



Children's experiences of midwives working in Aotearoa New Zealand's continuity of care model

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ABSTRACT

Background: Aotearoa New Zealand's Continuity of Care (CoC) midwifery model is recognised for its nationalised, public provision of one-to-one midwifery care. The model has distinctive pressures associated with workload, 24/7 on-call, and emotional intensity. While research has examined how these pressures affect midwives, little is known about how this model shapes the lives of midwives' children.

Aim: This study explores how the CoC model of midwifery can influence midwives' children.

Methods: We analysed qualitative interviews from 22 families with children aged 11–19 and adult children aged 20–40+ participated alongside a current or former CoC midwife. Iterative thematic analysis and reflexive team interpretation informed theme development.

Findings: The overarching interpretation, 'living in the shadow of the call', describes how families continually reorganised themselves around unpredictable CoC work. Five themes described these dynamics: (1) *Living on Alert*—chronic unpredictability shaping family life; (2) *When Work Enters the Home*—emotional spillover and blurred boundaries; (3) *Children as Stabilisers*—adaptive labour and role reversals; (4) *Holding the System Together*—reliance on extended networks and shared care; and (5) *Growing through the Demands*—long-term developmental consequences. Children described the costs of 'living in the shadow of the call', yet also how these experiences built resilience, independence, emotional maturity, and political awareness.

Discussion: Children perceived that CoC midwifery shaped their everyday rhythms, relationships and developmental experiences. Children's accounts highlight the growth and strain associated with living amongst unpredictable care work.

Conclusion: Recognising children's experiences is essential for developing sustainable continuity models that support midwives and the families who enable their practice.

Statement of Significance

Problem

Little is known about how Continuity of Care (CoC) midwifery work shapes the children who live alongside midwives, despite the model's unpredictable nature.

What is already known

CoC midwives experience high workloads, emotional intensity,

and 24/7 on-call responsibilities, with documented effects on their wellbeing and family life. Children's perspectives, however, are largely absent from the literature.

What this paper adds

- First in-depth qualitative evidence of children's experiences of COC midwifery.
- Insight into how the unpredictability, emotional intensity, and shared responsibility shape children's lives.

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- Implications for workforce sustainability that include supporting midwives’ families, not only midwives themselves.

Introduction

Continuity of Care (CoC) midwifery models are internationally recognised for improving clinical outcomes, strengthening relational care, and enhancing people’s maternity experiences [1]. Aotearoa New Zealand (NZ) remains the only country with a fully nationalised continuity of midwifery care model in which self-employed midwives, called Lead Maternity Carers (LMC), provide comprehensive antenatal, intrapartum, and postnatal care within a partnership framework to > 97% of pregnant women/people regardless of their obstetric risk [2]. Unlike many international models where ‘continuity’ is delivered by teams or limited to specific phases of care, Aotearoa NZ CoC midwives are supported to provide full continuity across the maternity experience for most risk levels, carrying individual clinical responsibility throughout. Midwives consistently describe this model as professionally meaningful [3,4] and deeply aligned with midwifery values of partnership, autonomy, and relational practice [5–7].

Alongside these strengths, research in Aotearoa NZ and internationally has documented substantial pressures associated with continuity of care midwifery practice. High and unpredictable hours, 24/7 on-call responsibilities, and professional isolation contribute to burnout, work-life conflict, and challenges sustaining practice over time [5,8,9]. Workforce studies across Australia, the United Kingdom, Canada, and Europe echo these concerns, noting that while continuity models offer significant professional rewards, they also place considerable on-call responsibilities on midwives’ personal and family lives [10–15]. These tensions have become central to the discussions of how to sustainably integrate CoC models.

Compared with rostered or shift-based midwifery, CoC practice is distinguished by its combination of full clinical responsibility, chronic schedule-unpredictability and constant availability. These structural features differentiate CoC work from other models of care and help clarify why its broader impacts warrant specific examination.

Despite growing attention to the wellbeing of midwives working in continuity-based models, only a few studies explored how this work shapes the lives of those who live alongside midwives. Family members experience CoC midwifery not as a bounded occupation but as a permeable, ever-present presence that enters the home through shared routines, emotional intensity and the unpredictability of the call [5,8,16, 17]. Existing workforce studies acknowledge the impact of case loading on midwives’ personal lives, yet the perspectives of children remain almost entirely absent from the literature. This absence is noteworthy given that continuity models rely not only on midwives’ professional commitment but also on the adaptability and support of their families [18].

This study addresses this gap by examining how midwives’ children experience and adapt to a parent in CoC midwifery work. Drawing on qualitative interviews with midwives and their children (aged 11 – 19) and adult children (20–42 years old), we explore how the structural features of the CoC model shape everyday family life, emotional worlds, and developmental experiences. Understanding these experiences is crucial for workforce sustainability and ethical practice in CoC models.

Methods

Study design

This study used a qualitative interpretive design to explore how children experience and adapt around CoC midwifery work. An interpretive approach was selected for its capacity to illuminate meanings, relational dynamics and everyday experiences that are not well

documented in existing midwifery workforce research. This design was particularly suited to exploring how children understood and articulated the impact of CoC midwifery on their lives.

Participants and sampling

The data analysed in this study were drawn from a larger project involving Aotearoa NZ CoC midwives and their families [5,19]. Participants were predominantly Pākehā (NZ European). Māori and Pacific Peoples midwives and their whānau/families were excluded from this analysis as separate, culturally grounded interview streams were undertaken with these communities. Interviews were undertaken either in the midwife’s home or online. The length of interviews varied between 70 and 150 min. All interviews were digitally recorded and transcribed professionally. All participants selected pseudonyms used in transcripts to protect their anonymity. An interview guide ensured a consistent approach within the interviews with current and former LMC CoC midwives (Appendix 1). Midwives and family members were asked their impressions of midwifery work specifically for themselves and for family life.

For the present study, we purposively selected interviews in which children participated directly. Children participated alongside their midwife parent in all interviews, and some interview also included a second parent or caregiver. No interviews were conducted with children alone. To minimise the relational dynamics that joint interviews can present [20], interviewers encouraged all people present, including children, to share their views or impressions of the topics being discussed. We made notes regarding our interpretations of relational (and power) dynamics among family members following interviews to support reflexive interpretation during analysis. Interviews were conducted by [hidden for blind review].

This subsample included midwives’ children, ranging in age from 11 to 42 years at the time of interviews, who reflected on their present or past home-life experiences of growing up with CoC midwifery. For this sample, all the midwives were birth mothers of the child participants. Relationship status of midwives, reported at the time of the interview, was that 17 were in long term relationships, while 5 were not. The final sample comprised 22 families as shown in Table 1.

Data analysis

Analysis followed an interpretive thematic approach as per Miles, Huberman [21]. A collaboratively developed coding framework guided analysis of the full dataset. For this paper, the code ‘family life’ was applied to the 22 interviews. NVivo (Lumivero, Release 15.2.1) software supported large dataset coding while systemic data management and iterative refinement of categories with the code ‘family life’ was done manually.

Thematic analysis proceeded in three iterative stages (Table 2):

1. Initial coding (line-by-line) to identify early categories such as disruption, emotional tone, and role organisation.
2. Pattern coding to explore relationships across and develop preliminary themes, attending to how work-related pressures entered and reorganized family life.
3. Theoretical integration into high-order themes captured the overarching patterns across families.

Throughout analysis, the research team engaged in comparison

Table 1

Age and gender of children interviewed with their midwife parent.

Age Range	Woman/Girl	Man/Boy	Other
11–19 (child)	8	1	1
20–42 (adult child)	9	3	

Table 2
Themes, sub-themes, descriptions and representative quotes.

Theme	Description	Sub-Themes	Representative quotes
Theme 1: Living on Alert - Chronic unpredictability shaping family life	Participants consistently framed unpredictability as a defining feature of family life.	family on call	... as a family, we can never like have something set in stone ever like because mum might get called away. Tilly, 19
		disappearing, absent, invisible parent	Sometimes I'd wake up and then Mum wasn't at home, then being like – Oh, she went to a birth or something... Chelsea, 19
Theme 2: When Work Enters the Home - Emotional spillover and boundary collapse	This theme captures how the intensity of midwifery work crossed into the family space, both practically and emotionally.	midwife's mental state affecting family	Very important life events have been missed, yeah. But there is some goodness to it but I don't see a lot of the goodness because I'm not at the births and that's like a perk of the job, it's the births, and I get to see the tired mum, stressed mum, the worried mum, which is a lot. It's taken a very big hit on Mum's mental health in the way that she thinks because it's constantly at that high stress level. Poppy, 27
		family life shaped by midwife's sleep requirements	And you always knew that if Mum was sleeping you didn't wake her. Not in a bad way, not that Mum would be grumpy, but you just knew that if she is crashed out on the couch that you give her the time she can get. Venus, 38
		family comes secondwhen you're out with people they always get your energy and when you come home the family get the kind of tired, grumpy version. Lilly, 40
Theme 3: Children as Stabilisers – Adaptive labour and role reversal	This theme describes how children assumed practical and emotional responsibilities to stabilise the family system.	playing an active role	Yeah, I've driven Mum, I've been on visits, I've been there when she didn't have another midwife with Covid equipment, and I've done that with her. Poppy, 27
		increased, additional care responsibilities	... So you'd wake up in the morning and, depending on whether Mum was there, somebody was there, and the girls would kind of

Table 2 (continued)

Theme	Description	Sub-Themes	Representative quotes
		closer family bonds because of LMC	sort themselves out for breakfast ... but me, I had to do their hair and I'd have to make sure their outfits for school, that they weren't just wearing stripes and spots North, 18
Theme 4: Holding the System Together – Extended networks and shared care	This theme describes how extended family, neighbours, au pairs, and community members played crucial roles in sustaining family life.	support from friends, neighbours, community member	Yeah, yeah. Yeah, closer than... Other people you talk to about their siblings, yeah, to the point... I mean, again, what you experience is what you think is normal so it's kind of weird to think that people don't have those sorts of bonds... George, 32
		paying for childcare	Yeah, well my Dad's mum, my Grandma, she lives in [town] so she can pick me up quite a lot of the time, and I've also got quite a lot of friends... all my friends live in [town], yeah, so I can go to their house for play dates just in case she's got something on. Sally, 11
Theme 5: Growing Through the Demands – Developmental consequences and adult identity	This theme captures how growing up in midwifery families shaped children's adult identities, values, and life choices	used to it	We used to have to get an au pair every once in a while so we could always get to school and stuff because Mum would be at the hospital and Dad would be working, and we'd have an au pair to take us places and stuff just because Mum couldn't. Julia, 12
		family immersion in midwifery	I don't feel like it affected me. If anything, it affected me in a way that's probably... It's hard to say whether it was this or whether it was just being an older brother, but quite resilient, quite adaptable, quite easy to change and figure things out as they go. George, 32
			I'm such an advocate for breastfeeding and home birth, I just tell everyone to have a home birth...I just didn't realise how weird it was. Nicole, 30

(continued on next page)

Table 2 (continued)

Theme	Description	Sub-Themes	Representative quotes
		children's character, mental health, behaviour shaped by demands of LMC work	<p><i>As a result of my mum's work I have a lot of self-dependency. I'm very, very... I don't like to trust other people, it's - I can do this, I've got this....</i></p> <p><i>I got to grow up watching the main female role model in my life uplifting women day to day; that was really empowering.</i></p> <p>Margaux, 20</p>

across interviews, family types, and temporal perspectives (childhood vs adulthood). This cross-case comparison supported the development of themes that reflected both commonalities and variation in children's experiences (Table 2).

Reflexivity and Trustworthiness

The interdisciplinary author team (two midwives and four management scholars) engaged in dialogue around the coding and category interpretation, acknowledging how their positionalities shaped analytic emphasis [22]. Additionally, to enhance trustworthiness as per Tracy [22], member checking was undertaken for the larger dataset; participants were invited to review and comment on themes generated from the 47 family interview dataset. This process ensured that codes resonated with participants lived experiences and provided opportunities to refine thematic framing. Specific feedback asked for more depth from their family, which drove the focus of the specific interpretations developed in the present paper. Reflexivity was further supported by iterative team discussions, balancing insider perspectives from midwives with critical systems analysis from management scholars.

Results

Analysis of interviews with former and current midwives' children and family members generated an overarching interpretation of midwives' children 'living in the shadow of the call' – a process in which families continually adapt to the unpredictable nature of birth work. Shadow, however, presupposes light: the call that shaped these families was same vocation that gave children an early understanding of care, women's bodies, and the significance of birth. Across both current and former CoC midwives, participants described patterns of flexibility, adjustment, and creative problem-solving alongside experiences of disruption and loss. Five interrelated themes emerged from the analyses, illuminating both the challenges children navigate and the strengths they develop.

Theme 1: living on alert – chronic unpredictability shaping family life

Across generations, children described living permanently in the shadow of the next call - planning always contingent, routines always provisional. The midwife's phone, pager, or client due dates created a constant backdrop of uncertainty. Participants framed this unpredictability as a defining feature of family life.

s - and then you got called out again. Julia, 12.

It would always be, you would have one day off and you'd go and do something and it was always that day.... It was always Murphy's Law, it

was every event, it was every one day that we had something planned, there would be something that she had to go off to. Lilly, 40.

Children spoke of living in a state of anticipatory vigilance, learning to hold plans lightly and adapt quickly. The continuous on-call nature of the CoC model, combined with the biological unpredictability of labour, meant that family plans often needed to be flexible. Over time, this unpredictability became normalised.

Yeah, I think it was definitely years of you not being around and stuff, but I don't feel like you just weren't there. But then again we grew up with this so it's hard to know what it would be like. Mike 22

What began as disruption in childhood evolved into an accepted way of life. Yet within this instability, many children developed attributes that they later described (Theme 5) as strengths.

Theme 2: when work enters the home - emotional spillover and boundary collapse

This theme captures how the shadow of the call entered the home - not only through disrupted schedules and practical logistics, but through emotional carryover. Children encountering the depleted, stressed version of their parent after long births and difficult cases.

Work-home Boundary Erosion: Participants described phones, pagers, and clinical conversations as regular features of home life. Children recalled overhearing details about labour and birth during everyday activities. Some families developed strategies to protect family time, such as hiding phones particularly during designated 'off' periods:

We ended up buying her a cordless phone because before cellphones existed and we just had our plug in phone, and you'd be sitting at the dinner table and she'd take a phone call at the dinner table and continue to talk through whatever was going on in the pre-birthing process as this person's going into labour while we're trying to eat dinner. Lilly 40

My older sister used to have to hide [mobile phone] on Mum's weekend off. She wouldn't stop checking it. Bango, 16

The home became an extension of the workplace, permanently shaped by the shadow of the client needs. Children became inadvertent witnesses to professional stress and clinical intimacy. The contractual requirements for constant availability [23] made creating clear boundaries between work and family life particularly challenging. Children and partners recognized that after long births or emotionally demanding cases, midwives returned home physically and emotionally depleted. Families learned to recognise the signs of fatigue:

The worst bit about your job. Seeing you have meltdowns and be so stressed out sometimes, because it has happened. Taylor, 24

Midwives themselves expressed awareness and regret about bringing work fatigue home.

I remember there was one day I came home from work on a Friday night and every Friday night I'd try to get home early, and every Friday night I failed. And I said to Margaux, and you might remember this Margaux, I said - I'm really sorry darling, the day just went crazy. And Margaux said to me - You say that every Friday night and a little part of my heart broke darling, I'm really sorry. Cate, current CoC midwife

It's ok. Margaux, 20

I just felt really bad. I just knew it was just too much, and I was trying to run a house. It's like I only had the kids half the time but when I had them it was everything, and I had the house full-time so just trying to keep a house running is just stupid; you have to pay all the bills, you have to put the rubbish out every week, there's no one else helping with adulting, it's you, and Margaux was trying to pick up the slack and I could see it and I didn't want her to do it. It was just a hard place; it was just a hard situation. Cate, current CoC midwife

This exchange came from an accumulated understanding developed over time between this mother and daughter, illustrating that the emotional weight of CoC practice was carried within relationships strong enough to bear it. This *emotional spillover* into the home - marked by a balance of fatigue, irritability and affection - was a central feature of family life. The emotionally demanding nature of midwifery practice shaped family relationships and children's daily experiences.

Theme 3: children as stabilisers – adaptive labour and role reversal

A striking pattern was the extent to which children assumed practical and emotional responsibilities to stabilise the functioning of the family. Many children helping with household tasks, supporting younger siblings, or being aware of their midwife parent's mood. Some took on responsibilities beyond typical age expectations, particularly when midwives' practiced in isolation or where their partners also had demanding jobs.

Keep Mum's stress levels down because she's busy, she's tired, she's dealt with this, she's just had this super-traumatic birth, keep the kids happy. I can do it, I can vacuum. If I make dinner that will keep her stress levels down; if I clean the kitchen it's just one less thing for her to think about, Margaux, 20

... she woke me up in the night to tell me she was going, but it might just be a note in the morning to say – Hey, can you get the other boys ready to go to school. I guess that's the role as the oldest of four boys; you just sort of lean into it and do it. George, 32

Children's accounts revealed how the shadow of life on-call developed practical skills of caregiving (preparing meals, managing siblings) and emotional labour (monitoring mood, reducing stress, avoiding conflict). The work context of the CoC model, with its unpredictable hours and on-call responsibilities, opened spaces in home life that children stepped in to fill. While many children developed competence and maturity through these contributions, some also expressed awareness that their maturity exceeded those of their peers. For some, the realisation of how much they had taken on came through on later reflection.

I think I didn't realise how much it impacted me until I kind of reflected on it with a friend. So I had a beautiful friend whose mum is also an LMC and we were like – Oh my gosh, we were like little mums, like 10-year-old mother. We were just these crazy kids who were just so mature and everyone like – Oh, you're so mature for your age. I was like – Well, I had to be, I had to grow up quickly because I had two kids at the age of 10. It's true. Yeah, I never processed it until... Because you know, everybody says – Oh, you're so mature for your age, you're so good. So well behaved. But I think I just... I don't know, I wouldn't say it negatively impacted me though. North, 18

This reflection captures the normalisation of this child's advanced responsibility –observed as maturity but was also a childhood compressed by necessity. Yet, North's reflection is offered without resentment, but instead someone making sense of an experience that, on balance, they have integrated rather than been defined by. Despite these adaptive responsibilities, midwives' families were rarely alone.

Theme 4: holding the system together – extended networks and shared care

Families rarely managed alone. Extended family, neighbours, au pairs, and community members played crucial roles in sustaining family life.

...and I guess we were lucky through Mum that we had [neighbours] two doors up; they were pretty much our second family, so as soon as she had something we would literally just go straight up to their house and stay up there for the night. Lilly, 40

I used to do a lot of after-school activities like at some points, it would be like every day at school. So it was also that kind of thing like picking up and dropping off and like so then having to arrange other things like going with someone else's parents or getting a family member to step in or something. Valentina, 27

These networks created connection between home, school, and community that buffered the impacts of unpredictable work demands, helping families establish stability and continuity. Families who had access to strong support networks described feeling more secure; those without such networks faced greater challenges. The structural reliance on informal, unpaid support systems created inequities, with some families—particularly those without nearby extended family—struggling to sustain CoC practice.

We don't have family here, it's just us. I've got some really good friends but you don't want to call on your friends all the time to help out. Jane, former CoC midwife

Jane's situation highlights the precarity faced by families without established networks. In her case, the absence of readily available support led to difficult trade-offs:

...for me being a mother was my priority which was why I took a low caseload. And we were always under financial pressure because I didn't work more. I could've worked more and had more money, but then it would've been even harder to be a mother. And, yeah, I often felt kind of torn between the two things.Yeah, it was an interesting time, not a suitable profession for a single parent, I know that now. Pearl, former CoC midwife

Pearl's reflection reveals the impossible choices created by the absence of support networks: reducing income to manage family responsibilities or increasing caseload at the expense of parenting capacity. For single parents or those geographically isolated from family, the informal infrastructure that makes CoC practice sustainable for others simply didn't exist, forcing decisions between financial security and family wellbeing. These immediate adaptations, however, also shaped children's long-term development in profound ways.

Theme 5: growing through the demands – developmental consequences and adult identity

This final theme captures how growing up in midwifery families shaped children's adult identities, values, and life choices – both positively and with complexity. Absorbing midwifery's values, politics, and bodily knowledge from an early age, many children became passionate advocates for this perspective in their own adult lives.

I'm such an advocate for breastfeeding and home birth, I just tell everyone to have a home birth....I just didn't realise how weird it was. Nicole, 32

I love my mum very much and I really respect her work. Actually, in my [work] I have a huge feminist female body influence through growing up with her, really helped being super-educated from a young age about the female body, about respect, consent, bodily processes. I first saw a video of a woman having a home birth when I was four years old maybe, so really, really inquisitive and amazing people to be surrounded by. Margaux, 20

This intergenerational sharing of values was complex and sometimes contradictory. Children expressed pride in their parent's work and commitment while simultaneously acknowledging the personal costs. Some became advocates of midwifery values while others chose different career paths.

Children also discussed how the unpredictability of their early lives had increased their resilience, adaptability, and flexibility as adults:

If anything, [it made me] quite resilient, quite adaptable, quite easy to change and figure things out as they go. George, 32

Together, these five themes illuminate how families navigate the distinctive work context of CoC midwifery practice. Families continually adapted their routines, roles and relationships to accommodate the unpredictable nature of birth work. The result is a pattern of ongoing adaptation - 'living in the shadow of the call' - in which families experience genuine costs and challenges yet simultaneously manage with creativity and resilience.

Discussion

This study explored how the Aotearoa NZ CoC midwifery model shapes, in challenging and generative ways, the relational and developmental the lives of midwives' children. The findings extend existing workforce research by showing that the distinctive features of CoC practice - unpredictable hours, emotional intensity, and constant availability [4-6,9] shape not only midwives but the everyday rhythms, relationships and developmental experiences of their families. While previous studies have highlighted the personal and professional challenges midwives face [3-7,9,24,25], children's perspectives have been almost entirely absent from the literature. This study addresses that gap, contributing to the dearth of children's voices in work research [26] by foregrounding children's voices and illustrating how they navigate, interpret, and adapt to the demands of birth work.

The findings align with workforce research documenting the realities of CoC practice - high workload, 24/7 on-call demands, professional autonomy, and emotional intensity [4-6,9]. While midwives value autonomy, continuity, and relational depth of the model [7,8,27,28], these same features shape family life in challenging and generative ways [17, 29]. By foregrounding families' experiences, this paper extends workforce literature and situates CoC midwifery practice with the broader relational context that enables it to function.

Midwives on 8- or 12-hr rostered shifts also undertake emotionally intense, high-stakes work, yet their families can plan around known schedules. Research on nonstandard but predictable shift work [30,31] shows quite different family outcomes compared to literature on unpredictable on-call schedules [32,33] and the findings here align well with the latter. Research on ambulance personnel documents substantially elevated rate of burnout, PTSD, and psychological distress compared to the general working population [34], consistent with the cumulative toll of on-call and emotionally intensive healthcare practice. Unlike rostered systems where practitioners return home knowing the next shift, the self-employed Aotearoa NZ CoC midwife carries continuous individual accountability. The family impact of demanding, on-call healthcare practice has been documented in related clinical context. Dyrbye, Sotile [35] found that work-home conflicts were experienced by nearly half of U.S. physicians and over half of their employed partners, associated with burnout and relationship difficulties for both. Qualitative research with NHS hospital consultants found that most organised family life entirely around clinical availability where routines adapting to on the practitioners rather than the reverse [36]. These patterns suggest that family adaptation to on-call healthcare work is recognisable across clinical settings, while the features specific to NZ CoC - biological unpredictability of birth, full risk spectrum accountability, no shift handover - intensify them in ways particular to this model of continuity of care.

Children's accounts reveal how the unpredictability became a defining feature of family life. The biological timing of labour, combined with the 24/7 nature of CoC practice, meant that plans were frequently disrupted and routines were challenging to maintain. Families developed 'anticipatory vigilance' - learning to hold plans lightly and adjust quickly when their parent was called away. The permeability between work and home reflects both midwives' passion for their work and the practical challenges of 'switching off' from work that is urgent and unpredictable [16]. Distinctively, Aotearoa NZ midwives provide continuity across most obstetric risk levels - from straightforward to complex pregnancies - intensifying clinical responsibility, emotional intensity,

and unpredictability. The structural features of self-employed COC practice, individual accountability, unregulated hours, and continuous availability across the full risk spectrum, create particular rhythms that extend into family life. Though these findings mirror research on irregular work schedules and family wellbeing [37,38], the unique characteristics of midwifery work, such as the unpredictable nature and timing of birth, adds a unique angle on this research.

Emotional spillover from midwifery work shape family dynamics in complex ways. Children described encountering the 'tired and grumpy version' of the midwife parent after long births, thus learning to read moods and approach cautiously, and in some cases conceal the own emotions to protect family equilibrium. Midwives themselves expressed guilt around their fatigue and mood. This reflects what work-family research describes as spillover, where occupational demands affect family emotional climate [39]. Children also described contributing to household function in meaningful ways - helping with siblings, household tasks, and emotional support. While this developed competence and maturity in children, consistent with resilience research [40,41], some also took on responsibilities beyond typical age expectations. This pattern, sometimes described in family research as parentification [42, 43], represents a notable adaptation where children assume caregiving roles typically held by parents. Understanding this dynamic helps us appreciate both children's capabilities and the importance of adequate support systems for midwifery families.

The gendered dimension of CoC midwifery practice adds further complexity. Drawing on the original full dataset of 47 midwife family interviews, Greenslade-Yeats, Mharapara [19] document how Aotearoa NZ LMC midwives navigate knotted work-home tensions rooted in their competing yet interdependent identities as midwives and as mothers. Patriarchal norms that position women as primary caregivers regardless of professional role, intensifying the wright of absence in ways that do not apply equally to fathers. This dynamic was visible in the child's perspective in Julia's account: her mother's absence required logistical solutions while her father's simultaneous work absence did not, reflecting an unspoken assumption that maternal presence is the domestic baseline against which other arrangements are measured.

The crucial role of extended support networks emerged strongly. Families with access to grandparents, neighbours, and community support managed more comfortably; those without such networks faced greater challenges. This reliance on informal networks mirrors the 'segregated' pattern Dumelow, Littlejohns [36] identified among hospital consultants, where family and community support systems organised themselves around the practitioners' availability; a finding echoed in physician work-home conflict research more broadly [35]. These informal support systems essentially function as infrastructure for midwifery practice, absorbing the practical rhythms unpredictable schedules. The intergenerational transmission of midwifery values around birth, whether hearing and participating in regular discussions or actually observing childbirth, represent an important inheritance. Reactions were complex in that children expressed pride in their parent's work alongside awareness of its personal costs. Some became passionate advocates while other explicitly chose different career paths or expressed ambivalence about childbearing, creating a multifaceted relationship with midwifery. This enhanced knowledge of physiological birth, maternity care and the health system can have both positive and negative effects for midwives' children. Knowledge and experiences of childbirth is associated with reduced fear of birth for future parents, but how and at what age this information is learned make this association more complex [44,45].

Recommendations

These findings have significant implications for workforce sustainability. There have been some workforce initiatives that support Aotearoa NZ midwives working in CoC [5], yet sustainability must also account for families' experiences and adaptations. Redistributing on-call

responsibilities to group practices, caseload sharing, and rostered backup can support families from chronic unpredictability while still maintaining relational care [8,25]. Support for families – whether through subsidised childcare, family counselling, or formalised connections with other midwifery families – could strengthen the informal networks that currently support CoC midwives. Professional education might also include realistic discussions about work-family integration, preparing future midwives and their partners to navigate these dynamics thoughtfully. Most importantly, these findings suggest that midwives' and their families' wellbeing are interconnected and supporting one requires supporting the other. Strong families help sustain midwifery practice; sustainable practice models help protect family wellbeing.

Strengths and limitations

This study has several notable strengths. The study centres children's voices in CoC workforce research – perspectives that have been almost entirely absent from the literature. Through its intergenerational design, including both current children and adults reflecting on their childhood experiences, this study enabled a comparison across developmental stages through the decades of CoC midwifery practice in Aotearoa NZ. This breadth of discussion illuminated both contemporary and reflected experiences. The inclusion of 22 families provided sufficient data to build cohesive themes for a qualitative interpretive methodology. Finally, the interdisciplinary research team brought multiple perspectives to data interpretation, enhancing analytical rigour through collaborative reflexivity.

This study has several limitations. Participants were recruited through midwifery networks, which may have introduced sampling bias toward families with strong views. Adult participants' retrospective accounts, spanning up to 30 years, introduce potential memory reconstruction and their interpretations cannot establish causation. Children's voices were also predominantly female. We also acknowledge that unobserved relational dynamics may have shaped what children felt comfortable expressing during the joint interview process, though this was introduced for ethical, practical, and data-quality reasons.

This research provides a foundation for future research examining how other family members – partners, grandparents – navigate CoC work, and how cultural context shapes family adaptation, particularly for Māori whanau and Pacific families whose values around collective responsibility and childbirth may differ substantially.

Conclusions

'Living in the shadow of the call' demonstrates how CoC midwifery's distinctive work context extends beyond individual midwives to reshape family life. The shadow represents the call's constant presence—shaping routines, emotional climates, and children's development even when no birth is imminent. Children described both strengths (resilience, independence, maturity) and costs (parentification, disruption, feeling secondary) developed in this shadow. Sustainable CoC models must recognise that the shadow falls on entire families. Supporting midwives requires supporting their children, partners, and extended networks. A shadow cannot exist without a light source. The call that disrupts these families was the same vocation that shaped their children's values and deepened their understanding of care. Policies must create conditions where families can thrive alongside CoC practice, not merely endure it—through redistributed on-call responsibilities, institutional family support, and realistic preparation for work-family integration. Taken together, these findings indicate that the family impacts observed in this study are likely to extend, to some degree, to other work arrangements that share similar structural demands of unpredictability and continuous availability.

Ethical approval

This study was approved by the Auckland University of Technology ethics committee (AUTEC Reference number 22/161) on 15 August 2022.

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CRediT authorship contribution statement

- Conceptualisation – Clemons, Greenslade-Yeats, Mharapara, Jackson
- Methodology - Clemons, Greenslade-Yeats
- Validation – Clemons, Greenslade-Yeats, Mharapara, Jackson
- Formal analysis – Clemons, Greenslade-Yeats
- Investigation - Greenslade-Yeats, Mharapara, Clemons
- Data Curation – Mharapara, Clemons
- Writing – Original Draft – Clemons
- Writing – Review & Editing – Clemons, Greenslade-Yeats, Mharapara, Jackson, Staniland, Ravenswood
- Visualisation - Clemons, Greenslade-Yeats, Mharapara
- Project administration – Mharapara
- Funding acquisition – Mharapara, Ravenswood, Clemons, Jackson, Staniland

Declaration of Generative AI and AI-assisted technologies in the writing process

During the preparation of this work the author(s) used COPILOT/ Microsoft to check for readability and to match the journal guidance to the manuscript (E.g., references, headings, layout). After using COPILOT, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication.

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Declaration of Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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

Appendix 1

PAKEHA stream revised guide – current LMCs

Pre-interview checklist:

- Explain the aims and background of the overall research project and the individual interviewer's role and background
- Consent forms signed?
- Pseudonyms for participants?

General prompt/follow-up questions

Referring to an answer to a previous question: Has that always been the case?

Can you give me an example of when xxx happened? Was that recently? (i.e., how did it impact family life etc.)

How common is that for your household/family?

Midwife's work and family life (descriptive questions before going in-depth on wellbeing)

1. **To midwife:** Can you provide a brief overview of the roles you've held as a midwife?
2. **To family member:** Can you briefly tell me about the members of your family and what they all do?
3. Tell me about your current work as an LMC midwife. (Ensure the following topics are covered in the response):

- Caseload (how many clients etc.)
- Types of pregnancies the midwife mostly attends to
- In what ways are you involved in the midwifery profession beyond your hand-on work with clients?
- Where do you offer to attend births? Do you have a central clinic clients come to?
- Clients (where they live, socio-economic status, cultural background, etc.)
- How many 1st time mums do you take a month or is it mostly returns?
- Details of midwife's practice group
- The organisation of time-off and on-call 24/7 cover
- Relationships with practice colleagues and back-up (working and personal relationships)
- Working relationships with hospital midwives, obstetricians, nurses, etc.

4. **Question directed to family member:** What are your impressions of [midwife's name]'s work as a LMC midwife? What are her relationships with clients like? What about her relationships with others in her practice?

LMC work and family life/wellbeing (questions directed to both)

1. **Question directed to family member.** What is it like for your family/whānau living with a midwife?
How does it work with chores, childcare, family care, etc.?
How do you all cope with juggling family and work responsibilities?
What are some of the positives and negatives of living with a LMC midwife?

Question directed to family member (if not answered above): In what ways does [midwife's name]'s midwifery work affect your family life and overall wellbeing? (Topics to cover):

- Physical, psychological, and emotional wellbeing of the family
- Interpersonal relationships within the family
- The broader social and community life of the family
- Financial wellbeing/security of the family

Directed to family member. We've talked about the impact of LMC work on family/whānau, but we have not focused on its impact on you. How does [midwife's name] LMC work impact your wellbeing as an individual?

- *The family member may have spoken to this in the previous section.*

Question directed to midwife: How is what [family/whānau name] saying resonating with you? Are your impressions of how your work affects your family's life and wellbeing similar or different to what [family/whānau name] is saying?

Question directed to midwife: Let's explore the opposite, how does your family life impact your work as an LMC midwife?

- Do you have support from outside your family/household?
- How do you manage what needs doing at home vs what needs doing at work and vice versa?
- Overall, how do you feel about balancing family and work needs?

For family member: Anything to add to all of that?

Midwife's wellbeing

Directed to midwife. So far, we've talked about how your LMC midwifery work impacts your partner/spouse/child, and the family as a whole. We've also discussed family life impacts your work as an LMC midwife. Now, I want to explore in greater detail how LMC midwifery work impacts you as an individual.

Can you start by telling me about what you enjoy about working as a LMC midwife?

What about the things you dislike or find challenging?

1. Digging deeper, can tell me about how your work as an LMC midwife affects the various aspects of your wellbeing?

- Physical, psychological, and emotional health
 - Interpersonal relationships
 - Spiritual health
 - Community and social connections
 - Hobbies
 - Financial wellbeing – e.g., feeling adequately compensated for work done
 - Other aspects of wellbeing?
2. **Directed to family member.** How is what [midwife's name] saying resonating with you? In terms of the impacts of LMC work on [midwife's name] wellbeing, how similar are your views, and is there anything you'd like to add?

LMC work and Community involvement

Directed to both. So, we've discussed how LMC midwifery work impacts [midwife's name] and the family/household. Could we now explore the impacts of LMC work on you and your family's broader social and community connections?

1. **Question directed to midwife:** How does being an LMC midwife in your community affect your involvement with that community?
- Does being a LMC midwife make you well-known in your community and, if so, do you feel like it's a positive and/or negative thing?

- Do you spend some of your time off-call engaging with social or community groups/events? **[If the midwife says no, we could gently enquire why and see if she would like to elaborate]**
 - If you engage with social or community groups/events, can you do it in the way you'd like?
2. **For midwife:** How does being a LMC midwife affect your partner's and family's community involvement and social life?
3. **Directed to family member.** How is what [midwife's name] saying resonating with you? Regarding the impact of LMC work on your family's community involvement, how similar are your views, and is there anything you'd like to add?

LMC work and sustainability in the midwifery profession

Directed to the midwife. Looking back at your career thus far, can you recall why you chose to become a midwife, and how your experiences working as an LMC compare to your expectations of the profession when you joined?

Directed to family member. How is what [midwife's name] saying resonating with you? What is your take on [midwife's name] initial expectations of LMC work versus actual experiences?

Directed at both. How do your experiences as an LMC midwife affect your thoughts on continuing in the role and in the profession?

- Do you see LMC midwifery as a 'job for life' or do you foresee a change in profession or role at some point?

Directed at both. What do the significant people in your life (children, parents, siblings, friends) think of LMC midwifery as a career?

Directed at both. How would you feel if your own children (or equivalent family members or friends) decided to become LMC midwives?

Directed at both. Given everything we've discussed, to what extent do you think LMC midwifery work is a sustainable occupation?

Directed at both. What would you change about how LMC work is organised and carried out to improve the wellbeing of midwives and their families and, ultimately, make the profession more sustainable for them?

PAKEHA stream revised guide – former LMCs

Pre-interview checklist:

- Explain the aims and background of the overall research project and the individual interviewer's role and background
- Consent forms signed?
- Pseudonyms for participants?

General prompt/follow-up questions

Referring to an answer to a previous question: Has that always been the case?

Can you give me an example of when xxx happened? Was that recently? (i.e., how did it impact family life etc.)

How common is that for your household/family?

Midwife's work and family life (descriptive questions before going in-depth on wellbeing)

5. **To midwife:** Can you provide a brief overview of the roles you've held as a midwife?
6. **To family member:** Can you briefly tell me about the members of your family and what they all did when [midwife] was a LMC?

7. **To midwife:** Tell me about your former as an LMC midwife. (Ensure the following topics are covered in the response):

- Caseload (how many clients etc.)
- Types of pregnancies the midwife mostly attended to
- In what ways were you involved in the midwifery profession beyond your hand-on work with clients?
- Where did you offer to attend births? Do you have a central clinic clients come to?
- Clients (where they lived, socio-economic status, cultural background, etc.)
- How many 1st time mums did you take a month or was it mostly returns?
- Details of midwife's practice group
- The organisation of time-off and on-call 24/7 cover
- Relationships with practice colleagues and back-up (working and personal relationships)
- Working relationships with hospital midwives, obstetricians, nurses, etc.

8. **Question directed to family member:** What were your impressions of [midwife's name]'s work as a LMC midwife? What were her relationships with clients like? What about her relationships with others in her practice?

LMC work and family life/wellbeing (questions directed to both)

Question directed to family member. What was it like for your family/whanau living with a midwife?

How did it work with chores, childcare, family care, etc.?

How did you all cope with juggling family and work responsibilities?

What were some of the positives and negatives of living with a LMC midwife?

Question directed to family member (if not answered above): In what ways did [midwife's name]'s midwifery work affect your family life and overall wellbeing? (Topics to cover):

- Physical, psychological, and emotional wellbeing of the family
- Interpersonal relationships within the family
- The broader social and community life of the family
- Financial wellbeing/security of the family

Directed to family member. We've talked about the impact of LMC work on family/whanau, but we have not focused on its impact on you. How did [midwife's name] LMC work impact your wellbeing as an individual?

- The family member may have spoken to this in the previous section.

Question directed to midwife: How is what [family/whanau name] saying resonating with you? Are your impressions of how your LMC work affected your family's life and wellbeing similar or different to what [family/whanau name] is saying?

Question directed to midwife: Let's explore the opposite, how did your family life impact your work as a LMC midwife?

- Did you have support from outside your family/household?
- How did you manage what needs doing at home vs what needs doing at work and vice versa?
- Overall, how did you feel about balancing family and work needs?

For family member: Anything to add to all of that?

Midwife's wellbeing

Directed to midwife. So far, we've talked about how your LMC

midwifery work impacted your partner/spouse/child, and the family as a whole. We've also discussed family life impacts your work as an LMC midwife. Now, I want to explore in greater detail how LMC midwifery work impacted you as an individual.

Can you start by telling me about what you enjoyed about working as a LMC midwife?
What about the things you disliked or found challenging?

3. Digging deeper, can tell me about how your work as an LMC midwife affected the various aspects of your wellbeing?

- Physical, psychological, and emotional health
- Interpersonal relationships
- Spiritual health
- Community and social connections
- Hobbies
- Financial wellbeing – e.g., feeling adequately compensated for work done
- Other aspects of wellbeing?

4. **Directed to family member.** How is what [midwife's name] saying resonating with you? In terms of the impacts of LMC work on [midwife's name] wellbeing, how similar are your views, and is there anything you'd like to add?

LMC work and Community involvement

Directed to both. So, we've discussed how LMC midwifery work impacts [midwife's name] and the family/household. Could we now explore the impacts of LMC work on you and your family's broader social and community connections?

4. **Question directed to midwife:** How did being an LMC midwife in your community affect your involvement with that community?

- Did being a LMC midwife make you well-known in your community and, if so, did you feel like it was a positive and/or negative thing?
- Did you spend some of your time off-call engaging with social or community groups/events? **[If the midwife says no, we could gently enquire why and see if she would like to elaborate]**
- If you engaged with social or community groups/events, could you do it in the way you'd like?

5. **For midwife:** How did being a LMC midwife affect your partner's and family's community involvement and social life?

6. **Directed to family member.** How is what [midwife's name] saying resonating with you? Regarding the impact of LMC work on your family's community involvement, how similar are your views, and is there anything you'd like to add?

LMC work and sustainability in the midwifery profession

Directed to the midwife. I am interested in your journey into and out of LMC midwifery. So, can you start by telling me:
why you became a LMC midwife?
how your experiences as a LMC compared to your expectations;
and finally
why you decided to move on from being a LMC?

Directed to family member. How is what [midwife's name] saying resonating with you? What is your take on [midwife's name] initial expectations of LMC work versus actual experiences and reasons for stopping?

Directed at both. What did the significant people in your life (children, parents, siblings, friends) think of LMC midwifery as a career?

Directed at both. How would you feel if your own children (or equivalent family members or friends) decided to become LMC midwives?

Directed at both. How does your current work as a midwife compare to your previous LMC work in terms of its impacts on you, your family life, and your family's wellbeing?

Directed at both. Given everything we've discussed, to what extent do you think LMC midwifery work is a sustainable occupation?

Directed at both. What would you change about how LMC work is organised and carried out to improve the wellbeing of midwives and their families and, ultimately, make the profession more sustainable for them?

Data Availability

Due to the sensitive nature of the questions asked in this study, survey respondents were assured raw data would remain confidential and would not be shared.

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