



Review

Midwifery and Midwives: A Historical Analysis

¹Najla Barnawi, ²Solina Richter and ^{*3}Farida Habib

^{1,3}College of Nursing-Riyadh, King Saud Bin Abdulaziz University for Health Sciences, Saudi Arabia

²Faculty of Nursing, University of Alberta, Canada

*Corresponding author email: fmh226@yahoo.com

Abstract

Midwifery, the first holistic profession in the world in which “care” has always been a women-centered phenomenon. It is a socially constructed practice that has gone through many historical transitions. Many of these have involved social controversies in terms of the meaning of care, the scope of its practice, and its standardized skills. The purpose of this paper is to explore and critically examine the major transitions on midwifery during history, looking in particular at the socio-cultural circumstances that are associated with these transitions through an historical analysis. Two objectives are intended to be explored; first, identify the major “macro” socio-cultural factors that shaped different meaning of “concept of care” in midwifery. Second, identify the major “micro” socio-cultural factors that changed the scope of practice in midwifery. Two main search approaches are used to collect the retrieved data; textbooks searching, and computer searching. *Textbooks searching phase* aims to identify the historical knowledge gap and different views of midwifery transitions based on four historical intervals ranging from Stone Ages era to Early Modern time. *Computer searching phase* aims to critique the different scholarly views that focus on the major social and cultural factors that shaped the practice scope midwifery during history. During this strategy a comprehensive review of the major electronic databases of MEDLINE, PubMed, and CINAHL was conducted. Midwifery is a woman-centered phenomenon and a socially constructed practice where macro and micro socio-cultural factors played a key role in its transition over the history. Power of social organizations, consistency of civilizations, and productivity of industrialization are the major macro social factors that changed the concept of “care” in midwifery from individualized concern to holistic approach. Gender identity, social class and authority, and accessibility of formal education are the main micro socio-cultural factors that changed the practice of midwifery from un-standardized practice to advanced scientific profession.

Keywords: Midwifery, History, socio-cultural factors

INTRODUCTION

Midwifery, the first holistic profession in the world, is the art of providing supportive care for women during their childbearing years (Lay, 2000; Leap and Hunter, 1993; Marland and Rafferty, 1997). Traditionally, midwifery was an unregulated practice in which females took the initiative based on their societies inquiries (Leap and Hunter, 1993; Marland and Rafferty, 1997). They were primary healers, and they took on the role of nutritionists, doctors, and spiritual advisors (Marland and Rafferty, 1997). Currently, midwifery is a profession that has a regulated scope of practice (Lay, 2000; RCM, 2001; ICM, 2002). At present a midwife is a person who graduated from an approved program that meets the essential

competencies of International Confederation of Midwives (ICM, 2002). Midwives may practice in any setting that includes home, community, hospital, clinic or health unit (Royal College of Midwives, 2001; Barger, 2005).

Within the philosophy of midwifery, “care” has always been a woman-centered phenomenon. The modern model maintains the approaches of home birth, the social aspects of giving birth, and the concept of holistic care (RCM, 2001). It does so by providing preventative measures, promoting normal and safe birth, detecting maternal and child complications, and applying emergency measures (Lay, 2000; RCM, 2001). As such, it is a socially constructed practice that has gone through

many historical transitions. Many of these have involved social controversies in terms of the meaning of care, the scope of its practice, and its standardized skills (Lay, 2000; Marland and Rafferty, 1997).

The purpose of this paper is to explore and critically examine the major transitions on midwifery during history, looking in particular at the socio-cultural circumstances that are associated with these transitions through an historical analysis. Two objectives are intended to be explored; first, identify the major “macro” socio-cultural factors that shaped different meaning of “concept of care” in midwifery. Second, identify the major “micro” socio-cultural factors that changed the scope of practice in midwifery. In the current study four consecutive historical periods, beginning with the Stone Ages, when midwifery was an exclusive non-standardized female practice, to the Modern era when midwifery has become a regulated profession are going to be analyzed.

Midwifery during the Stone Ages

The Paleolithic, Middle Stone Age, & Neolithic Periods (40,000 BC - 2000 BC)

Pregnancy and childbirth during the Paleolithic era were processes that required women to survive labor in a hard environmental lifestyle (Towler and Bramall, 1986). Women supported themselves during birth based on knowledge and skills they gained from observing other mammals (Towler and Bramall, 1986; Englemann, 1882). They prepared for labor by getting into a squatting position, cutting the umbilical cord, initiating breastfeeding, and creating a warm and safe environment for newborns (Towler and Bramall, 1986). These basic techniques, which were based on observational knowledge (Towler and Bramall, 1986; Englemann, 1882), are compatible with the current core concept of midwifery, which involves supporting a natural and safe birth.

Both genders were involved in the tasks related to care of pregnancy and childbirth. Each gender specific role was based on the specific environmental circumstances. For instance, during the Paleolithic era, the male’s role focused on maintaining family security while females gave birth and managed their labor (Towler and Bramall, 1986; Graham, 1960). In contrast, during Middle Stone Ages era (40,000 BC), the male’s role became more inclusive because of the need to combine it with long journeys. Men remained and provided help for their partners particularly during labor (Towler and Bramall, 1986; Graham, 1960).

During the Neolithic period, the male’s role was totally excluded particularly during 10,000 – 8000 BC and it

continued to be the same thereafter for 10,000 years (Towler and Bramall, 1986). Men’s role and energy in this era mainly focused on the adjustment related to the evolution of agriculture and associated technology (Towler and Bramall, 1986). As a results related to this changes in the social organization, old women were the main attendant at birth and gradually started fulfilling the role of a midwife (Towler and Bramall, 1986). Their birth experiences contributed to their skill and mainly focused on maintaining a clean environment, providing oral support, observing the progress of labor, receiving the newborn, and cutting the umbilical cord (Englemann, 1882).

Evidence suggested that herbalism was fundamental in providing perinatal care during this era (Marland and Rafferty, 1997; Phillips, 2005). There was a limited amount of herbs and natural resources; the knowledge of how to choose, mix, prescribe and use these materials were some the basic practices of a skilled midwife (Ehrenreich and English, 2010). Adapting with and surviving the difficult environmental circumstances were a macro socio-cultural factor that shaped the primal knowledge of midwifery care. Gender identity can be described as the micro socio-cultural factor that shaped the development of midwifery care during the Stone Age era.

Midwifery in Ancient Times

Midwifery in the Biblical Eras (2200 BC – 1700 BC)

Midwifery during the biblical era was a respected social practice performed by women of childbearing years (Blickstein and Gurewitsch, 1998). Their role focused on managing normal pregnancies and deliveries; they were skilled in vaginal examination, and in defining the gender of a fetus during breech presentations (Towler and Bramall, 1986; Blickstein and Gurewitsch 1998; Liu, 1979). Midwives during the biblical era initiated the use of birthing stool during delivery, and this practice continued for 3300 years (Towler and Bramall, 1986; Loose, 2008). Magic and witchcraft were practiced widely; a religious man, the Rabbi usually attended birth only to manage difficult cases; difficult delivery was seen as caused by witchcraft or black magic and it was believed that only the Rabbi could break this spell (Towler and Bramall, 1986; Loose, 2008).

The biblical era was the golden period in the history of midwifery in which women empowerment had an active role in framing some concepts of professionalism in midwifery. The existence of social class inequalities was a major macro-social factor that empowered the role of midwives (Towler and Bramall, 1986; Blickstein and

Gurewitsch 1998; Liu, 1979). For example, midwives particularly supported women from the low class and poor families (Towler and Bramall, 1986; Loose, 2008). Further, they initiated the concept of family-centered care by enhancing the husband and family participation during birth (Towler and Bramall, 1986; Blickstein and Gurewitsch 1998; Liu, 1979). In our view family-centered care as a practice is one of the main approach of professionalism in midwifery.

In addition religion, as a micro-social factor, led midwives to advocate for social justice and protection of minority women and their children. Monotheistic religion, which was a belief of minority populations, led midwives to overcome and challenge the political circumstances that threatened them (Towler and Bramall, 1986; Blickstein and Gurewitsch 1998; Zodak, 2010). A classic example was when Shifra and Puah, the famous Hebrew midwives, stood against the king's declaration of killing the Hebrews newborns (Towler and Bramall, 1986; Zodak, 2010).

Midwifery during Egyptian Era (3500 BC – 100 BC)

Egyptian civilization and its social construction were the main macro-social factors that shaped midwifery as a unique, social and female vocation. It shaped midwifery as an artistic and autonomous profession supported by advanced and scientific knowledge (Towler and Bramall, 1986). Egyptian midwives were more clinically orientated compared to midwives in the earlier eras (Towler and Bramall, 1986). They were able to determine the expected date of delivery, describe different styles of delivery chairs, and accelerate the delivery progress (Towler and Bramall, 1986; Allen, 2005; Holmes and Kilterman 1914; Nunn, 2002). Further, Egyptian midwives were famous in prescribing herbs as drugs, and they were aware of its pharmaceutical actions, particularly during labor (Towler and Bramall, 1986; Allen, 2005; Nunn, 2002). Male physicians, however managed the complicated and high-risk deliveries (Towler and Bramall, 1986).

Religion and social class, which were constructed based on political ranks (Towler and Bramall, 1986), are the major micro-social factors that shaped Egyptian midwifery. For-instance, women from privileged classes such as royal families always gave birth in a royal birth-houses or centers that usually attached to temples (O'Dwod and Philipp, 1994). In contrast, less privileged women usually labored or birthed on cool house's roofs that were structured and decorated by papyrus-stalk columns (Towler and Bramall, 1986). There is no evidence addresses whether the women from poor families or low social class, such as slaves, had been labored or birthed in a specific religious places or even by

qualified midwives.

It is important to address that during Egyptian era and in contrast with the Biblical era, social class inequalities was a micro socio-cultural factor that promoted the social image of midwifery rather than empowered the role of women from macro-level perspective. Indeed, it enhanced the scientific knowledge development in the history of midwifery and it been recognized as a female profession mainly among the midwives who provided care for noble and upper classes women.

Gender is another micro socio-cultural factor that provided deeper insight about the concept of professionalism in the history of midwifery during ancient Egyptian era. Evidence approves that there was no gender inequalities or hierarchal authority had been appeared between male and female professionals during this era. This implies that midwives, herbalists, and physicians worked collaboratively based on their specialities (Towler and Bramall, 1986). It seems that the Egyptian social construction of gender identity introduced the notion of gender professionalism in the medical field in general, and on midwifery in specific. Further, it created different meanings of "care" during pregnancy and birth based on the abilities of each gender.

For-example, female midwives usually managed normal or low risk pregnancies, and minor gynecological problems cases (Towler and Bramall, 1986). Being a female and sharing the same gender identity led the midwives to provide care with empathy and more sensitive approaches that compatible for female's needs. Whereas, male physicians managed complex pregnancies that had pathological situations, or cases that required surgical operations (Towler and Bramall, 1986). Being a male allowed the physicians to provide care with less empathy and more invasive approach mainly to maintain the life surviving for both the mother and her fetus. While, the herbalists, mainly females, provided clinical support as needed for both midwives and physicians (Towler and Bramall, 1986). This implies that care in pregnancy and birth is a value that had different views during this era and it was based on the gender identity and their clinical backgrounds.

Midwifery during Greco-Roman Era (500 BC to 400 AD)

The Greek civilization, which we consider it as one of the major macro-social factor during that era, shaped midwifery as an art and a scientific profession (Towler and Bramall, 1986). It was functioned as respected, social, autonomous, and paid vocation for women (Leap and Hunter, 1993; Towler and Bramall, 1986; Arvanitidou, 2009; Grant and Carter, 2004). The traditional Greek ancient practices of midwifery were religiously beliefs and

socially ranked (Marland and Rafferty, 1997; Towler and Bramall, 1986). For instance, during 500 BC, midwives ranked into; firstly, consultant midwives who managed difficult and critical cases. They usually had a religious character and a strong faith, wide social contribution, and strong clinical background (Leap and Hunter, 1993; Marland and Rafferty, 1997; Towler and Bramall, 1986; Arvanitidou, 2009; Grant and Carter, 2004). Secondly, practiced or herbalist midwives who usually attended the normal births (Leap and Hunter, 1993; Marland and Rafferty, 1997; Towler and Bramall, 1986). They had to be a decent woman, born children herself with a positive outcome, and knowledgeable about the different types of herbs that may be used during birth (Leap and Hunter, 1993; Marland and Rafferty, 1997; Towler and Bramall, 1986).

This social classification highlights that the religion and social class were the major micro-social factors that shaped the role and the clinical knowledge of the midwives during this era. In addition, it seems that the "herbalist-midwives" was established during the Greek era as a sub-classification of the midwifery profession. Further, this classification raises an important question about the role of the male physicians during this era. Evidence suggested that they were just intervening in breech presentation pregnancies or cases that were required internal operations. (Towler and Bramall, 1986).

During the Roman era, herbalism developed considerably and became more scientifically oriented profession compared to midwifery, which had a very little scientific contribution (Lay, 2000; Louros and Kairis, 1951). The reason of this variation is unknown; however, evidence addressed that herbalism, became a male domain practice. (Lay, 2000). It is reasonable to assume that there is a strong connection between gender identity and increasing the scientific knowledge in general during this era. Conversely, the real socio-cultural circumstances that justify this assumption are unclear and not been discussed.

In contrast, the scientific knowledge of midwifery was retrieved from the Egyptian literature (Towler and Bramall, 1986; Arvanitidou, 2009; Grant and Carter, 2004). Inasmuch as, midwives built up their skills from midwifery's experts who were usually females (Towler and Bramall, 1986; Arvanitidou, 2009). The ruling class and gender inequalities (Towler and Bramall, 1986). were the major micro-social factors, diminished the development of the scientific contribution in midwifery and its practice. Evidence suggested that the formal education was available only for men and the noble class "mothers" (Lay, 2000; Towler and Bramall, 1986; Louros and Kairis, 1951). Therefore, lay female herbalists and midwives persecuted from accessing the formal educational system, and they were not socially accepted compared to the Greek era and sustained likewise for two centuries (Towler and Bramall, 1986; Arvanitidou, 2009;

Louros and Kairis, 1951).

In late 300 BC, the social attitudes about female midwives and herbalists changed radically (Marland and Rafferty, 1997; Towler and Bramall, 1986). Many feminism movements empowered the roles of female midwives and herbalists who fought against gender inequalities to promote their scientific knowledge (Marland and Rafferty, 1997; Towler and Bramall, 1986). For instance, Agnodike, who introduced "men-wives" and practiced as a male obstetrician (Towler and Bramall, 1986), was one of the pioneers that introduced science in midwifery (Towler and Bramall, 1986; Arvanitidou, 2009; Grant and Carter, 2004). Agnodike charged for illegal practice of midwifery as a female (Towler and Bramall, 1986). She allowed to practice midwifery as an obstetrician after won the appealing round that performed by a group of women. (Towler and Bramall, 1986).

Philista, known later on as a popular professor in medicine, was another example who promoted the scientific knowledge in herbalism as medicine (Grant and Carter, 2004). She provided lectures behind a curtain, to prevent her beauty from distracting her students (Grant and Carter, 2004). Regardless to the challenges that these women faced; midwifery became more scientifically approach. In contrast with the Egyptian era, midwifery became a scientific profession under the hierarchy of medicine that supervised by male physicians.

The Byzantine Era (400 AD – 600 AD)

Byzantium was a highly organized society and had advanced governmental and social services. (Towler and Bramall, 1986; Grant and Carter, 2004). Development of the formal social organizations and public healthcare services were influential macro-social factors that regulated midwifery as a formal profession. For instance, initiating the "hospital-hotels" notion as a public healthcare services shaped midwifery as a valued social profession for women. (Towler and Bramall, 1986; Arvanitidou, 2009; Parker, 1997). Further, evidence inferred that the first midwifery hospital developed during this era; they managed by and for women (Towler and Bramall, 1986; Parker, 1997). Islam, as a micro-social factor, empowered the women's role in midwifery and maintained the concept of women-centeredness (Towler and Bramall, 1986; Grant and Carter, 2004).

The advanced social organization during that era had a positive impact on shaping midwifery as a profession regulated within the health care system; though, the scientific knowledge and clinical standards of midwifery did not improve during this era. Evidence suggested that midwifery during this era retrieved from Roman's culture (Towler and Bramall, 1986; Arvanitidou, 2009). This indicates that midwifery practiced in unscientific

approached and had no further clinical contribution (Towler and Bramall, 1986).

There was gender inequality with respect to formal education programs and payment rewards, which privileged men but not women (Towler and Bramall, 1986; Arvanitidou, 2009; Grant and Carter, 2004; Parker, 1997). However, the existence of the healthcare system and organized social services led midwives to provide their services in a competent and standardized manner, but without any formal education or training program (Towler and Bramall, 1986; Parker, 1997).

Dark Ages & Middle Ages Era (5th Century to 15th Century)

Early Middle Ages (5th Century to 11th Century)

Religion, specifically Christianity, was the main social factor that constructed the social life during Dark Ages, and this included the healthcare services (Marland and Rafferty, 1997; Towler and Bramall, 1986). This indicates that midwifery was a valued and religiously respected profession. Evidence suggested that women can only practice midwifery when priests declared and acknowledged their religious and moral status (Marland and Rafferty, 1997; Towler and Bramall, 1986). In some cultures, nuns practiced midwifery as a religious obligation (Marland and Rafferty, 1997), and they known as "occupational female doctors"(p.12) (Towler and Bramall, 1986). Because of the existence of gender inequalities in terms of education and job opportunities (Towler and Bramall, 1986; Ehrenreich and English, 2010), midwives did not attain any formal educational or training program (Ehrenreich and English, 2010). Their roles focused on assessing and managing pain during labor, and on maintaining hygienic and comfort status for mothers and their newborns (Towler and Bramall, 1986; Hughes, 1952).

High Middle Ages (12th Century to 16th Century)

Throughout the UK, Europe, parts of North America, and Scotland, midwives were socially marginalized and totally excluded (Towler and Bramall, 1986; Forbes, 1966; Marland, 1993). Many female healers and midwives sanctioned and tortured by burning or hanging as heretics or witches (Towler and Bramall, (1986); Forbes, (1966); Evenden, 2000). These criminals carried out based on the authority of the king and medieval church to suppress the competition of the new male medical

profession of physicians (Towler and Bramall, 1986; Ehrenreich and English, 2010).

In addition, gender inequalities that prevented women from formal education and job opportunities played on marginalizing midwives. For-instance, Jacoba Felicie, who was a skilled French midwife and healer, in 1322 legally denounced for practicing medicine and midwifery without licensing (Ehrenreich and English, 2010). This indicates that the patriarchal authority and masculinity movements had a direct impact on shaping midwifery more as medicalized interventions during Dark Ages.

Modern Era

Midwifery and Men-Wifery (17th Century to 18th Century)

Throughout seventeenth and eighteenth centuries, the booming of surgical instruments and institutional medical training introduced males in midwifery (*Men-Wifery*). For-instance, in the seventeenth century, barber-surgeons also known as forceps-men, attended many births mainly to manage difficult and hopeless cases (Kontoyannis and Katesetos, 2011; Stern and Facog, 1972). Therefore, they were socially neglected and perceived as unfortunate attenders (Kontoyannis and Katesetos, 2011; Cassidy, 2006). In 1750s, male midwives involved in midwifery license system (Kontoyannis and Katesetos, 2011; Cassidy, 2006). Though, they were controversial and questionable at the onset, and they viewed as deviant, improper, and scandalous (Ehrenreich and English, 2010). This social perception changed radically because of the positive reputation that they made in managing normal deliveries with live and healthy newborns (Kontoyannis and Katesetos, 2011).

In early eighteenth century, the rate attendance of men-midwives increased; therefore a classification system designated women who attended the birth as midwives while men as obstetricians (Evenden, 2000; Stern and Facog, 1972). They were academically privileged compared to female midwives as they perceived formal education and training (Kontoyannis and Katesetos, 2011). Their advanced skills in utilizing the instruments during labor and their qualifications signified the scientific development in midwifery (Kontoyannis and Katesetos, 2011). There are clear accounts that male midwives went to great extremes to respect modesty and reduce embarrassment (ICM, 2002; Nicopoullus, 2003). When a male midwife called to a birth, he would often drape women, tying the long cloth around his own neck; so that his eyes could not see what

his hands were doing (Towler and Bramall, 1986; Stern and Facog, 1972; Pilkenton and Schom, 2008).

Midwifery and Nursing during the Modern Period: Regulatory Professions United Kingdom and Europe

It seems that nursing was a demanded profession in UK and European countries rather than midwifery because the absence of regulated health care system (Towler and Bramall, 1986). Many bills were introduced to regulate nursing as a regulated profession, and considering midwifery under its scope of nursing (Leap and Hunter, 1993). For-instance, in United Kingdom (1887), established British Nurses' Association [BNA] to regulate the scopes of nursing and midwifery based on medical systematic training programs (Leap and Hunter, 1993; Evenden, 2000). The focus was to maintain the public safety and protection (Leap and Hunter, 1993; Evenden, 2000). In 1902, Midwives Registration Act Bill was reintroduced to consider midwifery and nursing as separate professions, but was refused (Leap and Hunter, 1993). In 1903, the House of Commons Select Committee accepted nursing registration but not midwifery (Leap and Hunter, 1993; Marland and Rafferty, 1997).

The Midwifery Act accepted in 1952, and the Central Midwives Board (CMB) was established to regulate the midwives registrations (Marland and Rafferty, 1997; Towler and Bramall, 1986; CMB, 1953). In March 31st of 1952, CMB removed the Society of Apothecaries and Queen's Institute of District Nursing from their committee board (CMB, 1953). Though, the Royal College of Obstetricians and Gynecology became an appointing as a co-supervisory regulatory body in CMB (CMB, 1953). Regardless to the limited scope of practice of midwifery, there were 17,512 women attained to practice; 4531 regular students and 4253 registered nurses trained and graduated as pupil-midwives (CMB, 1953). Indeed, the act developed the midwifery teacher's skills by offering Midwifery Teacher Diploma Examination and Midwifery Teachers Training College (CMB, 1953).

USA and Canada

In 1915, traditional midwifery was disappeared in American society, and it usually was practiced by foreigners with different ethnic background and in few areas in USA (Cutter and Viets, 1965; Hiestand, 1977).b They were practicing based on their experiences and without formal education or training or qualifications (Cutter and Viets, 1965; Hiestand, 1977). However, Mary Breckinridge in 1920s introduced a British nurse-midwife

model in American society (MacDorman and Singh, 1998). In 1925, she upgraded the model to include the concept of Frontier Nursing Service (FNS) (Breckinridge, 1952). FNS focuses on creating Community Based Nurse-Midwifery Education Program (McDonald and Blogger, 2011).

This model, which still exists, maintains the role of midwifery in the community and supports the public health nursing (Parkland Memorial Hospital, 2000; Plummer, 2000). The main focus was promoting the public hygienic level, providing accessible prenatal care, and initiating home visits (Hiestand, 1977; National Aboriginal Health Organization, 2004). Nurses-midwives in this model were able to manage normal and low complicated pregnancies (MacDorman and Singh, 1998; McDonald and Blogger, 2011). Based on the evidences, this model had a positive impact on the American midwifery (MacDorman and Singh, 1998; McDonald and Blogger, 2011). For instance, the maternal mortality rate was decreased, and the medical outcomes were impressive in light of the socioeconomic status particularly in Appalachian (Breckinridge, 1952; Relyea, 1992).

In Canada, midwifery was reintroduced as a regulated, autonomous, publically funded profession in most provinces during the 1990s (Benoit and Carol, 2005; Plummer, 2000). The experiences of midwives are essential in the Canadian midwifery. Therefore, midwives who practiced prior the legislation were required to submit a portfolio that meets the regulatory requirements (Benoit and Carol, 2005). Midwifery education and training is a main concern in Canada; it has various types of education programs that meet the approaches of home birth and social aspects of giving birth. For-example, direct entry programs of baccalaureate degree in midwifery exist in six provinces (Benoit and Carol, 2005; Relyea, 1992). Furthermore, there are three aboriginal midwifery education programs, some based on apprenticeship models (National Aboriginal Health Organization, 2004; O'Brien, 2012). The main aim of midwifery in Canada, is maintaining globalization in midwifery and sustaining the traditional aspect of giving birth such Inuit midwifery (O'Brien, 2012). The current legislation of midwifery in most Canadian provinces brought midwives into the mainstream of healthcare with universal funding for services (Bourgeault et al., 2004; Fleming, 1994).

CONCLUSION

Midwifery is a woman-centered phenomenon that contextualizes the care as a holistic approach that maintains social and cultural aspects of giving birth. We critiqued five historical eras and articulated the major

social and cultural circumstances that are associated with midwifery transitions. We conclude that midwifery is a socially constructed practice where macro and micro socio-cultural factors played a key role in its transition. Power of social organizations, consistency of civilizations, and productivity of industrialization are the macro social factors changed the image of midwifery from a social practice to be more qualified and regulated profession. However, gender identity, social class and authority, knowledge awareness and accessibility of education are the significant micro socio-cultural factors that influence the concept of care in midwifery. These macro and micro social factors are correlated to each other, though it seems that each played a main role based on specific periodic time.

Midwifery in our view is an art and humanized practice that deals with pregnancy and childbirth as a social event. This requires midwives as well as a society to understand that midwifery considers the social and cultural aspects of perinatal care. This is the main difference between being a midwife or an obstetrician. We are acknowledging the role of obstetric on managing the complicated or high risky cases, but it contrast with the approaches of midwifery. Finally, we highly recommend re-introducing the historical, social, and cultural aspects of midwifery to maintain the views of globalization in midwifery.

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