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Views and engagement with clinical research: A cross-sectional survey of New Zealand midwives and nurses

R.M. Robin Cronin [a,b,*], R.M. Billie Bradford [a,c], R.M. Kimberley Morris [a], R.M. Fiona Blaser [a], R.M. Ivy Shen [a], R.M. Shekinah Gafa [a], R.M. Shelley Ashcroft [a], R.M. Judith McAra-Couper [d], R.M. Celia Grigg [e], R.N. Cathleen Aspinall [a,f]

[a] Health New Zealand - Te Whatu Ora Counties Manukau, Auckland, New Zealand
[b] Department of Obstetrics, Gynaecology and Reproductive Sciences, University of Auckland, New Zealand
[c] Department of Obstetrics and Gynaecology, Monash University, Victoria, Australia
[d] School of Clinical Sciences, Auckland University of Technology, Auckland, New Zealand
[e] Health New Zealand - Waitaha Canterbury, New Zealand
[f] Department of Nursing and Midwifery, Monash University, Victoria, Australia

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ABSTRACT

Background: In New Zealand (NZ), the combined workforces of midwives and nurses comprise the largest proportion of the health workforce. Their involvement in clinical research is fundamental to delivering evidence-based healthcare, with clear benefits for consumers, clinicians, and organisations. Despite professional expectations to engage with evidence, little is known about their views and engagement with research.
Aim: To explore views and engagement with research among registered midwives and registered nurses in a large urban health district in NZ.
Methods: A cross-sectional, online mixed methods survey of registered midwives and registered nurses using an adapted validated tool. Quantitative data were analysed for differences between professions, and qualitative free-text responses were analysed thematically.
Results: Respondents comprised 77 registered midwives and 217 registered nurses. Almost half (47.3%, 139) had a postgraduate qualification. Few had been part of a research team (25.5%, 75) or had research skills. Main barriers to research involvement were lack of time and funding, alongside work-life balance. A key motivation was reducing health inequities for Māori and Pasifika communities. All respondents supported consumer participation in research. Nurses were more likely than midwives to report that conducting research was part of their role ($p = 0.040$) and to express concern about its impact on their workload ($p = 0.033$) and consumer participation ($p < 0.001$).
Discussion: Midwives and nurses reported similar positive research views and represent a motivated but underutilised research workforce. However, organisational and individual constraints limit research engagement.
Conclusion: Targeted investment in research capacity could help realise this untapped potential and improve equitable, evidence-based health outcomes.

Statement of Significance

Problem or Issue:

There is limited understanding of registered midwives' and registered nurses' views of, and engagement with, clinical research in New Zealand.

What is Already Known:

The involvement of nurses and midwives in clinical research is essential for evidence-based, high-quality care.

What this Paper Adds:

Registered midwives and registered nurses in New Zealand appear highly motivated to engage in research to improve care and

* Correspondence to: Department of Obstetrics, Gynaecology and Reproductive Sciences, University of Auckland, Auckland, New Zealand.
E-mail address: R.cronin@auckland.ac.nz (R.M. Robin Cronin).

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address ethnic health inequities, particularly for Māori and Pasifika communities. However, organisational and individual barriers limit their research opportunities. Targeted investment to strengthen research capacity could help unlock this untapped potential.

1. Background

Good research that can be translated into measurable health improvements is the cornerstone of high-quality evidence-based healthcare. [1] Healthcare organisations with active research programs report enhanced efficiency, greater satisfaction among healthcare consumers and staff, and improved staff retention. [2] Investing in healthcare research is also associated with financial benefits for organisations. [3] However, the registered midwifery and nursing professions, who undertake much of the "doing" of healthcare research, [4] are underrepresented in leading research projects. This gap can result in studies that don't fully capture the priorities and needs of midwives, nurses, or the communities they serve.

Nonetheless, globally, midwives and nurses are considered the backbone of healthcare, providing the majority of direct clinical care. [5] Their central role in relational face-to-face care uniquely positions them to identify evidence gaps in practice, facilitate research participation, gather data, and implement research findings in clinical settings. [6] Moreover, it is well recognised that midwives and nurses typically have a strong appreciation for research and are keen to integrate it into their practice. [7,8] For this reason, there is growing recognition of the importance of multidisciplinary research teams that include midwives and nurses to enhance the quality, relevance, and translation of research. [9,10]

To bridge the gap between clinical practice and academic research, countries with healthcare systems similar to New Zealand (NZ), including the United Kingdom, Ireland, and Australia, [11–14] have created clinical academic career pathways within their healthcare organisations. In NZ, there is no established requirement for dual clinical-academic roles for midwives and nurses within healthcare frameworks. While a small number of hospitals and universities offer ad hoc positions that blend clinical and academic duties, these are the exception rather than the rule. Furthermore, the professional landscape does not formally acknowledge or provide financial incentives for midwives and nurses who achieve a research master's or doctoral/PhD degree. Thus, those with advanced qualifications often move into leadership or educational roles or relocate abroad for better-supported clinical-academic opportunities.

For these reasons, midwives and nurses with research expertise in NZ are constrained in their ability to make meaningful contributions to research and to mentor emerging researchers. [15] The situation has been described as "research limbo" [16] where healthcare research hovers between the clinical and academic worlds without being truly valued in either. This means that many of the evidence gaps identified by midwives and nurses as they provide frontline care remain unaddressed and underutilised in shaping healthcare policy and practice.

In NZ, the organisation of maternity care further shapes opportunities for research engagement. Midwifery and nursing are distinct professions with separate regulatory authorities (the Midwifery Council and the Nursing Council of New Zealand) and independent education pathways for registration. Midwifery is an autonomous profession, with most care delivered through a continuity-of-care model by Lead Maternity Carers, who are often self-employed and community-based. While this model supports relational, woman-centred care, it also places many midwives outside organisational settings where research infrastructure and funding are typically located, which may limit opportunities for research engagement compared with hospital-based professionals such as nurses.

Therefore, it is important to explore the gap in knowledge of research capacity among registered midwives and registered nurses in NZ, through examining their views of clinical research and engagement in research. This information will contribute to developing a sustainable midwifery and nursing research framework in healthcare settings, thereby supporting quality improvement in health outcomes and promoting equity.

2. Methods

2.1. Study design

An anonymous self-complete cross-sectional, online mixed methods survey.

2.2. Setting

A single-centre study conducted in the large urban health district of Health NZ - Te Whatu Ora Counties Manukau in Auckland, NZ. The district serves a culturally diverse population, with the greatest number of births nationally (around 8000 annually) and the largest Pacific population.

2.3. Participants

Eligible participants were registered midwives and registered nurses currently providing healthcare within the district (collectively referred to as 'midwives and nurses'). Midwife participants included both core and Lead Maternity Carer (LMC) midwives, encompassing employed and self-employed roles.

2.4. Ethical approval

Ethical approval was obtained from the Auckland Health Research Ethics Committee (12/03/21; reference AH22024), with locality approval from Health NZ – Te Whatu Ora Counties Manukau. An amendment to include registered nurses was approved on 20/09/21. Participants provided informed consent, and all data were de-identified.

2.5. Recruitment

Recruitment of registered midwives was originally planned for 2021. However, midwifery workforce shortages in the wake of the COVID-19 pandemic persisted. The survey was subsequently placed on hold while additional funding was sought to employ research assistants to support recruitment.

During this period, the Nurse Director of Research in the health district requested that registered nurses be included in the survey. Internationally, midwives and nurses are often grouped together in research because midwifery commonly exists as a nursing subspecialty or is practised by nurse-midwives. In Aotearoa-New Zealand (NZ), however, midwifery is an autonomous regulated profession with a distinct model of care and education pathway, and the professions are therefore less commonly studied together. Despite these differences, including the registered nurses would strengthen the study by capturing the perspectives of both professions, who together represent a large proportion of the frontline health workforce and play important roles in supporting and delivering clinical research within healthcare settings. The survey was therefore revised to incorporate the registered nurses, and an ethics amendment and funding were obtained, enabling recruitment to commence in 2023.

The survey was promoted over a six-week period between 21/08/23 and 01/10/23. It was disseminated to midwives and nurses through established hospital-based midwifery and nursing email databases, including both employed staff and clinicians with access agreements (e.g., LMC midwives), via an emailed invitation with an embedded link to

the web-based survey hosted on the Qualtrics® platform. Research assistants visited staff workplaces, displayed posters, and verbally reminded staff about the survey. Participants self-completed the survey on a workplace computer or personal electronic device (e.g., computer, mobile phone, tablet) at a time of their choosing. A reminder email was sent three weeks after the initial invitation.

2.6. Survey instruments

The survey tool (Supplementary file 1) was developed in consultation with a team comprising experienced researchers, clinical midwives and nurses, advisors of Māori and Pasifika ethnicity, and midwifery students with an interest in research. Survey questions were informed by questionnaires on midwifery and nursing research from countries with similar health systems (United Kingdom, Ireland, and Australia) [7, 11–14,17–20] with novel context-specific questions for the NZ context. The questions included multiple-choice, five-point Likert scale items, and free-text, to collect quantitative and qualitative data. Initial variables collected included ethnicity, age, qualifications, work roles and hours, and research experience. Subsequent questions ascertained research skills, barriers and motivators to engagement in research, and views of research. The survey took approximately 15 min to complete.

2.7. Sample size

The minimum sample size for the survey (95% confidence level and 5% margin of error) was calculated to be 327 participants. This was based on a population of approximately 2210 eligible participants (218 registered midwives and 1992 registered nurses) within the Health NZ - Te Whatu Ora Counties Manukau district in 2023. [21,22]

2.8. Data Analysis

Data were exported from Qualtrics® and cleaned using IBM SPSS Version 30. Records with no responses were removed. Respondents were included if they responded to more than 80% of the questions. [23] This threshold was applied to ensure adequate data completeness for analysis while minimising unnecessary exclusion of partially completed responses, consistent with common practice in survey research. There was no imputation for missing data and incomplete responses were excluded from analysis. Not all survey items were mandatory, and some questions were conditional on earlier responses (e.g., research experience), resulting in variation in response numbers across survey sections. Due to small numbers, nurse practitioners (n = 6) were grouped with registered nurses (n = 211). Prior to analysis, any potentially identifiable free text data were de-identified, and an ID was assigned (midwives: M1 to M77; registered nurses: N1 to N217).

Survey data were analysed using descriptive statistics (number and %) for conventional survey items. Responses were compared using Pearson chi-square and Fisher's exact test for differences between the midwives and nurses and analysed in IBM SPSS Statistics Version 30. Statistical significance was defined at the p-value of < 0.05.

To simplify analyses, the 5-point Likert scale items were dichotomised into 'agreement' (mildly agree, strongly agree) and 'non-agreement' (neither agree nor disagree, mildly disagree, strongly disagree) for research barrier and motivators (Table 3) and views of organisational support, research role, and consumer participation (Table 4). This 'non-agreement' grouping was recommended in the literature [24] to allow focus on overall trends and meet the assumptions of statistical tests.

In response to the multiple-choice questions, some respondents selected 'other (please tell us)' and provided free text explanations. A sample of these explanations was used to illustrate the quantitative responses. In addition, a thematic analysis approach [25] of the free text answers to respondents views of groups of healthcare consumers less likely to participate in research was undertaken. This included familiarisation with the data, grouping responses using the study objectives, identifying emergent themes, and distillation into key themes that captured the scope and content of the data, using NVivo Version 14.

Less informative items from Table 3 were moved to the supplementary material to improve clarity and highlight key findings; the full table is provided in Supplementary File 1. For Table 4, only items demonstrating variation between groups and selected key items with near-universal agreement are presented; the full table is available in Supplementary File 1.

3. Results

Of the 488 who opened the survey link, 294 of the registered midwives and registered nurses completed ≥ 80% of the survey [26] and were eligible (77 registered midwives, 211 registered nurses, 6 registered nurse practitioners) (Fig. 1). This comprised around 35.3% (77/218) of the midwives and 10.9% (217/1992) of the nurses working within the health district. [21,22] The prioritised ethnicities [23] of the respondents self-identifying as primarily non-European (179, 60.9%), were consistent with the ethnic diversity of the health professionals in the district [27] (Table 1). Over half (150, 51.0%) usually worked ≥ 40 h per week, were aged ≤ 39 years (173, 58.8%), and mainly worked within the hospital environment (254, 86.4%). Compared with the nurses, the midwives were more likely to work fewer than 40 h per week, in a community-based environment, and report Māori or European ethnicity, and less likely to be of Pacific or Indian ethnicity and to have a postgraduate qualification.

A postgraduate qualification was common (139, 47.3%) and one in five (53, 18.0%) were currently undertaking postgraduate study. Just over one quarter (75, 25.5%) had ever been part of a research team or a research participant (82, 27.9%). A midwife wrote, *'I was a participant in research and carried out a research project for my Masters, but I think unless midwives are actively taking part in post graduate study there is no incentive and very limited time/brain space for any sort of research projects'* (Midwife M10). The majority who described themselves as lead investigators had undertaken a project for their postgraduate qualification, were conducting a workplace audit, or were research coordinators for their site. Most (200, 68.0%) were unaware of the free annual research week showcase in their health district, which includes midwifery and nursing research.

The research skill levels of the respondents were limited (Supplementary file 2: Table 1 and Fig. 1), with the most reporting that they had 'never done this' across all the research skills. Although, this paucity of research skills was rarely by choice, illustrated by this nurse, *'I really required the support to be able to navigate summarising dissertation to be a research article for a journal - and this was NOT available for me at the time.*

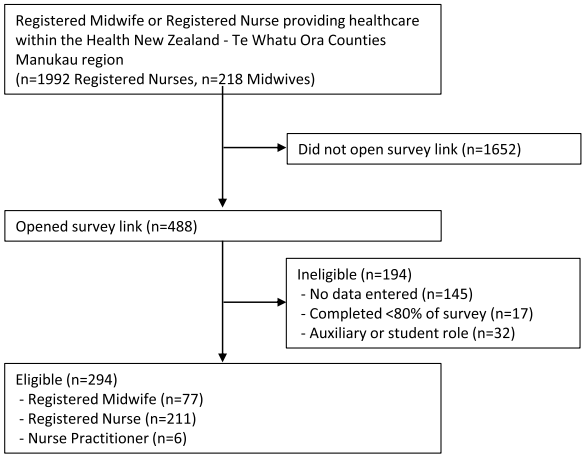

Fig. 1. Flowchart of a survey of research views and engagement among midwives and nurses in an urban health district in New Zealand.

Table 1
Respondent demographics and research engagement.

	n = 217 (%)	n = 77 (%)	p-value[a]
	Nurses	Midwives	
Current professional role			
Registered Nurse	211 (71.8)	-	-
Nurse Practitioner	6 (2.0)	-	
Midwife	-	77 (26.2)	
Usual work hours per week			
40 h or more	129 (59.4)	21 (27.3)	< .001
30–39 h	69 (31.8)	35 (45.5)	
20–30 h	14 (6.5)	18 (23.4)	
10–19 h	3 (1.4)	1 (1.3)	
< 10 h	2 (0.9)	2 (2.6)	
Main work environment			
Hospital-based	196 (90.3)	58 (75.3)	< .001
Community-based	3 (1.5)	16 (20.8)	
Clinical education/management	18 (8.3)	3 (3.9)	
Prioritised ethnicity			
Māori	17 (7.8)	9 (11.7)	< .001
Pacific	27 (12.4)	5 (6.5)	
Indian	45 (20.7)	4 (5.2)	
Asian non-Indian	56 (25.8)	15 (19.5)	
Other European	20 (9.2)	20 (26.0)	
New Zealand European	51 (23.5)	24 (31.2)	
Other ethnicities	1 (0.5)	0 (0)	
Age			
20–29 years	43 (19.9)	18 (23.4)	0.108
30–39 years	90 (41.5)	22 (28.6)	
40–49 years	43 (19.8)	13 (16.9)	
50–59 years	32 (14.7)	17 (22.1)	
≥ 60 years	9 (4.1)	7 (9.1)	
Highest qualification			
PhD/Doctorate	2 (0.9)	1 (1.3)	< .001
Master's degree	44 (20.3)	5 (6.5)	
Postgraduate diploma	41 (18.9)	7 (9.1)	
Postgraduate certificate	30 (13.8)	9 (11.7)	
Bachelor's degree	93 (42.9)	49 (63.6)	
Hospital-based certificate / diploma	7 (3.2)	6 (7.8)	
Currently studying			
Not currently studying	156 (71.9)	60 (77.9)	0.476
Currently studying	61 (28.1)	17 (22.1)	
PhD/Doctorate	8 (3.7)	1 (1.3)	
Master's degree	9 (4.1)	3 (3.9)	
Postgraduate diploma	8 (3.7)	3 (3.9)	
Postgraduate certificate	18 (8.3)	3 (3.9)	
Bachelor's degree	3 (1.4)	3 (3.9)	
Undergraduate diploma	3 (1.4)	1 (1.3)	
Hospital-based certificate	12 (5.5)	3 (3.9)	
Ever been part of a research team			
No	161 (74.2)	58 (75.3)	0.880
Yes (multiple choice answer)	56 (25.8)	19 (24.7)	
Research assistant	22 (10.1)	9 (11.7)	
Research nurse or midwife	18 (8.3)	12 (15.6)	
Lead investigator	14 (6.4)	3 (3.9)	
Co-investigator	9 (4.1)	1 (1.3)	
Project coordinator	6 (2.8)	2 (2.6)	
Advisor	2 (0.9)	2 (2.6)	
Ever been a research participant			
No	164 (75.6)	48 (62.3)	0.028
Yes	53 (24.4)	29 (37.7)	
Aware of annual health district research week showcase			
No	150 (69.1)	50 (64.9)	0.570
Yes	67 (30.9)	27 (35.1)	
Yes, have attended and presented	2 (0.9)	0 (0.0)	
Yes, have attended	23 (10.6)	6 (7.8)	
Yes, aware but not attended	42 (19.4)	21 (27.3)	

[a] Pearson chi-square or Fisher's exact test if expected cell count < 5

I felt under so much pressure to publish but did not have the tools to do this, I felt abandoned at my 'finish line' (Nurse N105). The most successful skills (moderate and high success) were finding literature (83 respondents, 28.2%) and critically reviewing (82, 27.9%) literature. There were no significant differences between midwives and nurses for any research skills.

When asked if there were groups of people that they provided care for who may be less likely to participate in research, 61% (166 of 272 respondents) reported that there were and explained why (Table 2). Following thematic analysis, the four main themes were time commitment for participation, understanding and communication barriers (e.g., language and cultural barriers), social and financial support impediments (e.g. barriers with access to transport, phone, computer), and lack of trust in research processes (worries about risks of research participation, data security, and communication of results).

Barriers and motivators to midwives and nurses' engagement in research were identified by 198 nurses and 72 midwives (Table 3). Structural barriers were the most prominent, particularly lack of suitable backfill, time, and funding, along with competing work roles and limited organisational support. Individual barriers were also widely reported, including work-life balance, personal commitments, and limited research skills. These patterns were consistent across both professions, with no significant differences between midwives and nurses. A community-based continuity-of-care midwife added, *'I wish I had time/money to do proper research or even read scholarly articles to highlight the profession, I barely have time or energy to write a postcard with all the increased responsibilities and stress, sadly'* (Midwife M7).

Motivation for engagement in research was grouped into equity and practice-driven, intellectual, and professional factors (Table 3). Equity and practice-driven motivators were most prominent, especially the desire to reduce health inequities for Māori and Pasifika communities and to address identified clinical problems. One respondent inquired, *'Can we have more indigenous research pathways to ensure we are capturing the voices of our patients we serve within our community and intentionally support our Māori nurses and midwives into a space of research'* (Nurse N148). Intellectual motivators included developing research skills and

Table 2
Views of groups of people who may be less likely to participate in research.

Do you think some groups of people are less likely to participate in research?			
	n = 201 (%)	n = 71 (%)	p-value[a]
	Nurses	Midwives	
No	80 (39.8)	26 (36.6)	0.637
Yes	121 (60.2)	45 (63.4)	
Themes	**Key quotes: Why do you believe some groups are less likely to participate in research?**		
Time commitment	- 'The time taken to participate and commitment needed is too much for some women.' (Midwife M41) - 'If people don't see the immediate benefit, the time commitment required can be a barrier.' (Nurse N39)		
Communication barriers	- 'Some groups have language barriers and would prefer to avoid unnecessary communication (not directly related to their care).' (Midwife M2) - 'Those with English as a second language, or limited language skills are less likely to take part in research.' (Nurse N80)		
Social and financial impediments	- 'Women that are unsupported and socially challenged with financial and social concerns will not see research as important enough to add to the commitments they already have.' (Midwife M58) - 'Those with social issues may have too much going on in their lives to want to participate, also contacting them may be an issue if they don't have adequate resources eg, phone, credit, data, wifi.' (Midwife M43)		
Lack of trust in research	- 'Research fatigue - Māori and Pasifika whaanau [families] are often asked to participate in research where they detail their experiences, but nothing seemingly changes as a result of this.' (Nurse N30) - 'There is a fear of being a 'guinea pig' and doing something that might harm the mother or their baby because it's still at research stage.' (Midwife M62)		

Table 3
Barriers and motivators to research engagement (nurses n = 198, midwives n = 72).

	Agreement		Non-agreement		
	n (%)		n (%)		p-value[a]
	Nurses	Midwives	Nurses	Midwives	
Research barriers					
Structural barriers					
Lack of suitable backfill	183 (92.5)	66 (91.7)	15 (7.6)	6 (8.3)	0.837
Lack of funds for research	177 (89.4)	63 (87.5)	21 (10.6)	9 (12.5)	0.661
Lack of time for research	176 (88.9)	62 (86.1)	22 (11.1)	10 (13.9)	0.532
Other work roles take priority	174 (87.9)	63 (87.5)	24 (12.1)	9 (12.5)	0.933
Lack of administrative support	164 (82.8)	65 (90.3)	34 (17.2)	7 (9.7)	0.131
Lack of support from management	148 (74.7)	59 (81.9)	50 (25.3)	13 (18.1)	0.216
Individual barriers					
Other personal commitments	173 (87.4)	66 (91.7)	25 (12.6)	6 (8.3)	0.328
Desire for work-life balance	179 (90.4)	70 (97.2)	19 (9.6)	2 (2.8)	0.064
Lack of research skills	167 (84.4)	61 (84.8)	31 (15.7)	11 (15.3)	0.939
Research motivators					
Organisational motivators					
Mentors available to supervise	179 (90.4)	68 (94.4)	19 (9.6)	4 (5.6)	0.293
Research encouraged by managers	178 (89.9)	65 (90.3)	20 (10.1)	7 (9.7)	0.927
Dedicated time for research	174 (87.9)	68 (94.4)	24 (12.1)	4 (5.6)	0.118
Equity and practice-driven motivators					
To reduce health inequities for Pasifika	195 (98.5)	68 (94.4)	3 (1.5)	4 (5.6)	0.084
To reduce health inequities for Māori	192 (97.0)	68 (94.4)	6 (3.0)	4 (5.6)	0.465
Problem identified that needs changing	193 (97.5)	70 (97.2)	5 (2.5)	2 (2.8)	1
Intellectual motivators					
Desire to prove a theory / hunch	193 (97.5)	68 (94.4)	5 (2.5)	4 (5.6)	0.253
To develop research skills	188 (94.9)	65 (90.3)	10 (5.1)	7 (9.7)	0.166
Professional motivators					
Increased credibility	190 (96.0)	66 (91.7)	8 (4.0)	6 (8.3)	0.211
Career advancement	189 (95.5)	65 (90.3)	9 (4.5)	7 (9.7)	0.143
Increased job satisfaction	185 (93.4)	68 (94.4)	13 (6.6)	4 (5.6)	1

[a]Pearson chi-square or Fisher's exact test if expected cell count <5; selected items are presented to highlight key findings; the full table is available in Supplementary File 2.
Adapted [19,20]

exploring clinical questions, while professional motivators related to career advancement, job satisfaction, and increased credibility. Motivation levels were high across all domains and were similar between midwives and nurses.

Views on organisational support, research roles, consumer participation, and the value of midwifery and nursing research are presented in Table 4. Overall, most respondents reported that their professional organisation supported midwifery and nursing research. However, midwives were less likely to agree that their national healthcare

Table 4
Views of organisational support, research role, consumer participation, and value of midwifery and nursing research (nurses n = 165, midwives n = 64).

	Agreement		Non-agreement		
	n (%)		n (%)		p-value[a]
	Nurses	Midwives	Nurses	Midwives	
Views of organisational support					
My professional organisation provides support	165 (87.3)	53 (82.8)	24 (12.7)	11 (17.2)	0.369
The national healthcare organisation provides support	162 (85.7)	47 (73.4)	27 (14.3)	17 (26.6)	0.025
My clinical workplace provides support	158 (83.6)	59 (92.2)	31 (16.4)	5 (7.8)	0.089
Midwifery/nursing research has the same support as medical research	95 (50.3)	24 (37.5)	94 (49.7)	40 (62.5)	0.077
Role in research					
Research allows me to provide the best treatments/ care	165 (100.0)	64 (100.0)	0 (0)	0 (0)	-
Research findings are applied in my practice	159 (96.4)	62 (96.9)	6 (3.6)	2 (3.1)	1.0
It is part of my role to carry out research	132 (80.0)	43 (67.2)	33 (20.0)	21 (32.8)	0.040
Views of consumer participation in research					
I support the patients I care for to take part in research	165 (100.0)	64 (100.0)	0 (0)	0 (0)	-
Taking part in research may cause/increase consumer anxiety	149 (90.3)	53 (82.8)	16 (9.7)	11 (17.2)	0.115
Supporting consumers to take part in research adds to my workload	143 (86.7)	48 (75.0)	22 (13.3)	16 (25.0)	0.033
I have been concerned about consumers taking part in research	112 (67.9)	20 (31.3)	53 (32.1)	44 (68.8)	< 0.001
I should decide if consumers in my care are invited to take part in research	110 (66.7)	32 (50.0)	55 (33.3)	32 (50.0)	0.020
Perceived value of research					
Evidence to challenge medicalisation	164 (99.4)	64 (98.5)	1 (0.6)	1 (1.5)	1
Helps reduce inequities for patients	162 (98.2)	65 (100.0)	3 (1.8)	0 (0.0)	0.561
Gives consumers a voice	162 (98.2)	64 (98.5)	3 (1.8)	1 (1.5)	1
Is valued by the medical profession	160 (97.0)	64 (98.5)	5 (3.0)	1 (1.5)	1
Gives midwives/ nurses a voice	133 (80.6)	47 (72.3)	32 (19.4)	18 (27.7)	0.169

[a]Pearson chi-square or Fisher's exact test if expected cell count < 5; selected items are presented to highlight key findings; the full table is available in Supplementary File 2.
Adapted [7]

organisation supported research (nurses 85.7% vs midwives 73.4%, $p = 0.025$). In addition, around half of respondents did not agree that midwifery and nursing research received the same support as medical research (nurses 49.7% vs midwives 62.5%, $p = 0.077$).

There was unanimous agreement that research enables high-quality care. A nurse who had prior involvement in research explained, *'I greatly enjoyed the research process and adding to the evidence base that drives our health care system'* (Nurse N27). Nurses were more likely than midwives to agree that it was part of their role to conduct research (nurses 80.0% vs midwives 67.2%, $p = 0.040$).

All respondents indicated that they would support consumers in their care to take part in research. However, the large majority reported that supporting consumer participation added to their workload, particularly among nurses (nurses 86.7% vs midwives 75.0%, $p = 0.033$). Nurses were also more likely than midwives to report concern about consumers taking part in research (nurses 67.9% vs midwives 31.3%, $p < 0.001$) and felt that they should decide whether consumers in their care are invited to participate (nurses 66.7% vs midwives 50.0%, $p = 0.020$).

Views on the value of midwifery and nursing research were also sought (Table 4), with no significant differences between professions. Almost all agreed that such research provides evidence to challenge medicalisation of care. This midwife observed, *'There's so much that needs answered, challenged, investigated'* (Midwife M8). Most agreed that midwifery and nursing research helps to reduce inequities for consumers (98.7%) and gives them a voice (98.3%) and that it is valued by the medical profession.

4. Discussion

This study examined midwives' and nurses' attitudes toward research and their levels of research engagement within a large, culturally diverse urban health district in Auckland, NZ. The aim was to address the gap in knowledge about how NZ midwives and nurses view and engage with research. Our findings suggest that midwives and nurses value clinical research, however, structural barriers continue to restrict active research engagement, despite professional expectations [28,29] and high levels of postgraduate qualification.

Among those who had participated in a research team, involvement was usually confined to auxiliary roles such as recruitment and data collection for projects led by the better-resourced medical discipline, a pattern also described internationally. [7,30,31] This seems counterintuitive, as midwives and nurses are uniquely positioned to support healthcare research through their relational care and their ability to translate research into clinical practice. [6,9,10] This is especially the case for continuity-of-care midwives, demonstrated by the late pregnancy sleep-on-side message continuing to be shared by midwives and actioned by 98.5% of pregnant women, several years following dissemination of the evidence. [32] Despite this potential, midwives' and nurses' contributions to research appear to remain constrained in practice. This mismatch highlights the interplay between structural and individual barriers to research involvement, which were consistent across both professions. Similar issues have been reported by counterparts in the United Kingdom, Ireland, and Australia. [7,11–14,17,18,33]

These constraints were also evident in how respondents viewed their role in supporting consumer participation in research. Many respondents were concerned that supporting consumer participation would add to their workload, particularly among nurses. They expressed a desire for greater control over how research was integrated into their clinical responsibilities, including whether consumers in their care should be invited to participate. In addition, concerns about the implications of research participation for these consumers further contributed to this hesitation. Taken together, these findings suggest a tension between strong support for consumer participation and the practical and ethical challenges of facilitating it in clinical settings. An Australian study [4] offers a possible explanation, reporting that midwives and nurses were more likely to engage in research when this enhanced consumer outcomes and when their contributions were recognised and supported. In the absence of these elements, research was viewed as time-consuming and overly difficult.

The findings suggest that both contextual supports (such as access to protected research time and organisational backing) and professional roles may shape research engagement. The greater concerns reported by nurses may reflect the more generalist role of nurses, who provide care to a wide range of consumers across the lifespan, often short-term and predominantly within hospital settings. It may also be related to traditional expectations of working within a medically led healthcare organisation. In contrast, NZ midwifery practice is grounded in an autonomous community-based continuity-of-care partnership model, with a strong emphasis on shared decision-making. [34]

Structural factors may further influence research engagement. The absence of professional recognition or pay scale adjustments for midwives and nurses who obtain postgraduate research qualifications in NZ further complicates efforts to build research engagement. While nurses with a master's degree have the option of becoming nurse practitioners with associated increases in salary and education funding, no comparable pathway exists for midwives. Opportunities for midwives to lead or engage in research may also be limited by the relatively small pool of funding available for maternity research in NZ. [35]

Both midwifery and nursing are predominantly female professions, and female-dominated areas of healthcare have historically received less recognition and research investment. [36] While this was not directly examined in the present study, it may further restrict opportunities for midwives to undertake research compared with nurses, whose broader scope of practice aligns with a wider range of funded research areas. This disparity may help explain the significant finding that midwives were less likely than nurses to agree that the national healthcare organisation (Health NZ - Te Whatu Ora) supports midwifery and nursing research. The fact that midwives may be self-employed immediately upon registration, whereas nurses cannot, may also lead to different expectations of organisational support.

Respondents also believed that some demographic groups were less likely to participate in healthcare research. They attributed this to the perceived time commitment involved; communication barriers between researchers and consumers; social and financial constraints, including limited internet access; and lack of trust in research. Given that midwives and nurses frequently undertake recruitment for healthcare research [4] and provide the majority of hands-on care, these insights will be valuable for designing more accessible research for groups that have been consistently underrepresented.

Motivation among respondents to engage in research was high across equity- and practice-driven, intellectual, and professional domains, with a particularly strong emphasis on reducing health inequities for Māori and Pasifika people. Intellectual and professional motivators, including developing research skills, career advancement, and job satisfaction, were also widely reported. Respondents widely agreed that midwifery and nursing research helps to address inequities and amplifies the consumer voice. This finding provides further incentive for stronger investment in midwifery and nursing involvement in research as a way forward to addressing ethnic disparities in healthcare.

In addition to strong motivation, all respondents expressed positive views about the impact of clinical research on consumers' care. There was unanimous agreement that research enables them to integrate evidence into practice and to support consumers to take part in studies. Most also reported that research helps them maintain the quality of care they provide and facilitates access to new treatments. Collectively, these findings demonstrate that the midwifery and nursing workforce, the largest health workforce, represents a largely ready and willing resource with substantial capacity for advancing healthcare research.

5. Limitations and strengths

To our knowledge, this is the first NZ study to explore clinical

research views and engagement among the midwifery and nursing workforce. The mixed-method design has allowed for a more nuanced understanding of the survey responses, particularly in relation to interplay between the midwifery and nursing perceptions of research. The study also has several limitations. The sample was drawn from a single health district, so the findings may not be generalisable to the wider midwifery and nursing workforce. The target sample size was under-recruited by 10%. Some respondents did not answer all questions, with comments suggesting this was primarily due to a limited understanding of research. In addition, those who responded may have been more interested in research and more motivated to participate than non-respondents, introducing completion bias. This suggests that those who did not complete the survey may have even less research understanding and engagement than the respondents.

6. Conclusion

This study offers new insights into the views of research and the level of research engagement among the midwifery and nursing workforces in a large, multicultural health district in urban NZ. Midwives and nurses had broadly similar research views, although variations in some responses may reflect differences in the underlying models of midwifery and nursing care. Overall, the findings suggest that, given the opportunity, midwives and nurses wish to be more actively involved in clinical research and are strongly motivated to improve future health outcomes and reduce inequities for the people they care for. This indicates considerable untapped research potential within the NZ midwifery and nursing workforces, which could be realised through strengthened resourcing and support from professional bodies and healthcare organisations.

Recommendations for the future

1. Develop formal processes within healthcare organisations to keep midwives and nurses informed about clinical research activities in their workplace. These should include opportunities to contribute their perspectives early in the research process and to participate in research teams where appropriate. Provide regular updates on research progress and share findings on completion.
2. Establish formal partnerships between universities and healthcare organisations to ensure that midwives and nurses who wish to engage in clinical research have access to funding, mentorship, and academic support within their workplace.
3. Develop clinical academic career pathways for midwives and nurses, in collaboration with their professional organisations and unions, to ensure appropriate recognition and remuneration for these roles.

Author contributors

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Author declaration

The authors declare: that the article is the author(s) original work. the article has not received prior publication and is not under consideration for publication elsewhere. that all authors have seen and approved the manuscript being submitted. the author(s) abide by the copyright terms and conditions of Elsevier and the Australian College of Midwives

CRediT authorship contribution statement

Conceptualization (RC); Methodology (RC, CA); Software (RC); Validation (RC, CA); Formal analysis (RC, CA); Investigation (RC, CA); Resources (RC); Data curation (RC); Writing – original draft (RC, CA, BB); Writing – review & editing (RC, CA, BB, KM, FB, IS, SG, SA, JM, CG); Visualization (RC, CA); Supervision (RC); Project administration (RC); and Funding acquisition (RC).

Ethical approval

Ethical approval was received from the Auckland Health Research Ethics Committee on 12/03/21 (reference AH22024) to survey registered midwives. Research locality approval was provided by Health NZ - Te Whatu Ora Counties Manukau on 27/04/21 (reference 1386). An amendment to include registered nurses was approved by the Auckland Health Research Ethics Committee 20/09/21 and endorsed by the locality. Participants provided consent for their de-identified information to be published. Data are not publicly available due to the potentially identifiable nature of survey transcripts but could be made available at reasonable request to the corresponding author.

Declaration of Generative AI and AI-assisted technologies in the manuscript preparation process

During the preparation of this work the authors used ChatGPT in order to check grammar and spelling. After using this tool/service, the authors reviewed and edited the content as needed and take full responsibility for the content of the published article.

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Declaration of Competing Interest

The authors declare no conflicts of interest with the submission of this manuscript.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2026.102214.

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