"I AM PROUD TO BE A MIDWIFE BECAUSE I SAVE A LOT OF LIVES": International Medical Corps' Graduate Midwives

Findings from an Evaluation of International Medical Corps' Midwifery Education Program in South Sudan

1. Background

Midwives save millions of lives each year. Investing in midwifery could prevent two-thirds of maternal and newborn deaths globally, as midwives are trained to provide a range of sexual and reproductive health (SRH) services, including management of uncomplicated pregnancies and deliveries, antenatal and postnatal care, and contraceptive services.

As the world's newest country, South Sudan has one of the highest maternal mortality ratios in the world, with an estimated 789 maternal deaths per 100,000 live births. Childbirth and pregnancy are the leading causes of death among women and girls in South Sudan due to the limited availability of quality obstetric services and skilled birth attendants. Only an estimated 19% of births in the country are attended by trained health personnel. International Medical Corps has contributed to reductions in maternal, neonatal and child morbidity and mortality in South Sudan by increasing the number of trained midwives in the country. International Medical Corps was among the first organizations to support midwifery education in South Sudan, contributing to the exponential increase in the number of midwives over a short time period. UNFPA estimates the number of midwives grew from eight at the time of independence in 2011 to more than 800 midwives. To date, 472 midwives have graduated from International Medical Corps' midwifery schools.

Since 2008, International Medical Corps has co-managed and supported three midwifery schools in South Sudan: Juba College of Nursing and Midwifery (JCONAM), Kajo Keji Health Sciences Institute (KKHSI) and Wau Health Sciences Institute (WHSI). The schools offer a diploma and a certificate program. The **registered midwifery program** is a three-year midwifery diploma program, which includes research, management and leadership training. The **enrolled midwifery program** is a 2.5-year certificate program similar to the diploma program in clinical training but does not include research, management or leadership training. The programs meet internationally accepted International Confederation of Midwives standards on essential competencies. Students' learning in the classroom is supplemented with demonstrations and practice sessions in the skills laboratory before their clinical practicum. Clinical practice takes place at the Juba Teaching Hospital, Wau Teaching Hospital and Comboni Hospital where students gain exposure to medical, surgical, pediatric and obstetric/gynecology units. Students also engage in clinical practice at primary healthcare centers (PHCC) to gain experience in primary care and community-level health services.

2. Methodology

In 2022, International Medical Corps—in collaboration with the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative at Columbia University—conducted a cross-sectional mixed methods evaluation of the midwifery education program to determine its strengths and weaknesses. This technical brief outlines the quantitative and qualitative findings related to the graduates of the midwifery education program.

1. **Quantitative survey:** 314 midwifery graduates of the three midwifery schools were interviewed via telephone.
2. **In-depth interviews (IDI)** were conducted with 15 graduates of the three schools who were currently working as midwives in or near Juba, Wau or Malakal.
3. **Clinical practice assessment:** A select group of 22 midwives completed a daily task register during one week with the amount of time spent each day on various services and tasks.

The Institutional Review Board of Columbia University and the Ministry of Health for the Republic of South Sudan determined the study to be exempt.

3. Results

3.1. Socio-demographics of graduates

- Survey participants (n=314) had a mean age of 32 years, and 59.2% were female.
- Nearly half (46.2%) were graduates of KKHSI, followed by WHSI (30.9%) and JCONAM (22.9%).
- Most (68.2%) completed the registered midwife program, while 31.8% completed the enrolled (certified) midwife program.
- Additional socio-demographic data for participants in the survey (n=314) and in the in-depth interviews (n=15) are in Table 1. All IDI participants also completed the survey.

Table 1: Socio-demographic characteristics of Midwife graduates

		Survey participants (N=314) %(n)	IDI participants (n=15)
Gender	Female	59.2% (186)	6
	Male	40.8% (129)	9
Age	< 30 years	37.3% (117)	8
	30-39 years	55.4% (174)	7
	40 years or older	7.3% (23)	0
Midwifery program	Registered (diploma) midwife (3 years)	68.2% (214)	10
	Enrolled (certified) midwife (2.5 years)	31.8% (100)	5
Midwifery school	JCONAM	22.9% (72)	2
	KKHIS	46.2% (145)	8
	WHSI	30.9% (97)	5
Year of graduation	2013-2015	20.7% (65)	3
	2016-2018	40.4% (127)	8
	2019-2021	38.9% (122)	4
Received scholarship support from International Medical Corps		93.0% (292)	15
Registered with South Sudan Nurses and Midwives Association (SSNAMA)		55.4% (174)	10*
Registered with Nurses and Midwives Council		40.8% (128)	9**

**No data for 1 person; **No data for 2 people*

3.2. Employment post-graduation

- Most graduates found employment within one year of graduation (Table 2).
- Around three-quarters (76.4%) were currently working as midwives in a clinical capacity, with 60.8% in a primary care facility and 35.8% in a hospital.
  - Nearly half (47.5%) worked in rural areas and 39.2% in towns.
  - Two-thirds (66.3%) were employed by NGOs or religious institutions and 25.8% by the MOH.
- Around two-thirds (66.6%) had held 2-3 jobs since graduation. The primary reasons reported for leaving previous jobs were being let go due to project closure or loss of funding (29.3%), finding a better job (16.9%), low or irregular pay (14.1%) or difficult work environment (13.8%).
- Over half of those working a non-clinical job said their job was SRH-related (e.g., SRH program manager, etc.).
- When it came to training, 40-49% reported receiving in-service formal refresher training on specific topics, and 28-48% reported receiving on-the-job informal training for individual services.

Table 2: Current employment of Midwife graduates

		Total (N=314) %(n)
Length of time after graduation before starting first job	Immediately or < 1 month	31.9% (100)
	< 1 year (more than 1 month)	57.5% (180)
	1 year or longer	10.5% (33)
Working currently as clinical midwife		76.4% (240)
Type of health facility working in	Primary care facility	60.8% (146)
	Hospital	35.8% (86)
	Other	3.3% (8)
Working in NGO-supported facility		88.7% (212)
Employer	Ministry of Health	25.8% (62)
	NGO/religious institution	66.3% (159)
	Private/self-employed	5.8% (14)
	Other	2.1% (5)
Location of work	Rural	47.5% (114)
	Town	39.2% (94)
	Juba	13.3% (32)
Reasons for leaving previous jobs*	Let go due to project closure or employer loss of funding	29.3% (172)
	Found a better job	16.9% (99)
	Low pay/not paid regularly	14.1% (83)
	Difficult work (e.g., colleagues, lack motivation, lack supplies, too busy)	13.8% (81)
	Insecurity/felt unsafe	8.0% (47)
	Wanted to continue my education	3.7% (22)
	Other	14.1% (83)

**Participants could give multiple reasons and may have left multiple jobs; therefore n>314.*

3.3 Quality of education and preparedness

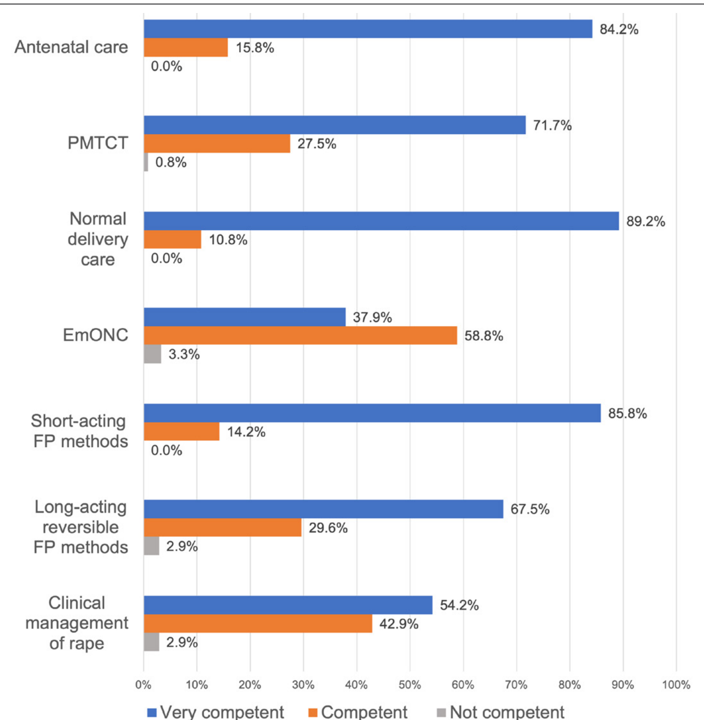
Overall, 100% of the surveyed graduates reported that the quality of education received was good or very good, and 99.4% said they felt well prepared to begin work as a midwife. More than 80% of currently practicing midwives reported feeling very competent to provide some services such as antenatal care, normal delivery and short-acting family planning (FP) methods (Figure 1, see right).

In the in-depth interviews, graduates attributed their competence to their training.

> "[The quality] was very good. ... First and foremost, the training was able to equip me with the skills, and those skills enable me actually to perform the midwifery work to the expectation. So, I can rate as very good because it has given me all the necessary skills that are needed to perform the duty of a midwife." *(Male midwife)*

Graduates described feeling underprepared and needing additional training to manage complicated deliveries, newborn care, care for survivors of gender-based violence, long-acting FP methods and post-abortion care.

Figure 1: Perceived competency to provide SRH services (n=240)



Note: PMTCT: prevention of mother-to-child transmission; EmONC: Emergency obstetric and newborn care; LARC: long-acting reversible contraceptives.

> "Let me say, when it comes to abnormal obstetrics, you know sometimes mothers will present with some complications... like abortions, obstructed labor, maybe premature fracture of membranes. Those are some of the complications [that] when a mother is presented with it... you feel like you are not comfortable. You feel less comfortable." *(Male midwife)*

> "In family planning, like this IUD, unless supported by another [on] how to insert, I cannot manage alone." *(Female midwife)*

The program's practical component was identified as a vital part of the education because of the skills learned in this setting. The majority of graduates agreed or strongly agreed that they had sufficient opportunity to practice with anatomic models (80.5%), and that they had adequate supervision from tutors when performing on real patients (85.0%). Clinical placements (60.1%) were most often reported as the element that best prepared graduates for work. They explained that their ability to apply their skills in practice demonstrated the strength of the education program(s).

> "What made me a successful midwife was the practical clinical attachment that I had. They gave me exposure and much experience, even when I was still a student, plus the tutorship that I had. So, the combination of the two made me the midwife I am today." *(Male midwife)*

3.4 Areas identified for strengthening

Graduates identified several challenges they faced during their training program and after graduation.

- **Inadequate mentorship and number of tutors**
  Although overall satisfaction with the faculty was high, some graduates identified the need for additional and better-trained clinical preceptors and tutors. Several graduates discussed weaknesses with some preceptors and tutors who supported their studies, primarily when they were too few, there was high turnover or the tutors and preceptors had limited skills.

- **Insufficient practice in some services**
  While the practical component of their training was consistently identified as a critical strength, graduates reported some gaps, including insufficient time and too few clients to practice on. Graduates recommended that there be more opportunities to see a variety of complications.

> "We came and realized that sometimes the number of students was more than the patients. So, any client that comes to the facility, if somebody grabs them already, then other students will not get. ... There is lack of patients." *(Female midwife)*

- **Conflict-related challenges**
  During periods of political unrest and insecurity, students and staff were unable to come to school and the schools often cannot operate. Class size was mentioned as a challenge, particularly after KKHSI moved to Juba to share space with JCONAM from 2016 to mid-2022, due to insecurity in Kajo Keji.

> "One of the other weaknesses of education here in South Sudan is also the insecurity issues. It is making the education very difficult because things may not go the way it has been planned. Sometimes your mind is here for studies; sometimes, also, some other problems arise due to insecurity, and it becomes very hard for the students really to put their mind and focus on what they are supposed to learn." *(Male midwife)*

- **Limited access to continued learning opportunities**
  One-quarter of surveyed graduates reported a lack of access to refresher training and limited access to guidelines or job aids. Graduates recommended continued learning, both through mentor or tutor follow-up after graduation and the ability to return to a training program for credential "upgrading."

- **Program funding and employment challenges**
  Graduates also called on the government of South Sudan for more sustained funding for the education program and job creation.

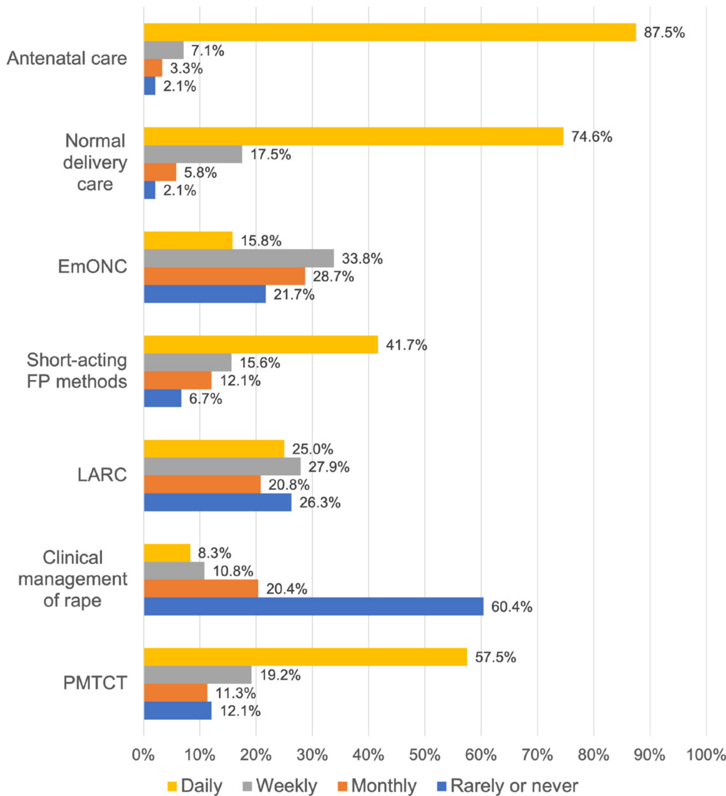
> "Then the other thing, also: to motivate the students who are studying, we also need enough jobs created. ... Even if the training may be okay, even if people are given the skills, but if there is no job, then it is useless." *(Male midwife)*

3.5 Frequency of providing SRH service in current practice (Figure 2)

- Most graduates reported providing antenatal care (87.5%), safe delivery care (74.6%), and prevention of mother-to-child transmission (PMTCT) of HIV (57.5%) daily in their current practices. They reported providing EmONC less frequently, with 15.8% providing this daily, and a third (33.8%) providing it weekly.

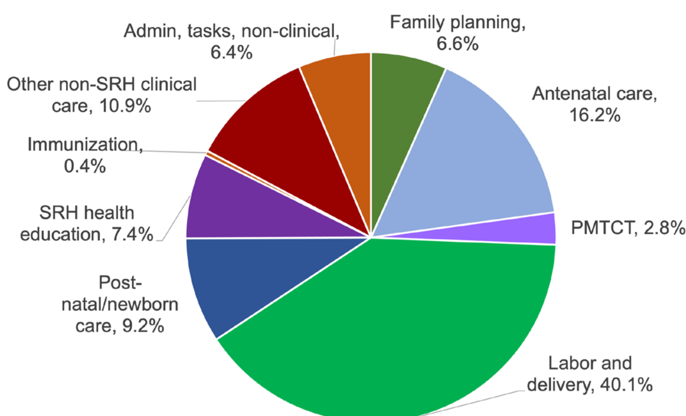
- While 41.7% reported providing short-acting FP methods daily, about a quarter reported providing long-acting reversible contraceptives (LARC) daily (25.0%) or weekly (27.9%).
- Clinical management of rape was the service provided the least often, with 60.4% providing this rarely or never.

Figure 2: Frequency of providing SRH services in current practice (n=240)



Data for 274 work days were recorded in the clinical practice assessment. Overall, midwives reported spending 82.3% of their time on SRH-specific tasks (Figure 3), with the most time spent on labor and delivery (40.1%) followed by antenatal care (16.2%). Just over 10% of their time was spent on other non-SRH services, like immunization or outpatient care.

Figure 3: Percentage of midwife time spent on services/tasks



3.6 Positive work environments

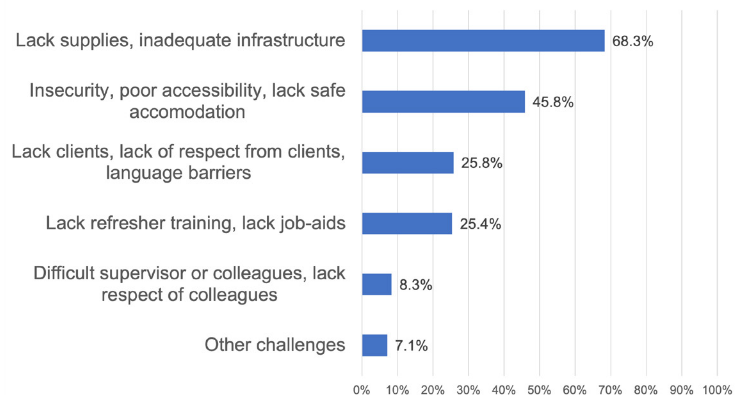
Graduates reported mostly positive work environments where their supervisors and colleagues were supportive and collaborative, and provided recognition for their work.

> "My superior has been so collaborative with me, and I can say this is the environment I enjoy working in most of the time because the supervisor is very cooperative. And then we always have case-sharing experience and knowledge sharing. My colleague also, we have enjoyed a very good partnership and we have been of help to each other, and whenever I need help, she always comes in, and whenever she needs [something], the reverse is always true." *(Male midwife)*

3.7 Service delivery challenges

Midwives described barriers they faced in providing good quality care (Figure 4). Common themes included **health system issues** (e.g., stockouts of medication, lack of basic equipment or insufficient staff to handle the case load); **access barriers**, namely transportation and communication (e.g., mobile phone credit); and **insecurity** due to the conflict, affecting both the midwife's and clients' ability to access the health facility.

Figure 4: Main challenges at work (n=240)



> "Some of the challenges or barriers could be sometimes we do not have the service that we needed to deliver, like for example, I'm supposed to be doing the BEmONC [basic emergency obstetric and newborn care] services, but when I came in, we did not have the MVA [manual vacuum aspiration] machine. Sometimes we have post-abortion cases to manage, so I feel like this is a gap, this is a barrier. I could not do my best. I have the skills and knowledge, but the device to perform is not there. That is one. Another is off and on supply of the commodities—family planning can sometimes be out of stock, and to be stocked will always takes some time." *(Male midwife)*

> “Another thing is the number of staff, especially where I am working; it is only me alone who is working here. So, when I am not there, then things will stop—there is nothing that will work because there is nobody who can make the record.” *(Male midwife)*

- **Low salaries and insufficient compensation** were frequently mentioned challenges. For some, the impact of their work outweighs the low salary, while others reported this as being a significant concern, even leading to the possibility of leaving the profession. Several midwives also mentioned working as volunteers in a health facility after graduation before being hired.

> “The salary I’m getting, the incentive is very little. But the service that I deliver to the community is more than what I am receiving, so I am very proud.” *(Female midwife)*
>
> “Salary is the problem also because the work we are doing, of course, is not for salary. If we were to say that this salary is not enough, then I would have to leave this job. But it’s because I am caring for the community and above all, I was trained to do it. So, I will continue to do it, but the salary actually does not match with the [work] we are doing. The work is too much. But it is not because of salary. If it is because of salary, I can go to do my private business.” *(Male midwife)*

- **Challenges with clients** were reported by 25.8% of surveyed graduates, including low client numbers, language barriers and lack of respect from clients. For example, they experienced reduced competency in some skills due to a lack of practice and negative community attitudes towards some services, in particular family planning.

> “I remember when I was working outside of the town, I could not travel due to insecurity issues. So, during such days I would always feel like, now I can’t make it to the field, but my clients and patients need me more than I could stay here. That created instability within myself whenever I’m blocked from access to my facility where I could be able to interact with my clients and patients. It always created a sense of insecurity and instability within me.” *(Male midwife)*

3.8 Advice for future students

Graduates called on current or future midwifery students to be dedicated to the profession and to pay attention during coursework and training, especially the clinical practice. Teamwork, humility, communication and flexibility were traits midwives identified as important for future colleagues.

> “As an upcoming midwife or as somebody who is interested to become a midwife, the person should also be somebody who is capable of working with any other person. Because sometimes people are different, people’s attitude are different, people’s characters are different to work with. So, you must be able to adapt to any situation—that’s when you will be successful in the work as a midwife. Both how to deal with the mother and even how to be with your team. You must be able to be flexible, actually.” *(Male midwife)*
>
> “If they are still in their school, they should cooperate with their teachers, when they were told to do something, they have to understand because the same thing we are learning here is the same thing you will transfer to the facility, to the hospital and you will be able to help the community.” *(Female midwife)*

3.9 Relevance and impact of education program

Graduates described how their training was relevant to the communities they served given that it filled a gap in health services in these communities. The midwives reported increases in service provision and uptake, including in health facility deliveries and use of family planning. The impacts identified by the graduates were attributed to their education/training and ability to provide important health services to the communities they are working in.

> “Yes, [the services I was trained in are] relevant because it’s helping people, like I said. For family planning, it’s helping mothers now to delay instead of just rapidly deliver [again]. Also, for mothers who are pregnant, they go for ANC, for focused antenatal care instead of staying at home and delivering from home, and also the importance of delivering in the hospital. It’s very relevant.” *(Female midwife)*
>
> “Throughout my service, I am able to manage them [complications], and I am able to contribute to the progress of the health facility in meeting the objective of reducing maternal and infant mortality…” *(Male midwife)*

Graduates reported that the communities were largely receptive and appreciative of their work. Although some male midwives reported facing initial reticence or feeling that they were not immediately welcomed in the community, most reported that eventually the community came to accept and even appreciate them.

> "They were happy about my services, and they used to encourage me, thanking me, even if not in the facility. Whenever I move around the community, I noticed that they are coming to me. They talk to me even if I don't identify them. Because when you are dealing with patients, it is them who know you. So, when I passed around, then they call me. They even, some of them went further, giving my own name to their kids." (Female midwife)

> "Yeah, you know the community was not having a midwife there… so the maternity was closed. So, once they take us there, the community were aware of it; they introduced us to the commissioner. They will start giving their services; people should not worry now. So, they were very happy seeing us [midwives] there. We are warmly welcomed by the community, including the local government." *(Male midwife)*

3.10 Pride and satisfaction in being a midwife

Graduates largely reported pride and satisfaction in their job and role as a midwife. A source of their ride came from the services they are providing to communities and the positive impact these services have on communities.

> "I am proud to be a midwife because I save a lot of lives." *(Female midwife)*

> "You know, working as a midwife, actually in my experience is a great joy, because you are saving lives and at the end of any successful work, you find that you are putting a smile onto the faces of these women who have delivered and to the family. So that joy gives me happiness and it actually motivates me in the work I am doing as a midwife." *(Male midwife)*

4. Conclusion

Midwives are critical in the fight against preventable maternal deaths and disability worldwide, especially in lower- and middle- income countries where healthcare facilities are few and far between. International Medical Corps' investment in midwifery education in South Sudan has proven to be very successful, having graduated nearly 500 midwives since 2008. Our graduates are satisfied with the education they have received, reporting it was of high quality and prepared them well to begin work as a midwife. They recognize the immeasurable benefit of International Medical Corps' midwifery education program and feel pride in the vital role they play in providing universal and equitable health coverage in South Sudan. They see the positive impact their services have on communities, demonstrated by the increase in service utilization and facility-based deliveries. Likewise, there is high acceptability and appreciation of the graduate midwives from the communities they serve.

The findings from this study indicate that graduate midwives are spending most of their time practicing the SRH-related skills they learned, suggesting they are performing their roles and responsibilities as expected through: 1) helping mothers to have a safe and healthy pregnancy, 2) helping mothers, who may have otherwise died had they experienced a complication while delivering at home, to have a safe childbirth, 3) helping mothers with postpartum and newborn care, and 4) helping women (and couples) exercise their right to decide when and how often to have children.

Moreover, International Medical Corps' midwifery education program has helped increase the reach of healthcare in South Sudan. Graduates are working throughout the country, with nearly half working in rural areas where there is a high need for skilled health workers. Midwives are filling a critical gap in health services in these communities and are ensuring midwifery care is accessible to even the most remote and vulnerable communities.

The impacts of International Medical Corps' midwifery education program are clear and extend beyond what can be measured. Continued investment is critical for International Medical Corps to sustain support for midwifery education and achieve its ultimate objective of reducing maternal, neonatal and child morbidity and mortality in South Sudan.

A pre-eminent first responder since 1984, International Medical Corps delivers emergency medical and related services to those affected by conflict, disaster, and disease, no matter where they are, no matter what the conditions. We also train people in their communities, providing them with the skills they need to recover, chart their own path to self-reliance, and become effective first responders themselves.

International Medical Corps is headquartered in Los Angeles, CA, and has offices in Washington, DC; London, UK; and Split, Croatia. For contact information, visit InternationalMedicalCorps.org/contact.

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