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Midwifery empowerment: National surveys of midwives from Australia, New Zealand and Sweden

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ABSTRACT

Background: the predicted midwifery workforce shortages in several countries have serious implications for the care of women during pregnancy, birth and post partum. There are a number of factors known to contribute to midwifery shortages and work attrition. However, midwives assessment of their own professional identity and role (sense of empowerment) are perhaps among the most important. There are few international workforce comparisons.

Aim: to compare midwives' sense of empowerment across Australia, New Zealand and Sweden using the Perceptions of Empowerment in Midwifery Scale-R (PEMS-Revised).

Method: a self-administered survey package was distributed to midwives through professional colleges and networks in each country. The surveys asked about personal, professional and employment details and included the Perceptions of Empowerment in Midwifery Scale-R (PEMS-Revised). Descriptive statistics for the sample and PEMS were generated separately for the three countries. A series of analysis of variance with posthoc tests (Tukey's HSD) were conducted to compare scale scores across countries. Effect size statistics (partial eta squared) were also calculated.

Results: completed surveys were received from 2585 midwives (Australia 1037; New Zealand 1073 and Sweden 475). Respondents were predominantly female (98%), aged 50-59 years and had significant work experience as a midwife (+20 years). Statistically significant differences were recorded comparing scores on all four PEMS subscales across countries. Moderate effects were found on Professional Recognition, Skills and Resources and Autonomy/Empowerment comparisons. All pairwise comparisons between countries reached statistical significance ($p < .001$) except between Australia and New Zealand on the Manager Support subscale. Sweden recorded the highest score on three subscales except Skills and Resources which was the lowest score of the three countries. New Zealand midwives scored significantly better than both their Swedish and Australian counterparts in terms of these essential criteria.

Discussion/conclusions: midwives in New Zealand and Sweden had a strong professional identity or sense of empowerment compared to their Australian counterparts. This is likely the result of working in more autonomous ways within a health system that is primary health care focused and a culture that

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constructs childbirth as a normal but significant life event. If midwifery is to reach its full potential globally then developing midwives sense of autonomy and subsequently their empowerment must be seen as a critical element to recruitment and retention that requires attention and strengthening.

Background

There is increasing evidence outlining the significant contribution midwifery care can make to pregnancy outcomes for women and infants (ten Hoppe-Bender et al., 2014). Provision of an appropriately educated well-resourced midwifery workforce is recognised as an essential element within national workforce planning activity (Homer et al., 2014). Despite this, several resource rich countries have reported facing a significant shortage of registered midwives (Büscher et al., 2009). A shortage of midwives could have serious implications for the care of women during pregnancy, birth and the early parenting period. Identifying strategies that support and strengthen the current and future midwifery workforce are therefore important.

The main factors associated with predicted shortages and current attrition include poor access to education, high workload, stress, lack of promotional opportunities and burnout (Büscher et al. 2009; Jordan et al., 2013; Mollart et al., 2013; Newton et al., 2014; Hildingsson et al., 2013). More importantly midwives have increasingly cited changes to their professional identity and role that limit their autonomy and ability to provide woman centred care as reasons why they no longer enjoy or want to practice midwifery (Curtis et al., 2006; Rayment, 2011; Sidebotham and Ahern, 2011). In part this appears to be driven by a number of factors. For many midwives there is an increasing sense that their professional skills are being usurped by the medical profession (Larsson et al., 2007; Greve, 2009; Shaban et al., 2012; Hadjigeorgiou and Coxon, 2014; Sidebotham et al., 2015). In addition, fear of litigation is thought to fuel a culture where reliance on the biomedical paradigm and technology is considered to be a safeguard or 'insurance' against blame (Savage and Francome, 2007; Karlström et al., 2009; Hood et al., 2010).

Although limited, there is also evidence that midwives' perception of the support or otherwise they receive from their midwifery managers contributes to decisions about whether they stay or leave the profession. The well cited United Kingdom work of Ball et al. (2002) demonstrated that feeling supported and valued by managers featured in 'why midwives stayed' in the profession. Conversely unsupportive management was a major contributing factor to why midwives chose to leave the profession (Curtis et al., 2006; Ball et al., 2002). Australian researchers Sullivan et al. (2011) replicated this work identifying the same key indicators. This preliminary examination of the literature suggests that the availability of adequate resources, support from managers and feelings of control and empowerment are key factors supporting retention of midwives across different midwifery cultures and practice environments in OCED countries.

In order to inform future workforce planning our team was interested in exploring this further. Specifically we were keen to compare midwives' sense of midwifery autonomy or empowerment from three countries that have distinctly different midwifery education frameworks, maternity systems and social policies related to parenting and children; Australia, New Zealand and Sweden. This collaboration is known as the Work Health and Emotional Lives of Midwives (WHELM) group.

Maternity/study context

Australia

Maternity care in Australia is provided by midwives, obstetricians, and general practitioners (GP) with or without an obstetric qualification. In 2013, a total of 304,777 women gave birth to 309,489 infants. The majority of births occurred in hospitals (97%), a small proportion occurred in birth centres (2%) and planned homebirths were rare (0.3%) (AIHW). In Australia there is access to free maternity care through the public hospital system for women who are eligible for the Australian national insurance scheme, Medicare. In public hospitals, employed obstetricians and midwives assist women during labour and birth. In private hospitals, midwives are employed by the hospital to provide inpatient care, including intrapartum care, whereas a private obstetrician with visiting access is the lead clinician and attends the birth. Private health insurance covers a proportion of the private hospital costs. The proportion of births in private hospitals was 29% in 2013 (AIHW, 2015). In 2014 there were 23, 862 registered midwives but not all of these are practicing (AIHW, 2016). In rural areas, GP obstetricians and midwives provide the majority of care. While birth centres and midwife-led services employ midwives to provide care for women throughout pregnancy, labour and birth, and post partum (continuity of care); access to these services is limited (Brown and Dietsch, 2013). Access to publically funded homebirth services is rare. More recently midwives were granted access to Medicare which means women can now claim a fee rebate for private midwifery services. Midwifery education takes place in the tertiary sector and all programmes must meet national accreditation standards (Australian Nursing and Midwifery Accreditation Council, 2014). Pre-registration programmes include undergraduate bachelor of midwifery degrees as well as postgraduate programmes for registered nurses to become midwives. Masters and PhD programmes are available for midwives.

New Zealand

New Zealand has a fully funded universally accessible maternity care system for the nearly 60,000 women giving birth each year. The underpinning principle of the system is 'partnership' between women and her carer. Women can choose their own lead maternity carer (LMC) who will organise and provide all of her necessary care from registration with the LMC (maybe as early as the first pregnancy test). This package includes all antenatal care in her home or clinics, labour and birth care and up to 6 weeks post partum and newborn care mostly at home (continuity of care). The LMC can be a midwife, a general practitioner or an obstetrician. Currently over 91% of women register for a LMC with the vast majority ($>93\%$) choosing a midwife as lead care provider (Ministry of Health, 2015). Midwives provide services for almost all rural women. If the woman requires additional obstetric or medical care the midwife LMC makes a referral and works alongside the specialist to ensure the woman receives appropriate care. A midwife LMC provides labour and birth care in any setting the woman may choose for example home, midwife led unit or hospital. In 2014, 3.4% of women had a homebirth, 9.1% gave birth in a midwife led unit, and the remaining 87.5% gave birth in an obstetric hospital setting, mostly with their chosen LMC attending.