

Community healthcare workers' experiences during and after COVID-19 lockdown: a qualitative study from Aotearoa New Zealand

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Abstract

Shortly after the COVID-19 pandemic reached Aotearoa New Zealand, stringent lockdown measures lasting seven weeks were introduced to manage community spread of the virus. This paper reports the findings of a qualitative study examining how lockdown measures impacted upon the lives of nurses, midwives and personal care assistants caring for community-based patients during this time. The study involved nationwide surveys and in-

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depth interviews with 15 registered nurses employed in community settings, two community midwives, and five personal care assistants.

During the lockdown, nurses, midwives, and personal care assistants working in the community showed considerable courage in answering their ‘call to duty’ by taking on heightened care responsibilities and going ‘the extra mile’ to help others. They faced significant risks to personal and professional relationships when they were required to take on additional and complex responsibilities for community-based patients. Despite the hypervigilant monitoring of their personal protective equipment (PPE), the need to safeguard family and community members generated considerable stress and anxiety. Many also faced personal isolation and loneliness as a result of lockdown restrictions. Moreover, the negative impacts of experiences during lockdown often continued to be felt once restrictions had been lifted, inflecting life during periods in which community transmission of COVID-19 was not occurring.

This article makes five core service delivery and policy recommendations for supporting community-based nurses, midwives, and personal care assistants in respiratory disease pandemics: acknowledging the crucial role played by community-based carers and the associated stress and anxiety they endured by championing respect and compassion; demystifying the ‘heroism’ or ‘self-sacrifice’ projected onto care workers; the timely provision of adequate protective equipment; improving remuneration, with adequate provision for time off; and regular counselling, peer support groups, and education on work-life balance delivered by support workers in recognition of stressors arising from these complex and isolated working conditions.

Keywords

Community Nursing and Midwifery, COVID-19 Pandemic, Personal Care Assistants, Feelings of Duty, Fear of Contagion, Work-Life Balance

What is known about the topic

- Community healthcare workers play a pivotal role in responses to pandemics.
- The COVID-19 pandemic has intensified many community healthcare workers' clinical duties.
- Pandemics pose risks to healthcare workers' physical and mental wellbeing.

What this paper adds

- During lockdown, community healthcare workers pressured themselves to be a 'good carer' or a 'hero'; caring for patients in the community often required 'going the extra mile' and acting beyond one's formal remit, further intensifying workload.
- The COVID-19 pandemic has negatively impacted community healthcare workers' wellbeing, as well their family and social lives – with impacts continuing even when COVID-19 was eliminated.
- Need for recognition of this workforce distinct from other care workers.

Introduction

Nurses, midwives, and personal care assistants are the largest groups of front-line healthcare service workers delivering care in communities in Aotearoa New Zealand (hereafter Aotearoa), yet are often the least recognized groups of healthcare providers (Green, 2020; Lukewich et al., 2021). These workers provide a spectrum of services ranging from supporting daily living to administering complex pharmaceutical interventions. They are pivotal in ensuring effective and ethical care provision for ‘home-based’ patients during pandemics (Ives et al., 2009; World Health Organization, 2020). Community based registered nurses, midwives, and personal care assistants deliver individualised patient care, most often in patients’ homes, away from their colleagues and institutional support systems. They often work irregular shifts in close physical contact with patients and in community settings, putting them at heightened risk of infection.

The impact of COVID-19 on healthcare workers, especially nurses, has been widely noted globally, with commonly reported difficulties including anxiety and stigma as a result of potential workplace exposure to COVID-19, inadequate PPE provision, proliferating workloads, and the trauma of having patients die of COVID-19 (Bagnasco et al., 2020; Maben & Bridges, 2020; Nyatanga, 2021). Such issues can contribute to burnout and attrition from the workforce (Feandez et al., 2020). Nevertheless, as De los Santos and Labrague (2021, 54) note, the literature has often placed more emphasis on hospital workers than staff working in the community. Hospital staff, particularly those treating COVID-19 inpatients, certainly face immense challenges – and international research suggests they have experienced a bigger drop in occupational satisfaction during the pandemic than community nurses (Savitsky et al., 2021). However, those providing healthcare in the community face distinct challenges that warrant consideration in their own right.

With patients unable to access regular clinics due to lockdowns, community healthcare providers have had to adopt new protocols, ranging from teleconsulting to providing clinical services in patients' homes (Corcoran, 2021; Oldman, 2020; Penfold, 2020; Stanley & Rawlinson, 2021; Yi et al., 2020). Mastering these new procedures can itself be a source of stress (Maben & Bridges, 2020). Moreover, although some healthcare systems implemented triage systems to reduce pressures on staff (Yi et al., 2020), many community nurses have seen their workloads intensify given the increased demand for home-care (Bowers et al., 2021; Green et al., 2020), and the medical complexities of treating and supporting recovery from COVID-19 (Green, 2021; Sun et al., 2021; Trueland, 2020). Community healthcare workers have sometimes also been tasked with enforcing social distancing between patients and their families (Sun et al., 2020).

To date there has been little research on the experience of community healthcare workers in Aotearoa – a country that has had a distinctive experience of the pandemic, given the rapid elimination of COVID-19 in 2020 following the swift imposition of stringent Level 4 lockdown measures, summarised in Table 1 (Cousins, 2020; Kvalsvig & Baker, 2021). Although small community outbreaks in August 2020 and February 2021 led to short periods of enhanced restriction (mostly in Auckland), Aotearoa enjoyed many months of freedom from COVID-19 until the incursion of the Delta variant triggered a further nationwide lockdown in August 2021, and the eventual abandonment of the elimination strategy in October 2021.

Community healthcare workers were seen by healthcare management as integral to the success of the initial lockdown, and by extension, the elimination strategy. They were instructed to be public health 'role models' and 'educators' (Brinkman, 2020) and have since been celebrated as 'heroes' (McClunie-Trust, 2021), which international literature notes can be a contentious term amongst nurses who sometimes felt they were not 'heroes' but 'being

Table 1. Summary of Restrictions at each COVID-19 ‘Alert Level’ in Aotearoa New Zealand (March - June 2020), as compiled from <https://covid19.govt.nz/assets/resources/tables/COVID-19-alert-levels-summary.pdf> [accessed 7 December 2020]

Level	4	3	2	1
Label	"Lockdown"	"Restrict"	"Reduce"	"Prepare"
Risk Assessment	Sustained and intensive community transmission occurring	Multiple cases of community transmission occurring	Limited community transmission could be occurring	Isolated local transmission could be occurring
Personal movement	Must stay at home in bubble except for essential personal movement	Must stay at home in bubble, except for essential personal movement. Bubble can expand but must remain exclusive.	No restrictions; physical distancing should be observed wherever possible	No restrictions; record-keeping encouraged
Gatherings	All gatherings cancelled	Up to 10 people allowed, but only for weddings, funerals, and tangihanga	Up to 100 people allowed**	No restrictions; record-keeping encouraged
Work	All workplaces closed except for essential services* and lifeline utilities	People must work from home unless that is not possible	Workplaces can open with record-keeping and physical distancing in place; alternative ways of working encouraged where possible	Workplaces open; must operate safely
Education	All facilities closed	Facilities open up to Year 10, but only with limited capacity - e.g. for children of essential workers	All facilities open; appropriate safety measures must be in place	All facilities open; must operate safely
Retail	All shops closed, except for essential services*	Shops can open but may not physically interact with customers	Shops can open; physical distancing must be observed in-store	No restrictions; record-keeping encouraged

* a full list of essential services, as of March 2020, is available at <https://duncancotterill.com/publications/covid-19-level-4-essential-services-march-2020>

** gatherings were initially capped at 50, but this figure was raised to 100 on 29 May 2020

martyred against [their] will' and inadequately compensated for their labour (Einboden 2020; Shan et al., 2021). This paper therefore draws on community healthcare workers' own accounts to map the issues that emerged as areas of concern for them during lockdown. It corroborates international research on primary care workforces, showing that heavy workloads together with inadequate PPE can cause considerable psychological stress (De Kock et al., 2021). It also reveals how the stringent lockdown measures implemented in Aotearoa placed additional workload pressures on community-based caregivers, who felt obliged to 'go the extra mile' and take on care duties extending beyond their formal remit. Moreover, it shows how the mental and relational strains of the pandemic continued even after COVID-19's elimination. It thereby highlights some of the negative corollaries of the elimination strategy initially adopted in Aotearoa, which should be considered when planning future pandemic responses. We conclude with policy recommendations to help mitigate these issues.

Methods

An exploratory approach guided our collection of data on experiences of delivering community healthcare under lockdown. Phase 1 involved analysing narratives collected in three online surveys, conducted at Levels 4, 3 and 2 of the lockdown (starting April 2020). These surveys, which were predominantly qualitative (see Long, 2020b) were advertised to the public via word-of-mouth and Facebook ad campaigns, receiving a total of 3644 valid responses. A follow-up survey in August 2021, which received 1040 valid responses, also informs our analysis.

Phase 2 involved in-depth interviews with 22 community-based healthcare workers: 15 registered nurses (public health, district, primary care, and mental health), two midwives, and

five personal care assistants. Twenty of these participants were women and two were men. The interviews took place between May 2020 and August 2020.

Sampling

Survey respondents were self-selected, with nationwide Facebook ad campaigns ensuring the surveys were promoted as widely as possible. Nevertheless, and as is common for survey research in Aotearoa (Houkamau & Sibley, 2019) the sample skewed heavily towards women, Pākehā (New Zealanders of European descent), and university graduates.

Participants for the interviews were recruited from the healthcare workers who took part in the nationwide surveys, as well as via social media flyers and snowball networking.

In what follows we do not attempt to provide a statistically representative or exhaustive account of the ways nurses, midwives and personal care assistants experienced the lockdown in Aotearoa. By foregrounding themes and issues that were voiced by multiple respondents, we nevertheless illuminate dynamics that we consider significant and widely shared.

Approach to the interviews

A guide for the interviews was developed from a literature review, as well as preliminary analysis of survey responses, and aimed at asking:

- (1) What worked and what was challenging about your living arrangements and those of your patients?
- (2) What arrangements had been made to make your workplace and caregiving spaces COVID-secure?
- (3) What are your thoughts on these arrangements?

(4) How did your household arrangements influence your work and life under lockdown?

Interviews were conducted primarily by EH. They lasted between 20 and 40 minutes and were held on Zoom or by phone after digital written consent had been granted and participant confidentiality assured (all names used in the text below are pseudonyms).

Analysis

Audio recordings were transcribed verbatim by the interviewer or via Otter.ai. Analysis was led by EH and followed Braun and Clarke's (2006; 2019) guidelines for using reflexive thematic analysis to identify similarities and contrasts across data points. First steps included familiarisation with the data, with the transcripts read repeatedly. Initial codes highlighted significant features of the data. These codes were then compiled into initial themes and data matched to each potential theme. The themes were then reviewed alongside the coded data and the complete data set, to provide a thematic map of our analysis. The themes were then refined and formally defined through weekly discussions among the research team over several months. Transferability was achieved through drawing out thick descriptions to frame contexts and settings (Liamputtong, 2019). Regular team discussion ensured confirmability, safeguarding against conclusions being unduly influenced by individual researcher bias.

Findings

Four main themes recurred across community health care workers' accounts of delivering care during the stringent first lockdown in Aotearoa:

(A) Going 'the extra mile' – Heightened professional responsibilities and additional care work;

- (B) The need to protect self and family;
- (C) Strain on personal relationships;
- (D) Long-term ramifications of the 2020 lockdown.

(A) Going ‘The Extra Mile’ – Heightened Professional Responsibilities and Additional Care Work

The requirement that people other than essential workers spend the seven weeks of Level 4 and Level 3 within a single ‘bubble’ – a small, exclusive social network, usually coterminous with a single household (see Long et al., 2020) – disrupted the flows of inter-household care that would usually support patients living in the community (Long, 2020a). The deep relationships that many carers had developed with their patients prior to COVID-19 were thus heavily leaned upon during lockdown – a development which could take a toll on workers at the coalface of community service delivery, who were left to absorb the risks. Moreover, many patients’ wellbeing was compromised by seven weeks of extended confinement. Participants described how their patients ‘got worse’ or ‘deteriorated’ due to changes in their routine, such as not being allowed to see their families, or being shut in their homes:

[...] it was like everything fell apart and those who had dementia got worse very quickly. So hard seeing family try and talk over walls and you could not really tell these patients what was happening.

Janice, Pākehā nurse.

[...] they picked up upon the stress of the outside world and it was like a spring just coiling up all the time.

Beatrice, Pākehā nurse.

Faced with such situations, participants overwhelmingly saw it as their duty to ‘go the extra mile’ and assist patients in need. A Māori personal care assistant from Wellington drew on her family history to explain the compassion she felt for her patients.

I would expect the same work of care for myself; I was brought up this way, being originally gifted as an adopted child to my aunt’s Māori family, it is natural of me to care. So, I went the extra mile. I put laboratory test results in letterboxes and got extra groceries for those living alone.

Molly, Māori personal care assistant.

‘Going the extra mile’ often involved working longer hours but was seen as unavoidable:

That is just what you do. You can’t switch off caring; it never goes away. What is wrong with going the extra mile? That is what my family did.

Mike, Pākehā nurse.

Increased workloads also arose from the number of safety protocols needed to mitigate risk, which increased dramatically during COVID-19. As one nurse articulated:

It’s giving of yourself and then our workloads increased so much, with extra cleaning, tracing, and hygiene protocols. These took *so* long. That’s why nursing is so exhaustive [sic]. It... it’s giving of yourself, then giving more at home, and in our family, and now along comes COVID-19.

Julie, Pākehā nurse.

Despite their exhaustion, however, participants often emphasized how they ‘had to keep going’ as they were driven by existing personal bonds with their patients. They took on extra personal tasks – which were often numerous and time-consuming, such as delivering groceries or running errands – without extra pay or time-off allowances. While they felt their extra work was valued by their patients and their patients’ families, they also experienced pleasurable feelings of heroism and self-sacrifice from doing more than was strictly required.

Apparent here is a moral notion of pandemic response, in which health service workers go above and beyond what is expected of them, and ‘good characters’ emerge (Brazeau et al., 2010). Many personal care assistants expressed taking on an extended identity, adding new dimensions to their unique care relationship with vulnerable patients living in what were often isolated conditions. The need to ‘keep on helping’ was frequently invoked as an unquestioned imperative integral to respondents’ moral identities – that was ‘what nursing [or caring] was’ and ‘what duty was’ (see also Fitzgerald, 2004, 335-6).

Moreover, most participants experienced deepened connections to and with their increasingly vulnerable community-based patients. A very particular ethics of care was enacted in moments of ‘going the extra mile’. One nurse outlined how ‘really caring’ involved more than simply carrying out the tasks that one was assigned:

There’s a difference between really caring for a patient in the community and carrying out tasks. I am emotionally invested in these older people who have such tough lives and are scared of the virus, many do not see their families – they do not have anyone else in their bubbles. Caring is a feeling that I don’t think you can ever really explain as a nurse. With time, you gain connection, and you share part of yourself with them.

Rachel, Pākehā nurse

Popular media depict carers, especially nurses, as dedicated and equipped with both the instinct and the motivation to serve: a self-sacrificing workforce that can be depended on against all odds (Shan et al., 2021). Many of our participants expressed similar notions, and used them to evaluate themselves as carers and as moral persons, taking satisfaction in having done what they thought was right despite the increased workload and absence of any formal recognition or remuneration (see also Blanco-Donoso et al., 2021).

(B) The Need to Protect Self and Family

Many participants described juggling complex work roles alongside protecting themselves and their families. Most of the personal care assistants interviewed were over 50 and many shared households with people who were older and vulnerable, such as older spouses, elderly parents who had joined their bubble for lockdown, and/or immunocompromised family members. Moreover, even when participants' household members were not vulnerable, they often felt compelled to protect them:

I am a home carer for older adults with severe health issues living alone. I needed to shower and dress them as well as feed some through tubes and give injections all while masked, plus my 16-year-old son was living with me at home. So, to keep him safe I had three bubbles; I slept in a shed to isolate him, so he was protected in his bubble, then I had all the work bubbles I needed to form with my home-based patients. I did this so my... so we would be alright and would not be contaminated. And on top of that people I know looked sideways in the supermarket at me.

Cath, Pākehā personal care assistant

Sandra, a Pākehā public health nurse in her 60s, had a husband undergoing cancer treatment. To protect herself and her family from COVID-19 she asked to undertake contact tracing duties (conducted over the computer and phone) to avoid going into patients' homes as cases spiked. While Sandra was able to make this change, many others could not. For them, the emotional labour of community-based care work in a pandemic meant risking not only their patients' health and wellbeing, but also their own, and that of those close to them (see also Major, 2008). While some devised strategies for managing the complex emotions that resulted, others reported feeling overwhelmed. Tracey, a Pākehā nurse, shared how she felt living with the fear of COVID-19 each day: 'I was so shaky all the time. I have to work as if nothing is happening, and I just want to be at home in my own bubble not here.'

This double challenge of caring at work and at home was made additionally stressful by the lack of access to adequate PPE. The nurses and personal care assistants spoke of feeling at the 'bottom of the pile' for the provision of equipment such as gowns, masks and gloves. Annie, a Pākehā community nurse, said 'I am working in total isolation with the physiotherapists all getting protective clothing ahead of me, despite the fact that they only saw patients for half an hour.' A community-based midwife had made gowns and masks in a sewing circle with other midwives (who could professionally share a bubble) so they all had enough PPE to attend home visits. Making their own PPE was considered not only to be protecting their patients, but also their family and community members.

(C) Stresses on Personal Relationships

Although the first national lockdown in Aotearoa was, by international standards, relatively short-lived, it had far-reaching repercussions for many people's relationships. Participants often described how being confined to separate bubbles had attenuated once-close connections. Kay, a Pākehā personal care assistant from Christchurch, described having

drifted apart from her best friend, who lived on the other side of town and had become preoccupied with their own bubble. Whilst not unique to essential workers (see Long et al., 2022), such dynamics of estrangement often affected them acutely. As Rowena, a Pākehā midwife from Nelson, explained, work was so stressful that many had ‘no mental or emotional energy left once off work’ to interact with friends. These pressures were compounded by the obligations they felt to provide continuing care and support to patients who they knew to be isolated, anxious, and/or at risk – for example, through phone calls in the evening and at weekends.

Both nurses and personal care assistants described facing community stigma as a result of their work. Some faced accusations of breaking lockdown rules when travelling for work, while others described being shunned or avoided in grocery stores by community members who feared they could be vectors of infection. Clara, a 29-year-old Pākehā primary health care nurse from Auckland, shared her sadness at having experienced stigma from family members, including her parents, who had refused to see her even several weeks after Aotearoa moved to Level 2 in June 2020, a time when the virus had been eliminated and no community transmission was being detected. ‘They’re too afraid,’ she explained, ‘they think I’m at higher risk of passing on COVID because of my job... and because of my job that meant my children were in day-care during level 3 too. They believed we posed a higher risk, despite these family members opening their bubble to other family’.

Proliferating workloads and anxieties regarding COVID-19 exposure could sometimes strain relationships within nurses’, midwives’ and personal care assistants’ bubbles, a challenge they addressed in various ways. One midwife used sonnets and love poems to provide a meaningful connection with her new partner, as well as renewing her relationship to God to seek strength during lockdown and finding support through her church community, especially their online poetry club, whilst living in a work bubble in a home birth

location. This indicates that while the lockdown was particularly hard for in-home carers and nurses, some did find support through the tough times. Others, however, became worn down by needing to provide endless compassion and kindness and then go home and do it all over again – with nobody in particular caring for *them* as they continued to work without any guarantees of extra personal protective measures for themselves or their families.

(D) Long-term ramifications of the 2020 lockdown

The themes above have identified issues affecting the wellbeing of nurses, midwives, and personal care assistants working in the community during the lockdown. However, although the most stringent restrictions on personal movement in 2020 ‘only’ lasted seven weeks, their ramifications have been felt by many community healthcare workers for much longer.

In some cases, these ramifications reflect the ongoing impact of mental health conditions that originated early in the pandemic and that were sustained amidst the ongoing devastation wrought internationally by COVID-19. Even after the seven-week lockdown, several nurses felt that the heightened anxiety amongst their patients, colleagues, and communities had not abated, and that their experiences of tending to patients in isolation, coupled with their own need for constant vigilance, meant that they themselves now lived with fear of the unknown or threat of contagion. Some reported being unable to exercise control over this fear. For example, Kelly, a Pākehā nurse, described how it was: ‘very hard to calm down from there. I feel like a tap has been turned on, and all the anxiety of my life is running nonstop. I still don’t think it has stopped.’ Our August 2021 survey revealed that such outlooks sometimes persisted for many months after COVID-19 had been eliminated from Aotearoa.

Other participants indicated long-term impacts of the stigma they carried as suspected vectors of COVID-19, either because loved ones remained anxious that they might transmit the virus or because damage to their relationships proved difficult to heal (see also Long et al., 2022). In some cases, experiences of lockdown even led participants to question whether they wanted to continue in their current roles:

I think it has reinforced how little nurses are valued in NZ, especially primary health care nurses. While supermarket workers got a temporary increase in pay to reflect the risk of working during this time, nurses got nothing. We got very little recognition and some people were rude to us... For many of us, it has left us feeling deflated and highly undervalued. It has definitely got me thinking of future career changes.

Clara, Pākehā nurse

While the moral imperative to care for others had led to many research participants ‘going the extra mile’ during lockdown, the pride they took in ‘having done the right thing’ was offset not only by the acute stresses they felt at the time, but the lack of support and recognition they subsequently received from both the community and the government.

Discussion

This study reveals how important notions of ‘being a good carer’ and ‘doing the right thing’ were for community nurses, midwives and personal care assistants during the first wave of the COVID-19 pandemic in Aotearoa. Their accounts present the pandemic as an extreme context requiring the repeated enactment of complex moral judgments. What is tested are the tensions between: nationally mandated health regulatory bodies’ ethical codes and practices (predicated upon the Hippocratic Oath of protection); rapidly reconfiguring what action can

take place to do social good and avoid harm in situations of professional isolation and potential danger; and needing to protect loved ones. Navigating these tricky ‘competing responsibilities’ (Trnka & Trundle, 2017) contributed to the psychological pressures facing this often-overlooked workforce.

Determination to ‘go the extra mile’, and ensure they were ‘really caring for’ their patients led many respondents to take on tasks outside their stated work remit. This added to workloads that were already soaring due to time-consuming COVID-19 protocols and increased demands for home care. Meanwhile, health care workers’ anxieties about the possibility of contracting or transmitting COVID-19 were ‘compounded’ by moral anxieties about whether they truly were ‘doing the right thing’. Many felt inherently compromised: they were providing care and support to patients in the community who were profoundly isolated – and often deteriorating clinically – as a result of the lockdown. However, by staying loyal to the call of duty, and attempting to maintain order in the face of adversity they also perceived that they put their patients and their own families at risk. Of note is the that the vast majority of community health care workers are female, working in a context where it is still widely expected that that women in the workforce will also assume family caring responsibilities (Duque, 2021, Shannon et al., 2019). Correspondingly there is the expectation that as both women and community carers they will go the extra distance both at home and at work. While the participants who responded to our call may have been the most likely to go above and beyond, hence not representative of all carers, the theme of ‘going the extra mile’ was sufficiently prominent to suggest it warrants close consideration in future pandemic planning.

Participants showed considerable determination and courage in ‘going the extra mile’; but they also felt exhausted and emotionally overwhelmed, sometimes reporting serious levels of anxiety. They often had to grapple with stigma, isolation and loneliness in

their personal lives. Moreover, many felt poorly supported by existing organizational provisions, particularly regarding PPE.

The notion of an obligation to sacrifice without extra resources (PPE, occupational wellbeing support, etc.) has been used to portray nurses as model citizens, as if being framed as ‘heroes’ were a reward in itself, conferring status on previously invisible groups (Appleton et al., 2020; Wilson et al., 2020). However, this places extreme pressure on this workforce (Shan et al, 2021). While the literature observes that many healthcare professionals are willing to accept the risks of their occupation in a pandemic, others perceive the risks of their work to be too high (Brooks et al., 2018). Such perceptions may be especially pronounced when workers’ sacrifices are not adequately recognised and the additional support they need to continue in the job is denied them. Such gaps in the institutional support of community-based healthcare workers have been shown to trigger adverse mental health (Nyashanu et al., 2021), and to impact upon retention (Halcomb et al., 2020; Sumner & Townsend-Rocchiccioli, 2003). As this study shows, it can also generate feelings of moral injury and injustice. When recognition and support were uncertain, delayed or given by their organizations to other health professionals first, it was perceived as an affront. Midwives in Aotearoa (many of whom are self-employed) were especially vulnerable to their ‘relative invisibil[ity] to the government’ and were vocal about their difficulties in accessing PPE and a lack of clear guidance on safety protocols, even as the strong emphasis on nurturing social connectivity in the New Zealand model of midwifery care impelled them to remain closely engaged with childbearers (Crowther et al., 2021). Given that inadequate action on the part of institutions can compromise the interpersonal ‘good actions’ taking place during pandemic times, more timely and effective procedures for fairly distributing support stand out as a policy priority.

To date, much literature on healthcare workers' experiences of pandemics has focused on the clinical burdens, risks, and fears that arise as a result of viral transmission (e.g., Bagnasco et al., 2020; De los Santos & Labrague, 2021; Green, 2021; Holroyd & McNaught 2008; Major 2008; Yıldırım et al., 2020). The case of Aotearoa, from which COVID-19 was rapidly eliminated in 2020 following a highly stringent lockdown, is instructive for highlighting the additional pressures that can result as a result of pandemic control measures themselves. Restrictions on household mixing not only contributed to a deterioration in the wellbeing of community patients, but also deprived them of many forms of practical support, which community health workers then felt obliged to provide. Meanwhile, the strict lockdown restrictions, in which one could not even meet outside for a socially distanced conversation, heightened these workers' own sense of loneliness and isolation. Opportunities to expand bubbles at Level 3 could, in principle, have provided relief. In practice, however, few participants took up this option, either facing stigma from prospective bubblemates or worrying they might be vectors of infection (Long et al., 2020; Long et al., forthcoming; Trnka et al., 2021). Such findings highlight how 'social distancing' – often framed as an ethical endeavour undertaken to ease pressure on health systems and healthcare workers (Jackson et al., 2020; Marchesi, 2020) – can actually generate distinct pressures for certain groups of the latter. Circumventing these pressures for this workforce should also be a priority for future pandemic planning.

Lastly, we note a significant irony. In countries that have been continuously dealing with surges of COVID-19 cases since 2020, there has been a concentrated, although somewhat belated, effort to develop protocols that safeguard community-based carers (Ballard et al., 2020). However, because Aotearoa did so well at initially eliminating COVID-19, there has been limited recognition of the extreme hardships that certain groups, such as community nurses, personal care assistants, and midwives, experienced during the 2020

lockdown period, nor policy developments aimed at addressing the professional and wellbeing issues that these caregivers are still experiencing as a result of those hardships. Notably, it was only after 15 months of extensive negotiation that, in October 2021, the New Zealand Nurses Organisation accepted a pay offer and called off strike action, stating that there was a ‘real opportunity here [for District Health Boards] to begin regaining the trust of their employees’ (NZNO, 2021). A final conclusion stemming from this study is thus that future pandemic planning should not only devise strategies for supporting community health workers through potentially protracted lockdowns, but must also proactively devise ways to minimise, remedy and compensate the repercussions of short-lived, but intensely stringent, modalities of infection control.

Recommendations

Efforts to address the consequences of heightened community-based care responsibilities during a pandemic must start by acknowledging these as legitimate concerns and making a sincere commitment to reduce the associated stress and anxiety. The additional duties and risks taken on by community nurses, midwives, and personal care assistants should be compensated via pay rises, especially in settings where other frontline workers receive such ‘rewards’ (as was the case for supermarket workers in Aotearoa). Moreover, staff must be treated with respect and compassion (Woods, 2020), and given adequate provision for time off (Moloney et al., 2018). It is imperative that PPE is provided in a timely manner.

Regular counselling, peer support groups, and support in achieving a manageable work-life balance must be provided in recognition of stressors arising from these complex and isolated working conditions. These should ideally be delivered by designated support workers, although regular team meetings or ‘huddles’ can also prove beneficial (Franzosa et al., 2021). Support measures should extend well beyond lockdowns themselves as the

psychological and social effects of stringent pandemic control measures can be long-lasting. To these initiatives needs to be added the demystifying of the ‘heroism’ or ‘self-sacrificing’ projected onto healthcare workers. Especially valuable during and after a pandemic, these are measures that should be considered best practice at all times.

Additional support for isolated patients (such as social media befriending groups) should also be considered to alleviate the burden on nurses, midwives, and personal care assistants. Where the epidemiology permits, more flexible pandemic control measures (e.g., allowing people to meet at a physical distance outdoors, or more scope to merge bubbles) could offer support to both isolated patients and isolated workers.

Above all, it is vital to recognise the specific contributions made by community healthcare professionals in navigating the multiple challenges of COVID-19 lockdowns while doing care work. Rather than collapsing them into an undifferentiated category of ‘essential’ or ‘frontline’ worker, these distinct contributions must be acknowledged – and anticipated in future pandemic planning.

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Conflict of interests statement

RS is Chairperson of Intersex Trust Aotearoa New Zealand and a board member of Pacific Women’s Watch. LT sits on the Board of Trustees of Koru School, Favona, Auckland. There

are no other relationships or activities to declare that could appear to have influenced the submitted work.

Ethical approval

Ethics approval for this research was granted by the Research Ethics Committee at the London School of Economics and Political Science (refs 11.08a; 11.08b; 11.08c) and the Auckland University of Technology Ethics Committee [ref 20/142]. It was further approved and ratified by the University of Auckland and Victoria University of Wellington's Human Participants Ethics Committee.

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All authors contributed to the conceptualisation and design of the study. EH conducted the semi-structured interviews with healthcare workers, led the thematic analysis of the transcripts, and wrote the first draft of the manuscript. NJL administered the surveys and led their analysis for this article. All authors had access to the data, contributed to the interpretation of the data, and wrote or edited portions of the final manuscript. All authors approved the final publication for submission and agree to be held accountable for all aspects of the work. EH is the corresponding author.

Data availability statement

Research data are not publicly available due to privacy or ethical restrictions.

References

- Appleton, N. S., Long, N. J., Aikman, P. J., Davies, S. G., Deckert, A., Fehoko, E., Holroyd, E., Jivraj, N., Laws, M., Martin-Anatias, N., Roguski, M., Simpson, N., Sterling, R., Trnka, S., & Tunufa'i, L. (2020). (Alter)narratives of 'winning': supermarket and healthcare workers' experiences of COVID-19 in Aotearoa New Zealand. *SITES*, 17(2), 51-77. <https://doi.org/10.11157/sites-id471>.
- Bagnasco, A., Zanini, M., Hayter, M., Catania, G., & Sasso, L. (2020). COVID 19—A message from Italy to the global nursing community. *Journal of Advanced Nursing*, 76(9), 2212-2214. doi: 10.1111/jan.14407.
- Ballard, M., Bancroft, E., & Nesbit, J. et al. (2020). Prioritising the role of community health workers in the COVID-19 response. *BMJ Global Health*, 5, e002550. <http://dx.doi.org/10.1136/bmjgh-2020-002550>.
- Blanco-Donoso, L. M., Moreno-Jiménez, J., Gallego-Alberto, L., Amutio, A., Moreno-Jiménez, B., & Garrosa, E. (2021). Satisfied as professionals, but also exhausted and worried!! The role of job demands, resources and emotional experiences of Spanish nursing home workers during the COVID-19 pandemic. *Health and Social Care in the Community*, [Early View]. <https://doi.org/10.1111/hsc.13422>
- Bowers, B., Pollock, K., Oldman, C., & Barclay, S. (2021). End-of-life care during COVID-19: opportunities and challenges for community nursing. *British Journal of Community Nursing*, 26(1), 44-46. <https://doi.org/10.12968/bjcn.2021.26.1.44>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2): 77-101. <https://doi.org/10.1191/1478088706qp063oa>

- Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, 11(4), 589-597, DOI: 10.1080/2159676X.2019.1628806
- Brazeau, C., Schroeder, R., Rovi, S., & Boyd, L. (2010). Relationships between medical student burnout , empathy, and professionalism climate. *Academic Medicine*, 85(10), S33-S36. doi: 10.1097/ACM.0b013e3181ed4c
- Brinkman, A. (2020). Coping with the COVID-19 virus. *Kai Tiaki: Nursing New Zealand*, 26(3), 25.
- Brooks, S. K., Dunn, R., Amlôt, R., Rubin, G. J., & Greenberg, N. (2018). A systematic, thematic review of social and occupational factors associated with psychological outcomes in healthcare employees during an infectious disease outbreak. *Journal of Occupational and Environmental Medicine*, 60(3), 248-257.
DOI: [10.1097/JOM.0000000000001235](https://doi.org/10.1097/JOM.0000000000001235)
- Corcoran, L. (2021). Delivering wound care during the pandemic. *British Journal of Community Nursing*, 26(S6), S34-S37. <https://doi.org/10.12968/bjcn.2021.26.Sup6.S34>
- Cousins, S. (2020). New Zealand eliminates COVID-19. *The Lancet*, 395(10235), 1474.
[https://doi.org/10.1016/S0140-6736\(20\)31097-7](https://doi.org/10.1016/S0140-6736(20)31097-7)
- Crowther, S., Maude, R., Bradford, B., Austin, D., Gilkison, A., McAra-Couper, J., & Krisjanous, J. (2021). When maintaining relationships and social connectivity matter: The case of New Zealand midwives and COVID-19. *Frontiers in Sociology*, 6, Article 614017. <https://doi.org/10.3389/fsoc.2021.614017>

- De Kock, J. H., Latham, H. A., Leslie, S.J., Grindle, M., Munoz, S-A., Ellis, L., Polson, R. & O'Malley, C.M. (2021). A rapid review of the impact of COVID-19 on the mental health of healthcare workers: implications for supporting psychological well-being. *BMC Public Health*, 21, 104. <https://doi.org/10.1186/s12889-020-10070-3>
- De los Santos, J. A. A., & Labrague, L. J. (2021). The impact of fear of COVID-19 on job stress, and turnover intentions of frontline nurses in the community: A cross-sectional study in the Philippines. *Traumatology*, 27(1), 52-59. <https://doi.org/10.1037/trm0000294>
- Einboden, R. (2020). SuperNurse? Troubling the hero discourse in COVID times. *Health*, 24(4), 343-347. <https://doi.org/10.1177/1363459320934280>
- Fitzgerald, R. (2004). The New Zealand health reforms: dividing the labour of care. *Social Science and Medicine*, 58(2), 331-341. [https://doi.org/10.1016/S0277-9536\(03\)00201-6](https://doi.org/10.1016/S0277-9536(03)00201-6)
- Franzosa, E., Gorbenko, K., Brody, A., Leff, B., Ritchie, C., Kinosian, B., Ostein, K., & Federman, A. (2021). "At Home, with Care": Lessons from New York City home-based primary care practices managing COVID-19. *Journal of the American Geriatrics Society*, 29(2), 300-306. <https://doi.org/10.1111/jgs.16952>
- Feandez, R., Lord, H., Halcomb, E., Moxham, L., Middleton, R., Alananzeh, A. & Ellwood, L. (2020). Implications for COVID-19: A systematic review of nurses' experiences of working in acute care hospital settings during a respiratory pandemic. *International Journal of Nursing Studies*, 111, 10363. <https://doi.org/10.1016/j.ijnurstu.2020.103637>.
- Green, J., Doyle, C., Hayes, S., Newnham, W., Hill, S., Zeller, I., Graffin, M., & Goddard, G. (2020). COVID-19 and district and community nursing. *British Journal of Community Nursing*, 25(5), 213. <https://doi.org/10.12968/bjcn.2020.25.5.213>

Green, J. (2021). RCN survey reveals 'relentless pressures' on district nurse services.

Primary Health Care, 31(2), 11-13. doi: 10.7748/phc.31.2.11.s5

Halcomb, E., McInnes, S., Williams, A., Ashley, C., James, S., Ferandez, R., Stephen, C., &

Calma, K. (2020). The experiences of primary healthcare nurses during the COVID-19 pandemic in Australia. *Journal of Nursing Scholarship*, 52(5), 553-563.

<https://doi.org/10.1111/jnu.12589>

Holroyd, E. and McNaught, C. (2008), The SARS crisis: reflections of Hong Kong nurses.

International Nursing Review, 55: 27-33. [https://doi.org/10.1111/j.1466-](https://doi.org/10.1111/j.1466-7657.2007.00586.x)

[7657.2007.00586.x](https://doi.org/10.1111/j.1466-7657.2007.00586.x)

Houkamau, C. A., & Sibley, C. G. (2019). The role of culture and identity for economic

values: a quantitative study of Māori attitudes. *Journal of the Royal Society of New*

Zealand, 49(S1), 119-136. <https://doi.org/10.1080/03036758.2019.1650782>

Ives, J., Greenfield, S. & Parry, J.M. (2009). Healthcare workers' attitudes to working during

pandemic influenza: a qualitative study. *BMC Public Health*, 9, 56.

<https://doi.org/10.1186/1471-2458-9-56>

Jackson, J., Posch, K., Bradford, B., Hobson, Z., Kyprianides, A., Yesberg, J. (2020). The

lockdown and social norms: why the UK is complying by consent rather than

compulsion. British Politics and Policy at LSE [blog],

<https://blogs.lse.ac.uk/politicsandpolicy/lockdown-social-norms/>

Kvalsvig, A., & Baker, M. G. (2021). How Aotearoa New Zealand rapidly revised its Covid-

19 response strategy: lessons for the next pandemic plan. *Journal of the Royal Society of*

New Zealand, 51(S1), S143-S16. <https://doi.org/10.1080/03036758.2021.1891943>

- Liamputtong, P. (2019). Qualitative research methodology and evidence-based practice in public health. In P. Liamputtong (Ed), *Public health: local and global perspectives. 2nd ed.* (pp.199-216). Cambridge University Press.
- Liu, Q., Luo, D., Haase, J. E., Guo, Q., Wang, X. Q., Liu, S., Xia, L., Liu, Z., Yang, J., & Yang, B. X. (2020). The experiences of health-care providers during the COVID-19 crisis in China: a qualitative study. *The Lancet Global Health*, 8(6), e790-e798. ISSN 2214-109X, [https://doi.org/10.1016/S2214-109X\(20\)30204-7](https://doi.org/10.1016/S2214-109X(20)30204-7).
- Long, N. J. (2020a). From social distancing to social containment: Reimagining sociality for the coronavirus pandemic. *Medicine Anthropology Theory*, 7(2), 247-260.
<https://doi.org/10.17157/mat.7.2.791>
- Long, N. J. (2020b). Lockdown anthropology and online surveys: Unprecedented methods for unprecedented times. *Studies in Indian Politics* 8(2), 294-297.
doi.org/10.1177/2321023020963839
- Long, N. J., Aikman, P. J., Appleton, N. S., Davies, S. G., Deckert, A., Holroyd, E., Jivraj, N., Laws, M., Simpson, N., Sterling, R., Trnka, S., & Tunufa'i, L. (2020). *Living in bubbles during the coronavirus pandemic: Insights from New Zealand*. London: LSE;
<http://eprints.lse.ac.uk/104421/>
- Long, N. J., Aikman, P. J., Appleton, N. S., Davies, S. G., Deckert, A., Fehoko, E., Holroyd, E., Jivraj, N., Laws, M., Martin-Anatias, N., Roguski, M., Simpson, N., Sterling, R., Trnka, S., & Tunufa'i, L. (forthcoming). On epidemiological consciousness and COVID-19: Envisioning vulnerability, hazard, and public health policy in Aotearoa New Zealand and the United Kingdom. In J. Robinson, S. Abram, & H. Lambert (Eds.), *How to live through a pandemic*. Routledge.

- Long, N. J., Appleton, N. S., Davies, S. G., Deckert, A., Fehoko, E., Holroyd, E., Martin-Anatias, N., Sterling, R., Trnka, S., & Tunufa'i, L. (2022). Pathways and obstacles to social recovery following the elimination of SARS-CoV-2 from Aotearoa New Zealand: A qualitative cross-sectional study. *Journal of Public Health*, Advanced Access. <http://doi.org/10.1093/pubmed/fdab394>
- Lukewich, J., Poitras, M.-E., & Mathews, M. (2021). Unseen, unheard, undervalued: advancing research on registered nurses in primary care. *Practice Nursing*, 32(4), 158-162. <https://doi.org/10.12968/pnur.2021.32.4.158>
- McClunie-Trust, P. (2021). Pandemic's impact on the profession. *Kai Tiaki: Nursing New Zealand*, 27(3), 13-15.
- Maben, J., & Bridges, J. (2020). Covid-19: Supporting nurses' psychological and mental health. *Journal of Clinical Nursing*, 29(15-16), 2742-2750. <https://doi.org/10.1111/jocn.15307>
- Major, C. (2008). Affect Work and Infected Bodies: Biosecurity in an Age of Emerging Infectious Disease. *Environment and Planning A*, 40(7), 1633-1646. <https://doi.org/10.1068/a40289>
- Marchesi, M. (2020). From sociality to social distancing: reversing values of solidarity in Italy. *Social Anthropology*, 28(2), 318-319. <https://doi.org/10.1111/1469-8676.12892>
- Moloney, W, Boxall, P, Parsons, M, Cheung, G. (2018). Factors predicting Registered Nurses' intentions to leave their organization and profession: A job demands-resources framework. *Journal of Advanced Nursing* 74(4): 864-875. <https://doi.org/10.1111/jan.13497>

New Zealand Nurses Organisation. (2021). Nurses accept DHB offer with firm majority.

Retrieved from

https://www.nzno.org.nz/about_us/media_releases/artmid/4731/articleid/6369/nurses-accept-dhb-offer-with-firm-majority

Nyashanu, M., Pfende, F., & Ekpenyong, M. S. (2020). Triggers of mental health problems among frontline healthcare workers during the COVID-19 pandemic in private care homes and domiciliary care agencies: Lived experiences of care workers in the Midlands region, UK. *Health and Social Care in the Community*, Early View.

<https://doi.org/10.1111/hsc.13204>

Nyatanga, B. (2021). When death is part of us: Supporting community nurses during the COVID-19 pandemic. *British Journal of Community Nursing*, 26(3), 150-151.

<https://doi.org/10.12968/bjcn.2021.26.3.150>

Oldman, C. (2020). Exceptional community nursing care during the COVID-19 pandemic.

Primary Health Care, 30(3), 5. doi: 10.7748/phc.30.3.5.s1

Pineda Duque J.A. (2021) Care Work: Professionalization and Valuation of Nurses and Nursing Assistants in Health and Old Age in Colombia. In: Araujo Guimarães N., Hirata H. (eds) Care and Care Workers. Latin American Societies (Current Challenges in Social Sciences). Springer, Cham. https://doi.org/10.1007/978-3-030-51693-2_12.

Penfold, J. (2020). Has the COVID-19 crisis changed community nursing in the UK forever?

Primary Health Care, 30(3), 13-15. doi: 10.7748/phc.30.3.13.s8

Savitsky, B., Radomislensky, I., & Hendel, T. (2021). Nurses' occupational satisfaction during Covid-19 pandemic. *Applied Nursing Research*, 59, 151416.

<https://doi.org/10.1016/j.apnr.2021.151416>

- Shan, M., Peter, E., Killackey, T., & Maciver, J. (2021). The “nurse as hero” discourse in the COVID-19 pandemic: A post structural discourse analysis, *International Journal of Nursing Studies*, 117, 103887. <https://doi.org/10.1016/j.ijnurstu.2021.103887>.
- Shannon, G., Minckas, N., Tan, D., Haghparast-Bidgoli, H., Batura, N., & Mannell, J. (2019). Feminisation of the health workforce and wage conditions of health professions: an exploratory analysis. *Human Resource Health* 17, 72. <https://doi.org/10.1186/s12960-019-0406-0>.
- Stanley, S., & Rawlinson, M. (2021). The only constant in life is change -- a case study of new working practices for podiatry and district nursing due to COVID-19. *Diabetic Foot Journal*, 24(1), 46-50.
- Sumner, J., & Townsend-Rocchiccioli, J. (2003). Why are Nurses Leaving Nursing? *Nursing Administration Quarterly*, 27(2), 164-171. <https://doi.org/10.1097/00006216-200304000-00010>
- Sun, Y., Song, H., Liu, H., Mao, F., Sun, X., & Cao, F. (2020). Occupational stress, mental health, and self-efficacy among community mental health workers: A cross-sectional study during COVID-19 pandemic. *International Journal of Social Psychiatry*. OnlineFirst. <https://doi.org/10.1177/0020764020972131>
- Sun, S., Xie, Z., & Yu, K. Jiang, B (2021). COVID-19 and healthcare system in China: challenges and progression for a sustainable future. *Global Health*, 17(14). <https://doi.org/10.1186/s12992-021-00665-9>
- Trnka, S., Long, N. J., Aikman, P. J., Appleton, N. S., Davies, S. G., Deckert, A., Fehoko, E., Holroyd, E., Jivraj, N., Laws, M., Martin-Anatias, N., Roguski, M., Simpson, N., Sterling, R., & Tunufa'i, L. (2021). Negotiating risks and responsibilities during

lockdown: Ethical reasoning and affective experience in Aotearoa New Zealand.

Journal of the Royal Society of New Zealand, 51(S1), S55-S74.

<https://doi.org/https://doi.org/10.1080/03036758.2020.1865417>

Trnka, S., & Trundle, C. (2017). Competing responsibilities: Reckoning personal responsibility, care for the other, and the social contract in contemporary life. In S. Trnka & C. Trundle (Eds.), *Competing responsibilities: The politics and ethics of contemporary life* (pp. 1-26). Duke University Press.

Trueland, J. (2020). Coronavirus in the community: the innovations helping nursing services keep up. *Primary Health Care*, 30(5), 6-8. <https://doi.org/10.7748/phc.30.5.6.s2>

Wilson, R. L., Carryer, J., Dewing, J., Rosado, S., Gildberg, F., Hutton, A., Johnson, A., Kaunonen, M. and Sheridan, N. (2020). The state of the nursing profession in the International Year of the Nurse and Midwife 2020 during COVID-19: A Nursing Standpoint. *Nursing Philosophy*, 21(3), e12314. <https://doi.org/10.1111/nup.12314>

Woods, M. (2020) Moral distress revisited: the viewpoints and responses of nurses. *International Nursing Review* 67, 68– 75.

World Health Organization. (2020). Coronavirus disease (COVID-19) outbreak: rights, roles and responsibilities of health workers, including key considerations for occupational safety and health. Available online at <https://apps.who.int/iris/bitstream/handle/10665/331510/WHO-2019-nCov-HCWadvice-2020.2-eng.pdf>

Wright St. Clair, V., & Seedhouse, D. (2005). The moral context of practice and professional relationships. In Whiteford, G. & Wright-St. Clair, V. (Eds.), *Occupation and practice in context* (pp. 16–33). Elsevier.

Yi, X., Binte Jamil, N., Gaik, I. T. C., & Fee, L. S. (2020). Community nursing services during the COVID-19 pandemic: the Singapore experience. *British Journal of Community Nursing*, 25(8), 390-395. <https://doi.org/10.12968/bjcn.2020.25.8.390>

Yıldırım, M., Arslan, G., & Özaslan, A. (2020). Perceived Risk and Mental Health Problems among Healthcare Professionals during COVID-19 Pandemic: Exploring the Mediating Effects of Resilience and Coronavirus Fear. *International Journal of Mental Health Addiction*, 16:1-11. <https://doi.org/10.1007/s11469-020-00424-8>