Meaningful work in Midwifery

2023

A Thesis submitted to Auckland University of Technology

In partial fulfilment of the requirements of a Master's degree in Business Management

Olivia Goldsworthy-Keeley

Faculty of Business

Abstract

There has been an increase in the study of meaningful work as scholars and practitioners seek ways to enhance an employees' sense of purpose. This exciting topic has been explored in several occupations and industries. Two competing approaches to meaningful work dominate the literature. There is the unidimensional perspective (meaning is achieved through a single dimension), and the multidimensional perspective (meaning is experienced through a range of dimensions).

This study applies a multidimensional perspective using the framework: The Map of Meaning—to investigate New Zealand facility based midwives' experiences. The Map of Meaning uses seven dimensions to consisder the meaningfulness or meaninglessness that the participant experiences in each area. A scoping review was completed to identify any literature based on meaningful work in midwifery. Results of the review concluded that no research has been completed to understand midwives perception of meaningfulness from their occupation.

Five New Zealand, facility based midwives participated in this research. Each participant completed a survey to present their own personal experience of meaningfulness within their role. Following this, in-depth interviews were conducted and transcripts were analysed using thematic analysis. Findings show that connection with others, differing philosophies and workload and staff shortages were the themes extracted from the data to show midwives experiences of meaningfulness or meaninglessness at work.

Table of Contents

List of Figures

List of Tables

List of Appendices

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

6th March 2023

_____

Signature Date

Acknowledgements

First, thank you to the five participants for sharing their stories that are the basis of my research. This research will contribute to the lives of these midwives. Their stories shed light to core midwifery and what these participants and other midwives around the world experience in the workplace.

Second, I thank my supervisors for their guidance in conducting this research and writing my thesis. The continuous support from my primary supervisor Dr Tago Mharapara with his work and well-being knowledge has made this research possible. In addition, the essential midwifery knowledge and support from my secondary supervisor Dr Janine Clemons helped me at each stage of my research. I will forever feel blessed to have worked with such an experienced and supportive team. Third, I thank Professor Marjo Lips-Wiersma for assisting me with using the Map of Meaning and granting copyright permission to display the diagram in my thesis. Fourth, I thank Auckland University of Technology for funding the interviews and transcriptions used for this research. Finally, thank you to Vicky Powell for transcribing the interviews.

I thank my family for supporting me during this research. My close friends who have contantly checked in to see how I have progressed. Most importantly my mum for being my number one supporter.

This study was approved by the Auckland University of Technology Ethics Committee (AUTEC 21/312).

1. Introduction Chapter

In this chapter, I introduce Meaningful Work (MW) as a research construct to be explored in the midwifery profession. I begin with a brief historical description firstly of MW. I show the gap in applied research on MW, as informed by a scoping review. Secondly, I introduce the occupation of midwifery. I explain what this profession does and problems that midwives face in New Zealand and internationally. The last part of this chapter describes the aim and structure of my research in greater detail.

1.1 Research Rational and Meaningful Work

MW is challenging to study due to a lack of definitional consensus and competing approaches to construct investigation (Bailey et al., 2019; Rosso et al., 2010). From a management perspective, understanding MW is relevant to increase engagement and productivity and decrease absenteeism in the workplace (Wrzesniewski, 1997). Increasing MW also has a positive effect of increasing fulfilment and satisfaction of individual workers (Snyder & Lopez, 200; Hackman & Oldham,1975). Different theoretical frameworks have been used as a guide to capture employees engagement with MW. These included the job characteristics model Hackman and Oldham, (1975), the Map of Meaning Lips-Wiersma and Morris, (2017), and The Work and Meaning Inventory Steger et al. (2012). A current issue when researching MW is the lack of agreement on how it is understood and modelled. It would be helpful for both scholars and practitioners to know which approach is best suited to most contemporary jobs (Both-Nwabuwe et al., 2017).

There are two competing schools of thought as to how MW is understood. These are through either a unidimensional approach or a multidimensional approach. The unidimensional approach

argues that the individual experiences MW through self-actualisation. This theory emerged from Maslow's theory Z (1981), which was the first theory to go beyond primary work motivators and explores holistic areas of employee behaviour. Drawing from this early theorisation, researchers have explored MW on a single dimension that focuses on an individual's relationship with their work (Hackman & Oldham, 1975, Lepisto & Pratt, 2017, Berg et al., 2013). However, the unidimensional approach to MW creates barriers to contextualising meaningfulness. These barriers include clarity about what MW is, the lack of definition for the employee to understand the difference between importance and meaning in the workplace, and the scales being too narrow to consider the meaning and the ongoing process of it (Both-Nwabuwe et al., 2017; Lips-Wiersma & Wright, 2017).

An alternative perspective to understanding MW is through the multidimensional framework. A multidimensional framework to MW assumes that meaning is understood through a range of connections with the wider world. This approach posits that several sources of meaning are involved in a complex interaction to determine an individual's overall meaningfulness at work (Bailey et al., 2019; Lips-Wiersma & Wright, 2017). The Map of Meaning (MoM) Lips-Wiersma and Morris (2017), was developed as a guide to understanding how individuals experience meaning through seven dimensions. These dimensions are; Integrity with self, Expressing full potential, Service to others, Unity with others, Doing and being, Service and others, and Inspiration and the Reality of Self and Circumstances. Without testing the MoM in different occupations, its universal applicability remains unknown.

1.2 Research Rational and Midwifery

A midwife is a health practitioner who has completed an International Confederation of Midwives (ICM) Essential Competencies for Basic Midwifery Practice, and Framework of the ICM

Global Standards for Midwifery Education qualification that is regulated in their country of work. The scope of practice for a legally licensed midwife is to work interpersonally with mothers in a partnership framework. To provide "care, support and advice" from pregnancy through to infancy. This care includes sexual and reproductive health services, protecting normal birth, assessing risk, preventing complications and working with multidisciplinary healthcare teams when care is outside of their scope (ICM, 2018). The points listed according to WHO, (2021) are that through collaboration with other stakeholders, midwives work to improve national health services while providing individualised care. There is broad international consensus on the criticality of a well-educated, supported, and motivated midwifery workforce to improve maternity health outcomes for birthing families. More effort is being directed toward the recruitment and retention of midwives to support a 2025 global commitment to United Nations Sustainability goals. Investment into midwifery aids successful birthing and contributes to normal labour with less chance of adverse risk (WHO, 2021).

New Zealand midwives are well integrated into the health system, practising in the community and in birth facilities such as hospitals and birthing centres. Facility-based midwives, known as 'core midwives', work with community-based midwives (Gilkison et al., 2017; Midwifery Council, 2010). Core midwives constitute 48% of the workforce and care for birthing women admitted to hospital (Ministry of Health, 2022). Although midwifery in New Zealand has advanced as a profession, it faces challenges related to professional recognition Mharapara et al. (2021) and the rising use of birth technologies (Pairman et al., 2023). Improving midwives' work conditions is relevant to decreasing the mortality rates of childbirth WHO, (2021). After all, how can positive recognition and acknowledgement occur without understanding the experiences and stories of those working in the field?

1.3 Aim of the research

This research explores core midwives' experiences of MW in New Zealand. The research aims to understand subjective experiences of meaningfulness/meaninglessness at work. The study asks two research questions: 1) What aspects of midwifery work do midwives find meaningful or meaningless? 2) Does the Map of Meaning effectively capture midwives' experiences of meaningful or meaningless work? This contributes to academic research by giving midwives a voice to express their work experiences, which contributes to their overall impressions of MW. As mentioned in Section 1.2, MW leads to higher satisfaction and fulfilment for the worker (Snyder & Lopez, 2001). New Zealand-based midwives face current issues with recognition in the healthcare industry (Pairman et al., 2023). Due to core midwifery making up the largest percentage of the workforce, this research allows midwives the opportunity share their experiences to advance the profession. In addition, while findings from New Zealand core midwifery may add to New Zealand-based literature, it also relates to international midwives and nurse-midwives that work within hospital settings.

The MoM is used as the theoretical framework to explore midwives' experiences of MW. This study has a twofold purpose, 1) midwives have an opportunity to share their experiences of meaningfulness/meaninglessness at work, and 2) it tests the appropriateness of using the MoM to explain meaningful/meaningless work for core midwives. Before starting this research, I conducted a scoping review to synthesise literature on midwifery and MW. Results revealed that there is no literature on MW applied to midwifery.

1.4 Thesis structure

This thesis has six chapters: 1) Introduction, 2) Literature review, 3) Methodology, 4) Results, 5) Discussion, and 6) Conclusion. Following on from this chapter, Chapter 2 organises the literature review into four sections. Section 2.2 defines and explains MW in detail. The

unidimensional and multidimensional models are described in detail. Furthermore, the MoM is explained in depth and each of the seven dimensions are described. In section 2.3, I present a literature review on the midwifery profession with a specific focus on New Zealand midwifery. In section 2.4, I present a scoping review of literature at the intersection of MW and midwifery. Finally, because of the limited amount of research on MW and midwifery, I present a short review on MW in nursing—an allied profession to midwifery.

Chapter 3 details my research methodology. In this chapter, I explain how the research is guided by applying the MoM to midwives. I outline the research ontology, epistemology and paradigm, provide a rationale for the research methodology and the data collection process. I used Thematic analysis (TA), Brune and Clarke (2019), to code the data using six steps of TA. Meaning was constructed from the transcrips to answer the research questions.

In Chapter 4 my findings are presented. The three main themes and subthemes that surfaced from the data are described. These are: Theme one: Differing Philosophies. Subthemes: policies/ procedures/ autonomy. Theme Two: Workload and Staff Shortage. Subthemes: sustainability and retention, and fatigue. Theme three: Connection With Others. Subthemes: connection with other midwives and connection with women/family members.

Chapter 5 is the discussion chapter. Here, I apply the research findings to my research questions. I also apply the MoM as an analytical tool to assess its effectiveness in explaining MW experiences in the midwifery profession. The last section of this chapter explains the limitations of research.

The final chapter, chapter six concludes the research. This chapter provides a detailed summary of the findings of this research and considers further research that may advance the topic of MW in midwifery.

2 Literature review Chapter

2.1 Introduction

This chapter is divided into four sections. First, I introduce and explain the meaningful work (MW) construct. I detail the unidimensional and multidimensional models of MW that dominate the research landscape. I expound the MoM, Lips-Wiersma and Morris, (2018) as the guiding theoretical framework for my research study. Second, I describe the midwifery profession with particular reference to New Zealand (NZ) midwifery, the location of my research study. I provide contextual information on issues midwives in NZ and the rest of the world face. I describe facility-based midwifery, the specific work setting explored in my research study. Thirdly, I present the findings of a scoping review I conducted on MW in midwifery. I provide a brief, comparative summary of MW in nursing to show how the construct has been studied in an allied profession. I conclude the chapter with a summary of each section.

2.2 Meaningful Work

The concept of 'meaningfulness' is difficult to define yet instinctively simple to grasp (Rosso et al., 2010). Meaning may be constructed subjectively, relationally, or societally (Pratt & Ashforth, 2003). Meaningfulness is often researched from a psychological, spiritual, or humanities perspective. Meaning dictates the value of a human's life. The root of meaning is for the human mind to experience value or purpose through connection (Snyder & Lopez, 2001).

According to Frankl (1985), "Man's search for meaning is the primary motivation in his life and not a secondary rationalization of instinctual drives" (p. 105). Chalofsky (2003) argues that meaningfulness applies to a state of being and implies that an individual has reached a

purposeful state in their life. Snyder and Lopez (2001), also posit that a world that does not incorporate meaning would vastly be less human. Spiritual freedom is what makes life purposeful and meaningful (Frankl, 1985). A summary of the meaningfulness literature suggests that to experience meaning, three constructs must occur, '*purpose*,' if something is worthwhile, '*sense making*' how we make sense of things, and '*coherence*' how all dimensions in our life unify (Lips-Wiersma, 2002).

There is no perspicuous definition of MW. Still, increased interest in the construct has focused, particularly among humanitarian scholars and practitioners, on how work aligns with life's journey (Bailey et al., 2019). Maslow (1981) stated that for employees to use their full potential, their work must be purposeful or meaningful. Ambivalence around MW as a concept makes it challenging to construct a single definition. However, MW has been shown to be a fundamental part of health and prosperity (Both-Nwabuwe et al., 2017). Experiencing MW is a 'state of being'. It is how the individual derives meaning and purpose from their occupation (Chalofsky, 2003). Hackman and Oldham (1975) describe MW as the "degree to which the employee experiences the job as one which is generally meaningful, valuable, and worthwhile" (p. 162). From a business management and human resource perspective, MW has been shown to enhance employee engagement, motivation and lower job absenteeism (Wrzesniewski 1997). Snyder and Lopez (2001), explained that when an individual experiences a high level of meaningfulness, they often feel more satisfied. This increases a sense of fulfilment, coinciding with the above findings. People are becoming increasingly interested in how important work is as a source of meaning and purpose rather than just providing an income (Super & Šverko, 1995). A definition for MW appears elusive because of the complexity of defining 'meaning' alone. Meaningfulness as a phenomenon is abstract and cannot be tested through physical properties, making it difficult to expound objectively.

In addition, MW has been researched by academics from diverse disciplines, generating conflicting results (Rosso et al., 2010). MW has been investigated in various fields, including the humanities, economics, spirituality, and occupational/work psychology (Bailey et al., 2019; Chalofsky, 2003). Theoretical models used to measure MW include the job characteristics model Hackman and Oldham, (1975), the Map of Meaning Lips-Wiersma and Morris, (2017), and The Work and Meaning Inventory Steger et al. (2012). An important aspect to note is that 'meaning' at work and 'meaningfulness' at work are often confused. Meaning at work occurs when a person understands the context of their role. On the other hand, meaningfulness at work refers to the perceived purpose the individual experiences at work (Both-Nwabuwe et al., 2017). Therefore, 'meaningful' and 'meaningfulness' are accurate words in this research area describing the explicit significance of work on the individual. MW has been investigated as either 'unidimensional' or 'multidimensional' (Bailey et al., 2019). The lack of agreement on how MW is modelled makes measuring the construct challenging. This complicates the application of insight in practice. It would benefit practitioners to have a model of MW they can apply outside academia (Both-Nwabuwe et al., 2017).

2.2.1 Unidimensional approaches to Meaningful Work

Several scholars have adopted a unidimensional approach to MW and argue that it is attained through the significance an employee puts on their job. In quantitative unidimensional studies, researchers often use single-item measures to investigate meaningfulness (Bailey et al., 2019; Hackman, 1976; Pratt & Ashforth, 2003). Several unidimensional scholars describe MW as a state of being. The other argument is that it depends on the person's profession and if that aligns with their 'calling' (Lepisto & Pratt, 2017). American psychologist Maslow was the first theorist to move beyond primary motivators and explore meaningful work. In this exploration, he used 'being values', which he described as B-values. These components were: truth,

transcendence, goodness, uniqueness, aliveness, justice, richness, and meaningfulness. Maslow expressed that an individual can reach self-actualisation by living a fulfilling and purposeful life. This was described as Theory Z and focused on teaching individual responsibility (Maslow, 1981). Lepisto and Pratt (2017) argue that meaningful work is an individual-level phenomenon derived from positive association with the employee's work. It is a eudaimonic state, where a manager/supervisor cannot control a worker's meaningfulness because it is based on the individual's relationship with their work.

The unidimensional view of MW, advances several perspectives on how an individual experiences meaningfulness. The realisation perspective describes meaningfulness as centred on an individual's fulfilments, motivations, and desires to achieve self-actualisation (Lepisto & Pratt, 2017). Some scholars suggest that a way to combat meaninglessness is through organisational strategies and 'job crafting', which can enrich people's work (Berg et al., 2013). The main variant between strategies used to enhance meaningful work is whether they are 'top-down' or 'bottom-up' (Lepisto & Pratt, 2017). This is relative to whether the manager restructures the job or if the individual job crafts. When an individual job crafts, it gives attention back to psychological desires such as autonomy and authenticity. Psychologists commonly refer to meaningfulness as 'discovering the self' and the realisation perspective is about bringing attention back to the self and achieving self-actualisation (Lepisto & Pratt, 2017).

The justification perspective is a second, less researched perspective to experiencing MW. This perspective interlinks organisational behaviour, psychology, and sociology. The perspective is derived from ambivalence toward one's work. Questions such as, "why am I here?" spark confusion about work and whether it is worthy (Lepisto & Pratt, 2017). Although the various perspectives are important for managers to consider, they differ significantly. The realisation perspective posits that individuals derive self-actualisation from their role. In contrast, the justification perspective requires the individual to derive value and worth from their role rather

than from attempting to intrinsically enhance it from self-efficacy. Although each perspective helps combat meaninglessness, they may resolve other organisational issues, such as lack of autonomy, rather than just strengthening MW.

Unidimensional perceptions for conceptualising meaningfulness are often based on the job characteristics model (JCM) by Hackman and Oldham (1975), an early attempt to map MW. However, this may promote the study of job characteristics rather than meaningfulness (Bailey et al., 2019). The JCM suggests that when an employee experiences skill variety, task identity, and significance, they will experience meaningfulness at work (Hackman & Oldham, 1975). Amongst unidimensional views toward meaningfulness at work, the psychologically derived JCM is the dominant theoretical framework for MW (Bailey et al., 2019). However, newer theories have diverged from this model. A common issue with unidimensional meaningful work scales is that they tend to have a lack of definition for what 'meaningful work' is and ask the employee to interpret what is important at work rather than what is meaningful (Both-Nwabuwe et al., 2017).

Lips-Wiersma and Wright (2017) identified three key concerns with the current unidimensional measures of meaning. Firstly, they are not accurate or extensive. Second, they do not successfully capture the individual's subjective meaningfulness as separate from the organisational outcomes. Third, they do not consider the ongoing process of achieving meaning which is essential for experiencing meaningful living.

2.2.2 Multidimensional approaches to Meaningful Work

Multidimensional frameworks for MW assert that meaningfulness encompasses connecting with the broader world (Bailey et al., 2019). Support for the multidimensional approach to meaningfulness stems from the research consensus that it is a complex interaction between different dimensions (Lips-Wiersma & Wright, 2017). Experientially, people's lives usually

revolve around numerous sources of meaning, which protects the individual from experiencing meaninglessness (Snyder & Lopez, 2001). Rosso et al. (2010) created the first multidimensional framework to achieve meaningful work through four major pathways: individualism, self-connection, contribution, and unification. All four pathways are theorised as necessary to achieve meaningfulness. The MoM was created as a simple guideline to connect the humanistic factors of a meaningful life to their work within an organisation (Lips-Wiersma & Morris, 2018). This multidimensional tool is the theoretical model for this research described below.

2.2.3 Theoretical Model: Map of Meaning

The MoM is a multidimensional model with seven dimensions that capture individual experiences of meaningfulness (Lips-Wiersma & Morris, 2018). The MoM has four core dimensions and three tensions. The four core dimension: Unity with Others, Service to Others, Expressing Full Potential, and Integrity with Self are necessary pathways for humans to find purpose and meaning (Lips-Wiersma, 2018). The research found that most people experience meaning through these dimensions. Although subjective, the MoM can also be worked into organisations and applied to different cultures and industries. It is not just for workers of high status and class but can also be applied to blue and pink-collar workers (Lips-Wiersma & Wright, 2012). Research about spirituality in the workplace has shown that developing these four pathways is meaningful and significant for employees regardless of their occupation (Lips-Wiersma, 2009). Following these four pathways and the three tensions: Doing and Being, Self and Others, and Inspiration and the Reality of Self and Circumstances. These tensions are necessary to create the balance required to achieve meaning. People who used the map as a framework have described it as being beneficial to visibly see meaningfulness in the workplace (Lips-Wiersma & Morris, 2009). Below, the seven dimensions are explained.

Definitions of the Seven dimensions: Four core dimensions:

Integrity with self: *This dimension refers to how true we are to ourselves in the workplace—to acquire integrity is to develop a deeper relationship with ourselves. This refers to how meaningfulness deepens from enquiring within ourselves about who we are becoming in the workplace. The core of this dimension is that if we do not examine ourselves, we become unengaged with ourselves at work.* (Lips-Wiersma & Morris, 2018).

Expressing full potential: *Expressing full potential refers to meaningfulness from our personal successes in life and from being able to accomplish all that we can. The dimension of expressing full potential speaks about outwardly directing our uniqueness into the universe. In the workplace, expressing full potential may entail doing your best at work, and having the freedom to express talents and expressions.* (Lips-Wiersma & Morris, 2018).

Service to others: *Service to others explains the humanistic need to make a difference and help others. This may be to one person or a wide range of stakeholders. Two subthemes from this dimension are making a difference and meeting humanity's and the planet's needs. Individuals experience meaningfulness from service to others because it takes attention away from just the self and helps ultimately support, assist, and improve the experience of other people. Examples of service to others in the workplace may be: supporting co-workers, challenging ideas to benefit staff/clients, sharing resources, and having consciousness toward how actions affect others. Employees may also experience service to others from the shared vision of their workplace. For example, if where they work gives back to the community in which they live* (Lips-Wiersma & Morris, 2018).

Unity with others: *Unity with others refers to the meaning we get from being with others at work, usually colleagues, and the joy we get from working together. This dimension coincides with expressing full potential because it considers being with others while expressing individuality. This may refer to working in harmony with others in a team, being part of a community, being interconnected in the workplace, creating synergy with others, and connecting over shared challenges.* (Lips-Wiersma & Morris, 2018).

Tensions. The tensions are an important aspect of the map because they are the essential elements that balance the above four core dimensions. Too much attention on one dimension may create a loss of meaningfulness in another area. For example, when focusing on self and expressing full potential too much, one may lose the connection with others in the 'service to others' and 'unity with others' dimensions. Meaningfulness is multidimensional and therefore is found through each dimension. The three tensions below link to create balance (Lips-Wiersma & Morris, 2018).

Inspiration: *Inspiration is at the core of the Map of Meaning. Humans must feel inspired to achieve meaningfulness, however, this also must be grounded within one's reality. Inspiration is when a person feels purpose and hope for something in the future. An example of inspiration in the workplace is feeling a vision for possible growth of an organisation in the future. An employee may ask themselves if they feel hope at work and excited about the future* (Lips-Wiersma & Morris, 2018).

Reality of Self and Circumstances: *Reality of Self and Circumstances considers that meaningfulness is only experienced in the present. This also considers that one must be aware of their*

environment and that it will never be perfect. For example a workplace may have shared values, however these may never be executed. The workplace would be out of touch with reality and what it is trying to accomplish (Lips-Wiersma & Morris, 2018).

Doing and Being and Self and Other: *Doing and Being represents the balance of looking within while taking action in the world. Firstly, Being, is the need to reflect. This may include checking in with self—physically and mentally—resting, and having patience. Doing is the need for action. This is the output one puts into the world. Doing alludes to getting on with the task at hand. In the workplace, to consider if one has the appropriate balance of this tension, one may ask themselves: "Do I have enough time to do what I need to do?"*(Lips-Wiersma & Morris, 2018).

Self is the need for constant development over oneself, whereas Others, is to make an impact for others overall in our life. In the workplace, one may question whether they can express their point of view or if they are unable to be themselves due to the workplace culture and other people (Lips-Wiersma & Morris, 2018).

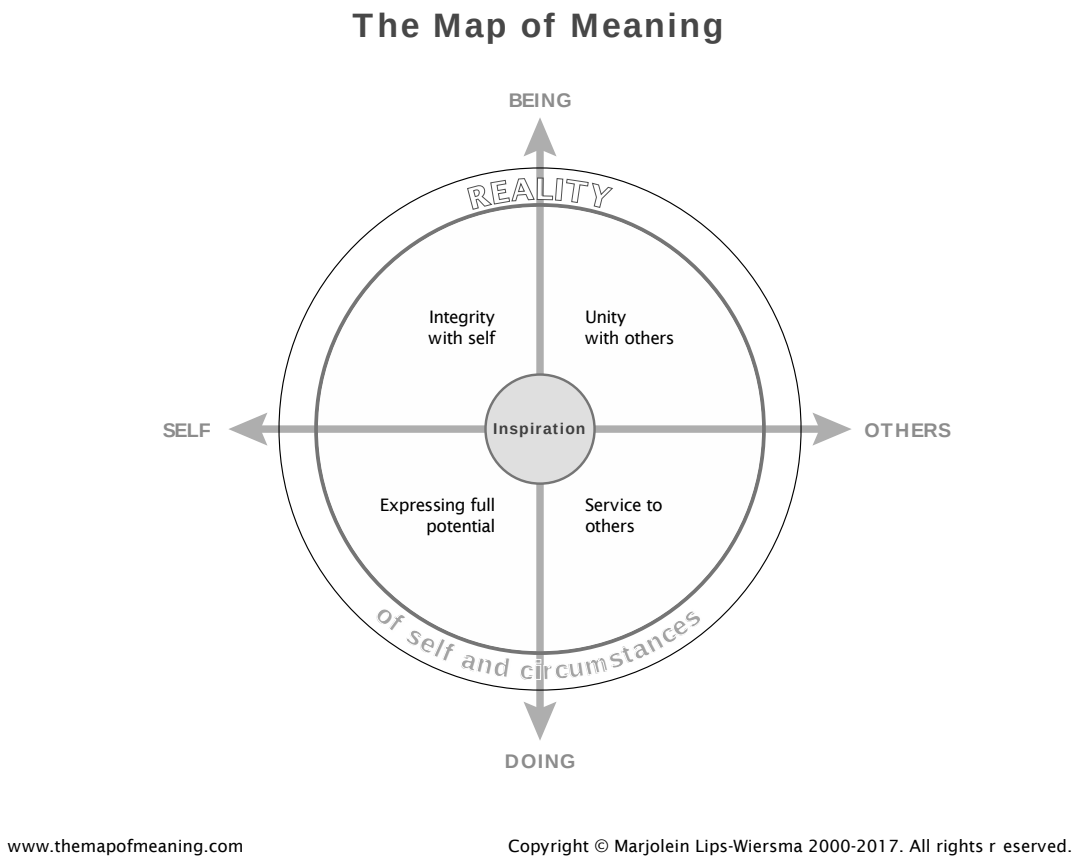


Figure 1 Map of Meaning (Lips-Wiersma & Morris, 2017)

2.3 Midwifery

Although midwifery is often referred to as an old profession, dating back to 40,0000 B.C., the International Confederation of Midwives, (ICM) (2018), recognition of midwifery as a profession distinct from medicine is a recent occurrence (White, 2019). "A midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located; who

has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery" (International Confederation of Midwives, 2018). Midwives are recognised as the experts on normal birth. Where complications of childbearing arise, they facilitate safe care for the woman and her baby(ies) through referral to multidisciplinary teams (Renfrew et al., 2014).

Midwifery is a complex profession, often considered a science and an art (Bates, 1995). Midwifery recognises the importance of the legal, political, historical, and community contexts within which it exists. Indigenous cultures uniquely practice midwifery which may be underpinned from a spiritual or holistic nature. Midwifery journeys are continuously changing and different regions have their own practices (ICM, 2018). Midwives work in a range of settings, including private homes, community settings, hospitals and clinics, or maternity units in NZ (Midwifery Council, 2010). In addition to working with women from pre-pregnancy through to the first weeks of a newborn's life Renfrew et al. (2014), midwifery work involves leading childbirth, conducting preventive measures, encouraging normal birth, and recognising complications or emergencies and referring to specialists appropriately (ICM, 2018; Pairman & McAra-Couper, 2014). The midwife respects the cultural values and beliefs of the women through partnership and negotiates the best practice for successful, empowered childbirth.

In 2015, as part of the International Sustainable Development Goals, the World Health Organisation (WHO) published a paper to decrease preventable maternal mortality. The aim was to limit maternal mortality to less than 70 per 100,000 lives. In 2015, the ratio was 216 per 100,000 lives. In addition, from the years 1990–2015, approximately 10 million women died internationally from maternal causes (Alkema et al., 2016). One of the main reasons for these deaths was poor quality maternity care. There is an international agreement stating that midwifery is essential to contributing to high-quality maternity services. Licensed midwives working with other healthcare professionals throughout the stages of pregnancy have been

proven to increase the standard of care and reduce risks around childbirth for both the mother and child (Renfrew et al., 2014; WHO, 2021).

Midwives are expected to collaborate with stakeholders to support the improvement of national health services and promote better referral systems while monitoring standard of care (WHO, 2021). Midwives collaborate with women and their families throughout the childbearing process, which is called the Partnership Model in NZ (Freeman et al., 2004). The Partnership Model is vital for midwives because it is a key component of how midwifery and autonomy is constructed (Freeman et al. (2004) and aligns well with inclusive and culturally safe models of whānau (family) -centred and patient-centred care. Referrals to other healthcare professionals are collegial but are led by the midwife in consultation with the family (Health Navigator NZ, 2022). The midwife has essential medical knowledge and technology, thus making midwifery an autonomous profession regardless of the work setting (Clemons et al., 2021; ICM, 2018; Zolkefli et al., 2020). Upon the occurrence of an abnormal finding or birth, midwives consult with specialist colleagues and, where appropriate, transfer their client's maternity care until the midwife can safely provide care again in the community. Referrals are consulted in partnership with the mother, thus empowering the family's self-efficacy (Renfrew et al., 2014).

Midwives have a distinctive role, and partner with the woman, her family, and healthcare providers. Client or whānau-centred care has led to an adverse relationship between midwives and other medical professionals, especially in hospitals (Epstein & Street, 2011). Midwives' knowledge being challenged by other healthcare providers within hospital settings decreases midwives' job autonomy (Hyde & Roche Reid, 2002; Clemons et al., 2021). The consensus for more inclusive care has only recently been agreed upon however, different medical perspectives make it difficult to sustain due to the high volume of patients that may enter a hospital, making

efficiency central (Epstein & Street, 2011). A study by Skinner and Foureur (2010), based on the collaboration and referral process between NZ midwives and obstetricians showed that 72% of midwives felt obstetricians aided them to re-establish care. When professionally recognised and supported, midwives can still give continuity of care to women who experience abnormal childbirth.

It has been challenging to integrate midwifery into health services globally due to conflicting national responsibilities of maternity care (Renfrew et al., 2014; Mattison et al., 2020). The evolving profession has an integrative framework which is also heuristic and is advised by Mattison et al. (2020) to enhance women's sexual and reproductive health and access to safe care. There is a global shortage of midwives (Homer et al., 2014). Countries with widespread political and health challenges will generally have a small midwifery workforce, and midwives will not be as well represented or heard. Barriers restrict the number of licensed midwives available in these health systems, where they may be perceived as inconsequential (Mattison et al., 2020). In a report exploring midwifery in 73% of the world's low-medium-income countries, ten Hoope-Bender et al. (2014) identified that 92% of maternal deaths and stillbirths occur in these countries. In addition, it was shown that 42% of global midwifery and medical staff are available in these countries. Midwifery care is a priority for reproductive, maternal and new-born health, and support is urgently needed for childbearing women and new-borns. Midwifery interventions could prevent most deaths related to pregnancy and stillbirths (Homer et al., 2014; ten Hoope-Bender et al., 2014). Midwifery care has the largest impact when working in an operative healthcare system with successful referral and transfer services to specialised care (Homer et al., 2014). In addition, the COVID-19 pandemic has affected midwifery care worldwide. The ICM has reported concerns about human rights being violated due to increased caesarean sections, not promoting breastfeeding and mothers being separated from their families and new-borns (Vivilaki & Asimaki 2020).

The populations of women and children receiving midwives' services need special assistance during pandemics due to the risk of physical and psychological harm (Hays & Prepas, 2015). Therefore, other health professionals are more inclined to intervene with medicalised strategies to gain control over the childbirth process. Midwifery must be safeguarded during such crises to protect the midwives' philosophy toward physiological childbirth (Vivilaki & Asimaki, 2020; Hays & Prepas, 2015). Findings from a scoping review focused on international guidance for midwifery during COVID-19, discovered that midwives needed to constantly grapple with changes and disruptions to maternity care (Crowther et al., 2021). Sudden changes to practice due to COVID-19 meant midwives had to adapt to innovative practices quickly. Yet, midwives responded to the pandemic with a commitment to continue providing care. Although the NZ government provided a grant to fund physicians and pharmacists during this time, the increase in workload for midwives was not recognised until the first nationwide lockdown in March 2020. Recognition only came after the government was pressured by the New Zealand College of Midwives and its members (Jones, 2020; Gilbertson & Sarty, 2020). Crowther et al. (2021) contend that NZ midwifery continued to provide service without interruption during COVID-19 because the profession is steeped in service underpinned by a philosophy of building and maintaining relationships.

On an international scale, midwives commonly report stress in shift work. An Australian study that surveyed hospitals employed midwives Mollart et al. (2013), found that almost two-thirds of participating midwives experienced emotional fatigue and one-third experienced burnout. A similar Croatian study by Knezevic et al. (2011) discovered that over two thirds of participant midwives reported stress due to physical, mental, and social demands at work. The stressors lead to long-term consequences for the workers' health and decreased quality of patient care. Work overload, lack of time, poor organisational management, substandard relationships, and

poor working conditions and facilities are sources of stress for clinical midwives and nurses (Wheeler & Riding, 1994; Yoshida & Sandall, 2013).

Autonomy is crucial for midwives to achieve satisfaction in the profession and is a critical attribute that sustains midwives in the field (Bloxsome, 2019). This refers to the capacity to make decisions and assessments within their scope of care (Mharapara et al., 2022). Midwives' experiences of being with women by building a connection during childbirth (where the women were unknown to the midwives) showed that self-awareness and adaptability enhanced the relationship with mothers (Bradfield et al., 2019). The importance of professional autonomy for midwives is evidenced because when it is constrained, especially prevalent for those working in hospital settings, they are restricted from using their full skillset (Clemons et al., 2021; Gaskin, 2010; Nedvědová et al., 2017).

2.3.1 New Zealand work context

The foundational philosophy of autonomous midwifery in New Zealand has been based on working within a 'partnership model' of care (Freeman et al, 2004, Gilkison et al., 2016). This partnership framework comprises two partners (birthing person and midwife) who build an important relationship based on power sharing, equality, and trust. Every birth is unique; therefore, each partnership will differ (Pairman & McAra-Couper, 2014). The Partnership Model developed for midwives aligns well with the concepts of whānau-centred and patient-centred care where carers consider the people in front of them, individualising their care as they learn the specific care needs of their clients/patients (Health Navigator NZ, 2022). These approaches are more meaningful to the health consumer, and provide a more nuanced, equitable, and accessible health service.

The Midwifery Council of New Zealand regulates midwives' scope of practice and competencies Midwifery Council of NZ (2010), where the midwife's scope starts at first contact in in-

pregnancy and ends at six weeks after the pregnancy is complete. Midwives are scoped to collaborate with other specialist healthcare providers when the mother or infant requires additional healthcare treatments or services (Pairman et al., 2023). Autonomous midwifery practice has been available in New Zealand for over 30 years, uniquely regulated separate from nursing by the NZ Midwifery Council (NZNO, 2011). This is protected through its scope of practice under the Health Practitioners Competence Assurance Act (2003). Autonomous midwifery practice, while agreed upon in principle through the International Confederation of midwives and growing in strength internationally, is still embedded through regulation alongside nursing.

Midwives' childbirth practice centred on the New Zealand midwifery model makes them maternity services experts (Pairman et al., 2023). In New Zealand, midwives are scoped to practice in different environments, including private homes, the community, hospitals, and birthing centres. Hospital-based midwives are colloquially called ‘core midwives’. Core midwives work alongside Lead Maternity Carers (LMC) and other specialist health practitioners to facilitate safe, woman-centred, evidence-based midwifery care. LMC midwives are self-employed, fully government-funded, and work in the community with a self-regulated caseload of clients. Midwives are scoped to facilitate maternity care, regardless of their work settings (Gilkison et al., 2017).

Until recently, NZ core or hospital midwives were employed by one of twenty District Health Boards (DHB). The midwives employed by DHBs provide woman-centred, relational midwifery care for clients admitted for hospital-level care during childbirth (Ministry of Health, 2022). Core midwives working in primary (midwife-led) or secondary (obstetric-led) hospital facilities are rostered for either eight or twelve hours shifts. These shifts are either morning, afternoon, or night shifts, to provide a continuous, funded midwifery service to

families (Pairman et al., 2023). Globally, most midwives work within hospitals or facilities (Edmonds, et al., 2020). There is a scarcity of countries that have introduced the continuity of care model of midwifery (Alba et al., 2019). Therefore, this study represents NZ's core midwives and international facility-based midwives.

Although midwifery in NZ has achieved significant advances in the profession, it faces challenges stemming from professional status and recognition. The profession suffers from an erosion of its relational skill set because of the commodification of birth through the global increase in birth technologies, introduced under the guise of risk management within hegemonic medical-dominated health service paradigms (Pairman et al., 2023). This imbalance in technology-driven, hospital-level care is demonstrated by the fact that the largest proportion of midwives in New Zealand is based in the hospital (47.8%), working alongside medical specialists. In comparison, community-based Lead Maternity Carer midwives represent only 39.2% of the workforce (Midwifery Council, 2021). Thus, more research focusing on the experiences of NZ's core midwives is warranted to inform the profession, consumers, employers, and policy-makers.

2.4 Scoping Review

2.4.1 Introduction

I conducted a scoping review to collate and synthesise the literature on meaningful work in the midwifery profession. Additionally, a scoping study helps identify gaps in existing knowledge. In conducting the scoping review, I followed the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA), (Tricco et al., 2018).

2.4.2 Search strategy

I developed my search strategy in conjunction with a librarian at Auckland University of Technology (AUT) who has expertise in health research. I searched three databases: Business Source Complete, Scopus, and CINAHL. The search terms, midwife* or midwif* and meaning* or meaningful* as per the table below. The search strategy applied filters that were necessary to gauge the appropriate data. Please see the search strategy for each database in the chart below. Slight variants are applied due to limitations in each database. All articles were run through Ulrichweb to confirm that they were peer-reviewed for quality purposes. After the searches were completed, all articles were downloaded to the Endnote X9 reference manager, where duplicates were removed. All abstracts were read prior to applying inclusion/exclusion criteria. Any articles that did not meet the inclusion criteria based on the abstract were excluded. Included articles were read and examined (see figure 3).

Database	• **Search term**	• **Filter**	**Number of results**
Business Source Complete	Midwif* and Meaningful* or Meaningful work	AB Abstract or Author supplied TXT ALL TEXT 2001–2021	• 19
• Scopus	Midwif* and Meaningful* or Meaningful work	2001–2021	• 29
CINAHL	Midwif* and Meaningful* or Meaningful work	AB Abstract 2001–2021	105

Table 1 Search Terms

2.4.3 Inclusion/Exclusion criteria

Articles were relevant if they were based on midwives and related to meaningful work experiences or meaning at work. Articles could be based on any stage of the midwives' career, from students to retired. All articles were published between 2001–2021. Figure 1 below shows the search results, following the PRISMA guideline chart.

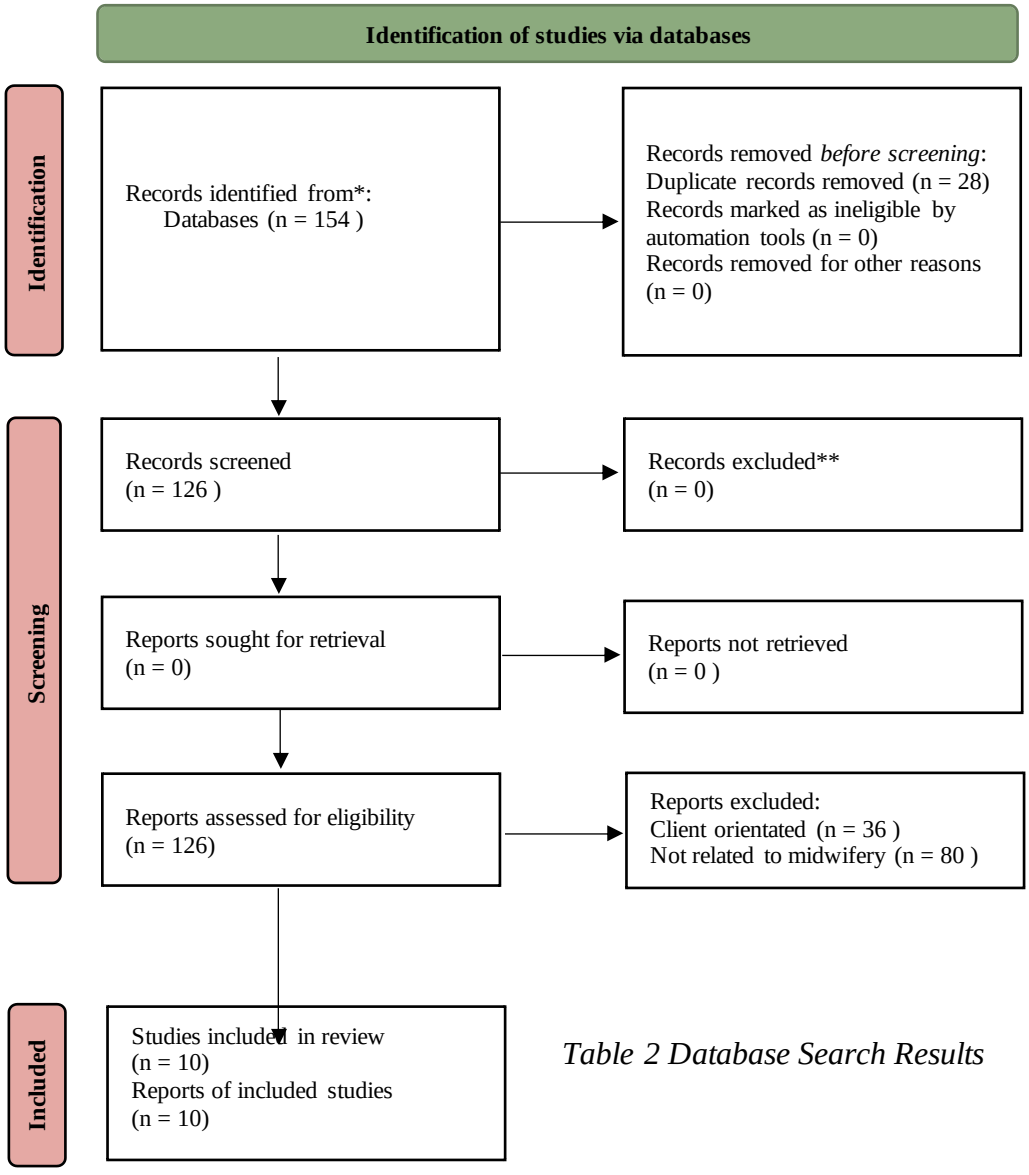


Table 2 Database Search Results

Reference	Research question or hypotheses	Findings
(Aune et al., 2011).	ational continuity as a model of care in practical midwifery studies." The basis of the study is to analyse how relational continuity of care can expand student midwives understanding of midwifery particularly, in terms of promoting normal pregnancy, and to enhance holistic relationships that benefit both midwife and mother.	nts will benefit from rational continuity as a part of midwifery studies, to enhance meaningful practice and to boost holistic care. Three main themes that emerged from the research were: rational continuity, personal development, & health promoting perspective.
(Aune & Lilleengen, 2013).	e visits by student midwives in the early postnatal period - a qualitative study of students' reflections." The aim of the study was to focus on students' experience with follow-up care a few days after childbirth.	emes emerged from the data from student midwives: Experience of meaningfulness & development of midwife identity.
(Baldacchino, 2010).	g in Lourdes: an innovation in students' clinical placement." Holistic care shifts from medicalised care toward spiritual care interacting, with the client and their environment. When a person is in tune spiritually with their self, it may help them strive for meaning and purpose in their life. Drawing from this epistemology, this study analyses student's learning and experience from practicing spiritual care in midwifery.	dent midwives and nurses provide 'spiritual' care for pilgrim's, during a clinical placement toward their studies. Key findings emerged into four themes: 1) teamwork, 2) holistic care, 3) trustful relationships, 4) personal spirituality. The findings suggested that enriching team spirit at work created a feeling of community that produced meaningful work. This can be transferred into medical units, and spiritual growth can be mutually beneficial for clients and healthcare

		professionals. Other findings showed that from creating strong relationships with pilgrims, students were able to reflect more meaning in their life.
(Bradford & Penny, 2016).	"Registered nurse and midwife experiences of using videoconferencing in practice: a qualitative systematic review of qualitative studies." Within nursing/midwifery, innovative drivers such as new technology methods are important to understand, so that personal standards can be considered during new developments.	eo communication may strengthen care within midwifery in a meaningful way, however it also comes with personal/professional limitations for midwives. When videoconferencing is used alongside face-to-face treatment it may strengthen the relationship, however when face-to-face contact is not possible midwives felt that there was less relationship possibility and understanding of the client's body/needs/mental considerations. It was seen as a complement rather than a complete model on its own.
(Crowther & Hall, 2015).	uality and spiritual care in and around childbirth." The aim of the study is to identify spirituality and childbirth's interconnectedness.	birth has proven to be deeply meaningful for those present, including the midwife, which is evident through repeated studies. Midwifery literature possesses reoccurring themes of spirituality and holism. However, spirituality is a unique experience and cannot be generalised. Midwives have identified that they feel meaningfulness through their profession.
(Jepsen et al., 2016).	alitative study of how caseload midwifery is constituted and experienced by Danish midwives."	turn for putting all efforts into caseload midwifery, midwives felt the desire to be appreciated and recognised which resulted in great job satisfaction and a sense of meaningful work. Five major themes that were derived from the data were: 1) having job satisfaction, 2) Working in a personalised profession, 3) creating own

		space/having autonomy, 4) created cohesiveness through knowing. 5) working in a rewarding job.
(Mitchell & Hall, 2007).	ing spirituality to student midwives: a creative approach." The purpose of this paper is to explore and understand student's perspectives from teaching methods that enhance spirituality and holistic care in midwifery and to determine students perspectives around the meaning of birth.	in theme was central to the spirituality around birth. Students stated that they need to understand the spirituality and meaning around childbirth as well as the emotions and feelings toward mothers. This is essential before midwives practice in the field to fulfil expectations of mothers. In addition, students felt that rather than focusing on methods/regulations it should be a vital part of midwifery training to focus on spiritual and meaningful aspects of this profession and what it entails. In addition, students stated that the group session caused a wealth of emotions that they would likely experience during childbirth, and this should be studied as part of training before practicing.
(Nao et al., 2015).	er development expectations and challenges of midwives in Urban Tanzania: a preliminary study." There is a shortage of midwives, particularly in Sub-Saharan Africa which includes Tanzania. Further research is necessary to understand meaningful desires for Tanzanian midwives.	Findings resulted in four main themes: 1) Motivation for learning. 2) Knowledge is power. 3) There is no end to learning. 4) Barriers to access higher education.
(Pace et al., 2021).	ife experiences of providing continuity of carer: A qualitative systematic review." Continuity care models have been recognised as the most effective models of midwifery practice,	wives felt that working in a continuity of carer model was both challenging and fulfilling. Positive aspects were that they are able to create meaningful relationships with mothers and have autonomy in their role. Negative aspects were lack of

	however they can be difficult to sustain. The aim of this study is to understand midwives' response and views of continuity of carer and what sustains this practice.	work/life balance and having conflict with other professionals in their team. Midwives used strategies to sustain being able to work in the continuity of carer model. These strategies were: 1) defining professional boundaries, 2) community of practice, and 3) flexibility and structure.
(Gilkison et al., 2018)	oman's hand and a lion's heart: Skills and attributes for rural midwifery practice in New Zealand and Scotland." This study aims to perceive the skills, qualities and, professionalism needed to work in rural midwifery.	s discovered that 'determination, resilience, and resourcefulness' are necessities of rural midwifery practice. Samples of results were from both Scottish & New Zealand midwives. Developing meaningful relationships with both colleagues and mothers allows rural midwives to sustain the practice.

Table 3 Findings and Inclusion Articles

2.4.5 Discussion/Conclusion

Findings show that researchers are yet to study midwives' perceptions of the meaningfulness or meaninglessness of their work. All the identified studies focused on individual aspects of midwifery: meaningful career development, the innate meaning derived from the spirituality of childbirth, and the sense of purpose and meaning of providing a holistic model of midwifery care in different settings. Themes about meaningful experiences at work emerged from the included studies, identifying how further research will allow for a deeper examination of how midwives perceive meaningfulness at work.

2.5 Meaningful work and nursing literature

The scoping review above identifies that no research has been completed to analyse midwives' meaningful work experience. However, another caring profession to which midwives are often compared, nursing, is an occupation where MW has been studied. This final section of the literature review chapter details a summary of meaningful work and nursing literature, with relevant findings that can be synthesised with this research project. It is important to note that it is not my intention to compare midwifery with nursing but to learn how meaningfulness is experienced in a healthcare profession that has published empirically on this aspect of work. The work design of many nurses and their relationship with medical specialists does align their profession well to the work context of core midwives. Extant literature highlights high demands for shift work within hospitals, leading to work-related stress. In addition, nurses experience high demands from a high client workload, staffing shortages, resource issues, multidisciplinary issues, poor working conditions, and a lack of work-life balance (Lambert & Lambert, 2001).

Pavlish and Hunt (2012) explored meaningful work in nursing by interviewing public and acute nurses. The study aimed to gain insight into nurses' meaningful work experience and how this impacted their working environments. The findings identified three main themes: connections, contributions, and recognition. Nurse participants explained that a learning-focused environment, working with a team, helpful management, and quality time with patients helped increase meaningfulness at work. However, task-orientated work, demanding relationships, and poor management were discovered as barriers to achieving meaningful work. A similar study by de Branganca & Nirmala (2018) aimed to understand nurses' meaningfulness at work compared to how the public views hospital nurses by using the meaning inventory scale (WAMI) and Porter Nursing Image Scale (PNIS). 163 public nurses participated in the study. Findings showed an association between the public view of a nurse and meaningfulness, which can be seen between the interpersonal capability of nurses and the interpersonal relations between a nurse and meaningful work.

Both-Nwabuwe et al. (2020) and Puriso et al. (2021) have recognised that meaningful work is a key theme in organisational-related research in nursing. For example, Puriso et al. (2021) explored professional autonomy in nursing and connected meaningful work to autonomy, explaining that autonomous decision-making and practice lead to enhanced meaningfulness at work. The themes that emerged from the data were: shared leadership, professional skills, professional collaboration, and a healthy work environment. Using the Map of Meaning, Both-Nwabuwe et al. (2020) argued that no theory exists to describe the relationship between autonomy and meaningful work. Thus, a theoretical framework would be necessary to guide healthcare organisations to centre resources as meaningful to achieving autonomy and meaningful work. This research focused on nursing literature, organisational science, and meaningful work. Findings showed that different types of autonomy impact different dimensions of meaningful work from a multidimensional meaningful work model. The model suggests that three forms of

autonomy: 1) professional autonomy, 2) personal autonomy, and 3) group autonomy relate to different dimensions of the MoM.

Similarly, when considering occupational well-being in healthcare, Kilponen et al. (2021) surveyed 1,024 healthcare workers to analyse how job tasks perceived as not necessary, unreasonable, outside of the workers' role, or not legitimate affected workers. Conclusions from the study stated that healthcare workers have diminished well-being and decreased meaningfulness at work from poor job design and illegitimate job tasks.

2.6 Chapter Summary

Meaningful work is not a new venture, and many organisations have considered how meaningful work has influenced the design of workspaces (Lips-Wiersma and Morris, 2018). Meaningful work has been researched from different schools of thought, and other avenues have explored how to capture and enhance meaning at work (Rosso et al. 2010). Lips-Wiersma and Morris (2018) created the Map of Meaning as a framework for understanding meaningful work. As identified in section 2.3, literature has shown that stress and burnout are topical for hospital-employed midwives (Yoshida & Sandall, 2013; Wheeler & Riding 1994; Mollart et al., 2013; Gilkison 2016). However, meaningful work is inherent to achieving purpose and wellness Both-Nwabuwe et al., (2017) and sustains healthcare workers, particularly during the COVID-19 pandemic (Rangachari & Woods, 2020).

Hence, to guide the current study, I advance the following research questions: 1) What aspects of midwifery work do midwives find meaningful or meaningless, and why? 2) Does the MoM effectively capture midwives' experiences of meaningful or meaningless work?

3 Methodology Chapter

3.1 Introduction

The following questions guide my research: 1) What aspects of midwifery work do midwives find meaningful or meaningless, and why? 2) Does the MoM effectively capture midwives' experiences of meaningful or meaningless work? Previously described in section 2.2.4, the (MoM) explores meaning as a multidimensional phenomenon. I will be applying it to midwives' work experiences. Although the MoM helps investigate meaning through experiences, it has not been rigorously applied to health professions. Therefore, I will use the MoM to explore how midwives experience meaning at work and evaluate its utility in midwifery.

The next sections of this chapter provide an overview of the choice of ontology, epistemology, and paradigm I use in this research. The methodology behind the research is then explained and justified. Following this, the data collection process is detailed with information about how participants were recruited and the steps performed before interviewing. Thematic analysis is used to analyse and interpret the data (Braun & Clarke, 2019).

3.2 Theoretical perspective

Ontology

The word "ontology" is an ancient Greek term, originating from "*ontos" (*being) and *"logos"* (word), and refers to the nature of existence (Gaševic et al., 2018). Therefore, it is the analysis of being (Crotty, 1998). It is a fundamental philosophical foundation for research to be consistent with the reputable stance from the quintessence of what is being considered (Gruber, 2018). Realist ontology assumes there is nothing beyond a finite object. Cognitively, all that

there is, is what meets the eye. It describes a non-theistic universe and refers to the basis that there is only one single reality (Morton, 2013). However, a relativist ontology believes that reality is subjective to the individual; therefore, there are multiple realities (Lincoln & Guba, 1989). Relativism claims that nothing exists aside from our thoughts. The role of science through relativism is to understand the truth of reality through human experience, implying that knowledge and reality are interchangeable. This thesis aims to investigate midwives' meaningful and meaningless work experiences. Put differently, midwives' experiences will signal whether they view their work as meaningful or meaningless (Tuli, 2010). Therefore, this thesis has a relativist core since reality is subjective to the individual, and there is objective truth (Hugly & Sayward, 1987).

Epistemology

Epistemology refers to the nature of knowledge (Tuli, 2010). Epistemology defines the nature of the connection between the researcher and the known, what is believed to be considered knowledge and how more claims can be made to constitute further knowledge (Grant & Giddings, 2002). The underlying philosophies in research design are essential, so the author can develop knowledge and understand the nature of this knowledge in the social world. This will impose the important distinctions that affect the method and research processes (Bahari, 2010). Thus, making it essential for this thesis to clearly outline the epistemological foundation for how knowledge will be collected for the reader to comprehend. Three main theories are used when designing research: *subjectivist, constructionist,* and *objectivist* epistemologies (Feast & Melles, 2010). According to Crotty (1998), constructivism dismisses the idea that there is an objective truth to be discovered. However, in constructivism, truth and meaning are constructed with our minds and the universe. In this stance, individuals will construct meaning differently, even if it relates to the same occurrence.

The data gathered for this thesis was through qualitative interviews to attain personal stories and then construct logic from them to answer the research questions. This used a constructivist epistemology to gather knowledge because it follows the presumptions of how we know what we know is incorporated with the theory of knowledge within the constructionist epistemology. This is embedded in the empirical participant observation findings (Feast & Melles, 2010). In this research, each participant's concept of reality is different, based on their relationship with their environment, even though they are working in similar facilities.

The central viewpoint of constructionism is for the researcher to analyse and synthesise the different constructions and meanings based on the participants' experiences (Bahari, 2010). Constructivism is unified with a relativist ontology because both express truths in multiple realities.

Paradigm

Paradigms serve as a framework for the researcher based on ontological and epistemological viewpoints. Since views are based on speculation, the philosophical root of each paradigm cannot be proven or disproven. However, paradigms intrinsically have differing ontological and epistemological foundations creating altering positions on the assumption of reality and knowledge (Scotland, 2012). Paradigms approach the research world with different assumptions toward the social world and what presents appropriate problems, knowledge, and criteria to answer such issues (Bahari, 2010).

It is essential to explain the appropriate paradigm that is at the root of research because it influences how the research is conducted and the world views that the researcher has. It is important to understand if the researcher holds a positivist worldview or an interpretive-constructivist one (Tuli, 2010). The objective of an interpretivist researcher is to understand the world through

subjective human experience, which is usually understood through participants' perspectives, understanding that their background and experiences will affect the research (Mackenzie & Knipe, 2006). The paradigm appropriate for this thesis is interpretivist. This is because the research will explore how midwives experience meaningful work through their experiences. The research questions are answered by deriving knowledge from the multiple realities that differentiate midwives' experiences. Interpretivism is usually applied to interpreting a pattern of meanings through subjective experience from participants' insights (Mackenzie & Knipe, 2006).

3.3 Methodology

According to Tuli (2010), research methodologies were initially concerned with quantitative research and involved observing the natural world to make objective discoveries. However, over the previous decades, researchers have shown a lack of satisfaction with quantitative methodologies to produce knowledge, especially within social sciences. The main argument against this research was that it does not consider the individuals being studied. Therefore scholars began to find different ways of conducting research and finally developed qualitative methodologies to understand the social world, human behaviours, and why they do things in specific ways (Tuli, 2010). As stated, holding a certain ontological position limits your epistemological reasoning. Therefore, methodologies communicate ontology and epistemology as a mode of investigation. "How we know the world or gain knowledge of it." The work of Denzin & Lincoln (Grant & Giddings, 2002, p.13). The research methodology selected for any research depends on the paradigm that conducts the research activity, the ontology, and the epistemology to derive how the knowledge will be gained through the methodology. These

features are central to qualitative research and the nature of social science because they shape the mode of inquiry (Tuli, 2010).

Gray (2021), states that phenomenology is a perspective used when collecting qualitative data. This research mode allows data themes to emerge rather than to answer concrete questions. Participants' actions are usually observed and interpreted in their social environment so that an observer can understand them. Phenomenologist research seeks participants' subjective opinions, relies on qualitative data, and produces contextualised findings (Gray, 2021). In addition, interpretive studies investigate participants' lived experiences and how they interpret them (Gray, 2021). The appropriate research methodology for this study is 'interpretive phenomenological analysis'. This qualitative approach aims to give an analysis of personal experience. Interpretive phenomenological analysis or 'IPA' recounts the lived experience in unique terms rather than in aforementioned terms and understands that this is an interpretative venture because humans are subjective when making sense of reality. It is an efficient methodology with research topics that are complicated, emotional, or ambiguous (Smith & Osborn, 2015; Palinkas et al., 2015).

This is the appropriate methodology for this research because data will be interpreted and analysed subjectively based on the participants' lived experiences and personal interpretations. Midwives will be asked to share unique insights, stories, and experiences based on questions from The Map of Meaning. Phenomenology aims to provide an account of lived experience without pre-describing the terms underpinning the research (Smith & Osborn, 2015).

3.4 Ethical Consideration

Before commencing the research, the research team submitted an ethics application to the Auckland University of Technology Ethics Committee. See appendix A. Essential ethical principles for this thesis were: Participants entered the research voluntarily and could withdraw during any phase of the process. Applicants were not approached; they were required to contact the research team if they were interested in participating. Each participant was given a copy of their transcript to read and review before analysis. This allowed the participant to amend the script or withdraw from the project. Interview transcripts were only used for research purposes, remained confidential to the research team for this project and were destroyed after use. Participants received an information sheet (appendix C) before agreeing to participate in the research. The information sheet detailed the purpose of the research, why the potential participant was appropriate for the research, how to agree to participate, what would happen with the research, and any discomforts or risks. Informed consent (appendix D) was necessary upon agreement with the participant information sheet before proceeding with the research. Participants were treated with respect throughout the research process. The research questions were open-ended, allowing participants to share as much or as little as they felt comfortable with.

3.5 Data Collection

I conducted one-on-one interviews using a structured interview guide to capture midwives' perceptions of meaningful or meaningless work. Participants were recruited through purposeful sampling. The participants work or have expertise in the area of interest and have

the appropriate characteristics to participate in the research. They may be recruited by acquaintances with experience in the common area (Panlinkas et al., 2015). I conducted five qualitative interviews. The main criterion for participants was to be employed as a core midwife in New Zealand. Participants were recruited using an advertising flyer (see Appendix B). My research supervisors have contacts in the midwifery profession, and they promoted the flyer across various midwifery platforms and groups. Interested participants were required to contact the researchers for further information about the project. If a potential participant met the research requirement, they received a participant information sheet and consent form (see Appendices C and D). Once the signed consent form was returned, interviews were held through Zoom due to COVID-19 lockdown restrictions and some participants being located in different New Zealand cities. The research questions, based on The Map of Meaning Lips-Wiersma & Morris, (2018), can be viewed in Appendix E.

After the interviews were conducted and transcribed, thematic analysis was used to investigate the data. Thematic analysis is a pliable and accessible approach to examining data qualitatively. Thematic analysis (TA) organises meaning by themes constructed from an intersection of the data, the research questions, and the researcher's philosophical orientation (Braun & Clarke, 2019). This followed an exploratory data analysis approach because it considered the participants' thoughts and feelings about the topic of interest. Following Braun & Clarke (2019), the six-stage thematic analysis method was applied.

Phase one: *Familiarising yourself with the data*. This phase involved engaging with the data by reading and rereading the transcripts of the interviews. This involved critically and analytically understanding the data and taking notes. Original assumptions from that data are used as grounds for deeper analysis. This phase aimed to understand the data content and selection of relevant ideas intimately.

Phase two: *Generating initial codes*. Codes were organised based on the seven dimensions of the Map of Meaning to synthesise the data. Codes indicated when stories or examples indicated meaningful or meaningless work for the midwives.

Phase three: *Searching for themes*. During this phase, codes were transferred to themes. A theme is a meaningful concept captured from the data and used to answer the research question(s). Similar concepts that emerged from the codes in the previous phase were turned into themes during this phase.

Phase four: *Reviewing potential themes*. In this phase, themes were reviewed for alignment with the initial codes and data set. Everything was checked for quality, and themes were selected, and the data set was reread to ensure that themes accurately portrayed a midwife's experiences.

Phase five: *Defining and naming themes*. In this phase, finalised themes were analysed to set up the stories retrieved from the data and answer the research questions. Direct quotes from the data sets were selected to represent themes that analytically demonstrated the story the themes were trying to portray.

Phase six: *Producing the report*. During the final stage, themes were logically presented to tell a story about the data, as seen in the next chapter.

3.6 Chapter Summary

This chapter provided the research design used to conduct this thesis and successfully answer the research questions. The philosophical perspectives: 'ontology' and 'epistemology' were discussed, which is essential for the reader to understand the core of the research and the author's positioning. Relativism and constructivism were justified, and interpretivism was the

appropriate research paradigm. ‘Interpretive phenomenological analysis’ was discussed as the methodology used for this thesis.

The data collection process was explained to recruit participants. Thematic analysis was the process used to interpret the data to successfully answer the research questions using a rigorous and flexible qualitative approach and to tell a story through the data sets. The findings can be viewed in the next section of this thesis.

4 Results Chapter

4.1 Introduction

This chapter narrates the results from the qualitative interviews using the thematic analysis reflective framework (Braun & Clarke, 2019). Three themes emerged from the data to answer the research questions: 1) What aspects of midwifery work do midwives find meaningful or meaningless, and why? 2) Does the MoM effectively capture midwives' experiences of meaningful or meaningless work?

The three themes that transpired from the data are 1) Differing Philosophies, 2) Workload and Staff Shortage, and 3) Connection with Others. Relevant subthemes emerged from these themes and are revealed in the table below. The chart below briefly defines each theme and introduces the subthemes, while figure 5 shows a thematic map. The map visualises a diagram of how each subtheme connects and provides an imagery example of how themes interlink. The following sections of chapter 4 detail each theme and subtheme, using quotes from the five participants' interviews. Participants are named as numbers (1–5) to protect the identity of individual midwives.

Participants	Profile
Participant 1-	Employment: Private facility. NZ European
Participant 2-	Employment: Public hospital NZ Maori
Participant 3-	mployment: Public birth centre Ethnicity unknown
Participant 4-	Employment: Public hospital

	Swedish
Participant 5-	Employment: Public hospital NZ European
Theme and definition:	**Subtheme;**
Differing philosophies: Meaningfulness impacted at work from differing philosophies expressed by multidisciplinary teams	Policies and procedures 2) Autonomy
Workload and staff shortage: Staff shortages create an increase in workload, vastly impacting MW	Sustainability and retention 2) Fatigue
Connection with others: Connection with women, families and other midwives enhance or prohibit meaningfulness at work;	Connection with other midwives Connection with women and families

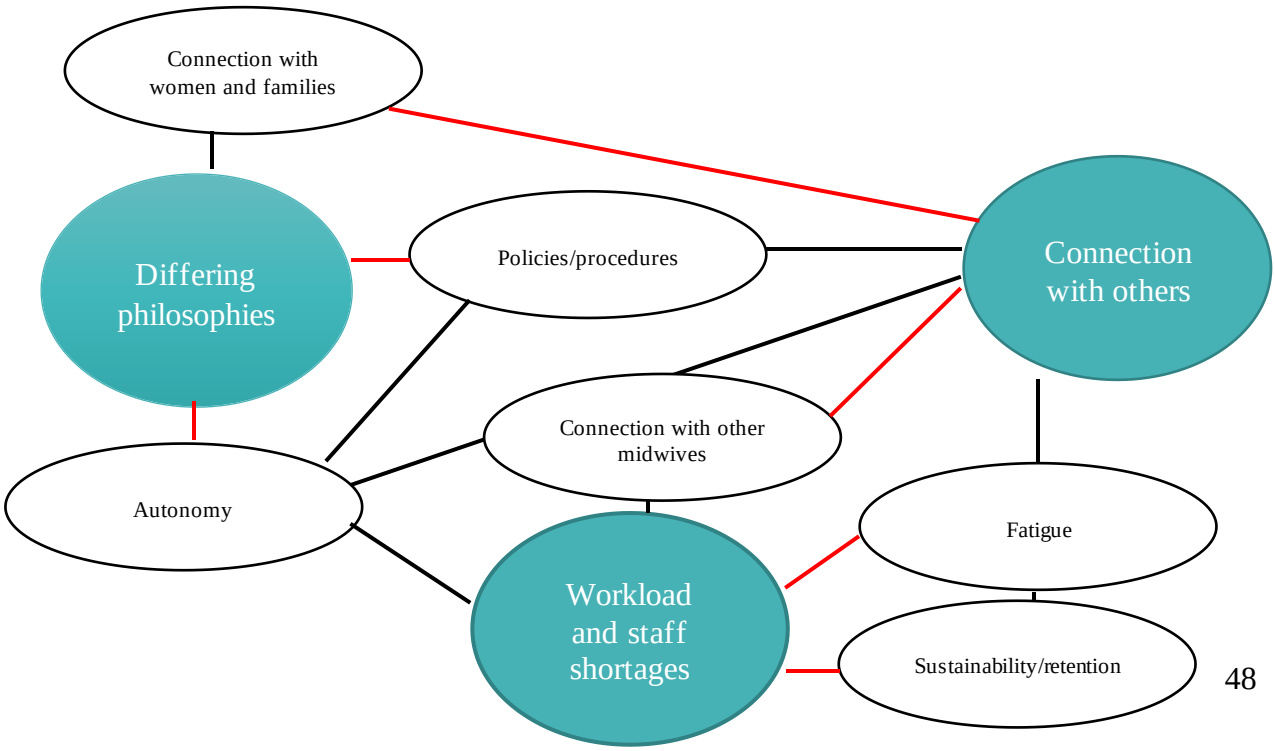
Table 4 Participant Profiles

***Key**:*

Each black and white oval is the subtheme. The turquoise ovals are the main themes.

The redline shows the connection between the subthems to the main theme.

The black lines conntects the separate themes the subthemes to each other.



3 p

Figure 2 Thematic Map

4.2 Theme one: Differing Philosophies

The first theme uncovered is the negative impact of differing philosophies amongst midwives, colleagues from multidisciplinary teams and their managers. All five participants shared stories about working in an integrated system with colleagues with different practice philosophies. Participants explained that their differing philosophies on what they were meant to do as healthcare professionals compared to what they were expected to do by multidisciplinary teams/managers led to the feeling that they were not utilising their skills as midwives. This can be seen in the examples below.

Participant 1: "Well, at the moment, we do have a new owner at work, and she's very keen to make the service we provide more like a hotel, I'd say, so we're serving meals, having to heat and cook meals, and making sure that the trays are beautiful and all… Yeah, that's when I feel like I'm not using my skills."

Participant 5: "Sadly, working in a big DHB like I was, it felt as though, rather than midwives working in partnership with obstetricians providing the care it felt that midwives were working within an obstetric-led service, and that's not a good situation…I think it's really not just how the midwife perceives her position within the place but how midwives are perceived within the place and how they're valued. If just that one thing was different then that can have a huge impact on all of this; how the midwife feels about herself, her integrity, how she works with others, how she's inspired, if she's reaching her full potential, and how she provides service to others. And it seems small but it's huge, its huge and I think that sits really central."

Conversely, if midwives worked cohesively with other healthcare providers, midwives felt a positive affiliation with work, as seen in the examples from participants below.

Participant 3: "When we are say transferring a woman from our birth centre to the hospital and then you just have to communicate with either the ACCM [midwife manager] or the registrar, and sometimes those interactions can feel really negative and you can feel like everything you've done is being questioned when you know you've provided really good, appropriate care and you just are seeking support, and sometimes that support's not forthcoming… Then on the flipside when you make a call and you're commended on everything you've done, it feels a lot more seamless; it feels great, you feel like — Cool, I'm being recognised as a good midwife that's busy but doing her thing as appropriately as she should."

Participant 5: "The DHB did an equity engagement project where they consulted with women who have used the service, with practitioners, midwives, obstetricians, to talk about equity and their parts in ensuring that was always central… …I felt very driven to be part of that because it was hope that the truth was going to come out and we were going to be able to make things better."

4.2.1 Policies/ procedures

Policies/procedures were central to participants' struggles with differing philosophies within their practice. The two examples below indicate how the policies and procedures within their workplace did not fully align with their philosophy as midwives.

Participant 2: "My skills don't lie in ticking boxes that people upstairs want me to tick, so then I end up feeling like my full potential's not being realised."

Participant 4: "We've got policies that we have to keep feeding the baby every three hours, especially now with the new growth percentile thing, we have a huge number of babies that are less than 10 percentile as per that growth chart, and although it's customised but they end up then staying for 72 hours on three-hourly feeds, and topping up, and I think it's exhausting for the babies and

it's exhausting for mothers… and with my midwifery experience I do not agree but I have to do so because of the policies."

4.2.2 Autonomy

Midwives also felt uninspired and frustrated when they could not practice autonomously because of policies and procedures set by the clinical facilities that employed them. Participants also highlighted that they often felt that the interactions between multidisciplinary teams and/or managers would restrict their autonomy, damaging a midwife's ability to express their full potential and negatively impacting personal integrity.

As seen above, participant 2 states that their philosophical difference with non-midwifery colleagues curbs their autonomy:

Participant 5: "Our philosophy as midwives is often quite different to a large maternity unit…sometimes within a DHB, within a place it can be quite difficult to exercise your autonomy, even though we are autonomous practitioners because there are so many tensions that influence that… It can be difficult for midwives when they're questioning whether the induction needs to be done when they know it isn't really clinically indicated but they're told to do it. So that's really difficult because they're not able to use their autonomy, but also their voice isn't also being respected by the obstetrician."

Participant 4: "Well, what's my role here? So I try and support her, this distressed person, and my philosophy is to support a woman with her own decisions, but I can't. I'm just a core midwife and I can't work with her together, basically, because I've been told not to."

The above quote explains how the participant has completely lost her autonomy, being unable to practice using her philosophy effectively due to being constrained by differing policies and procedures toward maternity care.

4.3 Theme Two: Workload and Staff Shortage

The second theme that emerged from the data is Workload and Staff Shortages. Findings suggested that a high workload negatively impacted meaningfulness at work due to staff shortages for core midwives. Participants expressed being unable to provide the care they were educated and prepared for due to the high demands of their current workload.

Participant 3: "I do feel a spiritual connection to midwifery; I feel like this is where I'm supposed to be, but it probably just all relates to that sense of wanting to do more but getting restricted from doing more because of acuity, because of the number of women I'm trying to provide good care to."

Participant 2: "Every day we've got too much work to do and not enough time. So all those things that take a bit more time get brushed under the thing and we become like a conveyor belt, and that's really hard for women and for midwives."

Midwives' lack of time to look after themselves during shiftwork led to burnout. However, when midwives felt that their workload was manageable, they felt an increased sense of satisfaction. This is explained in the example below.

Participant 4: "You have those lovely quieter shifts, and those are awesome and you feel like you've provided good care and you're not run ragged. Yeah, that's a really lovely fulfilling, satisfying experience, but almost because we're used to being so busy there's also this kind of crazy sense of feeling like you might be, I don't know, slacking off or something."

4.3.1 Sustainability and retention

A second subtheme central to workload and staff shortages is sustainability and retention. Participants spoke about how the harmful effects of workload and staff shortages have made midwives' workloads unsustainable, thereby creating retention problems. The examples below show participants addressing these problems.

Participant 4: "I truly hope from the bottom of my heart they look into the model as well — how sustainable is it because really and truly it's quite a mess, to be honest; it makes things so much messier, …So hopefully they will find a balance that would include the continuity, but also make sure that midwives get their time off and are not so overworked."

Participant 5: "… I think that things were so busy and fraught…we were so challenged with issues with recruitment and retention which I think a lots of DHBs are… there just wasn't enough time to just focus on doing your job. …. So it was incredibly difficult; there were so many staff vacancies…there might be no staff in one area, very few staff and you've got to just go with that and then cancel what you're doing. But then you feel accountable for those things that you're supposed to be doing but you can't because the needs are greater…The alerts came out if an area got to a point where safety was potentially compromised and they often came…In an ideal world you'd have enough midwives and nurses in order to take great care of the women that are using the service, and the people that weren't doing a clinical role wouldn't be needing to do that but unfortunately that's not the case."

4.3.2 Fatigue

A second subtheme uncovered under the workload and staff shortage theme was fatigue. Fatigue was identified as a consequence of having high workload and limited staff. Midwives reported not having time to address basic physiological needs such as eating, drinking and toileting. This is expressed by the following sentiments.

Participant 1: "I go to work and I'm concerned about what my workload is going to be. I mean, we have eight women and two birthing rooms and you're expected to run that on one person for 12 hours. So yeah, it gets very exhausting. Yeah, so I think I'm worn out…I get to about 5 o'clock and I think – Have I been to the toilet yet today? I mean, I know a lot of the girls miss

their meal breaks, you just don't get time; you're just constantly working for 12 hours at times and you forget to drink and eat..."

Participant 2: "What you need to do is, when this happens you need to fill in an incident form and all this sort of stuff. It's like the staff are exhausted. Like if I haven't had a chance to wee after 12 hours, the last thing I want to do is sit down and do an incident form, which will go nowhere. I've been a midwife for 17 years; I've filled out hundreds of incident forms and I've never had a reply to one that's about staffing levels..."

4.4 Theme three: Connection With Others

The final theme from the data is connection with others. Midwives repeatedly expressed examples of this theme during all five interviews, where connection with other midwives, mothers and family was a positive and purposeful experience.

Participant 3: "I constantly feel inspired by our work, and you just connect with families and it's such a beautiful feeling and I feel like — Oh cool, this is where I'm supposed to be and I'm doing a good job."

Participant 5: "We were not only doing the right thing for women which of course we do as midwives, but we were doing the right thing for each other as well in order to keep the women and the babies and midwives safe…I think that we're providing not just service to the women and the babies but service to each other."

4.4.1 Connection with other midwives

The first subtheme from connection with others is connection with other midwives. This subtheme relates strongly to the 'dimension unity with others' from the MoM. Participants felt support

from working with other midwives that helped them deal with the negative work factors of their profession.

Participant 2: "I think we've got a really good sense of unity. I think probably because it's such a challenging place to work we kind of all band together. I feel like people have got my back…There have been times, and certainly it's got worse during Covid, where that's the only thing that's given me meaning there."

Participant 5: "We needed to rely on each other to step in and out of different places, and when someone called for help they hoped that somebody was going to come, and I think in a lot of ways that sense of unity sat very central to that."

Participant 3: "Yeah, well our main interaction really is just handover, because as I said, it's just the one of us; we work with household staff, so sometimes we get that sense of… definitely get that sense of being part of a team and collaborating and planning care for a woman and her family, so that's really rewarding."

"Yeah, absolutely. I think when we're engaging with our LMC colleagues and coming up with appropriate plans for the care of the women and whatnot, yeah, it's really fulfilling and you definitely get that sense of providing meaningful care which is… well, it keeps you coming back."

Participant 4: "I think those busy shifts bring that unity really strongly and it's a wonderful team that I'm working in, and it's probably the only reason I'm still working."

4.4.2 Connection with women/family members

The second subtheme from connection with others is connection with women and family members. Participants felt a great sense of purpose from working with and connecting with mothers and their family. This strongly related to 'service to others' from the MoM. The quotes below show examples of midwives experiencing connection with women and family members.

Participant 4: "Well, all the time, all the time helping mothers and families and yeah, that gives me the satisfaction, yeah. Just helping; helping with everything, yeah."

Participant 5: "I had a really big sense of satisfaction coming out of that, knowing that we'd had not just a safe outcome for the baby; he went onto have surgery and did really well, but a safe outcome for the woman's experience which is also extremely important…I think as midwives that the whole ethos in providing service to women and babies, and we're absolutely there for them, working in partnership with them. I just think that's why we get up in the morning and go."

4.5 Chapter Summary

The findings chapter presented the three main themes from the data where midwives experience increased or decreased MW in their workplace. The first theme, Differing Philosophies, detailed participants' experiences with other multidisciplinary teams' conflicting philosophies, which impacted their MW experience. Two subthemes branched from this are 'Workplace Barriers' and 'Autonomy'. Workload and Staff Shortages were the second themes that emerged from the data. Sustainability, Retention, and Fatigue are subthemes from this second theme. These organisational factors are the implications of the pressures of a high workload and staff shortages that midwives face, affecting their MW. The final theme is Connection With Others. Participants illustrated the impact of connection with others and how this increased their MW. Two subthemes from this are connection with other midwives and connection with women and family.

5 Discussion Chapter

5.1 Chapter Introduction

This chapter responds to the research questions: 1) What aspects of midwifery work do midwives find meaningful or meaningless, and why? 2) Does the MoM effectively capture midwives' experiences of meaningful or meaningless work? The discussion chapter is split into three sections. First, the themes: Differing Philosophies, Workload and Staff Shortages, and Connection With Others are interpreted. Second, the MoM is applied to the midwifery profession to evaluate whether it adequately explains MW in midwifery work. Lastly, the limitations of the research are detailed.

5.2 Differing Philosophies:

Participants explained that they held a differing philosophy of practice compared to their managers and other members of multidisciplinary health teams. As result, midwives expressed negative sentiments about how they carried out their roles. This relates to the dimnsions: Expressing Full Potential, Unity with Others, Integrity with Self and Inspiration. Meaningfulness from expressing full potential refers to bringing unique talents into the workplace (Lips-Wiersma & Morris, 2018). Core midwives perceived that their care philosophy differed from the job's expectations. Consequently, they felt undervalued for what they offered. The subthemes of expressing full potential are creating, achieving, and influencing. When individuals have room for creativity at work, they feel a sense of freedo m of expression that adds to the larger picture (Lips-Wiersma & Morris, 2018). Participants did not express having any chance for creativity. Instead, they felt that their decision-making authority was undermined and undervalued. Additionally, they did not express a strong sense

of achievement as they often worked below their expectations based on their misaligned professional philosophy.

The last subtheme of expressing full potential is influencing. Influencing includes offering direction in the workplace and improving conditions (Lips-Wiersma & Morris, 2018). Although midwives felt undervalued for their expertise, participants shared positive affirmations about working in multidisciplinary teams. Midwives' also expressed feelings of hope and motivation in their work. Inspiration ties in closely with this subtheme. However, inspiration relates to hope for the future (Lips-Wiersma & Morris, 2018). Participants described a sense of hope in the scenarios where they could voice their opinions to multidisciplinary teams to create a difference in their workspace. The midwives' 2010 scope of practice states that ""The midwife works in partnership with women, on their own professional responsibility, to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn" (Midwifery Council, 2010). This gives them authority in the maternity service. Unsurprisingly, midwives experience a lack of MW when their autonomy and influence is stifled.

The Partnership Model developed for midwives aligns well with whānau-centred and patient-centred care concepts (Health Navigator, 2022). Carers consider the people in front of them, individualising their care as they learn the specific care needs of their clients/patients. These approaches are more meaningful to the health consumer and provide a more nuanced, equitable, and accessible health service. However, health consumers in an overloaded setting can create cognitive stress and make hospitalised care, which is the opposite of patient-centred (Epstein & Street, 2011). Midwives expressed that they could not provide care in partnership with their patients. Instead, they spent time doing other tasks, such as providing hospitality services for women and following medical procedures.

5.2.1 Policies and procedures

The first subtheme from differing philosophies is policies and procedures. Participants expressed that they often felt barriers within their workspace because they were expected to adhere to specific standards set by hospital managers. Most women have higher satisfaction in childbirth with a midwifery-led model (Dawson et al., 2021).

It is unsurprising that when policies and procedures are written in the medical model Davis-Floyd, (2001), and referred to by managers and multidisciplinary teams, midwives experience lower integrity with self. Organisational circumstances may prohibit workers from being true to themselves (Lips-Wiersma & Morris, 2018). Currently, in UK, midwifery services have regulations that encourage normal birth and risk management. From an organisational perspective, this social model is slow (Bryers & Van Teijlingen, 2010). Although midwives practice autonomously and guidelines are used to minimise risk and support safe practice, midwives expressed that this sometimes overrides their autonomy as practitioners. Some organisationally-focused models inhibit midwives' authority and interferes with their practice. In particular, participants expressed a divide between managers and their roles. Vivilaki & Asimaki (2020) contend that clinical guidelines should be rooted in midwifery philosophy such that policies and procedures are truly multidisciplinary. This is similar to how nurses experience reduced MW due to feeling micromanaged (Pavlish & Hunt, 2012).

5.2.2 Autonomy:

The relationship between midwives and obstetricians is essential in maternity services within hospitals. However, their relationship is complex as both are autonomous practitioners in maternity care. It is necessary that each profession respects and values each other's expertise to avoid conflict (Renfrew et al., 2014). Yet, from the interviews, midwives felt stifled by the

obstetric service. Job autonomy is hindered when other members of multidisciplinary teams unnecessarily question midwifery decisions (Clemons et al., 2021). When decision-making authority is questioned, meaningfulness can be affected. Puriso (2021) found that nurses must be involved in decision-making and shared goals in the workplace to have autonomy and experience MW. Managers may use a 'bottom-up' approach to support autonomy by allowing workers to restructure their roles to create or increase MW (Lepisto & Pratt, 2017). However, for this to be possible, managers must ask for and act on employees' feedback to give staff an influential voice towards increasing autonomy.

5.3 Workload and Staff Shortages:

The second theme extracted from the data was Workload and Staff shortages. Participants indicated that MW was inhibited due to demanding workloads and staff shortages. This is unsurprising, considering job factors such as burnout, stress, and workload often lead to midwives redeploying into a new profession (Nedvědová, D., Dušová & Jarošová, 2017). Pavlish & Hunt (2012) found that a key condition for MW in a hospital environment was having enough time with each patient. Midwives expressed that they cannot give enough time to each person due to workload pressures. Acuity was a recurring word during the interviews. Acuity means the clients were often unwell and needed close care and documentation (New Zealand Nurses Organisation, 2014). During quieter shifts, midwives described a sense of relief. However, these shifts were rare, especially after the COVID-19 pandemic. There must be a sense of balance at work for it to be meaningful (Chalosky, 2003). The lack of balance between workload and staff is drawn from the two tensions from the MoM, Doing and Being and Self and Others (Lips-Wiersma & Morris, 2018). The lack of balance from the tensions affects all of the other five dimensions of the map. The lack of balance between these tensions lies at the

core of meaning because they filter through all the core dimensions. This seems a sufficient reason why this theme was a strong and recurring topic that all five participants mentioned during the interviews.

5.3.1 Sustainability & Retention

Growth, balance, and well-being are essential to achieve MW. Thus, work-life balance supported by leadership is critical (Chalosky, 2003). The lack of balance for midwives in the workplace has led to retention challenges. A high workload combined with a lack of support from healthcare managers leads to a high job turnover (Nedvědová et al., 2017). Bloxsome et al. (2019) found that midwives stay in their roles even during adverse working conditions due to job satisfaction. It is difficult to understand the limit to which subjective experience may result in leaving a workplace or what may make them stay in a role due to the fulfilment of other dimensions. This is an example of where it is hard to capture MW from a framework (Chalofsky, 2003). However, midwives perceived that the cause for their high workload was due to staff shortages. Participants expressed that issues around sustainability in the workforce and retention meant that there are not enough midwives in facilities, leading to higher work pressures and demands and less work-life balance. This results from the tensions between 'Doing and Being' and 'Self and Other' (Lips-Wiersma & Morris, 2018).

5.3.2 Fatigue

Unsustainable work leads to fatigue, which is linked to retention and sustainability challenges. This is a common issue for midwives, who often show symptoms of fatigue from the demanding pressures of the occupation (Nedvědová, et al., 2017). Midwives are exposed to several

stressful situations, which decreases their ability to manage their workload while looking after their physical and mental health (Knezevic et al., 2011). As expressed by Knezevic et al. (2011) the leading cause of stress for Croatian hospital-based midwives is a lack of staff, resulting in fatigue. Similarly, a study by Lambert and Lambert (2001) identified that stress and fatigue for nurses is mainly due to limited autonomy, job pressures, issues with other physicians, and hostile workplace relationships. In the current study, fatigue is also linked to trying to balance tensions. Meaning is absent when self vs others or being vs doing is lost because one overtakes the other (Lips-Wiersma & Morris, 2018). Participants expressed that they did not have time for themselves due to the high work demands. Limited time to look after their needs (e.g. meals and bathroom breaks) resulted in fatigue. There is a clear link between job stressors and fatigue and reduced job satisfaction among midwives and nurses (Wheeler & Riding, 1994). Job satisfaction is hindered when midwives experience fatigue, which can lead to prolonged health issues (Nedvědová et al., 2017).

5.4 Connection With Others:

The final theme identified is connection with others. Participants provided many examples of connection with others when discussing experiences at work. The dimensions 'Unity with Others' and 'Service to Others' were key from the MoM. These were centred around the theme 'Connection With Others'. These two dimensions create tension on the map's side of 'Other'. Midwives described that connection with other families and midwives was a positive and purposeful experience. This was similar to the findings by Watson et al., (1999), where 80% of midwives were satisfied with their jobs and found the interaction with women and their families as the most purposeful experience in their role. The article concluded that although midwives experienced high satisfaction, they also experienced a lack of autonomy as

practitioners, suggesting that the relationships were more impactful than their job autonomy. This finding links to the subtheme autonomy (see 5.2.2). The midwives' lack of autonomy in this study decreased their meaningfulness at work. However, participants described feeling stimulated in their work from connecting with families. An interesting note is that although midwives described their connection with mothers, families, and other midwives as being a positive and purposeful experience, using words such as 'beautiful' and 'safety' when sharing their stories, it is difficult to understand if these attributes describe 'meaningfulness.'

Literature confirms that midwives must experience a sense of connection in their role to experience satisfaction (Bloxsome et al., 2019; Watson et al.,1999; Pace et al., 2001). This is not exclusive to midwives. Explained by Bailey and Lips-Wiersma et al. (2019), employees experience a great sense of meaningfulness from interconnecting with individuals around them in complex work environments. However, participants said that connection with childbearing mothers sustains them in their role. In addition, working with other midwives creates a sense of unity. A sense of camaraderie and community between employees can make daily tasks more meaningful. This is when meaningfulness goes beyond 'self' and is based on other interactions (Bailey, 2019; Lips-Wiersma et al., 2019). The theme, 'Connection', has been split into two subthemes. Connection with other midwives and connection with women and family members. Participants explained that these connections are essential in midwifery. However, they each bring about different implications. Illustrations from the interviews showed that connection in midwifery is built through service and partnership.

5.4.1 Connection with other midwives:

Connection with other midwives was repeatedly mentioned in the interviews as a positive experience described as sharing a sense of unity. Working in unity with others can lead to a shared

workload, employees motivating each other, enjoyment, and interconnection (Lips-Wiersma & Morris, 2018). One participant shared that they only experienced meaning during the COVID-19 pandemic by working in unity with others. The positive effects of unity amongst midwives, as found in the research interviews, could be transferred into other occupations and is not exclusive to midwifery.

In work settings, positive relationships employees have with each other lead to judgment around the nature of the role itself. It enhances employees' performance by working well together, sharing resources, increasing productivity, and providing psychological support. However, whether this affects MW depends on who initiates the interpersonal sensemaking and the motives (Wrzesniewski et al., 2003).

The negative implications from theme one, Workload and Staff Shortages, are significantly improved when midwives have positive relationships with each other. Participants said engaging with other employees kept them in their role, especially during busy and stressful periods.

5.4.2 Connection with women and family members

Midwifery practice is centred around a partnership model (Nedvědová, et al., 2017). Unsurprisingly, connection with women and family members is a finding of MW for midwives. Barriers to connection with families prohibit midwives from feeling that they can function adequately in their role. For example, phone consultations make midwives feel less empowered due to being unable to see the women in person (Bradford & Penny, 2016). Participants expressed satisfaction from working with women in partnership to provide a service. Similarly, the research on work satisfaction amongst midwives stated that most midwives experience satisfaction from working with childbearing women and feeling valued by them (Knezevic et al., 2011).

Pace et al. (2001) described working in partnership with women as fulfilling when midwives can create meaningful relationships. Facility-based midwives do not work in a continuity-of-care model, making it challenging to build meaningful relationships. Delivering a baby and feeling a sense of satisfaction from working with the mother is different to creating a meaningful relationship with the mother. The COVID-19 pandemic highlighted how essential it is for midwives to work in partnership with mothers. Being unable to see childbearing women in person due to COVID-19 restrictions made midwives feel frustrated and stressed and unable to cater to their needs (Crowther et al., 2021). This relates to the dimension 'Service to Others', which is about assisting others and making a tangible difference. This is what midwives do, and midwives must work in partnership with mothers to continue to practice (Bloxsome et al., 2019). Participants expressed that providing service to women is why they get up in the morning. This also relates to the dimension of 'Inspiration' when individuals feel motivated to go to work each day due to feeling aligned with their role (Lips-Wiersma & Morris, 2018).

However, on the other hand, the strain from the dimension Service to Others Lips-Wiersma & Morris (2018), when midwives care for mothers and their families, can lead organisations to take advantage of midwives' capacity to care for women. Midwives' concepts of emotional capability between managers, co-works, other teams and mothers show that alliances incentivise emotional labour. Midwives express awareness toward this and consider it an act of professionalism in the workplace, which may be subjective to different situations and relationships. However, this may hinder authentic connections with mothers and families, leading to a decrease in meaningful relationships.

Further recognition from organisations is necessary to acknowledge midwives' emotional demands, protect their retention, and decrease exhaustion (Plimmer et al., 2022). Furthermore, midwives experiencing exhaustion from over-exerting emotional support leads to an increased workload

and fatigue, relating to theme 4.3. Midwives must also be adequately supported by other midwives Plimmer et al. (2022) (4.4.1) and colleagues in different teams linking to theme 4.2.

5.5 MoM Applied to Midwifery

The three themes Differing philosophies, Workload and staff shortages, and Connection with others, were the key finding of where midwives experience meaningfulness or meaninglessness at work. The main obstacle is differing philosophies which branched into two subthemes: policies and procedures and autonomy. Barriers prohibit partnership—a core aspect of midwifery work. A second adverse workplace factor for midwives is workload and staff shortages. However, connection with others was shown to be critical for increasing midwives' MW. Bailey and Lips-Wiersma et al. (2019) state that the multidimensional construct of meaning suggests that all dimensions must balance to experience MW. However, it can be challenging to solve if the tensions are unbalanced.

It may be difficult to understand if participants shared experiences of meaningfulness or other positive attributes because of a lack of agreement on what MW actually means (Steger et al., 2012). For example, when considering the theme Connections with others, work may be described as a spiritual experience from working in a community with childbearing mothers and their families Gaskin, (2010). However, is this the same as meaningfulness? Lips-Wiersma and Morris (2018) specify that it is essential for managers and employees alike to understand what words describe meaningfulness. The MoM was created to capture words and stories that express meaningfulness or meaninglessness. Lips Wiersma and Morris (2018) explain that the map underpins what does and does not matter to the employee.

The recognition of self and the importance of work is an exchange between self and others. This may be through recognition from others, sharing the importance of work as an organisation and allowing employees to experience the sensemaking process of meaningfulness (Bailey & Lips-Wiersma et al. 2019). Considering this, it is unsurprising that differing philosophies within facilities hindered midwives from experiencing MW, resulting in a lack of autonomy. Clearly, a high workload and staff shortages also decrease MW experiences. Hospital-based midwives experience less autonomy than community midwives due to hindered autonomy, and limiting the development of meaningful relationships (Nedvědová, et al., 2017). However, participants in this research explained that the interpersonal exchange of connection was discovered as the key driver for midwives to experience MW. All of the participants spoke about inspiration. This makes sense because inspiration considers the alignment one has with what they are doing (Lips-Wiersma & Morris, 2018). The tensions—doing vs being and self vs others—can be considered across all themes.

The multidimensional approach to MW suggests that there must be a balance amongst the seven dimensions. It is clear to see from this research that midwives tensions are not balanced. However, as stated by Lips-Wiersma and Morris (2018), the question of what meaning differs for each individual. The Map may draw out a different sense of purpose or positive and negative organisational factors in the workplace. It may be used to signify areas that need development or to understand organisational pressure that is affecting workers. It does clearly show where participants lack purpose. However, capturing meaningfulness, a profound phenomenon might be too personal to grasp through a framework. As such, meaningfulness may be described as a present state Chalosky (2003), and that purposefulness has been achieved. Hackman and Oldham (1965) argue that it is a subjective state that management practices cannot prescribe.

Lips-Wiersma (2002) explains the three areas that must be in alignment to experience a sense of meaningfulness—purpose, sense-making and coherence. However, this raises other questions such as, what sensemaking procedures allow MW in different work environments? How can all dimensions be balanced at once in multi-layered workplaces? How can tensions be balanced to serve the needs of others and the self and produce organisational results? MW has created interest for scholars to understand how work and the experience of life align (Bailey et al., 2019). Although the MoM identified organisation factors that affected midwives' roles and captured a range of emotions midwives experience, it did not necessarily identify the significant purpose midwives experience from their roles (Both-Nwabuwe et al., 2017).

When tying the themes together, findings show that midwives have a negative affiliation with their job, resulting from hospital barriers, as identified in theme one. The main barriers are policies and procedures, and autonomy being hindered. This limits partnership, which is at the heart of midwifery. A lack of partnership stops midwives from connecting with mothers, a subtheme from Connection with Others. This was identified as an area where midwives experience MW when positive connections are maintained. Midwives explained that unbalanced workloads and staff shortages created negative work experiences. Identified in theme two, this also led to the two subthemes: Sustainability and retention, and fatigue. Although these are adverse work factors that lead to more serious consequences in the workplace such as burnout and prolonged fatigue Lambert & Lambert (2001), it is unclear if the MoM drew these experiences out or if any generic interview would have shed light on the difficult working conditions for midwives. Similar to nurses, midwives face a high work demand and pressures while working alongside other healthcare providers, which is no surprise when analysing literature on nursing/midwifery working conditions within facilities both in New Zealand and internationally (Midwifery Council 2021; Pairman et al., 2023; Knezevic et al., 2011).

Another note to factor in is that negative working conditions lead to a decrease in emotional capacity, but is this the same as meaningfulness/meaninglessness? Do all adverse working conditions equal an experience of meaninglessness in the workplace, and is the opposite true for meaningfulness? How is it known what is at the core of MW? Findings from the MoM when applied to midwifery are similar to findings that consider the working conditions of nurses. Hackman & Oldham (1975) have described MW as the extent to which an employee experiences their occupation as meaningful and purposeful. Frankl (1985) describes meaning alone as 'spiritual'. Lips-Wiersma, (2002) suggested a more complex definition of meaningfulness, that three fabricate areas must align: Purpose, Sense making, and Coherence. The MoM aims to unify these three domains through the seven dimensions. However, how is it known to what degree of extent the user experiences meaningfulness, rather than just a positive work fator, or an experience of satisfaction?

Are these experiences liner and recurring? Or did the participant just have a positive week? What is the magnitude of depth in the stories that are presented. Do they describe a spiritual or purposeful stance Frankl, (1985) or are they work characteristics that are experienced daily by everyone. Is it possible to unify seven complex dimensions? Potentially, if research questions were based off just one dimension of the map, such as inspiration, would similar answers be present still? The positive state that is described as MW can be known as eudemonic and it is argued by unidimensional scholars that this cannot be controlled by managers (Lepisto & Pratt, 2017).

The research for this study has presented three main themes, that can be controlled by managers to enhance the work environment for midwives. Theme one: Differing Philosophies can be monitored by managers to ensure midwives can experience full autonomy in the workplace and are respected by fellow healthcare professionals. Theme two: Workload and Staff Shortages can be controlled by managers to allow midwives to have appropriate breaks, and to

focus on sustainability and retention in the role. These two themes are lucid in terms of management. They are also likely identified as negative work based factors rather than expressions of meaningfulness or meaninglessness. When discussing these themes, participants expressed that it limited them from completing their scope of work successfully and from exercising their full potential. Psychologists refer to meaning self-discovery (Lepisto & Pratt, 2017).

MWs is often considered around how the workers experience connotates with their life's journey (Bailey et al., 2019). Participants scarcely mentioned examples of their work in relation to the wider value of their lives. The separation of all seven dimensions did cause confusion amongst participants during the research interviews, making it difficult to unify the theme of meaningfulness. The final theme, connection, was the strongest theme to draw upon MW experiences. This theme is also the most difficult theme for managers to control. Although managers may intervene in the workplace to ensure midwives have enough time with mothers and families to create connection, it is an organic partnership that is subjective. Meaning is for the individual to create purpose from connection (Snyder & Lopez, 2001). Surprisingly, participants did not discuss the process or experience of birth during the research interviews, which has been described as spiritual in other studies (Mitchell & Hill, 2007; Crowther & Hall, 2015). It seems that the depth of midwifery's holistic nature in a metaphysical environment was not presented in the research data.

5.6 Limitations of the Research

Core midwifery is urbanised and may be challenging to transfer into different areas of midwifery that is not facility based. This limits the relatability of the research compared to other midwifery work contexts (E.g. community midwifery). The results may be limited due to the research

questions being based on the MoM objectively, and questions were not tailored to the profession of midwifery. This may have led to participants discussing work-related factors and performance rather than MW expression. There were times when participants failed to understand the MoM as a whole during the interviews, and this may have led to fewer examples of MW and more emphasis on understanding different areas of the map and speaking to those, such as about different experiences at work. Although participants discussed organisational factors, they struggled to relate to the topic of MW itself. The words 'meaningful' and 'meaningfulness were scarcely mentioned in the research interviews by participants.

5.7 Chapter Conclusion

Chapter five presented the research findings based on the two research questions. First, the main findings, as presented in chapter four, were discussed. Precedent, these are the three main themes; Differing Philosophies, Workload and Staff Shortages, and Connection With Others. Second, the ability of the MoM is applied to the midwifery profession as a whole. Conclusions drawn from using the MoM state that although the tool is a useful source, it is difficult to understand if research results conclude MW or other positive attributes such as satisfaction. Similar to the identified issue that MW scales may ask employees to interpret value at work rather than MW, Both-Neabuwe et al., (2017), the MoM does the same. Suggestions for further research are to clarify how participants relate to the concept of MW.

6. Conclusion Chapter

The concept of MW in this research study was tested through the use of the MoM, a multidimensional tool encompassing complex interactions between different sources of meaning. A review of the literature demonstrated that MW was not well represented for the midwifery or nursing professions. This study included facility-based/core midwives as participants and explored how the application of MoM to their experiences supported a deeper understanding of MW for these health professionals. Core midwives found multidimensional meaningfulness through their connection with others, with each other and with the families they served. The strength of meaning in providing a service to others in unity gave them positive and purposeful experiences. These sustained them through difficult times (COVID-19) even when their job autonomy was low and their workload was unsustainbly high.

Meaninglessness was felt when the purpose of their work felt to be unaligned due to the job's expectation. This led to frustration over procedures that made little sense to them and a perceived loss of professional autonomy to overcome this structural constraint. The pressure of unsustainable workloads, staff shortages and resulting fatigue was seen as an inbalance in the tensions of MW.

The use of the MoM to identify an imbalance amongst the seven dimensions of MW discovered a misaligned purpose and challenges to sensemaking for their core midwifery work. The weight of purpose felt in the service to and unity with others did not appear to counter the reality of circumstances of their work within their organisations. Through the application of MoM, the reality and circumstances of a tired, overworked, under-resourced workforce were visible. However, it was difficult to apprehend if midwives expressed examples of MW or other positive/ negative emotions due to the difficulty to define and grasp MW through a tool or framework.

6.1 The Research Question

The questions that this research answered are: 1) What aspects of midwifery work do midwives find meaningful or meaningless and why? 2) Does the MoM effectively capture midwives' experiences of meaningful or meaningless work?

The research was based upon the multidimensional theory of MW, using Lips-Wiersma & Morris' (2018) MoM. The concept of MW has been studied since Maslow's Theory Z (Maslow, 1981). MW is a complex field. First the definition of meaningfulness itself is difficult to define, and many scholars have tried to research and capture it (Rosso et al., 2010). However, it is agreed that from a business stance it is beneficial to understand employees MW. Engagement with MW boosts productivity and performance engagement and decreases negative work factors (Wrzesniewski et al., 1997; Snyder & Lopez, 2001). The MoM was selected as the guide to interpret MW for this study. This tool was developed more recently than other popular models to engage with MW. It uses a multidimensional stance to capture the users engagement with meaningfulness or meaninglessness in the workplace. The multidimensional frameworks aim is to bridge the gap from unidimensional models by connecting the participant with the wider world through seven dimensions (Bailey et al., 2019). A recap of these dimensions is: Integrity with self, Expressing full potential, Service to others, and Unity with others, being the four core dimensions. The three final dimensions: Doing and being, Service and others, and Inspiration and the Reality of Self and Circumstances balance the core dimensions as tensions.

The map itself has been applied to many different industries, making it useful to continuously test it in order to understand its functionality and limitations when looking at a particular occupation. Midwifery is an essential and often undervalued occupation both in New Zealand and internationally.

In New Zealand, midwives practice in the community, private houses, or facilities (Gilkison et al., 2017). Midwifery is vital to minimise the risks around child birth, including death (WHO, 2021). Most midwives work in hospitals or facilities globally Pairman et al. (2023), and make up 48% of the midwifery workforce in New Zealand (Ministry of Health, 2022). It is essential to carry out research in this field to further advance the profession of midwifery. Although the career has come a long way in New Zealand, midwives often face issues with recognition, particularly alongside other healthcare workers (Pairman et al., 2023). Hence, giving midwives an opportunity to share their experience as practitioners is vital to add knowledge to the field.

6.2 Answering the Research Question:

Chapter 3 provided the methodology used to guide this thesis. I used a relativist ontology and a constructivist epistemology. The research extracted data from qualitative interviews, making constructivism the appropriate epistemology because it draws logic from participants to answer the research questions (Feast & Melles, 2010). Of course, this type of research considered a relativist ontology, valuing knowledge as subjective to each individual (Gruber, 2018). Although participants all work as 'core midwives', their experiences and value toward their occupation is unique. Therefore, the paradigm used for this research is interpretivism. Interpretivism holds the belief that meaning is derived from participant's unique experiences and patterns and this is analysed to generate new knowledge across repetitive themes (Mackenzie & Knipe, 2006). The underpinning methodology for this research is 'interpretive phenomenological analysis'. This qualitative methodology examines participant's distinctive experiences (Gray 2021). It is the appropriate methodology for the complex topic of MW, that analyses emotion and human experience (Palinkas et al., 2015). Before the research process started, ethics approval was granted (see appendix A). The essential principals for this research

were that all participants were volunteers, could exit the research process at any time, and approached the researchers themselves. Participants remained anonymous during all steps of the research, including the organisations where participants work. Research questions consisted of open ended interviews. Five qualitative interviews were conducted and used to answer the research questions. All participants were core midwives in New Zealand. A requirement for participants was that they are employed and not students. Due to COVID-19, interviews were held on Zoom (see appendix E for interview questions). Data from interviews was coded using the six steps of thematic analysis (Braun & Clarke, 2019). Findings from using thematic analysis were presented in three themes (See Chapter 4). These themes are: Differing Philosophies, Workload and Staff Shortages, and Connection with Others. Subthemes emerged from each of the main themes. Theme one, Differing Philosophies was identified due to participants sharing experiences of having differing philosophies to their colleagues in hospitals or the facility where they worked. The two subthemes that emerged from this are 1) Policies and procedures 2) Autonomy.

Workload and Staff Shortages was identified as a theme due to midwives experiencing unbalanced and high workloads. The two subthemes that transpired from this are 1) Sustainability and retention. 2) Fatigue. The final theme is Connection with Others. This theme was an important finding because midwives often expressed the value of working and connecting with others in their occupation. The two subthemes that related to this are 1) Connection with other midwives. 2) Connection with women and families.

6.3 Contribution to Knowledge and further research

The study contributed to the knowledge in both the fields of MW and midwifery. To date, no research has explored these two topics together. This research also centres on midwives'

voices, allowing them to express their experiences and opinions. The MoM adequately captured recurring themes relating to midwives' experiences of MW. However, meaning is an amorphous construct, and for some midwives, it may refer to spiritual connection; for others, it may refer to the ease they feel in the workplace. It is based on how the individual experiences their workplace and how they make meaning from this (Chalofsky, 2003). MW may just be too broad to investigate. Unlike stress, which can be considered from physical ailment that the worker possesses, meaning is a metaphysical reality, separate from the reality of work structures.

The MoM has reinforced issues midwives face in hospitals. It has successfully engaged participants to share work experiences that are subjective and personal. To create better working conditions for midwives, further research is necessary to limit workplace barriers and high work demands that stop midwives from practicing autonomously and in partnership with mothers and their families in this environment. In addition, midwives require more support and recognition within organisations to help improve retention issues and provide emotional aid for these workers (Plimmer 2022;Pairman et al., 2023; Hays & Prepas, 2015). The difficulty of understanding if the MoM educed examples of MW or other positive work attributes, consequently concludes that further research is necessary to seize a clear understanding of MW to comprehend examples of it. However the MoM clearly enforced examples of core midwives current issues and successes in New Zealand. Research to rectify solutions for issues that midwives face from differing philosophies, a high workload, staff shortages and fatigue is necessary to protect midwives underpinning philosophy of partnership and autonomy, Freeman et al. (2004) and facilitate recruitment and retention issues that core midwives face, in alignment with the 2025 global commitment to United Nations Sustainability goal (WHO, 2021). Midwifery is an essential service that every childbearing woman should have access to

globally. Midwives contribute to normal labour and minimise risk around childbirth ICM (2018), making the professionals leaders in reproductive health and childbirth.

7 References

Alba, R., Franco, R., Patrizia, B., Maria, C. B., Giovanna, A., Chiara, F., & Isabella, N. (2019). The midwifery-led care model: a continuity of care model in the birth path. *Acta Bio Medica: Atenei Parmensis, 90*(Suppl 6), 41.

Alkema, L., Chou, D., Hogan, D., Zhang, S., Moller, A.-B., Gemmill, A., Fat, D. M., Boerma, T., Temmerman, M., & Mathers, C. (2016). Global, regional, and national levels and trends in maternal mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. *The lancet, 387*(10017), 462–474.

Aune, I., & Lilleengen, A. M. (2013). Home visits by student midwives in the early postnatal period — a qualitative study of students' reflections. *British Journal of Midwifery, 21*(7), 510–519. https://doi.org/10.12968/bjom.2013.21.7.510

Aune, I., Dahlberg, U., & Ingebrigtsen, O. (2011). Relational continuity as a model of care in practical midwifery studies. *British Journal of Midwifery, 19*(8), 515–523. https://doi.org/10.12968/bjom.2011.19.8.515

Bahari, S. F. (2010). Qualitative versus quantitative research strategies: contrasting epistemological and ontological assumptions. *Sains Humanika, 52*(1).

Bailey, C., Lips-Wiersma, M., Madden, A., Yeoman, R., Thompson, M., & Chalofsky, N. (2019). The five paradoxes of meaningful work: Introduction to the special issue 'meaningful work: Prospects for the 21st century'. *Journal of Management Studies, 56*(3), 481–499.

Bailey, C., Yeoman, R., Madden, A., Thompson, M., & Kerridge, G. (2019). A review of the empirical literature on meaningful work: Progress and research agenda. *Human Resource Development Review, 18*(1), 83–113.

Baldacchino, D. (2010). Caring in Lourdes: an innovation in students' clinical placement. *British Journal of Nursing, 19*(6), 358–366. https://doi.org/10.12968/bjon.2010.19.6.47235

Bates, C. (1995). Can midwifery be both art and science? In (Vol. 3, pp. 67–68): MA Healthcare London.

Berg, J. M., Dutton, J. E., & Wrzesniewski, A. (2013). Job crafting and meaningful work.

Bloxsome, D., Ireson, D., Doleman, G., & Bayes, S. (2019). Factors associated with midwives' job satisfaction and intention to stay in the profession: An integrative review. *Journal of clinical nursing, 28*(3–4), 386–399.

Both-Nwabuwe, J. M., Lips-Wiersma, M., Dijkstra, M. T., & Beersma, B. (2020). Understanding the autonomy–meaningful work relationship in nursing: A theoretical framework. *Nursing outlook, 68*(1), 104–113.

Both-Nwabuwe, J., Dijkstra, M., & Beersma, B. (2017). Sweeping the floor or putting a man on the moon: How to define and measure meaningful work. *Frontiers in psychology, 8*, 1658.

Bradford, N. K., & Penny, R. A. (2016). Registered nurse and midwife experiences of using videoconferencing in practice: a qualitative systematic review protocol. *JBI Database of Systematic Reviews & Implementation Reports, 14*(5), 3–9. https://doi.org/10.11124/JBISRIR-2016-002679

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative research in sport, exercise and health, 11*(4), 589–597.

Braun, V., & Clarke, V. (2012). *Thematic analysis*. American Psychological Association.

Bryers, H. M., & Van Teijlingen, E. (2010). Risk, theory, social and medical models: a critical analysis of the concept of risk in maternity care. *Midwifery, 26*(5), 488-496.

Chalofsky, N. (2003). An emerging construct for meaningful work. *Human Resource Development International, 6*(1), 69–83.

Clemons, J. H., Gilkison, A., Mharapara, T. L., Dixon, L., & McAra-Couper, J. (2021). Midwifery job autonomy in New Zealand: I do it all the time. *Women and Birth, 34*(1), 30–37.

Crotty, M. J. (1998). The foundations of social research: Meaning and perspective in the research process. *The foundations of social research*, 1–256.

Crowther, S., & Hall, J. (2015). Spirituality and spiritual care in and around childbirth. *Women & Birth, 28*(2), 173–178. https://doi.org/10.1016/j.wombi.2015.01.001

Crowther, S., Maude, R., Bradford, B., Austin, D., Gilkison, A., McAra-Couper, J., & Krisjanous, J. (2021). When maintaining relationships and social connectivity matter: the case of New Zealand midwives and COVID-19. *Frontiers in Sociology, 6*, 614017.

Crowther, S., Maude, R., Zhao, I. Y., Bradford, B., & Gilkison, A. (2021). New Zealand maternity and midwifery services and the COVID-19 response: A systematic scoping review. *Women and Birth*.

Davis-Floyd, R. (2001). The technocratic, humanistic, and holistic paradigms of childbirth. *International Journal of Gynecology & Obstetrics, 75*, S5-S23.

Dawson, P., Hay-Smith, J., Jaye, C., Gauld, R., & Auvray, B. (2021). Do maternity services in New Zealand's public healthcare system deliver on equity? Findings from structural equation modelling of national maternal satisfaction survey data. *Midwifery, 95*, 102936.

Edmonds, J. K., Ivanof, J., & Kafulafula, U. (2020). Midwife led units: transforming maternity care globally. *Annals of global health, 86*(1).

Epstein, R. M., & Street, R. L. (2011). The values and value of patient-centered care. In (Vol. 9, pp. 100–103): Annals Family Med.

Feast, L., & Melles, G. (2010). Epistemological positions in design research: A brief review of the literature. 2nd International Conference on Design Education, University of New South Wales, Sydney, Australia,

Frankl, V. E. (1985). Man's search for meaning. Simon and Schuster.

Freeman, L. M., Timperley, H., & Adair, V. (2004). Partnership in midwifery care in New Zealand. *Midwifery, 20*(1), 2–14.

Gaševic, D., Djuric, D., & Devedžic, V. (2009). Ontologies. In *Model Driven Engineering and Ontology Development* (pp. 45–80). Springer.

Gaskin, I. M. (2010). *Spiritual midwifery*. Book Publishing Company.

Gilkison, A., McAra-Couper, J., Fielder, A., Hunter, M., & Austin, D. (2017). The core of the core: What is at the heart of hospital core midwifery practice in New Zealand? *New Zealand College of Midwives Journal,* (53).

Gilkison, A., Pairman, S., McAra-Couper, J., Kensington, M., & James, L. (2016). Midwifery education in New Zealand: Education, practice and autonomy. *Midwifery*, *33*, 31–33.

Grant, B. M., & Giddings, L. S. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary nurse*, *13*(1), 10–28.

Gray, D. E. (2021). *Doing research in the real world*. sage.

Gruber, T. (2018). Ontology. In

Hackman, J. R. (1980). Work redesign and motivation. *Professional Psychology*, *11*(3), 445.

Hackman, J. R., & Oldham, G. R. (1976). Motivation through the design of work: Test of a theory. *Organizational behavior and human performance*, *16*(2), 250–279.

Hays, K. E., & Prepas, R. (2015). The professionalization of international disaster response: it is time for midwives to get ready. *Journal of Midwifery & Women's Health*, *60*(4), 348–359.

Homer, C. S., Friberg, I. K., Dias, M. A. B., ten Hoope-Bender, P., Sandall, J., Speciale, A. M., & Bartlett, L. A. (2014). The projected effect of scaling up midwifery. *The lancet*, *384*(9948), 1146–1157.

Hugly, P., & Sayward, C. (1987). Relativism and ontology. *The Philosophical Quarterly (1950-)*, *37*(148), 278–290.

Hyde, A., Roche Reid, B. (2002) Midwifery practice and the crisis of modernity: implications for the role of the midwife . *Social Science and Medicine,* (58) 2613-2623

ICM (2018). *ICM Definitions.* International confederation of midwives. https://www.internationalmidwives.org/our-work/policy-and-practice/icm-definitions.html

ICM (2018). *The Origins of Midwifery.* International confederation of midwives. https://www.internationalmidwives.org/icm-news/the-origins-of-midwifery.html#:~:text=The%2

Jepsen, I., Mark, E., Aagaard Nøhr, E., Foureur, M., & Elgaard Sørensen, E. (2016). A qualitative study of how caseload midwifery is constituted and experienced by Danish midwives. *Midwifery, 36*, 61–69. https://doi.org/10.1016/j.midw.2016.03.002

Jones, A., (2020). *Specific Covid-19 Incurred Costs Reimbursement Announced.* New Zealand College of Midwives. https://www.midwife.org.nz/news/specific-covid-19-incurred-costs-reimbursement-announced/

Kilponen, K., Huhtala, M., Kinnunen, U., Mauno, S., & Feldt, T. (2021). Illegitimate tasks in health care: Illegitimate task types and associations with occupational well-being. *Journal of clinical nursing, 30*(13–14), 2093–2106.

Knezevic, B., Milosevic, M., Golubic, R., Belosevic, L., Russo, A., & Mustajbegovic, J. (2011). Work-related stress and work ability among Croatian university hospital midwives. *Midwifery, 27*(2), 146–153.

Lambert, V. A., & Lambert, C. E. (2001). Literature review of role stress/strain on nurses: an international perspective. *Nursing & health sciences, 3*(3), 161–172.

Lepisto, D. A., & Pratt, M. G. (2017). Meaningful work as realization and justification: Toward a dual conceptualization. *Organizational Psychology Review, 7*(2), 99–121.

Lincoln, Y. S., & Guba, E. G. (1989). Ethics: The failure of positivist science. *The Review of Higher Education, 12*(3), 221–240.

Lips-Wiersma, M., & Morris, L. (2009). Discriminating between 'meaningful work' and the 'management of meaning'. *Journal of business ethics, 88*(3), 491–511.

Lips-Wiersma, M., & Morris, L. (2017). *The map of meaning: A guide to sustaining our humanity in the world of work*. Routledge.

Lips-Wiersma, M., & Morris, L. (2018). *The map of meaning: A guide to sustaining our humanity in the world of work*. Routledge.

Lips-Wiersma, M. (2002). The influence of spiritual "meaning-making" on career behavior. *Journal of Management Development, 21(7), 497 – 520.*

Mackenzie, N., & Knipe, S. (2006). Research dilemmas: Paradigms, methods and methodology. *Issues in educational research, 16*(2), 193–205.

Maslow, A. H. (1981). *Motivation and personality*. Prabhat Prakashan.

Mattison, C. A., Lavis, J. N., Wilson, M. G., Hutton, E. K., & Dion, M. L. (2020). A critical interpretive synthesis of the roles of midwives in health systems. *Health Research Policy and Systems, 18*(1), 1–16.

Mharapara, T. L., Staniland, N., Stadler, M., Clemons, J. H., & Dixon, L. (2022). Drivers of job satisfaction in midwifery—A work design approach. *Women and Birth, 35*(4), e348-e355.

Midwifery Council (2010). *Midwifery (Scope of Practice and Qualifications) Notice 2010.* New Zealand Government. https://gazette.govt.nz/notice/id/2010-gs142

Midwifery Council (2021). *2021 Midwifery Workforce Survey.* Midwifery Council New Zealand

Ministry of Health (2022). *Maternity service specification.* National service Framework Library. https://nsfl.health.govt.nz/service-specifications/current-service-specifications/maternity-service-specifications

Mitchell, M., & Hall, J. (2007). Teaching spirituality to student midwives: a creative approach. *Nurse Education in Practice, 7*(6), 416–424. https://doi.org/10.1016/j.nepr.2007.02.007

Mollart, L., Skinner, V. M., Newing, C., & Foureur, M. (2013). Factors that may influence midwives work-related stress and burnout. *Women and Birth, 26*(1), 26–32.

Morton, T. (2013). *Realist magic: Objects, ontology, causality*. Open Humanities Press.

Nao, T., Shigeko, H., Yoko, S., & Sebalda, L. (2015). Career development expectations and challenges of midwives in Urban Tanzania: a preliminary study. *BMC Nursing*, *14*(1), 1–6. https://doi.org/10.1186/s12912-015-0081-y

Nedvědová, D., Dušová, B., & Jarošová, D. (2017). Job satisfaction of midwives: a literature review. *Central European Journal of Nursing and Midwifery*, *8*(2), 650–656.

NZNO (2011) *Midwifery Policy.* New Zealand Nurses Organisation. https://www.nzno.org.nz/LinkClick.aspx?fileticket=y3zjUm-NhWQ%3D&portalid=0

Organization, W. H. (2019). Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.

Pace, C. A., Crowther, S., & Lau, A. (2021). Midwife experiences of providing continuity of carer: A qualitative systematic review [Review]. *Women and Birth*. https://doi.org/10.1016/j.wombi.2021.06.005

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., & Brennan, S. E. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *Systematic reviews*, *10*(1), 1–11.

Pairman, S., & McAra-Couper, J. (2014). Theorectical frameworks for midwifery practice. *Midwifery: Preparation for Practice. Sydney: Churchill Livingstone Elsevier*, 383-3782.

Pairman, S., Tracy, S. K., Dahlen, H. G., & Dixon, L. (2023), *Preparation for Practice 5e.* Elsevier Health Sciences.

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and policy in mental health and mental health services research*, *42*(5), 533–544.

Pavlish, C., & Hunt, R. (2012). An exploratory study about meaningful work in acute care nursing. Nursing forum.

Plimmer, G., Franken, E., & Franken, M. (2022). Navigating emotional labour with emotional competence: insights from midwifery. *Labour and Industry*, *32*(3), 307-333.

Pratt, M. G., & Ashforth, B. E. (2003). Fostering meaningfulness in working and at work. Positive organizational scholarship: Foundations of a new discipline, 309, 327.

Rangachari, P., & L. Woods, J. (2020). Preserving organizational resilience, patient safety, and staff retention during COVID-19 requires a holistic consideration of the psychological safety of healthcare workers. *International journal of environmental research and public health, 17*(12), 4267.

Renfrew, M. J., McFadden, A., Bastos, M. H., Campbell, J., Channon, A. A., Cheung, N. F., Silva, D. R. A. D., Downe, S., Kennedy, H. P., & Malata, A. (2014). Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *The lancet, 384*(9948), 1129–1145.

Rosso, B. D., Dekas, K. H., & Wrzesniewski, A. (2010). On the meaning of work: A theoretical integration and review. *Research in organizational behavior, 30*, 91–127.

Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English language teaching, 5*(9), 9–16.

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British journal of pain, 9*(1), 41–42.

Snyder, C. R., & Lopez, S. J. (2001). *Handbook of positive psychology*. Oxford university press.

Steger, M. F., Dik, B. J., & Duffy, R. D. (2012). Measuring meaningful work: The work and meaning inventory (WAMI). *Journal of career Assessment, 20*(3), 322–337.

Ten Hoope Bender, P., Homer, C., Matthews, Z., Nove, A., Sochas, L., Campbell, J., & de Bernis, L. (2014). The state of the world's midwifery: a universal pathway, a woman's right to health.

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., Moher, D., Peters, M. D., Horsley, T., & Weeks, L. (2018). PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. *Annals of internal medicine, 169*(7), 467–473.

Tuli, F. (2010). The basis of distinction between qualitative and quantitative research in social science: Reflection on ontological, epistemological and methodological perspectives. *Ethiopian Journal of Education and Sciences, 6*(1).

Vivilaki, V. G., & Asimaki, E. (2020). Respectful midwifery care during the COVID-19 pandemic. *European Journal of Midwifery, 4*.

Watson, L., Potter, A., & Donohue, L. (1999). Midwives in Victoria, Australia: a survey of current issues and job satisfaction. *Midwifery, 15*(4), 216–231.

Wheeler, H., & Riding, R. (1994). Occupational stress in general nurses and midwives. *British Journal of Nursing, 3*(10), 527–534.

White, J. (2019) The Australian and New Zealand context. Chatswood. *Midwifery: preparation for practice* (pp. 5–20). Elsevier.

World Health Organisation (2021) *the state of the worlds midwifery 2021*. United Nations Populations Fund

Wrzesniewski, A., Dutton, J. E., & Debebe, G. (2003). Interpersonal sensemaking and the meaning of work. Research in organizational behavior, 25, 93–135

Wrzesniewski, A., McCauley, C., Rozin, P., & Schwartz, B. (1997). Jobs, careers, and callings: People's relations to their work. *Journal of research in personality, 31*(1), 21–33.

Yoshida, Y., & Sandall, J. (2013). Occupational burnout and work factors in community and hospital midwives: a survey analysis.

Zolkefli, Z. H. H., Mumin, K. H. A., & Idris, D. R. (2020). Autonomy and its impact on midwife practice. *British Journal of Midwifery, 28*(2), 120–129.

8.1 Appendix A- Ethics approval

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

17 September 2021

Tagonei Mharapara
Faculty of Business Economics and Law

Dear Tago

Re Ethics Application: **21/312 Meaningful Work in Facility-Based Midwifery**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until .

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.
8. AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: oliviagoldsworthy24@gmail.com

8.2 Appendix B- Newsletter & social media advert

Newsletter & scoial media advert

Study of Meaningful work in New Zealand midwifery

Employed (core) midwives are needed for a study on meaningful work experiences in New Zealand midwifery. When work is meaningful, it can help answer the question, 'Why am I in this job/profession?', and as such is a deeply personal experience. Participation includes survey completion (5-7 minutes) and a 60-minute interview scheduled at your convenience. Because we are seeking input from registered and practicing midwives, midwifery students are excluded from participation in this study. As a token of our appreciation for your time and effort, koha will be presented to study participants.

AUT Midwifery & Management
Janine Clemons (Janine.clemons@aut.ac.nz) & Tago L. Mharapara (tago.mharapara@aut.ac.nz)
AUTEC #21/298

8.3 Appendix C- Participant information sheet

Participant Information Sheet

Date Information Sheet Produced:

1 September 2021

Project Title

Meaningful work experiences in New Zealand midwifery

An Invitation

Drs Janine Clemons (AUT Midwifery), Tago Mharapara and Marjo Lips-Wiersma (AUT Management) invite you to participate in our research on meaningful work (MW) amongst New Zealand-based midwives. Our research seeks to develop a comprehensive understanding of NZ midwives' perceptions about MW experiences.

What is the purpose of this research?

MW refers to the individual subjective experience of the existential significance of work. When work is meaningful, it can help answer the question, 'Why am I in this job/profession?' and as such is a deeply personal and existential experience. Research in other health professions (e.g., nursing) has shown that the experience of MW affects wellbeing and retention. Thus, it is essential to investigate the effect of MW on midwives' wellbeing alongside the more structural factors affecting midwifery work. Research shows that workers who report high levels of meaning also report better psychological adjustment to work.

How was I identified and why am I being invited to participate in this research?

As a registered LMC or core midwife, you have been identified as a potential participant for this research. We have invited you to participate in our research based on your affiliation with our research partners at AUT Midwifery, the NZ College of Midwives, Rua Pōkai Ngā Māia I Te Rauroha, and Pasifika Midwives Aotearoa. Irrespective of your decision to participate or not in our study, we ask you to consider informing other midwives in your network about our invitation so they can contact us if they want to learn more and or participate in our research.

How do I agree to participate in this research?

Participation in this research is completely voluntary (it is your choice) and whether you choose to participate will neither advantage nor disadvantage you. You can withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible. ***If you choose to participate in this study, please sign the attached Consent Form, then scan, or photograph the Consent Form and return it to us at either one of the email addresses provided on the Consent Form. Alternatively, you can copy the content of the Consent Form into an email and send it to us with a sentence indicating your agreement to participate. If you use the second option, please ensure that you send us an email that clearly shows it's from you.***

What will happen in this research?

In Part One, you will be asked to complete a questionnaire with closed-ended questions about your work and non-work contexts, your experience of meaning at work, and demographic questions about you as an individual. The survey is estimated to take ten minutes or less. In Part Two, you will be interviewed by a member of the research team. The interview will be based on your scores on the Comprehensive Meaning at Work Scale (CMWS) completed in Part One. Interviews will be held at an AUT-facility or a mutually agreeable venue such as the midwife's practice office or public venue where a recorded interview can take place. Each interview will take approximately 60 minutes. After the interviews have been transcribed, participants will receive a transcript for review. Midwifery students taught by Dr Janine Clemons will be excluded from participation and inclusion of advice.

What are the discomforts and risks?

In completing the questionnaire or responding to interviewer questions, you may feel embarrassed about aspects of your work that you are not particularly proud of. However, we think that the study will have little to no psychological or emotional risk to you. You do not have to answer any questions that trigger disruptive emotions or that you find embarrassing.

8.4 Appendix D- Informed consent

Consent Form

Project title: ***Meaningful work experiences in New Zealand midwifery***

Project Supervisor: ***Tago L. Mharapara***

Researcher Team: ***Janine Clemons, Marjo Lips-Wiersma, Olivia Goldsworthy-Keeley***

To participate in this study, please read the information below, complete the Consent Form, and email a signed copy to tago.mharapara@aut.ac.nz OR janine.clemons@aut.ac.nz and we will contact you with further details.

- ○ I have read and understood the information provided about this research project in the attached Participation Information Sheet dated 01 September 2021.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study, then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details :

Mobile Phone Number .....

Email address .....

Mailing address .....

Date:

Approved by the Auckland University of Technology Ethics Committee on 17 September, 2021 AUTEC Reference number 21-312 & 21-298.

Note: Please retain a copy of this form for your records.

8.5 Appendix E- Research questions

Survey questionnaire

Upon providing consent to participate in the study, respondents received an email with a link to an online survey. Through the survey, we collected midwives' ratings of MFW through Lips-Wiersma and Wright's (2012) Comprehensive Meaningful Work Scale (CMWS). The CMWS is a 22-item research instrument that asks respondents to indicate how frequently they experience MFW along seven dimensions: 1) Unity with others; 2) Service to others; 3) Expression of full potential; 4) Integrity with self; 5) Balancing of tensions; 6) Inspiration; 7) Reality of self and circumstances. Participants provided MFW ratings on a 5-point Likert scale (1 = *Never* to 5 = *Very often*). We also used the survey to collect work-specific data (e.g., tenure, hours worked per week), non-work data (e.g., childcare responsibilities, volunteering) and demographic data (e.g., age, educational attainment).

Before the commencing the interview

1. Have the PPT slides with the Map of Meaning (MoM), individual, and profession-level diagrams opened and ready to share in person via Zoom
2. Choose a location, with no background noise, as these can often drown out the interviewee's voice. **Things to avoid:**

a. People chatting/laughing in the background

b. Banging doors/road and other external noises (close the door or window), barking dogs, birds

c. Chirping, rustling papers, clicking of pens/glasses/cups etc

d. Air conditioning units/heat pumps create a loud background noise on a voice file

e. If recording in a large room, or a room without carpet, it is helpful to put the Dictaphone on a towel, for example, to avoid 'echoing'.

f. Speak clearly and at normal speed and pitch. (There is no need to speak any slower than normal).

g. It is helpful if there are unusual names/places/foreign words etc., to spell these out, or email these.

h. If you experience buffering or connection issues at the start, stop the interview and start again. The transcription will only be as good as the quality of the recording.

The interview

Interviewer: *Kia ora _____ THANK YOU for the interest you have shown in our work and I appreciate the time you have put into completing our survey and making yourself available for this interview. As indicated in our earlier communications, this interview will be approximately 60 minutes and will cover your experience of work as meaningful in your role as an LMC midwife/core-midwife/clinical educator midwife.*

Step 1: Place the MoM between you and your interviewee (in-person) OR share it in Zoom. Make sure the font is large enough so you nor the interviewee must strain to read the words.

Briefly explain that the Map of Meaning is a visual representation of several research projects asking the question "what do people experience when they say their work is meaningful"? It was first used in practice in 2000 and has subsequently been used in educational, community and corporate settings and has received extensive practitioner feedback from all over the world.

Step 2: Briefly introduce each of the 7 dimensions of the MOM as such:

1. **Integrity with Self** - This refers to who we are becoming as a result of being engaged in our life and work. For e.g., developing the confidence to speak up at work.
2. **Unity with Others** - This refers to the meaning that we get from working and living together with other human beings. For e.g., pulling together to complete a difficult challenge
3. **Expressing Full Potential** - This refers to the meaningfulness of sounding our own note in the universe. It relates to the human need to create and accomplish.

4. **Service to Others -** This describes the meaning we derive from improving things for others. For example, through helping a colleague or making a difference to a client.

5. **Balancing tensions**

a. **Being v doing –** Balancing the need to focus inward and reflect, and the need to act in the world. Being focuses on the need to reflect, to make sense of things, and to evaluate (e.g., Why exactly are we doing this?) Doing focuses out into the world (e.g., We've talked enough, let's get on with it).

b. **Self v others –** Balancing the need to meet the needs of the self, while also meeting the needs of others. Wanting to get on with our own projects but we are simultaneously called to assist colleagues. Or when our work has become too focused on our own career and we are starting to lose the connection with others at work or home.

6. **Inspiration -** Meaningfulness is experienced when an individual feels aligned with some form of ideal or hope. In work it can for example express itself through a positive rather than cynical work climate.

7. **Reality of self & circumstances -** Meaningfulness cannot be experienced when we pretend, either in relation to ourselves or to our circumstances. It includes awareness that we are imperfect and live in an imperfect world. At work it can for example express itself through authentic emotions and realistic goals, rather than pretense and over-the-top expectations.

Step 2: Inform the interviewees that you don't expect them to be familiar with all the words and phrases in the MOM and they are welcome to use words that resonate with them in their roles. For e.g., if "Integrity with self" doesn't work well for you, perhaps "staying true to myself or my values works better". If "Expressing full potential" doesn't work well for you, perhaps "feeling a sense of accomplishment" works better.

Step 3: Place the interviewee's Map of Meaning (MOM) with their score from the survey between you and your interviewee (in-person) OR share it in Zoom. Gently take them through each of

the 7 elements of the Map. **Ask the interviewee to respond to unpack the questions below within the context of their role. Try to steer interviewees away from "corporate" language. For example, do not encourage them to change "unity" to "teamwork" as it give them a narrow range of experiences (only with regard to their team) and does not allow them to evaluate positive and negative meanings (teamwork can be both unifying and disunifying).**

Integrity with Self

i. At work, my sense of what is right and wrong gets blurred

ii. I do not like who I am becoming at work

iii. At work, I feel divorced from myself

2. **Unity with Others**

i. At work, I have a sense of belonging

ii. At work, we talk about what matters to us

iii. At work, we enjoy working together

3. **Expressing Full Potential**

i. At work, I make a difference that matters to others

ii. At work, I experience a sense of achievement

iii. At work, I am excited about the opportunities available to me

4. **Service to Others**

i. At work, I feel I truly help our clients

ii. At work, we contribute services that enhance human well-being

iii. At work, what we do is worthwhile

iv. At work, we spend a lot of time on things that are truly important

5. **Balancing tensions**

i. In this work, I have the time and space to think

ii. At work, I create enough space for me

iii. At work, I have a good balance between the needs of others and my own needs.

6. **Inspiration**

i. The work we are doing makes me feel hopeful about the future

ii. At work, the vision we collectively work towards inspires me

iii. I experience a sense of spiritual connection with my work

7. **Reality of self & circumstances**

i. At work, we face up to reality

ii. At work, we are tolerant of being human

iii. At work, we recognize that life is messy and that is OK

Step 4: Ask the interviewee to ask if there are any meaningful experiences that are important to them and that the Map has not covered, take note of these too.

Step 5: Go through the dominance analysis findings from the 2019 survey of NZ midwives. Invite the interviewee to comment on why specific job characteristics were dominant predictors of specific dimensions of meaningfulness. You could say:

"Findings from a national survey of NZ midwives show that several work characteristics are strong predictors of certain dimensions of meaningful work. I would like to know why you think that may be the case. For instance, decision-making autonomy ***which is the freedom to make decisions at work*** *was found to be a strong predictor of integrity with self and service to others at the profession-level. Why do you think that might be?"*

Other work characteristics definitions

- *Social support* is the extent to which a job provides opportunities for getting assistance and advice from either supervisors or coworkers

- Professional recognition is the extent to which other members of multidisciplinary health teams recognise midwives as professionals that contribute to caring for women, children, and their families.
- Role feedback refers to the extent to which a role imparts information about performance. Does the role provide clear information about a midwife's effectiveness in terms of quality and quantity?

Step 6: Ask feedback on the interview process and take note of the comments. (You will need this for a thesis or publication).

Step 7: Thank the interviewee for their time and let them know that after the interview has been transcribed, they will receive a copy to read and review for accuracy.

After the interview

1. Save the MP4 file to a folder in 3 places:

a. On the machine you are using

b. Your institutionally provided cloud storage (e.g., One Drive)

c. Dropbox - The ABC Secretarial drive for Vicky Powell to transcribe

2. Email me tago.mharapara@aut.ac.nz & cc vicky@abcsecretarial.co.nz notifying us that you have put an interview into the dropbox folder.