The midwives ordinance of Palestine, 1929: historical perspectives and current lessons

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Until 1929, midwifery in Palestine was relatively open to anyone and only partially regulated by the 1918 Public Health Ordinance, legislated shortly after the beginning of British rule. This article describes the factors that guided the shaping of midwifery and suggests possible sources of inspiration for the British legislator in crafting the Midwives Ordinance in 1929, including American, local (Jews and Arabs), and British ones. The Midwives Ordinance reflects the adjustment of midwifery to changes in the society that evolved under the British Mandate. The ordinance shows how the modern midwife’s role contracted relative to the traditional one, in the context of social processes in other countries, east and west. This historical research project is based on interviews, archive documents and research literature. It analyzes the British interests in regulating midwifery, including the rationale of preserving public health and reducing infant mortality, against a background of political power struggles as well as cultural, social and professional diversity (the tensions between the powers of doctors, nurses, and pharmacists).

Key words: gender, history, Israel, law, midwifery, professionalisation.

In 1917, the British took over Palestine from the Ottoman Empire that had ruled it since the sixteenth century. One of the characteristics of British rule, which lasted until the establishment of the state of Israel in 1948, was legislation in all eras of life, including health matters and midwifery. These changes took place within the context of a mostly Muslim society, into which waves of Jewish immigrants began arriving since the 1880s, mainly from Europe, changing the population composition. In this multicultural context, midwives went through a professionalization process.

Vena Rogers, the government’s superintendent of midwifery in Palestine (1929–45), described the status and centrality of the folk midwife (mostly Muslim), the Dayah, in society: ‘The Dayah or untrained midwife was a friend of the family; she delivered and named the child, attended all ceremonies and arranged its wedding, and her word was law’ (our emphasis). The Dayah’s word was ‘law’. She was an authoritative figure, participating in various life-cycle ceremonies among the families whose babies she had delivered. In 1929, this traditional midwives ‘law’ was ‘nationalized’ by the British Mandatory legislator, who set the duties and rights of licensed and unlicensed traditional midwives in the Midwives Ordinance (law or regulation in the colonies).
This article uses the 1929 Midwifery Ordinance and the circumstances of its legislation as a prism for the description and analysis of the development of midwifery during the British Mandate in Palestine (1918–48), while referring briefly also to the current status of the profession.

The central arguments are that by legislating the Midwives Ordinance in Palestine, the British were acting mostly to improve health standards in the country and regulate their rule there. As for the midwives, archival materials suggest that they did not initiate, but rather reacted to the regulation of their vocation (contrary to the situation in Britain, where the midwives took an active part of this process). We present a few layers of the ordinance as regulating a healthcare profession bearing a feminine orientation, in the service of the governmental interests. We consider whether the ordinance was indeed intended to protect the midwives’ autonomy or rather reduced their authority (when compared with other healthcare professionals, as well as among midwives), and whether it reinforced the profession as ‘feminine’, hence ‘inferior’ compared with other healthcare professions.

This case allows a look into a typical historical process in which there is no linear progression, but rather a complex movement. In this sense, the ordinance reflects an individual instance of the composite process of passage from traditional to modern society. In this process, the role and authority of both the midwives and the traditional midwives were reduced.

We present these views against the background of the legal and practical situation in midwifery up until the 1929 Midwives Ordinance legislation, from a viewpoint relating to the foundations of professional regulation. The characteristics of the legislation process were also applied against a background of political power struggles and cultural, social and professional differences.

Hence, the Midwives Ordinance, the background to its legislation and its application are an extraordinary test case for examining questions pertaining to the relation between law, medicine, nursing, class and gender, during the British mandate in Palestine.

### HISTORICAL BACKGROUND AND SOURCES OF LEGISLATION

Colonization brings about a transfer of culture, including professional models, into areas considered ‘filtering’. The imported models reflect utopian ideals from the country of origin, which might only be applied in a place in which colonizers hope for a fresh beginning, that is, in the target country. In Palestine, as in other colonies, professional models were imported by the colonizing regime. By the late Ottoman era, western midwifery knowledge started flowing into Palestine, supplanting the traditional practice, so the Midwives Ordinance was neither created nor legislated in a vacuum.

In 1861, the Ottoman authorities issued a new regulation concerning obligatory licensing of midwives. However, the traditional midwives were not part of this licensing process, which applied later only to the modern midwives who studied abroad, mostly in Europe. By 1901, there were six European-trained midwives in Jerusalem. The new midwives, as opposed to the traditional ones, dealt only with their specialized field and were only present at birth. By the end of the Ottoman period, three models of midwifery were common in Palestine:

1. The independent traditional midwife (Dayah), who had gained her practical knowledge through apprenticeship already during the nineteenth century; the folk midwife, the Dayah, was popular mostly within the Arab population.

2. The local woman from the Jewish community who had studied in Europe received a diploma and returned to Palestine at the turn of the twentieth century.

3. The midwife-medic (Feldscher) – a new immigrant arriving mostly from Eastern Europe at the turn of the twentieth century. The Feldschers studied basic courses in medicine, midwifery, nursing and pharmacology in order to practice in peripheral areas mostly in the former Soviet Union.

In 1918, soon after the British took over Palestine, the American Zionist Medical Unit (AZMU; later named Hadassah Medical Organization; hereinafter: ‘Hadassah’) arrived in Palestine on behalf of America Jewry, and dealt with care of women during their pregnancy and labor, bring-

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* To quote Shepherd: ‘The Mandate authorities tried to use the law books for a contradictory end to perpetuate local traditions and at the same time to facilitate change’. Naomi Shepherd, *Roughing it and: British rules in Palestine* (London: John Murray, 1999), 74.

* Bartal, Compassion and competence, 81–6.

* George Young, *Corps de droit Ottomans: Recueil des codes, lois, réglements, ordonnances et actes les plus importants* (Oxford, 1905).

* Rogers, 104.

* Nira Bartal, *Beginning of the nursing profession in Jerusalem: The 19th century until 1918*, in Jerusalem in the late Ottoman era, eds Israel Bartal and Hayim Goren (Jerusalem: Yad Izhak Ben-Zvi, in press) [in Hebrew].
ing along a fourth model of midwife: the nurse-midwife. This model was promoted in healthcare services by Hadassah, within Jewish society. It is also important to note that over time, the Hadassah model of midwives became the dominant one.

In 1918, the British published the Public Health Ordinance, which was one of the first British ordinances in Palestine. This ordinance aimed to protect the population from contagious diseases and also from unqualified medical practitioners. According to the ordinance, midwives were also obliged to present a diploma and to receive a license (licensed midwives). However, the British authorities did not rule out the already existing traditional midwives (Dayahs), which were allowed to work as before.

In 1929, the Midwives Ordinance was enacted. The ordinance presented two tracks, reflecting the existing division: one for licensing qualified midwives, mostly the nurse-midwives (Section 5)13 (licensed midwives) and the other for registering unlicensed midwives (registered midwives), mostly the Dayahs (Section 18).14 We will demonstrate how the ordinance had in fact changed the way in which these two types of midwives were authorized to work.

LAYERS OF REGULATION

Regulation carries a kind of a trade-off whose essence is protecting the public, while at the same time protecting implicated professionals from professional infringement.15 It also carries a governmental advantage of tracking those individuals subordinate to regulation as well as their clients.

In the Midwives Ordinance, the protected public is women giving birth (and their newborn babies), while theoretically also protecting the professionals engaged in childbirth by limiting competition and restricting it to authorized individuals. As the profession is mostly feminine, this is a special case of protecting women from women (that is, women giving birth from midwives) and protecting the midwives from other workers in the field (including unlicensed midwives). In addition, it seeks to serve public interests.

We seek to examine what, if anything, midwives gained from the ordinance in exchange for their licensing or registration, as well as what they were required to give or give up as a result. We will examine the British interests in legislation, as well as the relationship and ‘encroachment’ among midwives (that is, midwives who fulfilled the license requirements and were recognized as licensed midwives, as opposed to midwives who were allowed to register only and were recognized as registered midwives), and the relationship between midwives and other professionals such as doctors and pharmacists.

LICENSING AND REGISTRATION IN RETURN FOR REPORTING: MIDWIVES AS GOVERNMENT AGENTS?

As mentioned, the trade-off between the government and the professionals consists of the professional’s duty to report, in exchange for a protection from professional infringement. Already in early modern Europe, when licensing of midwives was mandated by the church, midwives testified on infanticide and maternal death—granting them an authority reflecting their education and the community’s respect. According to Broomhall, midwives in the sixteenth century testified on issues relating to women’s bodies, for example, virginity, rape, inability to give birth or abortion.16 The duty to report ought not to be regarded as negligible. Thus, viewing midwives’ role in society throughout history raises questions about their status—whether they were respected or marginalized17—and whether midwives, as symbols of ‘traditional femininity’ were ‘true’ representatives of women in the community or rather ‘agents’ of religious and government authorities. It seems that the British regime in Palestine preferred the latter option.

We claim that the British construction of the 1929 Midwifery Ordinance was masterful, based on the British Midwives Act of 1902.18 We also claim that the British in Palestine did not necessarily pass the Midwifery Ordinance in order to improve the status of midwives. Rather, they changed midwives’ status in order to achieve other functions—with licensed and unlicensed midwives alike serving as the

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12 See letter from Brenchlie to the General Secretary dated 14 July 1928, PRO CO 733/162.
13 5 (1) Application for a licence to practice midwifery shall be made to the Director who may grant a licence on being satisfied that the applicant — (a) has studied midwifery for a period of at least six months. The laws of Palestine (revised edition by Robin Hanay Dayyan, vol II. London, 1934), 931.
14 13 (1) Outside a prescribed area no person other than a licensed midwife shall practice midwifery unless her name is entered in a Register of Unqualified Persons practicing Midwifery, ibid.
18 Bordo, Compassion and competence, 92.
authorities' agents of change and adjusting their actions to the new rules, regulations and information.

As rulers of the land responsible for creating infrastructure — including health services — the British dealt with questions of statistics, demography and population. As such, it is not surprising that one of the first duties set in the 1918 Public Health Ordinance was the duty to report births and deaths imposed, among others, on midwives. The duty to report was especially important in a period when most births were home-births. As mentioned, the 1918 Public Health Ordinance made a license compulsory for midwives and also for physicians, surgeons, dentists and pharmacists. The beginning of this trade-off between a midwifery license and the duty to report can be found in this ordinance, and later in the Midwifery Ordinance.

The indicators of live births and newborn mortality rates are among the most important data in public health. The British had to obtain these data on the one hand, and to improve conditions on the other. The Midwifery Ordinance was based on the assumption that registration, licensing, training and government inspection of midwives would bring about the desired results. Support for this view may be found in British activity in Malaya and Honduras, but even in Britain itself, due to the concerns regarding infant mortality rates.

These demographic data became especially important: the British in Palestine had to report to the League of Nations, the international organization that had entrusted Palestine to the British mandate and was thus authorized to inspect the mandate's activities and the fulfillment of its conditions.

The data reflected the situation in Palestine, highlighting the difference between Arab and Jewish societies. Therefore, insofar as these data reflected significant differences between Jews and Arabs in Palestine, the British, with their double duty to both populations (the parity principle), sought to create a balance by improving conditions for the Arab population. As services provided by the Jewish and Zionist institutions in this matter were fairly good according to modern standards, the British focused on the Arab population,

![Infant Mortality](image)

**Figure 1** Infant mortality (Palestine): Number of deaths of infants <1 year old per 1000 live births.

Source: Based on data found in League of Nations Report, LON/1945.VIA.1, The Mandate System (30 Apr 1945).

wishing to minimize the gap with the Jewish population. At the same time, there is no doubt that the British legislators sought to improve health services in general and perhaps to unify a professional standard based on the accumulated knowledge in the field. They assumed that improving the professional standard of midwives will decrease the infant mortality rates. And in fact, archival materials suggest that the British legislators certainly achieved their goal in helping reduce newborn mortality among the Arabs.

In this connection, the statistics for infant mortality are particularly striking and satisfactory ... for the whole of the Palestinian population, the infant mortality rate has thus decreased by 37% in the course of the sixteen years 1922-38. The infant mortality rate in Palestine for 1938, 112 per 1,000, was lower than that for Egypt, a neighboring country (163 per 1,000), and than those of ten European countries.

However, the gap between the populations did not in fact change (figure 1).

### PROTECTION FROM INFRINGEMENT

As discussed above, licensing or registration placed reporting duties on midwives. As for the licensed midwives, the ordinance also demanded a mandatory course of study. The question is whether these licensing conditions

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provided the midwives with advantages and protection against infringement of their profession when compared with other healthcare practices and with (unlicensed) registered midwives.

**CREATING A LICENSED VERSUS REGISTERED HIERARCHY**

Section 9 of the Midwives Ordinance explains that the High Commissioner would restrict the areas where registered midwives would not be allowed to practice. That is, licensed midwives had the right to practice midwifery throughout the country, whereas registered midwives could only practice in certain areas, according to the need. The British legislator did not aim at distinguishing between Arab and Jewish populations, but focused on the actual conditions: in some areas, there were enough licensed midwives, and in others they were unavailable. One could conclude that the aim was the promotion of a gradual process of ‘phasing out’ Dayaḥ activities, while acknowledging existing constraints. The Mandate’s legal advisor at the time Norman Bentwich explained that ‘It is recognized by the Department that in the greater part of Palestine midwifery must be carried on for a time by unqualified persons’.24 This seemed to carry an advantage for licensed midwives and reduce competition.

Although the ordinance does not reveal this, the explanatory note to the draft reflects that at the eve of legislation, 1200 unlicensed midwives were already registered.25 A minority of these was under 40 years of age, and only few were literate. Thus, section 10 of the ordinance, requiring the registration of Dayaḥs, was no novelty. Why then had the British chosen to regulate midwifery by ordinance? First, the rules had to be made apparent to all. Second, based on the information gathered up to that point, ‘in many parts of the country, particularly in the larger towns, there are now almost sufficient licensed persons for the need of the communities’26 – which allowed the British authorities to restrict certain areas for licensed midwives only, or for licensed midwives who had applied at the time of the ordinance’s validation.

In addition, in all matters relating to registration and penalty, the legislator placed a heavy burden on Dayaḥs.27 This can be seen in the clause referring to penalizing Dayaḥs, which reflects a more suspicious attitude, necessitating stricter supervision than over licensed midwives.28 For example, the ordinance distinguishes in this case between a Dayaḥ’s ‘misconduct’ as opposed to a licensed midwife’s ‘unprofessional conduct’. One can assume that the distinction between a legally registered unlicensed and licensed midwife was influenced by the British law, legislated in a class-ridden society. The law associates the unlicensed midwife with a lower class, where the probability of honesty throughout all aspects of life, including the vocational one, was perceived to be lower than that found among the class of licensed midwives.

The attempts to ‘phase out’ the Dayaḥ activity can further be seen in the British legislators’ choice to omit the proposal of the Health Department Director of the time, Rupert Briencliche. According to the proposal, the Dayaḥs registered in villages were to receive payment rather than payment in kind, the latter of which was so meager ‘that only the lowest class of village women undertake the work’.29 Such an experiment had been applied successfully, according to the Health Department Director, in the villages around Hebron, as in Britain, where the local councils paid midwives from poor families.30 This proposal, which could have solved the problem of weaker populations who could not afford the services of unlicensed midwives, was not expressed in the ordinance.31

**REDUCING HIERARCHY AMONG LICENSED MIDWIVES**

We have described so far a trend to create hierarchies between licensed (mostly Jewish) and registered (mostly Arabs) midwives, yet in parallel, another trend of reducing such hierarchies was in fact taking place. This trend reflects the British interest to train relatively quickly and to license more midwives, especially among the Arab population.

24 Explanatory notes to the Bill by Norman Bentwich (Legal Advisor) dated 24 Oct 1928, PRO CO 733/162.
25 Similar data may be found also in the early 1930s. The total number of unlicensed village Dayaḥs practicing at the end of 1932 was 1171 (78%) and that of licensed midwives – 333 (22%). Rogers, 106.
26 Letter from Rupert Briencliche to the General Secretary dated 14 July 1928, PRO CO 733/162.
28 See Section 11 of the 1929 Midwives Ordinance, supra note 2.
29 Letter from Rupert Briencliche to the General Secretary dated 14 July 1928, PRO CO 733/162.
30 Ibid.
31 Else I. Young in her thesis presents the profession as passing from mother to daughter and stemming from a midwifery talent, a divine gift for the community, EG Young, 92–4.
The Midwives Ordinance ignored the model of Hadassah's nurse-midwife, who had studied nursing for 3 years and then specialized in midwifery, and granted a midwifery license to anyone who had studied for 6 months at a recognized institution.\(^3^2\)

A letter from the British Health Department Director to Hadassah stated the following:

Under the previous regulations in force in Palestine a course of only three months was required in respect of a person who was a graduate nurse. The longer course now obligatory applies equally to nurses and to persons who have had no nursing experience and brings the period of training into conformity with that given in England.\(^3^3\)

The suggested explanation is that the British placed minimum public-protection requirements for nursing studies in Palestine, as influenced by midwife-training courses in Britain. This suited their political intentions to encourage Arab women with no nursing training to study for a relatively short period and then receive their license. In other words, the Mandatory legislator sought to compare authorization conditions and by adopting the British model, and in the process practically blur the distinction between midwives who were also nurses, and midwives (mostly Arab) who had only studied midwifery. The legislators in fact rejected the American Hadassah model of a nurse-midwife as the only track for licensing, and allowed licensing based on midwifery studies alone, thus consequentially turning Jewish and Arab midwives with different levels of training into one legal entity. The aim was to create a uniform image of licensed midwives, at the expense of the unlicensed registered ones. In sum, against the background of the political context of a Jewish–Arab society, a matter of supply and demand dominated.

**FORMING BOUNDARIES BETWEEN MIDWIVES, NURSES AND PHYSICIANS**

The ordinance also increased some midwives' professional sphere of operation by granting licensed midwives the authority to 'heal or treat a women giving birth'. This power was ultimately eroded in later periods. However, despite the relative independence of the licensed midwife, the ordinance also reflected a process that enhanced the hierarchy between midwives and physicians, who benefited through the outcome of increased hospital birth rates.

Thus, this legislation—which bears characteristics of creating and defining a profession—seemed to impose limits on midwives. Certainly, we do not claim here that the British actually intended to discriminate between men and women; rather, they tried—in an attempt to improve healthcare services according to their perception—to place midwives under male-medical supervision.\(^3^4\)

However, certain struggles did accompany this change. Archival materials provide information regarding, for example, Zipa Stern, a midwife from the Jewish northern settlement of Rosh-Pina who was one of the first to receive a license. Despite being partially employed by the Hadassah Medical organization, Zipa disobeyed a doctor's order and refused to make a house visit to a mother who had previously given birth in the hospital. She claimed that she only treated mothers whom she herself had delivered, that her services were not free and that 'it was not her duty' to treat those who delivered in the hospital. The story of a local midwife emphasizes the passage from being independent to a situation where she acted under the authority of a medical establishment that set the work rules.\(^3^5\)

Moreover, doctors were not alone in trying to edge out the midwives; rather, they were joined by public health nurses. Katy Dawley's study concerning the United States at the turn of the twentieth century reflects the reality in Palestine as well, in this regard.\(^3^6\)

**FORMING BOUNDARIES BETWEEN MIDWIVES (FELDSCHERS) AND PHARMACISTS**

The Midwives Ordinance was part of a series of laws aimed at regulating various healthcare professions. In this context, the ordinance also deals with setting the boundaries and the interaction between the various professions other than medicine.

The 1918 Public Health Ordinance ruling that 'the license granted to a physician or medic incorporates the license to serve as a pharmacist too' means that the mid-

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32 Barot, Compassion and competence, 92–6.
33 Letter from the Health Department Director (signature unclear) to Hadassah directanship, 5 Dec. 1929, CZA J113/178 (in Hebrew).
34 See, for example, Section 15: A person authorized ... to practice midwifery shall call in the services of a licensed medical practitioner to any case in which the conditions require medical assistance etc. Section 17: An officer of the Department of Health authorized ... may enter ... for the purpose of inspection and supervision; or Section 13: No person except a licensed medical practitioner shall conduct a lying-in hospital maternity home.
35 Correspondence between Dr Baruch Barak and Dr Iser: Max Rubnov AZNU Director, 12 May 1921, 4 Nov 1921, 6 Dec 1921, CZA J113/6206 (in Hebrew).
The midwives ordinance (Palestine, 1929)

The midwifery license does not entail a license to serve as a pharmacist, as opposed to a medic, who is granted this authority. The quoted ordinance, as well as that of 1929, served to limit the professional practice areas of another group of midwives—the Feldshchers, who were medic-midwives and prepared medications according to their training. These were mostly new immigrants, trained in Eastern Europe for a multipurpose task. Rachel Lipschitz, a medic-midwife from Rehovot (a town in central Israel) who was employed by Hadassah, faced limitations on her work following this Ordinance. In a letter by the AZMU office to Ms. Lipschitz, it was found that ‘a new law on pharmacists requires a list of licenses of those dealing with selling medications and prescriptions’. She was asked for a description of her work and whether she had a pharmacist license. In reply to the management in Jerusalem, she wrote that ‘uncomplex prescriptions I prepare myself, and complex ones I hand over to the Rehovot pharmacy’. She attaches the Russian Medic School (Feldshchirna School) certificate, and claims to have worked at the school pharmacy and at ‘the pharmacy of the hospital where I was a medic’. Generally, the medic-midwives who were not considered to comply with the accepted model by Haïssah seemed to pose a threat on the organized medical establishment (and not only to pharmacists, as quoted), as they deviated from the traditionally defined midwife’s role and at times refused to follow orders from physicians.

CONCLUSION

The development of midwifery is an example of a professionalization process typical of the transition from traditional to modern society. The 1929 Midwives Ordinance reflects one key element in this progression. From an international comparative perspective, the regulation and its results were no different from those in other countries, in that they limited midwives and placed them under medical authority dominated by males. The ordinance must also be seen as a move away from home-centered birth toward the western, physician-managed hospitalization authority.

In fact, the Midwives Ordinance was not an initiative of the midwives as part of a struggle over their status. Rather, the ordinance was enacted as part of the British attempt to establish their rule in the country. Legislation was aimed at improving population health by reducing morality of newborns and their mothers. This improvement was for internal purposes of reducing the gap between Jewish and Arab populations, as well as for external purposes—justifying the mandate granted by the League of Nations. The ordinance shaped the boundaries and created hierarchies between the various professionals. In terms of the balance between Jewish and Arab midwives, the ordinance discriminated against the Deyolals who were mostly Arab, and increased supervision over them, compared with that of licensed midwives, who were mostly Jewish. However, it also somewhat harmed the position of (Jewish) nurse-midwives when compared with (Arab) licensed midwives, who had only undergone short training.

The legislation process is interesting as it created both equality and hierarchies—all in the legislator’s need of improving the healthcare conditions in the country. It also reflects one of the ways in which British legislation affected women in Palestine—in this case professional women and women in labor—all under the unique circumstances of Palestine, under which the British had to navigate between the Arab and the Jewish population.

CURRENT SITUATION

The mere enactment of legislation with characteristics of creating and defining a profession did little, from certain perspectives, to enhance midwives’ professional status. Currently, the ordinance, still in force, defines midwives’ duties as comprises of the following four authorizations: (a) to examine a woman in regard to childbirth; (b) to determine the woman’s diagnosis; (c) to write prescriptions for the woman; and (d) ‘to treat her or the child’. Unlike the original version, the current version of the ordinance forbids midwives from practicing ‘healing’. In other words, we see this as a reduction of the midwife’s role from ‘healing’—that is, equivalent to the role of a doctor, to ‘treatment’ alone—that is, equivalent to the role of a nurse.

Over the last 75 years since the 1929 the ordinance was passed, it remained in force and was amended only four times. In 1953, a ‘Midwife Census’ was held, encompassing re-registration and license replacement. In this case, too, the (Israeli) legislator sought to obtain data on the number of midwives in Israel and their professional training. In 1960, the ordinance was amended in order to ‘ease the shortage of

37 Correspondence between Rachel Lipschitz, medic-midwife from Rehovot, and AZMU office, 15 Sept 1921, 25 Jan 1922 and 2 July 1922, CZA J113/6554 [in Hebrew].
38 Dowley, 110–11: Another such example of the process is found in Japan Aya Home: Sando and their clients, midwives and the medicalization of childbirth in Japan 1868 to c. 1920: in New directions in the history of nursing: International perspective, eds Barbara Mortimer and Susan McGone (London: Routledge, 2005), 68–85.
39 For similar conclusions on the regulation of US midwives, see Raymond G. Devries, Making midwives legal (2nd edn. Columbus, Ohio State University Press, 1996).
40 ISA G-4265/2.
licensed midwives', according to the explanatory notes to the bill. In 1977, it was amended once again to allow the Ministry of Health's General-Director to delegate authorities according to the ordinance and regulations, similarly to the legal situation in other healthcare professions. Thus, midwives' position on the professional hierarchy was diminished.

It should also be noted that nurses in Israel today are authorized to work according to subsidiary legislation (regulations), and that midwives presently work under the supervision of the chief national nurse. In other words, although the Midwives Ordinance is still in force in Israel, midwives and nurses are grouped together as working under the same framework of regulations. Moreover, in the proposed Nursing Law of 2008, which has yet to be approved, we find that the midwife is recognized as an expert in nursing and that the Midwives' Ordinance is about to be cancelled.

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