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Scholarly Article

Toward a contextualized understanding of well-being in the midwifery profession: An integrative review

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Our integrative review synthesizes and evaluates two decades of empirical research on well-being in the midwifery profession to reveal (1) how researchers have studied midwives' well-being; (2) key findings of research on midwives' well-being; (3) underlying assumptions of this research; and (4) limitations of this research. We find that research on midwives' well-being is disproportionately focused on individual midwives, who are assumed to be largely responsible for their own well-being, and that well-being in the midwifery profession is generally equated with the absence of mental health problems such as burnout, anxiety, and stress. Researchers have largely taken a narrow and instrumental approach to study midwives' well-being, focusing on work-related antecedents and consequences, and overlooking the influence of nonwork factors embedded in the broader socioeconomic and cultural environment. Drawing on more comprehensive and contextualized well-being frameworks, we propose a research model that (1) expands the well-being construct as it applies to midwives and (2) situates midwives' well-being in broader social, economic, political, and cultural contexts. Although developed in the midwifery context, our proposed research model can be applied to a host of professions.

KEYWORDS: *well-being*; *midwives*; *integrative review*; *synthesis*; *midwifery profession.*

INTRODUCTION

In acknowledging its centrality to a well-functioning society, the United Nations recognized well-being as a sustainable development goal (Kowalski and Loretto 2017). While management and organization scholars also recognize employee well-being as a worthy endeavor (Fisher 2014; Nielsen et al. 2017), researchers have largely adopted an individualized approach to studying well-being across professional groups (Cooke 2018). An individualized approach is problematic because it minimizes the importance of contextual factors such as gender, ethnicity, socioeconomic status, privilege, and power in shaping well-being (Schwarz 2018). This is further compounded by the neoliberal characterization of employee well-being as an auxiliary to employee performance (Guest 2017). This market-driven characterization suggests that well-being is only worth pursuing to the extent that it improves worker and organizational performance.

Some scholars have criticized this approach to employee well-being for its narrow and instrumental focus (Guest 2017; Kowalski and Loretto 2017; Cooke 2018). They have called for well-being research that accounts for contextual factors that shape worker well-being, and they have advanced frameworks that situate employee well-being within broader social, economic, political, and cultural contexts. These frameworks include the socioecological systems model (Pocock et al. 2012), the sociostructural perspective on violence against employee well-being (Calvard and Sang 2017), and the total work health framework (Chari et al. 2018). Through an integrated review (Cronin and George 2020), we synthesize and evaluate the literature on midwives' well-being. In doing so, we ask, how does context (e.g. organizational, professional, societal) shape midwives' well-being?

BACKGROUND

Employee well-being: Individualized versus contextualized perspectives

In its broadest sense, well-being refers to 'a positive state of existence' (Chari et al. 2018, p. 590). Most

management and organization researchers have conceptualized well-being as a positive subjective state linked to employee performance. This is typified by well-being definitions referring to 'optimal psychological functioning and experience' (Ryan and Deci 2001, p. 142) and 'the overall quality of an employee's experience and functioning at work' (Grant et al. 2007, p. 52). Several researchers have integrated a social dimension into their well-being abstractions (Fisher 2014; Grant et al. 2007); some have incorporated a eudemonic dimension, such as perceived authenticity and meaningfulness of work (Fisher 2014; Sonnentag 2015); and others have added a physical health dimension (Leiter and Cooper 2017). The common thread running through these conceptualizations is that well-being is a phenomenon experienced by individuals, characterized by subjective elements (e.g. positive affect and attitudes, perceived meaningfulness) and, to a lesser extent, objective factors (e.g. physical health).

The individualized approach to well-being assumes that employees are responsible for creating, maintaining, and protecting their well-being (e.g. Plomp et al. 2016). This assumption is problematic because it absolves employers and governments of their responsibility to address structural and systemic factors that influence employee well-being. Individualized approaches reinforce existing power structures by putting the onus of creating and maintaining well-being on employees and, to a lesser extent, the organizations they work for (Calvard and Sang 2017). Instead of taking primary steps to improve well-being (e.g. job redesign), employers often resort to tertiary measures such as resilience training (Bardoel et al. 2014; Tonkin et al. 2018; Khan et al. 2019).

Consequently, scholars across a variety of disciplines are turning to contextualized approaches that situate employee well-being within broader social, economic, political, and cultural contexts. Contextualized approaches offer several benefits including a comprehensive understanding of the organizational, professional, and societal factors that shape worker well-being (Chari et al. 2018). Another benefit of contextualized research is that it allows scholars and others to make sense of worker behavior as a function of societal factors (e.g. gender, culture) in ways that individual characteristics (e.g. efficacy, resilience, optimism) cannot (Cooke 2018). Perhaps the strongest argument for more contextualized research is that it allows for an examination of the interactive effect of work, home, and community on a worker's well-being (Pocock et al. 2012). Understanding how organizational factors combine with family, community, and societal demands is likely to generate fresh insight into the antecedents of worker well-being.

We contend that both scholars and practitioners would benefit from a contextualized approach to understanding well-being in diverse professions. Members of various professions often face well-being challenges ranging from the specific demands of their work to those associated with the status of their profession relative to others in the same sector (e.g. midwives vs. obstetricians in maternity health). Thus, management and organization scholarship stands to benefit from research that fully incorporates contextual factors that shape employee well-being within and across diverse professional groups.

Well-being in the midwifery profession: Toward a contextualized understanding

Like other health professionals, midwives work in high-stakes environments that can adversely impact their physical, mental, and emotional health (Dixon et al. 2017; Fenwick et al. 2018a, 2018b; Hunter et al. 2019; Cull et al. 2020). However, midwives also face a unique constellation of well-being challenges that other health professionals may not experience, emphasizing the need for a contextualized understanding of well-being in the midwifery profession. These well-being challenges stem from issues relating to gender, historical tensions with the medicalization of childbirth, and western cultural hegemony in midwifery practice.

First, midwifery is a highly feminized profession across the globe (Kemp et al. 2021). In the UK, 89% of midwifery professionals identify as women (Nursing & Midwifery Council 2021). In the USA and New Zealand, the gender split is even more skewed with 98% and 99% of midwives identifying as women, respectively (American College of Nurse-Midwives 2021; Te Tatau o te Whare Kahu Midwifery Council 2022). For decades, researchers have demonstrated a gender gap in pay whereby jobs that are highly feminized pay significantly less than those dominated by men (Petersen and Morgan 1995; Bishu and Alkadry 2017). Recent work has also shown that informal, masculine gender norms such as total availability, working long hours, self-reliance, and aggression negatively impact well-being in highly gendered professions (Galea et al. 2022).

Second, medicalized childbirth is a source of consternation for midwives and impacts their well-being. Medicalized childbirth is associated with medical dominance and runs counter to the midwifery profession's philosophical orientation toward physiological childbirth (Shaw 2013). In addition to increased medical authority, the masculinization of maternity support, and the generalization of surgical interventions have all contributed to the prominence of medicalized childbirth (Clesse et al. 2018). It is a daunting prospect for midwives to be

constantly at loggerheads with medical colleagues over birthing processes.

Third, the hegemonic influence of westernized maternity care can negatively impact the well-being of midwives from other cultures and ethnicities. The professionalization of midwifery has ushered in standardized approaches to education, regulation, and models of practice. Regulation is meant to ensure that practice standards are maintained and both birthing families and midwives are protected (Kemp et al. 2021). However, westernized forms of regulation and standardization are not inclusive and disregard accumulated knowledge from Indigenous midwifery practices. For example, a recent study exploring maternal health and midwifery in Southern Mexico demonstrated that western health institutions and practices created culturally unsafe care for birthing families (Sarmiento et al. 2021). This was evidenced by negative attitudes toward traditional midwifery, preference for colonial languages and worldviews, and a general disdain for Indigenous culture. This creates unique well-being challenges for professional midwives serving Indigenous families and wanting to observe traditional birthing practices.

Midwives maintain key responsibilities for providing maternity care for women, newborns, and their families (Renfrew et al. 2019). The current, internationally recognized specification of midwifery is that of a profession only practiced by midwives. Midwives possess a unique body of knowledge, skills, and professional attitudes drawn from disciplines shared by other health professions such as science and sociology but practice within a professional framework of autonomy, partnership, ethics, and accountability (International Confederation of Midwives 2017).

Despite a defined specification, organized midwifery work is unevenly integrated into global health systems (Mattison et al. 2020). Complicated by the epistemological origins of modern maternity care, there is no clear consensus on how midwifery care should be delivered (Eri et al. 2020). Consequently, describing the global context in which midwives' work is challenging because of the range of models of care that are politically supported. Midwifery care can be fully integrated and easily accessible through a publicly funded service, or financially unsupported and thus hindering accessibility and service (Jefford et al. 2019). In most countries, midwives provide maternity care in hospitals or birthing units, and work 8–12 hour shifts. In a few places (e.g. New Zealand, Australia, Canada, the Netherlands), a continuity-of-carer model is available where the same midwife provides 24-hour on-call care for one family over their entire childbirth experience (Mattison et al. 2020; Clemons et al. 2021). Recently, there has been a rapid increase in educational support for midwives, which can be attributed to a commensurate increase in the political will to advance health outcomes for mothers and children (World Health Organization 2021). However, even in regions that have made strong investments in the midwifery profession through universal health care, workforce sustainability is precarious (Garcia de Frutos 2020), professional recognition is low (Mharapara et al. 2022), and organizational structures are fragmented and lacking in cohesion (Kemp et al. 2021).

For the reasons outlined above, our views align with those of scholars calling for increased attention to the context in management and organizational research (Johns 2006; Shapiro et al. 2007; Child and Marinova 2014). The impact of gender, medicalized childbirth, culture, and a host of other contextual factors on midwives' well-being has not been adequately recognized by researchers.

PURPOSE OF THE PRESENT REVIEW

Integrative reviews are tools for synthesizing findings from different communities of practice (Cronin and George 2020). Integrative reviews differ from narrative approaches by presenting a clear description of the search and selection criteria (Fan et al. 2022). By providing information on where the literature was found, when the search was conducted, who completed the search, what keywords were used in the search, the number of articles found, and why papers were included or excluded, researchers systematically search and collate literature on a particular topic within a specified timeframe (Callahan 2010). However, in doing more than describing the state of the published research in a reproducible way, integrative reviews advance new insights and develop theory through critical evaluation (Fan et al. 2022). The advancement of a conceptual framework is often the result of a well-executed integrative review (Elsbach and van Knippenberg 2020).

We recognize that scholars from a range of disciplines (e.g. midwifery, management, psychology, sociology) are working in parallel to investigate midwives' well-being, but we contend that this research can be improved by synthesizing empirical findings across communities of practice to generate new insights (Cronin and George 2020). In our integrative review, we collate, synthesize, and assess two decades of empirical research on midwives' well-being to identify (1) how researchers have studied midwives' well-being; (2) the underlying assumptions researchers have made in studying midwives' well-being; (3) the key findings of this research;

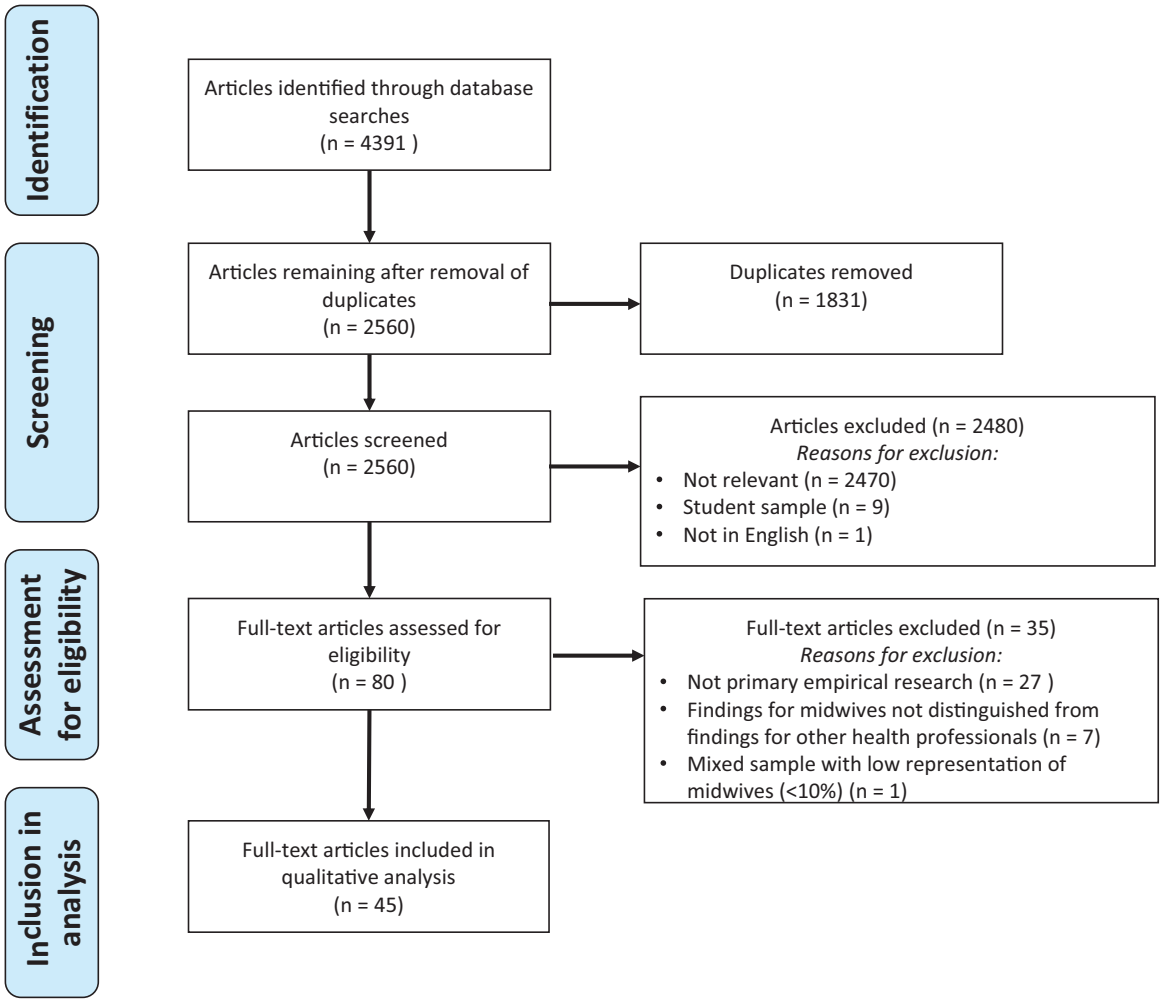

Figure 1 Systematic search process.

and (4) the limitations of extant research. This integrative review was guided by the following questions:

1. How have researchers studied midwives' well-being?
2. What are the key findings of research on midwives' well-being?
3. What are the underlying assumptions of research on midwives' well-being?
4. What are the limitations of research on midwives' well-being?

METHOD

To search and collate the literature on midwives' well-being, we followed the Preferred Reporting Instrument for Systematic Reviews and Meta-analyses (PRISMA) guidelines (Page et al. 2021). Fig. 1 illustrates the four main steps involved in our review process—identification, screening, assessment for eligibility, and data analysis.

Identification

Identification involved searching databases to locate a broad sample of articles relevant to our research questions. Two members of the research team searched four databases: Scopus, Business Source Complete, MEDLINE, and CINAHL Complete. Collectively, these databases yielded a broad sample of articles from both the organizational and medical literature on midwifery and well-being. Searches were limited to articles that were (1) peer-reviewed, (2) published between 2000 and 2020, and (3) written in English. Search fields were matched

as closely as possible between databases to include the equivalents of keywords, title, and abstract fields. The same search term strings were used in each database, with only minor modifications to punctuation based on database requirements, ensuring that the search was consistent across databases. The search term strings were:

1. (midwives OR midwife OR midwifery) AND (wellbeing OR 'well-being' OR 'well being')
2. Nurse AND (midwives OR midwife OR midwifery) AND (wellbeing OR 'well-being' OR 'well being').

All articles identified during this step (n = 4,391) were downloaded to Endnote X9, the reference management software we used to manage subsequent steps in the review process.

Screening

In the second stage, two members of the research team removed duplicate articles using a specialized function in Endnote X9, and then screened the remaining articles for relevance to our research question by reading titles and abstracts. Articles that investigated midwives' well-being or closely related phenomena such as burnout, job satisfaction, empowerment, stress, and relationships with mothers were included. Articles were excluded during initial screening if they did not specifically focus on the well-being of midwives or nurse midwives. For example, articles that focused on how midwifery practices impacted mothers' well-being were excluded. We also removed articles that had bypassed initial search limiters.[1]

Assessment for eligibility

In the third step, we performed an eligibility assessment of the 80 articles that passed the initial screening process by reading abstracts and, if required, complete texts. An additional 35 articles were excluded during this step on the basis that (1) they did not report on primary empirical research in the midwifery profession (e.g. they were reviews or discussion papers drawing on secondary data) (n = 27); (2) their empirical findings were not differentiated between midwives or nurse midwives and other medical professionals (n = 7); (3) the study included mixed samples of health professionals in which midwives made up less than 10% of the total sample (n = 1). After excluding these ineligible articles, we were left with a sample of 45 papers for our qualitative analysis.

Data analysis

At the final stage, we implemented a two-step process to analyze full-text articles. First, we used a data extraction table to summarize and code key information from each article by the study's aim, design, method, findings, and implications (Arksey and O'Malley 2005). The data extraction table allowed us to answer the first two descriptive research questions: (1) how have researchers studied midwives' well-being; and (2) what are the key findings of research on midwives' well-being? Next, we synthesized and assessed the full-text articles to answer the last two evaluative questions: (3) what are the underlying assumptions of research on midwives' well-being; and (4) what are the limitations of research on midwives' well-being? From the extracted articles, we sought to identify patterns or themes relevant to our third and fourth research questions (Cronin and George 2020). Drawing on our collective knowledge of the broader well-being literature, we worked together to develop and refine these themes through repeated rounds of reading and discussion.

FINDINGS

How have researchers studied midwives' well-being?

We coded the articles to identify the predominant study designs, methods, measures, constructs, theoretical perspectives, study locations, and work settings investigated in empirical research on midwives' well-being.

Study designs, methods, measures, and constructs

Table 1 shows the study designs and methods used in our sample. Most of the articles were quantitative (n = 24), followed by qualitative (n = 17) and mixed methods (n = 4). Nearly half of the quantitative studies (n = 20) used a cross-sectional survey design. Three studies used a pre- and postintervention design. Regarding qualitative research, interview studies were the most common design (n = 16). Individual interviews dominated this space (n = 8), followed by group interviews (n = 4) and combinations of the two (n = 4). A few studies supplemented interview data with diary entries (Bedwell et al. 2015) or researcher notes based on observations (Donald et al. 2014; Hunter 2006). The only qualitative study that did not employ interviews as a data collection technique used open-ended survey responses (Cull et al. 2020).

Table 1 also shows well-being measures and constructs used across quantitative, qualitative, and mixed methods studies. Mental health constructs were the most common (n = 27), followed by practice-related constructs (n = 14). Only one study used life satisfaction as a proxy for midwives' well-being (Jarosova et al. 2017). In quantitative research, most studies (n = 15) investigated burnout as a well-being construct, relying predominantly

Table 1 Research designs, methods, measures, and constructs in well-being research on midwives.

Research design	Quantitative: N = 24	Qualitative: N = 17	Mixed Methods: N = 4
Unit of analysis	Individual: N = 24	Individual: N = 17	Individual: N = 4
Design of study/ data collection method	Cross-sectional survey: N = 20 Pre- and postintervention study: N = 3 Diary study: N = 1	Individual interviews (including semi-structured, unstructured, photo elicitation): N = 12 Group interviews/ focus groups: N = 8 Ethnography (researcher notes and observations): N = 2 Diary study: N = 1 Open-ended survey: N = 1	Cross-sectional survey: N = 3 Individual interviews: N = 2 Focus groups: N = 1 Self-administered survey: N = 1
Measures and constructs	Mental health • Burnout: N = 15 • Depression, anxiety, and stress: N = 7 • Post-traumatic stress disorder: N = 4 • Exhaustion and fatigue: N = 1 • Affect: N = 1 Practice • Quality of work life: N = 6 • Job satisfaction: N = 4 • Empowerment: N = 3 • Perceived support: N = 3 Other • Life satisfaction: N = 1	Mental health • Stress: N = 5 • Fatigue and exhaustion: N = 2 Practice • Perceived support: N = 1 • Confidence: N = 2 • Relationships with mothers: N = 1	Mental health • Burnout: N = 1 • Depression, anxiety, and stress: N = 1 Practice • Confidence: N = 1

on the Copenhagen Burnout Inventory or the Maslach Burnout Inventory as measurement tools. Other mental health constructs commonly investigated in quantitative research included depression, anxiety, and stress (n = 7) and post-traumatic stress disorder (PTSD) (n = 4). Quality of work life (n = 6), job satisfaction (n = 4), and perceived empowerment and support (n = 3) were the most prevalent practice-related constructs in quantitative studies. Qualitative studies generally focused on stress as a mental health construct (n = 5) but also investigated fatigue and exhaustion (n = 2). Midwives' relationships with mothers (n = 1) and support from colleagues (n = 1) were also investigated as proxies for well-being.

Theoretical perspectives

Our review showed that empirical research on midwives' well-being is mostly atheoretical. A small number of qualitative studies (n = 3) employed theoretical frameworks that drew from other disciplines. For example, Donald et al. (2014) explored midwives' work–life balance by applying critical social science theory (Stevens 1989), while Holly and Swanson (2019) used the theory of planned behavior (Ajzen 1991) to identify facilitators and barriers to physical activity among midwives. In another study, researchers used the positive emotion, engagement, relationships, meaning, and achievements (PERMA) model (Seligman 2011) to examine the effects of positive psychology interventions on midwives' psychological well-being (Shaghaghi et al. 2019).

Study locations and settings

While studies in the sample were conducted in 22 countries across five continents, more than half of the studies were carried out in Australia (n = 15) or the UK (n = 9) (see Fig. 2). New Zealand was the only other country that produced more than two studies on midwives' well-being (n = 4). We limited our search to peer-reviewed journals written in English, which may partly explain the over-representation of English-speaking countries in our final sample.

Study participants were drawn from a range of midwifery work settings, including general hospitals (n = 10), tertiary hospitals (n = 8), and community organizations (n = 5) (see Fig. 3). Researchers using mixed samples frequently recruited participants through professional networks or through a larger collaborative project such as the Work, Health, and Emotional Lives of Midwives (WHELM)—an international project that has produced several studies (n = 4) on midwives' well-being in Australia, New Zealand, and the UK.

What are the key findings of research on midwives' well-being?

To summarize the key research findings on midwives' well-being, we developed a nomological network of

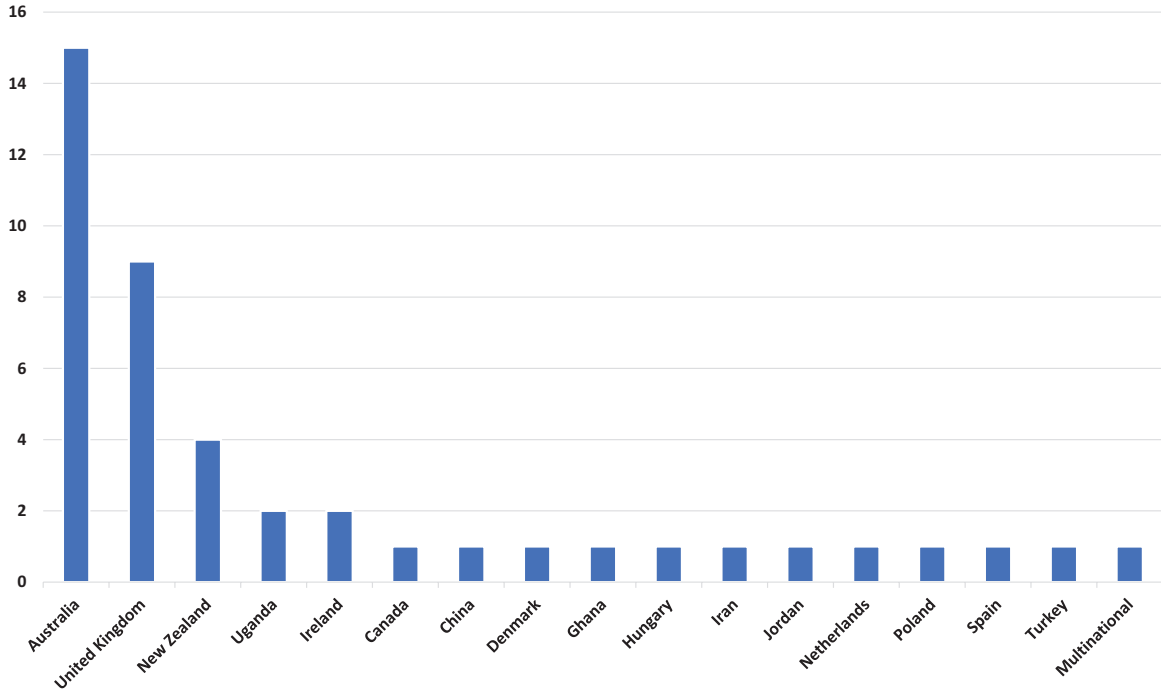

Figure 2 Study locations of well-being research on midwives' well-being.

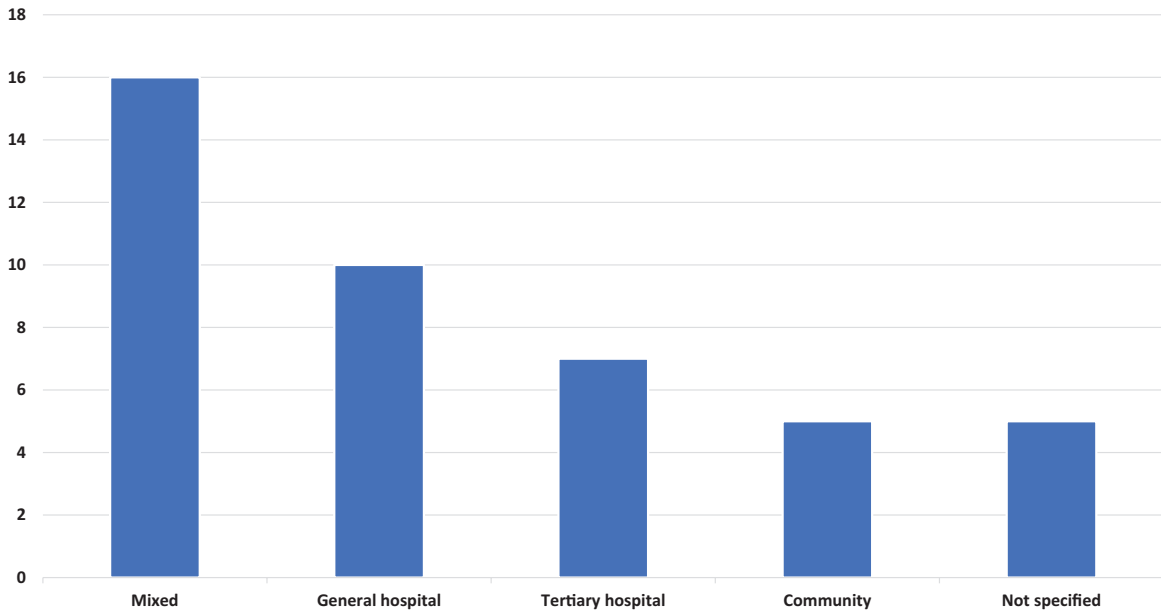

Figure 3. Work research contexts in well-being research on midwives.

antecedents and outcomes, as depicted in Fig. 4. From this network of antecedents and outcomes, we focus on predominant factors which are workload, managerial and peer support, model of maternity care, age and work experience, workplace culture, work–life balance, intent to quit, and professional loneliness. Developing a nomological network is consistent with other integrative reviews (e.g. Zhang and Parker 2019).

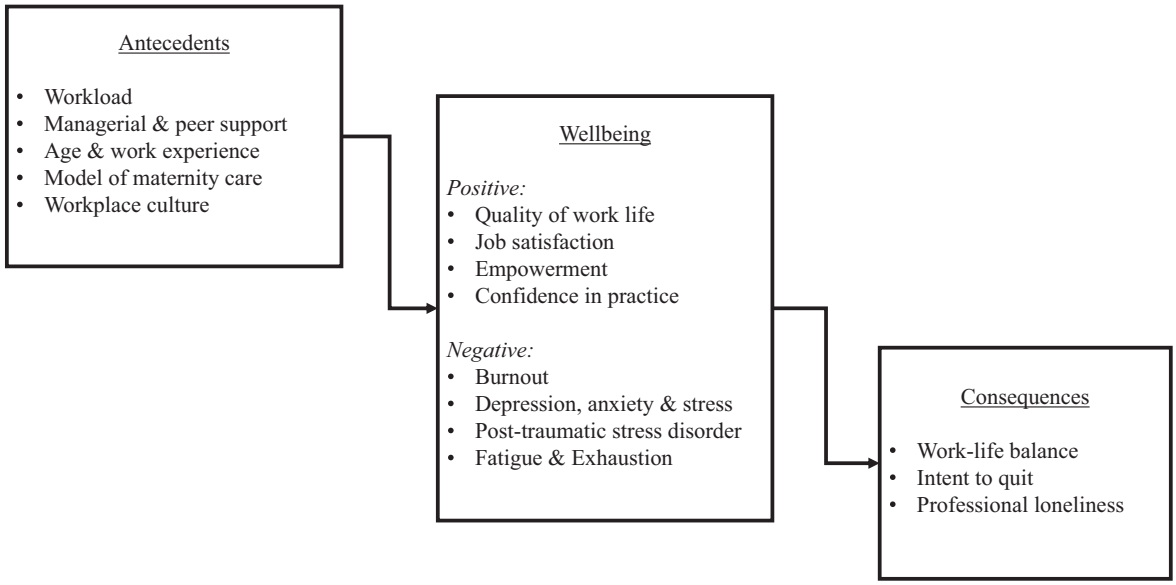

Figure 4. Antecedents and consequences of midwives' well-being.

Antecedents of midwives' well-being

Workload.

The most prominent antecedent of midwives' well-being in extant research is workload. Workload refers to the amount or quantity of work in a job (Spector and Jex 1998). In midwifery, the volume of work is compounded by time pressure, shift work, unpredictable and long hours, and lack of control over pacing (Leka and Jain 2010). Midwives reported heavy workloads due to poor staffing, excessive paperwork, scarce equipment, long hours with insufficient breaks, and unreasonable shift rosters (Krémer et al. 2016; Harvie et al. 2019; Stoll and Gallagher 2019; Cull et al. 2020).

Managerial and peer support.

Managerial and peer support encapsulates the encouragement, trust, and resources provided by senior management, line managers, and colleagues (Edwards et al. 2008). Our review shows that midwives' self-confidence is boosted when colleagues show trust, especially if those colleagues are influential and highly regarded (Bedwell et al. 2015). Midwives expressed considerable appreciation for managerial support that removes barriers and allows them to provide woman-centered maternity care (Dixon et al. 2017). Recent work has shown that environments characterized by managerial and peer support helped midwives cope with care for clients infected with Covid-19 (González-Timoneda et al. 2021). In contrast, poor relationships and lack of support have been shown to worsen midwives' well-being (Cull et al. 2020).

Model of maternity care.

Midwifery work models emerged as key drivers of well-being. Existing research has found that midwives providing maternity care in a fragmented, rostered model, experience higher levels of work-related burnout, anxiety, and depression (Jepsen et al. 2017; Fenwick et al. 2018b; Harvie et al. 2019; Hunter et al. 2019). These midwives also indicated that undesirable work factors linked to burnout (i.e. lack of managerial support, lack of professional recognition, and lack of development opportunities) were prevalent in their work setting (Dixon et al. 2017). In contrast, midwives working in a continuity-of-care model characterized by self-determined caseloads typically report better well-being outcomes. Midwives working in the continuity-of-care model reported reduced burnout and better work–life balance (Fenwick et al. 2018b).

Age and work experience.

Regarding demographic and employment characteristics, the literature we reviewed shows that age and work experience are strongly related to midwives' well-being. Most midwifery well-being research has shown that both younger (≤35 years old) and less experienced (5–10 years) midwives experience a greater reduction in well-being, especially burnout when faced with challenges and

other negative factors (Jordan et al. 2013; Henriksen and Lukasse 2016; Fenwick et al. 2018b; Harvie et al. 2019; Hunter et al. 2019; Amir and Reid 2020; Mohammad et al. 2020).

Workplace culture.

Workplace culture refers to the implicit social order of a collective (Groysberg et al. 2018). This unspoken social order underpins norms and attitudes that enable or stymie midwives in their roles (Catling et al. 2017). Midwives subjected to bullying and professional disrespect reported increased frustration, stress, and intent to quit (Catling et al. 2017; Geraghty et al. 2019). Midwives also identified compromised professional values and organizational restrictions as sources of reduced well-being (Harvie et al. 2019; Lewis et al. 2020). The external climate of work reviews and litigation was a notable antecedent of reduced well-being among midwives (Hood et al. 2010; Robertson and Thomson 2014).

Although we have summarized five key antecedents of midwives' well-being, the midwifery literature is fragmented. Other factors that shape midwives' well-being include high-needs clients/patients (Eadie and Sheridan 2017), the midwife–client/patient relationship (Hunter 2006), sleep deprivation (Donovan et al. 2020), and birth room designs (Hammond et al. 2017). We limited our summary to antecedents that appeared most frequently in the midwifery well-being literature.

Outcomes of midwives' well-being

Work–life balance.

Work–life balance refers to an individual's subjective assessment of the accord between their work activities, nonwork pursuits, and life in general (Brough et al. 2014). This definition proposes that work–life balance is a subjectively acquired resource that individuals can gain or lose depending on their work, nonwork, and life circumstances. Research has also shown that midwives experiencing low levels of well-being (i.e. high levels of emotional, physical, and mental exhaustion) reported difficulties in achieving work–life balance (Donovan et al. 2020). However, the work–life balance of self-employed midwives was influenced by the size and type of their caseload, rural versus urban locality, strength of collegial support structure for work relief, and the quality of interpersonal relationships with midwifery colleagues (Donald et al. 2014). Interestingly, researchers have not identified significant differences in the work–life balance of midwives working in continuity or non-continuity work models (Fenwick et al. 2018a).

Intent to quit.

Also known as voluntary turnover, intent to quit refers to individuals' deliberations about leaving their current role. Existing research has found that intent to quit the midwifery profession is primarily driven by compassion fatigue, dissatisfaction with workload, and work conditions (Harvie et al. 2019; O'Riordan et al. 2020). Other research has shown that midwives' intent to quit is driven by professional costs (e.g. licensing, insurance), job factors (e.g. scheduling, pay), interpersonal factors (e.g. bullying, conflict), family commitments, and physical and mental health concerns (Stoll and Gallagher 2019).

Professional loneliness.

Professional loneliness refers to negative subjective feelings regarding how an individual's affiliation needs are being met by the people they work with and their profession (Ozcelik and Barsade 2018). In midwifery, professional loneliness has been linked to exhaustion and to working in nonstandard environments such as obstetric high-dependency units (Eadie and Sheridan 2017). Recent work has also highlighted professional challenges for midwives working through the Covid-19 pandemic. Midwives have reported increased anxiety, uncertainty, discomfort, and lack of knowledge (González-Timoneda et al. 2021), all of which are attitudes and feelings that characterize professional loneliness. Also related to professional loneliness, midwives reported feelings of fear and isolation when dealing with external reviews and the litigation process (Hood et al. 2010; Robertson and Thomson 2014).

What are the underlying assumptions of research on midwives' well-being?

Midwives' well-being is equivalent to the absence of mental health problems

A common assumption in the literature is that midwives' well-being is equivalent to the absence of mental health problems. Across both quantitative and qualitative studies, mental health-related constructs were the most prevalent proxies for midwives' well-being (n = 26). In quantitative research, measures of well-being included burnout (n = 15); anxiety, depression, and stress (n = 7); PTSD (n = 4); fatigue (n = 1); and affect (n = 1). Qualitative studies also explored mental health constructs as underlying well-being concepts. Five qualitative studies focused on midwives' experiences of negative stress, while two studies explored their experiences of fatigue and exhaustion. Importantly, these findings imply that researchers tend to equate midwives' well-being not only with their mental health, but with the *absence* of mental health problems.

The most prevalent mental health constructs in the literature—burnout, stress, anxiety, depression, PTSD, exhaustion—are all indicators of *negative* mental health status. As such, an underlying assumption of extant research is that if a midwife is not experiencing some sort of negative mental health condition, they must be experiencing well-being.

Work-related factors primarily shape midwives' well-being

Another unspoken assumption of existing research is that work-related factors are the primary determinants of midwives' well-being. As shown in the previous section, the main antecedents of well-being examined in the literature relate to midwives' professional activities: workload, managerial and peer support, model of maternity care, work experience (and age), and workplace culture. While it might be expected that most research would focus on work-related determinants of midwives' well-being—given that being a midwife is, after all, a form of paid work—we posit that the almost exclusive focus on work-related factors stems from a false assumption: namely, that other aspects of midwives' lives are less important to their well-being. As discussed earlier, midwifery is a gendered, medicalized, and colonized profession (Clesse et al. 2018; Kemp et al. 2021; Sarmiento et al. 2021). Therefore, the assumption that proximal work-related antecedents are the primary factors shaping midwives' well-being discounts the importance of broader structural elements such as gender, culture, and labor legislation.

Midwives' well-being must be justified as enhancing work-related outcomes

The final unspoken assumption we see is that research on midwives' well-being is often conducted with a view toward enhancing work-related outcomes. This assumption was evidenced by the prevalence of studies treating practice-related constructs as proxies for well-being (n = 14) and in the focus on work-related outcomes—intent to quit, professional loneliness—as consequences of well-being, as shown in the previous section. We speculate that this assumption stems from a perceived need to justify well-being research according to the principles of the prevailing neoliberal socioeconomic order (Calvard and Sang 2017). Neoliberalism tends to treat employees in an instrumental fashion, primarily viewing them as a means of improving organizational performance (Guest 2017).

What are the limitations of research on midwives' well-being?

Lack of theoretical development and integration

Research on midwives' well-being is not theoretically well developed or integrated. This review revealed that most well-being research in the midwifery profession is atheoretical. Atheoretical research tends to focus on solutions for immediate problems and generates knowledge limited to a specific issue (Saunders et al. 2012). Only one quantitative study (Shaghaghi et al. 2019) and three qualitative studies (Donald et al. 2014; Eadie and Sheridan 2017; Holly and Swanson 2019) used theoretical frameworks a priori. For example, Holly and Swanson's (2019) use of the theory of planned behavior to understand facilitators and barriers of physical activity in midwives is unconnected to Shaghaghi et al.'s (2019) use of the PERMA model to explain outcomes of positive psychology interventions. The minimal and ad hoc use of theory may inadvertently constrain midwives' well-being research because there are no overarching frameworks to organize assumptions, explanations, and relationships (Ashkanasy 2016). Notably, none of the theories used in the existing research have situated midwives' well-being in broader social, economic, cultural, or political contexts.

Disproportionate focus on individual responsibility for well-being

Another limitation in the midwifery well-being literature is the disproportionate focus on the individual as responsible for creating and maintaining their well-being. Our sample was dominated by studies that explored proximal antecedents such as workload, age and experience, and interpersonal support as factors that shaped midwives' well-being. We also found that intervention studies aimed at improving midwives' well-being were conducted on individual midwives (Hunter et al. 2018; Shaghaghi et al. 2019). While midwives are employed as individuals, they work and live in collective structures. Researchers are increasingly connecting the well-being of individual workers to the well-being of people inside (e.g. clients, colleagues) and outside (e.g. family, community) of the workplace (Pocock et al. 2012). Ignoring collective elements produces a decontextualized understanding of what shapes midwives' well-being (Cooke 2018).

Lack of diversity within midwifery well-being research

While some elements of diversity (i.e. age, work experience) have been examined, other differences (i.e. parental status, household income, cultural background) are yet to be explored in any depth. The lack of research accounting for diversity amongst midwives has the unintended effect of presenting them as a homogenous group whose well-being is experienced similarly and shaped by the same factors. Like the families they care for, midwives represent diverse populations (Kennedy et al. 2006; Burton and Ariss 2014; Wren Serbin and Donnelly 2016).

Toward a contextualized framework of researching midwives' well-being

As expressed above, research on midwives' well-being has several limitations. These include a narrow interpretation of the construct, a general assumption that well-being is only important when it leads to improved individual and organizational outcomes, and an overarching focus on individuals' experiences, overlooking the broader context of the profession. While some scholars have investigated the effect of workplace culture, interpersonal relationships, and model of care as proximal antecedents (Bedwell et al. 2015; Catling et al. 2017; Fenwick et al. 2018b), more research is needed to assess the influence of broader, distal factors that also impact midwives' well-being. Drawing on broader contextual models of well-being, we develop and present a research framework to aid scholarship on the contextual elements influencing midwives' well-being. Although developed in the midwifery context, our proposed research model can be applied to a host of professions.

Theoretically integrated research

We posit that a stronger emphasis on theoretical integration will improve research on factors that enhance or hinder well-being. Theoretically integrated research expands knowledge of phenomena and can lead to universal principles of significance and value to organizations, professions, and society (Saunders et al. 2012). As illustrated in Fig. 5, we advance an overarching theoretical framework for investigating midwives' well-being incorporating proximal and distal contextual elements. Our framework combines well-being-related frameworks, including the total work health framework (Chari et al. 2018), the socioecological systems model (Pocock et al. 2012), and the sociostructural perspective on violence against employee well-being (Calvard and Sang 2017). These frameworks enable researchers to move beyond the atheoretical approaches to studying worker well-being. For example, the socioecological systems model maintains that work–life balance—a key facet of well-being—is tied to the intersecting domains of work, family, and community life (Pocock et al. 2012).

Construct expansion

An underlying assumption in most studies is that midwives' well-being can be equated to the absence of mental health problems. Scant research has explored positive indicators of midwives' well-being, such as happiness, self-efficacy, financial security, community involvement, physical health and fitness, and spiritual connection. To address this research limitation, we propose that future studies broaden what constitutes well-being for midwives. While constructs developed

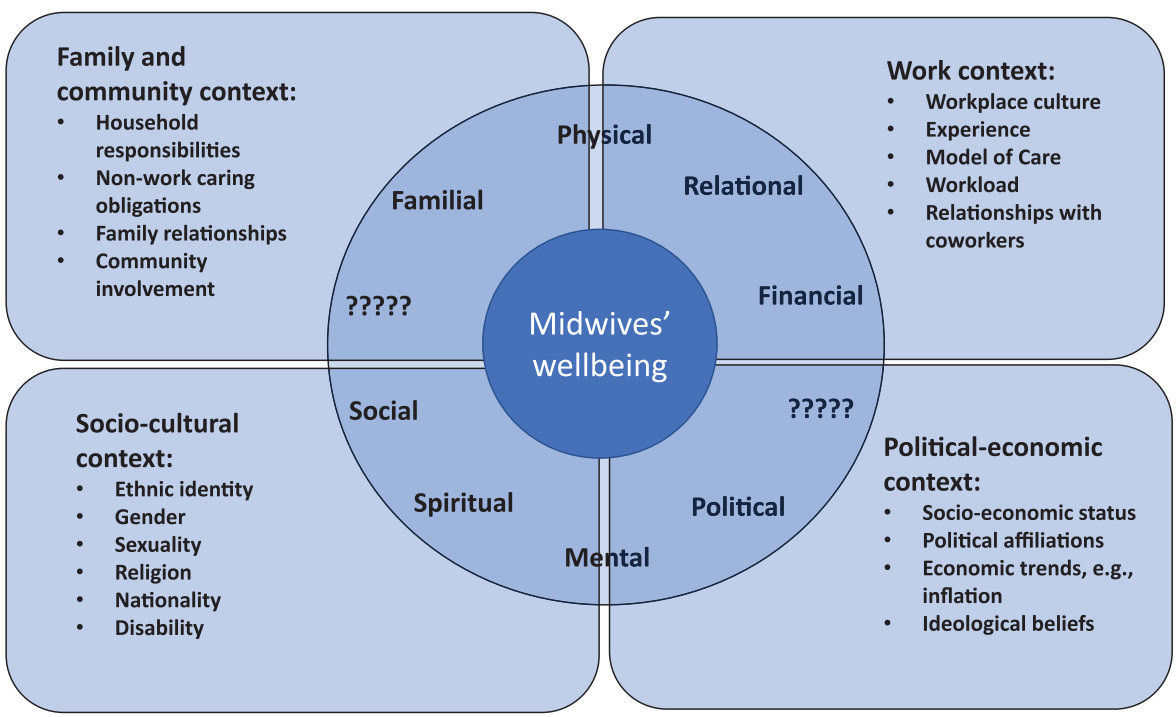

Figure 5. A contextualized framework for researching midwives' well-being.

in occupational health (Hakanen et al. 2018), management (Grant et al. 2007), and organizational behavior (Sonnentag 2015) dominate the employee well-being literature, we recommend broader, context-specific conceptualizations of well-being. Sociological and employment relations approaches may be better suited to exploring midwives' well-being because they account for contextual factors such as gender, ethnicity, religion, and socioeconomic status (Calvard and Sang 2017). Furthermore, in terms of investigating the subjective elements of well-being, it makes sense to ask midwives about what well-being means to them. In this respect, qualitative and inductive research conducted in the interpretivist tradition seems appropriate for expanding the well-being construct as it pertains to midwives, because it privileges the views and experiences of participants over the preconceptions of researchers (Gephart 2018).

Moving beyond the individual

We contend that research on midwives' well-being should move beyond the individual as the sole focus of analysis. While focusing on individuals is consistent with well-being research in management and organizational literature (Fisher 2014; Plomp et al. 2016; Tonkin et al. 2018), it fails to acknowledge broader, non-Western conceptualizations that position well-being as a collective phenomenon (Calvard and Sang 2017; Schwarz 2018). For this reason, we advocate for future research that incorporates both proximal and distal antecedents of midwives' well-being. Study designs that account for the influence of individual midwife characteristics, interpersonal relationships at work, family and community obligations, professional and regulatory bodies, labor laws, gender, practice, and culture are likely to produce a nuanced understanding of midwives' well-being.

A contextualized framework of researching midwives' well-being

Although developed within the midwifery context, Fig. 5 depicts a framework researchers can leverage to conduct contextualized well-being research within the professions. Our model draws from several disciplines including occupational health (Chari et al. 2018), industrial relations (Pocock et al. 2012), management and organization (Calvard and Sang 2017; Cooke 2018), and locates worker well-being in the center of overlapping contextual domains. The four domains we specify are the work context, the family and community context, the sociocultural context, and the political–economic context. Within each of these contexts, we give examples of distal factors that may influence midwives' well-being. For example, 'household responsibilities' and 'community involvement' could affect midwives' well-being in the context of family and community life (Pocock et al. 2012). Although the four domains are depicted as separate in the figure, we argue these domains are interrelated and influence one another. The four contextual domains overlap with the circle representing midwives' well-being to show how the domains can separately and together impact midwives' well-being, whether positively or negatively. Inside the circle representing midwives' well-being, we have proximal constructs such as 'mental', 'financial', and 'physical' to show that midwives' well-being is multidimensional and that certain contextual domains are more likely to affect specific dimensions of well-being than others (Chari et al. 2018). We intentionally leave some constructs as question marks because we do not claim to know all the factors that shape midwives' well-being (Calvard and Sang 2017).

Some extant research has explored how the work environment impacts midwives' well-being. However, researchers have paid little attention to how broader structures shape midwives' well-being. As explained earlier, midwives work in various healthcare systems that are embedded in larger socioeconomic and cultural structures (Eri et al. 2020; Mattison et al. 2020). For example, midwives in New Zealand and Australia work in state-funded healthcare systems that are part of postcolonial sociocultural structures. Historically, these structures have privileged Western ways of providing health care by mandating the use of a biomedical model and suppressing indigenous knowledge and practice (Vaka et al. 2016; Moewaka Barnes and McCreanor 2019). Researchers know little about how working within these structures affects midwives' well-being. Our contextualized framework of researching midwives' well-being provides a theoretical basis for investigating how sociocultural context impacts midwives' well-being. By including political–economic, sociocultural, and family/community domains, our framework shifts the focus from individual characteristics and organizational factors as the primary antecedents of midwives' well-being. Lastly, our model creates space for researchers to design studies that acknowledge and makes space for diversity within the profession.

CONCLUSION

Through an integrated review, we systematically sought and collated literature on midwives' well-being. We then proceeded to synthesize and evaluate the literature to understand how researchers have studied midwives'

well-being, key findings, underlying assumptions of extant research, and research limitations. We showed that research on midwives' well-being is disproportionately focused on the individual and is largely equated with the absence of mental health problems. We have also shown that researchers have limited their scholarship to individual and proximal work-related factors. While a narrow view of midwives' well-being may be useful for managing midwives, it prevents the implementation of structural, long-term solutions that address the actual things that limit well-being.

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NOTES

1 Scopus did provide a means of limiting results to peer-reviewed articles. Thus, one researcher checked all relevant articles located through this database in ULRICHSWEB to ensure peer-reviewed status. All articles identified via Scopus were peer reviewed.

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