials and Data Sources**

The materials employed in this dissertation are broadly based, and represent a spectrum of documents that could be collected from the National Archives of Malta, the
University of Malta’s Melitensia section (in which all materials relate to the Maltese Islands), the National Library of Malta, and Britain’s National Archives in Kew, West London. Additional readings were garnered from University of Toronto’s library system, and parish registers from one Maltese community were utilized in the assessment of family-level variation in infant mortality. The National Archives of Malta, located in Rabat, Malta, proved to be the major source for official documents that were carefully read for themes and discourses related to infant and child health and mortality, and depictions of Malta, the Maltese as a people, and Malta’s women and mothers. The documents found there included: Government Health Reports and National Censuses, various reports prepared by Malta’s Chief Government Medical Officer, Imperial Government correspondence (such as despatches between Malta’s Lieutenant Governor and the Secretary of State, and confidential ‘out’ letters), reports by commissions and committees (such as the Royal Commission of 1911, The Economic Advisory Council, and the British Social Hygiene Council), and various reports on the workings of Malta’s government departments, such as those related to public works, emigration, and charitable institutions.

The University of Malta’s Melitensia section was the main source of Malta’s Blue Books (the name given to annual reports produced by the governments of each crown colony and protectorate of the British Empire), as well as a collection of theses written about Malta, scholarly books and journal articles related to the Maltese Islands from a variety of disciplines including history and anthropology, visitor accounts and memoirs from the period under investigation, and a number of works of fiction which were set in Malta (most of which were written by Maltese authors). Materials of this nature, along
with additional official reports on varying subjects, some of which were missing or unavailable in Malta’s National Archives and Melitensia section, were obtained from Malta’s National Library, The National Archives in Kew, and the University of Toronto library system; however, the majority of the materials utilized in this dissertation originated in Malta’s National Archives and Melitensia section.

In addition to textual information, aggregate statistics were drawn from photocopies made of Malta’s Government Health Reports (1897-1955), censuses (1881-1957), and Blue Books (1901-1938) and subsequently inputted into several SPSS data files, concentrating on the years 1900-1938. Yearly infant mortality rates were recorded for all Maltese ‘localities’ (so-named in the government reports, which consisted of individual cities, towns, and villages, some of which were collapsed in the reports), for the Maltese Islands as a whole, and for Malta and Gozo separately, as were yearly statistics detailing the numbers and rates for marriages, births, and deaths. For each census point, the following additional information was available for each locality, the archipelago, and its two component islands: area (in square miles), population, population per square mile, persons per dwelling, and the percentage and number of agricultural and industrial workers. Marital status information for males and females according to age category and the monthly distribution of infant mortality was available only for the islands as a whole. All government reports categorized Malta’s various localities into

12 Today, the island of Gozo is separated from the main island of Malta by a 20-minute ferry-ride. Notably, although some data was available for the island of Gozo, for the purposes of this investigation this second, smaller, island in the Maltese archipelago was excluded from all analyses because of the difficulty of controlling for the large number of differing characteristics and potentially confounding factors. For example, in the early twentieth century, its inhabitants were socially and economically isolated from the mainland; thus inclusion of Gozo within the analysis would not have helped to explain differences within Malta as a whole, and risked skewing the results.
three types of “district”: urban, suburban, and rural. The relative location of each of Malta’s localities, in latitude and longitude, was also determined.

Two SPSS data files were constructed: (Aggregate 1 – A1) a file of yearly information including each locality’s district designation (urban, suburban, rural), as well as information for each locality, and for Malta as a whole, regarding numbers and rates of infant mortality, births, deaths, and marriages, and (Aggregate 2 – A2) a file which contained information for each locality, and for Malta as a whole, at each census point. Because some information was only available at each census point, the yearly infant mortality data obtained from the government reports, for the years 1900 through 1938, was collapsed into three cohorts: the years surrounding each of the census points, 1911, 1921, and 1931. That is, the average infant mortality rate and the average birth rate for each locality and region is the product of an average calculated for the years surrounding that date (1903-1916; 1919-1926; 1927-1938).13

As stated above, in order to assess family-level variations in infant mortality, additional data was collected from non-published sources in order to allow for the reconstitution of families. Specifically, permission was obtained (with L.A. Sawchuk) to access the parish registers of one small, rural, parish that was of a size that was amenable to the methods of family reconstitution, and which did not experience large-scale population increase, heretofore referred to simply as “Casal”, the Maltese word for village, to protect the confidentiality of the community. Digital photographs were taken (and subsequently transcribed) of parish registers from this small farming community, which allowed for the reconstitution of families – by linking marriage, baptismal, and

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13 Because Malta’s Blue Books did not extend beyond 1938, and because of the absence of information during World War I, this division of years was considered an effective way of capturing information representative of each census year and the decades under study, more generally.
burial records (described in detail above). It was possible to reconstitute 109 “complete” families, with marriage dates between 1900 and 1942. A complete family was one in which birth and death dates were available for both the husband and the wife, and neither spouse died before the wife reached the age of 50 years (as a woman is highly unlikely to have additional children beyond age 50). Only first time marriages were included in the analyses as family-building strategies in unions of higher marriage order often follow different schemes contingent on the number and ages of children conceived in a previous union (Kemkes 2006).  

Births (from the baptismal records) were linked to each couple based on the first and last name of the individual and the names of the parents. Deaths (from the burial records) were similarly detailed. Once the complete families were selected, two SPSS data files were constructed: Family Reconstitution 1 – F1, a file consisting of 109 families, which included information on the marriage date, the mother and father’s ages at marriage, the number of births and infant deaths in each family, the percentage of infants who died in each family, the interval between marriage and first birth, the intervals between each subsequent birth, and the average interval between births, and Family Reconstitution 2 – F2, a file consisting of 667 births (and 13 couples with no births), which included information on the marriage date, the mother and father’s ages at marriage, the mother and father’s ages at the birth of that individual, the individual’s sex, the individual’s year and month of birth, whether or not the individual survived the first year of life (and, if the infant died, the individual’s month of death and age at death), the number of births and infant deaths in that individual’s family, the

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14 While this definition of “complete” family is perhaps normative, and families in which one spouse died and/or remarried may provide interesting comparative information on patterns of infant mortality, these families are typically excluded from studies in historical demography because it is nearly impossible to obtain sufficient numbers for comparative purposes or to distinguish between the effects of additional factors at play within these families.
percentage of infants who died in that individual’s family, the interval between the previous infant’s birth and the birth of that individual, the sex of the previous infant, and whether or not the previous infant survived the first year of life.

There are some concerns regarding the reliability of any kinds of historical data; however, there is no reason to suspect an uneven distribution of underreporting (over time or by locality) in the health reports and censuses. As for the parish registers, these constitute one of the most widely used sources for historical demography, and this type of data is considered valuable because all events are recorded at the time they occurred and are thus not subject to problems of recall (Kemkes 2006). In addition, their extensiveness and accuracy can be gauged with a consideration of three factors: the concern of church leaders with the proper keeping of records, the skills of the local registrar, and circumstances in a community’s history and geography that affected the registrar’s or inhabitants’ ability to record vital events (Willigan and Lynch 1982). With regards to the parish registers in the community of Casal, their completeness is likely as a result of the importance of the Catholic Church in Malta, which had a long history and a great deal of power in the island, which was effectively a theocracy prior to the arrival of the British at the beginning of the nineteenth century, and the meticulous record keeping of the parish priest(s) evidenced by the consistency, orderliness, and care which was taken in the recording and storage of the parish registers over the years under study. In addition, the parish registers in Casal are likely to have captured virtually all families in the area because of strong Roman Catholic faith, traditions, and attachment to the local church. Baptism was profoundly important (to ensure a child would go to heaven), and customarily took place within days of birth, in part due to high rates of infant mortality.
during the period. Marriages were not recognized unless performed in the church; therefore, in Malta almost all marriages are likely to have been captured in the parish registers, as well. Ideally, one would like to combine and check the completeness and accuracy of parish registers by comparing the information to individual data from government censuses (Willigan and Lynch 1982), data which was unavailable in the case of Casal; however, as will be shown in Chapter 7, parish-level information relating to infant mortality seems to be consistent with aggregate data, another indicator of the reliability of the data collected.

Questions of reliability or quality, when it comes to the textual materials, are of a slightly different nature. As Burton (2004:292) has argued, “Imperial archives are not, and never have been, sites of pure knowledge, bearing as they do the still-legible traces of imperial power and colonial rule;” therefore, it is important to be attentive to the ways in which archives are marked by the trappings of colonial rule and its comprador elites. How this played out in the Maltese case is particularly interesting: since 1989, Malta’s National Archives have been located in the former Santo Spirito Hospital, in Rabat. With high ceilings and stone walls, the quietness and antiseptic quality of the room was palpable, and rules and procedures for the procurement of documents and their reading were strictly enforced. For each archival item that I wished to see, I was required to fill in an order form with its title and code number, which would then be retrieved from the strong-rooms by the staff members. Only a certain number of documents could be requested at a time (and per day), and all photoduplication was performed by staff members once I had completed the appropriate forms. Further, access to documents was conditioned by a closure period of 30 years for all public documents, and a closure period
of 80 years for confidential material. Additional regulations required that only pencils be used in the reading room, that no mark of any kind should be made on any document, that readers should not lean upon a document or place on it the paper on which they are writing, that the greatest care should be exercised in handling documents and turning of pages, and that foam book-rests should be used in line with the instructions available in the reading room (National Archives of Malta 2003). Importantly, although the rules for the handling of documents were not as extensive in the University of Malta’s Melitensia section and the National Library of Malta, similar procedures were necessary for the procurement of documents; that is, forms had to be filled out so that staff members could retrieve the desired materials. The bureaucratic nature of archival research in Malta – although characteristic of archival research in most locations – when combined with the setting of the National Archives in a former hospital, thus remain potent reminders and metaphors of the ways in which medicine and public health “were crucial means by which the quantification, classification, and bureaucratic knowledge of imperial administration took place” (Bashford 2004:112).

Many others before me have written about the ways in which the accumulation of information about the colonies and their inhabitants, through techniques of the survey and other forms of scientific knowledge production, were technologies of empire, both ways of constituting the ‘Other’ against which Europeans were defined, and serving aims and claims of colonial rule regarding ownership and possession as well as legitimacy (e.g. Briggs 2002; Foucault 1990; Lock and Kaufert 1998; McClintock 1995; Said 1978; Stoler 2002). History tends to be made by those who dominate: experts, governments, and dominant classes or political groups; and it is never a neutral presentation of facts
(Jordanova 1995; Mitchell 1996; Silverblatt 1991). Nevertheless, no matter how problematic, incomplete, and biased these types of sources might be, they remain the basic materials with which a historical researcher must work; therefore, rather than abandoning the entire enterprise, it is important to acknowledge the partialities of all perspectives, the uncertainties of the historical record, and to critically interrogate the materials available (Silverblatt 1991). Because many sources key to research in colonial history are necessarily the product of the colonial encounter, and were collected and deposited in archives for reasons very different from those guiding my research, I sought to read these documents with an eye for their original purposes and biases, the prejudices of their authors and the ends to which they were written (Silverblatt 1991). In this, they function as primary data that “can be turned to again and again to clarify, critically evaluate, or reinterpret the research for which they were gathered”; they can be revisited to re-evaluate previous research and to analyze data anew to address contemporary questions (Herring and Swedlund 2003:xiii).
Chapter 3 – The Location of Malta

The Maltese Islands are a small island archipelago, covering an area of only 316 km², located in the narrow channel joining the eastern and western Mediterranean, 93 km south of Sicily and 288 km north of Tunisia (see Figure 3.1). The maximum elevation of the islands is 250 m along the south-west coast, and it descends to sea level on the north-east coast. In terms of physical features, Malta has no mountains or rivers, but is characterized by numerous deep-water harbours, bays, creeks, sandy beaches and rocky coves (see Figure 3.2). The more urbanized area of the islands is on the eastern side, and at the beginning of the twentieth century, the remainder of the countryside featured a rocky landscape with few trees and a dense network of rubble and retaining walls surrounding a collection of small intensely cultivated fields (Buxton 1924). These low stone walls separating individual fields are frequently mentioned in writings about the islands; however, the most cited aspect in historical and contemporary texts is Malta’s position at the “geographical centre” or “middle” of the Mediterranean, its “strategic” location (e.g. Al-Roumi 1980; Balogh and Seers 1955; Barnes 1987; Bartolo 1998; Boissevain 1974; Borg Olivier et al. 1954; Cassar 2004; East 1940; Mitchell 2002).
Figure 3.1 – Map of Malta in the Mediterranean

(Central Intelligence Agency)
Importantly, reference to the islands’ position midway between the east and west is not simply a geographical observation, it has metaphorical connotations which are made evident with references to Malta’s position “midway between Europe and the Arab World” (Mitchell 2002:12); “on the front-line of Latin Christianity, in dangerous proximity to Islamic North Africa” (Cassar 2004:107); and “on a major cultural ‘fault
line’ between ‘Europe’ and the ‘Arab world’” (Sant Cassia 2000). For example, when Cutajar (2000:105) describes the islands as standing “at the crossroads between Europe and Africa, between Eastern and Western Mediterranean countries”, he then argues that the islands have been “culturally and politically a meeting ground and battleground between orient and occident.”

Malta’s location in the middle of the Mediterranean affected the islands in several ways: it was the primary reason that the islands were colonized by a sequence of external powers, it played a role in the definition of Malta’s economy, and it had a serious impact on Malta’s political and constitutional development. In addition, Malta’s positioning as between occident and orient is related to the island’s location at the crossroads of battles between eastern and western powers for control over the Mediterranean, which Maltese historiography constructs as battles for the survival of both Europe and of Christianity. Further, this designation as between East and West was tied to the origins and identity of the Maltese people, both religious and ethnic, but also in the form and structure of the Maltese language. As such, this chapter will explore Malta’s liminal “location” within the Mediterranean, in each of these domains.

**History of Colonization**

The first human settlements on the Maltese islands are dated to approximately 5000 B.C. and thereafter Malta is said to have been home to the Phoenicians, Carthaginians, Romans, Vandals and Goths, and Byzantines (among others) prior to an extended period of Arab rule (870-1090). In 1090, Count Roger of Hauteville established a Norman presence and from that point Malta became a feudal fief subject to successive holders of the Sicilian Crown (Ryan 1910). However, in 1530, Emperor Charles V, who
had inherited the islands from the last of the Castilian sovereigns, gave Malta to the Knights of Saint John, a Catholic military order charged with the care and defence of pilgrims to the Holy Land, after their expulsion from Rhodes.\textsuperscript{15} Although the Knights were challenged for possession of the islands, most notably by the Arabs in the famous ‘Great Siege of Malta’ of 1565, they retained their position until the arrival of Napoleon Bonaparte in 1798. Dissatisfied with French rule, in part because of Napoleon’s treatment of the Roman Catholic Church, the Maltese revolted, and two years later Bonaparte surrendered under the combined forces of the Maltese, the English, the Neapolitan, and the Portuguese. Under the 1802 Treaty of Amiens, Britain and France agreed to restore Malta to the Knights of Saint John; however, a Congress of Maltese protested (perhaps as a result of the declining power and economic position of the Knights) and requested that Malta be held under the sovereignty of the King of Great Britain, and subsequently in 1814 the Treaty of Paris confirmed the title of Great Britain to the Maltese Islands.

When describing the sequence of events that led to the British presence in Malta, many subsequently stressed the voluntary cession of the island to Great Britain. In some instances, this was stated as a point of fact: Sir Harry Luke, a naval officer in Malta until 1938, noted that the British became rulers of Malta “at the invitation of the Maltese people.” In others, it was argued to have been a wise decision: Mabel Strickland (1955), daughter to former political leader of Malta Gerald Strickland and editor of a prominent Maltese newspaper, noted that “our forefathers showed their foresight and admiration for

\textsuperscript{15} The Knights of Saint John have been variously called the Knights Hospitaller, the Sovereign Order of Saint John of Jerusalem of Rhodes and of Malta, the Knights of Malta, the Knights of Rhodes, and the Chevaliers of Malta. For a more extensive discussion of the role of Knights of Saint John in Malta see Castillo’s (2006) \textit{The Maltese Cross: a strategic history of Malta}, Savona-Ventura’s (2004) \textit{Knights hospitaller medicine in Malta: 1530-1798}, or Nicholson’s (2001) \textit{The Knights Hospitaller}, among others.
the British people” and “asked for British protection”, and contemporary historian Bartolo (1998:35) argues that in light of the British Empire’s economic and political power at the beginning of the nineteenth century “it is quite understandable that to many of the Maltese, association and protection of this nation – a share in the Pax Britannica was considerably attractive.” Moreover, at the beginning of the twentieth century, it was repeatedly asserted by a sequence of Malta’s political representatives that the islands were never conquered, and this was employed as a justification for their calls for greater rights. In these instances, hyperbole was frequently used: it was noted that the Maltese “trustingly…threw themselves in the arms of England, who, as they believed, would have assured to them and their descendants, the liberty for which they have fought” (Pullicino et al. 1903:32); that they placed themselves, “spontaneously, under the protection of the British Flag” (Elected Members 1904b:34); and that “the Maltese were not conquered, and thus are entitled to expect better treatment” (Mizzi and Cachia Zammit 1899b). In response to the repeated claims that Malta was “never conquered”, Englishman Eric Shepherd (1928:87) later argued that this was “an entirely meaningless boast” because “one does not of course “conquer” an island of such a size, one simply occupies it.” He further argued that the Maltese knew that they required protection and would be “annexed by some power,” therefore they selected Great Britain, as it was the best alternative and most likely option,

However, we British have nothing but our own stupidity to thank if a generation of Maltese is now growing up which passionately cherishes this foolish story. It was we ourselves, I understand, who first put that gloss upon the facts, and it has latterly considerably affected the trend of Maltese politics (Shepherd 1928:87).

Despite Shepherd’s later acknowledgement of the at least partial validity of the claims that Malta was never conquered, at the time Sir Mansfield Clarke, then Governor of
Malta, argued that that these claims were “unfounded” (1903b:34) and that “the Maltese did not spontaneously place themselves under the protection of the Great Britain” (1906:20) as was claimed.

In addition to patently denying the claims of the Maltese representatives, in response to their argument that any interference in local matters constituted a violation of the promises made by Great Britain when the Maltese ceded the islands, Mansfield Clarke (1903a:85) argued that “the Imperial Government has every right to interfere in any matter concerning the general welfare of the people in any British possession.” Thus, as Hull (1993:209) has contended, the Treaty of Paris was based on a misunderstanding: the Maltese thought they would be free to manage their own affairs within the British protectorate, and the British thought they were receiving a naval base with a malleable civil population. The latter was particularly important to the British in light of the Napoleonic Wars of the beginning of the nineteenth century, as they came to occupy Malta in part as a means to drive the French out of Africa and to expand their military and trading network (Goodwin 2002). Thus, according to Goodwin (2002) Britain lacked a deep interest in directing the development of the Maltese people; rather, as Mitchell (1998a:143) has argued:

It was a situation for which Maltese historians have coined the term ‘Fortress Colonization’. So long as strategic interests were not under threat, the colonial administration was happy to remain ignorant of local life.

Moreover, unlike other colonies, the Maltese Islands were not a site of agricultural or mineral exploitation requiring large numbers of local labourers. Rather, as East (1940:60) asserted in his book Mediterranean Problems, in comparison with other British colonies, “Britain… sought in the Mediterranean strategic bases and economic ends
rather than colonial areas for settlement and economic exploitation.” The island’s greatest assets were its position astride British imperial routes and its spacious deepwater harbours, first for the purposes of trade and thereafter as a military/naval base. Indeed, it was Malta’s strategic location which was the “main feature of her economic set-up” (Borg Olivier et al. 1955:91). As Dr. Alfredo Mattei (1911:35), one of the Elected Members of the Council of Government, explained: “our raison d’être in the British Empire is solely our harbour, where the British fleet can winter and repair vessels in times of peace or war.” As a consequence of their prioritization of Malta’s strategic importance, Malta’s economy gradually shifted to an almost exclusive dependence on imperial, especially military, spending.

**Malta’s Economic Profile**

Prior to the period of the Knights of Saint John, Malta’s economy was basically agricultural; however with the arrival of the Order’s fleet new avenues of employment within the harbour area opened up (Spiteri 2002). During this period the production of cotton and cotton products became a central feature of the Maltese economy, later serving as the second principal source of income during the eighteenth century, although from 1851 to 1891 employment in the cotton industry declined dramatically (Borg 1995). Agriculture constituted the main economic activity of the majority of Malta’s population during the nineteenth century, particularly in light of the fact that Malta had a weak industrial infrastructure; however, commerce was the predominant economic form on the island (Borg 1995). In this way, Malta’s strategic location served to shape the island’s economy. Specifically, from the beginning of the nineteenth century onwards, Malta became the main distribution centre for British manufactures in the Mediterranean region.
(Spiteri 2002), especially during the Crimean War (1854-1856) and following the opening of the Suez Canal in 1869, as this rendered the Mediterranean the main seaway to the East and Malta an important coaling and repair port for shipping (Barnes 1987). Thereafter, thousands of rural labourers moved from traditional agricultural employment to port occupations such as porters, carriers, and coalheavers and other jobs in the building, fitting out, and repairing of a large mercantile marine. However, by 1891 the harbour boom was over: a lack of investment in upgrading and extending facilities in Malta, in combination with increased competition from ports in Algiers, Gibraltar, and Port Said, caused a sharp rise in unemployment which was only partially contained through the creation of thousands of industrial and clerical jobs with the army and admiralty (Borg 1995; Mowatt and Chalmers 1911). As a consequence, the island’s economy came to depend increasingly not only on commercial activities but also on defence spending.

The Garrison and Fleet came to be Malta’s “arteries of life” (Casolani 1923:B4), and, until the relatively recent shift to a different kind of service economy, one catering to tourists, “the Maltese lived off the income derived from providing services as civil servants, clerks, soldiers, skilled fitters, semi- and unskilled labourers to the British colonial and military establishments which governed the islands for years” (Boissevain 1974:99). The economic position of Malta depended upon the Service establishments, particularly the naval dockyards, by far the largest employer of labour in the islands (Evans 1946). Malta’s strategic value thus came to be considered its “only natural resource” and its major source of income came to be the wages and salaries paid by the British Defence Departments; but defence spending fluctuated according to the ebb and
flow of international tension and conflict (Pirotta 1987:18), and employment opportunities and general prosperity in Malta varied according to these fluctuations as well as British expenditure on public works. Figure 3.3, which tracks Great Britain’s expenditure in Malta, and Figure 3.4, which shows Malta’s marriage rate from 1900 to 1938 demonstrate the degree to which the conditions of life of the Maltese were correlated with imperial spending. According to demographers, marriage rates have long been known to be linked with economic prosperity, as couples will often wait until they are more financially stable to enter into marriage (Oppenheimer 1994, 1997). Interestingly, this association was noted by Chief Government Medical Officer A. Critien in his public health report of 1922 in which he observed the small number of marriages and attributed it to the continued economic depression.

Figure 3.3 – Expenditure Incurred by Great Britain for the Military Protection of Malta

(Malta Blue Books)
Note first the parallel rise in expenditure and marriage rates in the early 1900s, followed by a sharp drop from 1906 on. Specifically, in 1901 a vast scheme to increase accommodation for His Majesty’s (H.M.) ships, costing upwards of three million pounds sterling, was approved and the construction of two new docks, a system of barracks, as well as a breakwater at the entrance of Grand Harbour was begun, employing thousands of Maltese (Mowatt and Chalmers 1911; Spiteri 2002). The extensive nature of these public works, along with the employment opportunities and expenditures associated with the maintenance of a large garrison and fleet, caused a demand for labour so great that wages of all descriptions were said to have doubled (Mowatt and Chalmers 1911). By 1905, nearly ten thousand individuals were employed in Malta’s Naval establishments (Mowatt and Chalmers 1911); however, these public works were completed in 1906 at which point the numbers employed therein were substantially reduced causing widespread unemployment and suffering (Spiteri 2002). This, in combination with reduced naval activity in Malta and increasing commercial competition from Algeria,
Tunisia, Egypt, Cyprus and Tripolitana, caused Malta to begin to experience serious economic problems (Camilleri 2000). By 1910, the economic decline “had reached crisis proportions” (Dobie 1967:70); employment in Malta’s Naval establishments had dropped from nearly ten thousand to 5,181, and Malta was in the midst of an economic depression (Mowatt and Chalmers 1911). As a consequence, in 1911, a Royal Commission, under the direction of Sir Francis Mowatt and Sir Mackenzie Dalzell Chalmers, was appointed to inquire into the finances, economic conditions and judicial procedures of Malta.

The second increase in British expenditure and Maltese marriage rates coincides with the First World War. That is, the declaration of War in 1914 brought a short-lived economic revival in Malta, such that business was brisk and unemployment practically nonexistent (Borg 1995; Spiteri 2002). Thousands of Maltese found jobs in the labour corps, the dockyards were run day and night increasing its workforce from its normal strength of approximately 3,500 men to 14,000 workers (Spiteri 2002), and Malta became the “nurse of the Mediterranean” as throughout the war many casualties were shipped to hospitals in Malta (Dobie 1967:73). The sharp drop in expenditure and marriage rates following Armistice in 1918 signals the economic impact that the end of World War I had on Malta: once again, unemployment reigned as work in the shipyards fell dramatically and nearly 15,000 men were released from employment related to the services (Dobie 1967). Peace conditions brought wholesale discharges from war and emergency establishments, business stagnation and widespread unemployment (Casolani 1926). In addition, food shortages and the hoarding of essential supplies during the war led to a consequent inflation of prices and an increase in the cost of living (Dobie 1967;
Spiteri 2002). As Al-Roumi (1980:143) observed: “economically Malta was in ruins. A large number of the population had little or nothing to eat.” The extent of economic distress is evidenced by the now-infamous Sette Giugno Riots of June 7th, 1919. Said to have been sparked by an increase in the price of bread, mobs broke into university buildings, homes of the editor of The Malta Chronicle, and a flour mill; the military was eventually called in when the police did not act decisively and the riots came to a head when they fired on the demonstrators, killing four and wounding others (Al-Roumi 1980; Dobie 1967). Political changes (which will be discussed in more detail below), and efforts to establish light industries in order to diversify Malta’s economy followed these riots; however, few new economic activities were actually introduced (Spiteri 2002).

From the end of the First World War until the beginning of the World War II, Malta’s economy was increasingly crippled as a result of a policy of retrenchment on the part of H.M.’s Dockyard. As Superintendent of Emigration Henry Casolani (1926:C25) observed: “every individual discharge from the Dockyard reacts on the very life of a circle of individuals who constitute the family of the discharged man or other connected dependents. It reacts injuriously on the revenue and on the internal peace of the country”; therefore, he argued that the then-present depression was the “severest depression of all” because it had “overtaken the discharged men when repeated forced leave and other reasons have reduced them to the lowest ebb of poverty”, when there was not an ounce of work to be had in the entire country. Rearmament by Britain in response to “the gathering clouds of war” stimulated the Maltese economy and relieved some unemployment beginning in 1936 (Spiteri 2002), and although comparable data was unavailable for inclusion in the above figures following 1938, World War II marked a
dramatic increase in both British expenditure and Maltese employment opportunities. Whereas in pre-war years unemployment was common in Malta and earnings were low, when war broke out unemployment virtually ceased to exist; for some occupations it was replaced by a labour shortage, and average earning rose sharply (Stivala 1948). As Evans (1946) explained “money poured into the country from abroad” because the services were maintained on a wartime footing for nearly seven years. Of course, this is not to say that the Second World War did not negatively impact Malta and its population. With the entry of Italy into the war in 1940, Malta was subject to a blockade and was bombed in a devastating manner by Italian forces, with nearly continuous bombing taking place between 1941 and 1943 (Stivala 1946). However, one benefit of the destruction of much of the Maltese Islands was that, following the war, extensive rebuilding was necessary, which again generated employment in public works.16

Some have argued that British prioritization of Malta’s strategic importance superseded all other considerations and was responsible for the subordination and underdevelopment of the island’s economy. For example, in an electoral address published in the Gazzetta di Malta, the Elected Members of the Council of Government, after resigning en masse as an act of protest, contended: “the Government shows but little regard for the population… being wholly absorbed in one sole idea, namely, the interests of the Fortress and the Naval Station” (1902:21). Similarly, nearly fifty years later, Thomas Balogh and Dudley Seers (both of Oxford University), appointed by the Labour Government of Malta to survey the island’s economic situation in 1955 and to indicate to

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16 As a result of the role Malta played in World War II, on April 15th, 1942, the Maltese Islands were awarded the George Cross by King George VI, which would thereafter be displayed on the Islands’ flag.
what extent Malta could legitimately expect economic aid from Great Britain, argued
that, with priority given to defence needs,

no effort was made until quite recently to develop alternative sources of
employment or to give the Maltese universal education and social
services. Britain is therefore responsible for the peculiar social and
economic structure that has grown up in the Islands, a structure the main
feature of which is that Maltese living standards depend wholly on
Imperial expenditure, upon the fortifications and military works, and upon
the expenditure of the garrison and the fleet in the Island (1955:16).

A grimmer picture could be painted: as living in a colonial fortress, the Maltese were
subordinated to military needs (Sawchuk 2001). As Frendo (1988:198) noted, at the turn
of the century Admiral Sir John Fisher wrote about Malta: “for imperial purposes, it has
no value whatever. It produces nothing. It has no manufacturers… it exists for the Navy;
and it exists by the Navy… Malta is a fortress, pure and simple.” This reliance was
understood to be potentially hazardous: prosperity was described as “artificial and
precarious” (Mowatt and Chalmers 1911:12; Evans (1946) wrote:

the island population will inevitably be faced with a most painful process
of readjustment in the near future. Unless new industries can be
established...the island economy will be hard put to it to absorb the
existing population, apart altogether from the additions which are arriving
so plentifully each year.

Thus, the local economy was an unstable one, centred almost entirely around British
colonial interests, and one that failed to meet the needs of the local population.

There is some debate as to the economic prospects of the Maltese islands prior to
their “request” for protection from the United Kingdom at the beginning of the nineteenth
century. For example, Bland (1994) has argued employment in the dockyard, along with
positions in bureaucracy and as servants, replaced a thriving centuries-old cotton
agroindustry and resulted in enforced dependency on imperial power and
counterdevelopment characterized by high unemployment and a displacement of labour from household production. On the other hand, it was argued at the beginning of the twentieth century by the British Commissioners of the *Royal Commission on the Finances, Economic Condition, and Judicial Procedure of Malta* that Malta’s own agriculture, industries, and commerce were never capable of supporting even its own inhabitants, let alone providing surplus for export: “They have always been able to rely on a large expenditure in the Island of revenues drawn from outside sources” (Mowatt and Chalmers 1911). The pattern whereby the Maltese islands relied on imports and had relatively small capacity for export can be observed in Figure 3.5. However, even the Royal Commissioners conceded that these sources of revenue, from foreign and imperial expenditure, “diverted industry from production for internal consumption and external trade to work for the Government and the foreign governing class” (Mowatt and Chalmers 1911). In any event, the entrepôt trade dwindled in importance, cotton growing and manufacturing, the leading industry of the nineteenth century, disappeared; the proportion engaged in manufacturing fell; land went out of cultivation, employment in agriculture fell; the fishing industry dwindled to a fraction of its former size; and “reliance on the Services involved also a serious distorting of the economy… [which] became increasingly an adjunct to the Service establishments” (Balogh and Seers 1955:8). As Falzon (2001:356) noted, the service establishments, most notably the dockyards, were “part and parcel of Malta’s fortunes as a fortress and naval base” and the Admiralty Dockyard was the “primary driving force of the local economy.”
Malta’s Political and Constitutional Development Following British Colonization

Malta’s position in the middle of the Mediterranean, and its importance to the British as a military and naval base had a profound impact on not only the island’s economy but also its political and constitutional development. As described above, from the very beginning of the British presence in Malta, the Maltese argued for more rights and a greater liberty to manage their own affairs, predicated on the fact that they were not conquered by the British but requested the protection of Great Britain following the departure of the Knights with the arrival of Napoleon. However, as Pirotta (1987:75) explains, “Britain regarded Malta primarily as an important strategic fortress and was averse to any action that might hinder Imperial defence policy”, and granting the Maltese greater power to manage civil affairs was seen as a move that might impede British interests. Thus, as Austin (1991:x-xi) observed, because of Malta’s strategic importance and concomitant vulnerability, from the arrival of the British to the granting of Malta’s independence in 1964, “the islands endured a series of advances and retreats… a constitutional game of snakes and ladders” whereby the Maltese were granted, and had
revoked, a series of constitutions which conferred varying degrees of political representation and powers to manage civil matters, according to the degree to which the Maltese representatives cooperated with British imperial interests.

In 1802, Malta fell under the Governorship of Admiral Sir Alexander Ball, who had assisted the Maltese in the expulsion of the French, and following the Treaty of Paris, Malta became a Crown Colony, under the sovereignty of Great Britain. Part of the British State, it was thereafter administered directly by the Crown, through its Governor Lieutenant-General the Honourable Sir Thomas Maitland. In 1835 Malta’s first constitution established a Council of Government which was purely consultative in nature. It consisted of the head of Government (then called Lieutenant Governor, not Governor), four official members (the Senior Officer in Command of the Land Forces, the Chief Justice, the Bishop, and the Chief Secretary to Government) and three unofficial members nominated by the head of Government: two Maltese, selected from the chief landed proprietors and merchants, and one British-born merchant (Borg 1995; Dobie 1967). Importantly, the lieutenant governor was expected to "consult and advise" with this council on all matters of difficulty or importance (which he alone could propose), but he could act without consent of the majority (Dobie 1967). According to Borg (1995:78), the Council’s make-up exposed “a bias in favour of security, expressed by a non-elected majority, while officially recognizing the elite groups that dominated Malta’s socio-economic reality.”

17 From 1981, what were formerly termed ‘Crown Colonies’ were referred to as ‘British independent territories’, only to be re-termed ‘British overseas territories’ as of 2002.
18 The inclusion of the Bishop on this earliest council speaks to the influence of the Roman Catholic Church in Malta, a topic which will be discussed in more detail below.
19 The importance of the Bishop’s role and the power of the Roman Catholic Church, as well as the division of the Maltese people according to social class will be discussed in greater detail in subsequent sections.
A new constitution was granted by Letters Patent on May 11th, 1849. In addition to the Governor, the Council of Government was to consist of eighteen members: nine official members, and eight elected unofficial members, and this represented the first time that the Maltese were allowed to vote under British rule. In the first election, only 3,486 were eligible to vote (of which 3,056 came out to vote) as the qualifications excluded the working classes and emphasized property ownership; only males over the age of twenty-one who possessed land or property of an annual value of 8.6s6d (100 scudi) or who occupied as a tenant a dwelling valued at 50 scudi annually, or who were partners in a mercantile firm were eligible (Borg 1995). In addition, there were property restrictions on those allowed to hold office; hence, the elections were essentially made by and for members of the landed, professional, and merchant classes (Boissevain 1965). Although this constitution did provide greater representation and voice to the Maltese, the fact that they formed a minority in council was seen as problematic, and in 1855 Maltese politician Mitrovich resigned, arguing that a minority of elected members could not make their influence felt against a bloc of official members (Dobie 1967). This marked the first instance in which a Maltese politician would resign in protest of the existing form of government; however, over the next century, this became a regular means of objecting to their lack of political power in council. In 1868, five elected members resigned after the Governor instituted a salary increase for an official that was not approved by the council; and they were subsequently returned in the next election (this would also become a pattern, resigning and returning unopposed in the following elections) (Dobie 1967).

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20 Letters Patent are issued under the Royal Prerogative and constitute a rare, if significant, form of legislation without the consent of Parliament.
The next twenty to forty years were a period of great political unrest. Notably, during the 1880s, two Maltese political bodies developed among Malta’s political leaders: the ‘Reformists’, under the leadership of Sigismondo Savona, who were mainly pro-British and supported government reforms, and the ‘Anti-Reformists’, headed by Dr. Fortunato Mizzi, who were against expenditure and mainly pro-Italian (Bartolo 1998). Mizzi and the Anti-Reformists won all eight seats on council in the 1880 elections, and thereafter demanded new constitutional order and vowed to oppose the government and to push for full control over local affairs (Dobie 1967; Frendo 1992). As part of this campaign, the party put forth and elected an illiterate organ grinder and a maker of terra cotta figures to call attention to the uselessness of legislature with an elected minority; thereafter the other six elected members resigned and the Governor dissolved the council, but elections were not held for ten months, effectively returning Malta to an Executive Council under British rule (Dobie 1967). Mizzi’s party did not simply desire greater representation, they objected to some of the changes that were being proposed and instituted by the British – particularly with regards to the language of government, the courts, and education, popularly referred to as ‘The Language Question’.

The Mizzians adamantly opposed any reductions in the importance of the Italian language, including

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21 The significance of the Italian language, culture, and heritage to the Maltese people will be discussed in more detail below; however, the ‘Language Question’ refers to a series of debates that raged from the mid-nineteenth century, wherein, for reasons that will be elaborated on below, the Nationalists supported the development of Italian culture and greater links with Italy, the maintenance of Italian as the language of the government and courts, and the continued presence of the Italian language in the schools (although some, at times, were willing to concede to a system of *pari passu*, the simultaneous teaching of Italian, English, and Maltese). On the other hand, over the years, the British authorities produced (and their sympathizers supported) commissions suggesting the development of indigenous culture and language, and through that, the use of English (Mitchell 2001), the establishment of English as the language of government and of the courts, and of the teaching of English through the medium of Maltese (although, some, at times, were willing to concede to a system of *libera scelta*, free choice, whereby parents would be able to chose whether their child would learn English or Italian in upper level classes). Occasionally, there were additional calls to teach Arabic, based on the assertion that Maltese was a bastardized version of this language and that learning Arabic would facilitate communication with the countries of North Africa. See Hull’s (1993) *The Malta Language Question* for a more extensive discussion of these debates.
increased use of Maltese and/or English in these venues. As a consequence, when a 1884 dispatch from the Secretary of State indicated that, despite their objections, Maltese would remain the language of instruction in the primary schools and Italian would not be returned to precedence over English, all of the elected members resigned, arguing that this was an insult to the Maltese and their representatives (Dobie 1967). Over the next several years, portions of or the entire body of elected members resigned and were re-elected a number of times in subsequent protests against government spending and the existing form of government.

Finally, on December 12th, 1887, Malta was granted a new constitution by Great Britain. The new governing council included the Governor and twenty members: six official members, including the Chief Secretary to Government, the Crown Advocate, and four others holding public office and serving on the Executive Council; ten unofficial members, elected by general electors; and four unofficial members elected by the special electors representing the clergy, the nobility and landed proprietors, the University graduates, and the merchants (Borg 1995). With the majority in legislature (14 of 20), this Council of Government was, in essence, a representative government, with "dual control", under British rule; however, imperial interests were safeguarded by the reservation of the right for the Governor to legislate by order in council (Frendo 1992; Dobie 1967). Mizzi’s party, now termed the Partito Nazionale (PN), swept the subsequent elections; however, one of the elected members who was also to serve on the Executive Council, Gerald Strickland, the son of an English naval captain and an aristocratic Maltese mother, crossed the floor to the official side to become Chief Secretary to Government (Borg 1995). Strickland’s tenure as the Chief Secretary, from
1888 to 1902, proved to be a period of great political upheaval in Malta. Over the next dozen years, Mizzi’s PN and S. Savona’s Reform Party would variously hold power in council; however, the two parties’ platforms were markedly similar in that they both protested expenses charged to the Malta treasury, showed sympathy to the clergy and pro-Italian ideas, and objected to the government’s tax policy (Dobie 1967). Thus, the elected members held up supply votes for the next several years and pushed for responsible government, regularly resigning en masse in protest. For example, in 1897, following a series of proposals by a select committee on education in Malta that would lead to the teaching of Maltese in years one and two, the choice of English or Italian in years three and four, and the study of both English and Italian in the fifth and sixth years of education (generally referred to as *libera scelta*, or ‘free choice’ because of the option to study either English or Italian in years three and four), the elected members, who wanted Italian to remain the primary language of education, resigned and the ordinance was passed in their absence (Dobie 1967).

The following year (1898), Colonel J.L. Hewson of the English army, refused to sign a transcript of his testimony as a trial witness because it had been translated into Italian, the language of the courts at the time. This led to two ordinances: that in criminal court, the accused (if he was British) could request that the case be conducted in English, and that in civil court a British party could be permitted to speak in English. Both measures were defeated when all elected members opposed the ordinances; however, they were subsequently passed by order in council at which point it was stated that the government would move to substitute English for Italian in all legal proceedings within fifteen years. In protest, all elected members of the council declared that they would
obstruct government projects; and in subsequent sessions they voted to discontinue public
works already under way, refused funds for a new hospital, tried to repeal a loan for the
extension of drainage and refused a revenue measure designed to produce additional
funds for this project, and approved only part of the necessary education funds (Dobie
1967). In response, all legislation that had been turned down during the sessions was
passed by order in council.

During this period, the Maltese, largely under the leadership of Dr. Fortunato
Mizzi repeatedly pushed for greater control and liberty to manage their own civil affairs.
In a series of petitions, public and private meetings, and official correspondence, the
Maltese representatives objected to the existing form of governance and demanded self-
government. For example, in a statement regarding the claims and grievances of the
Maltese, submitted to the Secretary of State for the Colonies Joseph Chamberlain on
behalf of the elected members, Mizzi and S. Cachia Zammit (1899a:4-5) argued that the
present form of Local Government could not fail to beget “a permanent feeling of distrust
and suspicion in the people”; protested against the “evils of a purely military rule, and…the entire absence of anything deserving the name of political liberty”; and declared that
the British Government had “hitherto ruled Malta with undisguised despotism without
attempting in any way to temper, or soften, or hide away the efforts of foreign rule” such
that the Maltese were expected to “blindly submit to the dictates of the local officials sent
out from England, and must never presume to dream of political liberty in however
restricted a sphere.” Specifically, they wished to have the power to determine all
questions related to legislation, the imposition of taxes, and the expenditure of public
moneys (Mizzi and Cachia Zammit 1899c), and they protested that the rule of a Military
Governor in Malta meant that all power was concentrated in his hands and he could override any decision of the Council whenever he disapproved of that decision (Mizzi and Cachia Zammit 1900). In response, Chamberlain (1899:21) stated: “I cannot say that it seems to me in the slightest degree probable that any Government would think of extending the Constitution. The Constitution of 1887 went far enough, and many people think it went too far”, and he argued that the measures initiated, including the extension of the drainage system, were of clear advantage to the colony (Dobie 1967). Moreover, in a February 1902 speech to House of Commons, Chamberlain professed that the practice of refusing money votes could not go on, and that if the childish game of the elected members proceeded they would be compelled to modify the constitution to give the government a controlling voice in the administration of the Island (Al-Roumi 1980).

In response to this threat, in a speech to the Council of Government, elected member Francesco Azzopardi (who would later replace Mizzi as leader of the Nationalists after the latter’s death in 1905) stated:

> the sooner the Secretary of State abolishes the Constitution the better will it be for us and for the whole people of Malta, because we shall, at least, be spared this continual piece of humbug which is termed a Constitution…. Malta is to-day actually governed… under a cloak of Constitutionalism, which is illusory (1902:17).

Shortly thereafter, in May of 1902, Gerald Strickland left Malta to take up an appointment as Governor of the Leeward Islands, in part because “the Colonial Office had become convinced that Strickland’s attitude toward Maltese leaders was a factor in the continuing public commotion and the stalemate in council” (Dobie 1967:59). However, despite this move, and in defiance of Chamberlain’s warning, the elected members rejected the education estimates to protest the government’s move to institute
'free choice’ (regarding the learning of English or Italian) in elementary schools (Borg 1995), after which the 1887 constitution was revoked, returning Malta to the 1849 form of council of government under British rule, as of June 1903. In the first elections, Nationalists were elected to fill all eight seats on council and they immediately resigned in protest against the loss of the 1887 constitution and the misuse of the right to legislate by order in council (Dobie 1967). The elected members continued to resign in the following six elections, which prompted the government to obtain permission to conduct business in the absence of the elected members and to limit the frequency of elections by allowing a period of twelve months to pass before an election needed to be held following a resignation or prolonged absence from council sessions (Dobie 1967). Again, much correspondence between Maltese leaders and British officials followed. For example, in 1903, the elected members of the late Council of Government wrote up a "Protest" to Governor Sir Mansfield Clarke in which they argued against the new constitution as well as “a whole century of political slavery” (Micallef et al. 1903:6-7; notably, this was translated from the Italian in which it was written); they argued that under the 1887 constitution the Government “decided to have its own will” by legislation through vetoes and Orders in Council, that the then-active 1849 constitution was a “sham” which only served to “mask the despotism of the Government before Europe”, and that it was an “old detestable subterfuge… meant to depict us as a free people, in order to make us feel more ignominiously our unbearable state of slavery.”

Once again, in response to these protests, the government argued that the constitutional changes were rendered necessary because of the refusal of the Elected Members to vote the supplies required for the education of the people and because of
their continued obstruction of useful and necessary legislation; further, they were
censured for their repeated resignations which “deprived the people, whom they claim
to represent, of taking part in, or giving advice upon, matters of public interest”
(Mansfield Clarke 1903:30). In a confidential letter to Lord North, Chamberlain
(1905:18) also contended that the changes to the constitution were “made absolutely
necessary by the abuse of the Constitution by the elected members” and went on to state
that “Malta, of course, is in the first place a fortress, and it is quite impossible to treat it as
a self-governing Colony.” Unaware of the firm stand of the colonial government in this
regard, in 1907 the elected members, now under the leadership of Azzopardi, decided to
put an end to their policy of abstention, and agreed to take their seats in council for the
first time in four years in hopes of entering into negotiations for a more representative
form of government (Dobie 1967). Again, their position was that the existing form of
government was inappropriate and deprived them of liberty; in the words of Azzopardi
(1908b:33; again translated from Italian) in a meeting of the council of government:

The Secretary of State, therefore, is he who decides our questions; the
Governor, who is the representative of the Secretary of State, give orders
and we must obey, because nobody here can go against the orders of the
Government. We are a small population, and unarmed population which
has no power to make its reasons prevail, and must submit to the brute
force of the nation by which it is governed…. It will rest with the latter
[the Secretary of State] to withdraw it altogether or grant us a Constitution
worthy of its name and not a mock Constitution, because, after all, I do not
see the reason why the Maltese, besides being oppressed, should also be
mocked! This Constitution is nothing but a mockery and a farce,
unworthy of the British Government and unworthy of ourselves. I should
prefer to see it abolished.

Thus, the Maltese leaders argued that no constitution would be preferable to the existing
form of government, and once again, when their protests went unheeded, abstention
became the order of the day (Dobie 1967).
Despite their policy of abstention, the elected members agreed to take their seats during the 1911 Royal Commission; however, following the publication of Mowatt and Chalmers’ report, which included recommendations for changes in taxation, ‘free choice’ of language in the schools, and the institution of Maltese as the language of the courts, all members again resigned, which set off another period of abstentionism with only Azzopardi and one other member regularly acting in council through the First World War (Dobie 1967).\(^{22}\) However, following the war, as stated above, popular agitation for a more liberal form of government, combined with major economic problems, culminated with the June 1919 riots, and later that year Britain announced that Malta would receive a more liberal constitution (Boissevain 1965). Ultimately instituted in 1921, this constitution granted the Maltese responsible “qualified” self-government: in effect it was a diarchy, with the Maltese given full responsibility for the management of all local affairs, whereas vital matters such as defence, foreign affairs, currency, immigration, passports, finance, and many other matters would continue to be the purvey of the Governor, allowing for continued British control over the strategic island fortress (Boissevain 1965; Dawe 1929; Frendo 1992; Spiteri 2002). Under this constitution, the Legislative Assembly would consist of thirty-two members, elected by literate adult males with property qualifications, and the Senate held seventeen members, seven elected by the general electors, ten by the special electors representing the nobility, the University graduates, the Chamber of Commerce, and the Trade Union Council, and two representatives of the clergy nominated by the Archbishop (Borg 1995). The party with

\(^{22}\) In part, the elected members protested the promotion of Maltese because they considered this to be a means of ultimately displacing Italian in favour of the English language. In addition, as will be discussed below, the Arabic origins of the Maltese language itself tied the Maltese to their North African neighbours, in contrast to the ways in which Italian emphasized their European heritage and identity.
the greatest number of seats in the Legislative Assembly would form the government, with its leader acting as Prime Minister; therefore, this period also marked the beginning of official political parties in Malta. In the first elections, there were four parties: the Nationalists (in the Mizzian vein) won four seats, the Constitutionalists and the Malta Labour Party (MLP) each won seven seats, and the Unione Politica Maltese (UPM, a party of moderate Nationalists) won fourteen seats. As a result, the UPM formed the government, occasionally supported by the MLP as they did not hold a majority, and Party Senator Joseph Howard became Malta’s first Prime Minister (at the request of the UPM’s leader, Monsignor Panzavechia).

The UPM later joined with the Mizzian Nationalists to form the Partito Nazionalista (PN), and they retained power (under Ugo Mifsud) until 1927, at which point the Constitutionalists, now under the leadership of the newly returned Gerald Strickland, rose to power. The Constitutionalists formed a compact government with the MLP, who had won three seats in the Legislative Assembly; however, their abilities to govern were impeded because they retained only a minority in Senate (Borg 1995; Dobie 1967). Nevertheless, Strickland embarked on a mission to emphasize the importance of the English language in education and the courts, at the expense of Italian (Borg 1995), pushed for restitution of Maltese as the written language of the islands, and branded those inclined towards Italian language and culture as disloyal (Bloomfield 1935). Moreover, Strickland and his government repeatedly clashed with the Roman Catholic Church; for example, when the Ecclesiastical Representatives in the Senate voted against Bills and Acts put forth by the state, this sparked several anticlerical demonstrations, and the

23 Strickland was the son of a British naval officer, which may partly explain why he was a strong promoter of English, as opposed to Italian, in Malta.
Constitutionalists attacked these senators, arguing that they acted not as priests but as politicians (Dobie 1967). In addition, Strickland personally demanded that the Superior of a monastery be deported as an undesirable alien, arguing that a monk had been transferred to England for supporting the Constitutional party. All this led the British government to believe that the root of the conflict between the church and state was the participation of Maltese priests in politics; therefore, they requested that the Vatican send a representative to investigate, who later denounced Strickland’s personal conduct and political ideas (although the specific grounds for this are unclear). This conflict between the Church and the State culminated when the Archbishop issued a pastoral letter (dated May 1\textsuperscript{st}, 1930) forbidding Catholics from voting for Strickland and his candidates or to stand for election on behalf of the Constitutional Party. In response, Governor du Cane proclaimed a state of emergency and suspended the elections (May 3, 1930) on the grounds that they could not be free (Borg 1995; Colonial Office 1951).

Interestingly, in a confidential dispatch issued April 23\textsuperscript{rd}, 1929, for transmission to the Governor and the Secretary of State for the Colonies and Dominions, A.J. Dawe (1929:96) argued that

At the present moment Lord Strickland is doing everything possible to magnify the Maltese Government at the expense of the Maltese Imperial Government. His policy appears to be based on the idea that Malta is of the same status as a Dominion and, as you are aware, we have recently had to call to the attention of the Government to the dangers of this position…. It is quite clear that if the present written Constitution is to be an effective instrument and not a scrap of paper these pretensions of Lord Strickland will have to be checked.

Dawe’s assertion that Strickland behaved as if Malta was a “Dominion” is noteworthy; at that time, a dominion within the United Kingdom had attained the status of "nationhood" and political independence, as opposed to a self-governing colony, which controlled its
internal affairs, but did not control foreign affairs, defence, or international trade. Therefore, Dawe’s comments imply that Strickland was overstepping his bounds, and the fact that this correspondence occurred prior to the pastoral letter, which purportedly sparked the need to declare a state of emergency, calls into question the true motivations of that latter. More, following the Royal Commission of 1931, which was to study the existing political situation in the Island, in 1933 the 1921 Constitution was reinstated, and candidates in the subsequent elections were nominated and elected while the ecclesiastical ban on voting for Strickland and his supporters was still in effect (Dobie 1967). As a consequence, the elections were won by the PN, and Ugo Mifsud became Prime Minister, with Dr. Enrico Mizzi (son of Fortunato Mizzi, who was so strongly in favour of the Italian nationality that in 1916 he was sentenced to prison, although later pardoned, for making anti-British and disloyal statements) becoming Minister of Education upon the untimely death of previous minister Mgr. Enrico Dandria. Consequently, despite the change in the Maltese Government, political tensions continued, this time because the Nationalist Government sought to systematically circumvent the provisions of the constitution dealing with language by setting up special Italian classes for elementary school students, making knowledge of the Italian language a requirement for minor posts in the government, establishing Italian elementary schools with nominal fees, and approving an expenditure of 5000 pounds for the teaching of Italian (Dobie 1967). This last point, in combination with Italian irredentist activities in Malta, led the Secretary of State to again declare a state of emergency, suspend the constitution, and return Malta to its 1813 status, crown rule, from November 1933 until 1936 (Borg 1995; Frendo 1992).
However, in 1936, instead of restoring the 1921 constitution, the constitution was revoked and a new one was declared, which provided for an elected council under British rule in the person of a Governor and Executive Council made up of five ex-officio members and such nominated members as were appointed by the Governor and approved by the secretary of state (Dobie 1967). With the declaration of World War II in 1939, this constitution was effectively suspended as the Governor assumed total rule during the hostilities. Following the Second World War, Malta’s political leaders once again used abstention as a political tactic: all elected members resigned in July 1945 in response to a recommendation that funds for social services be obtained via direct taxation, the Constitutionalist and Nationalists refused to even nominate candidates in the subsequent elections to protest the existing constitution, and in the following year, the nine elected MLP members resigned to protest the Government’s failure to improve conditions of food scarcity and inadequate housing; therefore, as of 1946, when no one would run for election, the council continued to govern with only one elected member (Dobie 1967).

Finally, in 1947, a new constitution restored a diarchy, this time with a Legislative Assembly (but no Senate) consisting of 40 elected members, but their power again did not extend to certain specified measures which were reserved to the Maltese imperial government under the governor, including defence, civil aviation, currency, immigration and nationality (Dobie 1967). This constitution would stand until 1958; however this did not constitute a period of political stability by any means. In 1949, Prime Minister Boffa of the ruling MLP threatened to leave the Commonwealth in response to the proposed discharge of 1,500 workers from the Dockyards, only to later be attacked and replaced by Dom Mintoff as head of the MLP because he was said to lack the “necessary qualities as
a leader”, and to have his government defeated in parliament in 1950 (Dobie 1967). Power then shifted to the PN, under Enrico Mizzi, back to Boffa (now head of the new Malta Workers’ Party), and then back to Dom Mintoff in 1955, who then proposed a scheme for integration with Britain. Despite vehement opposition from the Archbishop and the Roman Catholic Church, who argued that integration should not be attempted before the British government would include constitutional guarantees not to interfere with matters relating to family life, education, and other aspects important to the Church, Mintoff called a referendum in which 45% of the public voted in favour of integration; however, by April 1958, Mintoff declared in a public meeting that unless Britain’s terms for integration included measures to secure employment and increase financial contributions, his government would push for independence (Dobie 1967). Two weeks later, Mintoff and his MLP supporters in the legislature resigned in protest, which led to disorder and clashes between demonstrators and police, ultimately leading the Governor to ban public meetings and declare a state of emergency, once again returning Malta to direct British rule.

The next several years were marked by continued conflict between Mintoff’s MLP and the Church, who considered the political leader pro-Communist and at one point placed the entire MLP executive under an interdict, officially severing them from the Church, only to thereafter issue a pastoral letter encouraging the Maltese people not to vote for the Malta Labour Party in the 1962 elections, which were held under a draft constitution (Borg 1995). Unsurprisingly, the elections were won by the Nationalist Party, Giorgio Borg Olivier became Malta’s Prime Minister, Malta’s representatives immediately began working towards constitutional independence, and a Draft
Independence Constitution was approved by the house to be put to the public in a referendum. Once again, there was political infighting, with the Nationalists, supported by the Church, arguing that a strong “yes” majority would prevent the inclusion of anti-Catholic clauses in the constitution, narrowly winning with 54.5% of valid votes; although notably, nearly 60% voted no, cast blank votes, or spoiled their ballots, all of which were promoted as forms of protest by the other parties (Dobie 1967). Thus, on September 21, 1964, Malta was declared a sovereign state; however, in the terms of independence, Britain retained the right to station armed forces and associated personnel in Malta in times of peace and war for a period of ten years, in return for which Malta would receive 50 million pounds in aid to be put towards improvements in the water supply, port development, electricity, industrial development, tourism, agriculture, fisheries, and higher and technical education (Dobie 1967). In 1974, Malta was declared a Republic, March 31, 1979 – now celebrated as Freedom Day – marked the end of the British military presence in Malta, and in 2003, following another period of political debates and another referendum with a high voter turn-out (91%) and a narrow margin of victory (54%), the Maltese Islands officially joined the European Union.

This outline of Malta’s political and constitutional development was included to show the extent to which the British imperial government retained administrative control over Malta, regardless of the official form of government, as a result of the power to legislate by Order in Council, the capacity to declare a state of emergency, and to suspend and/or revoke Malta’s constitution.
Maltese Italianità

In the early decades of the twentieth century, a major area of contention between the British Government and the Maltese was related to the place of the Italian language and culture in the islands. Malta’s political leaders emphasized the place of Italian language, culture, and heritage, which they argued had a long history in the islands which should not be overturned to serve British interest. Borg (1995:83) has argued that there was an element of self-interest involved in these claims, as Italian was the language which defined and reproduced the dominant position of the traditional hegemonic groups, from which Malta’s political leaders were drawn. However, Malta’s political leaders’ emphasis on the place of Italian was also a means of asserting their Europeaness. As Hull (1993:166) argues, what the Nationalists “dreaded more than anything was the humiliating isolation from the mainstream of European life and civilization that would certainly result from the abolition of Italian”, and it was the Italian language (as a symbol of italianità, Italianess) which distinguished the Maltese as different from other peoples of the British Empire and established them as civilized and European – and not of the Arab world. For example, as Hull (1993:13) noted, during the 1931 Royal Commission Sir Ignazio Gavino Bonavita proclaimed that the abolition of the Italian language and laws:

could have broken asunder the link which, by the force of nature, binds this Island to Italy, and would again raise the geographical problem which our forefathers considered so humiliating, as to whether Malta belongs to Africa rather than to Europe, a valuable argument being lost in favour of our character as Europeans derived from our language and our laws. By wiping away all connection and intercourse with Italy, and estranging us altogether therefrom, Malta would be reduced to the condition of one of those isolated British possessions, or other distant colonies, separated from any other country, subject at all times to become a willing and easy prey to every powerful occupant.
Similar political rhetoric appeared at the turn of the twentieth century: Crown Advocate Sir Adrian Dingli (1878:115) argued that the best interests of the community at large and the intellectual condition of the Maltese would “much more likely … be maintained and improved by its remaining at the tail of Europe, than by placing itself at the head of Africa”; and others suggested that the suppression of Italian would render Malta a microscopic colony of supposed “Berber half-breeds” (“meticci berberi”) (Hull 1993:135) and the Maltese an “Anglicised African” (n.a. 1903b:90). Moreover, Dr. Fortunato Mizzi (1901:116) argued that “The language question is a question of dignity, of liberty, of bread.” Not only did Italian place them on par with other European localities and ensure their “dignity”, but Mizzi and his supporters objected to the imposition of English against the will of the Maltese, and argued that the promotion of English in Malta would result in an influx of immigrants from Britain seeking employment and would limit Maltese opportunities in the Italian-speaking Mediterranean littoral.

Mizzi’s last point, that Italian was more advantageous to the Maltese in terms of opportunity, was heavily debated, and raises the issue of the ways in which the Maltese identity was constructed in regards to emigration. During the nineteenth century, the Maltese generally emigrated to the Mediterranean littoral (Tunis, Tripoli, elsewhere in North Africa, Egypt, as well as Turkey and Algeria to some extent), and this was encouraged by the colonial government, in part as a means of extending the influence of the Empire throughout the Barbary Coast and further into the interior: “The language of the Maltese and the affinity of their customs to those of the Tripolines… tend to show that Maltese emigration would be the means of introducing education and civilization
into Africa more easily than by other European Nation” (Warrington 1850). Although evidently considered as coming from a “European Nation” and capable of civilizing the natives, when comparing the Maltese to the Arabs of Africa, Crowe (1850) argued “their language and habits are nearly the same.”

By the beginning of the twentieth century, although Mizzi argued that “the Maltese still had “their best outlet” in Tunisia and Egypt” and pointed to the large Italian populations of these countries as evidence of the continued usefulness of the Italian language” (Hull 1993:121), a lack of opportunities in the Mediterranean littoral was leading the imperial government to look further afield for Maltese emigration. Following World War I, a number of Maltese sought work in France and other devastated regions as the reconstruction effort lead to a labour boom (Casolani 1923), and there was some consideration of extending emigration to the South American countries in light of the strength of the Catholic Church and opportunities for employment in agriculture and stock raising (Casolani 1923), which again lent weight to Nationalist cries regarding the utility of the Italian language.

However, after the First World War, the bulk of emigrants were directed towards other countries within the British Empire as well as other English-speaking nations; consequently, the Maltese began to take on a new identity, that of British subject. Superintendent of Emigration Henry Casolani repeatedly described the Maltese as “white” and as “people of pure European stock” (1923:B4); however, the receiving countries of the Commonwealth did not immediately accept the British identity of the Maltese emigrants. Responding to descriptions of the Maltese as “coloured people, Eurasians, or dagos” (Casolani 1923:B3), what he termed “this colour fable” (Casolani
Casolani lamented limitations on the number of Maltese emigrants and the reluctance of Australians “to look upon the natives of these Islands as ordinary Britishers” and their tendency to regard the Maltese “as worse than foreigners” to whom the doors were open, seeing the Maltese instead as people of colour. In response, the identity of the Maltese was posited as unlike their neighbours to the south, with Casolani (1926:C14) arguing that “it is established beyond doubt that there is no admixture of Semitic or Arab blood in the Maltese.” However, the Maltese were not simply depicted negatively as ‘Arabs’, they were more often likened to the Italians and Greeks, at a time when “nearly every country had openly declared its preference for the Nordic races and its aversion to Southern Europeans” (Casolani 1926:C6). Casolani (1926:C13) railed against the treatment of the Maltese as aliens, when “as British Subjects of white European race, born in a self-governing State of the Empire, the native of Malta should enjoy free access… to any other part of the British Empire.” Moreover, he argued that it was imperative that immigration officials be informed of “the basic fact that although his home is in the Mediterranean, he should never, under any circumstances, be classed as a Southern European, in the sense which this expression has recently been much used – as he is more akin to the Welshman or the Irishman and other kindred races” (Casolani 1926:C14). As a consequence, the English language became a medium through which the Maltese could assert their British identity and improve their chances of successfully emigrating to British Dominions.

Importantly, however, Italian was not just promoted as a symbol of Italianess or for pragmatic reasons related to emigration, the Italian language was posited as inseparable from the Catholic Faith; therefore, any attacks on Italian were also
constructed as threats to the Church as well (Hull 1993). For example, in a public speech, Francesco Azzopardi (1901:124) proclaimed “our religion is entwined with the language question. If you look around you, you will perceive that, whenever the English language is used, the prevailing religion is Protestantism.”

**Maltese Identity: Roman Catholic**

This allusion to the links between the Italian language and the Catholic Church, along with repeated confrontations between the Church and State and the involvement of the Church in the political realm (described in the outline of Malta’s political and constitutional history above) show the influence of the Roman Catholic Church and the importance placed on Italian language and culture within the political arena. They also demonstrate the extent to which the Roman Catholic Church could influence the direction of state policy in the early twentieth century. Moreover, following Sultana and Baldacchino (1994), Cutajar (2000) argues that the Roman Catholic Church was one of the most powerful social agents in the Maltese Islands, with a presence as pervasive, if not even more so, than the state. In part, this is related to Malta’s colonization by the Knights of Saint John; during their reign Malta was in many was a theocracy, “as the three separate jurisdictions on the island – the Grand Master’s, the Bishop’s, and the Inquisitor’s – all considered the Pope as their ultimate earthly head” (Cassar 2004:101). However, through the British presence in the Islands, the Church retained its prominence, such that when Malta finally received representative government in 1921, one of the first

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24 The Grand Master was the head of the Knights of Saint John, and during their tenure in Malta, he had the status of a prince of the Catholic Church. The task of the Bishop, or Diocesan bishop, was to govern local regions within the Roman Catholic Church known as dioceses. The Inquisitor, or Grand Inquisitor, during this period was the lead official of the Roman Inquisition, a system of tribunals developed by the Holy See during the second half of the 16th century, responsible for prosecuting individuals accused of crimes related to heresy, including sorcery, blasphemy, and witchcraft, as well for censorship of printed literature.
orders of business was to pass ‘The Religion of Malta Declaration Act’, making the Roman Catholic Religion the religion of Malta (Dobie 1967), and later, as described above, Maltese political leaders Strickland and Mintoff both faced major political problems as a result of the opposition of the Church to their platforms and ideals.

Numerous contemporary scholars have noted the continuing importance of Catholicism to the Maltese. Cutajar (2000) argued that the Roman Catholic Church continues to have a strong influence on state policy, particularly on issues regarding the family, marriage, and sexuality, such that abortion and divorce are both illegal, and changes in the Family Law (1993) and the Marriage Act (1995) were only enacted after intensive consultations with representatives of the Roman Catholic Church. In addition, Lafayette (1997:99) claimed that “virtually 100% of the Maltese are baptized Roman Catholic”; Boissevain (1996, 1974) has noted that the Maltese are intensely devout and fervently practicing; Mitchell (1997) observed that 98 percent of Maltese were members of the Catholic Church with 85 percent practicing their religion weekly. Mizzi (1981:93) contended that “the influence of the Roman Catholic Church in the life of the Maltese cannot be overestimated. The Maltese are Catholic before all things: by tradition, by nurture, by education and by environment”; and Goodwin (2002:76) argued that being Maltese is “virtually synonymous with being Roman Catholic.” Similar comments have been made throughout Malta’s history, as well. For example, near the turn of the century Keenan (1879:3) argued that “all the children frequenting the Government schools were Roman Catholics”, and Tagliaferro (1892:49) noted that very nearly 99 percent of Malta’s population was Roman Catholic. Nearing the Second World War, Fairfield and Drummond Shiels (1938:4) maintained that “almost without exception, the people are
Roman Catholics and the influence of the Church permeates their whole lives”, and throughout the preceding decades, a number of other observers also noted the import of Catholicism to daily life in Malta (Peto 1927; Ryan 1910; Shepherd 1928).

This is not to say that the British Government did not attempt to curtail the Church’s power in Malta; in fact, they did so in several ways. In 1828, they limited ecclesiastical courts to Roman Catholics and to spiritual cases and they abolished the right to sanctuary; in 1846 Governor Sir Patrick Stuart attempted to forbid the celebration of Carnival on a Sunday (which was seen as a first step in a campaign of protestantization and incited a demonstration); and in several instances (1857 and 1898) the British government tried to limit or entirely exclude ecclesiastics from sitting in Council (Dobie 1967; Ryan 1910). Despite these moves to restrict the authority of the Church, as Boissevain (1965:7) has noted, the relations between Britain and the Church “remained extremely cordial” largely because of the considerable protection which Britain granted the Church in Malta. Moreover, as Borg (1995) has argued, the British sought to co-opt the Catholic Church; they hoped to secure a certain level of stability in their strategic colony in exchange for allowing the perpetuation of the Church’s dominant status. As a consequence, the British did not push for protestantization, they granted freedom of the press only after including a provision for penalties against anyone who offended Roman Catholicism, the Catholic hierarchy retained a number of important privileges including exemptions from paying taxes and the restoration of Canon Law (which Napoleon had tried to curtail by instituting civil marriage), and the Church maintained a near monopoly over elementary and higher education (Borg 1995). Further, the rich property and land of the Church, amounting to approximately one-third of immovable property in Malta at the
beginning of the nineteenth century, was never expropriated by the State (Boissevain 1965; Borg 1995; Mowatt and Chalmers 1911).

As the Roman Catholic Church held great power and authority, so did the Parish Priest, particularly in more rural areas in the early twentieth century. Even as late as the 1960s and 1970s, as Boissevain (1974) noted, there were no mayors, headmen, or councillors to represent or administer the individual villages (and elected members represented fairly large districts); therefore, in the absence of secular authorities, parish priests emerged as the traditional spokesmen in both religious and secular affairs, such that many continued to refer to them as *il-principal tar-rahal*, ‘the head of the village’. (Boissevain 1965:54). Priests thus held a role in public administration; however, they also assisted villagers (particularly the illiterate) with their affairs (Bartolo 1998), and they could back up their commands with sanctions that compelled respect and obedience among their followers (Boissevain 1974). A priest’s position was one of great importance in his community as he possessed authority in all religious matters, arranged the ceremonies which marked the stages of peoples’ lives (such as baptism and marriage), and ministered to both the spiritual and personal needs of his parishioners (Boissevain 1965).

The importance and authority of the Church, along with its wealth and power in the early twentieth century, was observed by Wignacourt (1914:20), who noted “the continual building of large and costly churches amid the wretched hovels of a populace which can barely live.” Nearly fifty years later, Cassar (1960:42) described the ways in which many churches were built and maintained through the voluntary labour of the villagers and their generous donations of money and produce; he noted that a village’s
church was “an object of loving care” whose parishioners sought to adorn it with
tapestries, marble flooring, gilding, and painting that would rival those in the churches of
neighbouring villages. As he explained:

Indeed the village churches form the most imposing landmarks of the
Maltese countryside, their domes and steeples standing out sharp and clear
on the horizon breaking the otherwise uniform skyline. The parish church
presides foursquare over the “Pjazza” that spreads in front of it
overpowering with its mass the houses that huddle around it (Cassar
1960:42).

Further, he argued that the commanding edifice of the church was a symbol of its
religious and social importance (Cassar 1960), a point that was similarly raised by Spiteri
(1968) who speculated that the existence of very beautiful churches throughout Malta
was the result of the fact that the Parish was the “the nucleus of all village activities” and
all parishioners worked for its improvement.

The importance of the Roman Catholic Church in Malta can also be understood in
the ways that the Maltese have constructed their history and which elements of the past
have been certified as state-sponsored official memory (Mitchell 2001). As Bartolo
(1998) has argued, over time, with the production of knowledge about the past, gaps are
filled, and myths take on a life of their own and come to be accepted as fact. Maltese
historiography tends to emphasize four notable moments in history which hold
significance in a Catholic context: the expulsion of the French because of their crimes
against the Church, the shipwreck of St. Paul and the advent of Christianity, the Norman
conquest of Malta from its Arab rulers, and the Christian victory in the Ottoman Siege of
1565. Each of these came to be considered as events of vital significance, “bequeathing a
legacy of memories and cultural achievements that helped to create a distinctive Maltese
community” (Cassar 2004:105).
The classic explanation for why the British gained possession of the Maltese Islands at the beginning of the nineteenth century is because Napoleon and the French pillaged Malta’s churches and sought to interfere with the power and status of the Roman Catholic Church. For example, Mabel Strickland (1955:15) referred to the tyranny of the French and how the Maltese “rose as a nation in arms” as a result of “insults offered to their religion.” Bartolo (1998:26) noted that it was “religious fervour, in a nation so staunchly Catholic, which provided the outburst of rage” against the French and their eventual expulsion. Laferla (1958:144), when speaking of the many political reforms initiated by Napoleon, including changes to civil administration, the tribunals and councils, abolishment of the nobility, and major educational changes, argued “all this and probably much more would the Maltese have patiently tolerated…had Napoleon not interfered with religion.” Instead, Napoleon limited the jurisdiction of the Bishop to purely ecclesiastical affairs, reduced the number of clerics, instituted civil marriage, and forbade the clergy to change their services (among other things), and the final insult lay in the authorities attempt to auction off the property of the Carmelite church in Mdina (Boissevain 1965). According to Boissevain (1965:6), “by these acts, the French attacked values that were at the very foundation of the Maltese social structure”, and the final affront to the Carmelite church incited a savage revolt, leading to the eventual defeat of the French. Notably, Borg (1995:66) has argued that this constitutes an exaggerated pro-Catholic discourse; accounts of the French period, as written for a Catholic audience, are largely focused on anti-Church legislation and Church-pillaging which took place, “generating a popular myth among the local population of an anti-Catholic, anti-clerical French invasion that was eventually met with heroic Catholic resistance.”
Although this was a significant moment in recent history, and formed the basis for subsequent interactions between the British and the Maltese, Boissevain (1965) notes that the most important recorded event in Malta’s early history was the shipwreck of St. Paul in A.D. 60 and his subsequent conversion of the Maltese people to Christianity. He argues that the Maltese are “intensely proud of the apostolic origin of their religion” such that Missierna San Pawl, ‘Our Father St. Paul’, is the principal patron saint of the islands, and the feast of his shipwreck is a national celebration (Boissevain 1965:4). The shipwreck of St. Paul is not seen as a fortuitous accident, but rather part of God’s greater plan for the Maltese people – a position which is reminiscent of colonial notions of divine providence – and is treated by most Maltese as evidence of a continuous Christian tradition thereafter (Mitchell 2001). That is, it is argued that following the conversion of Publius, the Chief Magistrate of the Islands, to Christianity, the Maltese became and thereafter remained followers of the Roman Catholic religion (Barnes 1987) – an argument which leaves out the fact that the Catholic Church did not even come into being until the fourth century (Bartolo 1998).25 This belief in the apostolic origins of Malta’s religiosity are so firmly held that a thesis written in the 1980s, by Warnecke, which suggested that St. Paul was not shipwrecked on Malta caused considerable controversy (Cassar 2004).

Regardless of whether or not St. Paul converted the Maltese, and irrespective of the pervasiveness of Catholicism in past centuries, according to Bartolo (1998), there is no reason to assume that Christianity continued unbroken, particularly in light of the long period of occupation and Islamic rule from 870-1090. Nevertheless, most Maltese history asserts that the Arab presence failed to threaten the well-established Christian

25 Within Maltese historiography, the conflation of Christianity and Roman Catholicism is common.
tradition in Malta; rather, Christianity is said to have lived on until the reconquest of Malta by Count Roger the Norman, “whose arrival in 1090 is narrated as a liberation” (Mitchell 2001:29). Fortunato Mizzi (1901:117) wrote that the Maltese, “by the Grace of God and the valour of Roger of Normandy” were “delivered from the Saracen yoke.” Additionally, Ryan (1910:27) describes the determination of Roger the Norman to drive the Arabs from Sicily and to expel the Emir from Malta, after which “The joy of the Maltese people was great. The Cross was uplifted once more above the Crescent; a Christian Prince ruled again.” And again, when it was suggested (by Wettinger, in 1989) that no documentation existed to suggest any degree of hardship or servility to Arab overlords, and he instead described the assimilation of the Maltese people to the culture, language and religion of their conquerors – that is, a conversion to Islam rather than the maintenance of Catholicism – some Maltese were outraged (Cassar 2004).

The final major stream of Maltese historiography is the so-called “Great Siege of Malta”, which is celebrated as a national holiday on the 8th of September each year. As the story goes, in 1565, the Turks raised a siege and, after four months, they were ultimately repelled by the Maltese who fought alongside the Knights of Saint John. Mitchell (2001:47) has argued that this version of events is questionable, and “the image of Knights and Maltese standing side by side in defence of a common enemy became distilled in such a way as to enable a local claim to the glories and achievements of what was essentially a colonizing power.” In contrast, Mabel Strickland (1955:15) argued that while the Military Order of St. John received the glory as defenders of Christendom, it was the Maltese, “the sons of the soil” who battled as a Christian people, “proud of having received the faith from the Great Apostle St. Paul and willing to die for their
religion.” However, Bartolo (1998:20) contends that the entire account has been vastly inflated; it places Malta as the “saviour” of Europe “from an inevitable Moslem invasion”, whereas, in his opinion, had the Turks won the battle, Malta would have been left devastated, the Knights would not have been wiped out, and the Turks would have had numerous other battle to face before ‘taking Europe’, therefore the Siege decided nothing.

The Maltese Language

In contrast to the ‘European’ identity claimed via Malta’s Roman Catholic faith and use of the Italian language, the Maltese language places the inhabitants of Malta alongside their North African neighbours. Contemporary linguists have classified the Maltese language as an Arabic dialect (see Hume 1996 for a discussion of the structure of the language) or as “Afro-Asiatic” and in the same linguistic family as Arabic, Hebrew, Amharic, Hausa, ancient Egyptian, and Aramaic (Goodwin 2002), and today it is argued that there is no doubt that Maltese derives from the Arabic introduced into Malta sometime between 870 and 1090 (Hull 1993). Other relatively recent scholars have also argued that Maltese is “basically Semitic” but “with a Romance superstructure” (Aquilina 1959), or noted that the “ancient tongue” had a Semitic structure enhanced by foreign additions and assimilations (Spiteri 1968:15). However, in the nineteenth and early twentieth centuries, there was a great deal of debate about its nature. For example, Fortunato Mizzi (1901:117) argued that the Maltese dialect contained more Italian than Arabic, a point which supported his desire for Italian to retain its privileged position in Malta. In contrast, twenty years later British anthropologist L.H.D. Buxton (1924:83) argued Maltese was “closely akin to Arabic” but with numerous words of Italian origin.
Similarly, local Maltese chemist Temi Zammit (1926:25) contended that the Maltese language was “Semitic and more especially Arabic”, although he noted that some considered it to be “a patchwork of corrupt Italian and Arabic patois” or of “European and African dialects” borrowed from the island’s series of conquerors. In some instances, the origins of the language were pejoratively described; for example, Maltese was labelled as a “bastard Arabic” in early twentieth century Gibraltar (Sawchuk 2001), and its foreignness was noted by Shepherd (1928:222) who claimed that “everything in rural Maltese sounds violent.”

However, the attitudes of others were less negative, emphasized the Maltese language’s similarities to ancient Hebrew and traced its origins to the Phoenicians, particularly in the early decades of the twentieth century (Ryan 1910). Mizzi (1901:117), for example, while acknowledging that the Maltese dialect had “to a great extent appropriated the Arabic style of diction”, was quick to point out that Maltese was “a dialect the groundwork of which is the Phoenician.” Interestingly, Gerald Strickland also claimed a Phoenician origin for Malta’s language in his booklet *Malta and the Phoenicians* in which he maintained that the Maltese had borrowed neither the religion nor the language of the Arabs (Bartolo 1998). As Frendo (1977:6) noted, when Strickland published this volume in the 1920s, he sought to argue that the Maltese were closer to the British than to the Latin race on the grounds that the Phoenicians had once established colonies in various fringes of the British islands. Thus, in Strickland’s case, the assertion that Maltese was a Phoenician language was a means to claim that the

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26 The differences between rural and urban forms of the Maltese language will be discussed in more detail in future chapters.
Maltese people shared a common ancestry with the British (Bartolo 1998). Similarly, Superintendent of Emigration Henry Casolani’s (1926:C14) contention that there was only a similarity in language between the Maltese and the Arabs because both had inherited their speech from the Assyrians, was used in conjunction with the claim that there was “no admixture of Semitic or Arab blood in the Maltese.” However, the racial identity of the Phoenicians themselves was open to debate; for example, whereas Strickland emphasized the connection to the British via the Phoenicians, ten years earlier Ryan (1910:14) argued that the Phoenicians left permanent traces of their occupation in the mode of thought of the Maltese, which he saw as preserving “a strong Oriental bias.” Further, he referenced the work of Professor Rawlinson, “a great oriental scholar” (Ryan 1910:15), to note similarities between the Maltese people and qualities Rawlinson had described as characteristic of the Phoenicians, the Jews, and the Arabs, and ultimately he concluded that while the Maltese never accepted Islam they were “essentially Oriental by race” (Ryan 1910:24).

Regardless, debates surrounding the linguistic origins of the Maltese language conflated issues of race and language. This is additionally evident in the writings of Shepherd (1928), who contended that “an abstruse ethnological point has become with [the Maltese] a major political issue”; after which he attempted to answer the questions “Who and what are the Maltese by race? What blood flows in their veins? Whence come the one or two root words of their own Maltese language?” He then argued that the

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27 Thirty years later, for his daughter Mabel Strickland (1955a:13) this was a means of arguing for equality with British citizens, as she stated: the “Maltese now feel that they are co-equal partners within an Empire with whose Motherland their Phoenician forefathers traded.”

28 This reference to Assyrians implies that the Maltese descended from the ancient Assyrians of Mesopotamia, a people whose civilization flourished between the third and first millennia B.C., and who were believed to be a Christian people related to the Phoenicians.
Maltese were made up of two races: Italians (whom he personifies as “Signor Mufti”) and Phoenicians (personified as “Lord Cherub”); although he then added a third sub-category, there before the other two and comprising nine-tenths of the population, the “aboriginal Maltese” (“Professor Zammit”) (Shepherd 1928:155-7). The resonance of the debates surrounding the Language Question are evident in his classifications, as is Shepherd’s impatience with the contentions that the Maltese were Italian or Phoenician in origin. Somewhat inconsistently, Shepherd (1928:218) then went on to divide the Maltese into “types” according to social class (which will be discussed in more detail in Chapter 8), only to ultimately conclude that “while the Maltese, like the Jews, are of very many types, like the Jews again they all have something in common. Is it the eye? Is it the nose? Heaven knows! But it is there. Though you cannot place it, you can see it; something Maltese, unmistakeable.”

Maltese Ethnology

In addition to Shepherd’s joint discussion of the linguistic and ethnic origins of the Maltese, the racial identity and origins of Maltese islanders was discussed or alluded to by several others. Importantly, although Lafayette (1997:1) has argued in his work on Maltese emigrants in New York City that “the Maltese are perceived as being white in the current political climate”, in the past their ethnicity and race was variously described. While some emphasized their Phoenician origins, others stressed the Maltese’s Arab or African ancestry. For example, Cassar (2004) notes one of the earliest commentaries on Malta’s race: in 1536, Jean Quentin d’Autun (Chaplain of the Order of Saint John) described the Maltese as having “a Sicilian character with a mixture of African” and Malta’s women as “uncivilized” and not able to mix with other people or to go out
without a veil “as if to see a woman is her the same as to violate her.” Similarly, Spiteri (1968) notes that in the eighteenth century, Spanish author D’Avalos described the Maltese as brown in complexion and possessing many characteristics common to people in the equinoxial regions of Africa. By the end of the nineteenth century, Keenan (1879), when discussing their continued use of the Maltese language, attributed it to their “characteristic Saracenic pertinacity”; whereas, Hull (1993) observed that in 1886 Dr. Ernesto Manara stressed that while their language might be Arabic, the Maltese civilization and ethnic complexion remained Graeco-Roman or Graeco-Latin.

In the first few decades of the twentieth century, a number of observers commented on the racial identity of the Maltese, particularly in reference to the typical attire of the Maltese woman; locally called the *faldetta* or *Ghonella*, this consisted of a long and full black silk or cloth robe, with a hood in which was enclosed a thin piece of whale bone to form an arch over the woman’s head. For example, Ryan (1910:5-6) noted that something of the “dim mysterious East” was felt in the mode of life of the people, “suggested in the street-cries, the hubbub of the market, in many names of persons and places, and also in the older architecture.” Further, he attributed the faldetta to Arabic origins, compared it to the “Eastern habit of veiling the faces of women” (Ryan 1910:25), and observed that the Maltese revered and jealously guarded their women, who were placed under “undue and antiquated restrictions” (Ryan 1910:108). Similarly, Wignacourt (1914:17) observed “a tendency for the original Hamitic strain to assert itself” amongst the Maltese, termed the faldetta a “relic of the past” (1914:24), described Maltese women as naïve, unsophisticated, simple, and inexperienced, and found that the treatment of women in Malta demonstrated a “Semitic influence, with its jealousy,
repression, and notions of proprietorship” which he ascribed to “an Asiatic and perhaps Mongolian origin” (1914:24).  

Importantly, descriptions of the Maltese as of mixed-Mediterranean origins was also common during this period. For example, Mowatt and Chalmers (1911:5) described the population as “South European” in type, but “fairer in colour” and of better appearance than the South Italians or Sicilians, and Goodwin (2002) noted that in R. N. Bradley’s 1912 case study *Malta and the Mediterranean Race* the Maltese were described as racially pure descendents of a dolichocephalic or long-headed Eurafrican or Mediterranean race from sub-Saharan Africa, in contrast to the Brachycephalic (shortheaded) Aryan races of Asia from whom Northern Europeans were descended. In this assessment, Bradley was likely borrowing from William Z. Ripley’s book *The Races of Europe* (1899), in which he described the Mediterranean race (purportedly prevalent in southern Europe, parts of North Africa, South Asia, and the Middle East) as moderate to short in stature, possessing dark hair, dark eyes, a dark complexion, and a long skull (dolichocephalic), likely due to racial mixing with Asian and African peoples.

The most extensive discussion of Malta’s racial identity appeared ten year later, in an early anthropological work by Buxton (1922) entitled *The ethnology of Malta and Gozo* for the Royal Anthropological Institute of Great Britain and Ireland. In this, he argues that Maltese women were darker in skin colour than men; their Parsons’ index of pigmentation was 74.9 compared to men’s 67.5, and according to Buxton, this indicated a

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29 In this context the term Saracen was used to describe people of Arab ancestry. Similarly, whereas through the nineteenth century, the term ‘Hamitic’ was used indiscriminately to refer to all peoples of African ancestry, in this instance, it is more likely to have been a allusion to the North-African origins of the Maltese people, signalling their consideration more advanced than other African peoples.
higher percentage of Mediterranean admixture.\textsuperscript{30} In contrast to Bradley, Buxton (1922:189) argued that while Malta’s “first race” was Mediterranean and akin to the inhabitants of North Africa, Corsica, Sardinia, and Spain, this “primitive stock” was succeeded by people exhibiting Armenoid characteristics.\textsuperscript{31} As a consequence, Buxton (1922:189-190) claimed that modern Maltese were of this second race, and while there was some uncertainty of their origins, he claimed that they were “not racially allied to the people of Italy, Sicily, or the Barbary coast”; rather, he argued that they could not have come from anywhere but the Eastern Mediterranean and noted affinities with the Carthagians and Phoenician traders. Importantly, Buxton (1922) argued that the Maltese were distinctly different from other inhabitants of the Mediterranean. He compared the Parson’s Indices of Maltese men (at 74.9) to those of other Mediterranean populations and found that the Cretans were “considerably darker” (78.0), the Albanians (at 53.5) were of “a very different racial stock”, and the resemblance between the Maltese and the Maniots (66.6) was “very striking” (Buxton 1922:187). Buxton also undertook a series of skull measurements of medieval crania and living Maltese individuals, and noted significant differences in the cephalic indexes and other cranial and facial features of the Maltese other inhabitants of the Mediterranean.

\textsuperscript{30} Here Buxton is referencing the work of F. G. Parsons (1920) ‘The Colour Index of the British Isles.’ By taking the percentage of dark brown and black hair, adding the percentage of dark eyes and dividing the result by two, he attains the colour index.

\textsuperscript{31} The term ‘Armenoid’ was coined at the turn of the century and later more explicitly defined by Carleton S. Coon (1939) in his \textit{The Races of Europe}; he described the Armenoid as a subrace of the Caucasoid race, with a somewhat darker pigmentation likely due to racial mixture with the Mediterraneans and the Alpines. According to Coon, Armenoids were relatively tall, with somewhat darker skin, large round usually black eyes, a round Brachycephalic head shape with a straight backing, high cheekbones, non-prominent chins, usually full lips, and often hooked noses. Importantly, in his paper Buxton acknowledged that he was operating under the assumption that there was “a real difference between the Armenoid and Mediterranean types”, a working hypothesis which he considered to be of great value, but “by no means a sure hypothesis” (1924: 86).
Years later, Captain E.M. Channing-Renton (1971:19), in his recollections of Malta between the two World Wars, spoke of the “call of the East” (although he also stated that Malta was not the “real East, like India” nor even the Near East) and described a “near-Eastern scene” complete with flat-roofed houses, typical of Eastern countries, networks of curious little stone-walls, palm trees, and innumerable goats. Significantly, one of the reasons that Channing-Renton (1971:19) found Malta to be akin to the “mystic East” was because of the “strange black hoods of the womenfolk”, yet another reference to the faldetta which was still worn by many women during that period. Similarly, Spiteri (1968:12) described the faldetta as similar to the “Oriental veil”, and traced its introduction to the domination of the Arabs (870-1090). Thus, over the span of decades, Malta’s purported eastern qualities – and the supposed evidence of their “Arabic” origins – included their language, their complexions and physical features, their life-ways, and the appearance and position of Maltese women.

Importantly, the controversy over the origins of Malta’s population continues, today, as two recent studies have attempted to trace the genetic origins of contemporary Maltese. In October 2004, National Geographic Magazine featured the work of “National Geographic emerging explorer” Spencer Wells and his colleague from the American University of Beirut, Pierre Zalloua; their study of Y chromosome markers in blood samples garnered from men in the Middle East, North Africa, southern Spain, and Malta purportedly revealed that “more than half of the Y chromosome lineages that we see in today’s Maltese population could have come in with the Phoenicians” (Franklin-Barbajosa 2004). The researchers then went on to speculate that this “significant genetic impact” may have been the result of populations from the Levant, likely the Phoenicians,
moving into the island and either killing off or swamping Malta’s population within the past two thousand years. However, this study was recently blasted by Alex E. Felice, in an article in the *Sunday Times* of Malta (Felice 2007). Drawing on his own experience in the Laboratory of Molecular Genetics in the Department of Pathology at the University of Malta, and his collaborative work with University of London’s C. Capelli and colleagues from Italy, France, Lebanon, Cyprus, and Israel on “Population Structure in the Mediterranean Basin: A Y Chromosome Perspective” (2005), Felice questions the validity of the DNA markers and standards of analyses employed in Wells and Zalloua’s study and states on behalf of himself and his collaborators “we consider that data somewhat flawed, and furthermore, unsound… [and] the weight of the evidence is poor” (Felice 2007). Moreover, Capelli and colleagues (2005) assessment of Mediterranean genetic structure through the analysis of Y chromosome distribution in eleven different populations with a battery of both fast and slow evolving markers, combined with published Y chromosome data from over fifty additional populations, determined that contemporary males in Malta were most similar to populations from Southern Italy, including Sicily and Calabria, with “a miniscule amount of input from the Eastern Mediterranean with genetic affinity to Christian Lebanon” (Felice 2007).

**Conclusion**

Several recent scholars have argued that the debates surrounding the ethnic and racial identity of the Maltese are responsible for both Maltese historiography’s emphasis on the importance of the Roman Catholic Religion as well as their political leaders’, particularly the Nationalists’, vehement insistence that the Italian language retain prominence in the Islands; that is, both Catholicism and Italianess position the Maltese as
Europeans in stark contrast to their Arab neighbours. In their uprising against Napoleon, the Maltese are presented as equals in opposition to the French and alongside the English and Portuguese. The story of St Paul’s shipwreck locates Malta in a European cultural sphere (Mitchell 2001) and, arguably, as “aboriginal Europeans, converted to Christianity even before the establishment of Rome (Sant Cassia 1999:248). In addition, whereas under the Romans the rulers of the islands and their subjects were one “in religion and sentiment”, the 220 years of Saracen rule were constructed as being characterized by apartheid, which could not have had any significant effect on the ethnology of the true Maltese (Hull 1993:136). According to Hull (1993:166), the Maltese were already uncomfortable with “the ignominious origins of their dialect” which could hardly be overlooked, so they denied any assertions that an Arabic language presupposed Arabic blood. As such, to question the story of St. Paul and/or to assert that the Maltese mixed with their Arab conquerors – and converted to Islam – were seen as “at best misguided, and at worst a malicious attack on Maltese history and identity” and their claims to (aboriginal) Europeanity (Mitchell 2001:25).

In contrast, the assertion that they remained true to the Roman Catholic faith through Islamic rule denies any possibility that the Maltese may have been assimilated to Arab culture or mixed with their Arab conquerors. Similarly, the story of the Great Siege not only reconfirms their positioning as enemies of the Turks and Arabs, but also places them as the valiant soldiers of Christianity who saved Europe from the scourge of Islam (Bartolo 1998). Thus, as Cassar (2004:128) contends, the figures of St. Paul, Count Roger and La Valette (who played a key role in the Great Siege of 1565) came to feature as “protagonists in the legitimacy doctrine”, and the stories in which they played a role
depicted the Maltese as protectors of Christianity and European Civilization through which the Maltese could claim for themselves a European past. Moreover, Cassar (2004:107) argued that Maltese historiography, including the tracing of Christianity back to St. Paul, should be appreciated “against the background of Malta’s geographical position” and may have acted as a form of compensation for the persistence of its Semitic language among the native inhabitants. Thus, Malta’s location within the middle of the Mediterranean had an impact on the island’s population that was both pragmatic and symbolic; its position astride military and trade routes limited its political and economic development while profoundly shaping the ways in which the Maltese self-identified in relation to the powerful groups which colonized the island and inhabited the lands in its surrounding areas.
Chapter 4 – The Discovery of Infant Mortality

Infant mortality in Malta has all the time given grave concern to all on account of the high figures registered year by year. Many factors have been invoked as being the cause of this mortality; much reproach has been the lot of the parties connected with the welfare of these infants since the beginning of the last decade. The investigation carried out demonstrates relevant facts which in no way justify the accusations that are made.

- Dr. Joseph Morana, An Investigation on Infant Mortality in Malta (1946)

Today, the infant mortality rate is a commonly calculated and familiar statistic to health researchers. However, it was not until 1877 that infants’ deaths were numerated and reported according to this measure (Armstrong 1986). In his persuasive paper *The invention of infant mortality*, Armstrong (1986:214) argues that the ‘problem’ of infant mortality was not waiting to be discovered so much as it was “invented by an analysis which established its existence.” The establishment of an overall statistic to encompass all infant deaths “suggests both the emergence of a social awareness of these young deaths and, more importantly, the social recognition of the infant as a discrete entity, a new object of social and medical interest” (Armstrong 1986:212). In effect, in the mid-to late-nineteenth century, the child, as political object, was discovered: infancy and infants, “childhood and children… became the subjects of legislative attention and were at the centre of social policy as they had never been before” (Stoler 2002:120).

Manderson (1998:35) attributes the discovery of the child to two factors, broadly defined: imperial history and the development of state demography. Consequently, this chapter will elaborate on the contribution of demography, with its focus on population and the compilation of population-based statistics, as well as the effects of particular historical events in the social construction of infant mortality outside and within Maltese borders. This will lead in to a discussion of the concomitant construction of an ideology
of motherhood as a serious responsibility in face of the needs of the newly discovered child and ‘bad mothering’ as the primary reason for the “problem” of infant mortality.

The Calculation of Infant Mortality

Stoler (1989:639) has argued that interest in reproduction in both the metropolis and the colonies was related to processes in “the modernization of colonial control”, and, following Hacking, she notes that “the power of categories rests in their capacity to impose the realities they ostensibly only describe” (Stoler 2002:8). As Foucault (1990:139) has persuasively argued, the power over life was partly deployed through a focus on ‘population’, the management and surveillance of births and deaths, and the conditions which caused them to vary, which he termed a “biopolitics of the population.” Thus, with the development of abstract scientific, medical, political, economic, and demographic languages and the creation of “population” as a new subject of scientific investigation (Jordanova 1995), censuses, civil registries, and statistical annuals became important means for states to track the births, deaths, numbers, characteristics, and social trends amongst their citizens (Birn 2005; Davin 1978) – what Jolly (1998b:182) has termed “part of a broader shift to a governmentality concerned with ‘population’” and census-taking. In an age of “enthusiasm for empire” (Manderson 1998:35), the major powers developed comprehensive systems for the collection and calculation of “vital statistics” as measures of population health and economic vitality (Birn 2005:1508). Thus health problems were “defined, described and ‘explained’ by the new professionals” of public health and social science who were in positions of power to both develop and disseminate this new ideology (Davin 1978:55). In this manner, the invention of the
Infant Mortality Rate (IMR), as a statistic, created infant mortality as a problem and rendered it a pressing concern at the turn of the twentieth century.

**Tracking Infant Mortality**

Within Malta, by 1876, Chief Police Physician A. Ghio had already adopted the categories of “children under 5” and “infants under 1 year” and reported the number and percentage of the total number of deaths which occurred during these periods, along with their purported causes.\(^{32}\) For example, he reported that 1419 of 2971 deaths (what he reported as 47\(^{33}\)) were children under 5, “of whom 854 or 28.7% were infants under 1 year” (Ghio 1876:4). The following year, additional information on the sex of these infants was included, with 883 deaths (531 male, 352 female) or 30 percent occurring amongst infants under 1 year. What these percentages translate into in modern-day terms are IMRs of 287 and 300 respectively, although it was not until 1898 that a “death-rate under one year” was calculated (Pisani 1898:12). In addition, it was not until several years thereafter that the terms “infantile mortality”, “infant mortality” (Samut 1904), or “infant mortality rate” came into use in the government health reports (Critien 1920).

By the year of Chief Government Medical Officer (CGMO) S. L. Pisani’s government health report (1898) the importance of statistical work was made paramount by the inclusion of “Statistics” as a subject heading. Pisani (1898:12) stated that births, deaths, a general death-rate, a death-rate under one year and under five years, along with the population of Malta and each of its localities, had to be “carefully collected and checked” and was “absolutely required for correctly establishing the state of health”, as

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\(^{32}\) From the beginning of the twentieth century, the Chief Police Physician would retain the title of Chief Government Medical Officer. The significance of the former title, along with a description of the structure of medical services in Malta, will be included in Chapter 5.

\(^{33}\) This percentage was calculated to be 47.76%, which by convention is today rounded up to 48%.
well as allowing for “comparative statistical studies” of “the population.” Thereafter, a variety of counts and rates – including the infant mortality rate – were calculated for each locality and for Malta as a whole. Moreover, by the 1911 census it was “considered advisable to obtain statistics” on infant and child death rates, such that two new columns were inserted in the existing household schedule “wherein each married woman was required to state the number of children born alive during the last ten years and those of them who died, stating the age at death” (Pace Bardon 1912:V). While the inclusion of this question in the Malta census in 1911 and subsequently in 1921 is a testament to the importance placed on the question of infant mortality – or its reckoning, by 1931, this series of questions was eliminated as “it was impossible to expect any accuracy from the result of this somewhat complicated enquiry” because no information could be gathered in the case of “motherless children”, and the “lower classes” in particular could not specify with “sufficient accuracy” the age of infants who had died; furthermore, any necessary data could be obtained “with absolute precision” from the records available in the Public Health Department” (Galizia 1922:2; see also Borg Cardona 1931:xi).

While ‘absolute precision’ is perhaps an exaggerated claim, unlike other British colonies in the early twentieth century, where only a portion of the territory was accounted for and the registration of births and deaths was not compulsory, leading officials to doubt the accuracy of recorded rates of infant mortality (Economic Advisory Council 1936:iv), in Malta, perhaps because of its relatively small size, all localities were accounted for and registration of births and deaths was required. Moreover, infant mortality rates were consistently high, hovering between 200 and 300 per thousand, prior to the Second World War (see Figure 4.1).
As stated above, statistics such as the infant mortality rate were calculated, in part, as a means of comparison, as a way of evaluating the health and vitality of a population in relation to others. As such, it would make sense to examine Malta’s infant mortality rate alongside that of other locations within and outside the British Empire. At the beginning of the twentieth century, England and Wales recorded an infant mortality rate (in 1899) of 163 per thousand, which at that time was considered to be a “disturbing increase over the rates of the 1880s” (Jolly 1998b:180); yet in this same period, rates in British colonies were significantly higher. For example, Jolly (1998b) noted that, in 1893 Fiji, 44.17% of infants died in the first year (a rate of 442 per thousand); and Malta and Malaya’s infant mortality rates hovered between 250-350 per thousand (Manderson 1998; Sawchuk et al. 2002a). Moreover, over subsequent years, the IMR fell significantly within the UK, as was the case in many of its other colonies. In Figure 4.2, infant mortality rates for Malta, Gibraltar, Ceylon (today Sri Lanka, off the coast of India) and the United Kingdom are plotted from 1898 through 1962. Although some of the
variation in the Infant Mortality Rate in the United Kingdom and Ceylon is obscured, as data was not available for all the years under investigation (hence the flattened line) this figure does show that the United Kingdom, along with Ceylon and Gibraltar, exhibited a gradual lowering of their infant mortality rates over time, whereas, during the period under investigation in this dissertation, the IMR in Malta remained very high. While it could be argued based on this diagram that Ceylon’s mortality profile shares more in common with that of Malta, the spike in infant mortality in the early 1930s is attributable to an outbreak of infectious disease (which appears to extend over several years due to the presentation of the data in this format, but was only noted for one year), and this dramatic increase is in stark contrast to an otherwise gradual lowering of the IMR.

Figure 4.2 – Infant Mortality Rate, Select Locations (1898-1962)

34 Interestingly, today it is a matter of some pride in that Malta’s IMR is amongst the lowest in the world, at 3.82/1000 live births. According to the World Fact Book, this is the 9th lowest IMR. Just to give an idea of scale, 2007 estimates place the highest rates in Angola (184.44), Sierra Leone (158.27), and Afghanistan (157.43), while Canada had a rate of 4.63 per thousand (Central Intelligence Agency 2007).
Thus, infant mortality rates in Malta were four times that of England, its colonial ruler, and the infant mortality rate declined much later in Malta than in the United Kingdom and other British colonies (Sawchuk et al. 2002a). Further, by the 1930s, when the UK had a rate of only 50-60 per thousand, Malta’s infant mortality rate was amongst the highest in the Mediterranean; for example, in 1935 Malta’s IMR was 286 as compared to 109 in Algeria, 121 in Cyprus, and 101 in Italy (Bland 1994). In the following year, Malta’s IMR dropped – for the first time (and not again until following World War II) – below 200 per thousand (190.3 per thousand), a rate which still ranked the island at the higher end, in terms of infant mortality, of a selection of British holdings examined by the Economic Advisory Council (1936; see Figure 4.3).

Figure 4.3 – Infant Mortality (1936) Selected British Holdings

It should be noted, again, that the Economic Advisory Council considered infant mortality statistics to be inaccurate for many of the British holdings because not all
territory was covered and there was not compulsory registration of births and deaths. However, they argued that a larger proportion of births would go unrecorded in these instances, rather than deaths; consequently, Malta’s (possibly relatively more accurate calculated rate) may have been closer to the “real” extent of infant mortality, with other locations’ infant mortality rates representing an overestimation. That said, with regards to accuracy, the infant mortality rate in Malta in 1936 was not representative of those in previous or subsequent years; therefore, the relative severity of Malta’s infant mortality is perhaps not very well captured by this figure. Attention should also be drawn to the position of Malaya immediately to Malta’s left; in her work in colonial Malaya, Manderson (1982) noted that infant mortality rates in the early 1900s hovered around 250 per thousand (e.g. 1904: 251.97; 1911: 270.47), and gradually declined from the 1920s onward, with a degree of annual fluctuation resulting from diseases such as influenza and malaria. The “accuracy” of these figures is uncertain, as well.

This attention to the accuracy of infant mortality (and other) statistics signals their symbolic importance. This is further evidenced by Fairfield and Drummond Shiels’ (1938:2) report in which they state: “the social hygiene problem, so far as [the Maltese] were concerned, was to improve their vital statistics, particularly in regard to children” along with raising standards of education and maintaining a low level of venereal disease. This phrasing seems to reify the numbers themselves, implying that the statistics needed to be improved, rather than the health or conditions of the people represented by the statistics. This follows from the above argument that the compilation of statistics was a mode of colonial control; that is, the preoccupation of British colonial officials with the management of their populations was a means of exerting and displaying their control,
power, and prestige in comparison to the other European states (Manderson 1998). However it was also more than that; it was a means of evaluating a state’s existing or potential manpower (Manderson 1998), as a loss of people meant a loss of resources, particularly in the case of infants “who were understood as wasted potential” (Jordanova 1995:382).

**Imperial History and the Need for Labourers and Soldiers**

In her groundbreaking work *Imperialism and Motherhood*, Anna Davin explored the moment in history when the ‘discovery’ of the child occurred and elucidated the social and political context for the preoccupation with infant mortality in nineteenth and twentieth century England (Davin 1978). She showed that concern with infant welfare was sparked at the beginning of the twentieth century by worries about fertility decline, combined with the ill health and consequent poor performance of British soldiers in the Boer War. As Dwork (1987:209) has simply stated, “war was good for babies;” and so was the threat of depopulation. New human lives were reconceptualized as extremely valuable, and there followed a “surge of concern about the bearing and rearing of children – the next generation of soldiers and workers, the Imperial race” (Davin 1978:12). A fundamental shift took place: children were seen as national assets, the capital of a country, and population was power (Davin 1978).

However, concern with the regulation of the population was not unique to that period; Foucault (1990:138) dates it to the seventeenth century, “when the ancient right to take life or to let live was replaced by a power to foster life or disallow it.” Nevertheless, within Britain, this was a marked departure from the mid-nineteenth century Malthusian view of population as a threat to finite resources, population decline came to be regarded
instead as an impediment to the maintenance of production, the expansion of the British Empire, and the perpetuation of the Anglo-Saxon race (Jolly 1998b). With the transformation of society from an agrarian to an industrial regime, children moved from a position of marginality to centrality (Handwerker 1986). Production and reproduction came to be linked in light of society’s overall need for labour (Feirmann and Janzen 1992). Population decline impeded the expansion of industry because large numbers of healthy infants – later to form a stable and able-bodied workforce – were required to ensure continued production (Manderson 1998). More, children came to be considered commodities, “a form of capital into which parents and others invest and who yield returns when they are capable of being fully economically active” (Jordanova 1995:378).

Population decline was also a harbinger of imperial collapse, as healthy babies (and great numbers of them) were seen as necessary not only to ensure strong, suitable recruits for future wars, but for the very maintenance of empire, as imperial domination required officers and officials, and expansion of territories called for soldiers and settlers (Davin 1978). As Jolly (1998b:179) argues, “the threat was not just the Boers in South Africa, but the rival imperial extension of France, of Germany, of the United States and of Japan”; population was both imperial armoury in the form of military might and in terms of political and economic colonization potential. However, this was not just a national concern; it quickly became a colonial problem as well. Following Davin’s study, a number of researchers have conducted historical studies of infant health and care in colonial settings, including: British Malaya (Manderson 1984, 1987, 1996, 1998), Belgian Congo (Hunt 1988, 1999), Australia and New Zealand (Mein Smith 1997), Ceylon (Jones 2002), Latin America (Birn 2002), the Philippines (McElhinny 2005),
Sudan (Boddy 1998), and Fiji and Vanuatu (Jolly 1998a, 1998b). These investigations emphasized the ways in which concerns regarding infant health and developments in the imperial centre were transposed upon colonized peoples in very different settings and contexts for political, economic, and ideological purposes (Manderson 1998).35

Prior to the twentieth century, international health organizations and colonial governments were largely concerned with epidemic infectious disease, which was seen as a threat to commerce and the health and lives of colonizers (primarily) and local workers (less-so). As such, attention was focused on battling infectious disease, and public health concerns that were more likely to affect the colonized alone were a low priority (McElhinny 2005:185). In addition, medical care was provided initially for the colonial elite, and subsequently extended to those in their direct employment, those working in export industries, agriculture and mining, or to those whose ill health might jeopardize that of the colonists (Manderson 1987). However, as depopulation and low birth rates became “dominant themes in a burgeoning, colonial demographic literature” (Hunt 1988:404), attention shifted to infant health and well-being. Thereafter, pragmatic concerns about ensuring the reproduction and maintenance of the labour force – paralleling those in the metropolis – emerged in the colonies: driven by the political economy of colonialism, it was considered economical to “breed” workers locally rather than rely on adult immigration (Hunt 1988:417). For example, in British Malaya, the need for labour for mining and plantations was paramount; with a high adult death rate and high costs associated with importing labourers, reproducing the labour force locally was deemed “the more efficient long-term strategy” for continued production

35 Importantly, some of these studies also noted movement from colony to metropole, which will be discussed in more detail in Chapter 5.
(Manderson 1998:35). As such, infant mortality and child health came to the fore, in both metropolis and colonies, as a pressing concern.

The relationship between infant mortality, mothering, imperial expansion, labour power, and population decline was not a simple one, however. In her work in the Pacific, Jolly (1998b) noted that a concern with population, simultaneous to that in the United Kingdom and other colonies, had different reverberations in Fiji and Vanuatu. Many white traders and settlers were dubious about the need to reduce indigenous infant mortality and to restore population growth, preferring to import ‘Asiatic’ labourers. In addition, “whereas the Fijian race and culture was perceived by the British colonial state to be worth preservation, in Vanuatu there was a far less sympathetic attitude to indigenous peoples” (Jolly 1998b:182). Along similar lines, in the UK, while many concerned with declining birth rates promoted the fertility of all classes, others – particularly eugenicists – espoused the curbing of working-class fertility (Jolly 1998). Recall, as stated above, population decline was also regarded as a threat to racial degeneration. The eugenics movement therefore sought improvement of the racial stock, or the “Imperial race”, by selective breeding of those with superior stock and propagandized, particularly amongst the upper and middle classes, to encourage ‘eugenic marriages’ and the procreation of the higher classes – to the extent that some middle- and upper-class women were denied contraception by their doctors (Jolly 1998). As Mullings (1995:129) has argued, when boundaries are threatened and rhetoric about fertility and population escalates, it is primarily women of the dominant class who are exhorted to have children, to ward off “race suicide” and the “decline of civilization.”
Attention to Infant Mortality in Malta

Within Malta, as in many other colonial sites, there was a surge of concern about infant mortality at the beginning of the twentieth century. Not only was this a moment in history when infant mortality statistics began to be calculated, but infant death came to the fore as a preoccupation within writings of the time. For example, CGMO R.P. Samut (1904:57) wrote that mortality in children and infants was “still very marked” and bemoaned the “great loss of life.” In the following year, he observed that “infant mortality continues to be very high” and that the infant death-rate was double that of England and Wales (Samut 1905:J4). Samut was succeeded as CGMO by Caruana Scicluna (1908:J4) who observed that Malta’s infant mortality rate “must be regarded as abnormal and preventable” because deaths under twelve months of age “should not” exceed 100 per thousand. By 1923, then CGMO A. Critien (1923:P2) observed that the loss of infant life in Malta was at an “indefensible high level” and described infant mortality as “the most disappointing feature in the health chronicles of these Islands”; whereas rates were steadily improving in other countries, he argued that “amelioration with us has been most desultory and there is no indication of a definite turn for the better.” It appeared that he was correct, as by 1931, he again spoke of an “enormous loss of infant life in these Islands” (Critien 1931:T7) as the infant mortality rate had reached an “extraordinary high level of 306.5 per 1000 births” (Critien 1931:T2). Others similarly noted that, in Malta, “mortality among infants is simply appalling; babies come and babies go” (Shepherd 1928:109); that the islands had “high infant mortality” (Buxton 1922:193); had “appallingly high infant mortality rates” (Economic Advisory Council 1939:119); and suffered from “a deplorably high infantile mortality” (n.a. 1942).
Accounts from after the Second World War noted that up until 1939 “the infant mortality rate in Malta was one of the highest in the whole world” (Cachia 1956:34), and that Malta used to have a “deplorably high” infant mortality rate (Galea 1954:248).

Thus initial concern over elevated rates of infant mortality in Malta appeared to coincide with its foregrounding in the United Kingdom and other British colonies. Moreover, within Malta’s Government Health Reports, in addition to the comments noted above comparing Malta’s infant mortality rates to those elsewhere in the British Commonwealth, suggesting that severity was judged comparatively, there are a number of references to the writings of individuals from the imperial centre, showing the ways in which understanding of infant mortality in Malta were shaped by these colonial “experts.” For example, in 1923, CGMO A. Critien cited Dr. Sir Arthur Newsholme, the Chief Medical Officer of England from 1908-1919, and his successor Sir George Newman’s (1926) *An Outline of the Practice of Preventive Medicine*, who held the post of Chief Medical Officer of England from 1919 to 1935 in addition to authoring a number of books on public health including the influential 1906 work *Infant Mortality. A social problem*. Similarly, in 1936, then CGMO A.V. Bernard quoted extensively from Dr. Mary Blacklock, a member of the Colonial Medical Advisory Committee in the 1930s.

**The Social Construction of the Child and of Motherhood**

Although Swedlund and Ball (1998:196) argue that health advocates recognized that there was “greater political value in emphasizing the loss of infants and young children than in describing losses in terms of general population”, this required the construction of children as different from adults, as unique and precious, as requiring
special attention and care (Higgins 2003), an idea which was a relatively new development. While in late-twentieth-century Western societies childhood is presented as a fragile, liminal, developmental stage, this was not always the case; this new ideology of the child developed, in part, in response to elevated rates of infant mortality (and the events in imperial history which provoked attention to infant mortality). In turn, this new conception of childhood as an important but perilous stage was related to a complementary new conception of motherhood as a serious responsibility, “one that required total and exclusive devotion” (Glenn 1994:14). In short, an infant or child (usually “he”) required constant, and intense, care and attention from one caretaker, the biological mother (Glenn 1994). The now-dominant ideology of intensive mothering, which constructs a mother as devoted to the care of others, self-sacrificing and not a subject with her own needs and interests (Arendell 2000), had it roots in this time period.

If infant mortality was an “effective focal point for grief and outrage”, good mothering became a focal point for idealization, pleasure, and adulation (Jordanova 1995:377). As Bordo (2003) has argued, women as mothers began to be assigned a subjectivity that included characteristics of sensitivity, tenderness, and caring. In her study, Lewin (1995) explores how this ideology of motherhood was internalized (in her sample of contemporary lesbian mothers in the United States); she observed an expectation of selfless devotion, altruism, nurturance, and access to sources of goodness:

By becoming a mother, a woman may perceive herself to experience a moment of transcendent unity with mystical forces; by being a mother, a woman makes a continuing contact with her inner goodness, a goodness activated by altruism, nurtured by participation in a child’s growth and development (Lewin 1995:111).
These same tropes were employed in constructions of motherhood in early twentieth century Malaya, where the Malay mother, in both scholarly and popular forums, was represented as “long suffering” and “self-denying” and her relationship with her children was sentimentalized. Similarly, during this period in Britain, a woman’s “moral strength” and “almost mystical power for good” were often invoked (Davin 1978:50). Motherhood became a powerful symbol; one ideal figure – the mother providing constant care and attention to her child – came to be seen as natural, universal, and unchanging (Davin 1978; Glenn 1994).

There are many studies of the historical and cultural construction of motherhood, women’s roles, and their transformation in late nineteenth and early twentieth century Europe and North America, (e.g. Apple 1995; Apple and Golden 1997; Glenn 1994; Moore 1988; Yeo 2005). Within these works, it is argued that, with the rise of industrialization and the gradual shift of manufacturing out of the (private/domestic) household and into capitalist industry (public) domain, “an earlier prescriptive model of femininity – the good woman as obedient and productive housewife” was transplanted by a powerful new doctrine of motherhood (Yeo 2005:4). Restricted to a reproductive role, which reified them as childbearers (Silverblatt 1991), “women were redefined from worker mothers to mothers of workers” (Yeo 2005:5). Womanhood and motherhood came to be treated as synonymous identities and categories of experience, mutually defining one another (Lewin 1995). As Irigaray (1977) has argued, while ‘man’ is recognized as separate and separable from ‘father’, there is no space within (male-centred) discourse for ‘woman’ disassociated from ‘mother.’ Whereas men appear in all of their historical specificity in a variety of roles and contexts (Glenn 1994:13), woman is
conflated with mother. A woman’s body came to be identified with its procreative potential (Jolly 1998b) and womanhood and motherhood came to have a “virtually automatic connection” (Lewin 1995:106).

Not only were women constructed as mothers, but a mother became a person without further identity (Rich 1976:22) opening space for mothering to be conceptualized as “the one true destiny for women” (Bordo 2003:95), her “justification in life” (Rich 1976:34); mothering came to be the presumed primary identity for most adult women (Arendell 2000:1192), overwhelming or overshadowing all other aspects of her identity (Lewin 1995), if not becoming her “sole mission” (Glenn 1994:3). Davin (1978:50) argues that this ascription of “new dignity” to the role of mother, as duty, destiny, and reward, and the prevailing idea that women/mothers should be at home “and children should be with their mothers” was a primary element of the ideology of motherhood. However, the ideal, full-time, mother was based on a Euroamerican middle-class model of the nuclear family that was then projected as universal (Davin 1978; Glenn 1994), and was not reflective of the situation of many women who worked hard within the home, and needed to work outside the home, in order to sustain themselves and their families, and who may have had extended families upon whom they could rely for assistance with tasks in the home. As Colen (1995:86) has argued, gender ideologies which present motherhood as a woman’s primary role and hold it in opposition to waged work both mask women’s wage work and serve to devalue and trivialize reproductive and home-based labour as unskilled “women’s work.”
Maltese Mothers

Representations of motherhood in Malta at the beginning of the twentieth century by both British and Maltese observers were in keeping with this larger ideological construction of motherhood as selfless, intensive, exclusive, and fulfilling. In terms of selfless devotion, the depiction of Maltese mothers is captured by the words of Malta’s Government Veterinary Surgeon and Superintendent of Slaughter-houses, Mr. Alexander Menzies MacFarlane (1911:200), “the mother especially has a great deal of attachment to her children and likes to keep them round about her” and by the Maltese expression, of local origin, “L’OMM ghal uliedha giddieba u halliela: A mother becomes a liar and a thief for (the love of) her children” (Aquilina 1972).

According to Falzon (2001), the heart of contemporary Maltese society is the family; he and scholars from 1970, 1990, and 2001 have noted that Maltese pride themselves on the strength of the family and its contribution to maintaining the social fabric such that having children gives an individual adult status and renders both men and women more complete persons (Aguis 1990; Boissevain 1970, 2001). Malta was (and remains, according to some) a context wherein the “traditional” roles of motherhood and homemaking are “highly socially valued” (Mitchell 1998a:147). Thus, as many researchers have argued over the past few decades, a woman was expected to find fulfillment through marriage, and as a mother, looking after her children, home, and husband (Abela 1998; Cutajar 2000; Mizzi 1981; Nicolas 1974). At the beginning of the twentieth century, Wignacourt (1914:22) contended that the Maltese woman “stands for sex and sex mainly.” However, his later claim that “in Malta woman remains a highly sexualized being, her main functions being to get married, produce offspring, stay
indoors, make dresses and look after the house” seem to indicate that his views were more consistent with those of contemporary scholars; that is, he did not regard Maltese women as erotic sexual beings but as reproductive ones (Wignacourt 1914:22). Thirteen years later, Peto’s (1927:53) description of “decidedly matronly” mothers “of seven at least”, whom he also called “the Maltese mamma” similarly suggests that Maltese women were viewed as mothers first and foremost. In addition, within the Maltese context, the primacy of a woman’s identity as mother is attested to by numerous proverbs stressing her role as childbearer (all from Aquilina 1972):

\[ Il-MARA tqila ġo did-dinja turi l' hila: \] The pregnant woman shows her worth to the world. (shows high regard for motherhood by Maltese)

\[ MARA bla żaqq bħal tieġ bla daqq: \] A flat-paunched (lit. paunchless) woman is like a wedding without a band. (women are expected to bear children or marriage will not be happy)

\[ lż-ŻWIEĠ minghar tarbija ma fihx tgawdija: \] Childless marriages are joyless.

Not only was it important for women to have children, but, according to Maria Calleja, through the early twentieth century, if no child was born during a reasonable time after marriage, the woman was blamed; infertility was her fault and it was primarily her responsibility to pray to the saints – particularly the Virgin Mary – to bring about pregnancy and childbearing (Galley 1994).

The effect of Roman Catholic teachings on the position and lives of women in Maltese society during the 1970s was noted by Sibyl O’Reilly Mizzi (1981) in her dissertation entitled *Women in Senglea: The Changing Role of Urban, Working-Class Women in Malta*. Because urbanization and the importance of wage-labour increased following the Second World War, the circumstances of women in the early twentieth
century would have been different in many ways from those of the women Mizzi interviewed, although she did include a number of older women in her sample whose child-bearing years would have extended from the 1920s to the 1950s; however, Mizzi’s analysis is nonetheless illustrative of understandings of women within Maltese Roman Catholicism. According to Mizzi (1981:94-5):

The Catholic Church teaches that a woman should be chaste, modest, loving, caring of others, and subject to her husband and/or father. Mary, the mother of Jesus, is held up as a model of female behavior and the Holy Family of Jesus, Mary and Joseph (a nuclear family) is offered as the model of family life.

Another Maltese scholar, J.P. Mitchell (1998b) similarly noted the importance of Catholicism for women in contemporary Malta, arguing that Maltese women produce their female identity through pilgrimages such as Our Lady of Sorrows (Id-Duluri), wherein thousands of women would walk barefoot behind the statue of Our Lady on the Friday before Good Friday as a demonstration of faith and devotion. Further, he argued that this linked “the suffering of Our Lady to the hegemonic model of the woman as a long-suffering, faithful servant to family and society” (Mitchell 1998b:73).

In addition to the importance of faith in the construction of female identity in Malta, Mitchell (1998b) observed that everyday performances, such as maintenance of the household by cooking, cleaning, childcare, and managing the budget were means for a Maltese female to produce herself as a women, demonstrating the degree to which her identity was located in her role as wife and mother. Lafayette’s (1997:75) recent study similarly found that today “women generally are homemakers who cook and take care of the children”; although she acknowledged that most women also work outside the home. Mizzi (1981) similarly noted that, in the 1970s, the division of labour in a household
followed sex lines, with men responsible for financial support, and women, as homemakers, responsible for food shopping, preparing, cooking, cleaning up, and childcare; therefore, many women strongly felt that caring for the home and household was their “chief raison d’etre and that any encroachment would lessen their worth to the family” (Mizzi 1981:88). In Mizzi’s view (1981:102), most women were taught that a woman’s role in life was to devote her life to her children; her life was to be centered around her children and later her grandchildren. Her relationship with her husband is tangential at best. Her day is spent cooking, cleaning and sewing, maintaining her home and family in perfect order and cleanliness. Her first duty is to others, not herself, and she cares for those under her protection with wondrous endeavor.

Thus, not only were Maltese women expected to be selfless and devoted to their children, they were mothers first and foremost, and the ideology of motherhood carried with it an expectation of domesticity. Maria Calleja’s recollections in her life history of women in early twentieth century Malta are remarkably consistent with Mitchell, Lafayette and Mizzi’s more contemporary observations (Galley 1994). Although Maria herself “refused the role traditionally assigned to a woman in the social network – that of housewife”, choosing instead to pursue a career in teaching, she described the duties of a married woman caring for five or six children, cooking, washing, cleaning, weaving, sewing, noting how busy a woman was and how she “worked and suffered” to raise and care for her family (Galley 1994:125, 27). Specifically with regards to the division of labour, she noted that “men were not expected, as a general rule, to give a helping hand, neither in the kitchen nor anywhere else” (Galley 1994:142). Consequently, in her eyes housewives were “confined to their houses, literally tied to the sink with all the washing
to be done, always busy feeding and nursing their numerous children, and cooking and serving their husbands’ needs” (Galley 1994:141).

Maltese Women and Work

Despite the supposed primacy of their role as homemakers, in addition to responsibilities inside the home such as cleaning, cooking, and childcare, many women – especially in rural families – reportedly had additional tasks such as feeding rabbits and chickens, simple gardening, as well as harvesting and planning, and taking sheep and goats out to pasture (Nicolas 1974:13). In fact, in his testimony before the Royal Commission in 1911, Government Veterinary Surgeon and Superintendent of Slaughterhouses Menzie MacFarlane acknowledged that a great deal of agricultural labour was in fact performed by women and children. And the regularity of women’s agricultural work is attested to even in later periods by its inclusion in Guze Chetcuti’s novel *An Alley in Malta*, in which one character speaks of her rural upbringing wherein most of the housework fell to her because her mother “spent her time in the fields with [her] father tilling the soil, hoeing, clearing and planting the new crops or driving the ox-drawn plough while [her] brothers sowed the seed” (1976:68). Similarly, in Maltese fishing communities, prior to the Second World War it was largely the responsibility of the woman to carry the fish to market in Valletta on their backs, an important and physically demanding type of work (Wilhelmsen 1977).

Manderson (1998) has noted that, from the mid-nineteenth century, women living and working in the colonies received relatively little attention; women’s productive
labour was overshadowed by their reproductive labour. This seems to have been the case in Malta; perhaps because many fishing and agricultural ventures were family-run, in many instances women’s labour in these domains was not recognized, despite its regularity. Instead, the most commonly cited examples of women’s work included lace-making, sewing, and various branches of needlework, which were taught in girls’ schools and were therein deemed “in perfect consonance with the pursuits and wants of the female population” (Keenan 1879:43), as well as domestic service. In the words of Fairfield and Drummond Shiels (1938:16), during the 1930s “domestic service [was] almost the only employment open to the Maltese girl outside her home.” This type of work was often performed by rural or Gozitan women in the homes of more wealthy or upper class suburban and urban families. It was both a low-status and low paying job with the highest wages in domestic service rarely surpassing the lowest wages in the trades (see Figure 4.4).

36 However, Manderson contrasts this to the acknowledgment of women’s work in prostitution, which received colonial attention and was subject to state intervention. This was similarly the case in Malta (see Walz 2006).
Despite the primacy of domestic service, and irrespective of Fairfield and Drummond Shiels’ claims, women were engaged in other forms of paid employment (see Figure 4.5, and Figure 4.6 for a comparison of men’s typical forms of employment). The frequency of women’s work in factories, building works, and in quarries is also suggested by the promulgation of an employment act in 1926 aimed at regulating women’s hours and conditions of employment (Lieutenant Governor 1926). Nevertheless, women’s wage labour is largely mentioned only in passing, and predominantly in order to reference its effects on the opportunities for employment for Maltese men. For example, in 1912, Pace Bardon’s report on the census noted that there was a decrease in the number of women engaged in “useful occupations”, particularly industrial employment,

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The specific reasons for the discrepancies in pay observed in Figure 4.4 are unknown; however, these may be related to the experience or training of the individuals, their hours of work, or their respective employers. For example, wages paid by British employers of domestic servants may have been higher than wages paid by members of Malta’s elite, who also retained employees for domestic services.
which he attributed to an absence of sufficient work since the lion’s share was taken up by the men, leaving women with little work other than domestic service.

Figure 4.5 – Occupation of Females, Malta 1881

Figure 4.6 – Occupation of Males, Malta 1881
Following the next census, Galizia (1922:25) noted that there was a substantial increase in females in the productive classes which he attributed to an altered sex constitution in the population (and was quick to argue that this phenomenon “cannot be attributed to the displacement of males by females” in most occupations), although he acknowledged that more women were finding commercial employment than heretofore. Figures 4.7 and 4.8 indicate the changes in the sex ratios of Malta’s population between the census of 1911 and 1921. Notably, while in 1911 there were only slightly more women than men in each age category, by 1921, the percentages of women in between the ages of 20 and 39 is markedly larger than the percentages of men in the same age group. Whereas in 1911 the number of people between the ages of 20 and 39 was 30,354 men and 30,777 women, by 1921 those numbers had decreased to 28,404 men and increased to 34,550 women. As such, Galizia may have been correct in his assessment that the increased number of women in the workforce was related to the altered sex constitution of the population. In real terms, some women may have been obligated to enter into wage labour during the First World War, or in the years thereafter, because of the death or departure of their spouses or as a result of the economic depression that struck Malta following Armistice.
Figure 4.7 – Sex Ratios by Age-Group, Malta 1911

(Malta Census 1911)

Figure 4.8 – Sex Ratios by Age-Group, Malta 1921

(Malta Census 1921)
Similarly, in 1936, women’s wage labour was discussed in reference to its effect on men’s employment opportunities: Curmi (1936:289) argued that “The continued increase in the number of women in employment – other than domestic work – has naturally interfered with the employment of men.” During the Second World War, much like other locations worldwide, hundreds of women were employed in Government and Service Departments; however, like elsewhere, “with the cessation of hostilities the services of the majority of women were dispensed with” and those jobs were given largely to ex-Service men (Knott 1947:408).

Women’s employment was understood by government officials to be supplementary rather than primary income; therefore, in times of labour shortage, women’s participation in the workforce was repeatedly judged according to its impact on employment opportunities for men. This, in combination with the fact that women’s work tended to be part-time and lower paid, meant that as late as 1959 a woman with any form of employment, regardless of her earnings, “should not be deemed unemployed” and was therefore not eligible for the unemployment registers (in contrast to men, who was eligible if he earned less than £4 a week from any occupation) (n.a. 1959). A dozen years later, in his work, Nicolas (1974:5-6) noted that Maltese women occupied “positions requiring less skill, training and responsibility because there is small choice in employment”, with women being trained for subordinate positions; and one reason for this was that “girls do not consider work as a career.” Instead, he argued:

Most girls work to get a wage and there is no interest in work or advances. They lack in other words a sense of career. They work for a living in order to save money before they get married. Besides, married women work not for money, but to meet their friends and have a chat…. Work after all is not considered important because it would generally stop after marriage. Women would only work if they really needed to. Therefore
work is not important for its own sake but for various other reasons (Nicolas 1974:8).

Abela’s (1998) more recent description of women’s employment lacks much of Nicolas’ sexist language and assumptions, but similarly notes that up until very recently, “women did not generally remain in gainful employment after marriage.” Further, any of a woman’s labours outside the home were considered secondary; as Wilhelmsen (1977:386) explained “a woman’s economic ventures must not interfere with her tasks as a mother and household keeper.”

**Maternal Responsibility and Mother-blame**

That women’s productive labour was downplayed and their reproductive labour was emphasized in Malta, such that they were expected to show their worth by bearing and raising children — and that they alone were responsible in the instance that no child was forthcoming — points to the relationship between ideologies of motherhood, maternal responsibility, and the attribution of blame to mothers. As infant mortality became a pressing concern, a new ideology of motherhood placed women at home, as the primary (if not exclusive) caregivers to their now-precious developing infants and children. Moreover, this ideology of motherhood was rooted in ideas about women and domesticity, but also individualism (Davin 1978). Reinforced by the protestant ethic, wherein it was within the individual’s power to prosper or fail, the mother became largely responsible for the proper development of her infants and children. While this might not appear surprising, because of the close association between women and children in contemporary ideologies, such that “the phrase women and children is so familiar to us that we take it as read that is comprises two closely related even equivalent taxonomic
categories”, it was not until the eighteenth century that children went from being “naturally” associated with their fathers to being associated with their mothers (Jordanova 1995:374). In this vein, despite the ‘vocabulary of concern’, which reflected anxiety about population decline, labour shortages, imperial decline, and building a race of strong men, the problem of infant mortality was represented as “particularly a woman’s concern” (Davin 1978:50).

Moreover, because women were presented as mothers, emphasis was placed on pregnancy, and the subjective focus of colonial medicine and administration was the infant rather than the woman (Manderson 1998). The health and welfare of women was not a concern in its own right; rather, their behaviour was monitored for the sake of their infants, whose lives were understood as extremely valuable. Additionally, while references to the infant mortality rate indicate that the statistic itself was what was regarded as appalling or deplorable, other comments reveal that infant death was also imagined as a personal loss to mothers. For example, in Malta, Fairfield and Drummond Shiels (1938:9) wrote: “Maltese mothers still lose one quarter of their children before they are 5 years old” and they remarked that this was an “appalling wastage of child life – and incidentally of maternal effort.” Similarly, following the drop in infant mortality rates, Galea (1959:227) observed that previously it was not uncommon to “come across a mother bewailing a number of dead babies or having one living baby out of six to eight pregnancies.” Moreover, if children were the responsibility of the mother, if the mother was the one who felt a profound sense of loss upon their death, then it followed that the mother, herself, was responsible for preventing infant and child death. With the discovery of the child, and the mother, the problem of infant mortality came to be seen
not simply as a woman’s concern, but as a mother’s fault. Furthermore, with the ideal mother epitomized in the bourgeois white middle class model, “other” mothers were seen as “deviant rather than different” (Davin 1978:14). Maria Tapias (2006), in her work on breastfeeding, infant illness and the politics of mother-blame in Bolivia, has noted that, over time and across cultures, scholarship on motherhood reveals a long tradition of blaming mothers for numerous social ills – from infant mortality to attention deficit disorder. Similarly, Scheper-Hughes (1984:536) has remarked on the tendency to “blame the gamut of human problems on ‘bad mothers’ and ‘bad mothering’.” With this in mind it is perhaps unsurprising that women/mothers – particularly those from the lower classes and the colonies – were increasingly blamed for their infants’ deaths, for elevated rates of infant mortality, for decreased fertility, population reductions, ill-health and racial degeneration, and imperial decline, which led to a growing state interest in the behaviours of mothering and women’s – or “mothers”’ – roles as carer and nurturers (Manderson 1998). This growing state interest in the behaviours of mothers was clearly reflected in the strategies of intervention implemented to combat infant mortality within metropolis and colony; therefore, in Chapter 5, the ways in which ideas of mother-blame shaped these interventions within and beyond Malta will be detailed and assessed.
Those who are born have a right to live; how... to guide the vagaries of injudicious feeding and a few other minor causes which individually swell our infant mortality belong to another province of our health administration:– our social medical service; it is for them to find the remedy as I am sure they will.

- Dr. Joseph Morana, An Investigation on Infant Mortality in Malta (1946)

As explained in the previous chapter, discourse on infant mortality largely concentrates on individual maternal abilities and practices. Perhaps as a result of a more general move towards an increasingly individualistic ‘modern’ attribution of blame and responsibility with the move to industrialization, women were given the power to build happy families and happy nations/colonies as well as the blame for any failures in this regard (Stivens 1998). That is, with the ‘discovery’ of infant mortality, and the construction of motherhood as a woman’s primary and important personal and national (or imperial) duty, women were given responsibility for child health and development, as well as the blame for ill-health and infant death. While the focus was on the child and infant health, to effect change interventions were predominantly directed towards women, chiefly “mothers”, but also health practitioners (Manderson 1998). That is, midwives and traditional birth attendants became subject to regulation; however, the majority of strategies aimed at reducing infant mortality centred on the mother and presupposed that infant mortality reflected a woman’s inability to be a good and proper mother (Manderson 1998). Somewhat counter-intuitively, the same women who were blamed for elevated rates of infant mortality, in part because of their so-called “inherent inferiority”, and because they lacked the intelligence (and will) to prevent the deaths of their own children, were also given the responsibility of maintaining the population and
lowering infant death rates (Apple 1995; Jolly 1998a). As a result, as many researchers who have examined infant mortality in early twentieth century metropolitan and colonial settings have noted, the overwhelming response to elevated rates of infant mortality was that mothers needed to be taught the art of ‘mothercraft.’ As Davin (1978:42) contends: “just as maternal ignorance had most frequently been made the scapegoat for infant mortality by the expanding health profession, so education for mothers had been the universally demanded solution.”

Much like the discourse on infant mortality, strategies of intervention into infant health were mainly instigated first in the United Kingdom and then gradually introduced into many of the colonies. They included: the training of midwives, the incorporation of pregnancy and birth into hospital-based medicine, the provision of antenatal and postnatal services, the establishment of infant welfare clinics, the initiation of home visiting, and the expansion of domestic science and health education (Davin 1978; Jolly 1998b; Manderson 1998). There is, however, some debate as to the timing of interventions in various sites; that is, some initiatives were likely first implemented in colonial sites and transposed into metropolitan centres, rather than vice versa. The abundance of archival materials from the perspective of the colonizers can obscure this fact and emphasize those initiatives that were led by the colonial governments (McElhinny, personal communication). Moreover, as Birn (2005: 1506) has shown in her analysis of the pioneering role of Uruguay in advancing child health as an international priority between 1890 and 1940, the history of international health is often examined from the perspective of metropolitan institutions such as the World Health Organization or the International Red Cross; therefore, “the motives, ideas, and operations of international health are
invariably portrayed as centrally determined, then diffused around the world.” Nonetheless, scholars have observed that some interventions were pioneered in the colonies; for example, Hunt (1999) argues that caesarean sections were pioneered in the Belgian Congo.

This chapter will describe the interventions initiated in Malta designed to combat infant mortality and will juxtapose these to interventions described in the UK and other colonies. Beginning with a brief description of the structure of medical services in Malta, specific attention will be given to the regulation of midwives, and the institution of consultation centres and of home visiting throughout Malta as means of reaching mothers and infants, and of teaching “proper” maternity. This will be followed by a discussion of the modernizing and rationalizing of mothering behaviours in relation to the state’s interest in controlling its population and creating reliable citizen-subjects. The final section will reflect on the meanings of infant mortality reduction strategies by exploring the ways in which medical interventions act as justifications for colonial rule, while simultaneously effecting change in the realm of infant health and obscuring the impact of poverty and colonial exploitation.

**Medical Services in Malta**

Savona-Ventura (1997) dates Malta’s first hospital to Rabat’s Hospital of St. Francis, which functioned under the rectorship of Franciscan Niccolo Papalla from at least 1372, and was later transferred to the Universita in 1433 whereupon its name was changed to Santo Spirito Hospital.38 With the arrival of the Knights of Saint John in 1530, Malta’s hospital services were expanded as part of a state-organized social services

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38 Santo Spirito remained open until 1967, and as explained in Chapter 2, this is now the location of Malta’s National Archives.
Although this was a military order, it was originally founded by Pope Pashall II during the time of the Crusades to administer and guard a hospital established in Jerusalem and to care for the Christian sick and destitute (Cassar 1965). Upon moving to Rhodes in 1310, the Order was responsible for the maintenance of a newly built hospital the likes of which surpassed any contemporaneous institutions; therefore, when they moved to Malta, the Knights also planned to establish a large hospital, and temporary one was initially built in Birgu, the maritime centre of Malta. In 1575 the Valletta Holy Infirmary was completed, which was extended and remodelled a number of times, such that by the eighteenth century it possessed 554 beds, with space for 900 in case of emergency (Savona-Ventura 1997). The Holy Infirmary was open to members of the Order, civilians, and slaves, and included provision for the deposition of foundlings (as did Santo Spirito), and according to Cassar (1965) this hospital remained far in advance of anything that the rest of Europe possessed. At the end of the Knights’ tenure (1798), the hospitals in use included Valletta’s Sacra Infermeria for men and the Casetta for females, Rabat’s Santo Spirito Hospital, two hospitals in Gozo’s capital city of Victoria, and the quarantine hospital on Manoel Island, as well as hospices for the elderly and infirm at Floriana and Saura Hospital at Rabat, and a small hospice for females at Zebbug (Savona-Ventura 1997). In addition to the establishment of hospitals in the islands, medical education in Malta was begun under the Knights, with the establishment of the School of Anatomy in the seventeenth century, which was transformed into the Faculty of Medicine with the founding of the Royal University in 1771 (Cassar 1965).
Thus, with the arrival of the British at the beginning of the nineteenth century, Malta already possessed a long history of medical services. Thereafter, the Faculty of Medicine and the University remained in operation, such that by 1879 Mr. Patrick Joseph Keenan, Resident Commissioner of National Education in Ireland, expressed the opinion that with a recasting of the medical curriculum of the university,

this little School of Medicine and Surgery might ... be able to hold its own with any other Medical College in the British Empire and be fairly entitled to the recognition and privileges accorded to students in the Universities and Colleges of Great Britain, Ireland and the Colonies (quoted in Savona-Ventura 1997).

Under British rule, the previously established hospitals continued to treat the Maltese population, although they were reorganized for the separate treatment of civilians, military and naval personnel. For example, the Holy Infirmary, which under Napoleon had been converted into a military hospital, remained so under the British (until 1919 when it was transferred to the Civil Government).

A number of other changes to the hospital system took place during the nineteenth and twentieth centuries: in 1850 a new Central Hospital was established in Floriana, in a building which had previously served as a home for pauper girls. Towards the end of the nineteenth century, both Rabat’s Santo Spirito and Floriana’s Central Hospital were depicted as crowded and inadequate to meet the needs of the population, particularly with regards to the isolation of patients with infectious diseases such as measles, scarlet fever, diphtheria, and whooping cough. However, despite 1885 recommendations to replace the Central Hospital with a larger building, financial provisions were not made until 1927, construction of St. Luke’s Hospital at Gwardamangia began in 1930, progress was stalled by the Second World War, and the building was not completed until the mid-1950s.
Consequently, even in 1937, the Central Hospital remained the principal general hospital in Malta, whose resident medical staff consisted of the Medical Superintendent, eight assistant medical officers, a chief pharmacist, and three assistant pharmacists, as well as a visiting medical staff of two physicians, five surgeons, two accoucher-gynaecologists, two pathologists, an ophthalmic surgeon, an anaesthetist, two radiologists, a dental surgeon, and three medical officers responsible for venereal disease, dermatology and disorders of the ear, nose, and throat (Savona-Ventura 1997).

In addition to these institutions, a number of private hospitals were established during the early twentieth century. The first private hospital, the Zammit Clapp Hospital, was opened in 1911 in Sliema; initially to serve as a Seamen’s Hospital and run by the Sisters of the Little Company of Mary (Blue Sisters), patients or their employers were required to pay for treatment, although expenses were partially defrayed by the government (Savona-Ventura 1997). By 1922, with the opening of the King George V Merchant Seamen’s Memorial Hospital, the Zammit Clapp Hospital began to serve as a children’s hospital, extending the War Memorial Ward for Children that was set up on the upper floor of the hospital in 1918 (Savona-Ventura 1997).

In addition to hospital services, Malta possessed an extensive system for the maintenance of public health and the provision of medical services during the 1800s, at the pinnacle of which sat the Chief Police Physician (the significance of this title will be discussed below). Importantly, following the cholera epidemic of 1885, the medical services of Malta were reorganized according to the structure of the British Government Medical Officers, forming a separate entity within the Department of Charitable

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39 Opened after a deed of donation by Emilia Zammit Clapp and her sister Mary Zammit, the hospital was named the Zammit Clapp Hospital but it was also called the Blue Sisters Hospital.
Institutions. The Chief Police Physician thereafter retained the title of Chief Government Medical Officer (CGMO), who at different times held the titles of Superintendent of Public Health, Director of Public Health Services, Inspector of Hospitals, President of the Medical Board, Advisor to the Government on matters of public health, and Inspector of Medical, Charitable, and Quarantine Establishments and Prisons (Calleja 2004). In 1937, another reorganization took place, with the merging of the Departments of Public Health and Charitable Institutions, thereafter termed the Medical & Health Department, with the CGMO as head. From that point onwards, below the CGMO, in order of declining authority, sat the Assistant Director of Public Health Services, the Senior Medical Officer and Senior Health Officer, four (4) Medical Officers of Health, thirty-two (32) District Medical Officers, and thirty-two (32) District Nurses (Johnson 1937a). According to the ‘Regulations for Guidance of the Commissioners of Charity’ of 1909, the responsibilities of the CGMO were internal management, discipline, good order, economy, and observance of the regulations (n.a. 1909). At the turn of the twentieth century, the position of CGMO was held by Professor S.L. Pisani, and upon his retirement in 1901, he was replaced by Lt. Col. R.P. Samut. In a series of confidential dispatches, the reasons for the appointment of Samut – who, according to then Governor of Malta Sir C. Mansfield Clarke “did not in any way fulfill the expectations which were entertained of him in his administration of the Department” (1905) – and the rationale for subsequent appointments made clear the responsibilities and status of the CGMO.40 On November 8th, 1901, Governor F. Grenfell wrote to Joseph Chamberlain that he could not recommend Dr. Giuseppe Caruana Scicluna as CGMO.

40 The nature of these expectations and the reasons why Samut did not fulfill them were not specified in the letter in question.
notwithstanding his good service and devotion to duty, because his knowledge of English and social standing did not appear to me of the standard required in an office in which there is frequent contact with the Military Principle Medical Officer, the Deputy Inspector General of Hospitals and Fleets and other English Members of the Council of Health.

As a result, Samut, a resident of Sliema and a military man who presumably possessed sufficient prestige and proficiency in English to interact with the English administrators in Malta, received the post. However, upon Samut’s retirement in 1905, Caruana Scicluna was deemed the best candidate for the position (the other name under consideration was the well-known chemist Temi Zammit), having been employed in the medical services for twenty-five years, and possessing considerable experience in and knowledge of sanitation and local laws relating to sanitary matters and buildings (and having earned the dislike of a section of the population as a result of his enforcement of said sanitary laws), particularly in light of the perceived need to reorganize the Sanitary Branch of the Public Health Department (Mansfield Clarke 1905). Moreover, in a confidential letter to the Secretary of State, Governor Mansfield Clarke (1905) expressed his opinion that

Dr. Caruana Scicluna’s knowledge of English is now quite equal to that of most other Heads of Departments, while his social standing is not inferior to that of other Government officers who are equally brought into contact with Naval and Military officers.41

Because of the existence of a Faculty of Medicine within Malta, it is likely that a large proportion of medical personnel working in Malta during the time period under investigation in this dissertation (including the CGMOs) were, in fact, Maltese; however, aside from the discussion of Caruana Scicluna’s position, the exact origins, social

41 Subsequent CGMOs (mentioned in this dissertation), who presumably possessed sufficiently high status and abilities in English, included: A. Critien (who held the position from 1917-1936, and will be discussed in more detail below), A.V. Bernard (1936-1939), J. Cauchi (1946-1948), and A.C. Briffa (1948-1951), who was thereafter replaced by J. Galea, who served through the 1950s.
standing, and nationality of the individuals who provided medical service in Malta is uncertain.

In contrast to the CGMO, at the lower end of the medical services hierarchy, were the District Medical Officers (DMOs). As of 1909, there were 26 DMOs in all of Malta and Gozo, with Valletta hosting two officers and each of the other localities served by one DMO; their numbers were later increased to thirty-two (by 1937) and then forty-two (by 1956). The primary responsibility of the DMOs was to provide “gratuitous relief… to the sick poor who cannot afford to pay for medical attention or medicines for themselves or their families”, which generally took place at a government dispensary where they worked specific hours two or three days a week, but also in patients’ own houses (n.a. 1909; Julyan 1879). DMOs were free to conduct unlimited private practice “provided that such practice does not interfere with the due and faithful performance of their public duties” (n.a. 1909; Cronin 1956; Julyan 1879). However, according to Julyan (1879:29) “everybody in Malta who lives by daily labour, that is every working-man, as well as every beggar, is considered to have a claim to receive medical assistance and medicines gratuitously” and many DMOs were said to “allege that the districts in which they live are too poor to contain paying patients”; therefore, few DMOs appeared to have sources of income beyond their government allowances and many complained that they were “very inadequately paid for work which occupies nearly all their time” (Julyan 1879:30). Over fifty years later, in a report on the medical services of Malta, John Cronin of the United Kingdom (1956) again observed that a DMO’s salary was not adequate by itself to maintain a satisfactory standard of living, and that this salary seemed
to be based on the presumption that it would be supplemented substantially by earnings from private practice.

Opinions on the District Medical Officers varied greatly. During his fieldwork in the early 1960s, Boissevain (1965) observed that DMOs were often the only professionals resident in a village, and while they tended to keep themselves aloof from the people with whom they worked, they were respected figures possessing a great deal of prestige. However, only a few years earlier, Cronin (1956) noted that – perhaps in light of their insubstantial salaries – a number of District Medical Officers’ “treatment of their non-paying patients falls below the minimum standards which can be tolerated”, including the simultaneous examination of several patients in the same room, such that “a substantial number of the sick population, whose incomes are insufficient, prefer to pay for treatment rather than receive it free from District Medical Officers.” Ultimately, Cronin (1956) concluded that the present system of organization and remuneration of District Medical Officers was contrary to public interest; he argued that it was a system “rarely employed in the medical services of progressive countries.” Moreover, he claimed that

The unsatisfactory nature of the District Medical Service is inherent in its fundamental structure. However useful a service of this type may be in backward or primitive communities, it seems to me quite unsuited to the needs of a highly civilised and progressive community such as Malta (Cronin 1956).

And he therefore recommended that the service should be abolished and replaced by a national comprehensive health service wherein the population could receive medical attention without direct payment, akin to that of the United Kingdom.
Prior to the Second World War, according to Andrews (2001), village doctors were held, along with priests, in high esteem (a viewpoint consistent with Boissevain’s for the later period). Alternately, just prior to World War II an article in the newspaper Mid day Views drew attention to the “soul-destroying night-mare” of the Government District Medical Service, with DMOs said to “enter a blind-alley employment”, poorly paid and without the possibility of advancement in government service or their profession or the opportunity for additional training (as was ostensibly guaranteed in the regulations governing their service), such that the author proclaimed “it would be difficult to imagine a more demoralizing service” (A Correspondent 1934). Importantly, although this comment was made over five decades earlier, Julyan (1879:30) observed that “many of them [DMOs] are men of such very inferior standing in their profession that their services are over remunerated at the low rates accorded to them.” The standards by which Julyan judged Malta’s DMOs is unclear, and any claims regarding the abilities of these physicians during the interim between Julyan’s (1879) disparaging comments and those of Cronin (1956) would be speculative at best; however, they suggest that the District Medical Service was not meeting the needs of the population during a number of periods in Malta’s history.

**The Regulation of Midwives**

Although the primary responsibility of DMOs was to provide general medical service to the sick poor, an additional important task that they performed was to “assist women in difficult cases of labour whenever called upon to do so” (n.a. 1909). However, in most instances, women undertook labour and delivery with the assistance of a midwife. As stated above, interventions into maternity were often in the form of the
regulation of midwives, and, in fact, this was one of the earliest interventions into birthing in Malta. As early as the eighteenth century, there were calls for the training and supervision of midwives; for example, in 1772 Dr. Guiseppe Antonio Cren(i), a surgeon with the Order of Saint John proposed to the Grandmaster a course of instruction consisting of lectures once a month or more to women intending to take up midwifery; although the formal teaching of midwifery did not begin until 1802 when Dr. Francesco Butigiec was appointed Teacher of Obstetrics at the Woman's Hospital to deliver lectures to medical students and midwives (Savona-Ventura 1997). By 1865, additional regulations for midwives were in place. A training program existed for ‘public midwives’ as well as those to be employed in Central Hospital and handbooks describing proper procedures for midwifery were produced through the 1870s (Calleja 2004). For example, Calleja (2004) explains that, in 1881, CGMO S.L. Pisani, wrote a book in the vernacular to help inform midwifery students, called Ktieb il-Kabla, and in 1897 Professor G.B. Schembri issued Taghlim ghal Istudenti ta’ l-iskola tal-Kwiebel ta’ L-Ispetar Centrali, which was reprinted in English in 1896 for the benefit of English Students.

Between 1883 and 1898, mandatory licensing of midwives was instituted, and in 1900 midwifery training was extended to include not only instruction and examination in the theory of midwifery but also examination in practical midwifery, and by the late 1930s, Bernard argued (1937:181) “practically every confinement in these Islands is

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42 Some midwives were fully integrated into organized medicine; for example, within the Central Hospital hierarchy of employees, they were listed amongst the “Minor employés”, along with barbers, mattress-makers, and nurses, among others (n.a. 1909).
43 The fact that Pisani and Schembri were writing these volumes in the Maltese language is further evidence that many of Malta’s medical service workers were, in fact, Maltese.
attended by a *certified* midwife” (emphasis added). This ran parallel to the implementation of licenses and regulations for midwives and birthing attendants in other locales, and appears to have preceded the regulation of midwives in the United Kingdom. That is, while in Britain one of the first steps taken to reduce the infant mortality rate also focused on midwifery practices, a Midwives Act was only introduced there in 1902, “to ensure that practicing midwives were trained and births registered” (Manderson 1998:35). Manderson (1998) noted that interventions in Malaya were aimed initially at midwifery services, and their primary goal was to control rather than replace the village midwife through early legislation and training, registration (as of 1908) and supervision of birth attendants, such that training programs were begun by 1910 and extended to most states by the late 1920s. In some other cases interventions into midwifery occurred much later; for example, in Ceylon, they were not in place until 1920 (Jones 2004).

Within Malta, a midwife not only had to be trained and registered, she had to qualify for said training at the Government School of Practical Midwifery. In order to gain admission into the course in midwifery, she had to meet certain requirements, published as part of the Comptroller of Charitable Institutions ‘Regulations for Midwives’ (n.a. 1905):

Chapter II: Admission of Students
Article 6:

No person can be admitted as a Student unless of good health, free from physical deformity, and above 18 years of age.

The applicants may be married, widowed or single. The married must prove the consent of their husbands, the single of their fathers or of the persons acting in their stead.

Article 7:

All applicants are to produce

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44 The training and examination of midwives was undertaken by a Board of Examiners appointed by the Chief Secretary to Government. For example, in 1905, the three examiners were Professors S. Grech M.D., S.Cassar M.D., and C. Mifsud M.D (who, based on their names, were all Maltese individuals).
1st Certificate of Birth
2nd Certificate of Moral Conduct from the Parish Priest.
3rd Certificate of General good conduct from the Superintendent of
the Police or one of the Syndics

and are able to speak, read and write Maltese and have a fair
knowledge of the first four rules of Arithmetic.

However, these rules of admission were regularly subject to change, and the length and
nature of training as well as the characteristics of the women who wished to become
midwives were contested issues.45 For example, the age of admission was variously
changed from over 18, to between 20 and 40, to between 20 and 35. In addition, on one
copy of the regulations contained in the Departmental Register for 1905, within a
collection of correspondence undertaken by the Comptroller of Charitable Institutions, it
was noted that the course was to be of two years in duration, but included in writing in
the margin were the words “too long” and an asterisk footnoted the following: “*unless
the students are ready for examination before that time”, indicating that this was not fixed
time period (n.a. 1905). These marginal comments were made by Professor Grech, in his
capacity as member of the Medical Board, as Accoucheur and Teacher of Practical
Midwifery at the Central Hospital, and as occupier of the Chair of Obstetrics at the
University. Later that same year, Grech wrote a letter to A. Marras (Superintendent of
Central Hospital) requesting that the course for midwives be no less than six months and
claimed that the “standard of general knowledge of pupil midwives required for
admission to the class of midwifery should be raised and some knowledge of general
nursing should be required from them before commencing the course in the maternity”
(1905). In fact, by 1909, training in nursing was required, although later this could be

45 What did not change during this period were the admittance requirements of permission from a married
woman’s husband or father, along with certification of a woman’s moral conduct on the part of her parish
priest and the police.
undertaken concurrently with training in midwifery (n.a. 1915), and by 1937, the program was extended to three years, with the first year devoted to training in nursing (Johnson 1937).

Another aspect of the regulations that changed frequently was the future midwife’s language proficiency. On one copy of the regulations, a prospective student was expected to be able to speak, read, and write Italian although this was scratched out and written in the margin was a note indicating that it was “subsequently amended as show here”, that is only a knowledge of Maltese was required (n.a. 1905). However, thereafter, a sub-committee of the Medical Board (1905) determined that “intending midwives should have a sound knowledge of the English or Italian language”; and while the Comptroller of Charitable Institutions, R. Micallef, in his (1905) letter to the Lieutenant Governor argued that “I doubt very much whether Maltese women possessing those qualifications [that is knowledge of English or Italian] will come forward to attend the school”, subsequently, this would be attempted on a trial basis. Micallef’s comments allude to the relationship between language and social class discussed in Chapter 3, whereby higher classes were often proficient in Italian and/or English in addition to their knowledge of the Maltese language, whereas lower classes typically spoke only Maltese. It also suggests that Micallef, himself, was of a higher social class than the typical student. By 1915, it was expected that a woman entering the school was knowledgeable in Maltese as well as being able to “read and understand another language” (n.a. 1915), perhaps as a means of raising the ‘standard’ of women who enrolled therein. Importantly, the debates over language proficiency for Maltese midwives were undoubtedly informed by the larger debates over the place of Maltese, Italian, and
English in the islands, as by 1937, under the threat of war, practical knowledge in English was made mandatory (Johnson 1937).

Following the final examination, the “qualified Midwives” would take an oath for the proper exercise of their profession and, upon payment of a fee, would be granted a diploma and a “Government Warrant” to practice their profession (n.a. 1905). However, thereafter, regulations for the practice of midwifery were also extensive. For example, in 1905, within the regulations for the practice of midwifery it was reiterated that a midwife could not practice without a license from the Head of the Government, and that this license would only be granted on the production of a certificate showing that the Medical Board was satisfied that the applicant was a British subject, of full age, that she had “obtained from the specially authorised School in these islands a diploma authorising her to practise midwifery”, and she was “of good character” (n.a. 1905). Some fifteen detailed regulations governing the activities of midwives were circulated in the government gazette. For example, in all instances midwives were prohibited from using surgical instruments or performing “any manual operation on the child whilst it is still in the mother’s womb or passages” (n.a. 1905). Every midwife was bound to call in a physician (or a DMO in the absence of a regular physician) in the case of any abnormal occurrence during labour or childbirth, and “as soon as the temperature, taken with the thermometer properly kept in the woman’s armpit for seven minutes, exceeds 101° Fahrenheit.” Further, in cases of puerperal fever or “inflammation of the womb” she was required to report these women to the Government Medical Officer of the area, and to abstain from practicing for five days during which she and her instruments would be disinfected as directed by the Superintendent of the Public Health Department; and she
could only return to work upon obtaining permission, in writing, from the Superintendent of Public Health.

Despite these extensive regulations, there were calls for stricter controls and the improvement of midwifery services in Malta. For example, Professor Grech argued that Malta’s regulations should be modelled on the principles of the 1902 Midwifery Act of England and Wales, that “midwives should be better controlled”, and claimed that:

The want of cleanliness in our midwives due to their limited knowledge of antiseptics, which is most difficult to make them believe in, their want of knowledge of general nursing, the social status of the class from which midwives are recruited, their want of general knowledge and education are some of the principal reasons to which the deplorable state of our midwives is to be attributed (Grech 1905).

As late as the 1950s, midwives in Malta continued to be derided: Galea (1954:248) found mothers’ preference for consulting the local midwife, rather than seeking “medical advice,” to be a contributing factor to neonatal mortality and found this tendency “regrettable because a timely medical examination may avoid much painful suffering and complications.” And Cachia (1956:41) lamented that the “midwife with her hold on people should come in for a complete overhaul”, that her handling of the newly-born needed to be revolutionized completely, and that “a strict system of supervision is the only way out for the time being.” These types of references to the low intelligence and status of women involved in midwifery, and attention to “insanitary birthing procedures”, including lack of hygiene in delivery and other “bad birth practices” as contributors to infant mortality, were not uncommon during this time period in other colonial settings as well (Jolly 1998b:189; see also Manderson 1998; Ram 1998; Rozario 1998). Manderson (1998:37) argues that such interventions into midwifery practices were designed not only to modify those practices, but that midwives were regarded as “gatekeepers” such that
their instruction was a means of addressing maternal ignorance. However, as stated above, interventions into midwifery were only one strategy for the reduction of infant mortality; others were more specifically geared towards altering the practices of mothering.

**Infant Welfare Centres and Home Visiting**

In response to elevated rates of infant mortality, infant consultation centres, following loosely on the *goutte de lait* of mid-nineteenth century France, were a large part of infant welfare efforts in England, Belgium, and abroad (Hunt 1988:405). Set up by government, mission, and voluntary associations, in some instances medical personnel from these centres supervised local midwives (Manderson 1998), and in others “hygienic milk depots” were set up to provide sterile milk for bottle-fed babies (Davin 1978:37). However, in large part these infant welfare clinics were designed to provide ante-natal care for infants and to teach mothers the “art” of child rearing: how to “properly” feed, clothe, and care for their infants (Hunt 1988; Manderson 1982). Davin (1978:39) describes the mandate of the Babies’ Welcome and School for Mothers, opened in 1907 in a poor West London district, which was applauded at the time and modelled elsewhere; it included consultations and weighing (of babies and mothers), dinners for suckling mothers, lessons on food and food values and prices (especially the feeding of suckling mothers), classes on simple cookery (for young wives and mothers), as well as lessons for mothers and young wives in the cutting and making of babies’ clothes, in the preparation for and care of babies, and in housewifery and domestic health. In addition, “outdoor” relief in the forms of visits to the homes of mothers attending the Welcome clinic was also conducted.
Infant welfare clinics like this one were opened in Malaya and the Belgian Congo from the 1920s onward (Hunt 1988; Manderson 1982), which coincided with the formation of a voluntary society called the “Mothers and Infants Health Association” in Malta in February of 1919 (as well as Britain’s Save the Children Fund described in Chapter 1).46 The association had the following aims: (1) to hold periodical meetings for expectant and current mothers at which advice and simple class teaching would be given on the “requirements of personal and domestic hygiene” (particularly the hygiene of infancy), on the feeding and clothing of infants, on prevention of disease and infant sick nursing, and on “rules of breast and artificial feeding”, (2) to establish home visitation of mothers and infants by voluntary lady visitors, (3) to establish baby clinics to carry on free consultations, at which babies would be weighed and medically examined at regular intervals, (4) to help necessitous mothers with gifts of baby clothing, soap, medicines, feeding bottles, milk and other infant foods at cost price or free, and (5) to provide cheap meals to mothers who could not get suitable and sufficient food at home (Critien 1920). At the time, the provision of meals and the establishment of home visiting were not possible; however, as of July 1919 consultation centres were set up in Hamrun, Valletta, Cospicua, and Zejtun. These four clinics, in some instances located in Government Schools after school hours, were staffed by a doctor, a lady visitor, and a helper for weighing and recording (all three of whom appear to have been Maltese), and held weekly sessions attended by between thirty and forty mothers (Fairfield and Drummond

46 Despite being a ‘voluntary’ association, the MIHA was created under the “auspices” of Lord Methuen, then Governor of the Islands, and Lady Methuen and was formed on a resolution proposed by His Honour W.C.F. Robertson, then Lieutenant-Governor (Critien 1920: 15); A. Critien (the CGMO from 1917-1936) was the chairman and animator (Bernard 1937: 189).
Aimed at “mothers of the poorer classes”, a Committee appointed to inquire into nutrition in Malta and Gozo stated:

We are of opinion that ante-natal and post-natal supervision as well as modern teaching of basic requirements of nutrition together with supply of milk to necessitous mothers will go a long way towards reducing debility and gastro-intestinal disorders due in most cases to faulty feeding of both mothers and infants (Briffa et al. 1937:IV).

According to Critien (1921:K6), the “professional advice and help” provided in these consultation centres were “bound to make an impression on the infant mortality rate” and should therefore be extended to “all the poorer and more thickly populated districts”, in his view, because very few mothers had the “knowledge necessary in order to protect their health and the health of their offspring; because many are in real need of help and encouragement in every way for the proper fulfillment of their mission.”47 Nevertheless, by 1938, it was observed that the death rate among the babies brought to these centres in 1936-37 was 237 per thousand – a rate which was, in fact, higher than the infant mortality rate for Malta as a whole in that same year (at 190.3 per thousand) – at which point Professor Critien and the newly appointed CGMO A.V. Bernard urged that “the work of the [Mothers and Infants Health] Association should be taken over by the Government, that official health visitors should be appointed and that an intensive campaign in mothercraft should be begun” (Fairfield and Drummond Shiels 1938:10).

Notwithstanding the numerous recommendations on the part of health officials such as Briffa and colleagues and CGMO Critien, these four clinics were not added to for nearly twenty years; it was not until 1947 that any more clinics were opened in Malta, at which point twenty-one Welfare Clinics were introduced, all of which were held in Government dispensaries (Cauchi 1947). However, despite the above references to the

47 Note here that motherhood is described as a woman’s “mission.”
need for “official health visitors” some form of home visiting, by District Nurses, was instituted prior to Fairfield and Drummond Shiels’ report. However, in contrast to Britain, where home visiting was one of the first steps in the supervision and education of mothers, from approximately 1860 onwards (Manderson 1998), home visiting came comparatively late to Malta. In 1921, home visiting was initiated on a trial basis, with only three “ladies” detailed for duty who visited 965 mothers and “advised as to their care, and the feeding and caring of their babies” (Critien 1921). The purpose of these District Nurses was:

a) to visit and tend the sick poor in their homes;
b) to advise mothers about the care of themselves and the feeding and caring of their children; [and]
c) to promote the hygienic improvement of the homes of the poor and working classes (Critien 1921:K6).

By the end of 1923, the number of District Nurses was raised to seven, in 1927 ten nurses were on staff (who visited 2,550 newly confined mothers in Malta), by 1938 there were sixteen in total, serving most of the islands’ localities (and visiting approximately seven thousand mothers), and by 1947, with the extension of infant welfare services the numbers of infants visited in their homes was said to be nearly 30,000 (Cauchi 1947).48 Interestingly, later Cachia (1956:41) lavished praise on the work of health visitors and called for an increase in their numbers, but he tempered his praise with the suggestion that a health visitor from England be brought in to show the Maltese ways to improve the work of local health visitors. This points – again – to an assumption of supremacy of British ways of knowing and the significance of hierarchies of knowledge surrounding maternity during this time period.

48 Eventually supplementing the district nurses were the voluntary helpers attached to the 4 clinics; however, they restricted their visits to newly confined mothers to Valletta, the Three Cities, and the principle suburbs.
Hierarchies of Knowledge and the Rationalization of Infant Care

In much the same way that discourses of mothering were predicated upon notions of the moral superiority of some mothers (upper-class women and colonizers), interventions into mothering followed hierarchies of race, class, and gender. That is, according to assumptions of the time, some women, by virtue of class and race, were deemed capable of undertaking the role of mother – the role of women in biological, social and daily reproduction – ‘naturally’ (Manderson 1998); thus, white women and their habits were held up as a moral models and correct practitioners, to be emulated in terms of house cleaning, infant feeding, and associated practices (Hunt 1988). For the majority, motherly love and maternal instincts were deemed insufficient; therefore, these mothers needed to be trained how to raise their children. That is, if only certain women were seen as able to fulfill their role as mothers ‘naturally’, the solution was that “other” mothers needed to be taught how to be ‘good mothers’ through infant welfare clinics and home visiting programs. Significantly, whereas in Britain and Europe, this was primarily a question of class, in the colonies it depended on a ‘hierarchy of race’, with white women deemed capable of instructing others in the ‘art’ of childrearing and the science of domesticity (Hunt 1988; Jolly 1998a; Manderson 1998). However, both race- and class-based hierarchies in presumed mothering abilities appeared in Malta: for example, in their discussion of the development of infant welfare centres, Fairfield and Drummond Shiels (1938:10) spoke of the importance of continued participation of voluntary workers such as officers’ wives as well as “Maltese ladies with sufficient goodwill and leisure” (women of the upper-classes). Thus, these “leisured women”, “with time to spare” (Fairfield and Drummond Shiels 1938:10), clearly were not the targets of interventions
into the practices of mothering; they were not deemed ignorant or incapable of caring for their infants. Additionally, references to ‘lady’ health visitors in Malta and elsewhere signalled that upper- or middle-class women were expected to help working-class mothers improve (Jolly 1998b).

As the higher-class and/or white mother was both an active instructor and a mother whose habits were held up as the correct model to be emulated, her infant feeding practices became both a measure and a guide for “other” mothers (Hunt 1988). Importantly, the theoretical underpinning for these mothers’ practices and much of the advice on infant feeding and childcare was provided by Dr. Truby King, the Dr. Spock of that generation, whose precepts included extreme separation of child from adult and a rigorous adherence to a regular feeding schedule (Davin 1978:47). However, as Scheper-Hughes (1984) has observed, such a strict feeding schedule can interfere with the biology of breastfeeding; as a result, despite repeated assertions within and outside of the Maltese context regarding the importance of breast-feeding, this type of scheduling may have actually prevented breastfeeding in some instances. Moreover, as white and higher-class women were vaunted as educators and model mothers, their inclination to regard breastfeeding “as déclassé, if not downright animalistic” (Manderson 1982:605) and to rely on bottle-feeding, established a powerful model, and bottle-feeding became a symbol of modernity in some settings (Manderson 1982, 1984; Scheper-Hughes 1984).49 Similarly, the provision of free milk and infant-feeding bottles in Maltese and other infant welfare clinics may have promoted bottle-feeding (Manderson 1982). Nevertheless, mothers in metropole and colony were expected to breast-feed according to a strict time

49 Within Malta, there is some evidence that breast-feeding was less common among the upper classes. See Chapter 7 for a more detailed description of infant feeding practices in the island.
schedule (often at four-hour intervals, with no night feeding) and to wean their infants by a specific age (Hunt 1988; Jolly 1998b; Manderson 1982, 1984; McElhinny 2005; Whitaker 2000), in order to discipline and not spoil their children (Jolly 1998b).

The inculcation of discipline and rationality were major themes in all interventions into infant health and maternity. This is consistent with Foucault’s (1990:139) discussion of the “anatomo-politics of the human body”, the ways in which the power over life was initially deployed via the disciplining of the individual body, its framing as a machine, and the ways in which its usefulness and docility were controlled by those in power. Thus, in much the same way that infant mortality and its associated ‘causes’ were framed by aggregate statistics, the practices of midwifery and mothering were moulded according to strict schedules, rules, and regulations. According to Davin (1978:54), this shows that a mother’s offspring were not merely expected to survive and be healthy, but to learn how to behave. Jolly (1998a:10) has argued that responses to infant mortality and depopulation went beyond instrumental aspirations of reducing mortality; rather “interventions – in homes, schools and other institutions in both metropolitan and colonial sites – were, as Foucault has persuasively argued, about governing life.” Surveillance and intervention by the state into birth and child rearing signalled the modernization of colonial and social control, parallel to that which Foucault detects in eighteenth and nineteenth century Europe (Jolly 1998b; Manderson 1996; Stoler 2002), an “investment in early childhood attachments, sentiments, and affiliations and a conviction that they were critical to making of reliable citizens, governable subjects, and modern nation-states” (Stoler 2002:19). That is, the bureaucratic means by which a state or colony administered and organized its populations, including medical
inspection and registration systems, were a means of producing “modern citizensubjects” in both metropoles and colonies (Briggs 2002:16).

All this required the training of children for citizenship, regularity, and discipline via scientific child-raising practices, particularly in view of the common perception that children were more malleable (McElhinny 2005). This is further evidenced by the implementation of programmes designed to reach children and ‘mothers of the future’, with young girls instructed, as “a matter of national concern… [and in preparation for their presumed future lifework] the all-important matter of managing a home and bringing up a family” (Vasallo et al. 1948:15). Within Malta, as in other sites, instruction in “housecraft” and “mothercraft” was recommended in the 1930s and eventually included in the curriculum set for girls over subsequent decades (Fairfield and Drummond Shiels 1938; n.a. 1950). According to McElhinny (2005:190) this targeting of children, of the next generation, implicitly communicated the belief that adults were not reachable by modern practices and ultimately “not eligible for sanitary citizenship, but young children were.” As Jordanova (1995:376) contends, reproduction was thought to generate “a complex potentiality that [needed] to be educated into responsible citizenship.”

Moreover, women, mothers, and mothers of the future, needed to be taught mothering (specifically “scientific mothering”) “in the name of civilization, modernity, and scientific medicine” (Jolly 1998a:1), and the ‘mothercraft’ movement emphasized both the superiority of certain mothers, with ‘others’ cast as ignorant and in need of instruction, but also asserted the superior knowledge of a variety of health professionals including doctors, district nurses and health visitors (Davin 1978). Specifically, in the
area of health, the colonial government first *defined* disease, illness, and health, then offered the technical expertise and institutions to deal with ‘medical problems’, allowing participation in those institutions by members of the elite of the population after appropriate apprenticeship within other colonial structures (such as the education system) (Manderson 1987:96).

To turn from a more general discussion of interventions as means of combating infant mortality and controlling mothering, the extent to which Malta’s population and mothers were subject to colonial controls should be assessed. Jordanova (1995:377) has referred to the focus on the quality of mothering from every stage through pregnancy and child-rearing, as the “good management” or “policing” of families. This is particularly noteworthy when referencing the Maltese context because, as stated above, Malta’s Chief Government Medical Officer was first titled ‘Chief Police Physician’ with his District Medical Officers first identified as ‘Police Physicians’ or ‘Medical Police’. Until Julyan (1879:29) recommended that their designation be altered to City or District Medical Officers and that they should be subject to the Comptroller of Charitable Institutions, this body of “professional men” were known as the Medical Police and were attached to the Superintendent of Police, although Julyan argued that their connection to the Police and Magistrates “should be so far retained as to secure their services, whenever necessary.”50

In fact, despite their change in title, the District Medical Officers retained many ties with the Police. Government dispensaries were “under the care of the Police” who were responsible for their safety and cleanliness and DMOs were expected to attend to the Police Force (along with employees of the schools and charitable institutions) of their

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50 Interestingly, at this point Julyan also suggested that the newly formed Sanitary Office be annexed to the Charitable Institutions, thus bringing medicine and sanitation together (Calleja 2004).
districts (n.a. 1909). In addition, it was under the discretion of the DMO as to whether or not a patient “or his responsible relative” could afford to pay for medicines or medical attendance (n.a. 1909), and as Pace Bardon (1911:27) revealed in the 1911 Royal Commission, in this endeavour the opinion of the police was sought: “we ask the police about the financial means of the patient and, according to the report of the police, we regulate what the man should pay.”

Allusions to the use of medical intervention as a form of social control and training in citizenship can be read in the words of Sir Walter Johnson, formerly director of Medical Services in Nigeria (1937a), who wrote:

Quite apart from the saving of human life, child welfare work and the work of health visitors is the most reliable and certain method of bringing the parents of the poorer classes into touch with the medical profession and so giving an opportunity to inculcate general principles of hygiene.

It is for this reason that he recommended the extension of child welfare clinics. Similarly, Aguis Ferante (1956:9) later wrote of the need for “more effective control of breast feeding and nutrition” as well as “better supervision of the growing child” as means of preventing sickness in children. Interestingly, although as Singer (1998a:228) has noted that the vital regulatory function performed by biomedicine – to observe, know, regulate, and use individuals through the manipulation of their bodies (Foucault 1977) – was concomitant with the secularization of society, in Malta the power of the Roman Catholic Church led to several calls for increased involvement by parish priests in the dissemination of medical advice. For example, Gulia (1875:14) suggested that a small book on sanitary subjects be published, with the view of educating those who attended public schools and who were ignorant of the rules of hygiene, and he argued that “the

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51 There is another connection between the two bodies: in 1954, the Central Hospital at Floriana was transformed into the headquarters of the Malta Police Force (Savona-Ventura 2001).
sound principles inculcated in a book of this kind could perhaps be easily explained by the Parish Priests to their flocks.” In fact, by the 1930s, Bernard (1937:165) noted that the Health and Medical Department “received very valuable help in our work from the Ecclesiastical Authorities, especially the Parish Priests of those villages where intensive sanitary action became necessary”, which he gratefully acknowledged. Following the war, CGMO Briffa similarly thanked the parish priests, for “exhorting their parishioners to follow the advice given to them by the Sanitary Officers and explaining to them the value of the various health measures recommended by the Department in the interests of public health” and “for their willing assistance whenever asked to cooperate with us by explaining to their parishioners the benefits accruing to the public health by accepting new methods in the prevention of disease” (1950:81).

The Scope and Effects of Infant Welfare Programmes

The “mothercraft” movement thus emphasized the superior knowledge of a variety of health professionals, placed certain sectors of the population in positions of power as models and educators (including the upper classes, and, in Malta, local priests), and put most women in a position of “powerless responsibility” (Rich 1976) by making them simultaneously responsible for the health and welfare of their infants, families, and nations while deeming them incapable of that responsibility and denying them control over the process (Apple 1997). As Apple (1997:105) has argued, under the tenets of scientific motherhood, mothers were accorded full responsibility for the care and raising of children, and, at the same time, their skills and knowledge were denigrated by insisting that mothers “needed the assistance of medical and scientific authorities in order to carry out their maternal duties successfully.” As such, the responsible mother would study
expert opinion and put herself and her family under the supervision of a doctor, preferably a specialist, whose instructions she would then execute (Davin 1978).

However, as Hunt (1988:432) has argued, infant welfare clinics and other forms of intervention “were not mere sites of colonial imposition, but of negotiation…. [w]hat was prescribed was not necessarily followed.” Therefore, it is important not to overestimate the effects of such interventions or to perceive working-class and colonized women as passive recipients of advice and instructions which they may have resented and which they often ignored or forcefully spurned (Jolly 1998b). State interventions would only have been partially effective as women (of all classes) would not have simply acquiesced or been complicit in their imposition (Stivens 1998); rather than succumbing to the messages of maternal improvement, they would have variously rejected or embraced or accommodated them selectively (Jolly 1998a). Ultimately, as Stoler (2002:10) states, “there was no panoptic imperial state” rather “colonial regimes were uneven, imperfect, and even indifferent knowledge-acquiring machines” that were neither omniscient nor omnipotent (Stoler 2002:206-7). Due to the relative gap in the voices of Maltese mothers and working-class people in the archival record, it is difficult to determine all of the undoubtedly complex and varied ways in which the Maltese responded to interventions into birthing and mothering processes. However, in the 1950s, CGMO Galea made a number of comments regarding women’s changing attitudes towards medical advice and interventions. According to Galea (1959b:570) “formerly mothers looked with indifference sometimes even with diffidence” on maternal services; whereas during the last decade there was a “better realization of the importance of the prenatal exam and treatment when required” such that “mothers [were] increasingly
availing themselves of all facilities at their disposal” (Galea 1959b:228). Galea (1959b) attributed declines in infant mortality as well as maternal mortality and morbidity to mothers’ having realized the importance of antenatal care and attention, and while he stated that the reduction observed in the infant mortality rate gave cause for satisfaction, he proclaimed: “what is more heartening is the new attitude of mothers, their greater response to our appeals, their cooperation and their appreciation of our advice.” Later, he extended his praise beyond mothers to include all citizens having finally realized “the importance of health in all the circumstances of life”, and argued that “public interest in matters of health is gratifying and should be fostered by all means because the more interest the public takes in the activities of this Department the more they will appreciate our efforts and the more cooperative they will become” (Galea 1959a:225). Galea’s comments regarding new attitudes and increasing cooperation of mothers (and other Maltese) speaks to the possibility that, in previous years, they resisted government interventions, but also to the importance placed on cooperation and appreciation in and of themselves.52

If, in fact, mothers prior to the Second World War were less inclined to accept medical assistance and advice, the potential reasons for this pattern deserve consideration. For example, in her work in Egypt, Morsy (1995:168) has observed that women prefer to deliver at home with a local midwife not because of “cultural attitudes” or traditional beliefs but as a result of “a measured judgement about the inadequate care extended to peasants and urban poor in modern health-care settings.” That is, women/mothers may have selectively accepted help and instruction, according to their

52 In addition to Galea’s comments, there is some evidence of resistance to the medicalization of birth and maternity in Malta, specifically with regard to the use of ‘traditional’ healers and medicines and the reported aversion of Maltese to be admitted to the hospital.
merits. In this vein, Jones (2002:285) argues “it would be arrogant to assume that recipients in the colonies were incapable of discriminating between those services and ideas which were useful and those which were not”; that is, mothers who accepted free food, medical advice, and treatment likely did so for “good pragmatic reasons” and not as a result of internalization of western ideas or submission to “state control” of reproduction. She further argues that “in viewing these policies through the prism of the imperialist agenda there is a danger that the real health benefits for the recipients of these welfare services are overlooked. They could have been both hegemonic and beneficial” (Jones 2002:289).

What were the “real health benefits” for recipients of infant welfare services in Malta and abroad? Manderson (1982:609) argues that in many locations throughout the nineteenth and early twentieth century western medical services were limited, public health facilities were poor, sanitation was negligible, and the knowledge necessary to prevent ill-health in infants and the spread of infectious disease was deficient. Similarly, Jolly (1998b:178) maintains that despite the similar forms of surveillance and intervention in a variety of colonial and metropolitan sites, various states lacked the motivation or power to fully implement projects which were therefore “uncertain in their forms and uneven in their effects”; for example, she found that education of mothers in Fiji was attempted far more vigorously than in Vanuatu. In Malta, following World War II, Wirth (1959:xxi) attributed the decline in death rates (and concomitant rise in population) to “advances in medical science, and especially arrangements to educate and help mothers and expectant mothers.” High praise was lavished on health authorities and the medical profession in Malta in an article published in the Lancet in the 1950s; they
were said to have “achieved a great deal in saving infant life (n.a. 1957:838). Galea made similar claims in the Government Health Reports: for example, he noted a decrease in the infant mortality rate which he considered to be the result of “the overall care and attention offered by the state” and argued that praise was due to the Child Health Officers and Health Visitors “who spare no pains in their endeavours to promote the health of babies brought under their care and attention” (Galea 1954:248-9). And later he argued that “it is a matter of gratification to record that within the short span of a decade the infant mortality rate in our Island has been reduced by more than 200%” such that the recorded rates were “within European averages” and compared “most favourably” with infant mortality rates in “other European countries bordering the Mediterranean littoral.”

Despite these claims, and despite the fact that the CGMO from 1917-1936, A. Critien, placed particular importance on improving the health conditions of infants – it was argued that “the subject nearest his heart was the welfare of babies and children” (Bernard 1937:189) – the extent and effectiveness of interventions into infant health were questionable. As explained in Chapter 4, infant mortality rates in Malta were significantly higher than in Britain and many of its other colonies, and these rates did not drop until after the Second World War, much later than in other sites. Moreover, when compared to the initiatives in the UK and other colonies, the number and scope of the interventions instituted in Malta were extremely limited. Whereas infant welfare centres existed from the mid-nineteenth century in France and England, the first consultation centres in Malta did not open until 1919, and in only four central locations (Valletta,

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53 Note that here, as detailed in Chapter 4, Galea compares Malta’s infant mortality rates to those of other countries, and Malta is here specifically described as a European country (the significance of which was discussed in Chapter 3).
Cospicua, Hamrun, and Zejtun), leaving most mothers, particularly those in rural areas, without accessible services until 1947. Importantly, while the timing of the opening of the first clinics in Malta coincided with the opening of infant welfare centres in other colonies, in comparison with the Belgian Congo, Ceylon, and British Malaya, for example, it took longer to establish fewer additional centres. The clinics themselves were described by the Chief Government Medical Officer J. Cauchi (1947:480) as “poor, ill-equipped, and overcrowded,” and the health visitors were said to be under-trained and required to cover much larger districts than they could efficiently manage. Moreover, Cauchi (1947:480) suggested a reduction in their workload, which signals the degree to which these individuals were overstretched:

Under present conditions, a health visitor should preferably have no other duties to perform, and her work should be limited to the care of not more than five hundred children under five years of age.

The comparative lack of social services in Malta is particularly evident when seen in the context of government expenditures per head of the population on all social services, which for the latter part of the 1930s was forty times less than in Great Britain (Dodd 1945). Moreover, the Maltese case was seen as exceptionally dire even in comparison to other British colonies, according to E.E. Dodd (1945:23) who proclaimed: “Social services expenditure is greater than that of Malta even in the Gold Coast.” Consequently, if interventions into infant mortality in Malta were measured according to their effectiveness in reducing infant death, or in terms of their scope as compared with interventions elsewhere in the British Empire, they could only be found inadequate and insufficient.
The Justification of Colonial Rule

This last discussion of efficacy has been placed in contradistinction to the portrayal of surveillance and interventions surrounding infant health as forms of biopower because several authors (e.g. Dwork 1987; Jones 2002; Mein Smith 1997) have questioned the value of “social control” models and discussions of infant mortality. For example, Dwork (1987) questions whether these types of social control models, typified by Davin’s (1978) work, are “particularly illuminating”; she calls for the evaluation of interventions into infant mortality according to contemporary medical understandings of the causes of infant mortality and argues that “it is impossible to understand the choice to institute one or another system if we ignore precisely that which was of greatest importance to turn of the century medical care providers: effectiveness in reducing the number of infant deaths” (Dwork 1987:228). Similarly, Jones (2002:289) maintains that “if it is accepted that good health is both universally discernible and a necessary adjunct to human capability, then practices which lessened infant and maternal mortality and morbidity were good practices whatever their origin”; and she urges that “it is ultimately on their ability to improve health and welfare that [medical and welfare] services should be judged” (Jones 2002:263). Mein Smith’s (1997) argument is slightly less polemic; she suggests a multifaceted approach in the study of infant survival and welfare, claiming that heroic celebratory medical explanations of the decline of infant mortality are insufficient but so are anti-heroic ‘social control’ interpretations.

Mein Smith’s point is an important one; specifically, one of the major problems with the orthodox medicalization critique in its less nuanced form, is its tendency to portray Western medicine as largely detracting from rather than improving people’s
health status, to depict medical personnel as intent on increasing their control and power over their patients rather than seeking to help them, and to imply that “the lay client [is] not the beneficiary but the victim of the consultation” (Atkinson 1995:33). While this may be an oversimplification of the nature and effects of biopower, and of the medicalization critique itself, it is nevertheless critical to remain attentive to the ways in which such a critique could be co-opted, thereby excusing unequal access to biomedical knowledge and treatments. Importantly, in a postcolonial context in which increasing numbers of people are fighting to gain access to western medical services and pharmaceuticals (particularly in light of the HIV/AIDS pandemic and the fight for access to anti-retroviral medicines amongst the world’s poorest nations and citizens), one must not lose sight of the power of biomedicine to reduce morbidity and mortality.

However, Dwork and Jones’s arguments are problematic for a number of reasons. Dwork takes for granted that the effectiveness of interventions aimed at reducing infant deaths was the issue of greatest importance to medical care providers, a position which fails to take into account that only those interventions which are actually instituted, measured, and understood as ways of addressing infant mortality can be evaluated in their effectiveness, and in most cases only a limited number of interventions and solutions were implemented. Further, effectiveness is not the only factor governing the implementation of medical or public health interventions; availability, cost, speed, and any number of other factors are also implicated. In addition, her claim that interventions should be evaluated based on contemporary medical understandings of the causes of infant mortality fails to take into account that contemporary understandings of infant mortality are shaped by past understandings, such that the mother-centred nature of
discourses on infant mortality in the early twentieth century has had a profound impact on the ways in which infant mortality is constructed and understood today.

Jones’ argument is problematic in large part because, in addition to her failure to acknowledge that the vast majority of researchers who could be included under the ‘social control’ banner are very much aware of the beneficial effects of medical interventions, Jones uncritically accepts one of the primary tenets of colonial rule – that it was justified because of its ‘benevolent’ motives and potential for improving the lives of the colonized. That is, although in some instances the rhetoric around infant mortality campaigns was closely related to guaranteeing a healthy labour force or to eugenic concerns about the “degeneration” of the imperial race (as described in Chapter 4), it was also frequently linked to rhetorical justifications of colonial state rule as ‘improvement’ (Jolly 1998b). Medicine and public health were therefore important vehicles for imperial aspirations to modernize and civilize and were part of the purported mission of imperialism to care, protect, and improve the lives of those who were less modern or uncivilized (Bashford 2004). British colonialism (for example) was purported to be “an educative, progressive, and civilizing force in primitive or degraded societies” such that intervention was not just humanitarian, but imperative (Levine 2004:136).

While colonial interventions into maternal and child health have been posited as a benevolent counterpoint to colonial military and labour regimes, scholars are increasingly arguing that interventions aimed at women and children were not exceptions to colonial rule, but alternative or principal ways in which it proceeded (McElhinny 2005). Particularly in the colonies, the discovery of the child, the medicalization of infant death, the teaching of “scientific mothering,” and other interventions designed to curtail infant
mortality, were part of a “means to establish the imposed political order as the legitimate power and authority” (Manderson 1998:94). As Manderson argues (1998), there may have been a state concern with tempering the costs of imperialism via the provision of welfare services, but this move was neither entirely beneficent nor benign; it served an ideological purpose, to legitimize colonial presence and to anaesthetize the assaults of colonialism. Moreover, as stated above, surveillance and interventions helped to define the levels of difference that made colonialism necessary, or, as Laura Briggs (2002:4) has argued regarding U.S. imperialism in Puerto Rico, “what makes “them” need “our” regulation and governance.” Briggs (2002:197) additionally maintains that humanitarian intentions and the force of the belief that the state (in her case the U.S.) was “doing good” was “a bulldozer that levelled all counterevidence in its path”; however, she does not imply that this was a cynical argument (that is, that the colonial state did not really believe they were improving anything); rather she points to the ways in which even “deadly earnest and acutely felt” arguments of imperialism as improvement authorized any number of interventions, regardless of their negative repercussions.

Importantly, there were many negative effects of colonization, and even of missions of welfare. For example, the surveillance and coercion of women in their maternal capacities, as Jolly (1998b:199) has argued, “promoted a racist denigration of the indigenous mother and a glorification of the white mother” in colonial contexts. Further, there was a fundamental contradiction inherent to colonial methods of improvement and civilizing missions; as Levine (1999:44) contends, beneficence, enlightenment, and freedom “claimed on behalf of colonial modernity could be realised only through coercive means.” Moreover, as Bush (2004:100) argues, there was a
“dissonance between the rhetoric of welfare and the economic pragmatics of Empire.” Not only was medicine historically introduced to solve the health problems created by imperialism itself (Bashfood 2004), but in many sites, despite the prevalence of discourses on infant mortality and other health problems, improving the conditions which generated those health problems was only a priority inasmuch as it furthered (or did not hinder) imperial political and economic aspirations. Thus, at the same time as interest in and attempts at improving infant and maternal health helped to legitimize colonial presence in a variety of sites, the specific strategies of intervention helped to conceal the effects of that colonial presence. Interventions were therefore selected not only for effectiveness but according to the costs of their implementation and the pathways of blame that inspired them and which they in turn would engender.

As a consequence, any assertions regarding the efficacy of altering mothers’ infant care practices in order to reduce infant mortality rates should be tempered with the realization that such interventions should be judged in comparison with other interventions; however, this is a difficult task when ‘bad mothering’ is assumed to be responsible for infant deaths. That is, while CGMO Galea attributed the drop in infant mortality rates in Malta following World War II to mothers’ reformed attitudes and appreciation of medical advice and interventions, this was also a period in which infant welfare programmes were radically extended and ostensibly improved (as noted above). Therefore, the dramatic drop in infant mortality rates in Malta which followed the Second World War could be attributed to either changing attitudes or to actual improvements in infant welfare programmes. However, during this same period a whole host of other changes took place. A new cohort of women, different in many ways from those raising
families prior to the war, may indeed have had different approaches to infant care, and
the presence of more infant welfare centres and the activities of an increased number of
home visitors may have had a significant impact on altering the practices of mothering,
but this was also a period of massive rebuilding of Malta’s homes and socio-sanitary
infrastructure. Further, it was a moment in time in which the so-called demographic
transition was occurring in Malta; that is, there was an overall shift from a period of high
fertility and high mortality to one of low fertility and low mortality, which according to
demographic transition theory is a result of economic development and simultaneous
improvements in public health and medical technology.

Disentangling the impact of each of these changes and developments (and others
which were undoubtedly happening, concurrently), and their contribution to
improvements in infant mortality statistics, and infant health, in Malta is essentially
impossible. Too many changes were occurring in the same historical moment. As a
result, in my opinion, trying to determine exactly what caused infant mortality rates in
Malta to fall following the Second World War is not as productive as attempting to
uncover the extent of variation in infant mortality within Malta during the early twentieth
century, seeking to highlight the multiple and overlapping factors which led to infant
death in Malta’s families and localities, and juxtaposing these findings with colonial
explanations of what was responsible for elevated infant mortality rates.
Chapter 6 – The Perils of Overpopulation

It will be realised that if our mortality had to fall within reasonable limits like that of other countries having a moderate infant death rate, the population of this country would present a formidable demographical problem... With all these weighty considerations, however, as to the proportions, the population of these Islands would assume, these deaths are clouds which darken our health horizon; they have no redeeming qualities, such as those often claimed, with reference to the survival of the fittest and elimination of the unfit. Infant deaths do not eliminate the unfit, the congenitally weak succumb in the first months of life, these deaths occur after the fourth month and it not seldom happens, after a terrible battle between their stamina and the adverse conditions of their environment.

Multiparity is a natural phenomenon prevailing in our midst and Nature is apt to find a balance for our excessive birth rate; much as we deprecate the loss of those we miss, Nature is sure to play its hand.

- Dr. Joseph Morana, An Investigation on Infant Mortality in Malta (1946)

In contrast to the UK and many of its other colonies at the beginning of the twentieth century, where declining birth rates and high rates of infant (and adult) mortality threatened the labour force and the potential prosperity of the nation and/or colony, in Malta, concomitant with local and international concern over elevated rates of infant mortality, colonial writings of the time regularly stressed Malta’s problems with “overpopulation.” In the words of Boissevain (1965:2) “the pressure of a numerous and fertile population on a very limited area has long been one of Malta’s most serious problems.” One of the earliest references to this problem in the colonial archive is Sir Penrose G. Julyan’s 1879 Report on the Civil Establishment of Malta; in this report, he touches on many themes that would be taken up over subsequent years in relation to Malta’s population size and growth. He wrote:

The dense and rapidly growing population of the island finds no adequate outlet for its energy among the Italian-speaking communities, and, by its prevailing ignorance of the language, is almost debarred from participation in the advantages offered to emigrants resorting to English-speaking
countries… it is evident that the agricultural resources of Malta and its neighbouring island of Gozo…including much barren rock, are already immensely overtaxed for the support of their population… while thee [sic] manufacturing and commercial opportunities of the colony, deteriorated in recent years, and constantly threatened by the vicissitudes of trade and the greater prosperity of other localities, are even now by no means adequate to the necessities of the people. The painful struggle for existence to which so large a proportion of the inhabitants is condemned, the alarming increase of pauperism, and the yet more alarming extent of infant mortality, attest the redundancy of the population, for which the only corrective appears to be a large and steady flow of emigration (Julyan 1879:56).

Julyan’s attention to population density and growth, concern regarding the availability of natural resources and employment opportunities, connection between population size, poverty, and infant mortality, and recourse to emigration as the best solution for the problem of overpopulation were all discussed in colonial writings. As such, each will be discussed, in turn, in this chapter. Specifically, this chapter will begin with a discussion of the influence of Thomas Malthus, and his ideas about the relationship between population, poverty, mortality, and personal inadequacy. This will be followed by an overview of attention to population size, density, and growth, as well as the associations between population, health, and economics in Malta, and the pervasiveness of Malthusian language and logic in writings about the island colony. I will conclude by highlighting the eugenic ideas and hierarchies of citizenship implicit in Malthusianism, the ways in which these interacted with discourses about infant mortality and led to the construction of overpopulation as a more pressing concern than infant death in Malta, and how these Malthusian ideas continue to influence contemporary development rhetoric worldwide.
The Influence of Malthus

Attention to (over)population, as well as blaming population growth and density for disease and mortality, joblessness, and resource depletion, are evidence of a Malthusian way of thinking. As Ross (1998:1) has argued, Malthusianism constitutes “a way of explaining poverty, death, and environmental degradation as products of human population pressure on resources.” In his (1798) *Essay on the Principle of Population*, Parson Thomas Robert Malthus created a “paradigm of population” (Willigan and Lynch 1982:21) whose influence was so pervasive and long-standing that it continued to reverberate in twentieth century Malta (and even today, in discussions of ‘population explosion’, particularly in the so-called Third World). Ultimately, Malthus put forth a framework which naturalized poverty and attributed it, along with starvation, to personal inadequacy and excess fertility (Ross 1998); population growth was promoted as the real cause of poverty, and people – particularly the working class, in Malthus’ formulation – needed to “exercise control over their own numbers” to improve their condition (Lis and Soly 1984:198). Further, Malthusian logic called for policy changes, such as the abolition of poor laws, to encourage the poor to limit their family sizes (Ross 1998).

Specifically, in his essay, Malthus (1798) explored the disequilibrium between the capacity of human beings to reproduce and that of the earth to feed them. He stated that “population, when unchecked, increases in a geometrical ratio. Subsistence increases only in an arithmetical ratio”, argued for the “superiority of the power of population to the means of subsistence” and further claimed that “the superior power of population cannot be checked without producing misery or vice.” Moreover, Malthus (1798) maintained:
The passion between the sexes has appeared in every age to be so nearly the same that it may always be considered, in algebraic language, as a given quantity. The great law of necessity which prevents population from increasing in any country beyond the food which it can either produce or acquire, is a law, so open to our view, so obvious and evident to our understandings, and so completely confirmed by the experience of every age, that we cannot for a moment doubt it. The different modes which nature takes to prevent or repress a redundant population, do not appear, indeed, to us so certain and regular; but though we cannot always predict the mode, we may with certainty predict the fact. If the proportion of births to deaths for a few years, indicate an increase of numbers much beyond the proportional increased or acquired produce of the country, we may be perfectly certain, that unless an emigration takes place, the deaths will shortly exceed the births; and that the increase that had taken place for a few years cannot be the real average increase of the population of the country. Were there no other depopulating causes, every country would, without doubt, be subject to periodical pestilences or famine.

This lengthy quote has been included because similar language and logic appears in colonial discussions about Malta: in addition to the attribution of poverty and mortality to excess population, particular attention must be drawn to Malthus’ use of the term “redundant population”, his discussion of the “means of subsistence”, the likelihood of “pestilence or famine” when population growth continued unchecked, and the need for emigration to redress the imbalance.

Attention to Population Size, Density, and Growth

Today, Malta hosts a population of 404,039 (as of 2005), whereas during the period under investigation the population was approximately 200,000 in an area of only 316 square kilometres, thus the population density was roughly 2.5 thousand people per square mile (2,327/sq mile in 1935; 3,339/sq mile in 2005), thereby rendering it “one of the most densely populated island countries in the world” (Lafayette 1997:30). In fact,

54 Today, Malta is ranked seventh in population density with 1,271 people per km² in an area of 316 km², behind Monaco (23,660/km² in an area of 1.49 km²), Macau S.A.R (17,699/km² in an area of 26 km²), Hong Kong S.A.R. (6,407/km² in an area of 1,099 km²), Singapore (6,369/km² in an area of 704 km²),

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in both contemporary and historical writings, second only to references to Malta’s strategic location, is talk of the island’s past and present (over)population, population growth, population density, and high birth rates. Population growth was certainly occurring as can be observed in Figure 6.1, which shows the progressive increase in the number of inhabitants of Malta (males and females). This magnitude of population growth was made possible because the birth rate consistently exceeded the death rate; for example, Figure 6.2 shows that birth rates were markedly higher than death rates through the period under investigation in this dissertation. Nevertheless, the ways in which this was discussed, problematized, and addressed varied throughout the years.

Figure 6.1 – Population Growth, Malta (1842-1995)

(Camilleri 2000)

Gibraltar (4,654/km² in an area of 6 km²), and Vatican City (1,866/km² in an area of 0.44 km²) (United Nations 2007).
For example, in his report on the Malta census of 1891, Tagliaferro gave considerable attention to the island’s population density (which he placed at 1,487/sq mile), which in comparison to other countries, he argued, placed Malta “among the most densely populated countries in the world” (1892:7). Interestingly, in a manner that was not repeated in later reports, he also explained that population density could also be expressed by “proximity”, that is, if the population were distributed evenly over the surface of the Islands each person would possess a hexagon with an area of 2,082 square yards, making the distance between the centres of two adjacent hexagons, or the ‘proximity’ of the inhabitants, 49 yards (Tagliaferro 1892).

While at times these references to Malta’s large population were neutral like Tagliaferro’s, in other instances they were decidedly more negative. As early as 1836, Sir George Cornewall Lewis wrote: “the real grievance of the Maltese, I am sorry to say…lies beyond the reach of the Commissioners and Governments, namely, the
excessive population of the Island” (as quoted in Casolani 1926). Similarly, at the opening of the Session of the Council of Government in 1903, the President of Malta argued:

The rapid increase of the population will, in the near future, become a cause of considerable anxiety. These islands are already far more densely populated than any other portion of the globe, and unless fresh outlets for the surplus population are discovered and taken advantage of, the overcrowding of the towns will become a serious difficulty (1903:31).

Overcrowding and elevated population densities were elsewhere mentioned (e.g. Wignacourt 1914; n.a. 1919), including in the report of the Royal Commission of 1911, where Mowatt and Chalmers also spoke of the “reckless increase in marriage and birth-rate” and the associated increase of the population as reactions to unwise government expenditure.

In the 1920s, talk of Malta’s population as a problem became increasingly common. For example, Buxton (1922:167) described Malta as “extremely overcrowded” (although he later referred to Malta’s increasing population as “very prosperous” [1924], by which he meant very large, showing a degree of ambivalence regarding the merits of population growth). Shepherd (1928:273) spoke of Malta’s “appalling over-population” as the main trouble in the island, and Gladys Peto (1927:59), in her travelogue *Malta and Cyprus*, described Malta as “extremely over-populated.” Similarly, in his report on the 1921 census, then Superintendent of Public Works J.A. Galizia wrote of “the problem of overcrowding” (1922:1) and his opinion that population densities (measured in persons per square mile) did not “afford a proper index of overcrowding” (1922:5). It is

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55 A similar argument was later made by Borg Cardona (1931: V), following the 1931 census; he claimed that “it must be remembered that densities in this composite form are of little interest as real guides to population pressure. As a rule populations are massed together in well defined areas and the density...
perhaps for this reason that, in the 1921 census, of a number of additional measures were introduced designed to account for “density of habitation”, including the proportion of families of varying sizes residing in tenements of differing sizes (Galizia 1922). Henry Casolani, Superintendent of Emigration in the 1920s, regularly wrote of Malta’s population in negative terms: “our Country is overpopulated and there is no space for them” (1923:B7); “the Country is perilously overflowing with people” (1926:C3); “our population is perilously increasing… it is definitely established that we have no room or scope for our present population” (1926:C6). Malta, in his eyes, possessed “hopelessly narrow limits…[and a] teeming population” (Casolani 1926:C6).

Such superlative — and inherently pejorative — language largely disappeared in the early 1930s, perhaps as a result of the worldwide economic depression (such that, perhaps, Malta’s problems could not be entirely attributed to factors operating within the island’s own borders), although attention to the problem of Malta’s growing population returned in the latter part of the decade. For example, Fairfield and Drummond Shiels made reference to Malta’s “crowded towns” (1938:4), and the Economic Advisory Council, after describing Malta as “one of the most densely populated European countries”, reported that Malta’s birth rate was “abnormally high” (1936:4), and later spoke of the problems associated with the rapid increase in population in several British colonies, including Malta (1939).

Discussion of Malta’s population problem was again picked up following the Second World War; in his report on the 1948 census, Stivala (1948:xii) noted that the island’s population was “growing at a faster rate than ever recorded” such that the figures, therefore…tend to underrate the effective density and reduce its value as a relative measure of living conditions.”
population density, particularly in the urban and suburban areas, was “very high compared to other Mediterranean Islands.”

In 1950, Schuster spoke of the necessity of “regulating the population”, and a report from the Colonial Office described Malta as “seriously overpopulated” (1951:8). Similarly, Thomas Balogh and Dudley Seers (both of Oxford), in their report titled *The Economic Problems of Malta*, claimed that “the continuous increase in population” was one of Malta’s “permanent problems” (1955:2). This sentiment echoed that of CGMO J. Galea (1952:99) who stated: “the perennial problem with us is the increase in population.” Interestingly, although he problematized Malta’s “excessive overpopulation” (1952:99), claiming that overpopulation had reached “alarming proportions” (1959:569), Galea later tempered his remarks with the observation that “a reduction in the population of a country is usually looked upon with some misgivings because if carried to extremes, it may undermine the vitality and the energy of the nation and also adversely affect its manpower” (Galea 1959:569).

Moreover, in the *Preliminary Report: Population, Housing & Employment Census of the Maltese Islands November, 1957* (n.a. 1958), it was noted that population growth had slowed, and rhetorical concern shifted to the decrease in the percentage of the population that was gainfully employed, as well as the changing age structure of the population. The author (1958) wrote that these were “two changes which pose not less serious demographic and labour problems”, and attributed the changes in part to the success of the emigration drive. This signals a parallel between the historical case of Malta and contemporary shifts in apocalyptic demography, wherein concerns regarding the

56 Note that here Malta is referred to as a “Mediterranean” island, whereas Fairfield and Drummond Shiels refer to it as a “European” country. See Chapter 3 for a discussion of the varying identities ascribed to Malta and the Maltese.
population explosion (particularly in poorer nations) are supplanted by those regarding population aging (particularly in richer nations).

While it was often unclear as to exactly why Malta’s population growth and density were of such concern to its administrators, at times, the reasons for this anxiety were overtly articulated. Galea’s last comment, above, points to the relationship between population size and economic factors (although in this instance it is positive), which will be discussed below. Malta’s population ‘problem’ was also reportedly a threat to the health of the islands’ inhabitants.

**The Relationship between Population and Health**

In numerous instances, population density and overcrowding were seen as major contributors to elevated mortality rates and morbidity in Malta. For example, in the late nineteenth century, Gulia (1875:9-10) argued that “it is a well established fact, that an unexplained increase in the mortality may from time to time occur amongst dense populations,” and Chadwick (1897) pointed to overcrowding as a contributor to Malta’s high death rate. More specific links between population density and the transmission of infectious disease were articulated in the early twentieth century: “if you get any epidemic, the more you are overcrowded the worse it is” (Mowatt and Chalmers 1911:74), and “the islands are so over-crowded that the effect of an epidemic would be serious” (Wignacourt 1914:168). Following the influenza pandemic of 1918, it was noted that the number of victims in Malta was relatively small “notwithstanding the density of the population” (n.a. 1919:3). Buxton (1922:193), in his early anthropological work, spoke of crowding in Malta as “biologically speaking, unsatisfactory” and warned that “excessive overcrowding may bring its own remedy, either in disease or in a
diminished fertility.” Similarly, following the Second World War, population growth and crowding was argued to be an impediment to the control of disease, particularly tuberculosis (Briffa 1949; Galea 1952).

In addition to epidemic diseases such as tuberculosis, and overall death rates, in Malta overpopulation was often blamed for elevated rates of infant mortality. Julyan’s comments (above) about the “alarming extent of infant mortality” as evidence of the “redundancy of the population” (1879:56) are just one example of this logic. In the majority of instances, elevated rates of infant mortality were tied less specifically to overpopulation; rather they were linked with elevated birth rates. For example, in early health reports CGMO Samut (1905:J4) wrote that “high birth-rate is an important factor in infant mortality”, particularly in the case of deaths due to debility. CGMO Caruana Scicluna (1908:J4) argued that “it can scarcely be doubted that this high mortality is intimately connected with our high birth-rate” and maintained that “it cannot be expected that with our high birth rate, our death rate can fall much lower than it is at present” (1910:J2). He subsequently provided examples from a number of European countries to support this claim that low birth rates were correlated with low death rates, and high birth rates with high death rates (Caruana Scicluna 1910).57 Nearly forty years later, this relationship was reiterated by CGMO A.C. Briffa (1949:xii): “a high birth rate in itself militates against a low infant mortality”; however, he extended the argument to include the adverse effects of overcrowding, professing that “the decrease of overcrowding is an

57 A degree of ambivalence is apparent in Caruana Scicluna’s later claims, however, where a declining birth rate is presented as a negative development: “however much our declining birth rate is to be deprecated, one of its immediate effects will be a fall in the number of deaths under wasting diseases and a concurrent improvement in the total infantile mortality death rate” (1913: I2; italics added).
important and necessary measure in the reduction of infantile mortality especially in our case where families are large.”

Significantly, in other locales where concern centred around the dangers of depopulation, such as early twentieth century Australia, the argument that high birth rates contributed to high infant mortality rates was subject to “trenchant criticism as old-fashioned and untrue” (Mein Smith 1997:31). Further, as explained in the Chapter 4, infant mortality was considered a serious problem in many locations because of low levels of fertility and, in response, populations were encouraged to increase their fertility levels. However, because high fertility was repeatedly cited as a cause of high levels of infant death in Malta, for this project I chose to empirically test the relationship between birth rates and infant mortality rates, over time, for both the Maltese Islands and a second British Mediterranean colony, Gibraltar (Walz and Sawchuk 2007).

For comparative purposes, Figure 6.3 is a scatterplot of birth and infant mortality rates for the British Mediterranean colony of Gibraltar. It appears that fertility and infant mortality are related in this case ($b=7.055$, $R^2=.443$, $SE=34.31$, $F=42.88$, $p<.001$); however, the exact opposite appears in Malta (see Figure 6.4), that is, in years with lower birth rates, there are actually higher infant mortality rates, and vice versa. Not only is “excess” fertility not causing high infant mortality, higher fertility appears to be somehow protective or indicative of years of reduced mortality risk ($b=-8.047$, $R^2=.261$, $SE=46.11$, $F=17.35$, $p<.001$; see Figure 6.4). It should be mentioned that there are problems with empirically testing the relationship between birth-rates and infant mortality rates because the same data (notably births) are included in both the calculation of birth rate and IMR; therefore, if a relationship between birth and infant mortality rates
is observed, this should not be taken as conclusive. That said, a lack of association, considering the contributing data, is quite noteworthy. Furthermore, in Figure 6.4, there are a number of outlying values, years in which the infant mortality rate was below 150 per thousand, which may have skewed these results. Nevertheless, even if the negative relationship observed between birth-rates and infant mortality rates in Malta is suspect, one can definitively conclude that there is not a positive association between the two. Further, with regards to the village of Casal, no correlation between IMR and birth rate was observed (b=-4.782, $R^2=.066$, $p=.187$; see Figure 6.5). Importantly, after empirical testing of the relationship between birth and infant mortality rates in all of Malta’s localities, this non-significant result was shown to be representative of the majority of Malta’s localities, over time.
Figure 6.3 – Yearly Birth and Infant Mortality Rates, Gibraltar (pre-1950)\textsuperscript{58}

\textbf{Yearly Birth and Infant Mortality Rates, Gibraltar (pre-1950)}

The three lines in this figure indicate the least-squares regression line (middle line), along with the mean 95% confidence interval lines. The value “R Sq Linear = 0.443” give the unadjusted $R^2$ value, a value that indicates the percentage of the variation in infant mortality captured by the regression line, but does not take into account added complexity in a model like the adjusted $R^2$ value. Typically used in multiple linear regression, the adjusted $R^2$ allows for a more valid comparison between models because it will decrease when an added variable does not improve the predictive value of the model.

\textsuperscript{58}
Figure 6.4 – Yearly Birth and Infant Mortality Rates, Malta (pre-1950)

Yearly Birth and Infant Mortality Rates, Malta (pre-1950)

Birth Rate, Malta

Infant Mortality Rate, Malta

R Sq Linear = 0.261
However, additional analyses were undertaken to determine the degree of relatedness of birth rates and infant mortality rates, across Malta. That is, an average infant mortality rate and an average birth rate for each census period (1911, 1921, 1931) was calculated for each locality, and the relationship between these two variables was assessed. In this instance, birth and infant mortality rates showed a positive association for only census year 1931 \((b=5.685, R^2=.337, \text{SE}=56.88, F=13.75, p=.001, \text{see Figure 6.6})\), higher birth rates correlated with higher infant mortality rates in this year.\(^{59}\)

\(^{59}\) The locality of Ghaxaq (Asciak) was excluded from the analyses in the years 1921 and 1931 because of an extremely high outlying average birth-rate value (62.72 and 73.89, respectively) which tended to skew the results. Unfortunately, within the archive there is no explanation for why Ghaxaq’s birth-rate was so
However, when the data was subsequently split according to district type, this relationship held only for the suburban districts for two of the census points, 1921 and 1931, although in this instance it was a strong positive correlation (1921: $b=8.114$, $R^2=.845$, SE=16.15, $F=27.31$, $p=.003$, see Figure 6.7; 1931: $b=13.275$, $R^2=.74$, SE=30.13, $F=14.26$, $p=.013$). The urban and rural districts demonstrated no significant relationship between birth and infant mortality rates.\textsuperscript{60} Importantly, as discussed in Chapter 2, outlying results can have a profound influence on regression analyses; thus, this result elevated. Nonetheless, because later analyses revealed Ghaxaq to possess higher than district-average infant mortality rates as well, its higher fertility levels are perhaps indicative of a relationship between birth-rates and infant mortality rates.\textsuperscript{60} The rationale for dividing the data into district type will be elaborated on in Chapter 8. Therein, it will also be shown that birth-rate was included in the regression analyses which were designed to determine the main predictors for infant mortality in Malta overall and in the various districts, and this variable was only found to be a significant predictor in the suburban areas, in census year 1921.
may have been strongly influenced by the outlying birth-rate value for the locality of Sliema. As a consequence, the analysis was rerun without Sliema, and the relationship between the infant mortality rate and the birth rate was no longer significant for the suburban district (1921: p=.134; 1931: p=.143). The relative importance of birth rate, as compared to other factors available for analysis, will be discussed in additional detail in Chapter 8; however, based on these analyses of the relationship between infant mortality over time and space, no conclusive association between the two, in Malta, is distinguishable.

Figure 6.7 – Infant Mortality & Birth Rate, Suburban District (1921)
The Relationship between Population, Health, and Economics

Despite my findings that birth rates were not a conclusive and significant predictor of infant mortality rates in Malta across the island and over time, many early twentieth century observers considered Malta’s elevated fertility and large population as threats to infant and general health and life; however their reasons for making this association were not always apparent. In many instances the pathways through which population affected health were unspecified; for example, the Chief Government Medical Officers failed to explain why high birth rates caused high infant mortality rates. In other instances, proximity engendered by overcrowding was simply linked to infectious disease transmission. However, in some cases population, crowding, health, and poverty were conflated, particularly following the Second World War. For example, CGMO Cauchi (1947:481), looking specifically at infant mortality, wrote:

It is evident that infections must play a very large part in causing death, and the incidence and severity of these infections are conditioned by such adverse environmental conditions, as poverty, faulty feeding and poor housing. Moreover, the families in Malta are usually very large and this makes of overcrowding a major problem, and accentuates poverty while wages are not adjusted to the size of the family. It is not uncommon to find a family of ten living in two rooms with very poor sanitary facilities and with only two or three beds in which to accommodate all the members of the family.

Here, it would seem that Cauchi is arguing that poverty and poor housing – and large families, with poor housing – cause overcrowding, which exacerbates poverty and causes infant mortality. This is not a simple relationship to untangle. CGMO Galea (1952:99) similarly contended:

As long as this excessive overpopulation remains, our problems and anxieties as regards public health will not diminish. Our population has been increasing at a very rapid rate and the indications are that it will continue to do so, at least for the foreseeable future. … [W]e are nearing
the saturation point, and if this state of affairs is prolonged there may be a deterioration in the standard of health.... The steady increase in population, the increasing congestion in the limited area of these Islands, the lack of productive industries and the ever present economic difficulties may exert their influence not only on the prosperity but also on the general health.

Galea’s argument is clearer: he argues that existing overpopulation, population growth, and increasing overcrowding – in combination with a lack of productive industries – is the cause of poverty and poor health; although what he means by “nearing the saturation point” is murky. A similar vague threat was uttered by Mabel Strickland – daughter of Gerald Strickland, former Chief Secretary to Government and Head of Ministry – who herself was the editor of one of Malta’s primary newspapers: she wrote “the population of Malta is increasing apace, and before long, overcrowding and economic pressure must bring things to a head” (1955:17).

What is clear from the above comments is that, in addition to the threat to human health of a large and growing population, Malta’s large population was sometimes seen as a problem for economic reasons. While at times allusions to the relationship between poverty and overcrowding were underdeveloped, in other instances more specific links were drawn between Malta’s population size and the availability of opportunities and/or resources. It should be noted upfront, however, that population size and growth were at times considered as positive economic signs, when this worked to the benefit of the British Empire, as is made evident by one early reference to population growth in Malta:

If, as is claimed, increase of population is a safe index of prosperity, then the general condition of the island under British rule must be considered to have been very flourishing on the whole, for during the period the population, if it has not actually trebled, has far more than doubled (MacMillan 1915:165, in History of the Maltese Islands, by Augusto Bartolo).
Much later, this comment was mirrored by Galea (1959:569), as quoted above, who acknowledged that population reduction might undermine “vitality” and reduce manpower; although he concluded that it was necessary in Malta where overpopulation “raised serious problems to the administration.” Accordingly, in Malta, population growth was overwhelmingly portrayed as having a negative economic impact. For example, Director of Navy Contracts Francis W. Roswell’s (1877:11) report on taxation and expenditure in Malta stressed that rapid population growth, without emigration, “had the most depressing effect upon the price of labour”, such that wages were going down in face of a “redundant population.”61 Similarly, one of the main reasons that the 1911 Royal Commission into the finances, economic condition and judicial procedure of Malta was undertaken, according to Secretary of State Lewis Vernon Harcourt (1911:2), was that “the population of Our Island of Malta has greatly increased, but the wealth of the inhabitants and the demand for labour has not increased in like degree so that many lack employment.”62 Unsurprisingly, considering their mandate, Commissioners Mowatt and Chalmers (1911:27) connected Malta’s population density to “the impossibility of providing adequate employment”, a condition which they argued was “yearly intensified by the high birth-rate.” Later, Shepherd (1928:273) conflated population and employment, arguing that the main “trouble” in Malta was “over-population – not enough jobs to go round.” Similarly, in a report on the economic conditions in Malta by the

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61 This opinion has become so commonplace in contemporary debates on population, labour supply, and wages that its veracity is seldom questioned. However, there remains disagreement among demographers (and others) regarding the relationship between economic growth and population growth and size, that is, whether or not population growth has positive or negative effects on prosperity and development (see the edited volume *The Population Puzzle: boom or bust?* for a range of contrasting viewpoints and policy perspectives surrounding population issues drawn from government reports, think tank studies, scholarly journals, magazines, newspapers, and books [Huggins and Skandera 2004]).

62 The shortage of employment opportunities may be one reason that there was concern about women filling “men’s” jobs, as discussed in Chapter 4.
Department of Overseas Trade, J.B. Greaves (1935:38) argued that Malta’s civilian population density, when compared with the markedly lower densities in the United Kingdom, Belgium, Italy, and Spain, suggested “in striking fashion one of the most difficult problems confronting Malta – viz. how to maintain and provide useful economic activities for her people,” a problem which grew “more pressing every year.”

Just a few years earlier, Peto (1927:59) linked Malta’s overpopulation with unemployment, as well, but also remarked “some percentage of the inhabitants are said to be entirely without resources.” The deficiency of resources, in light of Malta’s population was also noted by Buxton (1924:84) who wrote that Malta lacked adequate water and could not grow enough wheat to support its population. Thirty years later, Malta’s lack of food production was reiterated: Strickland (1955:17) noted that Malta’s entire agricultural output would only produce enough food for approximately 100 days of each year, and Borg Olivier and colleagues (1955) argued that both agricultural and fisheries production could not meet the requirements of the population (see Chapter 8 for a more extensive discussion of agriculture and fisheries returns in Malta). While some emphasized food shortages, T.O. Morris’s mandate was to report on the water supply resources of Malta, and he argued:

Malta is the most densely populated island of its size on the face of the earth, and, as a result of the constantly increasing demands for more water for agricultural irrigation, and more water for defence establishments, the problem of maintaining an adequate piped supply of good quality the year round becomes one of considerable difficulty (Morris 1952:1).

The significance of the statement about the defence establishments’ need for water is brought to the fore by his subsequent comments:

Unlike smaller fortress areas, such as Gibraltar and Heligoland, the problem in the case of Malta cannot be solved by drastic restriction or by
wholesale removal of the civilian population; and, unlike Aden, Singapore, and Hong Kong, there is no nearby mainland under British control from which additional supplies of potable water can be delivered by pipe line. Malta, to be of any value as a fortress, must manage on the resources from its own limited area of ninety-five square miles (Morris 1952:1).

This last quote clearly demonstrates that colonial officials were not merely looking out for the best interests of the Maltese population. Moreover, considering that the imperial establishments were the main employer of the island, even the discussions of the adverse impact on wages of a large population should be interrogated critically. In the same vein, any claims regarding the impossibility of securing adequate employment for Malta’s population must be assessed in light of the colonial government’s interests in the islands and its people – who (regrettably?) they could not remove “wholesale.”

Malthusian Language and Logic in Malta

Malthusian thinking, that is, discussion of population as a problem and linking it to poverty and disease, as well as overt Malthusian language, was evident throughout the period under investigation. Importantly, this was occurring within Malta at a time when, in other locations, population was understood as power, as a key to economic prosperity and imperial domination. The most striking examples of Malthusian thinking and language are found in the proceedings and report of the Royal Commission of 1911. In this report, the commissioners ultimately concluded:

We cannot leave the subject, however, without emphasising the fact that the difficulties, financial and economic, from which Malta is at present suffering can be traced almost in their entirety to the rapid growth of her population without a corresponding increase in their means of subsistence (Mowatt and Chalmers 1911:30).
The latter part of this quote – regarding ‘means of subsistence’ – was brought up a number of times by the Commissioners over the course of the proceedings of the Royal Commission. When interviewing Superintendent of Emigration, Joseph Howard, Mowatt and Chalmers (1911:293) asked “the difficulty in Malta seems to be that the population is continually increasing, and the means of subsistence are not increasing; they are strictly limited. That is the real difficulty is it not?”, to which Howard responded: “that is very natural, because the increase of the population is not proportionate with the increase of the means of our subsistence.” Additionally, Howard (1911:293) admitted that “the population will soon begin starving if it goes on increasing at its present rate.”

Similarly, when speaking with Maltese politician Francesco Azzopardi, the Commissioners reminded him that “the population of Malta increases very nearly 3,000 every year and Malta itself, unfortunately, does not increase at all…. As your population increases they will eat you out of house and home” (1911:355). When Azzopardi (1911) countered that “the increase in the population is proportionate to the increase of means” because a man without sufficient means would not have a family, the commissioners argued “I am afraid you will find that the poorer the population the faster they breed until they starve, all over the world.” Thus, although Azzopardi seems to have taken up Malthusian language, his argument is in opposition to Malthus’; that is, he contended that people would not continue to reproduce beyond their abilities to provide for their offspring. On the other hand, Mowatt and Chalmers seem to have embraced Malthus’ theory that poor people’s failure to control their reproductive potentials led to their own poverty and eventual starvation. Moreover, when Azzopardi conceded that this might be the case in some instances, Mowatt and Chalmers allowed that population growth might
be checked by “ultimately starvation or pestilence... Ultimately nature will cure the
disease, but we do not want to get to that rather tragic solution” – clearly Malthusian
language.

While the Royal Commission presents the most numerous and obvious examples
of Malthusian language, similar statements were also uttered later in the twentieth
century. For example, in his 1945 report to the Fabian Colonial Bureau titled ‘Strategic
Colonies and their Future: The Problems of Hong Kong, Gibraltar, Malta, Cyprus’, E.E.
Dodd (1945:20) wrote “the population of Malta has for many years been pressing hard
upon the means of subsistence.” In addition, although they do not use the term ‘means of
subsistence’ Balogh and Seers (1955:2) expressed a similar sentiment with their
observation that the “growth of population has been much faster than the rate at which
food output has expanded.”

The prevalence of Malthusian thinking is also attested to by A.V. Bernard’s
(1937) first health report as CGMO, in which he felt compelled to argue against this type
of logic. In doing so he quoted extensively from Dr. Mary Blacklock – who worked in
the colonial medical services in India and Africa and was the only woman member of the
Colonial Medical Advisory Committee in the 1930s – in his report. According to
Bernard, she wrote the following:

One might think that it is unnecessary to state this, but recently there has
been in a few colonies a tendency to decry welfare work for women and
children. It has been said, and said in all seriousness, that it is useless to
spend money on this work until the economic and general health
conditions of the country have improved; that a high infant mortality-rate
strikes a balance between the population and the means of subsistence, and

63 Presumably, the report he was quoting was Dr. Mary G. Blacklock’s (1936) Certain Aspects of the
Welfare of Women and Children in the Colonies (London, Colonial Office) [Reproduced from the Annals
of Tropical Medicine and Parasitology], a report which Vavrus (2002) argues was widely circulated and
often cited in administrators’ letters and reports.
that it is better to let children die if the world is not a fit place for them to live in.

At the first glance there may appear to be truth and reason in this argument; but on further consideration it is seen to be superficial observation and fallacious. In the first place, population and means of subsistence do not necessarily balance each other; a low population may be and frequently is due to ignorance on the part of the mothers, even in a land of plenty. Secondly, it ignores the fact that welfare clinics are meant primarily for the education of mothers and not for the treatment of sick children. Thirdly it fails to consider that, when no welfare work is done, many infants will die off, and many of those who survive will grow up in a weak and sickly state. The law of survival of the fittest may hold true for the jungle, but among human beings its truth is less manifest, as the loving care and foresight of even ignorant parents will frequently interfere with its action.

I hold firmly to the belief that the State has a definite duty towards every child which it as allowed to be born within its boundaries, and that, in the words of the Declaration of Geneva [of 1923], ‘The child must be given the means requisite for its normal development.’ (Bernard 1937:170-171)

Her discussions of the importance of educating mothers and the state’s responsibility towards the child recall issues discussed in previous chapters of this dissertation, and her references to mothers’ “ignorance” and the importance of improving economic and general health conditions will be taken up in later chapters; what is important for this argument is that Blacklock (and, by quoting her, Bernard) is employing – albeit arguing against – prominent Malthusian and misguided Darwinian discourses regarding the relationship between means of subsistence, population, and mortality as well as the mechanisms whereby the fittest survive. Nevertheless, it is important to note that Bernard ultimately concluded that, of the factors responsible for Malta’s elevated infant mortality rate, the “foremost to be taken into account [was] the great density of population on these islands of limited space and limited resources” (Bernard 1937:171), thus buying in to the larger Malthusian perspective. Similarly, ten years later, Morana’s (1946:6) need to argue against the belief that infant deaths would “eliminate the unfit”
and his ultimate conclusion that “Nature is apt to find a balance for our excessive birth rate” (see full quotation at the head of this chapter) point to the continued influence of Darwin and Malthus.

In keeping with the Malthusian perspective, the best solution to the problem of overpopulation, in the eyes of the Royal Commissioners as well as later administrators, was emigration. Mowatt and Chalmers (1911:293) made repeated references to the necessity of encouraging emigration; they saw “systematic emigration on a large scale” as the most important means of addressing economic issues, such that “emigration appears the most important subject we have to consider” (Mowatt and Chalmers 1911:355). Further, they stated “your only remedy for the increase in population, then, is emigration” (Mowatt and Chalmers 1911:293). Howard (1911:293) was convinced that “emigration must be, from all points of view, encouraged” and that it was the “only solution for this very difficult problem.” Even Azzopardi (1911:355) conceded that “the necessity of emigration, I think, is felt by everybody, and I think that everybody would like to see emigration carried out on a large scale”, but he contended that neither the government nor the prospective emigrant had the means to pay for the expense of emigrating.

Throughout the remainder of the period under investigation, emigration was repeatedly returned to as a means of addressing the population ‘problem’ of Malta. It was seen as a “remedy which [had] been to some extent effective in the past” in Malta (Economic Advisory Council 1939:44). As part of a committee representing the interests of Malta at a conference on the commercial and industrial policy of the British Empire following World War I, Parnis and colleagues (1917:8) argued:
the question of over population may be solved by a regular system of emigration, we hold that sufficient care has not been taken in the past to make our manhood more useful to the Empire and to give that technical instruction and education which would allow us to compete favourably with other British subjects or with foreigners.

Similarly, according to Malta’s Superintendent of Emigration Henry Casolani, “the great lands of the Empire [were] crying for souls.” (1923:B4). As such, “sparsely-populated countries” (Julyan 1879:56) were thought to “need population,” (Casolani 1925:C4). Further, as Casolani’s successor in the Department of Emigration argued, this would also effect “a more consistent distribution” of the population of the British Commonwealth as a whole; therefore, the “great Dominions” of Australia (and, to a lesser extent, Canada) were deemed “the best outlet for [Malta’s] surplus population” (Arrigo 1936:109).

This shows, once again, the primacy of British Imperial interests; not only is overpopulation a problem within Malta, but its solution, emigration, would help make the Maltese people “more useful” to the Empire – as presumably they were not particularly “useful” while residing in Malta itself. Moreover, as Ross (1998:53) has argued in the case of Ireland, the imperatives of colonial rule resulted in the creation of an economy which “tended to export labour in the absence of the productive means to employ it,” and the resulting outflow of emigrants serves to reinforce the popular view, shaped by Malthusian thinking, that the county was, and is, characterized by excess population. Similarly, in Malta, in lieu of developing local industries and increasing employment opportunities within the island, which may have negatively affected Imperial interests and access to inexpensive labour, the ‘need’ for emigration was stressed, and the outflow of people from the islands in search of opportunities abroad reaffirmed that Malta was indeed overpopulated. However, as discussed in Chapter 3, many of the countries –
including the British Dominions – to which the Maltese sought to emigrate did not embrace them with open arms, in part because they were not considered to be full-fledged British citizens.

**Overpopulation, Infant mortality, and Hierarchies of Citizenship**

According to Davin (1978:10), in the nineteenth and early twentieth century, misguided Darwinist notions of the struggle for existence, combined with Malthusian conceptions of the dangers of excessive population, were used by advocates of eugenics “who wanted a selective limitation on population growth to prevent the ‘deterioration of the race.’” That is, while depopulation, the need to ‘invest in’ infants and children, and the associated preoccupation with infant mortality were major national and colonial concerns, “short supply of the commodity was not the only problem: there was the question of quality as well as quantity” (Davin 1978:15). That is, the *right* people needed to have more babies. The *right* infants needed to survive: future workers and members of the imperial race. And, despite the repeated promotion by Malta’s emigration officials of their British identities, within the British hierarchies of race and citizenship the Maltese were not considered as full members of the imperial race.

Ross (1998) describes the way in which eugenics came into sharp focus in the 1870s and 1880s with the work of (Charles Darwin’s cousin) Francis Galton. Whereas Malthusianism carried the implicit assumption that the poor were unequal to the more privileged, eugenics rested on the assumption that these moral deficiencies were innate, that the poor were inherently inferior as a result of heritable traits. Thereafter, both diseases (as we today understand them) and social problems were medicalized and attributed to “dubious inborn traits” (Ross 1998:77). Within Malta, there are two overt
examples of this type of eugenicist language, both of which attend to the health of infants and children. Just as eugenics was gaining ground in the metropolis, Chief Police Physician A. Ghio (1876:21), after describing the delicate and tender nature of infants, their environmental and nutritional requirements, and their susceptibility to injury, wrote:

One may, then, imagine what must be the effects on infants, especially on those born with a vicious organism transmitted to them by their parents, when they are badly managed, badly nourished, and, in addition, empoisoned by the impure air of the dwellings above described. These are, above others, the causes of the developmental and constitutional diseases of infants, and of their liability to zymotic disease, and consequently of the great mortality among them in these islands.64

Moreover, the existence of inherent deficiencies was later reiterated by Fairfield and Drummond Shiels (1938:101) in their discussion of the training of institution children, children raised in Maltese orphanages; they contended that “it is often assumed that these children fail, as they certainly tend to do, because of bad heredity or natural perversity”, factors which the authors argued “may admittedly be present.” In addition to being injurious to the health of those afflicted, these inherent deficiencies were seen to threaten the entire social order, as the “excessive fertility” of the poor was thought to contribute to a deterioration of the “racial stock” of a nation; consequently, as stated above, many eugenicists (Dalton included) promoted the selective breeding of those thought to possess more “natural ability” or “civic worth” to increase their genetic representation and to improve the physical and moral attributes of a population (Ross 1998:60).65

64 Notably, in this quote Ghio also points to the effects of infant care practices and socio-sanitary conditions, which will be discussed in more detail in Chapters 7 and 8.

65 According to Birn (2002), more “positive eugenics” also existed (for example, in Latin America) which stressed the reforming of social and moral environments of parents and their children – including an emphasis on sanitation and ‘scientific’ conception and childhood – as a means to overcome one’s unfavourable genetic background. Thus acquired traits would be passed on to future generations, thereby improving society as a whole. This will be taken up in further detail in Chapter 8.
While overt examples of eugenic discourses in Malta are few in number, I would argue that the influence of eugenic ideas is suggested by the very argument that Malta was overpopulated. That is, this seems to be a clear case of “stratified reproduction,” a term employed by Ginsburg and Rapp (1995; as well as Colen 1995) to describe the power relations whereby some categories of people, and not others, are empowered to reproduce and nurture, and the ways in which “some reproductive futures are valued while others are despised.” Thus, despite the rhetoric about “appalling” rates of infant mortality, in the face of the more pressing problem of overpopulation, Maltese infants’ lives were somehow deemed less valuable and not worth saving. Importantly, if Maltese infants had been required as future labourers, or if Maltese men and women had been considered members of the imperial race, then perhaps the ‘problem’ of infant mortality would have been judged more serious than the ‘problem’ of over-population. Perhaps, if Maltese lives were valued in this way, the high birth rate and rapid growth of Malta’s population would have been portrayed as a sign of prosperity and potential rather than a threat to development, health, and wealth. Instead, Malta’s primary problem was seen to be overpopulation rather than under-population, excess fertility more than elevated infant mortality (as opposed to many other sites), as is evidenced by numerous allusions to the value of infant mortality as a check on population growth.

In Malta, in a number of instances, remarks were made which alluded to the ways in which a high birth rate were offset by a high death rate. Particularly during the 1930s – perhaps because of the shortage of employment opportunities due to the depression – this link was made explicit; for example, in a report examining medical and public health administration in Malta, Sir Walter B. Johnson (1937) suggested that, in Malta, a high
birth rate was “partly balanced” by a very high infant mortality rate. In Greaves’ (1935:38) report on economic conditions in Malta and Cyprus, population growth in Malta was perceived to be a more pressing concern; as he stated “in spite of an infant death rate” of over 250 per 1000 live births, the population was continually increasing (emphasis added).

During this same period, it was also implied that decreases in infant mortality would have negative repercussions as a result of Malta’s problems with population size and growth. For example, the rapid increase in population in Malta, and some other British dependencies (Ceylon, Basutoland, Trinidad, St. Vincent, Barbados, and Jamaica), described as “in varying degrees acute” by the Economic Advisory Council (1939:43) was seen as a “problem [that was] likely to become more serious as infantile and general mortality decrease[d].” Similarly, as noted at the head of this chapter, ten years later Morana (1946:6) argued: “if our mortality had to fall within reasonable limits like that of other countries having a moderate infant death rate, the population of this country would present a formidable demographical problem.” Looking back to previous decades, writers in the 1950s and 1960s argued that previously infant mortality was considered to be less worrisome than over-population. For example, in a chapter on antenatal services in Malta, Eminyan (1956:228) wrote:

Until recently the loss of kids wasn’t seen as a big problem... “Why bother about loss of lives” some people would ask, “what matters if fewer babies survive to the first twenty-four hours or their first month, when the problem that faces Malta to-day is one of a high birth rate and overpopulation?”

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66 McElhinny (2005:185) observed an opposite attitude in the Philippines; in a 1908 Islands Bureau of Health report, it was noted that, unless brought about by epidemic diseases, the high death rate among infants “does not alarm the health officer, as he knows that it will be offset by a higher birth rate”; in this instance the larger problem seemed to be the need to balance a high death rate with a higher birth rate.
Similarly, Ganado (1964:240) later wrote that, in light of the high birth rate and the existing ‘problem’ of over-population, infant mortality was thought of as a “safety valve”:

Not until 1943 was public opinion in Malta led to support the effort for lowering the infant death rate. Previous appeals had been meeting with a cold response. Public opinion had been alarmed by increasing over-population and had tolerated the high infant mortality rate as a safety valve. But reaction was provoked by the unprecedented death rate of the war. More enlightened views began to prevail.67

It is unclear to whom Eminyan and Ganado were attributing these opinions, whether they were speaking of Malta’s population in general, or about Maltese or British officials; however, based on the above quotes, their statements regarding the relationship between infant mortality and population size appear well-founded. That is, within Malta, there were numerous instances in which the reduction of infant and adult mortality was not entirely depicted as a positive development, but was seen as contributing to the greater problem of overpopulation.

Conclusions

In her work in Puerto Rico, Laura Briggs (2002) noted a preoccupation with overpopulation similar to that observed in the Maltese Islands. Although she does not explicitly flag Malthusianism in her analyses, Briggs’ work on historical and contemporary aspects and effects of overpopulation discourse demonstrates that the legacy of Malthus was (and is) operating in Puerto Rico. What she does note, plainly, is the pioneering influence of U.S. eugenicists like Raymond Pearl, under whom the

67 This reference to “enlightened views” demonstrates that colonial attitudes — and derogations of the Maltese population — still prevailed into at least the 1960s. This comment is also reminiscent of Galea’s claims, described in Chapter 4, that following the Second World War mothers were more receptive to medical interventions aimed at improving infant health and preventing infant mortality.
language of overpopulation “dominated the political and public health landscape in Puerto Rico in the 1920s and 1930s” (Briggs 2002:8). Much like Malta, poverty and slow industrial and economic “development” were blamed on overpopulation and excessive birth rates; moreover, Briggs argues that this depiction has carried over into contemporary discussions of Puerto Rico and Puerto Ricans. That is, in contemporary debates on poverty in the Third World, U.S. development rhetoric attributes this poverty to overpopulation rather than the legacy of colonialism – a connection that she argues is, in part, due to the participation of the former colonial powers in the North Atlantic Treaty Organization (NATO). Moreover, Briggs (2002:13) argued that “the term overpopulation could drive rhetoric and policy…without any empirical evidence that all that rising population causes – or was even historically correlated with – rising rates of poverty, unemployment, or any of these things.” Specifically with regards to the history of Puerto Rico, Briggs (2002:8) notes that in the 1940s and 1950s, in discussions of what was wrong with the island’s economy “U.S. colonialism did not emerge as a politically popular answer but “overpopulation” did. Women were having too many children and there was not enough food to go around.” Other examples of Malthusian thinking can be found in the work of Mullings (1995) on poor African American women considered to be a “redundant population” whose poverty was blamed on their excess fertility; Stivens (1998), who noted national and international bodies’ emphasis on unchecked population growth as a cause of poverty and underdevelopment in Malaysia; and Bush (2004), who found that India’s poverty, malnutrition, and famine were seen to be caused by a ‘population explosion’ – an explanation which she regarded as deterministic and evaded
any critique of imperial rule. Thus, it would appear that Malthusian thinking is alive and well.

Not only does the case of Puerto Rico provide some interesting parallels with that of Malta, but Briggs’ discussion of the tendency to blame overpopulation rather than colonial policy and exploitation warrants attention. In his work, Ross (1998:32) marked Ireland as the “colonial prototype”, a colony that “set the stage for future colonial enterprise” and a model that defined subsequent colonial encounters. There, from the early nineteenth century, Malthusianism labelled Ireland as “a resource-poor country whose poverty, agricultural crises and general unruliness were principally the result of surplus population” (Ross 1998:31). In Ross’s eyes, England created a role for Ireland within the larger British economy that made agricultural crises – like the infamous Irish potato famine – endemic; therefore, rural distress and periodic famine were not so much the inevitable effects of a large and growing population as imperial rhetoric implies, but the results of colonial rule. However, by arguing that poverty was the “natural” product of the fertility of the poor, rather than of the social and economic system, Malthus’ law of population acquitted the property-owning class of accountability, and poverty became a matter of individual, not systemic, responsibility (Ross 1998). Thus, in addition to leaving us “with an unremitting anxiety about ‘over-population” (Ross 1998:6), Malthusianism guaranteed the “innocence of colonial rule” (1998:31), and – today – continues to serve as a “necessary element of the mystification in the dynamic of capitalist ideology” (1998:6). To follow this argument through, pressure of the “population” on the “means of subsistence” and overall poverty are necessary to make the poor work cheaply, and as such are fundamental to capitalism (Ross 1998); therefore,
from a Marxian perspective, overpopulation is not an objective external condition but consequence of the social organization linking various different sorts of people to the means of production (Tilly 1984). This same argument can be applied in the case of early twentieth century Malta: whereas the colonial government blamed overpopulation and excess fertility for Malta’s poverty and elevated infant mortality rates, this obfuscated the role of colonialism and underdevelopment in the creation of an economy that could not sustain the island’s inhabitants and an environment that was perilous to their health. However, in the words of Ross (1998:56) “nothing could compare to blaming the poor themselves”; therefore, overpopulation was depicted both as a problem in and of itself and as a cause of the additional problems of poverty and ill-health in Malta.
Chapter 7 – Risky Decisions at the Level of the Family

The much abused ignorance of our mothers shows that it is not responsible for our high infant death rate.

Artificial feeding especially in subtropical climates unintelligently and carelessly carried out is bound to be responsible for infant deaths; this way of feeding the infant stands in direct ratio to the financial position of the family, so that a low income is a blessing in disguise as far as the nutrition of the newborn is concerned because as long as expensive artificial food can be met by the family’s income, the mother is sure to stuff it down her baby’s throat, creating a vicious circle which ends at her baby’s grave.

The adverse influence of multiparity on infantile mortality is to be expected; because the bigger the number of births, the greater the population at risk; it also influences the infant mortality through environmental causes such as the inability of the mother to care for too many children at the same time a numerous family very often can hardly be made to fit in with the family income, beside, the weakness, which naturally ensues after each successive birth does not leave to the mother sufficient strength to cope with the increased amount of work.

- Dr. Joseph Morana, An Investigation on Infant Mortality in Malta (1946)

In Chapter 6, the relationship between infant mortality and “overpopulation” was discussed and analyzed at the level of the population. This chapter shifts the focus from Malta as a whole to the community of Casal in order to examine infant mortality at the level of the family, and it is here where the two discourses most clearly intersect, because the hazards of an “abnormally” high birth rate and of excessive fertility are ultimately statements about individual inadequacy and the dangers of poor people having “too many” children. Nevertheless, in spite of the dual-preoccupation with overpopulation and infant mortality in Malta, aside from Morana’s (1946) comments outlined in Chapter 1 and quoted at the head of this chapter, there is surprisingly little written on the impact of multiparity on infant survivorship, and there are few comments about the large size of Maltese families.
Or, perhaps more accurately, there is unsurprisingly little written – considering the position of the Catholic Church in Malta, which has historically encouraged large families, discouraged birth control, and outlawed abortion. Even into the early 1960s, Father Borg Olivier, during meetings held for newly-weds and young mothers (later printed as “Some Suggestions to newly-weds and young mothers and the answers to the Questions they asked”) spoke of only four cases in which “planned parenthood” – using the “safe period or the Rhythm Method” – was acceptable to Pope Pius XII:

1. Where the doctor advises a couple against having children [b/c of health reasons]
2. When there is great probability that a couple will have defective children or pass on serious physical diseases to their offspring;
3. When economically (for example, inadequate salaries, exorbitant rents, insecurity of income, high cost of living) it is not advisable to have many children
4. When social conditions (for example, poor housing, living with inlaws, the licit desire to raise the children according to the family’s social position, the difficulty in fulfilling the duties and obligations of parenthood) do not permit having a large family (Borg Olivier 1963:35).

While these exceptions certainly cover a lot of ground, that ‘planned parenthood’ was seen as otherwise unacceptable is nonetheless significant, as is Borg Olivier’s conclusion that “large families, of course, have always been the Christian ideal, and there are many families in Malta to prove that God’s help never fails to parents of good will” (Borg Olivier 1963:35). With this statement, along with the his use of terms like “permit” with regards to having a large family, he makes it clear that the limitation of family size was only acceptable under the most extreme circumstances.

Recall, as discussed in Chapter 3, the Catholic Church was (and is) a very powerful social and political force in the island; therefore, both colonial officials and Maltese politicians and administrators were oftentimes wary of offending the Church, and
would generally only take a position in opposition to the Church in instances of extreme importance or under duress. As such, it would have been politically dangerous to vocalize disdain for larger families or to systematically encourage smaller families or birth limitation in this context.  

Disparaging comments do exist, and much like the citations relating to population size and growth in Chapter 6, references to Maltese family size and fertility reveal value judgments, casting the tendency towards (and the desiring of) large families as irrational and negative. For example: “families in Malta tend to be enormous” (Shepherd 1928:269), and “the Maltese breed like rabbits” (Bloomfield 1935:205). It is perhaps the positions of Bloomfield and Shepherd as English citizens, presumably writing for a metropolitan audience, that allowed these two to be so bold in their disdain for large families, as comments by Malta’s (likely Maltese) CGMOs are much more cautious in their tone. For example, while Chief Government Medical Officer A.C. Briffà (1949:xii) extended the association between over-population and infant mortality to include the effects of overcrowding and/or family size, stating “the abolition or at least the decrease of overcrowding is an important and necessary measure in the reduction of infantile mortality especially in our case where families are large”, he is careful to place the discursive focus on the perils of overcrowding. Similarly, in the 1930s, Bernard’s (1937:238) statements, that the bulk of infant deaths were the result of “poverty and ignorance coupled with numerous and frequent pregnancies” and that mothers “have not the possibility to bestow sufficient personal care on their babies when there are so many

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68 This would also have been inconsistent with one of the primary catalysts and rallying points of the preoccupation with infant mortality: the problem of depopulation and fertility decline in a variety of locations throughout the world (as discussed in Chapter 4). Considering the ways in which discourses on infant mortality within Malta were informed by influential texts written for and about the United Kingdom, it may have been difficult for Malta’s administrators to reconcile these differences.
children of tender age to be looked after”, foreground the impact of ignorance and maternal abilities rather than family size.

Despite their caution, the discourses of infant mortality and overpopulation do intersect with these comments on the impact of large families; consequently, I thought it important to assess the impact of family size (among other factors) on infant survivorship by examining individual families within one village in Malta. This chapter therefore begins with a brief description of the village of Casal before moving on to a quantitative assessment of the factors that shaped and determined the risk of infant death in the families in this community. The statistical results will then be counterbalanced by a discussion of the conclusions reached by colonial administrators, which were based in assumptions and attributions of ignorance, apathy, fatalism, and non-modernity, and my own interpretations and speculations on the meaning of these results.

The Village of Casal

The village of Casal is located in the south-western region of Malta, and hosted a population of approximately 1000 people during the period under study, which later grew to 2000 largely as a result of displacement of people from the more urban centres during the Second World War (see Figure 7.1). Much like the rest of Malta through the time period under study, the primary occupation of Casal’s inhabitants was farming, with residents employed on small family-run farms or market gardens (Fairfield and Drummond Shiels 1938). Of the 109 complete families who formed the basis for subsequent analyses, 96 families had at least 1 birth, the average age of marriage was 23

69 Again, to protect the anonymity of the village under investigation, it will be called “Casal”, the Maltese word for village.
(23.4) and 27 (27.1) for women and men, respectively, the average number of births was 6 (6.12), with the total number of births amounting to 667.

Figure 7.1 – Population: Casal, Malta

Demographers have come to recognize the Hutterite community as an appropriate comparative population for examining fertility, as they are the classic example of “natural” fertility (Heckman and Walker 1987; Larsen and Vaupel 1993). Compared to the Hutterites, the Maltese in the community of Casal seem to be having more of their children at later ages in part because of their later age at marriage, but this also indicates a certain degree of fertility control (see Figure 7.2).
Infant Mortality in Casal

Health reports recorded a yearly birth-rate, death-rate, and infant mortality rate for Casal. The fluctuation apparent in Figure 7.3 is attributable to the relatively low number of births and deaths in this small community; as such, a 5-year moving average was calculated to facilitate comparison with infant mortality rates in Malta, overall. Figure 7.4 demonstrates that reported rates of infant mortality in Casal were comparable to those for Malta overall (and for many of its localities), thus rendering it a valuable community to utilize as a case-study of micro-level conditions, and their effects on infant mortality.
As the bulk of the analyses of Casal’s infant mortality profile are based on information gleaned from the family reconstitution data (F1, F2), reported rates of infant mortality were compared to those gathered from the parish registers. The average of the reported infant mortality rates, for the time period, was 278 per thousand, whereas, the reconstitution data yields a slightly lower average IMR of 253. The lower rate recorded in the family reconstitution data is likely the result of the initial few years after 1900, in
which only the first few births following marriages which took place from 1900 onwards were captured – with no higher-order births (the importance of this will be made clearer below). Once these higher-order births began to be included, the family reconstitution data appeared to track the reported rates of infant mortality relatively well, thereby confirming the reliability of parish registers in capturing infant deaths (see Figure 7.5).

Figure 7.5 – Infant Mortality, Casal (1900-1938), 5 year moving average

![Infant Mortality, Casal (1900-1938) (5 year moving average)](image)

Much as for Malta overall, roughly ¼ of infants in Casal died before reaching their first year of life. In effect, 67 percent of the complete families (64 of 96 fertile families) recorded at least one infant death, the average number of deaths was two (1.76), and the average percentage of infants that died, per family, was 22 percent. Of these deaths, 18 percent were neonatal, occurring within the first 28 days of life, amounting to a neonatal mortality rate of 46.5 per thousand. In contemporary populations neonatal deaths (occurring during the first 28 days) are linked to the health of the mother and the care she receives during pregnancy and delivery; whereas, post-neonatal deaths (those occurring between one and twelve months) are typically the result of infectious diseases such as acute respiratory infections, diarrhoea, measles and malaria (Hall 2005). Thus,
the relatively small proportion of neonatal deaths as compared to post-neonatal deaths is
evidence that the vast majority of Casal’s infants were dying as a result of infectious
disease.

Importantly, if a family recorded at least one infant death, the average number of
deaths was 2.64 and the percentage of infant deaths was 32.3 percent – which amounts to
an IMR of 323 per thousand. Similarly, when comparing infants who died (169 of 667
births) to those who survived the first year of life, these infants came from families in
which, on average, 3.81 infants died (as compared to 1.92 for surviving infants), and the
percentage of infant deaths was 40.4 percent in these families (as compared to 20.8% for
surviving infants). This demonstrates a degree of clustering in Casal’s families such that
the risk of infant death was not spread evenly across all infants or all families. The aim
of this chapter is to determine correlations between cases of infant death and a variety of
family-level factors in an attempt to explain some of the reasons for the observed
clustering.

Because some families did not experience any infant deaths, a t-test was
performed to compare those families in which all infants survived the first year of life
(N=32) to those families that experienced at least one infant death (N=64). Again, all
available factors were included in the analysis: year of marriage, mother’s age at
marriage, father’s age at marriage, average birth spacing, and family size (measured in
number of births). Significant differences were observed for both family size (no infant
deaths: mean = 4.75 births, Std. Deviation = 2.69; any infant deaths: mean = 8.05 births,
Std. Deviation = 3.05; t=-5.185, p<.001), and average birth spacing (no infant deaths:
mean = 36.46 months, Std. Deviation = 14.71; any infant deaths: mean = 25.39 months, Std. Deviation = 7.43; t=4.802, p=.001) (see Table 7.1).

In addition, individual-level data was available for each birth (N=667); therefore a second t-test was performed to compare those infants who survived the first year of life (N=498) to those infants who died before one year of age (N=169). All available factors were included in the analysis: year of marriage, mother’s age at marriage, father’s age at marriage, mother’s age at birth of child, father’s age at birth of child, sex, month of birth, year of birth, birth order (i.e. child number), birth interval (i.e. months since birth of previous child), sex of previous child, and family size (i.e. number of births). Significant differences were observed for *birth order* (survived first year: mean child number = 4.53 in birth order, Std. Deviation = 3.00; died within first year: mean child number = 5.41 in birth order, Std. Deviation = 2.96; t=-3.285, p=.001), *family size* (survived first year: mean = 6.44 births, Std. Deviation = 2.87; died within first year: mean = 7.37 births, Std. Deviation = 2.45; t=-4.001, p<.001), and *birth interval* (survived first year: mean = 26.92 months, Std. Deviation = 15.35; died within first year: mean = 23.84 months, Std. Deviation = 13.39; t=2.196, p=.029) (see Table 7.1).
Table 7.1 – Factors Assessed for Correlation with Infant Deaths

<table>
<thead>
<tr>
<th>File</th>
<th>Family Reconstitution #1 (F1) N = 109 Families (96 fertile)</th>
<th>Family Reconstitution #2 (F2) N = 667 Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Variable</td>
<td>Any infant death in family</td>
<td>Survivorship (to 1 year)</td>
</tr>
<tr>
<td></td>
<td>- 64 families had at least 1 infant death</td>
<td>- 169 infants did not survive</td>
</tr>
<tr>
<td>Common Factors Tested</td>
<td>Number of infant deaths in family</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Marriage date</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mother’s age at marriage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Father’s age at marriage</td>
<td></td>
</tr>
<tr>
<td>Family Size (number of births in family)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Factors Tested</td>
<td>Interval between marriage and first birth</td>
<td>Percentage of infant deaths in family</td>
</tr>
<tr>
<td></td>
<td>Intervals between each birth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Average birth spacing</td>
<td>Mother’s age at birth</td>
</tr>
<tr>
<td></td>
<td>Percentage of infant deaths in family</td>
<td>Father’s age at birth</td>
</tr>
<tr>
<td></td>
<td>Birth order (i.e. child number)</td>
<td>Sex</td>
</tr>
<tr>
<td></td>
<td>Year of birth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Month of birth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Birth interval (mos since prev. birth)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sex of previous infant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Survivorship of previous infant (to 1 year)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>If infant did not survive:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Month of death</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Age at death</td>
<td></td>
</tr>
</tbody>
</table>

* grey cells indicate significant results

It is worth noting that no sex-bias was observed with regards to infant survivorship; that is, neither females nor males appear to have been at greater risk of death in the first year of life. Other studies have reported preferential treatment of one sex or gender: for example, in some instances males will be breast-fed and females weaned earlier (Kemkes 2006), or lack of investment in children will follow gender lines (Ballweg and Pagtolun-An 1992). Likewise, the year of marriage, the year of an infant’s birth, and the respective ages of that infant’s parents at marriage and his/her birth proved to be similar irrespective of an infant’s death or the presence of an infant death in the
family. More detailed analyses were therefore performed to assess the relative importance of birth order, family size, and birth spacing on infant survivorship within families and for each individual infant.

**Birth Order**

As stated above, there were significant differences in the birth order measures for infants who died and those who survived the first year of life. In part, this may be due to the survivorship differentials between first-born infants and higher-order births, as only 17 percent of first born infants died, whereas, 27 percent of subsequent infants did not survive the first year of life. A chi-square test was subsequently performed to assess whether or not there were differences in infant survivorship according to birth order, and significant differences were observed, with higher birth orders showing increased probability of death (Pearson Chi-Square=27.3, df=14, p=.018).

However, in light of the fact that infant deaths were also more likely to occur in larger families, and smaller families would simply not contain infants of higher birth orders, it was deemed necessary to control for family size in this analysis. As such, the individual-level data (F2, N=667) was split into three groups: families with 1-4 births (N=71), 5-8 births (N=177), and 9 or more births (N=250), and the chi-square test was re-run. Although a degree of variation was apparent, no significant differences were observed according to birth order, for each of the family size categories; for example, in a family with 9 or more births, the ninth infant seems to be at no greater risk than the first. Thus, it would appear that the increased risk for higher-order births is related to their occurrence in larger families.
Family Size

If one were to look at the relationship between number of births and number of infant deaths within each of the families included in this analysis (F1, N=96) in a very simplistic way a strong relationship would be observed, with more infant deaths occurring in families with more births (see Figure 7.6). However, in light of the fact that the population at risk is larger, this is not particularly meaningful.

Figure 7.6 – Number of Births & Infant Mortality, by Family

Consequently, rather than measuring only the number of infant deaths, a proportion was calculated; that is, the percentage of infants who died in each family was determined. Thereafter, the relationship between the number of births in a family and the
percentage of infant deaths was assessed by means of linear regression, and a correlation
was observed ($b=2.428$, $R^2=.170$, SE=17.87, $F=19.25$, $p<.001$; see Figure 7.7). This
indicates that larger families not only have a greater absolute number of infant deaths, but
the proportion of infant deaths in these larger families is also higher than in smaller
families. The analysis was subsequently redone, but removing the families in which no
infants had died, to assess whether or not this relationship held. In fact, it did not; when
examining only those families who experienced an infant death, there was no correlation
between the percentage of infant deaths and the size of the family ($R^2=.008$, SE=14.91,
$F=.52$, $p=.475$; see Figure 7.8). However, in light of the fact that this investigation is
attempting to explain, in part, why some families were experiencing infant deaths and
others were not, I decided to include families with no infant deaths in subsequent
analyses. It is my contention that these families are integral, not extraneous, to the
analysis; therefore, they should not be eliminated. Nevertheless, with the original $R^2$
value indicating that the regression line for number of births could explain only 17% of
the observed variation in the percentage of infant deaths, the predictive power of this
model is not particularly strong; therefore additional analyses were undertaken.
Figure 7.7 – Infant Mortality & Number of Births, by Family (N=96)

Infant Mortality & Number of Births, by Family (N=96)

Percentage of Infants Deaths, in Family

Number of Births, in Family

R Sq Linear = 0.17
Because larger families exhibited higher percentages of infant deaths, I considered it important to determine if there were other differences between larger and smaller families which may have accounted for differing rates of infant mortality; therefore, I divided the family-level data (F1) into three groups, according to the number of births in the family: 1-4 births (N=27 families), 5-8 births (N=35), and 9 or more births (N=34). An analysis of variance test (ANOVA) was run testing all available factors in the analysis: year of marriage, mother’s age at marriage, father’s age at marriage, average birth spacing, as well as two measures of family-level infant mortality (total number of infant deaths in family, percentage of infant deaths in family). Significant differences
between the three family size categories were observed for year of marriage, age of mother at marriage, age of father at marriage, average birth spacing, and both infant mortality measures (see Table 7.2). Notably, the number and percentage of infant deaths was smaller in smaller families. Additionally, smaller families had later marriage years, older ages for both mother and father, and longer birth intervals. This latter relationship between family size and birth intervals can be observed by plotting the number of births against the average birth interval, as well, with larger families presenting shorter birth intervals (b=-1.701, $R^2=.221$, SE =10.06, F=25.58, p<.001; see Figure 7.9).

Table 7.2 – Factors Assessed for Variation According to Family Size

<table>
<thead>
<tr>
<th>Factor</th>
<th>Family Size</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>F</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of Marriage</td>
<td>1-4 Births (N=27)</td>
<td>1923</td>
<td>12.90</td>
<td>4.80</td>
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<td></td>
<td>5-8 Births (N=35)</td>
<td>1915</td>
<td>10.38</td>
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<tr>
<td></td>
<td>9+ Births (N=34)</td>
<td>1916</td>
<td>9.76</td>
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<td>Age of Mother at Marriage</td>
<td>1-4 Births (N=27)</td>
<td>25.44</td>
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</tr>
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<td>9+ Births (N=34)</td>
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<td></td>
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<td>Age of Father at Marriage</td>
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<td>Average Birth Spacing (in months)</td>
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<td>.57</td>
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<td>9+ Births (N=34)</td>
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<tr>
<td>Percentage of Infant Deaths</td>
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<td>12.04</td>
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<td>9+ Births (N=34)</td>
<td>30.52</td>
<td>19.29</td>
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</tr>
</tbody>
</table>

* grey cells indicate significantly different means
However, because there were three outlying average birth-spacing values which are likely to have strongly influenced these results, this analysis was redone, removing those families in which average birth-spacing was greater than sixty months. As a consequence, the strength of the correlation between number of births and average birth spacing decreased (\(b=-1.090, R^2=.153, SE=7.88, F=15.70, p<.001\); see Figure 7.10). The removal of these values eliminated families which had only one birth, and lowered the number of families under analysis (Families with 2-4 births: \(N=20\)), and when the ANOVA was rerun, this altered the computed statistics and rendered the differences between the age of father at marriage for the three family sizes non-significant (see Table 7.3). Table 7.3 indicates which of the three family-size groups had a mean that was
different enough from the others that it is unlikely to have been the result of chance, as illustrated by the shaded squares. Unsurprisingly, the number of infant deaths in the three family sizes was significantly different. In addition, the smallest families had a later age at marriage and the age of the mother at marriage was greater, compared to families with 5-8 and 9 or more births. The largest families also exhibited a significantly higher percentage of infant deaths, and significantly shorter average birth-spacing, when compared to the smallest families and those with 5-8 births. Finally, Figure 7.11 illustrates the fertility profile of families of the varying sizes, utilizing medians in place of means, demonstrating the differences in the age of marriage for mothers and in average birth intervals according to family size.

Figure 7.10 – Birth Spacing & Number of Births, by Family (N=89)
Table 7.3 – Factors Assessed for Variation According to Family Size

(Outlying Spacing Values Removed)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Family Size</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>F</th>
<th>Sig</th>
</tr>
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<td>9.76</td>
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<td>Age of Mother at Marriage</td>
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<td>2.96</td>
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<td>Percentage of Infant Deaths</td>
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<tr>
<td></td>
<td>5-8 Births (N=35)</td>
<td>20.15</td>
<td>18.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9+ Births (N=34)</td>
<td>30.52</td>
<td>19.29</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* grey cells indicate significantly different means

Figure 7.11 – Median Birth Spacing, by Family Size
Birth Spacing

As previously stated, average birth spacing was found to be shorter in families that experienced at least one infant death, and for infants who had died. Therefore, the relationship between average birth spacing and the percentage of infant deaths was plotted, with the outlying birth-spacing values excluded from the analysis, and a correlation was observed ($b=-.968$, $R^2=.183$, $SE=17.51$, $F=19.51$, $p<.001$, see Figure 7.12). Again, to assess whether this relationship held when families who experienced no infant deaths were excluded, the analysis was rerun for only those families with one or more infant deaths. In this instance, the relationship remained, although the predictive value dropped dramatically ($b=-.597$, $R^2=.089$, $SE=14.29$, $F=6.07$, $p=.017$, see Figure 7.13). This suggests that birth-spacing had an effect on infant mortality which extended beyond the presence or absence of infant deaths, and may have been related to higher percentages of infant deaths in certain families.

In light of the observed relationship between family size and infant mortality as well as the observed relationship between family size and birth spacing, the relative importance of family size and birth spacing on infant survivorship was also assessed. When both number of births and average birth spacing were included in the regression analysis (again, outlying birth-spacing values were excluded), birth spacing proved to be the more important predictor, but including family size improved the predictive power of the model minimally ($b=1.138$ [births], $b=-.809$ [spacing], $R^2=.211$, $SE=17.31$, $F=11.48$, $p<.001$). This indicates that birth spacing was relatively more important than family size as a determinant of the proportion of infants that died, in each family.
Figure 7.12 – Infant Mortality & Birth Spacing, by Family (N=89)
As larger families were found to have both higher proportions of infant death and shorter birth intervals, and shortened birth intervals were also correlated with higher proportions of infant death, it became imperative to untangle the relationship between family size, birth interval, and infant mortality. That is, I speculated that an infant death might have led to the shortening of the subsequent birth interval, as an infant’s death has been shown to have an impact on subsequent fertility and/or the desire for another child (Kemkes 2006). Consequently, in order to assess independent differences in birth spacing across family size (which may have had an effect on infant mortality) from those that were affected by the death of the preceding infant, an additional examination of the individual-level data (F2, N=667 births) was undertaken. Specifically, to control for the
influence of a previous infant death, the data was split in two groups: births where the previous infant died within the first year of life (N=149), and births where the previous infant survived the first year of life (N=422). Thereafter, an ANOVA was run to determine if significant differences existed in the mean birth intervals for each family-size category. As shown in Table 7.4, when the previous infant died the subsequent birth interval was not significantly different for each of the three family sizes, whereas, when the previous infant survived significant differences were observed in the subsequent birth interval, according to family size. Again, it was the birth-spacing value of the families with 9 or more births that was significantly different from the mean birth spacing in the smaller families. Figure 7.14 shows the relative similarities in birth spacing between the various family sizes, in instances of a prior infant death, and conversely the significant differences in birth spacing when the previous infant survived the first year of life. This indicates that shorter birth intervals were characteristic of larger families, and not merely a product of higher infant mortality within these families.

Table 7.4 – Birth Interval Variation by Family Size and Previous Infant Survivorship

<table>
<thead>
<tr>
<th>Factor</th>
<th>Family Size</th>
<th>Mean birth interval (mos)</th>
<th>Standard Deviation</th>
<th>F</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous Infant Survived</td>
<td>1-4 Births (N=48)</td>
<td>36.31</td>
<td>18.89</td>
<td>16.72</td>
<td>.000</td>
</tr>
<tr>
<td>(N=422)</td>
<td>5-8 Births (N=150)</td>
<td>31.45</td>
<td>16.78</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9+ Births (N=224)</td>
<td>24.76</td>
<td>12.28</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous Infant Died</td>
<td>1-4 Births (N=7)</td>
<td>21.57</td>
<td>12.87</td>
<td>1.36</td>
<td>.269</td>
</tr>
<tr>
<td>(N=149)</td>
<td>5-8 Births (N=39)</td>
<td>21.64</td>
<td>12.66</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9+ Births (N=103)</td>
<td>18.42</td>
<td>10.18</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* grey cells indicate significantly different means

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70 The sum of these two groups is 571 births because an assessment of the influence of a previous-infant’s survivorship can necessarily only include second or higher order births; therefore, 96 first-births are excluded from this analysis (667-96=571).
The Effects of Breast-feeding and Weaning

One reason for variations in birth intervals is weaning practices; studies show that breast-feeding reduces fecundity and fertility, as when a mother breastfeeds the resumption of ovulation, and hence the conception and birth of subsequent children, is delayed (Lawrence 2000; Kemkes 2006; Tommaselli et al. 2000). There is anecdotal evidence that breast-feeding was common in early twentieth century Malta, although extent and the timing of weaning is uncertain. The earliest references to breastfeeding include comments about the “insufficient suckling” and “premature weaning” of infants towards the later part of the nineteenth century (Gulia 1875:10). Similarly, by the 1920s, Shepherd (1928:270) spoke disparagingly of a common “hot-summer diet of coffee, sardines and tomato-macaroni” which he was happy to hear that his servant, Dolores, was discouraging a sister from feeding her infant. Morana (1946), in his study of infant mortality in Malta (discussed in detail in Chapter 1), found that in 53 percent of the deaths he investigated the infant had been artificially fed, although he did not report rates
of breast- or artificial-feeding more generally. Referring to both existing practices and those of the past, in the 1950s, Cachia (1956:37) spoke of the “early and indiscriminate use of farinaceous foods” while noting the reduction in previously more common “mouth-to-mouth feeding.” However, more recent depictions and recollections seem to indicate that breastfeeding was commonplace. For example, in Ebejer’s (1969) novel In the Eye of the Sun, set in Malta during the preceding decades, the main character’s sister is described as breastfeeding so regularly that her brother proclaims “can that child do nothing but that?” (Ebejer 1969:9). Similarly, in her interview of a sample of Senglea’s female population, Mizzi found that only 22 percent and 29 percent of women between the ages of 45-59 and 60-75 (who would have been in their childbearing years from 1920 onward) reported that they never breast fed any of their children, with 70 percent and 65 percent, respectively, breastfeeding all of their infants (Mizzi 1981).

A portrait of the degree of variation – and recommendations – in breast- and/or artificial-feeding patterns can be gleaned from the 1939 report of the Committee on Nutrition in the Colonial Empire. They emphasized that “complete breast-feeding of the infant is of very great importance; its importance can indeed hardly be over-rated”, yet they also stressed that “supplementary dietetic substances” such as cod liver oil, fruit juice, and (after six months of age) iron-yielding foods might be desirable to include, and that “where it is impossible to attain the ideal of breast-feeding, artificial feeding of the infant must be carefully thought out” (Economic Advisory Council 1939:24-25). Morana’s (1946:6) perspective on artificial feeding, quoted at the head of this chapter, was less sympathetic; recall, he wrote that if artificial food could be afforded “the mother is sure to stuff it down her baby’s throat” thereby causing the infant’s death. A decade
later, in his contribution ‘The Infant in the Home’ in *A Survey of Child Welfare Problems in Malta by Save the Children-Fund*, Cachia (1956:34) stated, in passing, that breastfeeding was far less practised in the upper classes, but he also lamented the lack of information on the prevalence of breastfeeding in the islands: “it is sad to think that in 1956 we have no knowledge of the percentage of mothers that breast feed their babies, and the period for which they breast feed them.” In fact, no systematic survey of infant feeding practices was undertaken, and nothing regarding duration, or the timing of introduction of supplementary foods was recovered from the archives. In the absence of any such historical documentation, the biometric method originally devised by Bourgeois-Pichat (and modified by Knodel and Kinter), which plots the age structure of infant deaths, was employed to determine breast-feeding and weaning patterns (see Chapter 2). When all births were included in the analysis, the slope of the line from 1-6 months was steeper than that of 6-12 months (ratio=0.786) suggesting that a substantial proportion of Maltese women from Casal either did not breast-feed or weaned their infants at an early age.

In light of the differing birth-spacing patterns in the variously sized families, it was hypothesized that there might be differences in infant feeding practices as well. Because of the very few infant deaths (only 11 in total) which occurred in families with four or fewer births, the births were split into two groups: those births which took place in families with 1-8 births (N=62 families, 306 births), and those births which took place in families with 9 or more births (N=34 families, 311 births).[^71] Significant differences existed in the average birth spacing of these two groups of families (1-8 births = 32.14

[^71]: Notably, only 58 families with 1-8 births (for a total of 302 births) were included in the calculations of birth spacing, as four families had only one birth.
months, Std. Deviation = 12.73; 9+ births = 23.00 months, Std. Deviation = 4.53; p = .000) as well as in the average percentage of infant deaths (1-8 births = 16.62%, Std. Deviation = 17.94; 9+ births = 30.52%, Std. Deviation = 19.29; p = .001).

The break in the line, which marks the timing of weaning, suggests that infants who died in families with 9 or more births were weaned at 2 months of age, whereas, infants who died in families with 1-8 births were weaned at 4 months (see Figure 7.15). As previously stated, the assumption behind the biometric method is that spikes in cumulative mortality are attributable to the weanling diarrhoea syndrome, as the cessation of breast-feeding and the introduction of weaning foods puts infants in contact with contaminants from the environment via food and water which they ingest in place of breast milk.

Figure 7.15 – Biometric Results, According to Family Size
Unfortunately, information on cause of death for the infants from Casal was not available. However, historically and contemporaneously, cases of intestinal infection – and weanling diarrhoea more specifically – are more common in the hot summer months, particularly in the Mediterranean region (Reher and Gimeno 2006); therefore a seasonal increase in infant deaths can be used to infer if diarrhoea was a major cause of infant death. In Malta overall, and in Casal itself, infant mortality had a strong seasonal component; a much higher proportion of infant deaths occurred between the months of June, July, and August, the hottest and driest months of the year in Malta (see Figures 7.16, 7.17, 7.18, 7.19). The similarities in the seasonal distribution of infant mortality between Malta and Casal – when coupled with the relative proportions of neonatal versus post-neonatal deaths – is further evidence that the causes of infant mortality in Casal were similar to those of Malta overall; that is (as stated in Chapter 4), the major cause of infant death in Malta and Casal for the period under investigation was diarrhoeal diseases.

Figure 7.16 – Seasonal Distribution of Infant Mortality, Malta
Figure 7.17 – Seasonal Distribution of Infant Mortality, Casal

![Seasonal Distribution of Infant Mortality, Casal](image)

Figure 7.18 – Average Monthly Temperature, Malta

![Average Monthly Temperature, Malta](image)
Several conclusions can be drawn from the above analyses: (1) Infants in larger families were at an increased risk of death in the first year of life, (2) Infants in families with shorter birth intervals were at increased risk of death, (3) In larger families birth intervals were shorter (or, vice versa, shorter birth intervals resulted in larger families), the mothers and fathers were younger when they married, the marriage date was earlier in the period under investigation, and the age of weaning (at least in the case of infants who do not survive) was earlier.

To help clarify the relationship between these variables, and to show the degree of variation in birth spacing within individual families, 4 families of varying sizes are presented in Figure 7.20, and their fertility (and mortality) profiles are discussed below.
Family D208: Married in 1933, Mr and Mrs Attard (pseudonym) were 36 and 27 years old, respectively. They had their first child, a girl, 11 months later, another girl 19 months thereafter (who died 9 months later, in November), a boy 32 months after that, and their last child, another girl, 42 months later. Mrs Attard was 36 when her 4th and last child was born; with 3 of 4 children surviving infancy.

Family D12: Married in 1902, Mr and Mrs Debono (pseudonym) were 29 and 22 years old, respectively. They had their first child, a girl, 23 months later, their 2nd child, another girl, 23 months thereafter (who died 3 months later, in August), a boy 26 months after that, another girl after 25 months, and their last child, another boy, 33 months later. Mrs Debono was 33 when her 5th and last child was born, with 4 of 5 children surviving infancy.

Family D7: Married in 1901, Mr and Mrs Farrugia (pseudonym) were both 18 years old at marriage. They had their first child, a girl, 14 months later (and she died after only 7 days, in November), another girl was born 13 months later, a third girl was born 24 months thereafter, their 4th child was a boy born 26 months after that (who died, 7 months later, in October), another girl was born 20 months thereafter, a boy was born 24 months later, their 7th was also a boy, born 45 months later (also died, after 7 days, in September), 12 months thereafter another girl was born, and their last child, a girl was born 43 months later. Mrs Farrugia was 37 when her 9th and last child was born, with 6 of 9 children surviving infancy.

Family D20: Married in 1903, Mr and Mrs Frendo (pseudonym) were 20 and 18 years old, respectively. They had their first child, a boy, 11 months later, their second child, another boy, was born 35 months later (and died after 9 days, in February), a girl was born 17 months thereafter (and died within 2 months, in August), another girl arrived 22 months after that, yet another girl was born 22 months thereafter (who died, 4 months later, in July), their 6th child was a girl, born 27 months later (and died after 3 months, in
December), their 7th, a girl, was born 15 months later (also died, after 7 months, in August), 25 months thereafter another girl was born, 23 months after that another girl, 36 months later their 10th child, another girl, was born (who died 9 days later, in March), and their 11th and last child, a girl, was born 38 months later (and died, at 5 months, in November). Mrs Frendo was 41 when her 11th and last child was born, with only 4 of her 11 children surviving infancy.

To select just two of the above families, in what ways are the Attard family – who experienced only one infant death – different from the Frendos, who suffered seven? Certainly, Mr and Mrs Attard married much later in life, later in the period under study, had fewer children, and these births were separated by a greater number of months; however, which of these factors was most important in determining the survivorship of their infants? And what other factors may have played a (possibly even more significant) role?

As previously stated (see Chapter 1), in 1946, Dr Morana concluded that multiparity was the most important factor influencing elevated rates of infant mortality in the Maltese Islands. Although his methods were undoubtedly flawed, the analyses outlined above could allow for a similar conclusion; that is, one could conclude that infant mortality was causally related to larger family sizes, that mothers were having “too many” babies. Based on the above analyses, it would also be possible to speculate that young mothers (or parents?) – particularly those captured in the family reconstitution analyses who were beginning their families in the early 1900s – made an “ignorant” decision to cease breastfeeding and to wean their infants at a very early age, thereby causing heightened infant mortality, as well as the observed shortened birth intervals and larger families. Lacking the “training” essential to ensure that “proper” methods of infant care and “modern” feeding practices were employed, these young mothers unwittingly caused the deaths of their infants.
The liberal use of scare-quotes, as well as the dialogic shift in the above paragraph – from young ‘parents’ to young ‘mothers’ – is here intentional, as contemporary interpretations of statistical analyses often take on the perspectives that have evolved through history, unselfconsciously and without attention to the assumptions lying therein. The terms ‘too many’, ‘ignorant’, ‘training’, ‘proper’, and ‘modern’, are borrowed from earlier discourses of infant mortality, yet they represent ideas which continue to circulate and shape contemporary understanding of the determinants of infant death. Similarly, at first blush, it feels awkward to write or read of parents’ decisions to wean; rather, in keeping with prevailing ideas about the primacy of mothers in infant- and child-care, it is more comfortable to speak of the decisions and abilities of mothers.

**Maternal Instinct, Maternal Ignorance**

As discussed in Chapter 3, women in Malta were largely responsible for the care of their offspring. Essentialized as mothers, and following the terms of institutionalized motherhood, these women were expected to possess a degree of maternal “instinct” rather than intelligence (Rich 1976:42). Moreover, it was believed that “the intelligence of the average mother [was] rather poor” (Cachia 1956). As Jolly argues (1998:4), the corollary of this expectation (that a woman naturally possesses the ability to mother) is that some women are judged as wholly lacking such an instinct, and, in others, it is often deemed “all too insufficient” (McElhinny 2005:189). For example, in 1920, Malta’s CGMO Critien, in reference to mothers attending infant consultation centres (discussed in detail in Chapter 5) in the preceding decade, wrote:

No more direct confutation can be had than at these consultations of the general belief that mothers, no matter how young and inexperienced, possess all the knowledge required for the healthy rearing of children, and
no better proof that maternal instinct without knowledge almost inevitably leads to disaster (Critien 1920:16).

This derision of (expected) maternal instinct is consistent with a prominent discourse, which resonated in early twentieth century Europe, the colonies (including Malta), and the Americas – the attribution of blame for depopulation and elevated infant mortality to the ignorance, irresponsibility, and heartlessness of mothers (Davin 1978; Hunt 1988; Jolly 1998b; Manderson 1982, 1987, 1998; McElhinny 2005; Moffat and Herring 1999; Swedlund and Ball 1998).

The most resounding discourse during the early twentieth century was that of maternal “ignorance.” For example, in British colonial Malaya, similar references were made to mothers’ carelessness, “the ignorance of mothers in feeding babies” (Manderson 1982:605), and “ignorant prejudices which in the past have been so inimical to infant welfare” (Manderson 1982:613). In the Belgian Congo, the ignorance and “irrational” infant feeding practices of women were blamed for elevated mortality rates (Hunt 1988). The weight of this rhetoric is made evident by the content of John Burns’ presidential address, at the first National Conference on Infantile Mortality, held in 1906 in the Caxton Hall, Westminster, in which he stated: “at the bottom of infant mortality, high or low, is good or bad motherhood” (Dwork 1987:114). He attributed these ‘preventable’ deaths to “cruelty, overfeeding, under-feeding, ignorance, stupidity, or improper feeding” (Davin 1978:28).

Importantly, there was a fundamental contradiction inherent to discourses about motherhood and maternal ignorance regarding infant care: it implied that all mothers (Maltese included) possessed a maternal instinct, yet only some women, by virtue of class and race, were thought to be able to undertake the role of mother ‘naturally’. For
example, working-class women, in the British system, were thought to be, by definition, ignorant or at the very least irresponsible (Davin 1978). In contrast, the “maternal paragon” (Yeo 2005:6) was the white middle-class woman of western Europe and North America, absorbed in nurturing activities, and situated in the biological nuclear family; she was held up as the normative standard – the model against which mothering practices and arrangements were evaluated (Arendell 2000:1195) – and compared to her habits anything else was considered not merely different but wrong (Davin 1978:53).

Thus discourses of ignorance and the like were “predicated upon notions of the moral superiority of the colonizers as well as the technical superiority of their science” (Manderson 1998:30). In part, this moral superiority was defined according to conventional understandings of differences according to race, class, and gender – colonial categories based on assumptions of the inherent superiority of the British ‘imperial race’ over all others which served to maintain differences between colonizer and colonized and constituted the ‘Other’ against whom the European was defined (Davin 1978; Said 1978; Stoler 2002; Stoler and Cooper 1997). Thus, the paternalistic tone that emerged in Europe with reference to working-class mothers “resurfaced in the colonial context with distinct racial dimensions” (Hunt 1988:406). Accepted notions of racial difference and essentialism served to explain the poor response of ‘native’ women to health services and attempts at behaviour change in terms of their intellectual shortcomings (Manderson 1998). As Swedlund and Ball argue (1998:213), the term ignorance did not simply denote a lack of education and a corresponding solution; it was also profoundly associated with otherness and racialist and gendered notions of “inherent deficiency that could not be easily remedied.”
Maternal Ignorance in Malta

Within Malta, much as in other locations, chief among the posited causes of elevated infant mortality rates was ignorance; for example, according to CGMO Samut (1905:J4) “the infant mortality continues to be very high owing principally to debility, overfeeding, and bad nursing of infants and ignorance of hygienic principles on the part of their parents.” With regards to deaths from enteritis and diarrhoea, he had this to say: “this frightful death-toll is attributable to neglect of the most elementary rules of hygiene, and there is no doubt that many lives might be saved if parents would use more care in feeding and nursing infants” (Samut 1905:J9). Similarly, in the previous year (1904), the Chief Medical Officer of Malta wrote:

The great loss of life is by no means due to the insanitary conditions of the dwellings of the poorer classes but to the improper feeding and undue exposure of the children. Ignorance of the requirements of the hygiene of infants is rampant, and the sooner the parents are taught how to bring up their offspring in a proper way the better for the people in general and for the reputation of our Islands (Samut 1904:57).

Samut’s suggestion that “parents” needed to be taught how to raise their children is also noteworthy, as a few years later his replacement CGMO Caruana Scicluna also suggested that the “diseases” of Debility and Enteritis (which he attributed to pre-natal cause and overfeeding, respectively) could be prevented “to a certain extent by a better education of the parents” (1910:J2). Both of these references to ‘parents’ as opposed to ‘mothers’ were an unusual occurrence at the time; much more often, the mother alone was labelled as ignorant and incapable of properly caring for her child.

It is unclear why Samut argues so vehemently that infant mortality was due to improper care of infants and not to the (in)sanitary conditions of the homes of the poor; however, it may signal a attempt to shift blame from the government and/or sanitary
officials to the poor themselves. Thus, “hygiene” here seems to refer to more to individual practices and the requirements of infants in regards to overall health and cleanliness, rather than general conditions of the home; although what specifically this term was meant to encapsulate is unclear. Maltese mothers were certainly described as ignorant in regards to infant feeding and clothing; as Cachia (1956:37) stated “more babies were killed in the past for lack of feeding than because of overfeeding” because mothers starved their infants on the “flimsiest excuse of some vomiting on the baby’s part, or loose or green stools”, or the “early and indiscriminate use of farinaceous foods”, as well as overclothing of infants. Interestingly, these sentiments echoed a Maltese newspaper article from over twenty years earlier, which pointed to a tendency of women to attribute any problems with their infants to digestive upset, and discouraged overclothing. The article, titled “Wit and Wisdom for Womankind” – thereby highlighting its audience as women and mothers – had the following advice to give:

> When children, especially babies, are cross and irritable, it is nearly always put down to a digestive upset of some sort… but not infrequently the cause is simply the poor mite is so overburdened with clothes that it is hot, sticky and uncomfortable […]soaked in perspiration,] making the little creature liable to chills (1924b).

Moreover, this understanding of maternal ignorance, lack of ‘hygiene’, improper feeding, and overall responsibility for infant deaths has carried over into contemporary understanding; for example, when speaking of the deaths of her siblings in infancy, Maria Calleja had this to say: “the women – I mean the mothers – had a bad, unhygienic custom of masticating the child’s food in their own mouths, and they passed it on to the child by hand… that’s why we had so many children dying young” (Galley 1994:32). Similarly, Cassar (1984:32) has recently argued that diarrhoea was common in Malta during the
early twentieth century “due to ignorance of the principles of infant feeding on the part of most mothers.”

However, “most” mothers apparently did not mean all mothers. In the 1930s, in their discussion of the development of infant welfare centres, Fairfield and Drummond Shiels (1938:10) spoke of the importance of officers’ wives and “Maltese ladies with sufficient goodwill and leisure” (women of the upper-classes) and their continued voluntary work in the infant welfare clinics and as home visitors. Thus, these “leisured women”, “with time to spare”, clearly were not deemed ignorant or incapable of caring for their infants (Fairfield and Drummond Shiels 1938:10). Similarly, in the 1950s, Cachia (1956:34) spoke of the “utter lack of hygiene and rather poor intellectual capacity of the mother,” but, in reference to enteritis-related deaths in infants under 9 months of age, he claimed that this was “a comparatively rare disease in the better class group of people.” Importantly, these quotes demonstrate that racial dimensions of ignorance were overlaid with those based on class; not all Maltese women were seen in the same light.

**Apathy and Fatalism in Malta**

According to Davin (1978:41) accusations of maternal ignorance “often carried with them implications of wilful neglect, assertions that anyway poor parents would just as soon their infants died.” Similarly, in Malta, references to maternal ignorance were oftentimes coupled with accusations of apathy. To return to a quote from a previous chapter:

> Not until 1943 was public opinion in Malta led to support the effort for lowering the infant death rate. Previous appeals had been meeting with a cold response. Public opinion had been alarmed by increasing over-population and had tolerated the high infant mortality rate as a safety
valve. But reaction was provoked by the unprecedented death rate of the war. More enlightened views began to prevail (Ganado 1964:240).

In addition to its obvious references to overpopulation, Ganado’s comments regarding the effects of the Second World War are noteworthy. As shown in Chapter 4, infant mortality rates in Malta did peak during World War II (at 345 per 1000); although the IMR in Malta overall and many of its communities had approached or surpassed 300 per thousand in previous years therefore this peak was not as much of an aberration as Ganado’s comments suggest. However, infant mortality rates did fall dramatically following the War, which Ganado seems to attribute to the changing attitudes of the Maltese people, rather than the massive structural changes that took place during this period. Thus, his perceptions are consistent with discourses of the time, which looked to individual deficiencies and capacities, rather than larger-scale social, political, economic, and sanitary conditions, for the roots of infant mortality and ill-health in Malta.

Moreover, the above quotation alludes to a common perception of the time — that the Maltese were apathetic and unconcerned with elevated infant mortality rates. In some instances this is made explicit and tied to (over)-population and multiparity; for example, in the 1930s Johnson (1937:1) claimed “the very high infant mortality rate... tends to be regarded with apathy, probably owing to the high birth rate and general overcrowding of the population.” In others, from a much earlier period, it is tied to socio-economic conditions; for example, in a report on sanitary conditions and mortality in Malta, Dr. G. Gulia wrote (1875:10): “moral supineness [sic] engendered by poverty has rendered the parent apathetic of consequences…. Hundreds of sick children have been allowed to die, no effort being made towards their recovery.”
In the absence of first-hand testimony on the part of the mothers in question, and because of the historical nature of this research, it is impossible to determine the degree of veracity of these assertions of maternal apathy. Nonetheless, a degree of apathy would be understandable in the context of such elevated rates of infant mortality; however, acceptance of death, once it has already occurred, particularly within a devout Roman Catholic population, does not mean that the Maltese did not value the lives of their infants or do their utmost to prevent their deaths. Yet assuming the normalcy of infant deaths for Maltese allowed others to create further arguments for condemnation. For example, while writing for the Save the Children Fund, Debono states (1956:215) “it is the normal thing among the older mothers to have lost half to three quarters of their children before the first year of life.” Recall that these deaths were described as ‘appalling’ to the authorities; whereas they were a ‘normal’ part of life for Maltese mothers.

The frequency – and perhaps a degree of acceptance – of infant deaths is attested to by a number of Maltese expressions (as recorded in Aquilina’s *A Comparative Dictionary of Maltese Proverbs*, 1972) including:

*Ahsbilhom ghall-maghmudija u wara ghat-TMIDDJA*: Prepare (the child) for christening and then for burial. [local origin]

*Man-NEJBIET lesti l’kfejniet*: When children begin to cut the eyeteeth, get the shroud ready. [local origin]

*M’isbah il-genna ghal dik it-TARBIJA li tmut fil-fisqija*: What can be better than Paradise for the child who dies when still in its swaddling clothes! [local origin]

What these proverbs show, in addition to the typicality of infant death, is the common Maltese custom whereby one was expected to rejoice in the face of infant deaths,
provided that the child had been baptized (and most baptisms occurred on the day of birth) as babies would then go straight to heaven (Galley 1994). In her life history, Maria Calleja speaks of the commonplace occurrence of infant funerals, and her father’s role as a carpenter, charged with the task of building coffins:

I watched him doing the small white baby coffins. He did, on average, two a week, and the church bells would ring, as we call it, a *frajha*; *frajha* really means “glory” because that’s special when a baby dies: the church rings something beautiful, not something sad (Galley 1994:32).72

What the above proverbs and quotes do not express is how the families felt about the deaths of their infants; rather, they suggest that the expected, public, response to death in this Roman Catholic community was one of acceptance and faith. However, in the minds of some British citizens, this was tantamount to “slipshod, happy-go-lucky fatalism” (Shepherd 1928:109).73

Such accusations of fatalism were not limited to the deaths of infants, however. According to Adams and Cooke (1957), two UK physicians who visited Malta to compile a survey on old age, nurses and health visitors found that, in general, the Maltese tended to “wait until they are really ill before consulting a doctor, and [took] the fatalistic view that ‘what must be, must be’.” In light of the dearth of medical services, the poor quality of medical care, and the costs associated with receiving assistance (as described in Chapter 5), it is likely that the Maltese did not immediately consult doctors in instances of illness for reasons other than fatalism.

Importantly, such references to fatalistic attitudes can be seen as part of a larger discourse on ‘Mediterranean fatalism’, an Orientalist discourse which attributes to many different groups in the Mediterranean region a mentality or culture whose foremost

72 Later Galley (1994: 187) notes that *frajha* is from *ferah*, “to rejoice.”
73 Accusations of fatalism were also present in other contexts (e.g. Manderson 1998; Stivens 1998).
feature was a deep, unshakeable resignation about the inevitability of future (and past) events and one’s inability to effect change (Falzon 2001; Schneider 1998). The pervasiveness of this discourse can be attested to by its importance in the denouement of one of the most well-known novels set in Malta, *The Jukebox Queen of Malta*. At the end of the novel, when Rocco (an American soldier stationed on the island during the Second World War) must leave the woman with whom he has been intimately involved, the author – also American – writes:

> He understood… that lurking inside her, deep in her feelings, was a latent fatalism. It was the fatalism of the Maltese, which ran even deeper than their religion. And why not, after so many centuries of domination – from the Phoenicians, Carthaginians, Romans, all the way to the Arabs, the Knights, and now the British. A quiet hopelessness had settled in. Rocco had sensed this about them, talking with them. In Melita too there was this feeling of abandonment, hidden under her smile, under her tenderness. All along, while they had been making love, living together, she had been preparing, every day, for the worst, knowing that sometime, sooner or later, he would go, one way or another. And now it was happening (Rinaldi 1999:357).

It is interesting that Rinaldi treats fatalism as a more essential quality of the Maltese than even religion because elsewhere Roman Catholic beliefs were placed as the source of fatalistic attitudes; for example, references were made to the average, poor Maltese peasant-woman’s faith in the “Bambino’s inscrutable will”, the will of God, and her concomitant powerlessness to prevent the deaths of her infants (Shepherd 1928:109).

Although the degree to which the Maltese were fatalistic is open to debate, there is evidence that mothers (and others) actively sought divine intervention regarding health issues. For example, while Goodwin argues (2002) that many practices have fallen into disuse since infant mortality rates have decreased in recent decades, he points out that Maltese culture remains rich in religious customs and rituals performed to ensure
successful deliveries and infant survival. Similarly, Galley (1994) speaks more specifically of the behaviours of Maltese mothers, who would implore the Virgin Mary to facilitate pregnancy, childbearing, and breast-feeding, and to keep their infants in her protection. At chapels and shrines, in places of worship such as the “Madonna of Delivery” in Qormi, these mothers would place “many small silver items (anatomical representations of the female body, figurines of babies in swaddling bands, sacred hearts, etc.), as well as beautifully embroidered clothes worn by the new born child on the day of its baptism” (Galley 1994:203). When a baby was seriously ill, Maria Calleja explained, “the mother would take him to Qala sanctuary of the Immaculate Conception in San Kerrew crypt” and pray to the Madonna, or another saint, to make him well again (Galley 1994:27). Galley, herself, commenting on Maria Calleja’s discussion of a young mother’s tendency to seek supernatural protection for an infant after the previous loss of several others, had this to say:

In any case, it is interesting for our purposes to observe ex-voto paintings related to the protection sought by parents after the birth of a child: an interior scene appears recurrently with a young mother holding her baby to the Virgin, while several corpses of infants lie on the bed, as if to signify, in a very realistic almost-constraining address to the Protector, that tribute had been paid to death already (Galley 1994:186 n.21).

Alternately, Lanfranco pointed to an ancient custom practiced in Malta surrounding the so-called “changeling” (mibdul):

Parents used to take such a child to a devotional site where there was a chapel, statue or wayside niche, placed it in the sand or dust and implored that their proper child be returned to them, believing that the sick one must have been placed there through the evil of the devil in exchange for theirs (Lanfranco 2004:47).

74 Note the use of “him”, the male pronoun. This was quoted directly from Maria Calleja, and while it may simply be a ‘generic’ use of the masculine, it could serve as an indication of the importance of sons and their survival in Maltese families – although, as previously stated, the parish-level analyses did not reveal any gender bias in infant survivorship.
This allusion to evil and the power of the devil ties in to another aspect believed to be evidence of the Maltese people’s so-called fatalism: their ‘other’ superstitious beliefs, such as the force of the ‘Evil Eye’ (Shepherd 1928:109). References to the power of the ‘evil eye’, curses, the exertion of bad influence on a baby due to jealousy and envy, and the need to ward off such malevolence by forming the horns (putting out the small finger and forefinger) were not unusual at this period in history, as suggested by popular and scholarly accounts of the early twentieth century (e.g. Ebejer 1969; Ellul 1995; Wilhelmsen 1977).

**Tradition versus Modernity**

Such references to Maltese fatalism, apathy, superstition, and belief in the will of God – in addition to serving as implicit critiques of the teachings of the Catholic Church – carry with them the weight of un-modernity. Following Mitchell (2002), in Malta like in other so-called Mediterranean countries, the importance of religion “was posited as evidence of its traditionality, in contrast to a more secular, rational modernity” (Mitchell 2002:6). In addition, historically, it is women (and particularly “non-European” women) who have been cast as more traditional and ‘religious’, as compared to their male counterparts (Bashford 2004:125).

Although McClintock (1995:22) argues that the colonies and uncharted areas of Africa, the Americas, and Asia “were figured in European lore as libidinously eroticised… porno-tropics for the European imagination”, Levine (2004) contends that this homogenized view of non-Western peoples as “morally lax and sexually unencumbered” (Levine 2004:135) was juxtaposed against a simultaneous depiction of
colonial societies as “unusually prudish” (Levine 2004:150). Within Malta, this latter depiction appears more commonly. For example, Wignacourt (1914:23) described Maltese peasant girls as “naïve and unsophisticated” and characterized by “a simplicity and inexperience in the ways of the world.” Notably, women in Malta were seldom (if ever) portrayed as the ‘morally lax’ type; even Maltese prostitutes, seen as ‘other’, were presented as women who had “fallen” because of the repressive and prudish society in which they lived (Walz 2006). This can be read in the work of Fairfield and Drummond Shiels who wrote of the “Maids from Gozo and country districts” who became barmaids:

The simple maiden who leaves her rural home only to be led astray by the temptations of the town is one of the oldest and commonest of social problems. In Malta the situation is made unusually difficult by the acute contrast between the girls’ sheltered and puritanical upbringing and the modern outlook of a great sea-port and garrison (1938:15).  

Reference to the naïveté and ignorance of the Maltese peasant girls, and the implicit critique of her “puritanical” upbringing (and the Catholic Church), is thus placed in stark contrast to the modernity of the (British-run) sea-port and garrison. Importantly, the traditionality of Malta’s women was not limited to religion, but extended to child-care practices not clearly related to Catholicism (see Chapter 5 for a discussion of the perceived need to instruct mothers in “modern” techniques of childcare).

Pathways of Causality and Correlation

The above discussion of the foci of concern surrounding infant mortality in Malta is presented both for its own sake, but also to provide a counterpoint to consider in the interpretation of the statistical analyses. Specifically, the results of the analyses of the

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75 Recall, Gozo was the smaller of the two Maltese Islands, and it was a rural and purportedly more backward region. Importantly, according to a number of reports and correspondence, these ‘barmaids’ were in effect clandestine prostitutes (e.g. Mansfield Clarke 1905, Strickland 1902, Critien 1920b):
family reconstitution data could be utilized to support any of the above discourses: young mothers were too “ignorant” to understand proper weaning techniques; living in an environment with such a high individual and collective infant mortality rates left the Maltese “apathetic” regarding the prevention of infant death; and/or those who married earlier in the period under investigation were less exposed to more “modern” teachings. However, the relationships between infant mortality, family size, birth spacing, and weaning – not to mention those between age and education, incidence and apathy, decade and modernity – are not simple ones; therefore, to avoid falling into the trap of ‘blaming the victim’, other possibilities should be considered.

Notably, infant mortality is not simply the result of family-level choices; as previously stated, it may also influence fertility-related behaviours. Kemkes (2006) explains that demographers have distinguished three pathways through which infant and child mortality affects generative behaviour: (1) physiological effects, as the death of an infant causes the cessation of lactation and the resumption of ovulation, increasing the likelihood of further births; (2) behavioural replacement, the deliberate attempt to replace a child who dies at an early age in order to attain a desired number (or gender ratio) of children, and (3) insurance effects, wherein fertility is adjusted in a precautionary manner according to the expected number of deaths. All of these pathways may decrease time to weaning, shorten birth intervals, and increase the number of births in a family – which are therefore the effect of elevated infant mortality within certain families, rather than the cause of higher levels of infant death.

Similarly, perhaps early weaning was not the cause of infant illness, but the result; infants may have been deliberately (or unintentionally) weaned because of debility
or illness. Moreover, from a causal point of view, the clustering of infant mortality in certain families may be related to social or behavioural characteristics, but there are many reasons to believe that it is also the result of shared genetic or hereditary factors (Kemkes 2006; Sastry 1997b). Because the assessment of weaning age using the biometric method is based on the examination of infants who did not survive the first year of life, it is impossible to assess the weaning age of survivors; therefore, it is possible that the weaning age of infants who survived did not differ from those who died. That is, despite the correlations between family size, shorter birth intervals, younger age at weaning, and the percentage of infant deaths within families, at the level of individual infants, it is impossible to compare risk or probability of death by weaning age itself. As a consequence, it is possible (even likely) that infants who were weaned at the same age, even those within the same families, varied in their ability to survive thereafter for reasons related to their biological make-ups. Further, infants who were weaned at the same age within different families and environments would almost certainly have varied in their ability to survive.

In addition, other factors not included in the analyses may have tracked these differences in weaning patterns across family sizes. For example, individual differences in a woman’s social status, social network support, and knowledge and power to control her fertility and child-rearing practices are not available, and may have influenced the survivorship of her infants. Based on the parish and archival materials available, it was impossible to evaluate the presence or extent of disparities in wealth within Casal, and this may have affected rates of infant mortality. Importantly, early weaning has been associated with maternal employment outside the home (Fein and Roe 1998; Kimbro
2006), which is more likely in poorer families. In addition, as Ward argues (1995), one’s social class is a strong determinant of the timing of pregnancy; a large number of studies have shown that early parenthood is strongly associated with poverty. Similarly, larger family sizes are typical of more rural and/or working class families who require additional labourers for agricultural production and benefit from the wages of children to supplement the income of the family as a whole (e.g. Morsy 1995). Therefore, it is possible that early marriage age and early weaning (as seen in those who had larger families) were correlated with increased poverty, and a more hazardous socio-sanitary environment.

Increased poverty would also have had an adverse impact on the health and/or impaired nutritional status of the mother, both of which have also been associated with earlier age of weaning in more recent studies (Scott and Duncan 2000; Sellen 2001). As such, the impact of maternal well-being, associated with the recurrence of stressful events such as childbirth, lactation, and child-rearing should not be overlooked. Specifically, as Kemkes (2006) explains, *maternal depletion*, defined as “a broad pattern of malnutrition resulting from the combined effects of dietary inadequacy, heavy workloads, and energetic costs of repeated rounds of reproduction” can influence maternal health and newborn child survival (see also Shell-Duncan and Yung 2004). Thus, while previous studies have shown higher risk of infant death in larger families (Bhargava 2003), this could be attributable to, among other things, maternal malnutrition, debility, and exhaustion (Scott and Duncan 2000; Shakya and McMurray 2001) – particularly when

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76 In these instances, in keeping with Caldwell’s (1982) “wealth flows” hypothesis, it is advantageous for parents to maximize family size, as wealth – in the form of labour-power, wages, prestige and the like – flows from children to parents; therefore, it is beneficial for a family to have more children.
coupled with shorter birth intervals, as observed in Casal – as well as the availability of resources within the families under study.

In fact, within the archives, there was some attention to maternal health, largely couched in terms of its effect on infant health. As argued in Chapter 4, women were presented as mothers and the subjective focus of colonial medicine and administration was the infant; therefore, the health and welfare of women was important insofar as it impacted the survival and development of their children. For example, at a meeting in February of 1919 (at which the “Mothers and Infants Health Association”, discussed in Chapter 5, was formed) CGMO Critien spoke of the importance of promoting maternal welfare. Later, in his yearly health report, he summarized this portion of his address, wherein he insisted:

that the health of the mother was intimately on with [sic] that of the unborn baby and the slightest cause of ill-health that is not removed or mitigated was bound to harm the child congenitally, and hence the welfare of the future mother should so concern us during the whole ante-natal period as well as during labour (Critien 1920:I6).

As such, by the 1930s the Committee on Nutrition in the Colonial Empire stressed the need to supervise maternal diets based on common understandings of crucial periods in child development:

It is to-day generally recognised that from the nutritional point of view the pre-natal and immediately post-natal periods are the most important in the life-span, and that the diet of mother and child during these months may affect fundamentally the child’s whole development (Economic Advisory Council 1936a:172).

Although breast-feeding was encouraged (see Chapter 5), it was recognized that it could be inadequate if the nursing-mother herself was not provided with proper nourishment (Economic Advisory Council 1939). In fact, both before and after the Second World War
it was reported that working class mothers – particularly nursing and expectant mothers – were malnourished and underfed, had diets of poor quality leading to poor physique and ill health, which in turn was correlated with premature birth and the inability of the mother to suckle and care for her child (Cauchi 1947; Economic Advisory Council 1936b). However, the Committee on Nutrition in the Colonial Empire may have been somewhat dismissive about the relationship between maternal health and infant health, arguing that “obviously in extreme conditions, where the state of nutrition of the mother is bad at the outset and if her supply of food be defective, the offspring must suffer” (Economic Advisory Council 1939:21, emphasis added). In contrast, following World War II CGMO Cauchi (1947:481) acknowledged that “mothers must be well fed if they are to produce the necessary quantity and high quality of breast milk.”

Regardless of the import placed on maternal nutrition as related to the health of infants, in both instances the mother was evacuated from a central position with the discursive focus on the child such that, even in discussions of her health, it was not important for her sake, but for that of her infant’s future development (Jolly 1998a). Moreover, undernourishment in Malta, particularly amongst expectant and nursing mother, was in some instances conflated with ignorance: “poverty and ignorance are the main causes of such malnutrition as exists” (Economic Advisory Council 1936a:119), a statement with carries with the assumption that poorer classes, or mothers themselves, were responsible for their poverty, ignorance, and food insecurity.

As late as the 1950s, with regards to underemployment and poverty, Galea summed up the average individual in one word: “Hardship.” He went on to describe the average Maltese citizen in the following ways:
with ample means is exceptional. Most male[s] … are unskilled labourers incapable of employing themselves in lucrative occupations, they earn wages which are usually quite inadequate to maintain their frequently large families. Another familiar figure is the harassed mother of a large family living on restricted means (Galea 1952:125).

This quote points to the adverse conditions in which mothers raised their infants, and speaks to the prevalence of poverty, but twice references the import of large families to the equation. Thus, once again, focus is shifted away from the economic structures of Malta within which its inhabitants struggled to earn a living, and poverty was attributed to individual fertility decisions, which themselves were implicitly condemned through disparaging language. Thus, the historical and social construction of infant mortality included a discourse on apathy that was not limited to infant death, but – as was the case in the United States – extended to the “poor’s ‘persistent apathy’ about improving their own condition or observing rules of hygiene and sanitation” (Hargraves and Thomas 1993:20). Environmental and socio-economic factors were thus not entirely disregarded in discussions of infant mortality in Malta; however, as outlined in Chapter 6, the conditions of poverty and hardship were deemed the responsibility of the individual, rather than the system within which he or she found him/herself. Moreover, the abilities of the mother were deemed more important than the conditions within which she lived; for example, in *A Survey of Child Welfare Problems in Malta* by the Save the Children Fund, the emphasis was placed largely on bad mothering:

Many others under similar conditions at home achieve very good result [sic]. It is the mother in question that [sic] is at fault. Results are equally poor, even when social standards are good, if the mother is of poor capacity (Cachia 1956:40).

77 Nearly a century earlier, Malta’s inhabitants were similarly blamed for augmented mortality rates in the islands resulting from the ravages of epidemics, which were “attributable to the listless apathy of the people to all the measures required for the removal of predisposing causes” (Gulia 1875: 11).
The primacy of the individual, and the importance of maternal capacity (or lack thereof) as a cause of elevated rates of infant mortality is not only observable in the ways in which administrators wrote about the Maltese, it is also evident in the kinds of interventions which were instituted in the British island colony, as these tended to be aimed at altering the individual behavioural practices of mothers and midwives (see Chapter 5). However, colonial administrators were caught at the crossroads of two prominent and juxtaposed discourses: the importance of curtailing infant mortality and the perceived necessity of reducing population size and growth (as explained in Chapter 6), which may explain why the strategies of intervention were limited in scale and efficacy. That is, perhaps in light of the intersecting and conflicting discourses and imperatives of population- and infant mortality reduction, colonial authorities’ references to ignorance and apathy of the Maltese were really an example of projection: Was it the British who found themselves lacking the knowledge and the experience to successfully lower the infant mortality rate (ignorance)? And was it the British who remained indifferent and uncertain as to the merits of reducing infant deaths in the context of over-population (apathy)?

Regardless of the knowledge of colonial administrators or the merits of their strategies of intervention, the quantitative analyses undertaken in this chapter suggest that multiparity and an earlier weaning age were associated with greater risk of infant death within individual families. Therefore, perhaps reducing family sizes or encouraging women to prolong breast-feeding would have effectively reduced infant mortality rates. However, it is important not to lose sight of a fundamental fact: the reason why early weaning was dangerous to infant health in Malta was because these infants would
thereafter be exposed to food and water sources which were contaminated and unsanitary. Having more children and/or weaning those children at a specific age were not, and are not, in and of themselves dangerous to infant health. As a consequence, the extent of inter-family variation in infant mortality (and any assessment of the efficacy of interventions initiated in the islands) presents an incomplete picture of the patterning of infant deaths in early twentieth century Malta. Specifically, it risks foregrounding the impact of individual decisions, thereby mirroring colonial perceptions, and downplaying the importance of the varying resources which Maltese (mothers and others) had at their disposal and the conditions in which they birthed and raised their children, which – as will be shown in the following chapter – were characterized by poverty and an underdeveloped socio-sanitary infrastructure.
Chapter 8 – Regional and Socioeconomic Variation in Infant Mortality

If infant mortality is to be influenced by urbanisation this investigation shows conclusively that we are in for a spell of steep rises... the country is decidedly being urbanised even in the villages.

Only in 68 instances [of 225] of the households inspected showed absence of hygienic disposal of night soil; in these 68 cases, however, conditions were as bad as they could be... hygiene of the several villages is well under way and it is hoped that when the present conditions are removed, and appreciable fall in the diarrhoeal diseases of infants will be realised.

- Dr. Joseph Morana, An Investigation on Infant Mortality in Malta (1946)

In Chapter 7, I showed that colonial explanations tended to blame elevated rates of infant mortality in Malta on excess fertility and improper infant feeding practices, and my analysis suggests that early weaning, regardless of the reason and irrespective of the undoubtedly varying effects of this on different individuals, was of great risk to infants; however, I argue that this was only the case because of the conditions within which Maltese families were obligated to live. The importance of living conditions will therefore be discussed and quantitatively assessed in this chapter to broaden this investigation of infant mortality in Malta to include the extent of intra-island variation, in an attempt to present a counterpoint to the colonial understanding which focused narrowly on the individual. This chapter will describe how, at the beginning of the twentieth century, a significant social, political, and economic divide existed between urban and rural Maltese, and I will empirically test the effect of this divide on rates of infant mortality in Malta’s urban, suburban, and rural districts. However, because this division glosses over many additional disparities – for example, in geographic location, area and household crowding, and employment opportunities – these analyses will be followed by a more detailed statistical and descriptive examination of disparities within
these districts, including a detailed discussion of differences in occupation, social status, and socio-sanitary infrastructure which characterized Malta’s various regions and localities, and the ways in which these disparities (including the division between urban and rural Maltese) were naturalized and racialized in colonial writings. This chapter will conclude by highlighting the instances in which the relationship between living conditions and health statuses were noted in writings about the colony, and the ways in which these discourses were de-emphasized in favour of explanations which centred on the behaviours of individuals.

The Division Between Urban and Rural Life

Today, as Aguis (1990:314) argues, “the urban-rural difference is very hard to discern”; because many of Malta’s towns and villages adjoin each other “to the extent that the central and southern areas one can speak of a continuous conurbation”, he claims that localities “mingle inextricably” such that it’s hardly possible to speak of a rural and an urban condition (Aguis 1990:314). However, in the period under investigation in this dissertation, the divide between urban and rural Malta was purportedly significant. Buxton (1922), in his anthropological endeavours in the early 1920s, reflected that the separation of urban and rural was more of a social than a geographical cleavage, reflected in a marked difference in the conditions under which the populations lived. That is, despite the small size of the island, which forced people to live in close proximity, there remained a marked division between country and town, and considerable differences between the rural regions (Malta’s villages), and the urban regions known as Il-Belt (the city of Valletta and its environs). For example, Wignacourt (1914:14) stated plainly “the people divide themselves naturally into town and country.” According to Boissevain,
who conducted fieldwork in Malta in the 1950s and 60s, there were “two worlds of Malta: town and country” (1970:69). Boissevain spent the majority of his time in a relatively small village, and the way of life and network of contacts that he developed there he deemed “completely alien” to his upper-class friends from the towns such that his occasional sorties among them highlighted the cleavage between the villagers and the townspeople (1970:69).

Specifically, Boissevain noted differences in education, dress, manners, behaviours, interests, and language between country and town dwellers – and traced much of these differences to the tendency of upper class Maltese inhabitants having “studiously imitated” their “foreign masters” who resided in the cities (Boissevain 1965:28; Boissevain 1974:99). With regards to language, he pointed to noticeable differences between the vocabulary, inflections, and pronunciations used in town and country: he spoke of the use of many more Italian and English words and expressions in the towns, the tendency of Maltese inhabitants of Sliema (an upscale neighbourhood which will be discussed in more detail below) to speak more English than (English-accented) Maltese and of “the heavy consonants and broad vowels of the uneducated countryman” (Boissevain 1965:28, emphasis added), many of whom spoke local dialects in addition to a standard Maltese taught in area schools. Moreover, because Boissevain acquired his proficiency in the Maltese language in a small village (which he refers to in his work as Hal-Farrug), he found that in interactions with townspeople, women in

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78 Although the timing of Boissevain’s fieldwork does not correspond with the main period under investigation in this dissertation, the insights he provides are useful; and there is good reason to believe that the social structures and divisions he describes were in existence just a few decades earlier.
particular “cooed in their English-accented, Italianized Maltese at the quaint, rustic way I spoke their language” (1970:69).

These references to ‘heavy’ and ‘broad’ pronunciations and ‘quaint, rustic’ Maltese are not merely statements of fact regarding language differences; they reveal value judgments. Similarly, with regards to common practices and interests, townspeople not only preferred different means of socializing and entertainment such as formal visits, large receptions, recitals by British Council musicians and Shakespeare’s plays (Boissevain 1996), they regarded “the religious feasts, processions, and fireworks, so characteristic of village life, with abhorrence” (Boissevain 1974:99). According to Boissevain, until the late 1950s, attitudes of both rural and urban Maltese towards the countryside itself were largely negative; it was considered dangerous, uncouth, and uncivilized such that bourgeois inhabitants of the towns looked down upon villagers, who in turn looked down on their farming neighbours (Boissevain 2001). In regards to his residence in Hal-Farrug, Boissevain’s town-based acquaintances found it inconceivable that anyone would choose to live in such a locale, assumed a tragedy must have befallen him and his family, and spoke in a patronizing and disdainful manner about Hal-Farrug, villages like it, and the people who lived there (Boissevain 1970).

Others also reported major differences in the life-ways of urban and rural Maltese. In her life history, Maria Calleja recalls villages before World War II as places with no opportunities in contrast to the more prosperous towns (Galley 1994). Bloomfield (1935:211) spoke of the farming villages he visited on his country excursions during the same period as “far removed from life in Valletta”, and went on to describe the small

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79 As discussed in Chapter 3, use of the Italian language, in contrast to the ability to speak only Maltese, was a marker of higher status within Malta.
farm holders as “living sparsely... hording their money, too conservative to trust in a bank.” While Maltese villages were often referred to in this way, hinting at their backwardness, attitudes towards the smaller (even more rural) island of Gozo highlight the divide. Fairfield and Drummond Shiels (1938:15) noted the “simple peasant life” in Malta’s rural regions, but emphasized the “even harder conditions, more primitive education and certainly even greater tendency to restrict feminine activities” in Gozo. In contrast, contemporary scholars argue that, in the past, more built-up landscapes, such as those of the urban and suburban regions, were associated with ‘civilization’ (Boissevain 2001), and the elite “generally despised the peasantry” and aspired to “genteel living in the city” (Sant Cassia 1999:260). The potency of this former contempt for rurality can be attested to by its enduring nature; even very recently, a “generalized negative attitude” of mainland Maltese towards village-dwelling Gozitans has been noted, with the latter viewed as backward in education, behaviour and dress (Lafayette 1997:76). Similarly, Andrews (2001:18) noted the recent inclination of Maltese individuals, even in her own family, towards prejudice against and disdain for Gozo, to judge it on its rural features, and to “jibe at the fact that many Gozitans were so backwards as to not wear footwear till the late sixties.”

However, portrayals of Malta’s rural and urban inhabitants were not one-sided; for example, in 1914 Wignacourt (1914:14) – spoke disparagingly of townspeople and idealized the village peasant, albeit somewhat condescendingly, as “a simple, contented, hard-working, thrifty, good-humoured fellow, capable of little beyond his daily round, but carrying that out to perfection.” Stereotypes arising out of social and cultural

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80 Interestingly, the habit of going without shoes was a symbol that was taken up by Ebejer (1969) in his novel, to highlight a conflict between a farmer (who himself had “bare feet, dark and cracked like ancient roots”) and his son; the father insisted that his son wear shoes to demonstrate that he was educated.
differences between town and country were also not solely directed at the rural Maltese. Several decades later, Boissevain (1965:28) argued that while the villager was sometimes portrayed as “an illiterate rustic who spends his money on wine and fireworks, without a thought for the future of his children”, the typical townsmen was often described by villagers as “a white-collar worker who goes to cocktail parties, tries to look like an Englishman – pipe, tweeds and moustache – and speaks English to his children.” Additionally, he argued that both caricatures were gross exaggerations which contained elements of truth. For example, the preference for foreign words amongst some townspeople (particularly those of Sliema) earned them the “the collective, and slightly derogatory, nickname of tal-mama, which derives from the habit of using the Italian word mamà (mother) instead of the Maltese omm” (Boissevain 1965:28).

It is interesting to note that in recent years there has been a revaluation of “traditional” houses, songs (ghana), festivals, religious feasts, processions and fireworks, and other icons of Malta’s “rural past”, particularly among well-off young Maltese couples from urban middle-class areas (Boissevain 1996:108). This is occurring, as Boissevain argues, among young people and their parents who never experienced such life ways, regarding residences, pastimes, and activities that “less than two decades ago, they abhorred” (Boissevain 1974:99). Malta scholars have interpreted it as a form of nostalgia or ‘rediscovery’ of the traditional, embraced as ‘heritage’ (Boissevain 1996; Sant Cassia 2000). However, following Heller (2003), this could be a form of commodification of culture, and more specifically a means whereby middle-class Maltese have sought to retain privileged control over the resources of authentic Maltese identity.
in the context of a globalized new economy in which heritage tourism is an important component.

However, ultimately Boissevain argued that the divide between the two regions was not mainly a matter of language; rather:

The separation between town and country corresponds to a rough division of economic and political power, for villagers look to the urban area for employment, income and patronage. First of all, the seat of government is Valletta, and most of the senior civil servants live there or in Sliema… Secondly, almost all the professionals, wealthy business men, landlords and other important people who influence the affairs of the country live and work in the city or its suburbs (Boissevain 1965:27).

The divide between urban and rural regions thus corresponds to a difference in geography but also in social status and in wealth. The importance of occupational differences, along with social status, patronage, and area of residence, will be discussed in more detail below; however, Figure 8.1 shows the major differences in annual wages between domestic workers (of the lowest status, and one of the few means of employment available for women, although not geographically localized), agricultural workers based in rural localities, and those engaged in trade and manufacturing, who generally lived in the urban and suburban towns near the harbours (Galizia 1922). As Maria Calleja recalls, prior to World War II farm labourers and farmers were much poorer than the civil servants and business people who lived in town, although not as poorly paid as the predominantly female domestic workers (Galley 1994).
District Variation

In light of the purported divide between urban and rural Malta during the period under investigation in this dissertation, I considered it imperative to assess the degree to which this social division was reflected in differences in infant mortality rates in the more urban regions as compared to the rural localities. Recall, in the government health reports, censuses, and other documents, villages and towns (referred to as “localities”) were originally organized in three categories: Urban (around Valletta), Suburban (the suburbs around Valletta), and Rural Districts (outside of the more built-up area). Utilizing these categories, imposed by the colonial administrators, a comparison was made between the average infant mortality rates in urban, suburban, and rural localities, at each census point (using data file Aggregate 2 – A2). Notably, in the early twentieth century, cities and urban areas were often extremely crowded and unsanitary places to live – “graveyards of mankind” (according to British microbiologist John Cairns, as quoted in Garrett 1994); therefore, lower IMRs in the less densely populated rural regions, and higher rates in the urban regions would be consistent with this belief. In
contrast, the more privileged position of Malta’s urban dwellers would suggest that these localities would be characterized by lower infant mortality rates. In fact, although there was considerable variation within each district type, infant mortality rates in the rural regions were consistently higher, and based on an analysis of variance test (ANOVA) the differences between the districts’ mean infant mortality rates was significant or borderline significant for each of the three census years (see Table 8.1). Notably, for census years 1911 and 1921, the Urban District showed significantly lower infant mortality rates than the other regions; whereas, by 1931, it was the Rural District whose infant mortality rate was higher than the others.

Table 8.1 – Variation in Infant Mortality Rates Across Maltese Districts

<table>
<thead>
<tr>
<th>Year</th>
<th>District</th>
<th>IMR</th>
<th>Standard Deviation</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1911</td>
<td>Urban (N=5)</td>
<td>213.87</td>
<td>33.16</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suburban (N=7)</td>
<td>267.95</td>
<td>42.02</td>
<td>3.01</td>
<td>.066</td>
</tr>
<tr>
<td></td>
<td>Rural (N=18)</td>
<td>270.58</td>
<td>50.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1921</td>
<td>Urban (N=5)</td>
<td>204.75</td>
<td>37.14</td>
<td>5.91</td>
<td>.007</td>
</tr>
<tr>
<td></td>
<td>Suburban (N=7)</td>
<td>263.45</td>
<td>37.48</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rural (N=18)</td>
<td>300.02</td>
<td>64.61</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1931</td>
<td>Urban (N=5)</td>
<td>206.07</td>
<td>31.35</td>
<td>9.37</td>
<td>.001</td>
</tr>
<tr>
<td></td>
<td>Suburban (N=7)</td>
<td>256.71</td>
<td>53.99</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rural (N=18)</td>
<td>326.77</td>
<td>66.67</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* grey cells indicate significantly different means

In addition, when a linear regression analysis was run, the categorical variable “District” (as divided into urban, suburban, and rural) was determined to be a significant factor in the variability of the infant mortality rate, with rural communities demonstrating higher rates of infant mortality, particularly in the 1931 cohort. It should be noted here that linear regression is not typically performed on categorical variables; therefore, this result is illustrative rather than conclusive. What I wish to show in this analysis is that District designation was an important determinant, with rates of infant mortality lower in
Urban districts, higher in Suburban zones, and highest in the Rural regions. For example, the $R^2$ value for 1931 ($b=62.045$, $R^2=.407$, SE=58.99, $F=19.21$, $p=.000$; see Figure 8.2) indicates that the model containing district explains approximately 40 percent of the observed variability in the infant mortality rate.

Figure 8.2 – Malta Infant Mortality Rate & District Designation (N=30)

Lower predictive values were observed for the other census years in the regression analyses (1911: $b=23.862$, $R^2=.138$, SE=47.04, $F=4.47$, $p=.044$; 1921: $b=45.701$, $R^2=.299$, SE=55.04, $F=11.87$, $p=.002$), a result which is potentially indicative of a widening gap in infant mortality rates across districts. Consequently, additional analyses were undertaken to assess the degree to which these disparities between the various district types changed, or persisted, over time. Historical studies of long-term
trends in infant and child mortality have noted a closing of the gap between previously
disparate groups; for example, based on a mix of data from Sweden, Austria, the United
States and Great Britain, Antonovksy and Bernstein (1977) argued that the gap in infant
mortality between the highest and lowest social classes in the Western world narrowed
between 1910 and 1960. However, studies in late nineteenth and early twentieth century
Holland and Prussia recorded a widening of inequalities between social classes with
regards to infant mortality (Van Poppel et al. 2005). Consequently, the data (A2) was
split according to district type, and an ANOVA was run to determine whether or not there
were significant differences in infant mortality rates over the census years, in each of the
districts. In effect, infant mortality rates in the urban and suburban regions appear to
have been decreasing (although the variation was not statistically significant); whereas, in
the rural regions infant mortality rates in each of the census years were getting
progressively worse (see Table 8.2).

Table 8.2 – Variation in Infant Mortality Rates Over Time

<table>
<thead>
<tr>
<th>District</th>
<th>Year</th>
<th>IMR</th>
<th>Standard Deviation</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>1911</td>
<td>213.9</td>
<td>33.16</td>
<td>.105</td>
<td>.901</td>
</tr>
<tr>
<td>(N=5)</td>
<td>1921</td>
<td>204.8</td>
<td>37.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1931</td>
<td>208.2</td>
<td>31.35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suburban</td>
<td>1911</td>
<td>267.9</td>
<td>42.02</td>
<td>.110</td>
<td>.896</td>
</tr>
<tr>
<td>(N=7)</td>
<td>1921</td>
<td>263.4</td>
<td>37.48</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1931</td>
<td>256.7</td>
<td>53.99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>1911</td>
<td>270.8</td>
<td>50.75</td>
<td>3.824</td>
<td>.028</td>
</tr>
<tr>
<td>(N=18)</td>
<td>1921</td>
<td>300.0</td>
<td>64.31</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1931</td>
<td>326.8</td>
<td>66.66</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* grey cells indicate significantly different means

Disparities within Communities

Importantly, while it would be possible to accept, at face value, that urban regions
differed in important ways from their suburban and rural counterparts, and to attribute the
variations in IMR to the factors alluded to in the discourses discussed above – such as a lack of education, lower standards of living, disparities in wealth and social and political clout – additional inequalities would be glossed over in a discussion of urban versus rural conditions. Specifically, were infants at greater risk in certain rural regions as opposed to others? What factors – aside from ‘district type’ – were correlated with more elevated rates of infant mortality? And, what defines urbanity or rurality?

As previously stated, a great many variables were available for analysis. However the vast majority co-varied with District (urban/suburban/rural), such that their relative contribution to IMRs could not be assessed when district type was included in the regression analyses. That is, significant correlations were observed between District and the following factors: Distance from Valletta, Latitude, Longitude, Population, Persons per square mile, Persons per dwelling, Number of Agricultural workers, Percentage of Agricultural Workers, and Number of Industrial workers, all of which individually could have affected infant mortality rates in their own rights (see Table 8.3). 81 The only variables that were not strongly correlated with District were Birth-rate and the Percentage of Industrial Workers. 82 For example, all urban centres were very close to Valletta, had similar longitudes and latitudes, had large and densely packed populations, had a greater number of persons per dwelling, and had fewer agricultural workers and more industrial workers. In essence, what defines an urban centre is its population’s size

81 It should be noted that the reckoning of persons per square mile has been questioned by several sources. For example, Borg Cardona (1931) argues that this measure of population density does not serve as a true guide to population pressure because populations tend to mass together in well defined areas whereas density figures include open spaces of country which are sparsely populated. As such, these figures fail to capture the fact that many of the inhabitants of the suburbs and rural centres live under what could be described as urban conditions (Galizia 1922). Unfortunately, no other measure of population density was available for analysis; therefore, population per square mile was employed despite its purported limitations.

82 The role of elevation was not assessed because there was very little variation, with the max elevation at 253 meters.
and density, which increases the likelihood of a greater number of persons residing in each dwelling; additionally, the employment prospects of its inhabitants are less likely to be agricultural; and, in Malta, the urban localities were one continuous urban zone, separated in name more than in area.

Table 8.3 – Spearman’s Correlations According to District Designation

<table>
<thead>
<tr>
<th>Significant Variables</th>
<th>1911 N=30</th>
<th>1921 N=30</th>
<th>1931 N=30</th>
<th>All Years N=90</th>
<th>Nature of Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance from Valletta (km)</td>
<td></td>
<td></td>
<td></td>
<td>rho = .875 p = .000</td>
<td>Rural localities are farther away from Valletta</td>
</tr>
<tr>
<td>Latitude</td>
<td></td>
<td></td>
<td></td>
<td>-.374 &lt; .042</td>
<td>Rural localities are located in more southerly areas</td>
</tr>
<tr>
<td>Longitude</td>
<td></td>
<td></td>
<td></td>
<td>-.568 &lt; .001</td>
<td>Rural localities are located in more westerly areas</td>
</tr>
<tr>
<td>Population</td>
<td>-.695 &lt; .000</td>
<td>-.670 &lt; .000</td>
<td>-.683 &lt; .000</td>
<td>-.682 &lt; .000</td>
<td>Rural localities have lower population sizes</td>
</tr>
<tr>
<td>Persons per square mile</td>
<td>-.857 &lt; .000</td>
<td>-.876 &lt; .000</td>
<td>-.870 &lt; .000</td>
<td>-.867 &lt; .000</td>
<td>Rural localities have lower population densities</td>
</tr>
<tr>
<td>Persons per dwelling</td>
<td>-.544 &lt; .002</td>
<td>-.680 &lt; .002</td>
<td>-.711 &lt; .002</td>
<td>-.630 &lt; .000</td>
<td>Rural localities have fewer persons per dwelling</td>
</tr>
<tr>
<td>Number of Agricultural Workers</td>
<td>.679 &lt; .000</td>
<td>.641 &lt; .000</td>
<td>.679 &lt; .000</td>
<td>.674 &lt; .000</td>
<td>Rural localities have more agricultural workers</td>
</tr>
<tr>
<td>Number of Industrial Workers</td>
<td>-.694 &lt; .000</td>
<td>-.583 &lt; .000</td>
<td>-.696 &lt; .000</td>
<td>-.655 &lt; .000</td>
<td>Rural localities have fewer industrial workers</td>
</tr>
<tr>
<td>Percentage of Agricultural Workers</td>
<td>.870 &lt; .000</td>
<td>.876 &lt; .000</td>
<td>.876 &lt; .000</td>
<td>.867 &lt; .000</td>
<td>Rural localities have a greater percentage of agricultural workers</td>
</tr>
<tr>
<td>Average Birth Rate</td>
<td>.066</td>
<td>.053</td>
<td>.397</td>
<td>.168</td>
<td>Rural localities have a higher birth rate, but only in 1931</td>
</tr>
</tbody>
</table>

Non-significant Variables:

| Percentage of Industrial Workers | -.183 | -.122 | -.203 | -.152 | N/A |

* grey cells indicate a positive correlation

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83 District designation is treated as an ordinal variable (Urban = 1, Suburban = 2, Rural = 3) because a natural order existed among the groupings, with a smaller number indicating a larger population, a more densely populated area, and a more southeasterly location.
Despite the prominence of the discourse on urbanity as opposed to rurality, it should not be used to infer that all inhabitants of urban, suburban, or rural regions were homogenous. Within each district type, there was a great degree of variation in regional, locality-based, and individual employment, education, social status and general living conditions. At the level of the individual, for example, there were considerable differences in the standard of living of professionals living in the towns as compared to that of the average countryman (Boissevain 1965), but certain individuals within each locality had higher status and more important social positions as a result of educational, occupational, and wealth differentials (Lafayette 1997). In rural villages, professionals such as the government District Medical Officers and other more affluent individuals lived in the finest houses on the main squares of a village, with poorer people living in the alleys and streets remote from the square (Boissevain 1965). In addition, in rural regions wealth and status was reckoned according to the amount of land one had access to and the length of time one’s family held that land (Lafayette 1997). In spite of these disparities, Boissevain argued (1965:51) that until World War II, “there was relatively little difference in the standard of living of most villagers.”

However, Boissevain’s main area of study was not socioeconomic conditions, nor was it variations in health status, let alone the distribution and experience of infant mortality; therefore, I suspect that his statement is based more on anecdotal observations rather than extensive investigation or knowledge of the degree of variation in standards of living throughout Malta and its constituent villages. As a result, within this investigation, noting differences between urban, suburban, and rural regions IMRs was considered only a primary step in determining the extent of intra-island variation in infant mortality. As
such, it became important to determine whether there were additional disparities within each type of district. Therefore, in addition to separating the available data by census year (1911, 1921, 1931), the data was separated into three ‘Districts’ for subsequent analyses.

As Valletta was the main centre of commerce, the location where the majority of the population resided, and essentially the hub of the island, individuals residing in the localities closest to Valletta may have had increased access to employment, resources such as foodstuffs and other shipments, and other advantages like a more developed sanitary infrastructure which could have explained the relatively lower rates of infant mortality in the urban centres. It was therefore hypothesized that proximity to Valletta would be associated with lower rates of infant mortality, and three variables were used to assess the spatial dimension of infant death: Distance from Valletta as measured in kilometres, Latitude, and Longitude. Additionally, because rates of infant mortality were higher in rural regions, and one of the defining characteristics of rural living is a reliance on agriculture, it was hypothesized that localities with a greater number and percentage of agricultural workers, and concomitantly a lower number and percentage of industrial workers, would have higher infant mortality rates. Finally, once the differences between urban, suburban, and rural districts were controlled for, it was hypothesized that localities with higher populations, greater population densities, and a greater number of persons per dwelling would have higher IMRs – as crowding was a colonial explanation for increased mortality (as noted in Chapter 6), and it has been associated with greater susceptibility to disease and increased mortality in contemporary studies (Congdon 2001; D’Souza 1997).
A stepwise regression analysis was performed in order to evaluate the influence of each of these previously mentioned factors on IMR within each separate district – Urban, Suburban, and Rural. No significant results were obtained for the urban region, likely due to the low number of cases (N=5, for each census year) and to the relative lack of variation in the variables for this region. In order to increase the sample size, the years were subsequently combined for the Urban region (N=15), and in this instance, the Percentage of Industrial Workers came back as significant (b=4.296, adjusted $R^2=.289$, SE=26.75, $F=6.69$, $p=.023$). For the suburban region (N=7, for each census year), Latitude proved to be negatively correlated with infant mortality; that is, in areas of higher latitude, the more northerly localities – such as those above Valletta, rates of infant mortality were lower. Again, as noted in Chapter 6, in the suburban region the localities with lower birth rates had lower rates of infant mortality in 1921; although as previously stated this is likely due to the outlying value for Sliema (see Table 8.4).

Table 8.4 – Regression Results: Suburban District

<table>
<thead>
<tr>
<th>Year</th>
<th>Predictor</th>
<th>Adjusted $R^2$</th>
<th>Std. Error</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1911</td>
<td>Latitude</td>
<td>.755</td>
<td>20.81</td>
<td>19.47</td>
<td>.007</td>
</tr>
<tr>
<td></td>
<td>Average Birth Rate</td>
<td>.814</td>
<td>16.15</td>
<td>27.31</td>
<td>.003</td>
</tr>
<tr>
<td>1921</td>
<td>Average Birth Rate &amp; Persons per Square Mile</td>
<td>.961</td>
<td>7.40</td>
<td>74.98</td>
<td>.001</td>
</tr>
<tr>
<td>1931</td>
<td>Latitude</td>
<td>.691</td>
<td>30.01</td>
<td>14.41</td>
<td>.013</td>
</tr>
</tbody>
</table>

For the rural regions (N=18, for each census year), once again Latitude proved to be a significant predictor in 1911, 1921, and 1931, with more southerly localities demonstrating higher IMRs; however, the addition of Distance from Valletta in 1911 improved the predictive power of the model, with villages closer to Valletta showing higher infant mortality rates. Moreover, in 1931, Longitude proved to be the most significant predictor of infant mortality in the rural regions: villages of higher longitudes
(that is, those that were more easterly) had higher rates of infant mortality; however, the addition of Latitude in 1931 improved the predictive power of the model, with villages of lower latitude showing higher infant mortality rates (see Table 8.5).

Table 8.5 – Regression Results: Rural District

<table>
<thead>
<tr>
<th>Year</th>
<th>Predictor</th>
<th>Adjusted $R^2$</th>
<th>Std. Error</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1911</td>
<td>Latitude</td>
<td>.544</td>
<td>34.25</td>
<td>21.31</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Latitude &amp; Distance from Valletta (km)</td>
<td>.656</td>
<td>29.78</td>
<td>17.19</td>
<td>.000</td>
</tr>
<tr>
<td>1921</td>
<td>Latitude</td>
<td>.456</td>
<td>39.05</td>
<td>14.40</td>
<td>.002</td>
</tr>
<tr>
<td>1931</td>
<td>Longitude</td>
<td>.556</td>
<td>38.94</td>
<td>21.01</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>Longitude &amp; Latitude</td>
<td>.665</td>
<td>33.79</td>
<td>16.90</td>
<td>.000</td>
</tr>
</tbody>
</table>

To review, in 1911, proximity to Valletta was correlated with higher rates of infant mortality in the rural districts (in combination with latitude), a result contrary to the hypothesized relationship (see Figure 8.3). However, in 1911 (and, for the record, for all of the years under investigation), proximity to Valletta co-varied with the following factors: (1) Latitude, villages closer to Valletta were also the more southern villages (Pearson correlation: .468, p<.001); (2) Longitude, villages closer to Valletta were also the more easterly villages (Pearson correlation: -.881, p<.001); (3) Persons per square mile, villages closer to Valletta had higher population densities (Pearson correlation: -.512, p=.030); and (4) the Number and (5) the Percentage of Agricultural Workers, villages closer to Valletta had fewer agricultural workers (Pearson correlation: .472, p=.048 and .481, p=.043, respectively). Because of the large number of other factors which co-varied with this variable, there is not a great deal of explanatory value to this relationship.
In 1931, for the rural districts, the variable with the most predictive power was Longitude; again, contrary to the relationship hypothesized, eastern villages demonstrated higher rates of infant mortality than more westerly villages (see Figure 8.4). As stated above, longitude was correlated with Distance from Valletta, but it co-varied with three additional variables: (1) Latitude, villages of higher longitude (those more easterly) were also the more southern, lower latitude, villages (Pearson correlation: -.647, p=.004); (2) Persons per square mile, villages of higher longitude (those more easterly) had higher population densities (Pearson correlation: .473, p=.048); and (3) Number of Agricultural Workers, villages of higher longitude (those more easterly) had fewer agricultural workers (Pearson correlation: -.517, p=.028).
Finally, the variable that appeared most frequently in the regression analyses was Latitude, with both suburban and rural localities of lower latitudes (those more southerly) demonstrating higher rates of infant mortality (see Figure 8.5). With regards to the suburban localities, towns south of Valletta had higher rates of infant mortality than those north of Valletta; and – importantly – the only significant co-variation was in the percentage of industrial workers, with the more southerly towns hosting a greater percentage of industrial workers (1931: Pearson correlation: -.801, p=.031). Within the rural regions, localities located in the more southern area of Malta had higher rates of infant mortality. As previously stated, latitude co-varied with Distance from Valletta and with Longitude, and this relationship is largely due to the geography of Malta – with its
oblong shape, the location of its more urban centres, and the distribution of its various towns and villages throughout the island. In addition, borderline associations were observed between latitude and the number of agricultural workers (with more southerly regions hosting fewer agricultural workers), as well as the percentage of industrial workers (with these regions hosting a greater proportion of industrial workers).

Figure 8.5 – Infant Mortality & Latitude, Rural District (N=18)

In summary, IMR increased, in both the suburban and the rural districts, as one moved from the northwest to the southeast regions of Malta. This southeast region also hosted fewer agricultural workers (in the rural areas) and more industrial workers. In addition, in the urban district, infant mortality rates were greater in areas with a greater percentage of industrial workers. In order to interpret these results, they must be placed
into context; specifically, the explanation of these findings must attend to differences between the rural regions in the northwest of Malta as compared to those of the southeast, differences between the northern and southern suburbs of Valletta, and differences in occupation, as well as taking into account the previously observed (and widening) disparities between urban, suburban, and rural regions.

**Life in Malta’s Rural Districts**

To a researcher familiar with the Maltese context, the most striking difference between northwest and southeast Malta is the relative importance of agricultural as opposed to fishing-based pursuits, with fishing communities predominantly located in the southeast region of the island. While above the distinction is made between urban and rural dwellers, this glosses over differences in localities’ respective livelihoods and occupations which could have important consequences for the health and well-being of the inhabitants of the various regions (as well as their infants). In some instances, occupations in agriculture and fisheries were discussed conjointly. For example, Borg Olivier and colleagues (1955:93) spoke of the two occupations as being traditional to the islands, employing large sections of the population, but noted that “unfortunately they have not progressed with time and their produce now lies hopelessly behind the requirements of the population.” However, in large part, they should be addressed separately, and were discussed separately in historical accounts.

With regards to agricultural pursuits, the generally disparaging comments about rural village life (see above) were largely directed at farming communities, in part because agriculture was “by far the largest and most important industry” (Mowatt and Chalmers 1911:6). In 1910-11, the estimated area under cultivation on the island was
41,865 acres of a total area of 75,000 (some of which Peto later [1927:59] argued was “useless for cultivation”), with most farms consisting of small holdings of 3-5 acres surrounded by high loose stone walls to protect the crops from wind and water erosion (Mowatt and Chalmers 1911).84 Although a large number of persons were employed in agricultural pursuits, these small farms were largely run on a family basis, with the majority of workers being family members (including women and children), few of whom were full-time employees as much of the work was seasonal or part-time in nature (Curmi 1932; Knott 1947). Although most farmers also kept animals such as mules, cows, sheep, donkeys, pigs, and poultry (Zammit 1926), in addition to the ubiquitous goats and rabbits, the cultivation of fields was primary. After the decline of the cotton industry in the mid-nineteenth century, the principal crops grown were wheat, barley, sullah (red clover), and beans which were used to feed a farmer’s own livestock; potatoes and fresh vegetables such as tomatoes and onions, which were staple foods of local consumption and were the main export crops; as well as small quantities of cumin and other vegetable seed, grapes (called ‘vine’, used for table grapes and for wine), and carob, olive, and fig trees (Colonial Office 1951; Tagliaferro 1892; Zammit 1926). In addition, in the valleys and in select well-sheltered fields, fruit trees could be grown yielding oranges, pomegranates, lemons, pears, apples, peaches, nectarines, and loquats; however, the shallow soil of most fields was not adapted to the growth of trees, indeed, the Maltese landscape is notable for its lack of trees (Strickland 1955a; Zammit 1926).

In the 1920s, Zammit (1926:12-13) spoke positively, if somewhat condescendingly, about the typical Maltese farmer; he claimed that “the Maltese

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84 Today, the vast majority of Maltese farms remain small in size, and the loose stone walls surrounding the fields are a characteristic feature of Malta.
husbandsmen [sic] is an expert in using his fields to the best advantage” and “the methods of cultivation used in Malta are quite primitive, but so well adapted to the condition of the soil that they could hardly be improved.” Nearly thirty years later, Strickland (1955a:17) spoke similarly of their “old-fashioned” yet effective techniques: “In the cultivation of his fields the Maltese farmer would be hard to beat; his most certainly is an art which goes back to Biblical days.” However, interestingly, much earlier accounts considered the typical methods of the local farmer – which consisted of crop rotation and the use of hoes and small animal-drawn ploughs – not as adaptive but as backwards: “The land is capable, however, of being used to better advantage. The farmers do not fully understand the requirements of continental markets, and are ignorant of modern methods of cultivation” (Mowatt and Chalmers 1911:6).85

This latter quote comes from the 1911 report of the ‘Royal Commission on the Finances, Economic Condition, and Judicial Procedure of Malta’, and was a conclusion reached after a series of interviews during which the commissioners enquired extensively into the methods and standards of living of Maltese farmers. Individuals who gave evidence included Mr. Alexander Menzies MacFarlane (Government Veterinary Surgeon and Superintendent of Slaughter-houses); when asked about the kind of life the agricultural population led, whether they were well-nourished or half-starved, he responded “you ought to see some of them that are starved a bit. Some of them really do feel the pinch; especially in the outlying districts now you will come across them where they are pinched” (1911:204). He then went on to describe the typical diet of the agricultural population, which consisted principally of bread supplemented with oil,

85 Note, again, the use of terms such as ‘ignorant’ as opposed to ‘modern’.
cheese, tomatoes, onions, and potatoes, as most farmers could not afford to purchase meat; therefore – after some prompting by his questioners – he admitted that their standard of living had gone down. Nevertheless, he argued that “they have no ambition in life; so long as they live with their mule and their goat, they are quite happy” (Menzie MacFarlane 1911:204).

During the course of these proceedings, the royal commissioners also inquired into farmers’ interactions with village brokers and pitcali (agents who purchase farmers produce and sell it in the local markets). In Menzie MacFarlane’s (1911) opinion, these agents and pitcali (singular: pitcale) would fix a ring and agree not to overbid each other, such that cultivators were forced to accept the price they were offered. Similarly, Mr. Lawrence Manché, MD (Late Surgeon Lieutenant-Colonel, late Professor of Ophthalmology in the University, and Ophthalmic Surgeon on the Civil Hospital), testified that many agriculturalists were in financial difficulty, indebted to moneylenders (many of whom were pitcali themselves) as a result of the rings of purchasers who would later sell this produce in the market for more than double the price they offered to cultivators. Manché (1911) explained that prices could be fixed because of the means whereby the produce was sold; the cultivator would bring his goods to the pitcale, buyers would whisper in the ear of the pitcale the price they were willing to pay, and the pitcale would distribute the vegetables accordingly, paying a percentage of the sale-price (which no one other than the pitcale was privy to) to the farmer. According to Manché (1911:343), the agriculturalists were aware of the fact that the pitcali sold their goods for significantly more than they were paid, arguing “we are not treated fairly.”
In response to the testimony of Menzie MacFarlane and Manché, the commissioners interviewed Floriana pitcale Mr. Salvatore Gatt. Unsurprisingly, Gatt claimed that the system of private bidding was an old custom “to the advantage of the vendors, because if bidding is made public then a certain ring can be formed and they keep down the price”, and that selling one’s produce through a pitcale ensured a higher price because a pitcale could attract more buyers than an individual vendor (1912:486). He assured the commissioners that he fixed a price at the highest bid, only lowering it when items went unsold, and only received a small commission to cover all risks and bad debts; however, he also admitted to advancing money to his vendors such that they were at times indebted to him and he acted, in the words of the commissioners, like “their banker.”

These testimonials point to the economic and social marginalization of the typical Maltese farmer, particularly in comparison to the town-based pitcale to whom he was often indebted; however, the position of the typical fisherman in Malta was often even more insecure.

**Fishing Communities of Malta**

The main centres for fishing in Malta were Marsaxlokk, Wied-iż-Żurrieq, and Marsascala – all of which were located in the rural southeast region of Malta, an area which recorded the highest rates of infant mortality in the island of Malta. While it would be unwise to assume that agriculturalists (as described above) could be in a more advantageous position than other Maltese inhabitants, contemporary descriptions of fishing communities and those who engage in fishing as their primary occupation indicate
that this can be an extremely insecure livelihood (e.g. Branch et al. 2002). First, much of the above discussion of the interactions between cultivators and pitcali can be extended to apply to those between fisherman and their middlemen, as a different group of pitcali specialized in fish that they would purchase from local fisherman for sale in the urban localities. And, through the 1950s, auctioneers were found to be selling the fish for one price and quoting another, lower one to the fisherman (Wilhelmsen 1977:531). Thus, as Manché (1911) explained, the fisherman received even less for their catch than the agriculturalists received for their produce such that Manché asked them – pointedly and extremely unsympathetically – “well, you are a stupid kind of people; why does not one of you go and sell it even in the streets in the casals, if not in the Valletta market?”; however, this was not seen to be possible for fisherman who took whatever payment they could get in order to allow them to return to the sea to fish again. Importantly, indebtedness appeared to be more common amongst fisherman, who would occasionally borrow money from pitcali to repair their boats or mend their nets, such that an individual fisherman might have to give whichever pitcale forwarded the loan all the fish he caught in an entire year in repayment (Manché 1911).

The low price fisherman received for their catch was partially attributable to unfair pricing on the part of the pitcali; however, it was also related to the seasonal nature of the profession, the relatively low quantities of fish that could be caught, and the perishable quality of fish. Although fish was an essential subsistence food and an important means of generating income for fisherman, the quantity of fish that one could catch fluctuated greatly according to the season, with the larger catches landed between

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86 This assertion is not unproblematic; for example, Béné and colleagues (2003) argue that well-known adages such as "the fishermen are the poorest of the poor" or "the fishery is the activity of last resort" do not reflect the complexity of the real situation.
May and November (see Figure 8.6). The availability of fish would necessarily affect the prices which could be garnered in the market; therefore, when more fish could be caught prices would be kept low, and fishermen were not in a position to negotiate higher prices during the low-season as quantities of fresh fish were imported to meet local demand (Colonial Office 1951). Moreover, remarkable variation in prices on the part of retailers – with up to a three-fold change in price over the course of a week – made it difficult for the fisherman to predict price levels such that they could be affected adversely (Burdon 1956).

Figure 8.6 – Average Monthly Yield, Fishing (1949-1953)

In some instances, the adverse conditions facing fishermen were described as being out of their control. For example, T.W. Burdon (former deputy director of fisheries in Singapore), in his 1956 ‘Report on the Fishing Industry of Malta’, acknowledged that the productivity of the Mediterranean sea was not high due to a scarcity of microorganisms (hence the clear water) on which sea-life depended, in combination with years of heavy fishing. In addition, Burdon (1956) argued that the paucity of fish and the sea’s depth – in light of the limited capabilities of Maltese fishing boats – kept fisherman to the fisheries in and near the territorial waters of Malta. Although Burdon’s observations are
made in the 1950s, the capacities of the Maltese fishing boats and the corresponding
limits on the catches made by fisherman at that point are likely representative of the
entire period under study. Similarly, a 1951 report from the Colonial Office
acknowledged that the fishing vessels employed by the Maltese (undecked, at under 40
feet, and propelled by diesel engines) were only suitable for use in smooth seas;
therefore, they were confined to fishing within 25 miles of the island and unable to reach
more prime fishing grounds 100 miles to the west (Colonial Office 1951). In addition,
Burdon (1956:10) pointed out that the area in close proximity to Malta was “a region in
which the Armed Forces [were] extremely active”; therefore, in lieu of restricting their
fishing activities, many fishermen accepted the additional danger of bombing, firing, and
the like as an additional occupational hazard. This would have been an even more
significant risk during the build-up to and active fighting of World War I and II.

On the one hand Burdon was supportive and positive regarding the efforts of
Maltese fisherman, whom he described as progressive and possessing extensive
knowledge of local fisheries, stating “the ability of these fishermen is outstanding and
although they work under a serious disadvantage they continue to make an important
contribution to fish supplies” (1956:12). However, he also contended that they had little
contact with the world beyond Malta and did not learn about new developments in fishing
technique – which was aggravated by their comparatively low standard of education
(Burdon 1956:12). Perhaps it was because of their less extensive education, but during
the time period under investigation a fisherman’s status was generally believed to be
quite low, as attested to by the proverb “Min jaqbad ix-XLIEF hajtu ssir tief: He who
takes to fishing ruins his life” (Aquilina 1972). In part, this may have been related to the
insecurity of the occupation; references to the eastern coast’s “poor fisherman” at the end of the nineteenth century (Tagliaferro 1892:17) and Maria Calleja’s memories of people coming, almost daily prior to the Second World War, from the fishing areas to beg are evidence of their relative poverty (Galley 1994). Regardless, as Wilhelmsen (1977:395) explained: “The attitude toward the fisherman in those days was that they were uneducated ruffians capable of handling only fish and not much more.” Sir Temi Zammit’s short story “A Small Advantage and a Big Bargain” (as translated by Ellul 1995) takes up this commonplace attitude toward the occupation of fishing. In the story, a young girl, Rose, injures herself and is helped by a young man, Paul, whom she perceives to be an untidily dressed typical seashore fisherman, although she is surprised by his kind words and good behaviour, because “one would not have imagined all this from a poor fisherman” (Ellul 1995:33-4). Significantly, after Rose and Paul become friends, she finds out that he is, in fact, a gentlemen, when his parents – referred to as baron and baroness, and adorned in gold jewellery – come to ask Rose’s aunt about marrying their son, Paul.

Zammit’s story places the marginalized social and economic position of the Maltese fisherman in stark contrast to the upper-class gentlemen, but also demonstrates clearly that Rose’s position (even as an orphaned villager being cared for by a lone aunt) was superior to that of Paul, if he was only a ‘poor fisherman’. Consequently, this one short story highlights the degree of inequality which existed within rural regions, such that the inhabitants of the southeast regions who relied on fishing for their livelihoods were of a lower status and suffered from a greater degree of poverty than even the average Maltese farmer, while simultaneously pointing to the more significant divide
between lower and upper classes in Malta. In the next section, this discussion of division according to occupation will be extended beyond the rural region to include occupational and class differences within the suburban localities.

**Suburban Differentials in Occupation and Social Status**

Many researchers have remarked on the significance of class to the Maltese. The social structure in Malta was (and remains, according to some scholars) highly stratified, with institutionalized social inequality well captured by the Maltese proverb “one shoes the horse and the other rides” (Goodwin 2002). This two-way split of the Maltese population was also evidenced by the decision of the Lieutenant Governor, in 1905, to divide tramway carriages into two classes (Lieutenant Governor 1905). On a slightly different plane, Sultana and Baldacchino (1994) identify 3 classes in contemporary Malta, the Dominant Class (a power elite), the Petty Bourgeoisie (the middle class), and the Subordinate Class (whose level of income and power at work and beyond is low or virtually non-existent). This first group, those of the upper classes, had connections, moved in the right circles, and came from noble or wealthy business families (Andrews 2001:25). Prior to World War II, Maria Calleja recalls referring to this group as *is-sinjuri*, a title of respect (Galley 1994:31). Moreover, although they resided in the most beautiful dwellings in the urban centres, she noted the importance of the use of the Italian language, more so than differences in housing or dress, as a sign of distinction and culture.

Interestingly, class divisions were regularly brought up in discussions of the usefulness of English, Italian, and Maltese. For example, Patrick Joseph Keenan (Resident Commissioner of National Education for Ireland), in his ‘Report upon the
Educational System of Malta’, stated that for the labouring classes – later referred to as the lower classes – the vernacular (Maltese) would be sufficient; whereas the middle classes would be best served by knowing English. In contrast, in a letter by Crown Advocate Sir Adrian Dingli (1878: 115), included in Keenan’s report, he argued that the lower classes would be better served in “their few humble wants”, and to bring them into the sphere of the language of the higher classes, by learning to read and write English or Italian rather than Maltese; whereas the middle and upper classes would be required to know Italian or English to obtain a good education (see Chapter 3 for a more extensive discussion of the importance of language in Malta).

In part, this division into social classes followed the division between urban and rural areas of residence; however, within each of these district types, there was an additional division according to occupation. As explained above, within the rural regions the divide between the primacies of the livelihoods of farming versus fishing is significant; similarly, within the urban and suburban regions occupational differences denoted differences in social and economic status. For example, *is-sinjuri* consisted mainly of wealthy people such as doctors, lawyers, and rich businessmen (Galley 1994); the middle-classes comprised those engaged in trade, the professions, and public service, with policeman and soldiers in the native regiment ranking somewhat lower than middle-class, but higher than the labouring or lower classes. Farmers and fisherman of the rural regions fell below this group, with servants in the bottom strata (Keenan 1879). According to Boissevain (1965), in the 1950s and 1960s education was an important marker of social status because, in addition to allowing people to read (thus freeing them from dependence on patrons to interpret written documents), it led to better employment
opportunities, particularly in civil service, the professions, and many commercial enterprises.\textsuperscript{87} However, one’s occupation, in and of itself, was most important in determining one’s social status; and he noted the most significant difference between non-manual jobs (professions like priest, doctor, lawyer, chemist, or teacher) which held the highest status, and manual occupations (such as farming), which were of lower status (Boissevain 1965).

Other more contemporary scholars similarly pointed to the disdain for manual labour among the Maltese. For example, Goodwin (2002) noted a bias amongst Maltese against work in rustic settings, jobs that are physically exhausting, or involved getting dirty, such a manual work. In his novel, \textit{An Alley in Malta}, Chetcuti (1976:74) had one of his characters tell the girl he loved: “you only love the boy from Valletta because of his smart clothes and his snow white handkerchief tucked in his pocket. You have no time for me with my torn trousers, working with a spade instead of a pen.” However, this is not a new phenomenon, in a report on primary schools in Malta from just after World War II, Vassallo and colleagues (1948:13) noted a prejudice against the learning of a trade amongst young people who preferred to attend Secondary School or the Lyceum in hopes of achieving a clerical post. Prior to the war, Maria Calleja contrasted the “hard time” people in the village had, having to get up at four o’clock in the morning to work out-of-doors, to those who held “soft jobs” to which they wore coats, shoes, and stockings (Galley 1994:33). Even earlier, in 1926, the head of the department of

\textsuperscript{87} This reference to patronage also helps to explain why civil service was considered to be a high status job. As a government clerical officer, one held a “steady, relatively easy job with a good cash income and a comfortable pension...[and also had] ready access to influential persons in the government” (Boissevain 1965: 51). For more information on patronage – that is the importance of influential patrons who use their influence to assist and protect some other person, usually of a lower class – in Malta, see Boissevain (1965, 1974).
emigration wrote of the importance of training Maltese youths in trades in order to improve their opportunities abroad; he argued that young men needed to understand a salient truth “that there is no shame in manual labour” (Casolani 1926:C7), and:

these unfortunate youths should be taught to work with their hands as well as with their brains, and it should be impressed upon them from childhood that they should not be ashamed to take the coat off their backs (Casolani 1925:C3).

That these claims were even made, that Casolani had to argue this point, suggests that manual occupations were indeed considered lower in status during this period, as well.

While these differences in status, income, and education are noteworthy, they are of particular importance to this investigation of infant mortality insofar as they corresponded with residence patterns; and, in fact, within Malta’s suburbs and urban areas, much like in the rural regions, one’s occupation was a strong determinant of one’s area of residence.

**Social Divisions and Area of Residence**

Although the relationships between area of residence and occupational group should not be overstated, as there was certainly a degree of intermingling of populations within each locality and region in Malta, there are trends that are nonetheless noteworthy. Specifically, in the urban and suburban regions, the areas above Valletta, historically and contemporaneously, were wealthier and more upper-class areas. As Abela (1959:Li) stated in his report on economic activities in Malta following the 1957 census, “the professional, managerial, administrative and clerical classes are largely in the Suburban North (Gzira, Msida, St. Julian’s and Sliema) and the Central (Attard, Balzan, Lija and Qormi) locality groups.” The town of Sliema, in particular, started off to house the
British during the nineteenth century and would go on to become associated with sophisticated Maltese gentry (Andrews 2001). Galley (1994:201, n.86) argues that Sliema did not become a crucible and a symbol of elite living until following the Second World War; however, even prior to that period it was home to Malta’s wealthiest individuals. As Boissevain (1974:104) explained, in 1974:

For the past forty years it [Sliema] has been regarded as the best residential area of the island and many of the upwardly mobile government, military and business classes have moved there. It is predominantly a white-collar residential area. Many English and other foreign residents live there.

Importantly, Sliema’s high status (or the high status and wealth of the suburb’s residents) appears to have been reflected in lower rates of infant mortality. Figure 8.7, which separates the localities into three district types, shows that Sliema and St. Julian’s – the wealthiest suburban region – had a distinctively low IMR, even compared to other suburban regions, as evidenced by its outlying value.88 To return briefly to the disparities discussed above, in the rural regions, Ghaxaq, located in the poorest rural region in the southeast of Malta, was also an outlier in comparison to other rural regions; that is, Ghaxaq’s IMR was significantly higher than the other localities (Urban N=5, Suburban N=7, Rural N=18; df=29, F=5.907, p=.007).89

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88 Within the government reports and censes, some Maltese localities were discussed and enumerated conjointly, as was the case with Sliema & St. Julian’s.
89 While the figure is for 1921, it should be noted that both Sliema & St. Julian’s and Ghaxaq were outliers for the other census years.
In contrast to Sliema’s exceptionally high status and the concentration of professional occupations in that suburb, the towns below Valletta were areas in which employees of the dockyard and other industry workers, such as quarrymen were most likely to reside. (Recall that these were the areas which recorded a greater number and proportion of industrial workers in the statistical analyses as well.) Importantly, these were also the less well-remunerated forms of employment. As Gulia (1875:11) noted toward the end of the nineteenth century, the bulk of the population in the three cities (that is, Vittoriosa, Cospicua and Senglea, all south of Valletta) and their environs was made up of people of the poorer classes, whom he additionally described as “very backward in hygiene.” Even today, this area remains largely industrial and working-
class, in contrast to the upscale – and tourist-focused – areas north of Valletta, such as Sliema.

The Meaning of Social Divisions

The division between urban and rural, and the distinctions between upper, middle, and lower classes in Malta were (and are) of importance to the people of Malta; therefore, the construction of these categories requires a degree of attention. In her analyses of nearby Italy, Schneider (1998:4) has argued that “Italians have reified their internal differences in relation to a much wider context for defining difference”, a context set by the dominant colonial and neo-colonial powers of the nineteenth and twentieth centuries, (that is, England, France, and the United States). Following Said (1978), Schneider (1998:5) argues that the divide between northern and southern Italians was informed by “the radically dichotomous discourse on Orientalism” such that simplistic binary categories “made distinctions into entities” (following Herzfeld 1997:15). However, she also noted that this propensity towards binary opposition connected with popular cosmologies of difference between North and South; Europe-wide, both northerners and southerners had historically seen the “other” as “different and in some respects morally inferior” (Schneider 1998:4). However, within Italy this developed into what she terms the “Southern Question” discourse, wherein by the end of the nineteenth century, the South came to signify backward, agrarian, clientelism in contrast to the North’s advanced, industrial, well-governed, civic society – a difference which became not only essentialized, but racialized. Following social Darwinist Herbert Spencer, Southern Italians were posited as possessing inferior Mediterranean-type genes which threatened to
dilute the northerners’ European (Alpine, Aryan, Celtic) endowment (Schneider 1998:10) and were represented as “as racial or cultural others whose differences from northerners were intrinsic and for all time” (Schneider 1998:12). Importantly, Schneider (1998) argues that these negative orientalist constructions are usually assumed to emanate from outsiders; however, she points to the complicity of Italians (particularly the elite) in reinforcing these constructions to define themselves.

Within Malta, a similar history of class division is present; going back to the sixteenth century, the Knights of St. John imposed an ideology of status and social standing, the divine right of some to rule over others – particularly the rights of the aristocracy over commoners (Goodwin 2002). Consequently, with the arrival of the British in the early nineteenth century, they found a society that was not a blank-slate awaiting the imposition of binary categories, but a population with a history of hierarchy and inequality. However, the division of Malta’s people into urban versus rural or separate classes was not restricted to the Maltese; indeed, the most notable examples of the racializing of these categories come not from the Maltese themselves but from outsiders writing about the Maltese in the 1920s.

The first example of the racializing of Malta’s various populations comes from the “anthropological” endeavours of L.H.D. Buxton, who wrote two papers: ‘The ethnology of Malta and Gozo’ (1922) for the Royal Anthropological Institute of Great Britain and Ireland, and ‘Malta: an anthropogeographic study’ (1924), for the Geographical Review. In this latter paper he is most interested in the racial identity of the Maltese population as a whole (as discussed in Chapter 3), whereas, in the former he notes internal variation. Specifically, borrowing from the division of the census, he
examined the islands as two areas, Urban and Rural, and included the island of Gozo as well. Buxton (1922) noted significant differences between the urban and rural districts in their skeletal and cranial characteristics, as well noticeable differences between urban, rural, and Gozo populations with regards to their pigmentation, with rural and Gozo groups demonstrating higher Parsons’ indices (urban 67.4, rural 67.7, Gozo 74.5) indicating that they were considerably darker “suggesting a higher percentage of Mediterranean admixture.” He ultimately concluded, however, that the internal differences within Malta were insignificant compared with differences between Malta and other inhabitants of the Mediterranean (see Chapter 3).

The second example comes from the writings of Eric Shepherd in his travel memoirs entitled *Malta and Me* (1928). Although he ultimately argued – in keeping with Buxton’s claim – that there was something distinctive about the Maltese (see Chapter 3), he also noted a large degree of internal variation according to class:

There are many, many types of Maltese; ranging from the typical Mediterranean appearance of the lower classes, to the distinctive Hittite head of some of the nobles. I know nothing of the Hittites, except what I have seen of them on vases and bits of frieze; but there is no mistaking the fact that the same long narrow head is to be found among the Maltese. Then there is the Maltese that might be an Arab – and the Maltese that might, but for pigmentation, be a Negro. The Arab type occurs in all ranks of society, but the Negro is confined to the lower (Shepherd 1928:218).

Thus, hierarchies of race and class appear to coincide in Shepherd’s eyes, such that the lower classes were more likely to be Mediterranean or ‘Negro’ in type, whereas the noble, upper classes were seen as Hittites – a Biblical people mentioned in the Old Testament (although their long narrow head placed them below northern Europeans according to cephalic criterion). Class differences in racial purity are similarly hinted at
by Wignacourt a dozen years earlier, who, when speaking of the upper class Maltese, mentioned that he was impressed by their “breadth of culture and the receptivity for new and advanced ideas” but noted that:

even in this stratum of society, there is a tendency for the original Hamitic strain to assert itself, and this in a carelessness as to accuracy, a lack of self-criticism, and a pursuit of the bent unchecked by the inhibitive faculties. The imagination is wont to run riot as if the control centres of the brain had not developed (1914:17).

Notably, ‘Hamitic’ was a term used by Europeans to designate a people as African in origin, and the additional comments regarding their lack of inhibitions and underdeveloped brains was consistent with prominent beliefs regarding peoples of African descent.

**Poverty and Infrastructure**

Previous studies have noted health inequalities and variation in infant mortality rates according to social class or socio-economic status (e.g. Alam 2000; Black et al. 2003; Shakya and McMurray 2001; Uchudi 2001); therefore, the patterns observed in Malta, wherein infant mortality seems to be correlated with poorer and more marginalized communities is to some degree unsurprising. However, there is a danger in stopping at this conclusion, as it reifies the differences in social class or occupational groups and implies that lower classes are essentially unhealthy or incapable of ensuring their own health and well-being. It is not so much noteworthy that those in higher social classes exhibit more favourable health outcomes; rather the reasons for these differentials are worthy of study. Following Van Poppel and colleagues (2005:273), who examined infant and child mortality in three Dutch regions in the nineteenth century, the importance
of geography must be attended to; that is, socio-economic and social class differences “might reflect significantly the influence of spatial factors such as the quality of sewerage, water supply, or air” as higher social classes were (and still are) more likely to live in better environments, and lower classes in poorer environments. Consequently, I considered it essential to assess the degree to which socio-sanitary infrastructure coincided with Malta’s rural, suburban, and urban discrepancies in infant mortality rates, as well as the observed differentials between the varying regions within which Maltese persons of the various occupational groups resided. Unfortunately, the data available was insufficient for statistical analyses; therefore, the following discussion is necessarily descriptive and speculative more than conclusive.

As early as 1888, CGMO Pisani observed disparities in the sanitary conditions of the different regions and social classes, and called for the improvement of sanitation:

No time should be lost in carrying out all the needed improvements: – drainage of villages, water supply, sanitary buildings for the poor and for the labouring classes, sanitary improvements of existing houses as opportunities permit, [and] ventilation of overcrowded areas (Pisani 1888:21).

Pisani’s comments point to several problems: unsanitary dwellings, a lack of sewerage and drainage, and an inadequate supply of pure water, each of which will be discussed in turn. With regards to the homes and dwelling-houses in Malta prior to the Second World War, those inhabited by the rural populations and the suburban and urban lower classes were spoken of in very negative terms. Maltese politician F. Azzopardi (1901:122) described the homes of the poor as “unfit for animals”, a sentiment that echoed Chief Police Physician A. Ghio’s (1875:6) description of the dwelling-houses of the lowest and poorest classes as “unfit for human habitation.” The dwelling-houses, known locally as
kerrejja, were tenement buildings common to urban, suburban, and rural districts; built around a central, open courtyard, each floor had between ten and twelve rooms, and each room was typically occupied by a single family, such that the kerrejjet were “extremely overcrowded” (Mitchell 1998c:88). Other types of dwelling were similarly crowded, variously reported as housing 8-10 persons per room (Gulia 1875), 6-8 persons in one or two rooms (Cachia 1956), or 7-12 persons in one to two rooms (Adams and Cooke 1957). Notably, overcrowding was not restricted to urban centres; in 1922, superintendent of public works J. A. Galizia (1922) noted that a huge percentage of families lived in one or two rooms, and the highest proportion of families in overcrowded dwelling was in two rural villages.

Cassar (1960) described the typical farmhouse as consisting of two stories, which may have become more common in post-war reconstructions; however, most depictions indicated that they were one-story dwellings with thick walls made of soft stone blocks and few windows. Bloomfield (1935:208) spoke of “the simplest form of peasant dwelling”, a farm consisting of “single-roomed cube, set against the rockside” with separate small shelters for cooking, goats, and farm gear. However, most rural inhabitants did not live permanently on their land, but kept a home in the nearest village.

Boissevain described the house he rented in one rural village as consisting of:

a room that opened onto the street, another behind that, and a small room with a sink, which opened onto a little courtyard at the other side of which was a third room which until very recently had been used as a stable. The house was very sparsely furnished and the courtyard was lined with an elaborate system of cages housing chickens and rabbits, and clouds of flies (Boissevain 1970:65).

While it is unclear whether or not this house was typical of the village within which he resided, in light of his position, it is highly unlikely that Boissevain rented a home that
was significantly less well equipped than that of his neighbours. Moreover, the propensity of village (and, perhaps more surprisingly, urban) Maltese to keep animals in their homes was well recorded throughout the period under investigation in this dissertation. Pisani (1888) spoke of the keeping of poultry and other animals in ill-paved courtyards. Nearly fifty years later Johnson (1937) noted that “most houses in villages contain, actually within the houses, a certain number of goats or other animals”; and in the 1960s Cassar (1960) similarly remarked on the keeping of domestic animals such as a donkey, cow, mule, or poultry within one’s home (although a pig often received its own living quarters in a small out-building). Figure 8.8 shows the layout of a village house in Zebbug, located in central Malta, and lends credence to these claims of the tendency towards the keeping of animals in one’s home.
Figure 8.8 – Plan & Elevation of a Village House at Casal Zebbug

Note, as well, that in the drawing at the top, the absence of windows is apparent, and that below, “rabbits & children” are given one room, the well is located in the room of the “cow & other animals”, and the “dung hill” (right next to the well, no less) is afforded the

(Sutherland 1867)
largest room in the house. According to Maria Calleja, until the 1930s few people had a bathroom although many did have a toilet (Galley 1994); therefore, it is possible that the unlabeled room blocked-off within the larger room for the “cow & other animals” was the lavatory or privy-area.

This image marks a “well”; however most rural Maltese dwellings had an underground water tank from which they drew their water. The water in these tanks, or house cisterns, was rain- or surface-water collected from the roofs of dwellings and often from the streets (Pisani 1888; Johnson 1937). Unfortunately, these tanks were said to be liable to contamination, particularly by sewage overflowing from cesspits (e.g. Caruana Scicluna 1911; Schuster 1950; Tressider 1884) that were employed in place of a more extensive sewerage and drainage system (see below for a more extensive discussion of the sewerage system). While in the rural regions, from the turn of the century many villages did have a public tap from which pure water was said to be obtainable, most rural dwellers continued to rely on more easily obtainable water from their individual house-tanks. In light of their risk of contamination, Chadwick (1897:19) lamented that “the consumption of pure water [remained] ridiculously small” in the villages at the turn of the century. Improvement of the water supply began after Chadwick’s 1897 investigation, such that the old system of distribution by open aqueducts into public and house tanks was eventually replaced by a piped supply (Morris 1952). This latter development was greatly accelerated after the 1909-10 epidemic of typhoid fever, a waterborne infection which struck Pembroke Camp (as well as Floriana, Valletta, and Sliema), and was traced to pollution by human excreta from the catchment areas of the Wignacourt spring of Buzigrilla, near Rabato, which was one of the springs that contributed to the public water
supply for these more urban areas (Zammit and Morris 1912; Zammit 1931). Shortly thereafter, in addition to having the water supply run in iron pipes, chlorination of the water was gradually adopted (Zammit 1931). Nevertheless, the supply of adequate quantities and quality of water for domestic purposes was often cited as “one of the most urgent problems in Malta” (Schuster 1950:XV; see also Balogh and Seers 1955; Chadwick 1896; Robertson 1917; Galea 1952; Morris 1952).

Figure 8.8 also attests to the rural practice of keeping manure in one’s home (Ghio 1876), which would later be transported to the fields and used as fertilizer. The central village of Zebbug, in particular, was a location where a good deal of refuse that had been collected from the towns was stored for fermentation into manure (Bernard 1937); therefore, this image may not be entirely typical of most village homes – although the collection and storage of refuse was said to be widespread (e.g. Johnson 1937). In fact, Zebbug was home to many “zibbel boys”, young men who would scavenge the streets and collect refuse on a donkey cart to store in zibbel houses for fermentation and subsequent sale as manure (Johnson 1937). This livelihood was made possible, in part, by the tendency for Maltese persons to throw their refuse into the streets – a practice that caused a great deal of consternation amongst the authorities, both at the turn of the century: “slops and excreta are thrown into the garden or into the street” (Chadwick 1897:19); “the inveterate practice of throwing slops and excreta into the street gullies is likewise the cause of serious inconvenience (Pisani 1898:11); “you cannot go anywhere without coming across heaps of filth deposited by householders on the wayside” (Twelves 1904); and in the 1950s: “a certain proportion of householders do not cooperate with our efforts to keep the streets clean” (Galea 1952:103). The government did
institute a refuse collection and disposal scheme, around 1938, wherein refuse was pulverized and sold for use as manure (Gatt 1939); however, as late as 1947 CGMO J. Cauchi (1947:479) admitted that due to an insufficient number of vehicles available to collect refuse, “it remained necessary to tolerate the collection of part of the house refuse, even in the cities, by private refuse collectors with consequent unhygienic storing of the refuse for conversion into manure.” Therefore, director of public works C. Micallef (1947) was pushing for the extension of the Refuse Collection Scheme to the entire island, a plan that he recognized would take some time, such that localities out of reach of the present scheme would continue to be served by scavengers and private collectors.

What is not clear in Figure 8.8 is the fact that the vast majority of rural homes were not connected to a drainage system, but had to rely on cesspools. Moreover, this reliance on cesspools was one of the reasons given for villagers’ propensity to throw their refuse into the streets. As CGMO Caruana Scicluna (1905b) explained in a letter to the Lieutenant Governor: “in several localities in the country districts inhabited by the poor the practice is resorted to of throwing slops and night soil over the surface of the road to avoid filling the private cesspits and having to pay for their being emptied.” This practice apparently continued through the 1950s, as Galea (1959b) was moved to encourage the institution of free emptying of cesspools by the government to counter the tendency of the people to throw slop, foul, and waste water over loose earth, to bury it in the soil, or to allow their cesspools to overflow onto the public thoroughfares.

The reason that so many villagers had to rely on cesspools was because the sewerage and drainage systems of the island of Malta did not extend into the rural regions. In fact, although in 1872, Ghio and colleagues reported that the existing
The sewerage system was faulty, badly constructed, and insufficient (as it only covered a very small number of localities), by 1959 only 60% of Malta was covered by proper waterborne sewage, with the remainder still relying on cesspits (n.a. 1959). The reasons for the slow extension of sewerage and drainage to the entirety of Malta are complex and connected to the island’s political leaders and their fight for Malta’s independence (see Chapter 3 for greater detail). Recall, towards the end of the nineteenth century, Malta’s councillors repeatedly refused to pass the estimates required to improve and extend the drainage system, and attempted to repeal loans granted for public works, as a means of protesting their lack of political power in council and the respective financial contributions of the imperial and local governments. As a consequence, in 1901, the provision of funds for the gradual and systematic sewerage of the island had to be passed by Order in Council. Thereafter, provisions for sewerage and extensions were made every year in the estimates; however, there was always a risk that the Maltese representatives would refuse to vote in favour of these public works – particularly if large sums of money were required. As Galea (1959b:577) later remarked, at the beginning of the twentieth century “the question of sewerage raised political storms which raged for years.”

However, what is particularly noteworthy with regards to the extension of the sewerage system is how it was done, that is, the sequence in which the various regions of Malta were connected to the system. In 1872, the urban localities of Valletta and the ‘Three Cities’ (the term used for the combined areas of Vittoriosa, Calcara, and Senglea) had sewers, as did the suburbs of Curmi, Birchircara, and Hamrun; however, and as stated above, even these were unsatisfactory (Ghio et al. 1872). By 1887, the drainage of
the urban cities had been remodelled, with the old deep sewers cut in the porous rock replaced by glazed earthenware pipes (Pisani 1888). In 1904, the drainage system remained limited to four of the five cities (Debono 1911). By 1910, Sir Alexander R. Binnie and Dr. G.F. Deacon, in their report on the Malta drainage and sea-water flushing scheme, found that two-thirds of the population (121,132 people) was provided with main drainage, whereas the other third (66,759) had no drainage system whatsoever. Moreover, because of the concentration of the population in the urban regions, this meant that a large number of localities were not being served. In addition to the St. Andrews and Imtarfa Barracks, the localities that were listed as having some form of drainage included:

Urban: Valletta, Floriana, Cospicua, Vittoriosa & Calcara
Suburban: Sliema & St. Julian’s, Curmi, Zabbar, Hamrun, Misida and Pietà
Rural: Rabato & Notabile

On the other hand, the suburban localities of Birchicara (which, above, was listed as having at least an old sewer system) as well as Tarxien and Paola (in the suburban south) and all other rural localities were entirely lacking in drainage.

The completeness of the sewerage system in the towns which possessed main drainage at this moment in history should not be overstated; a report in 1923 noted that a major street sewer was finally completed in Hamrun and Galizia, spoke of the importance of extending the sewered area, particularly in the partially-drained suburbs of Hamrun and Birchircara, and remarked on the need to give priority to the construction of sewers in the central, more thickly populated, rural villages – such as Attard, Lia, and Balzan.

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90 It should be noted that Notabile, a walled city and contemporary heritage site, is entirely surrounded by the town of Rabato. Moreover, it was a more elite place of residence, despite its location in the rural area.
Moreover, by 1947, Birkirkara, Lija, Attard, and Balzan, as well as the populous villages of Zebbug and Mosta, still required extensions in their respective drainage systems (Micallef 1947b). According to Micallef (1947b:330) “great strides” were achieved in that year, with 13,450 feet of sewer laid; however, by 1950, Schuster (1950:XIII) argued that the Government programme, which had allotted £1,770,000 for the extension of “proper sewerage to all the principal inhabited places in Malta” would have to be drastically cut. In addition, in 1952, several individuals spoke of the continued need to gradually extend the sewerage system to all villages, as had been suggested many years prior (Galea 1952; Morris 1952). Even as late as 1958 – when the government considered the issue important enough to necessitate questions regarding the extent of sanitary arrangements and domestic amenities be included in Malta’s census – a huge proportion of Maltese households were still lacking connections to the public sewer system (Wirth 1959). Notably, whereas in the suburban-north and suburban-central regions 90% of homes were connected to the public sewer (recall, these were areas of higher-class and lower IMRs), in the southern group (the area with the highest rates of infant mortality), only 36 percent of homes were connected to the public sewer (Wirth 1959).

**The Relationship Between Socio-sanitary Conditions and Health Statuses**

What this descriptive analysis of the dwellings, water supply, and sewerage system in Malta’s various districts and regions suggests is that rural Maltese localities – particularly the more south-easterly localities – were largely lacking in basic sanitary infrastructure necessary for a safe and healthy environment. As Chesnais (1992:47) has argued in the case of contemporary underdeveloped nations, wide mortality differentials
between social strata in the poorest countries can be attributed to the “coexistence of advanced sanitary conditions in certain Westernized urban strata, together with the most primitive conditions in impoverished communities.” While his unexamined use of the terms ‘Westernized’ and ‘primitive’ are problematic, Chesnais’s point is valid; that is, there are often major infrastructural differences between rich and poor communities that have importance consequences for their respective health and mortality profiles. Moreover, previous studies have noted significant relationships between water supply and sanitation and elevated rates of infant mortality (e.g. de Souza et al. 2001; Woldemicael 2000). As such, there is reason to believe that this was the case in the Maltese context, particularly in light of the gradual extension of sewerage to the suburban regions in contrast to a complete absence of sewerage and drainage in the rural regions, and particular disregard for development of the southeast region. Notably, the extension of sewerage in the suburban region seems to have corresponded to improvements in IMRs in that area and widening differentials between the two types of district.

Up until this point in the dissertation, I have avoided discussion of ‘causality’ or aetiology, other than to note the predominance of postneonatal infant mortality and the importance of infectious and diarrhoeal diseases in the Maltese context. Other researchers have discussed the difficulties with assessing cause of death in historical populations, due to under-reporting, misclassification, and vague or symptomatic causes of death; changing philosophies, taxonomies and perceptions of disease; and as a result of physicians’ varying diagnostic abilities, approaches to disease causation, and understanding of pathological processes (e.g. Moffat and Herring 1999; Sawchuk and Burke 2000). Tables 8.6 and 8.7 speak to the difficulties in tracking and disentangling
causes of death in Malta over the study period. Table 8.6, drawn from Malta’s Health Report of 1923, lists all the diagnoses of causes of death in individuals under one year of age, grouped according to ‘Disease Category’. There are 36 different causes of death accounting for 2084 infant deaths; of these 1159 (55.6%) are attributed to five different types of ‘Diseases of the digestive system’, four of which are forms of diarrhoea/enteritis, and the second most important disease category is ‘Diseases of early infancy’, which accounted for 698 (33.5%) of infant deaths. Table 8.7, drawn from Malta’s Health Report of 1952, demonstrates the incommensurability of disease categories; for example, within ‘Diseases of the digestive system’ there are four types of diseases (accounting for 302 of 949 deaths, 31.8%), only one of which seems to be a form of diarrhoea/enteritis, and the category ‘Diseases of early infancy’ appears to have been supplanted by the category ‘Diseases peculiar to the first Year of Life’ (accounting for 448 deaths, 47.2%), including the vague diagnosis of ‘Other diseases pec. to 1st year of life’. This latter diagnosis may have served as a catch-all category in instances where the physician (if one was present) found it difficult to make a more specific diagnosis. Moreover, the sheer number of ‘diseases’ and the inconsistency in the classification systems renders these types of lists of causes of death of limited use.
### Table 8.6 – Causes of Infant Death According to Malta Health Report of 1923

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>Diseases Resulting in Death Under 1 Year of Age</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Diseases</td>
<td>Diphtheria</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Influenza</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Erysipelas</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Tetanus</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Tuberculous meningitis</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Rickets</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Syphilis</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Leucocythaemia</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Anaemia, Chlorosis</td>
<td>15</td>
</tr>
<tr>
<td>Diseases of the Nervous System</td>
<td>Meningitis – other forms</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Convulsions with teething</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Other infantile convulsions (under 5 years)</td>
<td>19</td>
</tr>
<tr>
<td>Diseases of the Circulatory System</td>
<td>Infective endocarditis</td>
<td>1</td>
</tr>
<tr>
<td>Diseases of the Respiratory System</td>
<td>Other bronchitis</td>
<td>107</td>
</tr>
<tr>
<td></td>
<td>Broncho-pneumonia</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Pneumonia (type not stated)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Empyema</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other pleurisy</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Pulmonary oedema and congestion</td>
<td>1</td>
</tr>
<tr>
<td>Diseases of the Digestive System</td>
<td>Infective enteritis</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Diarrhoea</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Enteritis</td>
<td>1016</td>
</tr>
<tr>
<td></td>
<td>Gastro-enteritis</td>
<td>121</td>
</tr>
<tr>
<td></td>
<td>Intestinal obstruction</td>
<td>2</td>
</tr>
<tr>
<td>Non-venereal Diseases of the Genito-urinary System and Annexa</td>
<td>Acute nephritis</td>
<td>8</td>
</tr>
<tr>
<td>Diseases of the Skin and of the Cellular Tissue</td>
<td>Phlegmon</td>
<td>1</td>
</tr>
<tr>
<td>Diseases of the Bones and the Organs of Locomotion</td>
<td>Diseases of the Bones</td>
<td>1</td>
</tr>
<tr>
<td>Malformations</td>
<td>Congenital hydrocephalus</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Congenital malformation of heart</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Other congenital malformations</td>
<td>12</td>
</tr>
<tr>
<td>Diseases of Early Infancy</td>
<td>Premature Birth</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Infantile atrophy, debility &amp; marasmus</td>
<td>540</td>
</tr>
<tr>
<td></td>
<td>Icterus neonatorum</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Atelectasis</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>Injuries at birth</td>
<td>58</td>
</tr>
<tr>
<td>Affections produced by External Causes</td>
<td>Injury by fall</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2085</strong></td>
<td></td>
</tr>
</tbody>
</table>

(Critien 1923:P23-P26)
Table 8.7 – Causes of Infant Death According to Malta Health Report of 1952

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>Diseases Resulting in Death Under 1 Year of Age</th>
<th>Number of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infective and Parasitic Diseases</td>
<td>Whooping Cough</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Diphtheria</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Tetanus</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Tuberculosis of meninges &amp;c.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Septicaemia</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Measles</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Mycoses</td>
<td>2</td>
</tr>
<tr>
<td>Infective and Parasitic Diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatism, Diseases of Nutrition etc.</td>
<td>Rheumatic fever</td>
<td>1</td>
</tr>
<tr>
<td>Diseases of the Blood &amp; Blood-forming Org.</td>
<td>Other anaemias</td>
<td>2</td>
</tr>
<tr>
<td>Diseases of the Nervous System &amp; Sense Org.</td>
<td>Encephalitis</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Meningitis</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Intra-cranial lesions of vasc. orig.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Epilepsy</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Convulsions in children under 5</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Diseases of the ear &amp; of the mastoid etc.</td>
<td>2</td>
</tr>
<tr>
<td>Disease of the Respiratory System</td>
<td>Diseases of the larynx</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Bronchitis</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>Broncho pneumonia</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>Lobar pneumonia</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Pneumonia</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Gangrene of lung</td>
<td>1</td>
</tr>
<tr>
<td>Diseases of the Digestive System</td>
<td>Diseases of the buccal cavity</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other diseases of the stomach</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Enteritis &amp; diarr. (under 2 years)</td>
<td>299</td>
</tr>
<tr>
<td></td>
<td>Hernial, intestinal obstruction</td>
<td>1</td>
</tr>
<tr>
<td>Diseases of the Skin and of the Cellular Tissue</td>
<td>Diseases of the skin, etc.</td>
<td>2</td>
</tr>
<tr>
<td>Congenital Malformations</td>
<td>Congenital Malformations</td>
<td>32</td>
</tr>
<tr>
<td>Diseases peculiar to the first Year of Life</td>
<td>Congenital debility</td>
<td>186</td>
</tr>
<tr>
<td></td>
<td>Premature Birth</td>
<td>113</td>
</tr>
<tr>
<td></td>
<td>Injury at Birth</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Other diseases pec. to 1&lt;sup&gt;st&lt;/sup&gt; year of life</td>
<td>114</td>
</tr>
<tr>
<td>Deaths from Violence</td>
<td>Accidental mechanical suffocation</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Accidental drowning</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other accidents</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>949</td>
</tr>
</tbody>
</table>

(Galea 1952:220-223)
Not only is it difficult to track and compare causes of infant death in Malta across the decades under study because of the changing taxonomies, it is also difficult to determine how these varying causes of death would be categorized according to contemporary diagnostic criteria. While some of the causes of death from 1923 and 1952 are familiar to the contemporary observer, such as ‘Rickets’, ‘Bronchitis’, or ‘Congenital malformations’, diagnostic criteria for each of these may have differed greatly during the 1930s, 1950s, and today. Similarly, ‘Diseases of early infancy’ and ‘Diseases peculiar to the first Year of Life’ may be comparable to contemporary understandings of perinatal infant mortality (deaths which occur during the first month), a category which is problematic in itself because it groups infant deaths by time of occurrence, not aetiological agents or symptoms. Nonetheless, contemporary understandings of these deaths attribute perinatal mortality to the fetal environment; for example, maternal diseases, maternal heavy work, pre-pregnancy nutritional status, and low energy intake during pregnancy have been associated with intrauterine growth restriction and preterm birth, both of which are correlated with heightened perinatal mortality (Victora and Barros 2001). As explained in Chapter 7, the effects of maternal nutrition on infant health and well-being was noted by early twentieth century observers, and in Malta some of the infant mortality may have been associated with maternal undernourishment and overwork; however, as previously stated, diarrhoea was the most important cause of infant death in early twentieth century Malta.

Contemporary studies of diarrhoea aetiology and epidemiology have traced episodes of diarrhoea in infants to a number of pathogenic agents, including enterotoxigenic *Escherichia coli* (ETEC) and the enteropathogenic (EPEC),
enteroinvasive (EIEC), enteroadherent (EAEC), and enterohemorrhagic (EHEC) forms of *E. coli*, *Campylobacter jejuni*, *Salmonella*, *Vibrio cholerae*, *Clostridium difficile*, *Aeromonas hydrophila*, *Staphylococcus aureus*, *Vibrio parahaemolyticus*, *Shigella*, rotavirus, and *Cryptosporidium* (Black et al. 1982; Black et al. 1989; Cheng et al. 2005; Cho et al. 2006; Torres et al. 2001). The predominant mode of transmission of these organisms is the fecal-oral route, either via person-to-person spread through contaminated hands, or ingestion of food and water sources contaminated by the feces of humans or animals such as cattle, swine, and birds. A number of studies have noted the importance of safe water in reducing gastrointestinal disorders and diarrhoea incidence in infants (e.g. Wolff et al. 2001; Wright et al. 1991); in addition to the risks associated with drinking contaminated water, water used to prepare food and to clean cooking utensils can be a source of contamination of foods including milk (Black et al. 1982; Black et al. 1989; Cheng et al. 2005; Shulman 2003). The latter may be of particular significance in the Maltese context, because prior to the Second World War, most people consumed raw, unpasteurized, goat’s milk and, according to contemporary observers, this milk was rarely boiled despite recommendations from Malta’s Department of Public Health (Bland 1994). In addition, the seasonal nature of infant mortality in Malta, with heightened death rates in the summer months, suggests that bacteria such as *E. coli*, which proliferate

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91 Recommendations to boil milk were first made by Maltese physician Dr. Temi Zammit, in 1905, who traced the source of *Brucella melitensis*, the bacteria responsible for the zoonosis Brucellosis (variously named undulant fever, melitensis, Malta fever, or Mediterranean fever) to goats’ milk and goats’ blood. Although the symptoms associated with Brucellosis – including inconstant fevers, sweating, weakness, anorexia, headaches, depression and muscular and bodily pain – makes it unlikely that this was the etiological agent responsible for the majority of infant deaths in Malta, Zammit’s recommendation to boil milk would have reduced the transmission of other bacteria. However, many Maltese people did not have the means to heat raw milk to the required temperature for the required duration (heat at 63° to 65°C for 30 minutes), and were subject to contradictory information about the merits and drawbacks of boiling milk. In addition, whereas pasteurized milk was not available to the general population of Malta until after World War II, following Zammit’s discovery the colonial government immediately began providing pasteurized milk to the British garrison (Bland 1994).
in hotter temperatures, may have been the aetiological agent responsible for the prevalence of diarrhoea among Malta’s infants (Black et al. 1982; Robins-Browne 1984). Alternately, Cho and colleagues (2006) found that a seasonal pattern was observed in enteric infections related to *S. aureus* and *V. parahaemolyticus* in addition to that associated with *E. coli*; therefore, these pathogenic agents may have played a role, although most contemporary studies have found *E. coli* to be the agent responsible for the majority of diarrhoeal disease (Robins-Browne 1984; Torres et al. 2001).

Irrespective of the specific source or pathogenic agent responsible for enteric infection in Malta, the use of cess-pits rather than a piped sewage system, the keeping of livestock within the home, the use of human and animal excrement as agricultural fertilizer, the storage of rainwater in underground tanks in lieu of a piped water supply, and the overall paucity of water for sanitary and drinking purposes would have created a prime environment for fecal-oral transmission. Without adequate means to dispose of excrement and other refuse, and lacking sufficient and sanitary sources of water necessary to reduce fecal-oral transmission, *E. coli* and other related organisms likely took a toll on Malta’s population. In the case of infants, it is possible that the combined effects of impaired nutritional status and low birth weight resulting from malnourished and overworked mothers, the absence of passive immunity due to early weaning, and exposure to infectious organisms in an unsanitary environment may have led to enteric disorders leading to malnutrition, dehydration, and increased susceptibility to additional infectious diseases (Sawchuk and Burke 2000).
Importantly, it is worth noting that it was not that local officials never recognized the relationship between sanitary conditions and health status; as early as 1875, in his discussion of mortality rates in Malta, Gulia (1875:10) noted:

Of course, there have been other predisposing causes that have had their share in augmenting the habitually high mortality of these islands, such as supine ignorance of hygiene, want of cleanliness, perverse and faulty construction of the dwellings, overcrowding, polluted water, want of, or bad, sewage and drainage.

References to “supine ignorance of hygiene” imply individual responsibility (see Chapter 7 for a more in-depth discussion of ‘ignorance’); however, these do not detract from attention to conditions of poverty such as housing, water supply, and sewerage. While most discussion of social conditions referred more generally to health and mortality, Ghio (1876:21) spoke specifically of the impact of impure air and unclean dwellings on infant mortality: “infants are those who suffer most from unhealthy dwellings.” In 1876, Ghio and colleagues (1876:16) noted that Cospicua “the worst of the three [cities]” in regard to cleanliness and drainage, also exhibited the highest mortality rate (at 30.5 per thousand). Earlier, Ghio (1872) focused more specifically on the existing system of sewerage and drainage, which he described as “most prejudiced to the health of the daily increasing population.”

92 Similarly, in 1888, following a local cholera epidemic Pisani drew particular attention to the significance of proper sewerage. After comparing death-rates in the Urban and Suburban groups to those in the Rural group, and finding that rates were lower in the latter group, Pisani went on to compare the population of the drained and undrained areas. He found that “the relative healthiness of the areas under consideration judged from the death-rate during the year” placed the drained areas of the urban and

92 Note the reference to “daily increasing population”, a statement which implies that the increase of the population was also a negative development (see Chapter 5 for more on the discourse of population growth in Malta).
suburban regions first, followed by the rural areas, with the undrained areas of the urban
and suburban regions recording the highest mortality rates (Pisani 1888:18). He therefore
concluded:

It was made evident by the number of cases and deaths from cholera that
the fortified towns, drained and supplied with good water suffered least
whilst among the villages, which are all undrained, those suffered most
which were dependent on surface water collected during winter in tanks
(Pisani 1888:18).

Additionally, the following year, in his report, Chadwick (1897) noted the correlation
between sanitation and mortality, remarking on the reduction in death-rates in the Three
Cities – particularly in comparison to higher rates in the rural districts – which he
attributed to improvements in sanitation. Moreover, he drew attention to the “low
sanitary condition of the villages”, their lack of water and absence of sewerage, the
unsanitary and overcrowded condition of the houses therein, which he deemed as
contributing factors in their high death rates (Chadwick 1897).

Despite this abundance of attention immediately prior to the twentieth century,
which may have been in response to the elected members’ refusal to vote for the building
of a new drainage system proposed by the imperial government (see Chapter 3) as well as
a reflection of general ideas about relations of causality with regards to disease and
mortality, the importance of social conditions to mortality and health received relatively
little attention thereafter. Some attention to the relationship between the water supply
and health followed the typhoid epidemic of 1909-10 (e.g. Caruana Scicluna 1910); in
particular, the minutes of evidence from the 1911 Royal Commission demonstrate that
the relationship between sanitation and health was an important area of inquiry for
Mowatt and Chalmers. For example, in their interview of Professor Francis Debono, MD
(Inspector of Agriculture; Prof. of Natural History, Hygiene and Medical Jurisprudence; and Director of the Botanical Gardens), the commissioners specifically asked “as the water supply has been completed, and as the drainage scheme is progressing, do you find any alteration on public health?” to which Debono responded “yes, a great alteration, and especially the lowering of the death rate” (1911:74). Thereafter, where Debono appeared to place greater emphasis on the contribution of drainage to the lowering of mortality, Mowatt and Chalmers brought his attention back to the improvements in the water supply (following the typhoid outbreak of the previous year). Similarly, in their interview of The Hon. Mr. Giuseppe Caruana Scicluna MD (Chief Government Medical Officer and Superintendent of Public Health), the commissioners noted a general fall in the death rate over the last 12 years, and enquired as to its cause, to which the CGMO responded “of course to the general improvement in the sanitation of the Island. We have spent a lot of money on sanitation in the last few years.” The discussion then proceeded as follows:

Q [Mowatt and Chalmers]: During those 12 years, to take two things, water supply and drainage, do you attribute the fall in the general death rate to the improvement effected by water supply and drainage?
A [Caruana Scicluna]: Yes, I am sure of it.
Q: Can you detect the improvement in the particular areas which have recently been drained as they come into the operation of the system?
A: There is something in my report about the undrained area. The death rate in the urban and suburban area, if I may take it, say, for 10 years, was for 1902-3, 25.59 [per thousand]; whilst for 1910-11 it is 21.24. There is an evident decrease in that area, the urban and suburban, since the extension of the system.
Q: How far does that correspond with the completion of drainage schemes in that area, or the completion of the water supply in that area?
A: In some parts of these areas, such as Hamrun, Sliema, Curmi, which are in the suburban area, the drainage was completed within the last six or eight years.
Q: As the drainage schemes are completed do you find any diminution in the death rate?
A: Yes.
The insistence of the Royal Commissioners on the relationship between sanitation and health may have been related to the (above described) controversy regarding the necessity – and funding – of an extensive sewerage and drainage system. As such, their focus on the health benefits of extending the sewerage and drainage as well as improving the water supply may have been sparked by colonial frustrations with Maltese resistance to these projects. Importantly, Caruana Scicluna’s comment about the reduction in overall mortality in the urban and suburban districts, and the ways in which he ties these reductions to the extension of the drainage system lends weight to my claims that differences in infant mortality in Malta’s localities were strongly correlated with disparities in the socio-sanitary infrastructure. Nevertheless, thereafter, the relationship between health and sanitation essentially disappears from the archival record. In its place was attention to individual behaviours and practices, and their relationship to health, particularly the health of infants.

**Conclusion**

In 1923, in CGMO A. Critien’s yearly health report, attention to the importance of living conditions reappeared, while in the same breath the reasons for the foregrounding of interventions at the level of the individual were highlighted.\(^93\) He wrote:

> It is now fully recognized that “infancy is the best time for the prevention of disease” and public health action has set itself to protect the health of the child from the threshold of life along the most unsheltered and precarious age of childhood into adolescence. Thus the antenatal care of the mother, infant welfare and the welfare of the school child count now amongst the principle elements of a national policy of Preventive Medicine and form everywhere, after municipal sanitation and the

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\(^{93}\) Recall, Critien served as CGMO from 1917 to 1936, was said to be devoted to the amelioration of infant and maternal health in the island of Malta, and in addition to initiating and supporting interventions, he wrote extensively about infant mortality and the need to address the factors which contributed to elevated infant death rates.
prevention of communicable disease, and integral part of every public health programme.

There is no doubt that municipal and domestic sanitation exercise a direct influence on the health of both old and young and that, together with domestic cleanliness, they have a very vital bearing on the prevalence of and mortality from diarrhoeal disease. This is extremely important, when we consider that our death-rate from infant diarrhoea is larger by itself alone than the total infant death-rate in any white country in the world.

Thus action on general lines intended to raise the sanitary level of the immediate surroundings of dwellings is sure to break in upon a set of forces antagonistic to infant life and health. What is required, therefore, is a deliberate health policy directed to improve the sanitation of dwellings and their surroundings, regulate and control the disposal of refuse, extend the sewerage system, increase the water supply and lower the water rates. Much has been achieved in this direction, but further action is necessary. Unless the people, however, are made conscious of this necessity and insist on sanitary progress, knowing how intimately the physical well-being of each individual and of the community as a whole is affected thereby, no headway will be made. Education is the substratum and the mainspring of all sanitary progress and reform. Home hygiene should, therefore, be taught systematically at all schools, elementary and continuation, Government and private.

It would be shortsighted, however, in the face of persistently enormous child mortality, to wait for the effects of a more intense general public health policy. The worse the environment the more immediately useful becomes knowledge and encouragement. “The more unsatisfactory and unwholesome the housing conditions the more necessary is it for the working mother to know how to keep her baby in reasonably good health partly for its personal well being, but also for her own sake, so that in her over-full life she may be spared the avoidable anxiety and trouble caused by sickness due to improper care of herself and her child”. [quoted from An Outline of the Practice of Preventive Medicine: - Sir George Newman K.C.B., M.D., D.C.L., F.R.C.P., p.91] Hence the need of State or Municipal action, concerned with the care of both mother and child (Critien 1923: P3).

This lengthy quote has been included in its entirety for a number of reasons. First of all, it reiterates some of the points raised in previous chapters of this dissertation about the ways in which discourses which moved between colony and metropole shaped understandings of infant mortality in Malta: Critien quotes a British “expert”, compares Malta to other “white” countries, notes that “everywhere” certain policies are in place,
and embraces ideas about the precious nature of the child and the importance of improving Malta’s vital statistics, while naturalizing the association between women and children, and noting the need to teach “mothers” how to care for their infants. More importantly, this quote also shows that Critien recognized – even foregrounded – the importance of sanitation in dwellings and their surroundings, disposal of refuse, extension of the sewerage system, and improvement of the water supply as means to reduce (infant) mortality in Malta. Moreover, in his eyes, education in “home hygiene” was a means to empower the Maltese to demand large-scale sanitary reforms, and he saw the care and teaching of mothers and their children as an interim solution, rather than the best or ultimate remedy for elevated infant and child mortality rates.

Similar sentiments were expressed by the Economic Advisory Council, in 1939; in their discussion of Malta, they wrote:

> it is only necessary for instruction – enlightened, sympathetic and understanding – to be given for real progress to be made. Thus without any change in the economic level it should be possible everywhere to reduce infant mortality rates very considerably by increased attention to infant welfare and particularly to the feeding of mother and child (Economic Advisory Council 1939).

Thus, in these instances, maternal education was not necessarily regarded as the most effective strategy, rather, it was posited as the easiest and most plausible strategy, a way of intervening at the level of the individual, rather than society, and one that did not require economic reforms.

In the British context, Davin (1978:26) has argued that instruction in motherhood in the early twentieth century was likely seen as more “attackable”, as “there seemed more chance of educating individuals, future or present mothers, than of banishing poverty.” More, she contends that it provided an easy way out, “it was cheaper to blame
them and to organize a few classes than to expand social and medical services, and it avoided the political problem of provoking rate- and taxpayers by requiring extensive new finance” (Davin 1978:26). Focusing on the inadequacy of individuals – mothers – thus provided “a more acceptable explanation of infant mortality and ill-health than the shortcomings of society” (Davin 1978: 54). Her condemnation of these reforms, or of their limited scope, is suggested by the language and tone that she uses. However, the above-noted comments from Critien and the Economic Advisory Council suggest that, in Malta at least, the motivations for improving education (for mothers and others) were more nuanced than implied by Davin’s argument that this was an “easy way out”, that it was “cheaper to blame them.” Rather than promoting mothercraft as the best or only solution for elevated infant mortality rates, rather than implying that mothers alone were responsible for the deaths of their infants, it seems to me that individual-level interventions such as infant welfare clinics were seen as a better strategy than doing nothing at all, and as a strategy which could be more rapidly implemented than massive ventures to rebuild Malta’s socio-sanitary services and economic conditions, in order to more immediately curtail infant mortality. However, the fact that such large-scale projects would have required a significant financial contribution from the colonial government, a government which was relatively ambivalent regarding the merits of reducing Maltese infant mortality in light of its problem of overpopulation, should be acknowledged.

In addition, I share Davin’s (1978:12) contention that the focus on advice and instruction on motherhood “obscured to an extent which now seems astonishing the effects on child health of poverty and environment” and any observations about the role
of maternal nutrition and conditions of poverty were overlayed by the rhetoric about motherhood. That is, the focus on maternal education and the behaviours of mothering, along with midwifery practice and antenatal care, shifted attention from the economic and structural factors women could not control such as poverty, housing, sanitation, and poor nutrition (Manderson 1998; McElhinny 2005). Moreover, standards established in these teachings were unrealistic in the context of the types of accommodation in which working-class and colonial mothers found themselves; as Davin (1978: 52) states:

No amount of instruction and advice, whether from the Medical Officer of Health’s leaflets, or a district medical visitor’s calls at the house, could remove the basic handicaps of overcrowding, of damp, ill-drained, airless, bathless, tapless lodgings, of shared and filthy ash closets and middens. No training for motherhood would ensure a supply of fresh uncontaminated milk, or provide food when there was no money.

This point is brought home by the large – and growing – disparities in infant mortality rates between Malta’s wealthiest and poorest districts and localities, shown in the quantitative analyses in this chapter, which followed the supposed prioritization of lowering the island’s infant mortality via (the albeit limited) provision for instruction in motherhood and other interventions aimed at improving birthing and infant-care procedures. While the divide between urban and rural districts, and upper and lower classes, in Malta has been essentialized, naturalized, even racialized, what I tried to show in this chapter was the ways in which broad disparities in income, employment, access to resources, and sanitary conditions, which sometimes tracked these geographical and social categories and sometimes created still more internal divisions, were reflected in the ways in which infants in Malta died.
Chapter 9 – Conclusion

Throughout this dissertation I have aimed to go beyond an assessment of proximate- and intermediate-level risk factors associated with infant mortality in the British island colony of Malta by considering the larger context within which these infant deaths occurred. Specifically, in the introduction of this dissertation, I argued that the project that poses a greater challenge as an object of intellectual discourse, not to mention as a framework for political activism, transcends the disentanglement of primary determinants from webs of epidemiological variables. It is the investigation of the historical and social factors that produce (and reproduce) risk – factors that then are constructed as medicalized risk categories (Morsy 1995:172).

In order to accomplish this task, I have combined quantitative and qualitative analyses, as I am of the opinion that this is the best way to elucidate the complex nature of infant mortality. Thus, in addition to employing many of the classic methods of historical demography in order to discern the patterns and factors correlated with varying rates of infant mortality in Malta, I have drawn attention to the social, political, and economic context and the circulating discourses which had a significant impact on infant mortality rates, the ways in which infant deaths were understood, and the strategies of intervention designed to combat infant mortality.

As a colony within the British Empire, the Maltese Islands were strongly influenced by the changing tides of international tension, as the archipelago was brought under British control at the beginning of the nineteenth century, not for purposes of resource extraction or labour power, but due to its strategic location in the middle of the Mediterranean and its value as an outpost within Britain’s naval, military, and trade network. In order to retain control over the island’s strategic location, British officials denied the Maltese administrative and political control by limiting constitutional
development and rescinding political power when the initiatives proposed or denied by Maltese representatives ran counter to British imperial interests. Economically dependent on British imperial spending, employment opportunities unrelated to the services were limited; therefore, the economic profile of Malta was closely tied to fluctuations in international tensions and large-scale construction projects funded by the British government. When the breakwater or dockyards were expanded, and during the course of World War I and II, Malta’s population was relatively prosperous; whereas, when these projects were completed and when defence spending was curtailed, the Maltese were plunged into poverty and hardship.

The discovery of infant mortality in the United Kingdom and its colonies has similarly been linked to the effects of international tension: concern was sparked at the beginning of the twentieth century, following the Boer War, as British anxieties centred on falling fertility rates and the expected consequences in terms of labour shortages and reductions in suitable recruits for military and imperial expansion. This new conceptualization of infants and children as valuable resources led to the essentializing of women as mothers and engendered a new ideology of motherhood as a serious responsibility and one for which not all women were naturally equipped. As a consequence, women outside of the dominant white middle class, women of “other” classes and races, were depicted as deficient and in need of training and education if they were to become proper mothers. Moreover, they were blamed for the deaths of their infants and strategies designed to combat infant mortality focused on intervening in the behaviours of mothering. Infant welfare centres and home visiting programs thus focused on “improving” maternal practices associated with infant care as a means to
reduce infant mortality rates. However, in Malta, irrespective of the ostensive concern with elevated rates of infant mortality, the timing and scope of even these interventions was slow in developing and insufficient to meet the needs of the population.

I have argued that the inadequacy of interventions designed to combat infant mortality in Malta were related to a concomitant concern of colonial administrators with the perils of population growth and elevated fertility levels on the island. That is, whereas elsewhere in the British Empire, population decline sparked anxiety and the desire to reduce infant mortality rates, within Malta infant mortality was seen – at least in part – as a safety valve in the context of high population density and growth rates. Further, I argued that this was tied in to the perception of the Maltese as “other”; not considered as members of the imperial race, their lives were considered of less value to the Empire. Moreover, despite the fact that poverty and its attendant health consequences were directly tied to the policies and priorities of colonial administrators; Malta’s problem of “overpopulation” was posited as a threat to the economy and the health of the island’s infants and adults. Once again, the focus of blame for economic stagnation and infant mortality centred on individual mothers, with Maltese mothers disparaged for having “too many babies.” However, the quantitative analyses that I undertook in this dissertation indicate that, despite colonial impressions, birth-rates and infant mortality rates in Malta were not correlated, neither over time, nor across Malta’s various localities. That said, the statistical analyses based on data from one Maltese community did reveal that in larger families a higher proportion of children died within the first year of life, a finding which could be used to support colonial interpretations of the relationship between high fertility and high infant mortality.
Additional tests indicated that larger families had shorter birth intervals, and based on the results of the biometric analyses, these shortened birth intervals may have been related to an earlier age of weaning – which in turn may have been a significant factor in explaining more elevated rates of infant mortality in larger families. This finding could also be interpreted as supportive of colonial interpretations of infant mortality, which centred on the effects of maternal ignorance regarding proper infant care and feeding practices and the apathy of mothers regarding infant deaths in the face of elevated fertility and mortality. However, I argue that it is not so simple to determine what was specifically responsible for infant deaths at the level of the family, as it is impossible to distinguish the varying effects of family size, birth intervals, and weaning practices. Further, the role of a myriad of other factors, including maternal nutrition, biological fortitude, and socio-economic conditions, could not be assessed for their effects on infant mortality in these Maltese families.

Because of the absence of information relating to socio-economic conditions at the level of the family, in Chapter 8 I chose to assess the effects of social and economic inequality on disparities in infant mortality throughout Malta’s districts and localities. While not discounting the potentially serious consequences of early weaning, I argued that in early twentieth century Malta the weaning period was dangerous because of the environment within which the Maltese were forced to live. Moreover, I demonstrated that despite the fact that the divide between Malta’s urban and rural regions and Maltese social classes was essentialized and at times racialized, significant disparities in political power, economic position, and socio-sanitary infrastructure existed across and within Malta’s various districts, and infant mortality rates tracked these larger disparities to a
remarkable degree. Malta’s lowest classes, poorest communities, and areas with the least well developed sewage and refuse removal systems exhibited the highest rates of infant mortality, and the gap between the districts with the highest and lowest rates of infant death grew over the decades under study.

This last point brings my discussion back to the contemporary, as within the 2005 *World Health Report – Make every mother and child count* it is written that “progress has slowed down and is increasingly uneven, leaving large disparities between countries… as well as between the poor and the rich within countries” such that “national averages that show progress may conceal persisting or widening inequalities” (World Health Organization 2005). My investigation of infant mortality in Malta is a perfect example of this phenomenon: at a time when British officials were prioritizing the reduction of infant mortality in many locations and achieving progress in that regard, in Malta rates of infant mortality remained tremendously elevated for decades following their reduction elsewhere. Moreover, the national averages reported in Malta’s Health Reports, while showing little progress, nonetheless concealed widening inequalities between Malta’s richest and poorest communities and significant disparities in the proportion of infant deaths experienced by individual Maltese families.

Unfortunately, contemporary discourses on the relationship between infant mortality, mothering, and poverty replicate many of the discourses which circulated in early twentieth century Malta, if in more nuanced ways, such that conditions of poverty and the disparities in infant mortality that they engender continue to be blamed on the individuals who suffer the most. In Malta, when colonial administrators adopted a Malthusian perspective, excess population and fertility were seen to be the causal factors
of poverty, morbidity, and mortality, and Malta’s colonial status within the English, or world, capitalist system was neglected. Although overt Malthusian language is rare in contemporary discourses about poverty and ill-health, Malthus’s legacy has left us with “an unremitting anxiety about ‘over-population’” (Ross 1998:6) such that population growth is overwhelmingly seen as “a major, perhaps decisive, obstacle to economic progress and social betterment of the underdeveloped world” (Bauer 2004:341). Not only does the phrase “population problem” mean “overpopulation” to the majority of people, but it “conjures up images of malnourished and dying children, burgeoning slums, deforestation and desertification, and an unending cycle of poverty, disease, illiteracy, and social and political chaos” (Germain and Ordoway 2004:262). Bauer (2004:341) argues that poverty is not caused by population growth or pressure and is not a major threat to prosperity because “economic achievement and progress depend on people’s conduct, not on their numbers”; nonetheless, many continue to assert that population growth inhibits economic development. Importantly, then, if individuals are responsible for their own levels of poverty, as a result of excess population, then the responsibility for elevated rates of infant mortality in poorer populations is once again attributed to the poor themselves.

Moreover, understandings of the ‘overpopulation’ problem which centre on the so-called third world often view the women therein as “producers of too many babies” (Germain and Ordoway 2004:262). As in Malta, this is a location where discourses on infant mortality and overpopulation intersect, where poverty, population, and infant death are attributed to individual ‘mothers’. Thus, today, some of the most common interventions include the medical provision of contraceptives and oral rehydration
therapy (ORT), as well as initiatives to “educate” mothers, which are focused on the individual and are designed to reduce both fertility and infant mortality. Where women do not limit their fertility and where ORT does not solve the health problems of infants and children, this reinforces the image of these “other” mothers as ignorant, and once again poor health is attributed to personal failure (Morsy 1995).

While I do not wish to speak against the merits of improving education, making available treatments such as ORT, as well as implementing additional measures such as growth monitoring, generalized immunization, the promotion of breast-feeding, and the distribution of food supplements to mothers and infants, following Scheper-Hughes (1991:1146) I would argue that

these initiatives are sensible, but do nothing to alter the underlying structural causes of child death in the world: poverty, low wages, food shortages, unclean water, the entry of women into new forms of wage labour that prevent breastfeeding, and the sexual exploitation oppression, and abandonment of women and children by men who are themselves the victims of poverty.

More, it is not just that these types of individual-level interventions fail to address structural causes of infant, child, and adult morbidity and mortality, rather, their foregrounding and the public discourse that they engender obscures the importance of economic, social, and political contexts and the power structure changes needed to redistribute resources within and between societies to ensure that inequalities in health are ultimately reduced (Birn 2005).

To return once again to the 2005 World Health Report, they write of barriers in access to medical services such as antenatal care and argue that “without a real commitment to strengthening district health services, talking about the priority status of mothers and children is likely to remain mere lip service” (World Health Organization
2005). However, they additionally state that “people excluded from health care benefits… are also usually excluded from other services such as access to electricity, water supply, basic sanitation, education or information” and cite as one of the reasons for failed progress in improving the health of mothers and children “the failure… to invest adequately in public health and a safe environment” (World Health Organization 2005). Initially, my quarrel with the conclusions of the WHO were that their scope was too narrow, with its emphasis on health services, but I supported their message that saying that the health of women and children is a priority – which we have been doing for over a century – is simply not enough. Part of me was caught up in the view that “the healthy future of society depends on the health of the children of today and their mothers, who are guardians of that future” (World Health Organization 2005). I, too, lost sight of the ways in which the child was constructed as different and special and somehow of more value than the adult. I, too, allowed myself to accept the taken-for-granted association between the mother and child and the related essentializing of women as natural-intensive and compassionate mothers, which was born at one moment in history. I, too, lost sight of the value of the infant mortality rate as an index of larger problems that disproportionately affect children. In the introduction of this dissertation, I wrote of my desire to contribute to a revitalization of the use of the infant mortality rate as an indicator of conditions within an environment that negatively impact human health and well-being, and this is where I would like to conclude. The infant mortality rate may not be a perfect measure, and it was born at a moment in history under circumstances which should be acknowledged, but I believe that this investigation of infant mortality in the early twentieth century Crown colony of Malta reveals that a narrow focus on saving
(certain) infant lives rather than all lives, an emphasis on proximate and intermediate
determinants of infant mortality, and the concomitant structuring of interventions to assist
individual mothers to care for their individual infants obfuscates the larger inequalities in
access to resources, sanitary sources of food and water, and other basic necessities of life
which have a tremendous impact on morbidity and mortality of infants and adults
worldwide – and that the effects of these structural factors far exceeds variation in health
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## Appendix 1 – Factors Correlated with Infant Mortality in Biomedical Literature

<table>
<thead>
<tr>
<th>Level:</th>
<th>Factor</th>
<th>Reason/How this is said to affect infant mortality</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>Weight/Nutrition</td>
<td>- multiplicative effect of infection and malnutrition&lt;br&gt;- increased risk of diarrhoea&lt;br&gt;- related to gestational age&lt;br&gt;- last link in long chain (including maternal anxiety, care…)&lt;br&gt;- decreases immune and non-immune defenses&lt;br&gt;- related to SES, maternal nutrition</td>
<td>Ballweg &amp; Pagtolun-An 1992; Black et al. 2003; Bland 1994; de Souza et al. 2001; Feyistan et al. 1997; Frisch et al. 1992; Scott &amp; Duncan 2000.</td>
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<tr>
<td>Family/Mother</td>
<td>Maternal Age</td>
<td>Increased risk found among younger and older mothers – variously defined as between 15-19, under 18, 20, 21, over 34, 35, 40&lt;br&gt;- physical/physiological immaturity&lt;br&gt;- decline of efficacy of reproductive system with age&lt;br&gt;- operates through birth interval, size of baby&lt;br&gt;- lack of childcare skills&lt;br&gt;- lack of access to health care</td>
<td>Alam 2000; Alam et al. 2001; Ballweg &amp; Pagtolun-An 1992; Feyistan et al. 1997; Ikamari 2000; Pederson 2002; Savona-Ventura &amp; Grech 1987; Shakya &amp; McMurray 2001; Swenson et al. 1993.</td>
</tr>
<tr>
<td></td>
<td>Parity</td>
<td>Increased risk for first and higher order births – variously defined as above 3, 4, 5&lt;br&gt;- reproductive system adapting to pregnancy&lt;br&gt;- inadequate prenatal care&lt;br&gt;- mothers take improper care of selves during pregnancy&lt;br&gt;- behavioral: unwanted birth&lt;br&gt;- related to increased age of mother</td>
<td>Alam et al. 2001; Ballweg &amp; Pagtolun-An 1992; Feyistan et al. 1997; Ikamari 2000; Pederson 2002; Savona-Ventura &amp; Grech 1987; Swenson et al. 1993; Van Poppel et al. 2002.</td>
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<tr>
<td>Family/ Mother (continued)</td>
<td>Birth interval</td>
<td>Increased risk for infants born after a shorter birth interval – defined as less than 12, 17, 19, 24 months – or a longer interval, such as greater than 36 months - maternal depletion: insufficient time to recover health - sibling competition for resources - increased transmission of disease - shortened interval because of stop in breastfeeding - result of pre-mature birth</td>
<td>Ballweg &amp; Pagtolun-An 1992; Feyistan et al. 1997; Ikamari 2000; Murphy &amp; Wang 2001; Pederson 2002; Shakya &amp; McMurray 2001; Swenson et al. 1993; Uchudi 2001.</td>
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<tr>
<td>Family Size</td>
<td>Increased – or decreased – risk for infants born into larger families - sibling competition - increased transmission of disease - OR increased quality of childcare/number of caretakers</td>
<td>Uchudi 2001</td>
<td></td>
</tr>
<tr>
<td>Consanguineous marriage</td>
<td>- biological effects</td>
<td>Pedersen 2000.</td>
<td></td>
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<tr>
<td>Behaviours</td>
<td>Feeding Practices</td>
<td>Exclusive breastfeeding for 4-6 months shown as protective – although others found an association between breastfeeding and IMR -Breastfeeding leads to: - reduced exposure to infectious agents - improved immunity - nutritional needs are met - particularly important in a poor environment - Breastfeeding as indicator of parental investment</td>
<td>Black et al. 2003; de Souza et al. 2001; Fildes 1995; Huffman et al. 2001; Uchudi 2001; Van Poppel et al. 2002.</td>
</tr>
<tr>
<td>Disadvantage</td>
<td>Poverty/SES</td>
<td>References</td>
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</table>
|                      | - reduced access to medical care  
|                      | - job anxiety  
|                      | - conditions nature of housing, diet, water supply and sanitation, medical care, social status, education  
|                      | - which in turn affects undernutrition, disease, injury  
| Employment           | - loss of employment: lose access to medical care  
|                      | - maternal employment: poor quality child care  
| Education/literacy   | - have fewer children  
|                      | - childcare: improved hygiene, feeding practices  
|                      | - health: earlier detection and treatment of illnesses, use of health care services, better communication with providers, less fatalistic  
|                      | - socio-economic status: better income, marriage to more educated men, better living conditions  
|                      | - social status: resources to act autonomously, increased intellectual skills, bargaining, authority, confidence, change family dynamics  
|                      | - to becomes more child-centred  
|                      | - intelligence: ability to think about complex situations  
| Divorce/marital disruption | - access to health care  
|                      | - access to food  
| Water supply/sanitation | - exposure to water-borne diseases and infections  
|                      | - better personal and food preparation hygiene: reduce diseases transmitted by faecal-oral route  
| Access to health services | - related to family conflict  
|                      | - related to SES  
|                      | - factored into parental investment  
|                      | - affects gestational age and birthweight  
|--------------------------|-------------------------|----------------------------------------------------------------------------------|----------------------------------------|
Appendix 2 – Statistical Procedures

All statistical analyses were performed with SPSS 14.0. Simple linear regression and multiple linear regression analyses were employed to assess the relationship between infant mortality rates and a variety of variables included in the aggregate data sets (A1, A2), as well as between the incidence and percentage of infant deaths in the family-level data sets (F1, F2). Additional tests performed on the family-level data sets (F1, F2) included Pearson’s and Spearman’s chi-square tests, t-tests, analysis of variance tests, and the assessment of weaning patterns via the biometric method. More detailed descriptions of the specific analyses run and the variables included in the analyses are discussed within the chapters of this dissertation. Below, the procedures employed and their respective assumptions are described.

Regression Analyses: Least-squares linear regression is used to explore the nature of the relationship between two continuous random variables by investigating the change in the response variable \( y \), according to changes in the explanatory variable \( x \), the ultimate objective of which is to predict or estimate the value of the response that is associated with a fixed value of the explanatory variable (Pagano and Gavreau 2000). Multiple linear regression includes multiple explanatory variables in order to investigate a more complicated relationship between a number of different variables and the response variable \( y \). The assumptions of this statistical procedure are that the observations are independent, that the distribution of \( y \) values is normal, that the relationship between the explanatory variable(s) and the response variable is described by a straight line, and that the standard deviation of the \( x \) values is constant (homoscedasticity). Importantly, in the case of multiple observations, regression is not very sensitive to minor lack of normality;
although influential observations in the form of outlying values can greatly affect the results and should therefore be eliminated from the analyses whenever possible (Moore 2000).

**Chi-square tests:** Chi-square tests are used to compare observed and expected counts in a contingency table in order to determine if the observed proportions are different enough from the expected proportions that they are unlikely to be the result of random variation. Larger chi-square values are evidence that the observed proportions are not equal, and a p-value below 0.05 indicates that this relationship is statistically significant, and unlikely to be due to chance. Correlation analysis can also be employed to quantify the degree to which two random variables are linearly related (Pagano and Gavreau 2000). Pearson’s correlation coefficient indicates whether the two continuous variables are negatively or positively correlated, and Spearman’s rank correlation coefficient is a nonparametric method used to assess the relationship between ranked values, such as ordinal data, each of which gives a dimensionless number between –1 (negative correlation) and 1 (positive correlation), with a corresponding p-value.

**T-tests:** T-tests are employed to compare means for two sample populations and to determine whether the differences observed between the sample means are too large to be attributed to chance alone, with the p-value indicating the probability of obtaining a pair of sample means as discrepant or more discrepant than the observed means (Pagano and Gavreau 2000). The assumptions of the t-test are that the data represent a simple random sample from the population, that samples are independent, and that the observations form a normal distribution. In practice, the t-test is a robust procedure, whose p-value does not
change much even when assumptions are violated; therefore, unless the sample is very small (less than 15 values), it is sufficient that the distribution be symmetric and single-peaked. As with regression, outliers can strongly influence the results, and larger samples improve the accuracy of the p-values, such that even in the case of clearly skewed distributions t-procedures can be used if the number of observations exceeds 40 (Moore 2000).

**Analysis of Variance (ANOVA):** The ANOVA $F$ test is employed to compare sample means in instances in which there are more than two populations. Like the t procedures, it is robust, with the most important assumption being that of normality, such that it becomes more reliable as sample sizes increase (Moore 2000). Unlike the t-test, ANOVA assumes equality of variances; however, it is not too sensitive to violations of this assumption, such that the $F$ test is approximately correct when samples have the same or similar sizes and the largest sample deviation is no more than twice as large as the smallest sample standard deviation (Moore 2000)