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SYSTEMATIC REVIEW

What is known about midwives' well-being and resilience? An integrative review of the international literature

Lynnelle Moran RM[1] | **Kim Foster RN, PhD**[1] | **Sara Bayes PhD, RN, RM**[1,2]

[1]Australian Catholic University, Fitzroy, Victoria, Australia
[2]Edith Cowan University, Joondalup, Western Australia, Australia

Correspondence
Lynnelle Moran, Australian Catholic University, Building 403, 8 – 14 Brunswick St, Fitzroy, VIC 3065, Australia.
Email: lynnelle.moran@acu.edu.au

Abstract

Background: Internationally, the midwifery workforce is facing a professional crisis due to numerous organizational and individual factors that have led to midwives leaving the profession. These factors include high levels of workplace stress, systemic barriers to providing woman and person-centered care, trauma, and burnout. The COVID-19 pandemic magnified these pre-existing stressors and adversities and has further disrupted midwives' ability to practice within their professional norms. In order to understand how midwives can be better supported, there is a need to understand what contributes to and detracts from their well-being and resilience.
Aim: To investigate and synthesize the extant international knowledge on midwives' well-being and resilience in the context of workplace stress and adversity.
Method: Integrative review of the literature published in peer-reviewed journals.
Results: Thematic analysis of the literature resulted in three core themes: (1) risk factors and adversity; (2) protective factors and resilience; and (3) sustaining factors and well-being in midwifery. Findings from this integrated review highlight that several factors associated with workplace adversity can also be sources of protection depending on their presence or absence. Within the included studies, there exists a broad use of concepts and definitions that are applied to well-being and resilience, resulting in a lack of uniformity and cohesion.
Conclusions: In this review, we identified a high level of workplace adversity and the subsequent impacts on midwives' well-being and resilience. A series of protective factors and strategies that can be used to improve the well-being of midwives and support resilience within the profession were also identified; however, further research of the population is required. In addition, the development of cohesive well-being and resilience concepts specific to midwifery is recommended, as is the development and application of uniform terminologies and definitions.

KEYWORDS
midwifery, psychological well-being, resilience, stressors, well-being

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1 | BACKGROUND

Internationally, the midwifery workforce is in crisis and under significant strain due to high rates of burnout, with 20% of midwives suffering severe symptoms of depression, anxiety, and stress.[1,2] Extensive research has illuminated numerous organizational and individual factors that lead to midwives leaving the profession; these include high levels of workplace stress, bullying, systemic barriers to providing woman and person-centered care, feelings of complicity, post-traumatic stress, isolation, and burnout.[3–10] Traynor[11] contends that adversity in healthcare comes from two different sources. The first is the stressful nature of the work itself, where clinicians deal daily with the gravity of responsibility inherent in their role and potential exposure to trauma and suffering. The second comes from systemic and organizational factors such as a lack of resources, low staffing, and high workloads. These sources of adversity interact with each other, and the COVID-19 pandemic has further magnified these pre-existing stressors and disrupted midwives' ability to practice within their professional norms. The challenges posed by COVID for managing care provision have also heightened the prevalence of moral distress, trauma, and professional uncertainty for midwives.[12] Yet, an expectation exists for midwives to adapt positively to the psychological, emotional, and physical demands of the profession.[3,13,14]

Historically, resilience has been emphasized as an individual characteristic; however, a more contemporary understanding from a social ecological perspective considers resilience a process of positive adaptation to stress and adversity that involves interaction between environmental and community resources and the person's own resources and capacities.[15,16] The process of positive adaptation can lead to individuals' positive well-being following adversity.[17] This concept of resilience provides a more sustainable approach to understanding and intervening in the well-being of midwives. Given the sustained and growing workplace stressors on the midwifery workforce, preventative and responsive healthcare systems are required to support them.[18] In order to understand how midwives' well-being can be better supported, there is a need to investigate and synthesize existing knowledge relating to their well-being and resilience.

A preliminary cursory search was performed using Google Scholar, Cochrane, Joanna Briggs Institute (JBI), and Prospero databases to identify any existing literature reviews on this topic. Four prior relevant reviews were identified. Wright et al.[19] used a scoping review to explore the literature on methods for reducing stress and increasing resilience in the midwifery community. The authors noted a deficit of research on this issue and noted that each included study recommended the implementation of workplace programs to reduce stress and build coping skills for midwives.[19] Pezaro et al.,[9] in their systematic mixed methods review, directly connected the well-being of midwives to the quality of maternity care provided and recommended the urgent development and implementation of effective and meaningful interventions to respond to the prevalence of psychological distress experienced by midwives. The authors noted that there was a shortage of eligible and robust studies for inclusion. A literature review by Cramer and Hunter[20] explored the significance of midwives' well-being in relation to their working conditions. They concluded that a strong correlation existed between poor emotional well-being among midwives and various modifiable working conditions, such as staffing levels, workload demands, and midwifery access to continuity of care models. They suggested that with proactive organizational leadership, several risks to midwifery well-being could be modified, controlled, and improved.[20] Finally, Clohessy et al.[5] conducted a concept analysis to define the concept of resilience in the context of midwifery. The reviewed literature included nursing and a focus group of midwifery students to explore the emerging concept.[5] The resulting defining attributes of resilience in midwifery included social support, self-efficacy, and optimism. Consequences of being resilient were coping or adaptive capacity and positive mental health, which are consistent with contemporary understandings of resilience as noted above. While these findings help to develop understandings of resilience in the field, they are limited by the inclusion of nursing literature and of students who are not yet registered practitioners and may lack practice experience and contextual understanding of the workplace. All four reviews acknowledged that it was problematic that included evidence was not limited to a midwifery population. Subsequently, we intentionally sought to focus only on midwifery evidence and excluded research involving students and nursing populations. Thus, the aim of this review is to investigate and synthesize international knowledge on midwives' well-being and resilience in the context of workplace stress and adversity.

2 | METHODS

2.1 | Design

An integrative review method was used, as this approach allows for the inclusion of a range of types of empirical studies which can help build a comprehensive understanding of the topic. This type of review is conducted using systematic processes.[21]

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2.2 | Search strategy

Following the preliminary search and informed by a detailed search strategy designed to assess what was known about midwives' resilience and well-being, a systematic search was performed using the following databases: CINAHL, Medline, PsycINFO, MIDIRS, and PubMed with a final search also performed using Google Scholar. Search terms were derived from the review question: "What is known about midwives' well-being and resilience?", as well as existing literature on the participant, and in consultation with an experienced librarian. Key search words using Boolean operators included midwi* (midwife, midwifery, midwives) AND Resilien* (resilience, resilient, resiliency) AND Well* (wellbeing, well-being, wellness) OR Psychological well*.

Full-text articles were screened and assessed with hand searches of the reference lists performed. Peer-reviewed, empirical papers published in English between January 2011 and September 2021 were included to provide a comprehensive review of existing evidence. Editorials, theoretical discussion papers, reviews (narrative, systematic, and integrative), dissertations, and book chapters were not included. As registered and practicing midwives were the focus population, papers that included student midwives were excluded. In addition, studies that included nursing where the midwifery data were unable to be isolated were also excluded.

2.3 | Search outcome and quality appraisal

The search yielded 509 results, of which 48 were reviewed in full text and assessed for eligibility. Twelve studies met the criteria for inclusion (see Figure 1). Included studies were critically appraised for relevance and quality using standardized JBI, CASP, CEBM, and MMAT quality appraisal tools (see Table 1). Papers were reviewed independently by two reviewers and any anomalies discussed until consensus was reached. There was a range of quality across studies; however, none of the 12 studies were excluded as all studies offered valuable knowledge to the line of investigation and included under-represented populations.

2.4 | Data synthesis and analysis

Data from each study were considered in accordance with the review aim by the first author. Relevant data were extracted and grouped using constant comparison method.[21] These groupings were reviewed by all authors and then synthesized into a final "story" that answers the review aim. As a result, the following three themes were identified: (1) risk factors and adversity; (2) protective factors and resilience; and (3) sustaining factors and well-being in midwifery.

3 | RESULTS

3.1 | Description of studies

Twelve studies were included. They were from Australia ($n=3$), New Zealand ($n=2$), the UK ($n=2$), Iran ($n=2$), Hungary ($n=1$), and the USA ($n=1$), and one was conducted across multiple countries. There were five qualitative studies: four used a qualitative descriptive design,[22–25] and one used a qualitative survey approach.[26] Of the six quantitative studies, four were cross-sectional,[27–30] one was a randomized control trial,[31] one a cohort study,[32] and one a mixed method study.[33] Cull et al.,[26] Dixon et al.,[27] and Fenwick et al.[28] all drew upon the results and findings of the WHELM study—an international study that investigated the emotional health and well-being of midwives. Cull et al.[26] used the UK data, Dixon et al.[27] used the New Zealand data, and Fenwick et al.[28] used the Australian data to report on local contexts. Study characteristics are summarized in Table 1.

3.2 | Risk factors and adversity in midwifery

While all studies included in this review mentioned the stressors experienced by midwives, six provided findings on stress risk factors and adversities associated with the midwifery profession. Findings across studies were grouped into two domains: the nature of adversity, and the impacts of adversity, and their associated subthemes.

3.2.1 | The nature of workplace adversities for midwives

Two subthemes relevant to the nature of adversities experienced by midwives were developed: organizational and systemic factors, and the inherent nature of midwifery work.

Organizational and systemic factors involved extensive systemic factors within the workplace that were often chronic in nature. These included staff shortages, poor skill mix, excessive workloads, abandonment of agreed upon staff to patient ratios, time constraints, lack of uncertainty around roster or area of work, lack of flexible

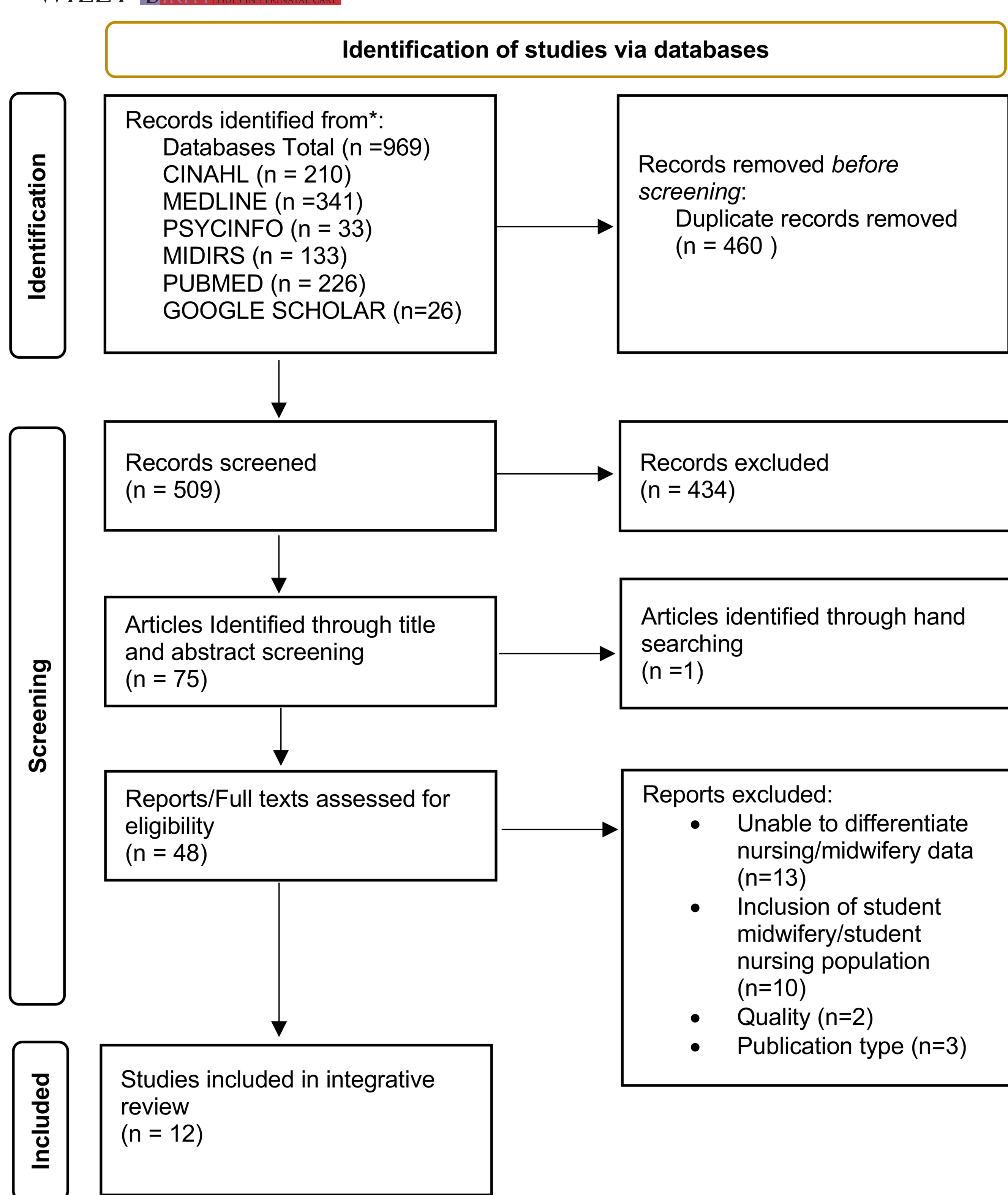

FIGURE 1 Prisma flow diagram of included studies.

work options, increasing medicalization and clinical complexity, and risk-averse hospital policies and protocols that inhibited midwifery autonomy and clinical decision-making.[22,24,26] One UK study interviewed 620 early career midwives and found that the strongest theme was the immense personal pressure felt by midwives as a result of workplace stressors.[26] The authors found that staff shortages and unmanageable workloads were the main cause of employee dissatisfaction and that these affected mental health and compromised patient safety. For example,

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TABLE 1 Midwives' well-being and resilience: Summary characteristics of included studies.

Author/s (year) Country	Study aims	Design & methods	Setting & participants	Key findings	Limitations	JBI quality score
Catling et al. (2017) Australia	To explore the midwifery workforce culture from the perspective of midwives.	Design: Qualitative description Data collection: Group and individual semi structured interviews	Setting: Urban, regional, and rural based midwives in Australia. Participants: ($n=23$) participants. 19 midwives in hospital maternity units (public and private settings), 11 worked in a CoC model (MGP or PPM) and three in rural/regional settings.	Dominant themes: *Bullying and resilience* • Hierarchical structures • Horizontal violence • Elements of resilience *Fatigued and powerless midwives* • Feeling powerless to effect change • Compassion and empathy fatigue *Being "hampered by the environment"* • Systemic factors inhibit provision of woman-centered care • Time constraints and workload pressures impacting on quality of care • Dissonance between "real midwifery" and "obstetric nursing" *Importance of support for midwifery* • Mentorship, strong midwifery leadership, teamwork, and acknowledgment are seen as central to creating a positive workplace culture. • Improved staff well-being and morale	Small sample size Homogenous sample (All female, predominantly urban settings) Participants recruited through online midwifery social networks therefore may not be representative of wider midwifery population.	89%[a]
Cull et al. (2020) UK	To establish the key, self-described factors of satisfaction and dissatisfaction at work for early career midwives in the UK and to suggested appropriate and effective retention strategies.	Design: Qualitative cross-sectional Data collection: Qualitative data analysis of free text responses to two primary questions	Setting: UK (Included subset of UK WHELM study respondents) Participants: ($n=520$) Early career midwives = <5 years. Registered Midwives who were RCM members. 520 free text responses about satisfaction and 512 free text responses about dissatisfaction at work.	Four themes: *Work stress* • Immense pressures felt by midwives • High levels of anxiety, depression and burnout *Role satisfaction* • Inherent pleasure of midwifery, a source of pride and self-esteem • Sense of fulfillment *Interpersonal factors* • Strong team works as a protective factor against stress of the workload, adversely, bullying was widely reported. • Negative and positive r'ships with colleagues *Role support* • Need for personalized, compassionate care for midwives and timely communication around rostering, • Widespread dissatisfaction from pressure to do double shifts, no breaks and remuneration that failed to align with responsibilities. ○ Improving the well-being of midwives is crucial to support ongoing recruitment, aid retention efforts and provide a safe maternity service.	Cull (Author) is an early career midwife and was mindful to not allow her own personal exp/beliefs and views to influence interpretation of results.	100%[a]

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TABLE 1 (Continued)

Author/s (year) Country	Study aims	Design & methods	Setting & participants	Key findings	Limitations	JBI quality score
Dixon et al. (2017) New Zealand	To explore the emotional well-being of midwives in NZ. To describe and compare demographic and work-related factors of (a) self-employed (b) employed by an organization or (c) both self-employed and employed. To also explore factors associated with burnout within each of these 3 groups.	Design: Survey Data collection: Online survey using Depression, Anxiety and Stress Scale (DASS-21), Copenhagen Burnout Inventory (CBI), Perceptions of Empowerment in Midwifery Scale (PEMS) & Practice Environment Scale (PES).	Setting: Various models of care/practice settings all based in New Zealand. Participants: ($n=1073$) participants ($n=473$) self-employed, ($n=452$) employed and ($n=148$) both employed and self-employed. Recruitment via New Zealand College of Midwives.	○ Self-employed midwives reported higher levels of empowerment and better emotional health. ○ Midwives working in an exclusively employed capacity were significantly worse off with higher levels of personal and work-related burnout, and considered themselves to be less skilled, less autonomous and having less professional standing when compared with self-employed/CL colleagues. ○ Despite working more hours, self-employed/CoC midwives were emotionally better off. ○ Lack of support from midwifery management contributed to attrition and burnout.	MW were recruited using convenience sampling and questionnaire was self-administered. May result in possible response bias due to those with strong opinions motivated to respond.	83%[b]
Fenwick et al. (2018) Australia	To compare the emotional and professional well-being as well as satisfaction with time off and work–life balance of midwives providing continuity of care and midwives not providing continuity of care.	Design: Survey Data collection: Data extracted from the larger WHELM Australian study data. Online survey distributed by ACM to members. Copenhagen Burnout Index (CBI), Depression, Anxiety and Stress Scale (DASS-21) & Perceptions of Empowerment in Midwifery Scale (PEMS—Revised)	Setting: Australia Participants: 1037 survey respondents. Midwives in research admin or management roles were excluded. ($n=862$) participants ($n=214$) working in CoC and ($n=648$) working in non COC model.	○ CoC models contribute to lower levels of burnout, depression and anxiety and reported higher levels of midwifery empowerment compared with non-CoC models. ○ CoC cohort had statistically significant lower rates on the DASS 21 and CBI scales and significantly higher ratings on PEMS. ○ Ratings among groups were similar in relation to moderate–high satisfaction with time off and work–life balance.	ACM members only and midwives self-selected to participate. Professional body (lower lvl of National professional engagement compared with NZ therefore possible response bias). Disproportionate sample sizes. Single item questions on work–life balance/time off may have resulted in blunt appraisal.	92%[b]

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TABLE 1 (Continued)

Author/s (year) Country	Study aims	Design & methods	Setting & participants	Key findings	Limitations	JBI quality score
Gebriné et al. (2019) Hungary	To explore the sense of coherence (SOC) and work values (WVs) impact on stress and perceived health of midwives and to evaluate the mediating effect of WVs between stress and health.	Design: Cross-sectional, correlation Data collection: Questionnaire—paper based survey with 2 instrument. SOC short form. Super's Work Values Inventory. Subjective Health measured by a tool created by the authors. Stress was measured using subscale from Demand-Control-Support scale.	Settings: 13 major, regional hospitals across Hungary Participants: ($n=228$) 500 midwives from across all 13 hospital settings were randomly selected. 228 surveys were completed.	○ Midwives reported a high levels of stress, average SoC and average subjective health. ○ Preferred work values included altruism, economic returns, and supervisory relations. ○ The greater the respondents SoC, the less work-related stress was reported. ○ A strong positive correlation was also identified between SoC and subjective health. In addition, stress was associated with poorer self-reported health. ○ Health was identified as a significant predictive factor for intention to leave the profession.	Sampling bias may exist as sample selection was at discretion of midwifery unit leader and authors had no control over the sampling selection process at hospital. High number of returned surveys excluded due to being incomplete.	67%[b]
Gilkison et al. (2017) New Zealand	To investigate what sustains midwives who have been in hospital practice in NZ for more than 8 years?	Design: Qualitative descriptive Data collection: In depth qualitative interviews	Setting: New Zealand, urban and rural areas represented. Participants: 22 midwives. Between 8 and 40 years experience. 10 midwives worked in tertiary level units, 5 in secondary level units and 5 in primary units & remainder in other settings.	○ Sustainability of core midwifery relies on having effective r'ships with women, whanau, colleagues, and management. ○ Midwives are sustained by a love of the profession, diversity of work, feeling valued and having control over work conditions. ○ Core midwives spoke of feeling invisible; however, research identified that core midwives have unique skills and are valued contributors to the NZ maternity service. ○ Participants articulated that there are limits to the flexibility and adaptability that can be expected of midwives.	Data collected from midwives working in diverse settings and geographical areas of NZ therefore the study findings may not generally be representative of all midwives.	89%[a]

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TABLE 1 (Continued)

Author/s (year) Country	Study aims	Design & methods	Setting & participants	Key findings	Limitations	JBI quality score
Hunter and Warren (2014) UK	To explore clinical midwives' understanding and experience of professional resilience and to identify the personal, professional, and contextual factors considered to contribute to or act as barriers to resilience.	Design: Qualitative descriptive Data collection: Closed online discussion group hosted by the RCM: UK Online Communities. Group session over 4 weeks—facilitated by research team—Online discussion forum structure. Stage two: Expert panel of 4 midwifery representatives reviewed the thematic analysis & selected data extracts.	Setting: Online Participants: 18 midwives self-selected/expressed interest in participating. 12 registered for discussion groups and 11 participated. All were practicing midwives with 15+ years "hand on clinical experience" and who self-identified as being resilient.	Four themes: • *Challenges to resilience* • *Managing and coping* • *Self-awareness* • *Building resilience* ○ Recorded as an unexpected finding was the significance of professional identity for developing resilience including feelings of "belonging" and "love" for the profession. ○ Further insight was gained into enduring resilience strategies and the role of "protective self-management" and self-awareness to recognize stress triggers and take steps to minimize their impact. ○ Participants acknowledged the importance of peer support for promoting resilience and the need for nurturing r'ships for vulnerable colleagues	Findings represent experience of a small and self-selected sample of UK midwives with a wealth of experience who self-identified as resilient with capacity to "Bounce back." This sample does may not represent all experiences on resilience for midwives in early/establishment phases of their career nor capture possible changes to clinical and environmental demands within midwifery. No demographic data was identified/included for participants.	89%[a]
Jarasnova et al. (2016) Multi Country Study	To examine the association between the domains of job satisfaction and competent of subjective well-being in relation to hospital midwives.	Design: Cross-sectional descriptive Data collection: Self completed questionnaires—identical across participating countries. Measuring 3 main areas: job satisfaction, subjective well-being, and participant demographics. Data statistically analyzed using IBM SPSS and various tools such as Positive and Negative Affect Scales/MMSS and PWI. A one-way ANOVA procedure was used for group comparisons.	Setting: 45 hospitals across 7 countries including 2 Asian and 5 European countries: South Korea, Singapore, Czech Republic, Italy, Poland, the Slovak Republic, and Portugal. Participants: Convenience sample of midwives from 45 hospitals. 1520 questionnaires distributed to hospital midwives from across 7 countries ($n = 1190$). 15 questionnaires were excluded due to being incomplete. Inclusion criteria: registered midwives, 1 year+ exp, fluent in language of country of practice. Respondents divided into 2 groups—midwives working in labor and birth settings ($n = 462$) and midwives working in other clinical settings ($n = 728$). Participation was voluntary and data de-identified. Mean duration of experience was 15.6 years.	○ Results confirmed a slight correlation between the domains of job satisfaction and both components of subjective well-being in midwives. ○ Significant differences were identified between type of workplace and job satisfaction.	Limitations include the cross-sectional study design, the convenience sample, nonrandomized sampling, and limited scope of the measuring instruments used. Some missing data about Portugal sites. Did not explore cross cultural differences/aspects that may effect the inquiry.	75%[b]

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TABLE 1 (Continued)

Author/s (year) Country	Study aims	Design & methods	Setting & participants	Key findings	Limitations	JBI quality score
Sabzevari and Rad (2019) Iran	To explore and describe resilience strategies against workforce pressures in midwives in Sabzevar, Iran.	Design: Qualitative descriptive Data collection: Semi structured deep interviewing method and purposeful sampling was used	Setting: Mobini Hospital, Sabzevar Participants: 12 midwives enrolled. 10 with Bachelor degrees, 2 held Master degrees. Years of midwifery practice ranged from 1 to 20 years with a mean of 8 years. Midwives who encountered severe stressors were also selected using snowball method.	Five major categories: • *Self-management* • *The presence of supporters at work* • *Sense of usefulness* • *Nature & creation of life* • *Accountability.* ○ Findings acknowledged that all resilience factors fell upon the midwife and did not refer to the role of the system in creating resilience.	Purposeful sampling used; however, limited explanation of the process of selection/recruitment provided. Sampling occurred until data saturation. Interviews were conducted by a male researcher on site at the hospital. Both factors may have inhibited participants.	89%[a]
Shaghaghi et al. (2019) Iran	To investigate the effect of positive psychological interventions on the psychological well-being of midwives.	Design: Randomized control trial Data collection: Cluster sampling methods—centers were divided into 2 groups: intervention and control Participants randomly assigned to two interventions and control groups responding to Ryff's Psychological Well-being questionnaire in 2 stages.	Setting: Midwives working in five community health centers in Mashhad City, Iran. Participants: ($n=60$) midwives randomly assigned into two groups. 13 midwives excluded in intervention group due to irregular participation. No change to numbers in control group. Inclusion criteria Midwifery degree and =>1 year clinical practice, no recent referral to psychologist or hospital admission for mental illness, no hx of mentally affecting drugs, no work impacting medical condition, and no severe score from the DASS 21. Participants excluded if involved in major stress event during the study.	○ Positive psychological interventions can be effective in the psychological well-being of midwives. ○ Results recommended the use of Seligman's PERMA model to improve the well-being of midwives	Inconsistent numbers in control/intervention groups. High demands on participants (time and homework requirements) resulted in 13 withdrawals from study, affected results.	45%[c]

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TABLE 1 (Continued)

Author/s (year) Country	Study aims	Design & methods	Setting & participants	Key findings	Limitations	JBI quality score
Sullivan et al. (2011) Australia	To determine factors that contribute to retention of midwives, that is, why do midwives stay?	Design: Survey undertaken in 2 phases. Data collection: Qualitative and quantitative data collected Phase one: focus groups to adapt a questionnaire used in the *Why Midwives' stay?* English Study for use in the Australian context. Phase two: distribution of questionnaire	Setting: Health service in NSW, Australia comprising of 7 maternity units including a tertiary referred hospital, 3 district type hospitals, a small rural unit, and a stand-alone midwifery-led unit. Participants: 392 midwives employed in the health service were eligible to participate. ($n = 209$) responded.	Three key factors were identified: • Midwifery relationships • Professional identity as a midwife • The practice of midwifery ○ Motivation was aided by individuals with a positive outlook, job satisfaction, and a sense of belonging.	Study setting may not reflect/capture all maternity sites or midwives in NSW/Australia. Response rate of 53% may indicate that dissatisfied midwives may not have responded to questionnaire. Study conducted in public hospital setting therefore does not capture midwives from private/independent midwifery practice. Tool used may not measure what it is intended to measure as formal reliability and validity analysis was not undertaken with this specific tool.	>75% of criteria met[d]
Wright (2018) USA	To evaluate the effectiveness of a holistic, web-based program using holistic modalities for stress reduction and improved coping among certified nurse-midwives.	Design: Cohort study Data collection: Participants completed pre and post intervention questionnaire using Perceived Stress Scale (PSS) and Coping Self-Efficacy Scale (CSES)	Setting: United States of America Participants: 10 midwives recruited via email using membership lists from the American College of Nurse-Midwives. Inclusion criteria: Certified nurse-midwife in clinical practice or higher education, with internet access.	○ Findings suggest potential stress reduction and improved coping skills after using holistic techniques in a web-based format.	Small sample size does not allow for evaluation of statistical significance. Results cannot be generalized. Lack of racial, gender and geographical diversity. Limiting in terms of equity as dependent on technological access.	>75% of criteria met[e]

[a]Critical Appraisal Skills Programme (CASP) Qualitative Studies Checklist (2019).
[b]Center for Evidence Based Management (CEBM) Critical Appraisal Checklist for Cross-Sectional Study (2014).
[c]Critical Appraisal Skills Programme (CASP) Randomized Controlled Trials Checklist (2019).
[d]Mixed Methods Appraisal Tool (MMAT) (2018).
[e]Joanna Briggs Institute (JBI) Reviewer's Manual. The Joanna Briggs Institute (2017).

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one participant reported having high stress levels in response to dangerous practices such as caring for up to 12 high-risk mothers and babies at a time.[26] Three studies reported midwives' inability to practice “real” midwifery and provide woman-centered care due to excessive workloads and systemic pressures.[22–24] This finding was further confirmed by Cull et al.[26] with study participants feeling that they operated as “obstetric nurses” rather than as midwives.

Workplace culture was a further frequently cited source of adversity, with bullying and midwife-on-midwife horizontal violence, lack of social and professional supports, hierarchical structures, and medical dominance resulting in midwives feeling powerless, and many reporting moderate-to-high levels of stress and anxiety.[22–24,26,30] These studies highlighted that adversity in midwifery creates a practice environment where conditions can threaten patient safety and compromise the quality of midwifery care.

The inherent nature of midwifery work refers to the unique stressors associated with midwifery practice; these include the gravity of clinical responsibility the midwife assumes for both mother and baby and the emotional labor involved in supporting families who experience bereavement, birth trauma, and adverse clinical events.[22,25,32] These practice-related stressors are exemplified in the Catling et al.[22] study, which captured the experience of a midwife who left the profession after just 2 years as she could no longer witness the emotional and physical abuse of childbearing women. In addition, Cull et al.[26] reported that being unable to practice in accordance with one's midwifery philosophy resulted in professional dissonance for several midwives in their study.

3.2.2 | The impacts of workplace adversity for midwives

Five studies identified the relationship between workplace adversity and midwives' negative psychosocial and physical well-being, which manifested in levels of sick leave, job dissatisfaction, low morale, poor work–life balance, burnout, compromised patient care, risk of increased clinical error, and the inability to endure in the midwifery profession.[22,26,27,30,32] The authors reported numerous physical and psychological impacts for midwives including stress, distress, depression, anxiety, heart palpitations, exhaustion, poor sleep hygiene, substance use, flashbacks, emotional and physical exhaustion, emotional distress, vicarious trauma, and post-traumatic stress syndrome.[22,26,27,30,32] Furthermore, Cull et al.[26] found that workplace stressors resulted in exhaustion and “a consequent impact on mental health” (p. 552). This finding confirmed what Catling et al.[22] reported 3 years prior—that the persistent nature of exposure to adversity from both systemic and practice-related stressors affects midwives by means of symptoms of fatigue, feeling powerless, a loss of empathy and compassion toward the women in their care, and no energy left to advocate for systemic change.

3.3 | Protective factors and resilience in midwifery

This theme addresses concepts of resilience and the protective factors that promote resilience in the reviewed literature. Each of the three studies on resilience contained contrasting interpretations, understandings, and applications of the concept. Both Sabzevari and Rad[25] and Gebriné et al.[29] used a definition of resilience that was trait-based, reflecting one's ability to “cope well with adversity.” Hunter and Warren,[24] on the contrary, explored the concept of resilience more widely and identified the complexities that exist when there is a lack of uniformity in terminologies and definitions. The authors described and examined broad uses that range from resilience as a trait, or as a set of coping mechanisms, to processes of emotional adaptation in the face of adversity. Collective findings highlight that several factors associated with workplace adversity can also be sources of protection depending on their presence or absence (see Table 2). The following protective factors that support resilience were identified and grouped in two domains: personal protective factors and resilience strategies, and external protective factors and resilience strategies.

3.3.1 | Personal protective factors and resilience strategies

Personal protective factors and strategies refer to personal characteristics, behaviors, and skills used by midwives to manage adversity. These included having personal autonomy, a strong sense of self, a sense of coherence, and characteristics such as altruism, optimism, pride, and self-esteem. While most of the included studies discussed the importance of autonomy in the context of midwifery, five studies specially referred to protective factors relating to autonomy.[24–28] In these studies, autonomy generally referred to midwives' ability to exercise choice, clinical judgment, and control in relation to their sphere of practice. Of the included studies, only one provided a definition of autonomy.[27] Across studies,[24–28] autonomy was found to be central to midwives' perception of themselves as

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TABLE 2 Risk and protective factors.

Organizational and systemic factors	
Risk factors	**Protective factors**
Workplace culture	
• Lack of autonomy	• Midwifery autonomy
• Lack of sense of cohesion, low morale/burnout	• Sense of cohesion
• Excessive/unmanageable workloads	• Diversity of work
• Inadequate staffing	• Adequate staffing including/skill mix
• Rostering constraints	• Considerate rostering and flexible employment options
• Inability to practice woman/person-centered care	• Ability to practice woman/person-centered care
• Medicalized practice environment inhibiting midwifery philosophy	• Practice environment that integrates midwifery philosophy
• Work setting (birthing/postnatal/antenatal environment)	• Work setting (nonbirthing/postnatal/antenatal)
• Model of care (Core)	• Model of care (Continuity of Care)
Interpersonal relationships	
• Bullying	• Supportive and respectful professional relationships
• Hierarchical across several domains	• Nonhierarchical
• Horizontal violence	• Co-operative relationships across Models of care/teams/disciplines
• Lack of midwifery leadership	• Strong midwifery leadership
• Lack of connection with peers	• Sense of connection with peers
• Lack of social and professional supports	• Social and professional supports
• Lack of team work	• Strong and effective team work
The inherent nature of midwifery work	
Risk factors	**Protective factors**
Midwifery identity	
• Gravity of clinical responsibility	• Gravity of clinical responsibility
• Barriers to forming meaningful r'ships with birthing women/people	• Forming meaningful r'ships with birthing women/people
• Altruism may lead to self-sacrifice and lack of self-care	• Strong sense of purpose and reward
• Compassion fatigue and burnout	• Sense of vocation and desire to contribute to the greater good.

resilient practitioners and provided midwives with a sense of control and self-determination. In addition, possessing or developing personal attributes such as a strong "sense of self," self-awareness, optimism, pragmatic adaptable responses to adversity, and an ability to recognize stress triggers were advantageous in terms of supporting personal resilience.[22,24] Participants in two studies[22,24] described pragmatic and proactive strategies to support their resilience which included mood-changing activities, the ability to separate work from home, reflective practices, and workplace-supported or facilitated initiatives. Furthermore, participants reported developing "protective self-management,"[24] where they learned to anticipate stress and develop strategies to avoid challenging situations and or relationships. The authors[24] identified that having previously endured adversity could foster the development of resilience and be generative in nature, with midwives playing a key role in helping build resilience among their colleagues. Furthermore, Gebriné et al.[29] reported that a strong sense of coherence resulted in lower levels of work-related stress, and altruism was a driving characteristic of midwives.

3.3.2 | External protective factors and resilience strategies

External protective strategies included practice-related, behavioral, interpersonal, and workplace culture characteristics that influenced midwives' ability to manage adversity. Fenwick et al.[28] identified the Model of Care as a significant protective factor, reporting that compared with midwives working in a core capacity, midwives working in a continuity of midwifery-led care model experienced significantly lower levels of anxiety, burnout, and depression and higher levels of midwifery empowerment. Continuity models were also seen to provide midwives with a greater sense of autonomy, empowerment, and the ability to practice more completely within the midwifery scope and to apply philosophy of midwifery and knowledge.[27] In contrast, Gilkison et al.[23] found that midwives working in a core midwifery model developed the skills of flexibility and adaptability in order to flourish.

Several studies recognized the protective value of a positive workplace culture.[22–26,33] This was characterized

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as the presence of respectful and supportive professional relationships, strong midwifery leadership, positive acknowledgement and recognition, the availability of flexible work options, access to meaningful and appropriate supports to promote midwifery well-being and resilience. Formal supports within the workplace were described as clinical supervision and opportunities to debrief, whereas informal supports were characterized as connection with like-minded midwives, family, friends, and social supports.[22–24,26] However, in one study, employer provision of "resilience training" was poorly received by midwives and resulted in frustration, with a participant stating that work pressures were so great there was no time to even attend the training.[26] Sabzevari and Rad[25] found that the expectation and responsibility to be resilient fell upon midwives rather than on the organization to address systemic stressors and shortfalls. In addition, Gilkison et al.[23] noted there are limits to the expectations of resilience and adaptability placed upon midwives and used the example of frequent late changes to place of work in order to fill service shortfalls resulting in dissatisfaction and feelings of instability among midwives.

3.4 | Sustaining factors for midwives' well-being

Of the included studies, seven explored various forms of well-being in the context of workplace adversity. However, few studies measured psychological well-being, which refers to optimal positive psychological (i.e., mental and emotional) functioning that supports a person's abilities, skills, and adaptive capacity to overcome challenges over time.[34,35] Across the studies, various scales and inventory tools were used to measure well-being, including positive affect (PAS), practice environment (PES), and perceptions of empowerment in midwifery (PEMS). One study used the personal well-being index (PWI) to specifically measure well-being[30] and found a positive correlation between job satisfaction and subjective well-being. One New Zealand-based study found that midwives working in continuity of care models reported significantly improved levels of emotional health.[27] Australian midwives working in continuity of care models also returned significantly higher PEMs scores and reported better emotional and professional well-being compared with midwives working in noncontinuity settings.[28] Of note, each study used differing terminologies and concepts of well-being such as emotional well-being,[26,27] emotional and professional well-being,[28] psychological well-being,[31] mental well-being,[32] staff well-being,[22] subjective health,[29] and subjective well-being[30] which inhibited the ability to draw cohesive findings across studies.

Two studies evaluated an in-person[31] and virtual well-being program.[32] In their randomized control trial, Shaghaghi et al.[31] found that in the postintervention comparison of control and intervention groups, the mean total score difference on psychological well-being of midwives was significantly higher for the intervention group compared with the preintervention results. There were, however, some concerns in relation to the integrity of the processes used in terms of participant recruitment and allocation. The virtual well-being intervention designed by Wright[32] reported a 25% reduction in the mean score of perceived stress postintervention for the intervention group, and an 18.6% difference among the total mean scores, indicating an improvement in coping self-efficacy compared with controls. Low overall participant numbers and a drop in post-test survey returns impeded the ability to obtain results of statistical significance.

Of the seven studies that focused on midwives' well-being and associated sustaining factors, two subthemes were identified.

3.4.1 | Organizational and systemic factors

Positive workplace culture was directly associated with midwifery well-being, workplace performance, and satisfaction.[22] Strong midwifery leadership and management, mutual respect among colleagues, strong teams, and collegial support contributed to a positive workplace culture which was connected to staff well-being and improved morale.[22,26] Gebriné et al.[29] found that a greater sense of coherence and control over one's work was positively associated with one's subjective health and negatively associated with stress levels. Effective communication, particularly around rostering, was also key. Rosters that were communicated in advance provided adequate rest periods between night duty and day shift and had minimal changes in terms of area of work, which offered midwives a sense of stability and contributed significantly to their well-being and sustainability.[23,26] In addition, Fenwick et al.[28] found that midwives providing continuity of care reported improved emotional and professional well-being. This was supported by Dixon et al.,[27] who found that midwives providing continuity of care had better emotional health and reported lower levels of burnout, anxiety, stress, and depression.

One study found that midwives who worked in the birth suite setting reported lower levels of job satisfaction compared with midwives who working in other clinical settings such as postnatal.[30] Several studies[22,23,26–28,30–32]

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reported the impacts of protective and sustaining organizational factors on midwives' well-being such as positive workplace culture, professional relationships, and model of care. These were associated with greater staff satisfaction, improved maternal and neonatal outcomes and lower mortality, and less staff attrition and burnout.

3.4.2 | Midwifery identity & the inherent nature of midwifery work

Studies repeatedly identified that midwives were motivated by a strong sense of vocation, a desire to contribute to a "greater good," and by a sense of belonging.[24,26,33] Midwives reported significant personal and professional satisfaction from the relationships formed between them and birthing women and people, as well as providing woman and person-centered care, promoting and supporting normal physiological birth and the ability to advocate for, and work in partnership with families.[23,24,26] In addition, Sullivan et al.[33] found professional identity to be a key motivator for why midwives remain in the career, as well as strong midwifery relationships and the practice of midwifery.

4 | DISCUSSION & PRACTICE RECOMMENDATIONS

Contemporary resilience theory acknowledges that promotion of resilience is a shared responsibility among employers, organizations, and the individual.[15] People's ability to positively adapt and be resilient to adversity is dependent on interactional factors and processes in their personal, social, and physical ecologies.[15] While resilience at work is increasingly being investigated, it is important to acknowledge critiques of resilience as a concept and its application. Traynor[11] argues that the well-intended promotion of individual resilience urges staff who are experiencing adversity at work to acquiesce and persist and, therefore, support the status quo. This focus on the individual may lead to a lack of responsibility by organizations and systems in their duty of care to reduce staff stressors where possible and support and promote staff well-being. It is also important to note that while the professional and personal characteristics embodied by midwives are critical to the provision of connected midwifery care, these characteristics may also serve as a barrier to resilience, with midwives' enduring adversity and chronic stress at great personal and professional cost.

The meaning we have made from the findings of this review, and consistent with a social ecological approach, are a series of recommended strategies outlined in Table 3 and Figure 2 to improve well-being and strengthen resilience for midwives. At the individual level, we recommended that meaningful self-care and well-being practices be promoted and support networks be fostered. At the work unit or team level, strong midwifery leadership and the promotion of positive team culture and professional relationships is vital to enhance cohesion and reduce bullying and horizontal violence.[22,26,36] At the organizational level, recognition and support of the scope of midwifery and the need for autonomous practice is key, as well as a commitment to the creation and cultivation of a positive workplace and well-being culture.[4,20] Safety initiatives including safe staff-to-patient ratios, appropriate training, staffing and skill mix, and manageable workloads are fundamental.[26,28,33] Access to support mechanisms that promote clinical supervision, debrief, and reflection is essential as well as the provision of appropriate psychological supports.[37] At the profession level, strengthening of the professional body and midwifery identity is necessary to advocate for systemic change.[38] In addition, workforce planning strategies addressing educational needs, enhanced staffing, appropriate remuneration, career development, staff well-being, and retention are critical to ensure the sustainability of the profession. These factors can be used by the profession, organizations, work units, and individual midwives, to strengthen support for staff and to enact proactive strategies to enhance their well-being.

5 | STRENGTHS AND LIMITATIONS

While this review has identified a series of protective factors and strategies that can be used to improve the well-being of midwives and support resilience within the profession, it was limited by a small yield of eligible studies for inclusion, as well as the emerging nature of evidence and quality of research in the field. In addition, three of the included studies drew upon data from the one international study and some of the included studies could not be applied to all practice contexts. The lack of cohesion and uniformity around well-being and resilience terminologies and concepts made it difficult to draw strong thematic conclusions. The strengths of this study included the synthesis of robust data surrounding workplace adversity and protective factors in relation to midwives. Two of the studies included provided insight into an under-represented midwifery population, reinforcing the global nature of the workforce issues impacting midwives' well-being and resilience.

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TABLE 3 Social ecological strategies and resources to improve well-being and strengthen resilience for midwives.

Professional	Strengthening of the professional body
	Promotion of the role of midwifery
	Workforce planning strategies
	Advocacy for profession and workforce
Organizational	Understanding and recognition of the midwifery role, scope, and professional autonomy
	Support for the provision of care in line with midwifery values
	Creation and cultivation of a positive workplace and well-being culture
	Strategies to reduce adversity including appropriate staffing, training, skill mix, and manageable workloads
	Support career and skill development
	Provision of and access to support mechanisms such as clinical debrief & appropriate psychological supports
	Access to CoC programs and flexible work options
Work unit/Team	Strong midwifery leadership
	Respectful professional relationships
	Positive team culture
Individual	Self-care and well-being practices
	Support networks/protective factors

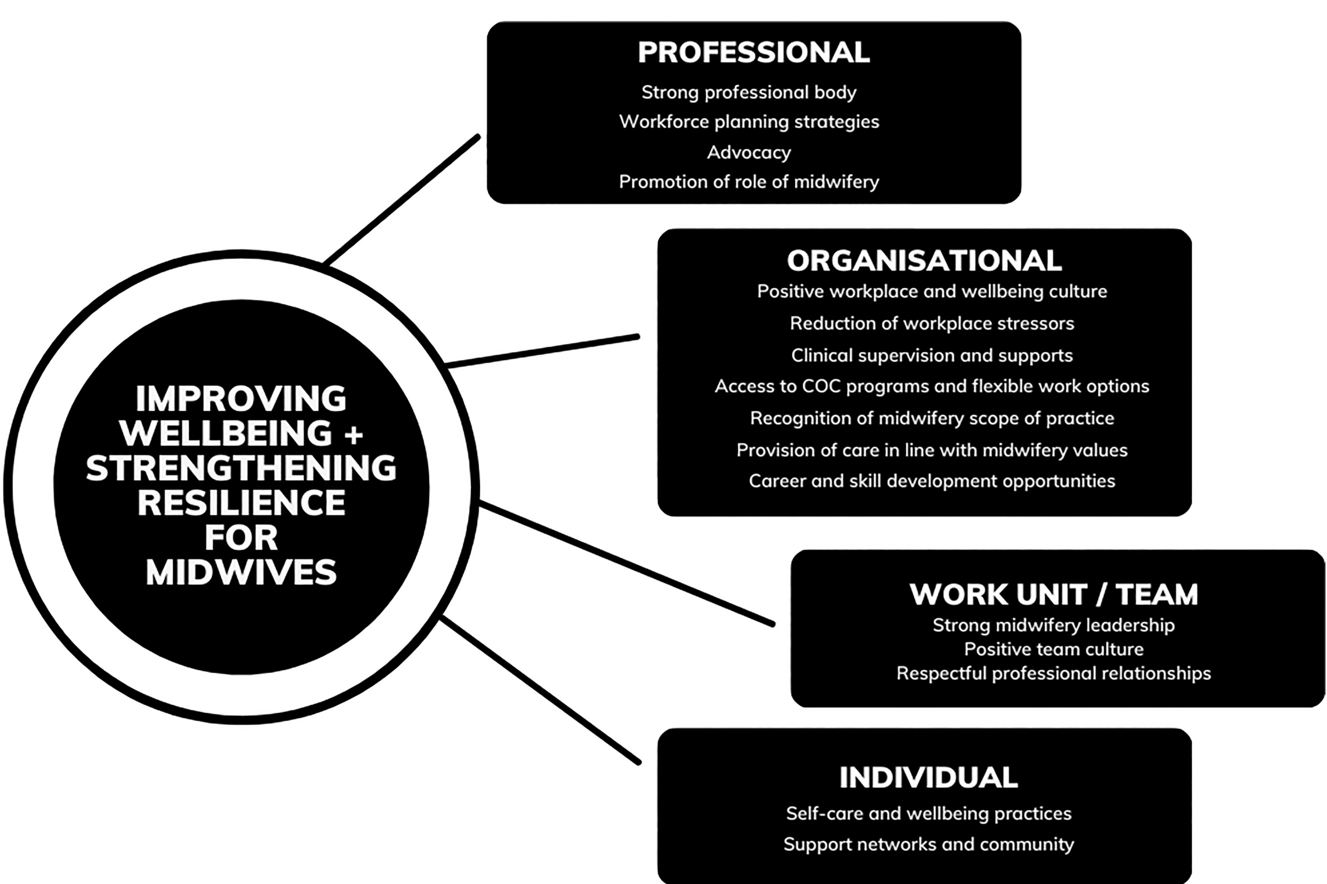

FIGURE 2 Social ecological strategies and resources to improve well-being and strengthen resilience for midwives.

5.1 | Conclusions

The aim of this study was to analyze existing international knowledge on midwives' well-being and resilience in the context of workplace stress and adversity. It is important to acknowledge the rapidly deteriorating working conditions experienced by midwives, including the negative impacts of the COVID-19 pandemic which has

led to further burnout and the loss of experienced and dedicated midwives from the profession. Swift action is required to reduce the risk of psychological injury and address the crisis that faces the midwifery workforce. Of note and as discussed, further research and investigation of midwifery-specific populations (excluding student midwife and nurse populations) is recommended to identify and authentically represent the unique professional context. In addition, the further development and utilization of cohesive well-being and resilience concepts specific to midwifery is recommended, as is the development and application of uniform more terminologies and definitions.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ORCID

Lynnelle Moran https://orcid.org/0000-0003-4942-7972
Kim Foster https://orcid.org/0000-0001-6931-2422
Sara Bayes https://orcid.org/0000-0001-7121-9593

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