Message from a Senior Midwife for International Day of the Midwife

Annie Clark [1]
Senior QI Advisor MNCH, USAID ASSIST Project/URC

This message from Annie Clark, Senior QI Advisor for MNCH, was originally posted [2] on URC's website to commemorate the International Day of the Midwife, which was celebrated on May 5.

To all my sister and brother midwives, I wish you a Happy International Day of the Midwife! My favorite term for midwife is the French phrase, “sage femme,” meaning “wise woman,” an apt description for the midwives I have worked with all over the world.

When I first began attending home births in California in 1976, the state had no midwifery education program. Its first nurse-midwifery education program began two years later at the University of California, San Francisco. I applied and was accepted in 1979. I had two options: a one-year program that led to a certificate in nurse-midwifery and a two-year program that led to a Master’s. Unable to afford the latter, I opted for the one-year program. Now, all US nurse-midwifery programs take at least two years and lead to a Master’s. Also, now nurse-midwives can be licensed in all 50 US states. And they are increasingly recognized as providing much-needed services.

According to the International Midwifery Award bestowed by the International Confederation of Midwives and Save the Children, “Midwives and others with midwifery skills are the single most important cadre for preventing maternal, neonatal deaths and stillbirths, but the number of midwives falls far short of the need.”

The value and versatility of midwives cannot be overstated. “Midwives deliver not only babies, but also provide comprehensive sexual reproductive health services, including family planning counseling and services, postabortion care, treatment of malaria in pregnancy and the prevention of mother-to-child transmission of HIV. Midwives can help prevent two-thirds of all maternal deaths and half of newborn deaths, provided they are well-educated, well-equipped, well-supported and authorized,” notes the midwifery award. Such prevention can be accomplished through:

- Quality pre-service education programs with opportunities for adequately supervised clinical practice by clinical preceptors;
- Supervision and mentorship on the job;
- Continuing education; and
- Retention, which is achieved by an adequate salary, safe and clean working conditions, reasonable work hours, professional and career advancement opportunities, recognition and other basic benefits (e.g., health insurance), and adequate equipment, supplies and medicines to perform required services.

Looking back on my 40-plus years in this field, I clearly see the positive impact of these enabling factors. I recall my first mentor, to whom I am forever indebted. She was a British-trained nurse-midwife attending home births in the US. I was a registered nurse with a baccalaureate...
degree, and through her mentoring I acquired my first, basic midwifery skills. I also was fortunate to attend a high-quality nurse-midwifery education program based at San Francisco General Hospital (SGF). As the county hospital for the city of San Francisco, SGF gave me opportunities to work with clients who were primarily poor and of diverse ethnic backgrounds. There, my midwifery tutors also served as mentors and supervisors, expanding my knowledge and skills. The Chief of Obstetrics, the late Jim Green, also a mentor for midwives, did not hesitate to provide training for midwives along with the medical students, interns and residents, even in areas of advanced practice, such as circumcision and the method for converting a breech to a vertex presentation.

Since nurse-midwifery was such a new profession in California, job opportunities were few. Again, I was blessed to be accepted for a two-month internship with a practice in northern California, where I became a staff nurse-midwife doing full-scope midwifery (prenatal, intrapartum, postpartum, family planning and gynecology) with the three obstetricians and another nurse-midwife. During my internship, I was further observed, supervised and mentored. I continued there for more than 11 years and delivered more than a thousand babies at the rural community hospital, plus a few at home. Mendocino Coast Hospital was clean, attractive and well equipped, with two large labor/delivery rooms where a client’s family members, including children, were welcome to provide support. The labor and delivery nurses who assisted the midwives in caring for laboring and postpartum women were exemplary. We functioned as a team and provided mutual support in our efforts to care for the women and families who came to us. However, to continue working I needed health insurance and an employer’s contribution to a retirement fund. The doctors who owned the practice were providing neither. Told that I could not continue to go without health insurance, they took no action.

I was blessed once again to find a position as a staff midwife in Hawaii, on the small rural island of Kauai. The salary was comparable, but also offered health insurance, a 401(k) plan and a continuing education allowance. The obstetric practice was part of a multi-specialty medical group located near a medium-sized hospital. It had three labor/delivery rooms, again welcoming family members to provide support.

In 1984, my best friend, another nurse-midwife, volunteered to work in a refugee camp of 26,000 people in Somalia. Her letters inspired me to pursue a career in international midwifery. During my time in Hawaii, I acquired a Master’s in Public Health, specializing in international health. My friend, by then working in Indonesia, gave me a field work opportunity and my first mentorship in international health and midwifery.

However, six years after moving to Kauai, my husband died unexpectedly; by then our children were grown. Several months after his death, I accepted a Senior Technical Advisor position with the American College of Nurse-Midwives (ACNM) in the Department of Global Outreach (DGO). This was the door that enabled me to pursue a career in international midwifery and public health. My friend, by then working in Indonesia, gave me a field work opportunity and my first mentorship in international health and midwifery.

My last work for ACNM was secondment to a 16-month position in Pakistan as the maternal-child health technical advisor for a primary health care project in earthquake-affected areas. All my previous international work had been short term: three to six weeks. The longer time in Pakistan enabled me to learn about the culture, the people and the country. It also led to the development of much stronger bonds with my co-workers, but that also made it harder to leave at the project’s end.

When I returned to the US in mid-2011, ACNM DGO was in financial straits; I accepted a position as Senior Quality Improvement Advisor for maternal-newborn-child health with University Research Co., LLC (URC). My work here has further expanded my knowledge and skills, focusing on quality improvement in health care. I now see the critical importance of a systems approach to improving health care and addressing a health system’s multiple levels, from community to national, to achieve effective and lasting changes.

In my work for the USAID Primary Health Care (HCI) Project in Iraq, managed by URC, I have trained doctors and midwives as trainers in both basic and emergency obstetric and newborn care. They, in turn, are training other providers, despite violence and unrest. My work in Afghanistan for HCI meant
I could help launch a program to improve essential newborn care, including newborn resuscitation integrated with active management of third stage of labor (AMTSL), and to provide technical assistance to the URC Afghanistan team to integrate family planning into postpartum care. We saw dramatic improvements despite the extremely difficult environment. Now providing technical assistance to ASSIST, I have again trained trainers in essential newborn care, newborn resuscitation and AMTSL in the Kayes region of Mali.

Amid international recognition that midwives are essential to achieving reductions in maternal and newborn deaths, I am heartened by the fact that after many years of too little progress in reducing global maternal mortality, the estimated number of maternal deaths has finally fallen from 500,000 annually to 290,000. I hope that, with renewed commitment and effort, the number will further be halved in the next 10 years. I am also hopeful that the focus on reducing newborn mortality, combined with the commitment of health ministries to programs like Helping Babies Breathe, will at least halve newborn mortality.

To those who are inspired to pursue midwifery, I encourage you. The world does indeed need midwives, now more than ever.

**Topic(s):** Maternal, Newborn, and Child Health [3]
**Related Countries:** Global [4]