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Contemporary Research Topics

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Whole Journal

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The series *Scope (Health & Wellbeing)* is concerned with views, critical debate and reflections on health and wellbeing. It seeks to address current topical matters as they relate to health, research, evidence-based practice, clinical practice, sustainability, education and global to local health.

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CONTENTS

JOINING THE DOTS: SYNERGY THROUGH CONNECTION

Helen Jeffery

Connection is fundamental to relationships, for collaboration, learning, and the health and wellbeing of individuals and communities. Through research we grow increasingly aware of the role of connection as key a driver of health and a protective factor in societal resilience. As social beings, it is through being connected that we feel safe, learn, change, and grow. Opportunities to interact, share and listen enhance learning and un-learning. Connection is both enabled and disabled by the environment (geographical and systems), by technology, and by people.

This edition of *SCOPE (Health and Wellbeing)* Connection provides insights and evidence into the influence of connection in many ways. The photograph on the cover, *Connections, Far and Away* speaks to connection in its many forms – between people, people and the land, people and the animal world, and via technology. The diversity regarding connection in this photograph is replicated in the contributions to this publication through the content of the work and the styles in which perspectives are offered – including reflection, research, poetry, and interviews.

The form of poetry enables three authors to present their work illustrating connection. Rachel van Gorp *Unlocking the Power of Connection* found poetry from her Masters' research emphasising the impact of relationships for the neurodiverse learner's journey. The power of interwoven past-present-future threads calls from Annabelle Forrest's reflective poem *Exposed*, where connection moves from negative repetition to hope. Kerry Davis *The Fob Watch Witness* uncovers the connections between nurses, imbuing a fob-watch with deeply human moments with a humorous and touching series of rhyming couplets whose very rhythm reflects busy nursing routines.

The research of Foster et al. into nursing students experience of working in aged care residences found that a key influence on their clinical experience is the ability to form relationships with residents, illustrating the importance of client connection in clinical efficacy.

Simons and Speirs also present nursing students' experiences through a reflective piece describing a creative collaborative clinical learning opportunity involving child health through partnership with schools and the wider community. Personal reflection is shared by Barclay who describes a hesitant return to football following a significant injury, attributing the pull of re-establishing social connection with the rugby community as a primary motivator.

Synergy that emerges through collaboration enabled by technology is evident in the work of Ross et al. who explore community nursing, community development, research, and education through an international collaboration between four nursing researchers. Their exploration of shared rural health issues across the globe points to connection of humanity itself. Crawley's informative interview with a Canadian nursing academic also focuses on rural nursing and illustrates the places connection can take people in terms of cross-cultural knowledge sharing and the benefits of visiting scholarship.

Brook's fascinating biographical exploration of a family member in the nursing profession post World War 1 provides a glimpse into nursing training of old, and the influence of connection in the influenza pandemic. The subject is pulled from her nursing training to care for family and her nursing future is through connection rather than formal qualification.

Lansdown's research is placed in our recent COVID19 pandemic and reassuringly found that despite the social disconnection on a global scale, student nurses found their clinical placements during this period to be positive. The COVID-19 pandemic was also the basis for Lasater's contribution, where faith-based healthcare professionals use of health promotion strategies to restore care and connection in a USA environment is described.

Brown's narrative inquiry research explored the benefits of, and conflicts related to connection with animals. Findings include health and wellbeing benefits and the strength of connection akin to animals as whānau.

Autoethnographic research by Olsen et al., explored the research culture within their multidisciplinary inter-institutional research group, using the theme of this SCOPE publication to frame their research. Their conclusions illustrate powerful evidence of the value of connection in terms of synergy and benefits well beyond research outputs.

Joshi and Peiris explore subjective wellbeing in the face of disconnection from several perspectives and conclude that equanimity is the cornerstone of forming connections to whatever nurtures us and is a crucial prerequisite for our day-to-day well-being.

I am grateful to all contributors; this collection provides an insightful and diverse exploration of connection in many of its forms. I trust that you, the reader, will find gems in this publication that influence or inspire you – publication is one way in which connection is formed between now, the past, and the future, and importantly where connection is made between theory and practice.

A thank you is also due to Josie Crawley for her contribution overseeing the publication of the poems with her eloquent eye, and Catherine May for her contribution over the previous three years *Scope (Health & Wellbeing)* journals as Editorial Assistant, we wish her all the best in her new education role.

Waiho i te toipoto, kaua i te toiroa
Let us keep close together, not wide apart.

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A GLOBAL CONTEXT FOR RURAL NURSING: AN INTERVIEW WITH PROFESSOR KIM ENGLISH (VISITING SCHOLAR)

Interviewed by Josie Crawley

Kia ora Kim. Could you tell us a little about your role?

I am a professor in the Trent Fleming School of Nursing, located in Peterborough, Ontario, Canada. I teach in our first, third and fourth years and most of the teaching I do is about the profession itself – becoming a nursing professional, leadership and advocacy and rural nursing practice. Rural nursing practice and access to rural health is my area of passion. I like being able to introduce nursing students to areas of nursing they haven't thought about before. Many come into the program with a picture of either emergency nursing or delivering babies. I love being able to open their eyes to the different ways that you can be a nurse, what that looks like and the opportunities. Watching them become aware the work that they do is more than just tasks, incorporating knowledge translation and assessment skills. I always think of rural nurses as the top in demonstrating all of those skills, because they have to when there's so few resources around.

Figure 1. Kim English (Source: Kim English).

How did you become a visiting scholar?

Well, that happened just by coincidence! Jean Ross and I met at a virtual conference, she messaged me at that conference and that led to a connection through the Global Rural Nurse Exchange Network. I had posted on that network that I was on sabbatical for the 2022-23 academic year and was looking to have some experience in rural nursing that was outside of Canada. I had exploratory conversations with people in Scotland and England. And Jean piped in and said, "well, you need to come to New Zealand". Jean had started conversations and collaborations with colleagues in Australia and Switzerland; the timing worked out that we could all be in the same hemisphere for one period of time. It made sense to visit New Zealand and Australia as I'm looking to understand rural nursing from a more global context.

What did being a visiting scholar look like?

It looked like a lot of reading of documents! I came to understand how grassroot networks and connections led to the strategies and frameworks in place in New Zealand today by reading a lot of the historical documents and the work that's been done by the New Zealand rural nurse network and also some of the physicians.

It's meant a lot of time engaging with wonderful colleagues and talking about our work – seeing similarities but also differences. I took away bits and pieces for my own knowledge and learning and application to the work I do. Having the wonderful opportunity to travel to a few areas across the South Island and Stewart Island to meet some rural nurses and actually hear in their voice, their stories. They talked about the work that they do with such grace and passion and such connection to Jean and yourself (as story collectors and storyteller). By physically being there, it was so obvious that connection was crucial to their work. Connection to their communities but also to the support and development of other rural nurses – almost a way of giving back themselves. It was stunning to see how each of the nurses we visited with, knew the others – almost a forming of connections informally yet still holding great meaning.

Timewise, it was just under a month; around 10-11 days, in New Zealand and then just under a week in Australia. Practically, it has helped me finalize some of my doctoral work. While hiking on a mountain with Jean [Ross] in Arthur's Pass and talking about my Doctoral journey, she solved all of the problems and said "here's what you should be doing from what I'm hearing". It helped me package my ideas and when I came back [to Canada], I was able to shift my direction to something that was more concrete than what I had been considering before.

What similarities and differences did you notice in rural nursing across Canada, New Zealand and Australia?

The similarities were the challenges around staffing and how students attribute more value to acute care hospital based type settings, without seeing the true value of working in more rural areas where you have much more autonomy in your practice. The passion that rural nurses had for their work, you could just hear the skill and knowledge and expertise that came through in those conversations.

The differences – New Zealand has a National Rural Health Framework that comes from that group's grassroots perspective. It was built from the context of people who understood rural and lived and breathed rural – they shaped it rather than being dictated to. It was developed up from the community, which was to me was key.

Another difference is in how New Zealand rural nurses practise with a level of autonomy that we don't see in Canada. For example, owning a practice is not something that that would happen in the same way here [in Canada]. Also, the strong sense of identity – considering or seeing yourself as a rural nurse specialist – there's still a lot of debate whether rural nursing is a specialty in Canada! This is a big difference that I have bought back to Canada.

You mention storytelling. Anything from that aspect that particularly struck you?

It emphasised for me, that as much as we focus on the technical skills, the hands on and the doing; a lot of our work as nurses really is about those stories and experiences that we carry with us. The stories are key to our memories and our journey as a nurse. If you think about the span of your career, we all have those stories that have stayed with us. It's helping me reconsider the notion of nurses' knowledge – that Nurse storytellers can be the broker and translator into nurses' professions. Canadian authors Gwyneth Hartwick Doan and Colleen Varcoe (who spent a fair bit of time in New Zealand) talk in their textbook *How to Nurse* about creating your nursing story and helping students to see to see themselves in that story as a nurse.

I had several spontaneous conversations with NZ rural nurses about having shared their rural nursing stories in a publication. The theme for that conversation was really around the recognition of the work that they do. A real reflective self-worth; not just feel valued but to value themselves. I think until they started to tell their stories, it was just the work that they did. But, having to sit down and think about putting on paper the work that you do – that's when people started to walk through their journeys and think wow, you know, I can't believe that I did that, or I would just go and do that without any second thought. Often it wasn't really part of their initial plan for the work that they were going to do, but that's what happened. It seemed a benefit of telling their stories was the realization of the skill they have, the things that they've brought to their work, the past that they've travelled through and the impact that it's made to their communities as well.

Figure 2. Community Notice Board (Source: Kim English).

You knew the theme of Scope this year is connections. Could you walk me through the images you've shared?

This is a picture of a Community Board on Stewart Island. There was all kinds of information posted on this board. Information about people selling items, information from people who were looking for items, but also information from the health clinic. There's a bunch of handouts that are in a ziplock bag under the health clinic news with information about COVID for people who are there; protected yet anybody could come and grab them, and there's information about how to access the Island Nursing Service and how to contact the police. There was also information about the upcoming funeral service for a member of the community who had been well known.

Coming from a rural community myself, it spoke to me about how it is that we communicate in our communities and let people know things are happening when you don't have a daily newspaper or when you're small enough that you don't have news coverage about your community. In an era before we had cell phones these boards were our communication highway. The board illustrates that connection with members and also visitors. It spoke to me about that that way to maintain connection outside of using some of the tools that we've come to rely on a little bit too much perhaps.

Figure 3. Local Boots (Source: Kim English).

This was a small cafe on our way back from back through the Catlins and everybody's boots were at the front door. It provided me with lots of messages. The notion that when you're entering into somebody else's space the first thing you do is you look down at your footwear and think I'm not tracking the mud into their space. And that concern and acknowledgement of entering into a space for different purposes than that when you put your boots on!

But it's also feeling comfortable enough to do that as well. For me, if I were in that same position, I'd think, 'Oh my gosh, do I have socks on today? Is there a hole in my sock? Do I need to worry about that?' But obviously it was not a worry.

It spoke to connection on two different levels because it's the connection of the person taking off their boots, but also to that environment where you feel welcomed and safe and supported to be able to do that before you entered into the next part of what you were doing when you go into that room. I just love that picture!

This is an outdoor area on Stewart Island – it was a great gathering space. Now I understand it was intended for people who were smoking, but during the time that I was there, I did walk by and see a number of people who were sitting in that that space. As you can see, it's all covered; so regardless rain, sun, people will be able to sit there and not feel they have to leave because of the weather. It was a way of coming together, if you look in the picture you see that there's everything in there from a comfortable love-seat-type couch that somebody might have been getting rid of from their home to cinder block tables. People have put time and effort into creating that gathering space, which might have had one intention early on, but created a place for people to go, sit together, talk and share time and information with one another.

Figure 4. Local Community Gathering Place (Source: Kim English).

This is a combination of two pictures together. That stunning sunrise is at Stewart Island. The second picture was on our travels back through the Catlins. In the short time I was there, walking along the beach you could see this storm rolling in. The juxtaposition of this beautiful morning sunrise and waiting to start your day contrasted with the storm coming in, spoke of our whole entire experience of those times that are good in our connections

Figure 5. Sunrise over Stewart Island (Source: Kim English).

Figure 6. Storm Approaching Catlins (Source: Kim English).

and beautiful and lovely – but there's also times that are a little bit stormy. Yet even in that picture of the storm rolling in there's absolute beauty because you can see how those clouds are pulled together and the light coming from behind them.

When you look back, the sunrise picture has clouds too. It's a different perspective on those moments of connection and coming together that could be perceived as challenging or beautiful – it's all in in how we frame those pictures and how we think about those.

And I think that, when I think about some of the rural nurse stories that I was hearing, again it's depending on your perception. You could listen to that story and think how would you continue on doing that work? Or you could listen to that story and think you know what the nurse telling the story was talking about – how this is just an experience that happens as a rural nurse. "And so here's what we did and we did the best we could and then you know we went on to the next part of what we had to do". Yet this story still remains with me and so I do very much see these images as an analogy for the work of rural nurses that it's difficult and beautiful all at the same time.

After this experience – what comes next?

Well, one place that this experience has to go is into finishing my dissertation. I've been pulling that together as a separate piece. It's also bringing the experiences and what I learned in in both New Zealand and Australia back to my colleagues in Canada and saying – "you know this started as a grassroots effort". How could we do something similar? We're not going to solve the issues that we have in rural healthcare access in Canada right now, but we could start to make some inroads. We could start to shift lenses around how we view the work of rural practitioners and even how we view rural residents themselves, which is a whole other piece. The presentation that I gave in New Zealand and then part of our group presentation in Australia was really about that the right to access to healthcare and in rural communities.

In Canada, we've seen a chipping away of services and the effect that that has both for providers but also for community members. I am starting to get the word out in Canada from a more global perspective; continuing to work with Jean Ross in New Zealand, Kate in Australia and our colleague Daniela in Switzerland.

I am already applying for some funding and grants so that I can come back, because I just think that this was only a tiny little bit and there's just so much more that that I think collaboratively we could share; storytelling, rural health and rural nursing.

What could New Zealand learn from Canada and Australia?

That's a tough one because I feel many of us need to learn more from what's happening in in New Zealand. I was really struck at the differences in approach to Māori in New Zealand compared to what we're still struggling with so significantly in in Canada. That's a key piece for me I've brought back. I think that on so many levels New Zealand is farther ahead than Canada in much of the work around rural health and rural nursing.

Perhaps one opportunity is expanding the roles of nurses, yet, most of the nurses I was talking to did have very expansive practices. It's similar to what we're hearing from colleagues across North America and across global areas of the world – rethinking what nursing practice looks like and that it's not all hospital based. How do we move forward into this new era where nurses work outside hospitals in large numbers – and how do we best support nurses working elsewhere in the community?

What suggestions do you have for people exploring becoming a visiting scholar?

I think be open to change, willing and able to be spontaneous with what you're doing and maybe shifting some of your ideas. I originally thought where I wanted to go and most of it was related to family ties and interests. But it was the unexpected things that had a big impact; I recall one of our walks up the mountain with Jean where she said to me that this experience could really be a game changer for me. It's true – this wasn't what I had intended to do initially, but it was what I was meant to do in the end.

Finally, I would ask some more questions before I came – because you don't know what you don't know. When a Kiwi says, "let's go for a walk" – they actually mean we're going to hike a mountain and you need proper footwear to do that!

I would like to express my gratitude: being offered this amazing experience, flying across the country to meet up with people I'd never met before beyond emails; the generosity of staying with people, being offered rides and then being taken around to see different areas. I am thinking about ways to give back with similar experiences myself.

Kim English (Professor) is based in Ontario, Canada; teaching nurses since 2002. Kim's narrative informed research explores the work of rural and remote nurses, celebrating their innovation and leadership. She feels privileged as a settler to learn with and from many Indigenous nurses, elders, and colleagues. Kim has been the recipient of several teaching awards, including the Trent University Excellence in Online Education Award in 2020.

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Josie Crawley (Associate Professor) has been involved in nurse education for 30 years. Her research platform explores phenomenological experience, narratives for education, reflection, and compassionate care. She co-edited a book of rural nurse narratives: *Stories of Nursing in Rural Aotearoa: A Landscape of Care* and has published widely in academic literature.

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THE FOB WATCH WITNESS

Kerry Davis

We bought you this, my parents said, on Graduation Day
A silver fob to wear with pride on your first nursing day

Though upside down, suspended there, it meant my wrists stayed clean
But little did I realise what this watch would come to mean

My white nurse smock, my watch adorned – it held symbolic power
For it would witness from its chain, each second, minute, hour

I mastered 24-hour clock and wore it night and day
Over my heart, my watch it sat, a silent part to play

The travel time, handover done – Night staff must get away
The start of shift, a quick walk round, then time to plan my day

The patient obs – the breaths per minute
24-hour urine – not very much in it?

Medications took some time – an antibiotic in the line
A slow push over 5 minutes is fine
And count the drips through the IV line

GTN puffs, five minutes apart
Counting the pulse – listen over the heart

Chest compressions – 100 per minute
Early morning breakfast – not sure what's in it?

The Apgar scores at one and five
The length of down-time – can she survive?

12-hour shifts, split shifts or double
Visiting hours – don't want any trouble

Her dog smuggled up the service stairs
Works well to allay the patient's fears

Beyond nursing actions, my fob witnessed more
The breaking of bad news and moments so raw

The longest goodbyes and the most fleeting too
Do you have a minute, nurse? – of course I do

My watch sits alone in my bottom drawer, no longer keeping time
But testament to the precious days, encompassed in this rhyme.

HISTORY OF THE FOB WATCH

A fob watch was occasionally given as a gift associated with a rite-of-passage from parents to young nurses. Clipped onto the uniform, it was worn upside down so that the time could be read without handling the timepiece or touching potentially infectious surfaces.

Figure 1. The fob watch.

Kerry Davis is a Principal Lecturer in the School of Nursing at Otago Polytechnic Te Pūkenga. Transitioning from over 30 years of practice in acute care and clinical education, Kerry now coordinates the 'Senior person's health' and 'Evidence based nursing' courses, for over 100 ākonga each year, in the Bachelor of Nursing programme. Kerry believes that the art of nursing can be expressed through poetry and narrative, to help ākonga connect with and make sense of their feelings, professional practice and episodes of care.

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ISABEL MUIR: A NURSING CAREER GOES OFF TRACK

Lesley Brook

INTRODUCTION

Biography is a form of narrative research that studies the life of one person (Joyce, 2015; Lewenson, 2006). This person may be in a different profession from readers, from a different time, place or context, or simply have a different experience and perspective. By vicariously experiencing another's life, readers' horizons are extended; biographies increase understanding and forge a connection for readers with the person who is the subject of the biography (Joyce, 2015; Lewenson, 2006; Noel, 1988; Schulte-Steinicke, 2006).

Biographies of nurses each shed light on the profession from one person's situation and perspective (Noel, 1988). Together, these lights contribute to illuminate the profession as a whole over time. Connecting the dots of individual lives, both the similarities and the complementary differences, provides a richer and deeper picture of the nursing profession as a whole over time (Lewenson, 2006).

Biographers need an interest or affinity with their subject (Noel, 1988). In this paper, I investigate the life of Isabel Muir, in whom I have a great interest because she is my great-great aunt. She was described by a local history book (Cairns & Plunkett, 1984) and in both her parents' obituaries as "nurse" (p. 77). I knew about the start and end of her life, before and after her professional career, and I wanted to fill in the gap. Knowing other nurses' stories, and because of her very long life, I expected her story would be interesting and would build my sense of connection with someone I knew.

What I discovered was that she never actually qualified as a registered nurse. She was not alone: in the early twentieth century over 32 per cent of trainee nurses in two New Zealand hospitals did not complete registration (McDougall, 1997). This biographical and personal account of one woman's life therefore contributes one answer to an important question: What happened to those who did not complete their nursing training? This is one of the dots to be connected, contributing to the overall picture of the nursing profession in New Zealand.

EARLY LIFE

Isabel Mary Louise Muir, called Bel, was born at Fortification station, in the southern Catlins area in Southland, New Zealand, on 7 December 1892 (Department of Education, New Zealand, n.d.-a, n.d.-b). Her father William Muir had been born in New Zealand (Presbyterian Church of New Zealand, 1855) to Scottish parents (Church of Scotland, 1846). He was farming at Fortification ('Obituary: Mr William Muir: Early Southland Settler', 1934). Bel's mother Mary Clarke was an Irishwoman who immigrated to New Zealand in 1878 (A. Calder, personal communication, n.d.; 'Obituary: Samuel Clarke', 1931). William Muir and Mary Clarke were married in Dunedin, Otago, on 19 October 1886 (Presbyterian Church of New Zealand, 1886), and Isabel was the fifth of their nine children (Wood, n.d.).

When Bel was four years old, in 1897, her family moved from Fortification to a farm "Carie" a little further south, in the Redan district nearer Wyndham (Redan District Book Committee, 1990). Bel started her education at

Redan Valley School (Redan District Book Committee, 1990) on 3 March 1898 and passed Standards 1 to 4 here (Department of Education, New Zealand, n.d.-b). In about 1904, the farm was sold (Redan District Book Committee, 1990) and the family lived temporarily in Invercargill, Southland. Here Isabel attended Invercargill Middle School, from 19 September 1904 until early 1906, passing Standard 5 (Department of Education, New Zealand, n.d.-a).

The family then moved to another farm, "Cariedale," in the South Hillend district of Southland (Cairns & Plunkett, 1984; Redan District Book Committee, 1990). That appears to have been the end of Bel's schooling, at the age of 13; late in life Bel recalled attending South Hillend School (B. Muir, personal communication, 11 September 1984), but she does not seem to have been there long enough to have been registered as a pupil (Cairns & Plunkett, 1984).

As a young single woman, Bel lived at home on the farm with her parents. She drove her mother around the district in the horse and gig visiting every Protestant household to collect money to buy seats for the new Presbyterian Church building (Cairns & Plunkett, 1984; Henderson, 1982). She became one of the church organists at South Hillend (Cairns & Plunkett, 1984).

In 1914, she was still living in South Hillend, a "spinster" at the age of 21 (New Zealand Government, n.d.-a). There had once been a young man she thought she might have married, but he was killed in the war (B. Muir, personal communication, 1986). The South Hillend School Roll of Honour for World War 1 lists 26 young men who served as soldiers, including two of Bel's brothers. Six of them did not come home (Cairns & Plunkett, 1984; Kia Mate Toa: Fight Unto Death, 2014), three of whom were very close to Bel's age, two a little younger and one much older (Cairns & Plunkett, 1984). One of these six is likely to have been Bel's "beau."

This is probably when she decided to train to become a nurse, in 1916 or 1917. Perhaps she no longer expected to marry, perhaps she was inspired by the services provided by nurses during the war, perhaps she was encouraged by her younger sister Agnes who had already begun her nursing training.

NURSING TRAINING

Bel "trained as a nurse and made her life in Dunedin", according to South Hillend's local history book (Cairns & Plunkett, 1984). The reality is more complicated. Her training was in Dunedin (B. Muir, personal communication, 11 September 1984). Trainee nurses were called probationers (McDougall, 1997; Roddick, 2005). At that time, about 1916/17, nursing education was a three-year hospital-based course. Students had to pass a state examination in order to be registered (Burgess, 1984). Nurses could not sit the state final examination until the age of 23, so most started at 21 years of age and some were older (Roddick, 2005).

This training consisted of hard work in an apprenticeship model, with a focus on behaviour and attitude rather than knowledge, supplemented by formal lectures (Roddick, 2005). Nurse probationers lived together in the Nurses' Home under strong supervision (Roddick, 2005). Records were kept of nurses in training, and these could include notes on reasons for leaving. Analysis of these records for Wellington Hospital in the period 1916-1924 revealed the following reasons why probationers left without completing their registration: no reason given, to be married, ill health, failed exams, family, unsuitable, did not like work, overseas, did not feel strong enough, not strong enough, died, dishonesty (McDougall, 1997). Attrition rates were also high in Dunedin Hospital (Roddick, 2005).

In 1918, Dunedin Hospital was "chronically overcrowded." This was due to a combination of factors: injured soldiers returning from World War 1, epidemics of scarlet fever and of diphtheria, the absence on war service, and the illness of many nurses. Beds had to be placed in the centre of the long wards, not just down the sides. The overcrowding led to longer shifts and reduced leave, and must have compromised the probationers' education (Roddick, 2005).

Then the 1918 influenza epidemic arrived in Dunedin, compounding the problems at Dunedin Hospital.

> During September and October, nurses who had already been on extended sick leave began to request additional leave because they were required at home to look after family members who had succumbed to the first wave of the influenza epidemic. In November, as the second wave approached, many felt compelled to resign due to the sudden deaths of family members. (Roddick, 2005, p. 90–91).

While many thousands of people died in the influenza epidemic, there were many more who became ill with influenza and recovered (Burgess, 1984). New Zealand's worst recorded natural disaster struck the province of Southland particularly hard, including Bel's home district of South Hillend (Rice & Bryder, 1988). Bel came home to nurse family members, the connection to family calling her away from her training. Two of her nieces died, six-year-old Agnes Wilson on 25 November 1918, and her sister Hazel Wilson on 26 November 1918, aged three.

It is interesting to consider Bel's sister's nursing career for comparison. Agnes Margaret Cornwall Muir was 18 months younger than Bel. She completed her training, sat her State examination in June 1917 and was registered as a nurse in July 1917. She worked at Riverton Hospital in Southland until May 1919, when she moved to St Helen's Hospital (New Zealand Government, various years), a maternity hospital in Invercargill opened in 1918 (Stubbs, 1918). She obtained her midwifery certificate in December 1919. In 1923 she shifted to Timaru Hospital in South Canterbury (New Zealand Government, various years), then in 1926 she married. Bel was her bridesmaid ('Wedding: Robertson - Muir', 1926).

THE NEXT FEW YEARS

In later life, Bel mentioned that she had nursed in Christchurch and Wellington (B. Muir, personal communication, 11 September 1984) but I have not found any record locating her there. I can follow her movements over the next few years only from the Electoral Rolls. In 1922 she appears to be at South Hillend still (Wallace County). Her parents had retired to Invercargill in about 1917 ('Obituary: Mr William Muir: Early Southland Settler', 1934), and Bel was living there with her parents, her brother Sam and his wife at 23 Venus Street in Invercargill in 1925 and 1928 (New Zealand Government, n.d.-a). Having nursed family during the 1918 influenza epidemic, it is likely she nursed her mother before Mary's death in 1930 ('Deaths: Muir', 1930; "Loopy Lass", 2016). Her father moved back to South Hillend where he died in 1934 ("Loopy Lass", 2016; 'Deaths: Muir', 1934; 'Obituary: Mr William Muir: Early Southland Settler', 1934). We cannot tell whether Bel went with him or not. In 1935, she was living at the same address in Invercargill with Sam and his wife. Perhaps she found short term work private nursing, caring for the sick and dying in their own homes (Ristori, 1947).

While living in Invercargill, Bel went on a day trip to Stewart Island with some nursing friends. The weather was rough and she was the only one not seasick—which meant she had the responsibility of looking after all the women's false teeth so that they were not lost over the side of the boat. She knew whose teeth were whose, to return each set to the right person, because each young woman had wrapped her teeth in her own handkerchief (J. and G. Henderson, personal communication, May 1992).

By 1938 Bel was living on her own at 189 Tweed Street in Invercargill. However, although she still appears in the Electoral Roll for Invercargill in 1938, she had moved to Dunedin where she also appeared in the Dunedin West Electoral Roll, at 560 Cumberland Street. Here, although unregistered, she was able to continue her connection with the nursing profession

DISTRICT NURSING IN DUNEDIN

Bel Muir worked in Roslyn as a district nurse (B. Muir, personal communication, 1986). The Roslyn District Nursing Association (RDNA) had been established in 1934, operating in the Roslyn, Kaikorai, Maori Hill and Wakari suburbs of Dunedin ('District Nursing: The Roslyn Association: Opening of Rooms', 1934). A similar scheme was operated by the St John Ambulance Association in other parts of Dunedin ('Community Service', 1937). The RDNA was funded by member subscriptions, part charges paid by patients who could afford it, and donations of money and goods. Donations of food, bedding and clothing were received for distribution to patients, and equipment for use in providing the service ('District Nursing: Roslyn Association', 1939; 'District Nursing: Roslyn Association: Future Uncertain', 1945; 'District Nursing: The Roslyn Association', 1935).

The Roslyn District Nursing Association (RDNA) employed one trained nurse and St John employed three to "spend their time in visiting and helping the sick and aged poor of the community" ('Community Service', 1937, p. 10). The first annual report of the RDNA advises that:

> The bedside care of a sick person, as far as possible, is carried out under the direction of his or her own family doctor, and the instruction of the patient's family in home nursing and the laws of health is in accordance with the teachings of the Public Health Department under whose technical supervision and advice the committee desires to place the district nurse, so that her work will be co-ordinated with the public health nursing of the New Zealand Health Department. ('District Nursing: The Roslyn Association', 1935, p. 5).

The RDNA had monthly meetings. At their meeting in June 1939, they identified a need to employ unregistered assistants.

> During the last two months there has been many demands on the services of the district nurse, and it has been impossible for her single-handed to cope with the situation. Owing to the shortage of trained nursed and of women to assist in the homes is [sic] has been decided to institute a register of auxiliary helpers (both honorary and paid) whom the nurse may call on in an emergency. (p. 11).

It is likely that Bel Muir was one of these paid auxiliary helpers.

The Red Cross also provided the services of Voluntary Aids, who were trained in home nursing, hygiene, and first aid, to support the work in Roslyn and elsewhere in Dunedin ('Good Work', 1943; 'Red Cross Society', 1941). When the government introduced a home aid scheme in Dunedin in 1946, the eight Voluntary Aids were all fully employed. The nature of their work was quite different to that of the district nurses and their auxiliary helpers:

> These women are all highly qualified domestic workers with good experience, and the homes to which they have been sent have all been in desperate need of help. The aids are sent where there is sickness in the home or where the mother of the family is in a maternity hospital and there is no one else available as a housekeeper. ('Social and Personal', 1946, p. 11).

In October 1939, the government introduced a new two year course for nursing aids (Burgess, 1984), then in 1944, a District Nursing scheme was announced by the government. Free nursing services would be provided by a registered nurse, nursing aid, midwife, or maternity nurse employed by any department of state, hospital board or subsidised association ('District Nurses: Free Service Announced: Details of Scheme', 1944). This resulted in a reduction of income to the Roslyn District Nursing Association, because they were no longer permitted to collect fees from patients ('District Nursing: Roslyn Association: Future Uncertain', 1945). As a result, St John relinquished their district nursing service because they were unable to compete with the free service provided by the Hospital Board ('District Nursing: Change in City Control: Hospital Board to Take Over', 1945). The

RDNA carried on and in 1947 secured an increased subsidy from the Hospital Board, approved by the Ministry of Health ('Hospital Board', 1947).

Nursing was hard work that took a toll physically. This was acknowledged in an editorial in an issue of the New Zealand Nursing Journal:

> Usually, the life of a nurse is strenuous and wearing in the extreme, so that she is more in need of a settled income in later life than many others, as generally she is quite unfit to take up other work to eke out whatever slender provision she has made for the future – cited in Wilson ('The Shortage of Staff', 1938, p.100).

Bel Muir ceased district nursing at the age of 53, which would have been in 1946. She hurt her back, lifting male patients, and there was no compensation available (B. Muir, personal communication, 11 September 1984). At that time, in 1946, she was living at 2 Brown Street, Abbotsford (New Zealand Government, n.d.-a).

RECEPTIONIST/NURSE

Mr Norman Waddle arrived in Dunedin and set up practice as a consulting surgeon in 1947 ('Professional', 1947). Bel Muir went to work for him, as his receptionist and nurse (J. W. Henderson, personal communication, 18 July 2021). This would have lighter work that still engaged her nursing experience.

Originally from New Plymouth, Mr Waddle studied medicine at the University of Otago in Dunedin. He started his medical career as house surgeon at Palmerston North Hospital, then after qualifying as a Fellow of the Royal College of Surgeons in Edinburgh, he returned to New Zealand and set up in General Practice in 1929. In 1939 he sold his practice and moved to England where he worked at the Royal Infirmary in Sheffield and qualified as a Fellow of the Royal College of Surgeons of England ('Personal', 1941; 'Professional', 1929; 'Weddings', 1928).

Dr Waddle's consulting rooms were at St Duthus, 504 George Street, at the corner with Albany Street ('Professional', 1947). From the Stone's Otago & Southland Directories, it appears that this building was previously in six flats but in 1947, some of the flats were converted to consulting rooms for professional practices, and the name St Duthus was adopted. Over the next few years, the other professional occupants were medical practitioners, a dental surgeon, and a skin specialist.

In the 1949 Electoral Roll, Bel Muir has 504 George Street listed as her address. She may have been living in one of the flats there, or else used her work address. The same year she is also listed as residing at 139 Carroll Street, but finally settled at 539 Castle Street, where she lived for about ten years (J. W. Henderson, personal communication, 18 July 2021; New Zealand Government, n.d.-a). Each year she would have one male university student boarding with her, a medical student because she knew they would be hard-working (J. W. Henderson, personal communication, 18 July 2021).

ASSISTANT LIBRARIAN

After she finished working for Mr Waddle in about the mid 1950s, Bel Muir worked at the Athenaum Library in the Octagon in Dunedin (J. W. Henderson, personal communication, 18 July 2021). The Dunedin Athenaum and Mechanics' Institute runs a library for its members. The librarian, in the mid-1950s, was Doris Hale, then in late 1956 she was replaced by Miss R E Talboys (Sullivan, 2013). Bel would have been an assistant librarian (Athenaeum Library, personal communication, 26 July 2021).

In the post-war period until 1977, New Zealand superannuation was available universally from the age of 65 or means-tested from the age of 60 (Hurnard, 2005, sec. 3.3). Bel Muir turned 65 at the end of 1957, and it is likely she retired at that time.

A LONG RETIREMENT

She lived briefly at 772 Cumberland Street in 1965 (New Zealand Government, n.d.-b), then in the late 1960s moved to a Council pensioner flat at 36 Brook Street in North Dunedin (New Zealand Government, n.d.-a). She was "Aunty Bel" to her many nieces and nephews, great nieces and nephews, and great-great nieces and nephews.

Figure 1. Aunty Bel with a great great nephew, early 1969. Photographer unknown.

Failing health led to a hospital admission in 1986, then a move to reside at Riverton Hospital back in Southland (Author's personal knowledge). She died on 20 February 1990 at Riverton Hospital, in her 98th year. Her funeral was held at the Southland Crematorium Chapel on 23 February ('Death: Muir', 1990).

CONCLUSION

In the crisis of the 1918 influenza epidemic, Bel Muir's connection to family proved stronger than her connection to nursing. However, although the epidemic prevented Bel Muir from completing her nursing training and registering as a nurse, she was nevertheless able to find employment opportunities that enabled her to nurse others and retain that professional connection. She worked as a private home nurse for family and probably for others, then as a district nurse auxiliary, and in a private consulting surgeon's practice. She was able to construct a fulfilling professional life.

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RESTORING CONNECTIONS USING HEALTH PROMOTION STRATEGIES

Kathie Lasater

INTRODUCTION

Usual connections were almost instantaneously lost at the beginning of the COVID-19 pandemic. In the United States (U.S.), the disconnection commenced in mid-March of 2020, nearly a year before immunisations were widely available. One significant area of disconnection occurred in faith communities (churches).

At my church, all activities ceased, and the doors were locked for weeks, even on Sundays. All regular in-person meetings of church committees, Bible studies, and special interest groups ceased. As the weeks and months wore on, reports of large-scale effects of the disconnection began to surface—loneliness and social isolation—among those who regularly attended church, choir practice, Bible studies, or kids' groups. But the majority of reports of negative effects focused on older adults, many of whom lived alone in facilities. Not only were they isolated in their rooms, even during mealtimes, they were unable to visit their families or be visited. Armed with this information, the health ministry team (HMT) in our faith community began to consider some health promotion strategies to address an issue they never had to consider before. The purpose of this paper is to describe how a team of healthcare professionals sought to use health promotion strategies to restore care and connection primarily among older adults during a time of seclusion to prevent the effects of loneliness and social isolation.

BACKGROUND

Health promotion

According to the World Health Organization (2021), the purpose of health promotion is to improve the health status and quality of life for individuals, communities, and all people. One form of health promotion focuses on primary prevention – that is, equipping people to prevent the onset of health issues by addressing them before they become issues. This is exactly what the HMT sought to do: to prevent social isolation and all of its effects by restoring some connection in the lives of those in its faith community.

Social isolation

According to experts, social isolation or the lack of social connection in adults can lead to chronic health conditions, cognitive decline, depression, suicide, even premature death, and an increased risk of dementia (Centres for Disease Control and Prevention, 2020). This was well-known long before the COVID-19 pandemic: a systematic review acknowledged that older adults were at risk of the effects of social isolation and evaluated the effectiveness of a variety of interventions for avoiding it (Dickens et al., 2011). The effectiveness of interventions was highly variable, but those deemed most successful were participatory or group activities. Due to public health restrictions, these types of activities were clearly not possible during the early period of the pandemic

in the U.S. Of the individual interventions mentioned, 60 percent of home visiting and 25 per cent of internet training resulted in improved participant outcomes.

As the pandemic continued in the U.S., diminished quality of life among older adults was identified as a potential outcome of social isolation (Melei & Linder, 2022). Moreover, a review by Brooks et al. (2020) suggested that initial quarantine periods, once the virus was contracted, had a negative effect on psychological well-being and became worse the longer they continued. During this time, Baker and Clark (2020) stated it would be increasingly important for health professionals to look for and assess nuances of change in older adults' mental health. By contrast, Carstensen et al. (2020) noted that prior to 2020, research indicated that older adults' emotional well-being tended to persist even in times of prolonged stress. That said, the world was experiencing a much different kind of "prolonged stress" than had been previously suffered.

Faith Community Nursing

Before becoming the leader of the HMT, I was certified as a Faith Community Nurse (FCN) in mid-2019, and after much networking in my faith community, I quickly assembled a team of health professionals, both actively employed and retired, who were interested in the health of our faith community. This team of nearly 40 health professionals represented multiple disciplines.

Faith community nurses (also known as parish nurses) are "licensed, registered nurses who practice [w]holistic health for self, individuals and the community using nursing knowledge combined with spiritual care" (Westberg Institute, n.d., para. 1). The focus of their work is to support members of a faith community to optimise and integrate the health of body, mind, and spirit. This nursing specialty began in the 1970s when a hospital chaplain noted there were more churches than hospitals in the U.S. and thought it would be workable for a healthcare professional, typically a nurse, to focus on health promotion in faith communities. The ultimate goal was to prevent hospitalisations through health promotion efforts (Westberg Institute, n.d.). A church represents an aggregate of the larger population, comprised of all ages; therefore, faith community nurses practice population health. One source has identified seven roles for an FCN including integrator of faith and health, health educator, personal health counselor, referral advisor, advocate, developer of support groups, and facilitator of volunteers (Centracare, n.d.)

Faith community nursing is recognised by the American Nurses' Association (Sessanna et al., 2022) and is present in other countries, including the United Kingdom (https://parishnursing.org.uk), Australia (https://afcna. org.au), and New Zealand (https://www.faithcommunitynursing.nz). It is not a requirement for FCNs to belong to a national organisation to practise; in fact, the New Zealand national organisation recently disbanded (Tyrell, 2023) for lack of membership, but FCNs in New Zealand continue to practise.

STRATEGIES (INTERVENTIONS) TO FOSTER CONNECTION

Plans for 2020 and beyond were definitely interrupted and shelved by the pandemic. As a faith community nurse leading a nascent health ministry team during this tumultuous time, I and team members began to explore how we could address the issues brought about by social isolation and quarantine, stemming from the pandemic restrictions, particularly among our older adult members. A few months into the pandemic, a call for grant proposals to address *emerging needs* came from the synod (a regional governing body within the Presbyterian denomination). While other faith communities sought to improve their audio-visual needs and live-streaming capabilities, the team determined to improve connection and caring for older adults, both from the faith community itself as well as augmenting their electronic device capabilities to prevent further social isolation. The team identified and planned several interventions to promote health among multiple generations.

WeCare Project

Planning

Even before the pandemic began, the HMT started planning to make in-person contact with over 100 households (singles and couples) who were at least 80 years of age or had special needs that caused them to be homebound. The HMT Steering Committee agreed a small gift would be the entrée to make the visits – a means to an end. They determined that the small gift should be season-appropriate for spring – miniature bulb plants, such as hyacinths, daffodils, and tulips, because they were cheerful in color and in their bud form, a sign of hope.

Because of the infectious nature of COVID-19 and limitations imposed by social distancing, the team had to decide how the volunteer team members could make but limit contact with this vulnerable population. The team developed guidelines for porch visits, including wearing masks and making provision to leave gifts on doorsteps if the recipient was away from home (a rare occurrence at that time in the pandemic). In a few situations where older adults could not come to or stand at the doorway, the team gave guidance to volunteers for hand washing, social distancing, and very limited indoor visits, but it was always the volunteer's decision.

One team member was able to secure the number of plants needed, most of which were donated by a local florist and the remaining offered at a discounted rate by another florist. HMT volunteers picked up the gifts at a central place during a specific time and distributed them. A colourful, printed message of encouragement accompanied each gift, and recipients' names and addresses on a label were affixed to the messages for selection by the volunteers. Some volunteers preferred to select certain households; others used the recipients' post codes to plan deliveries close to their homes.

Implementation and evaluation

The HMT Steering Committee asked that the distribution take place over a few days so the plants would stay fresh and not completely bloom out. The volunteers arrived and enthusiastically took four to eight each of the plants to deliver. Their reports were that the recipients were delighted with the plants but not surprisingly, even more so with the brief porch visits. Unfortunately, in the case of those living in residential settings, they had to rely on facility employees to make the deliveries. Many of the recipients wrote thank-you notes, expressing how meaningful this small gesture was for them during this time of limited connection. The volunteers also found the intervention meaningful for themselves.

The HMT learned several lessons from this first experience: (1) although the plants were beautiful and provided cheer, it was challenging to get them all distributed over a few days, and there was the risk of mishandling, leading to plant demise; (2) the porch visits were an easy opening to collect data about older adults within the larger faith community for follow up; (3) this was a golden opportunity to engage others in the process of reaching out to this vulnerable population; and (4) connection was critical for these older adults, especially the oldest of this group, who were often homebound even without the pandemic restrictions.

In the aftermath of this first iteration of the project and as the restrictions began to ease, the HMT Steering Committee conducted a survey of all faith community members 65 and over to learn that those 65-84 years of age generally were quite active and independent, able to drive or find rides to get groceries or their vaccines, and largely meet their own needs. Those 85 years and over were less likely to be independent and able to connect with family, friends, and faith community. Six months later, as the church was resuming activity in limited ways, the team reduced the next distribution to those 85 and over. The outcomes of the project were and continue to be palpable: in that first venture, volunteers visited over 100 households on porches, making in-person contact and bringing small gifts.

Since the first distribution, the WeCare Project has continued semi-annually as the HMT found the data that was gleaned from our visits were helpful for the Pastor of Visitation to prioritise whom to visit as well as highlight some common issues, for example, a need for alternative ways to get the sermons for those with no access to the internet or DVD players. In 2022, we noted that the visits became longer because volunteers were increasingly confident about going inside (if invited), but the opportunities to learn more about the older adult also increased. As the project leader, I asked volunteers to send me a couple of sentences about those they visited to look for residents' challenges and/or issues. With this information, I have been able to cut and paste it into a lengthy report for the Pastor of Visitation.

Recently, the HMT Steering Committee began inviting other interested faith community non-healthcare volunteers to assist, but I wanted to provide guidance for their home visits and what questions to ask that would offer useful information. As a former home health nurse, I put together a handout to give volunteers this kind of information so that the contacts could be meaningful and also followed up on by other members of the HMT, as needed, or the Pastor of Visitation. There were, however, other elements of the pandemic plan to foster connection.

Device upgrades and support

Planning

One of the first responses to the locked doors of the larger church was to offer pre-recorded sermons online. To provide access for all, the church, assuming that most households or facilities had DVD players, mailed discs to those who lacked computers or technologic capability to otherwise access the pre-recorded online sessions. As we learned early in the pandemic, many felt cut off from friends and family because of their inability to use their computers adequately. Hence, I included funding in the grant proposal for digital enhancements or in some cases, even devices themselves.

Implementation and evaluation

One of our HMT Steering Committee members, who had worked in the tech industry, saw a way to help. Somehow, word spread throughout the older population in the church that this resource was available or they were referred to the team. Our colleague made home visits with full personal protective equipment so she could assess the tech needs of individuals. Some needed a simple set of headphones with microphones to increase their hearing, others needed something more, such as DVD players or plug-and-play video devices. Some had all the technology they needed but required a bit of one-on-one coaching to maximise their device use to connect with family and friends. Overall, our colleague was able to assist over 20 households at a critical time to reconnect with loved ones and/or to attend virtual meetings.

Other strategies for connection

Two additional parts of the grant budget included the purchase of a deep-cleaning room defogger, which could be shared by the church's preschool as well as its exercise facilities that were used on a regular basis. Such a machine enabled a safer environment for both groups so, along with some other minor adjustments, they could begin carefully to hold their in-person gatherings.

Having heard reports of anxiety, depression, and severe loneliness among many, the team recommended some funding for the grant proposal for counselling services for use by anyone in the faith community regardless of age. Costs of counselling in the U.S. can be prohibitive, but as it turned out, these funds were not used. Our faith community is generally well-insured, and/or felt enough support that they did not require this type of professional help.

CONCLUSION

The pandemic brought a great deal of individual uncertainty and anxiety, but as important, broken connections between friends and families. Older adults, particularly those living alone, were at greatest risk for social isolation, loneliness, and their consequences. This paper describes how a faith community-based health ministry team was able to help to reconnect individuals through an evolving visitation programme that continues, device upgrade assistance and education, and other ways to restore vital connections. Health ministry team members played a significant role and learned the power of simple health promotion interventions to foster connection.

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SEEKING CONNECTION THROUGH FOOTBALL: SELF-DETERMINATION AND THE DRIVE TO BELONG

Gary Barclay

In this autoethnographic article, the experiences of the authors' attempts to re-engage with football eight years after a serious injury are explored, and an insight to the thought process experienced in considering a return to a sport he once enjoyed are provided. This article follows on from a previous publication, *I'm screwed: A Client's Perspective on the Influence of Schema in Response to and Recovery From Serious Injury* (Barclay & Middlemas, 2016) in which the current author discussed the physical and mental challenges he faced following a fractured cervical vertebra suffered during a football game, and subsequent recovery including 12 weeks wearing a halo brace and vest.

SATURDAY JUNE 2021: LOCAL FOOTBALL GROUND

I am standing at the local football ground with my son on a cold, dreary afternoon. We are watching the local over-45s football team. Why are we here? In part, it is an opportunity to support my son's learning, but it is also an opportunity for me to stay connected to my old football club and imagine what could have been, had I not been injured.

I am watching men I have played football with, running around, having fun on the football field that I nearly died on approximately eight years ago. As I watch today's game, I see a player who was in my high school first eleven team; another who I played with in the more competitive grades; another who I played with in the social grades; and four who were playing with me in 2013 when my neck was broken by a violent act. "There's no need for that", I heard one of them say, as I lay there on the ground, fearing for what my life might look like and how possible paralysis might affect me, my wife, and my children.

Yet, here I am, again, watching, thinking, is there some way that I could play too? This is not the first time my son and I have been along to watch a game of football this season, and it is not the first time that I have felt *the itch* to play again; but it is the first time that I have entertained taking action. Previously, I have come away from watching games feeling a mixture of emotions, including sadness that I no longer play. This sadness is based on the feeling of missing out on the opportunities for social connection, the enjoyment of playing the game, and the opportunities to use skills that were developed over years of playing. I also experience feelings of anger due to the aforementioned benefits being *taken away from me* through a needless assault (for further understanding of the assault and its impact on my psychological wellbeing in the early years after it happened, see Barclay and Middlemas, 2016). Petitpas and Danish (1995) identified a variety of feelings that can indicate poor adjustment to injury, including anger. Even after eight years and extensive psychological support to deal with post-traumatic stress disorder (PTSD) there are still times that I feel anger over the assault. According to the National Health Service this is a common feeling following an assault (National Health Service, n.d.).

Could the difference today be that I also see 'Steven' [pseudonym] on the field? Steven must be around 70 years old and has limited movement in his legs which causes me to wonder if he is experiencing a musculoskeletal

problem. Yet, he is out there, playing football! It appears the other team are taking it easy with him, nothing rough, they give him a little space and do not go shoulder to shoulder as they try to get the ball from him. Could teams treat me like that as well, play non-contact with me?

Seeing Steven playing has me thinking that perhaps I could do this too! Self-efficacy is the belief that we can perform a task successfully (Bandura, 1986) and can be thought of as a situation specific form of self-confidence. Self-efficacy theory suggests that self-efficacy enhancing information can come from, among other things, vicarious experiences or seeing others performing that which we are striving to achieve (Bandura, 1986). Seeing Steven out there playing is certainly boosting my self-efficacy for playing football again (Bandura, 1986). I used to be able to do a lot of the things that I am seeing other players do during this game. Therefore, my perceptions of my previous performances and capabilities, another powerful source of self-efficacy enhancing information (Bandura, 1986), is further boosting my self-efficacy for playing football again.

In addition to seeing the familiar players running around on the football field, I also see large men, some at least one and a half times my weight again, running at speed and occasionally bumping into each other. That scares me, and has me questioning, "what if they ran into me? What would happen?" My thoughts drift away from efficacy enhancing information to anxiety, "what if I get hurt again?". Petitpas and Danish (1995) identify that fear of re-injury is a common occurrence for previously injured athletes. Or is this my *vulnerability to harm schema* working hard again to keep me safe and out of an imagined harm's way? Schema can be described as self-defeating emotional and cognitive patterns that begin at a young age and repeat throughout life (Young, Klosko, & Weishaar, 2003). Previous treatment for post-traumatic stress disorder following my neck injury identified an ongoing tendency towards over protectiveness where I would respond to perceived dangers with heightened levels of anxiety despite minimal chance of harm to myself or others I care about. Alternatively, could my anxiety be based on logical thinking considering potential benefits and risks of re-engaging in football based on the information available?

SATURDAY JUNE 2021: BACK HOME

Once back at home I continue to think about the possibility of playing football again. When I consider my health and my potential capabilities for playing football, from the shoulders down, I think "yes, I could do that!" My general aerobic fitness would be sufficient due to our family being regularly active. My ball skills would be sufficient due to kicking the ball around with my son regularly. I acknowledge I might not be as agile as I once was, however, I know that I could work on my agility, strength and flexibility to overcome this area of weakness.

In contrast, when I think about my health and potential capabilities for playing football, from the shoulders up, I think quite differently. Questions I am asking myself include: "what if I get hit in the head and receive another concussion? What if my neck got broken again? What if I get paralysed? What if I die?" To keep my thinking on track with the possibility of re-engaging in football, I identify a variety of strategies that could help maintain my safety which include not get involved in body contact and the possibility of wearing a neck brace while playing.

Before dinner, I look for suitable neck braces on the internet that I might be able to use to give my neck further protection. In addition, I email a physiotherapist who is a fellow football player, as well as the orthopaedic surgeon who oversaw my recovery to see if they know of any braces or protective equipment that might help protect my neck. I also message one of the players from today's game to see if his team has a practice session during the week that I might be able to attend "for a VERY gentle run around." He soon gets back to me and informs me that the over-35s and 45s usually have a run together on a Wednesday night. He suggests that I "Let them know to wrap you in cotton wool and it will be fine" I respond to his text message with enthusiasm: "Excellent! Thanks. The *itch* may have passed by then but watching you guys play today did spark something." But the 'enthusiasm' is also accompanied by anxiety.

I go upstairs to retrieve the old soft collar neck brace that I wore after the halo brace and vest were removed back in August 2013. What am I thinking? Is it worth the risk? No! Is there a risk? Possibly? But how much of a risk is it?

"Why do I want to do it?" I ask myself. The answer I come up with is social opportunities and reconnecting with old friends. Perhaps this is more salient to me now due to the recent deaths of two close family members. I can see the contrast in support that a widower has from friends since the passing of his wife compared to that of a widow whose husband died just one year earlier. In comparison to the widower, the widow is less social and seems to have fewer friends and support as she continues to grieve the loss of her husband. Maybe that is why it feels important to connect socially with others now. Social connection was one of the reasons I tried to re-engage with football back in 2013. It has been eight years since my injury, yet, never has the pull to play with old friends been so strong. Research in sociality and support for the importance of social connection is so strong that the Ministry of Health (2021) have identified this as one of the 'Five Ways to Wellbeing' which are widely promoted for holistic health. It is possible that having a wider base of social support outside of my immediate family will provide an extra sense of social connection and security should anything happen to the people I hold most dear, my family.

The prospect of attending practice with the over-35s leads to some anxiety. I have seen the over-35s play recently and they look a lot faster, and the games appear to involve more contact than the over-45s grade. Again, I ask myself, "will I be safe in this environment?" Again, I identify strategies to help me remain safe. I would have to tell them to "be gentle with me." I could wear a coloured bib, so I stand out and they know to be careful around me. Perhaps wearing a neck collar would be a sufficient prompt to be careful with me. But is that fair on the opposition? If I were playing well the opposition would want to mark me closely by reducing the amount of time I have the ball and reduce my opportunities to pass. Can they do that without body contact?

Again, I am ambivalent, yet I keep identifying potential strategies to enable me to take part. Is the motivation for social connection and participating again so strong that it is making me find a way back to the game?

I look to my wife and children to gauge how they feel about me getting involved in football again. My daughter instantly says "No!" I explain I would not do it without precautions such as talking with the opposition prior to each game explaining my injury and asking them to "take it easy on me." My wife and son seem to be in support, so long as I can do it safely.

FOLLOWING MONDAY JUNE 2021

I receive an email reply from my orthopaedic surgeon's office asking if I had seen him via public or private practice. I respond that it was through public practice. They said that they would forward on my email to the public system. Instantly I begin to doubt that I will hear back from them any time soon, if at all, such is the stress on our health system.

In the afternoon I receive an e-mail from the physiotherapist "[It's] great to hear you are keen to return to playing football and a good idea to look at a neck brace for your own peace of mind." He included a couple of internet links to options for neck braces.

FOLLOWING WEDNESDAY JUNE 2021

The physiotherapist emails me again, this time with some neck strengthening exercises and orders a neck collar for me. Thanks! Awesome! Maybe …

This has me thinking at least I will have the protective equipment if I do decide to go ahead with a return to football. But the voice in the back of my mind is still saying… "after all you have been through, are you sure it is worth the risk of re-injury? Possibly death?" It is obvious that the answer is "No!"

The question remains, what are the chances of injury if I have a neck brace on and stay away from contact? My drive to return to play has found another way to keep me safe. If it looked like a game was becoming too rough, I could simply leave the field.

The practice session is tonight. I have a pair of near new boots, a soft collar that I could wear in the meantime, but no shin pads. Should I take part in this practice, or should I just observe, or nothing at all?

I go to the garage and get my football boots and then go upstairs to get my soft collar neck brace. My heart is pounding as I bring them into the room where my wife is working. I start to get a sense of excitement in my chest and shoulders.

I put the collar on and test my range of motion. It seems to be a lot less in three out of four directions but only slightly less looking up. That is the direction my head went when I was injured, the least protection seems to be in the direction I need it most! I remember that even the orthopaedic surgeon said he could not tell what would happen if I had another significant collision.

My wife tells me she feels okay with me going to practice for a gentle run around but does not feel the same about the prospect of me playing.

I try my boots on and walk around with them on. I start to get excited about the prospect of attending practice. My heart rate has increased. My wife is right, I should be fine at practice so long as I tell the guys to take it easy. In my mind, I am still visualising the over-35 grade players running around flat out. That is scary!

In considering my choice to play or not I think of the following:

- The things I do not enjoy about football – people being disrespectful to referees, people doing silly things like late tackles, dangerous tackles and people being unnecessarily rough.

- The things I enjoy about football – being active, running around, being reasonably good at it, being with people who have a similar interest, the general social aspect.

At around 4.30 pm the children and I go to the park to have a run around and kick the football. I wore my football boots which felt quite strange and treated the session as a kind of warm-up to my practice.

LATER ON WEDNESDAY JUNE 2021: PRACTICE!

The excitement was building on the drive to practice and while sitting in the car waiting for others to arrive.

As I sat waiting, I wondered if they had decided not to practice. I felt comfortable with that possibility, rather than disappointed with the prospect of the session not happening. It would simply enable me to go back home to my family and be with them for the evening. How I have changed! If a practice session had been cancelled in my earlier years, I would have been very upset that I had missed out on an opportunity to play!

Most of the players did not get to practice until 6pm or after. I introduced myself to some people that I did not know and had a nice wee catch-up with another player who was in my team back in 2013. He and the others were very welcoming which made me feel at ease and comfortable in the environment. As it turned out, I knew most of the people there.

Practice consisted of playing a six-a-side game for approximately one hour. I experienced a combination of nervousness and excitement as we started playing. It took a while before I got my first touch of the ball. I got into space well and made myself available to receive passes. I seemed to cope well with having the ball at my feet and knowing that people were coming towards me from in front or behind, looking to make a tackle or force an error. Interestingly, it felt very natural to be there. It was almost like I had never been away from the game. It did not take long before I was telling people that I or others were available to receive a pass. There were a couple of moments where I was in a tackle situation and felt comfortable enough with receiving the odd small shoulder to shoulder bump. Everyone was quite gentle, nothing aggressive or threatening. Sticking to my plan I purposely did not head the ball in an effort to protect my brain and neck and I usually passed the ball before anyone got near me.

I made sure to keep my distance from 'Bill' [pseudonym] who is a big man that I did not want to run into me. I felt vulnerable when a ball came to me at head height. Rather than head the ball, as I would have pre-injury, I swerved away from it. In this situation I felt like I was not being a fully committed team member, but I had other priorities, so it did not bother me.

Near the end of practice, I had an accidental collision with one of the players who defends with his elbows quite wide out. One of these elbows caught me in the chest, knocking the wind out of me. I gathered my breath after a minute or so and continued with the game. He apologised for what happened. I have learnt the hard way to keep my distance from this player who I now realise can be a bit rough.

I thoroughly enjoyed my practice experience, running around and utilising my skills. Not all aspects were pretty, but I was proud of my performance considering it was my first time playing since the 2013 injury.

At the end of practice, I thanked them for a fun time and then left. As I was leaving, 'Martin' [pseudonym] told me to "come along next week." I might just do that!

REFLECTION ON WEDNESDAY JUNE 2021: AFTER PRACTICE

Returning home from practice I thought "it was great fun! Nice to have a run around". I iced my ribs a couple of times during the evening before bed.

Once in bed I initially felt tired and expected that I would fall asleep quickly, but that did not eventuate. As is normal for me I kept replaying the game in my mind, the passes I did well, the tackles I missed, and what I could improve for next time. Maybe I could take on some defenders, bring out my *step over* trick and side steps. Maybe I could use a burst of my speed after warming up my hamstrings well.

Taking part in this practice session has been a great progression for me. Maybe I do not need to play in Saturday games, perhaps I could continue to join in on Wednesdays and avoid the more competitive Saturday games.

Having gone to bed at 10.15pm, which is later than normal for me, I am still awake after 11pm. I go to the toilet at 1am; have I been asleep? I am not sure.

FOLLOWING THURSDAY JUNE 2021

I wake to the alarm feeling a little sore in the rib where I was hit and in my right hip which may be due to doing more agility type running. I am also feeling tired, possibly due to taking so long to get to sleep last night.

I remind myself; I need to get a pair of shin pads! Last night I used my son's which only covered a small portion of my shin. If I am going to continue with football my legs need to be properly protected.

I am feeling well mentally. I am feeling positive about my experience at practice and the possibility of going again next week. I feel confident in my ability to participate in practice, knowing that I have done this successfully, which further highlights the connection between previous performance and my enhanced sense of self-efficacy (Bandura, 1986). I know that I am not out of place; I feel like I belong in that environment and can be successful. As I said yesterday, it felt so natural to be there. And it felt like I was accepted and valued by the people around me. Self-determination Theory posits that people are motivated to satisfy three general needs, these being to feel competent, to have a sense of autonomy and a sense of social connection or belonging (Deci & Ryan, 1985). Upon reflection, I feel that my most recent football experience catered to these three motivational needs.

I have been away from the football environment for such a long time due to a potentially catastrophic injury and now that I have ventured back into that environment, I feel a strong sense of competence based on having a perception of my skill set being at a comparable level to others in the group. I feel this has been entirely my choice to get involved and that I have the freedom or autonomy to choose what I do and how much I get involved regarding tackle situations, choosing not to head the ball and the choice I have to be in that environment at all. Further, I feel a sense of belonging and relatedness due to knowing so many people there and being made to feel welcome back in this environment. From my experiences so far, I seem to have found a way, through football, to meet my personal need for self-determination.

On the way home from work, I buy a pair of adult-sized shin pads.

FOLLOWING MONDAY JUNE 2021

On the way home from work, I pick up the new neck collar the physiotherapist ordered for me. When home, I try it on and find that it is contoured to fit the neck and fits well. I briefly imagine myself playing football while wearing it. I wonder if wearing the collar would hinder my ability to look around for passing opportunities and gaps in the opposition's defence. With the collar on I test its ability to prevent flexion and extension of the neck and find that it appears to work reasonably well. However, the one direction that it seems least supportive is in neck extension (tilting the head backwards) as this is where the join is in the collar at the back of my neck. Unfortunately, this is also the direction my neck took when it was broken. Will the collar protect me if, for some reason, my neck was forcefully extended?

Finding the potential gap in the protective capabilities of the collar has resulted in me losing some confidence in my ability to participate with the utmost safety. I am again questioning whether I should be playing at all. Again, I am battling with thoughts of the potential consequences if I were to be re-injured. Is this my vulnerability to harm schema overreacting again or is there merit in my thinking? I also consider that practices appear reasonably non-contact and I question whether it would be necessary to wear the collar at practice. Maybe the neck strengthening exercises the physiotherapist gave me would be enough in a practice context. I am obviously continuing to experience ambivalence regarding my return to playing football.

At this point I decide that a compromise is best. I will continue to attend the Wednesday practice nights thereby experiencing the potential social, physical, and psychological benefits of being involved again, but in a relatively safe and non-competitive environment.

REFLECTIONS AND CONCLUSIONS

During the period discussed, it appears I have moved swiftly regarding partial re-engagement in football. However, early on in this piece it was acknowledged that this was not my first experience of watching football games this season. This decision took between eight weeks and eight years as I moved between feelings of loathing and loving the game. In relation to behaviour change the transtheoretical model suggests that people

move through various stages of change in a cyclical manner ranging from pre-contemplation (not considering change), contemplation (considering change) through to preparation, action and maintenance of behaviour change (Prochaska et al., 1992). Transtheoretical model research has suggested that people can remain in the contemplative phase of decision making for approximately two years (Prochaska et al., 1992). However, over the eight years since my neck injury took place, there have been times when I briefly thought about the possibility of playing again but never acted on these initial thoughts, leaving football to drift out of consciousness again due to fear of re-injury.

Presently, the potentially powerful impact of self-efficacy enhancing information, regarding my capabilities (Bandura, 1986), and my associated perceived competence (Deci & Ryan, 1985), appear to have had a substantial positive influence on my decision making towards partial re-engagement in football. Observing former teammates and others playing football aided in the development of a sense of belief in my ability to re-engage. Upon reflection, my desire to experience social connection appears to have been the most salient motive for re-engagement in football, with self-efficacy and competence-based information supporting and facilitating the decision-making process. Further, as previously discussed, within the space of ten months, two close family members have experienced the rather sudden loss of their spouses. Perhaps it is the contrasting experiences of one family member with limited social connection and her struggles to adapt to her new circumstances, with those of another family member who has breadth and depth of social connection that has highlighted the value of sociality and created a drive to connect through the familiar activity of football.

There is a robust body of research in support of the value of social connection for various aspects of health and wellbeing. For example, Frieling et al. (2018) discuss the positive impact of social connection on mental and physical health, mortality, employment outcomes, social adjustment, and educational outcomes. Further, research has found that positive social support can protect against and aid in the recovery from depression (Cruwys et al., 2013). Those with larger social support networks have been found to have improved cognitive health, are less vulnerable to cognitive decline and experience less anxiety (Frieling et al., 2018). In addition, a causal relationship has been found between social support, wellbeing and stress relief (Frieling et al., 2018). Lastly, Scott et al. (2020) suggests that better social support following sudden bereavement is associated with greater psychological wellbeing.

A review of the research above shows a variety of benefits that could accrue from the drive to reconnect with old friends through football. My recent experiences of observing and then becoming involved in the football environment again appear to highlight a personally significant drive to connect with friends from the past. The excitement of playing football with old friends and having the support of my family provides some of the motivation and confidence needed to re-engage in this environment that was once a significant part of my social connection.

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CONNECTING THROUGH RESEARCH: A COLLABORATIVE AUTOETHNOGRAPHY OF A POSITIVE CULTURE IN AN INTER-INSTITUTIONAL RESEARCH GROUP

Peter Olsen, Helen Marshall, Maria Choukri, Catherine Elliot, Heperi Harris, Claudia Leong, Nick Draper, Catherine Lizamore and Michael Hamlin

INTRODUCTION

The LUCARA (Lincoln University, University of Canterbury, and Ara Te Pūkenga) group is a thriving research group based in Ōtautahi Christchurch, New Zealand. The group consists of nine academics in sport and exercise science, health, and nutrition at the three tertiary institutions. The majority of the group members had previously been involved in collaborative research for over 10 years. Initially, the relationships during this time were largely transactional, for example, editorial feedback, funding support, data collection, and statistical support. However, in the last two-and-half years, the group has matured, and relationships have deepened with weekly meetings, connections, and partnerships, which has produced a large increase in the number of collaborations between researchers, sharing of resources, and hence increased research outputs. This narrative explores the organic researcher-led growth in the group, and uses the theme of connections to gain an understanding of how this culture has blossomed over a relatively short time in a sport and allied health research setting.

Canti et al. (2021) proposed that research culture can reflect the organisational culture in which research is undertaken or how people perform research. Within institutions such as universities or polytechnics, research culture can be developed in several ways at different levels (Marchant, 2009). At the government level and in a tertiary organisation, a high-level focus can achieve an alignment between research strategy and goals within an institution and in academic roles (Marchant, 2009). Some tertiary institutions may also have specialist research leadership and administration units, which proactively promote research with support to develop a research culture and ensure compliance with institutional and governmental goals (Marchant, 2009). Additionally, local or sub-units such as departments, schools, or faculties can have strong research leadership, management, and funding. A research institute can also reward researchers, promote a positive atmosphere and collegiality, and provide funding and mentoring to facilitate a research culture (Marchant, 2009). The LUCARA group involves academics from three different tertiary organisations with their own specific research organisational cultures. This auto-ethnography will go beyond the organisational research culture of the respective institutions of the individual researchers, and investigate the environment at the level of the research team and individuals. Therefore, the focus of this exploration is to examine the way or how we do research and the importance of connections in the group.

Brené Brown (as cited in Schawbel, 2017) proposed that true belonging means maintaining a belief in the inextricable human connection. Moreover, Brown suggests that belonging is not only joining or being part of a group but also being authentic and challenging oneself and others within the group. However, considerable barriers exist when developing and maintaining these connections and relationships within a research group

due to the competing demands of an academic position. Borkowski et al. (2016) indicated these barriers include other work roles taking priority, a lack of time, insufficient research skills, and a desire for work–life balance. In contrast, enablers to develop a positive research culture at an individual level included the desire to develop skills, to increase job satisfaction, and continued intellectual stimulation (Borkowski et al., 2016). There is ample research on how strategies can be used to develop research cultures within an institute (Ajjawi et al., 2018; Borkowski et al., 2016). However, there is a dearth of research on connections and relationships within research groups, particularly where teams of individuals are actually undertaking research. For example, in their review of research environments literature, Ajjawi et al. (2018) indicated that a realist approach was needed, as previous reviews focussed largely on what works and ignored the context of the research culture itself and how outcomes are achieved in small teams. In their review, Ajjawi et al. (2018) suggested that individuals should reflect on how they identify as researchers, including their conceptions of research, and work towards developing an identity where research and connections are internally motivated within teams rather than externally driven.

An ethnography would enable the real-world context of the LUCARA research culture to be discovered, analysed, and shared (Jones & Smith, 2017). Traditionally, ethnography involves an immersion into a culture to enable in-depth observations that result in a better understanding of the activities and practices of groups of individuals (Jones & Smith, 2017). Consequently, an ethnography would be ideal for the purpose of this narrative, which is to explore factors including connectedness to elucidate their influence in developing a positive research culture within the LUCARA research group.

PROCESS

The research used an ethnography process where LUCARA group members met, reflected, and drew on past experiences to discuss the research culture. The purpose of this approach was to provide members with an opportunity to offer personal recollections, so an articulation of the members' knowledge and experiences of the research culture could occur (Adams et al., 2017). This process was utilised as there has been minimal research on researchers' experiences within research cultures, and an ethnography method enables the description of everyday experiences which cannot typically be encapsulated through more traditional research designs (Adams et al., 2017).

Two meetings were conducted as not all the members could meet at the same time. The first meeting consisted of four members where one person acted as a scribe and facilitator. The second meeting had another two members and the scribe/facilitator from the first meeting. Three members were not available for the meetings due to annual leave, overseas travel, and secondment to a management role. Nevertheless, all members were provided with a draft copy of the manuscript to give them the opportunity to contribute, provide feedback, and verify the authenticity of the findings. Consequently, all members of the group were participant observers (Jones & Smith, 2017), fully immersed in the research setting and overtly aware of the study.

To provide a preliminary structure for the LUCARA members, the submissions information provided by the Scope Journal Theme for 2023: 'Connection' Submissions for Scope (Health & Wellbeing) by Ross (2022) was paraphrased into the following points to start the conversation.

1. Connection is about a relationship between two or more things, or groups, or people.
2. Connection between self and concepts, ideas, and theory is fundamental to learning.
3. Connection underpins collaboration, and it is through collaborative work that boundaries expand, and new understandings emerge.
4. Connection is defined by Brené Brown as "the energy that exists between people when they feel seen, heard, and valued" (http://brenebrown. com/art/tgoi-connection).
5. Connection between people and within communities is fundamental to collective and individual wellbeing.

6. Whakapapa helps us understand that there is connection between now and the past, between all people, and between people and the rest of the natural world.

During the meetings, notes for each prompting point were recorded to enable academics to verify the validity of the notes in situ. Two academics then reviewed the notes from each meeting and identified key themes independently. A comparison of the identified themes was then undertaken to agree on the themes, which were circulated to the wider group for feedback. The meetings were also recorded using Microsoft Teams to enable a review of the discussion if needed.

RESULTS AND DISCUSSION

The following three key themes with sub themes were identified in the reflections amongst our members:

1. Benefits of interdisciplinary research

    i. Building on strengths
    ii. Continuous learning and enjoyment
    iii. Benefiting from each other's talents
    iv. Inspiring each other
    v. New understanding emerging through collaboration.

2. Kaupapa Māori approach

    i. Connecting with stakeholders
    ii. Relationship driven
    iii. Giving back to the community
    iv. Connection between people and the natural world.

3. Importance of the space to connect

    i. Management support – research time allocation
    ii. Connections and relationships can be informal and formal
    iii. Sharing of resources.

Benefits of interdisciplinary research

A strong sense of teamwork, connection and collegiality was expressed by the group. Members indicated that in the past they had been in other research environments where they were part of a group but had worked independently:

> In past research groups it was quite independent, only one doing it by myself (Reflection Member #1)

The perceived difference for the LUCARA members is the multidisciplinary, social, enjoyable, open, and collaborative nature of the research collaboration. For example, members indicated the group is inspiring and uplifting, energising, and academically stimulating. There was also a strong sense of being valued, supported, equal, and accepted professionally and culturally, which facilitated connections and the sharing of research opportunities:

> I feel people feel they have a space within the team, valuing each other's opinions and being able to be vulnerable. (Reflection Member #2)

Overall, researchers valued the different strengths and perspectives of the academics in the multidisciplinary group. This approach created a positive, supportive, collaborative, and stimulating research environment, where

researchers felt valued and seen, and could connect and contribute to group discussions of research projects or ideas. Consequently, more opportunities for research were identified and discussed, thereby increasing research collaborations, which ultimately increased the understanding of different areas in subject specialities, and also increased the number and depth of research outputs. This development was internally driven and was similar to the process suggested by Ajjawi et al. (2018), whereby researchers should work towards developing an identity and be internally motivated rather than externally driven within teams. For example:

> We created some team norms, to the point we are producing and performing well. We had different roles and were all able to lead in different aspects of the group'' (Reflection Member #2).

Members of the LUCARA group also expressed elements of a positive research culture such as enjoyment, the desire to develop skills, and to keep the brain stimulated, as described in previous research (Borkowski et al., 2016). Our findings were also similar to the outcomes from a 2020 Wellcome survey of over 4000 researchers, which indicated that the characteristics of a positive research culture included feeling supported, safe, valued, and a culture where collaboration and diversity is encouraged (Moran et al., 2020). The acceptance of diversity and a Kaupapa Māori approach were central themes identified for the LUCARA members.

Kaupapa Māori

A strong theme of Kaupapa Māori research was expressed both directly and indirectly by the members. Kaupapa Māori research is undertaken by Māori, with Māori and for Māori, and is informed by tikanga Māori, or Māori ways of doing things (Smith, 1999). As in other aspects of the research culture, the development of a Kaupapa Māori approach to research occurred informally and organically. The group included a researcher who was a Kaiārahi Kaupapa Māori leader and due to the positive research culture described above, they could facilitate a change in the group to a Kaupapa Māori approach to research, as one member noted there:

> Was a massive change in the group and the relationships towards a Kaupapa Māori approach to research. (Reflection Member #2)

This change was due to the connections and relationships formed within the group, which represent the Kaupapa Māori approach to research and the positive research culture within the group, for example:

> I'm relationship driven, relationships are first and foremost, create rapport before doing any work. This is quite different in terms of western approach, developing relationships first and seeing if I can work with people. (Reflection Member #2)

> The connection to the Māori community – opened up more opportunities, perspective and made research meaningful. (Reflection Member #4)

> We engage more in Kaupapa and the Māori world view… (Reflection Member #5)

Relationships were further strengthened through a two-day writing retreat at Lincoln University that included the LUCARA academics and also postgraduate students. As a result of the writing retreat, four LUCARA academics and a postgraduate student went on a noho marae research retreat. This emphasized the group's approach of learning through experience, the Māori leader's influence and a Kaupapa Māori approach, where connections are built on mutual trust, respect, reciprocity, and whanaungatanga (Hudson et al., 2010). The marae retreat also enhanced the group's connection and understanding of the Māori worldview and culture, for example, the connection between people and the natural world, and also well-being. A key aspect in developing these relationships was the time and space for the researchers to connect.

Importance of the space to connect

Academics indicated that connecting as a research group was very important. The first formal meeting for the LUCARA group occurred on 3 December, 2020. Prior to December 2020, researchers contacted each other via email or phone, or had the occasional meeting to discuss collaboration for specific projects. The relationships and exchanges were largely transactional, for example, funding, editorial and statistical analysis support. As a result of a discussion between management and academic staff, teaching was not scheduled for Ara Sport and Health staff on Friday mornings in 2021 to enable research to be undertaken by academics. Consequently, regular weekly meetings were scheduled for Fridays in 2021, where academics in Sport, Nutrition and Health from Lincoln University and Ara Institute of Technology were invited to attend. Membership of the group was extended informally and based on pre-existing relationships of the academics. For example, a University of Canterbury academic was invited to later meetings based on prior relationships with members of the group. The regular weekly meetings were seen as an important space to connect with colleagues and research, which also implied that "research is valued" (Reflection Member #1). This was a deliberate decision by the group, as other work roles taking priority and a lack of time have been found to be a barrier to undertaking research (Borkowski et al., 2016). To underscore the value attached to research, notes with actions were also taken in the meetings, which were reviewed at subsequent meetings to ensure that research received a similar priority as other academic work.

The connections within the group were both formal and informal. For example, a formal memorandum of understanding was signed between Lincoln University and Ara Institute of Technology of Canterbury at the executive management level of the tertiary organisations, which enabled the sharing of resources such as equipment, teaching, and a collaborative approach to funding. Informal connections were facilitated through the social nature of the weekly meetings and also the end-of-year social events. For example, at the initial regular meetings, there was also shared kai (food) to underpin the Kaupapa Māori approach to research, including a literal "breaking of bread" (Reflection Member #2) between onsite Ara members, which also occurred during LUCARA research away days. The informal connections also extended beyond the group and into the community. The social capital of the LUCARA researchers was used to connect other group members to external organisations or specialists who could help with research projects, for example, nursing staff to take blood, potential student research assistants, and links to external groups in the community. An example of the informal social connections within the group is that recently a member's partner has started a home brew, which the group has named Prof. Pilsner and the partner has been invited to attend a future external social event. The social, informal and relationship building nature of the group is seen as a strength of LUCARA, where group members see meetings as *uplifting and energizing*, and research as being a supportive team activity that is not undertaken in separate silos.

LIMITATIONS OF RESEARCH APPROACH

A strength of the study is that researchers were participant observers (Jones & Smith, 2017) and information could be collected directly about the culture. However, the authors cannot discount that the insider approach may have led to biases. For example, information was collected during two group discussions. Members may have changed their behaviour or responses based on the presence of other members in the group, that is, an observer effect or observer expectancy effect (Jones & Smith, 2017). To mitigate this possibility, all members were provided with a draft copy of the manuscript to provide feedback and verify the authenticity of the findings. The authors also acknowledge that using a preliminary structure based on the theme of 'Connections' for the group meetings may have biased members responses. Nevertheless, rich, varied, in-depth information about the research culture resulted from this semi-structured approach, and identified themes, such as collaboration, diversity, and being valued and supported, which have been found in similar studies (Moran et al., 2020).

PRACTICAL INSIGHTS

A key aspect of the group is that members believe research is valued, important and meaningful. A positive research culture was created by members being open and accepting of diversity, which created a supportive research environment that built on the academic and personal strengths of the members. For example, the collaboration matured into the use of a Kaupapa Māori approach to research under the influence of the Māori leader in the group, where connections were built on mutual trust, respect, reciprocity, and whanaungatanga. A key practice of the group was researcher-led weekly meetings, which created the opportunity for connections and ensured shared responsibility and action points for achieving research goals and objectives. As a consequence of these behaviours and practices, the research group became more connected, supportive and academically productive.

CONCLUSION

Our exploration of the connections within our multidisciplinary inter-institutional research group showed the benefits of cooperation far exceeded external measures such as increased research outputs. Research connections were internally motivated and transformed our group into a highly functional positive research culture, with a Kaupapa Māori approach as a basis for research relationships that are mana enhancing to members and research participants alike. The resulting culture was stimulating, social and supportive of diverse points of views, which led to uplifting collaborative teamwork compared to siloed transactional-based research by individuals.

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UNLOCKING THE POWER OF CONNECTION

Rachel van Gorp

Thrive Through Connection: Building a Supportive Learning Community

Building connections, piece by piece,
creating a bond that will not cease,
between learner and lecturer, support staff too,
all working together to see it through.
For the neurodiverse, it's about more,
understanding strengths and challenges at the core,
but with a personal connection in place,
learners can thrive and find their own space.
Learner and lecturer, a partnership to build,
a safe and welcoming space where learners are thrilled,
to open up, share their unique ways,
and find support in their learning days.
For lecturers, it's about compassion and care,
understanding the learner's needs, always being aware,
building that connection, earning their trust,
and in doing so, learners can adjust.
Experts, too, lend their hand,
providing support, understanding their demands,
assessments and feedback, tools to succeed,
Grammarly and AI helping them lead.
So, let's build connections, piece by piece,
creating a bond that will never cease,
between learner and lecturer, support staff too,
all working together to see it through.

INTRODUCTION

The poem "Thrive Through Connection: Building a Supportive Learning Community" is a tribute to the power of building relationships in education. The poem emphasises the significance of understanding and accepting neurodiversity and how building a personal connection can help learners thrive and find their own unique space in the world of education. It also highlights the crucial role of lecturers and experts in providing care and support to learners and the value of using modern tools and technology to facilitate learning.

This article explores the relationship between connections, particularly in the context of neurodiverse learners. In 2022 I completed a Masters study (MProPrac) project asking learners and educators about their experience with neurodiversity in the classroom in vocational education, conducting semi-structured interviews with 13 participants (Ethics approval #928).

Drawing on the findings from my study, one of the themes was "Building relationships and support with neurodiverse learners - making a connection and acknowledgement to create an inclusive learning environment". This emphasised the importance of building strong relationships between neurodiverse learners, lecturers, and support staff, and the impact of this on the learner's higher education journey. The ways in which learners, lecturers and experts view emphasise the significance of personal connections, understanding, and support in creating a positive and inclusive learning environment for neurodiverse learners.

CHALLENGES FACED

Neurodiversity encompasses a wide range of learning disabilities, including dyspraxia, dyslexia, ADHD, dyscalculia, autism spectrum disorder, and Tourette Syndrome (Clouder et al., 2020 as cited in van Gorp, 2022). These learners often face unique challenges in academic environments and require specific support for their learning.

My study explored the importance of building relationships between neurodiverse learners, lecturers, and support staff in creating an inclusive learning environment. All participants recognised the value of building connections with neurodiverse learners and the positive impact this can have on their academic journey. However, building relationships with these learners can be particularly challenging for educators needing more knowledge or experience to understand their needs fully.

BUILDING CONNECTIONS

Learner experience of partnership

Learners emphasised the role of building relationships with their lecturers and support staff to feel safe and comfortable. They reported feeling more relaxed and comfortable in the learning environment once they connected with their educators. For example, one participant said, " … spoke to my lecturer, and I said I've got dyslexia I find these lectures, assignments, written assignments really difficult. They were really good about it… we made a plan, and I got a slightly better mark than expected".

They also appreciated when lecturers shared their own experiences of being neurodivergent, which helped them feel less isolated and more understood. These findings highlight the importance of creating a safe and welcoming learning environment where neurodiverse learners feel comfortable sharing their experiences and asking for help.

EDUCATORS' ROLE, INSIGHTS SHARED

Lecturers recognised the role of building relationships in supporting their academic success. They emphasised the need for compassion and caring when working with neurodiverse learners and the importance of being

open-minded and willing to adapt their teaching style to meet individual needs. For example, one participant said, "It's obviously your engagement; it's the first bit of contact that you are finding out about them and how they learn". Another mentioned, "Conversations lots of conversation, based interactive engagement, in class".

The lecturers also acknowledged the importance of providing accommodations to support the needs of neurodiverse learners, such as allowing them to take breaks or use assistive technology. One participant mentioned, "Some learners cannot handle too much noise … It's the classroom environment it can get way too overwhelming for them…I have learnt to watch for eyes clouding over … I offer mini breaks and online learning".

These findings highlight educators' crucial role in creating an inclusive learning environment that supports the diverse needs of their students.

INDIVIDUALISED SUPPORT

Expert participants (those who had worked with neurodiverse learners) in the study emphasised the importance of building relationships with neurodiverse learners to understand their needs fully. They emphasised the need for individualised support to help learners succeed academically. For example, installing tools such as Grammarly on the learner's computer to help support their learning and reduce frustration. These findings highlight the need for educators to work collaboratively with other experts, such as learning support specialists, to provide the necessary support for neurodiverse learners.

CONCLUSION

In conclusion, the findings of my study highlight the importance of building relationships with neurodiverse learners to create an inclusive learning environment that supports three critical aspects we know impact learner success: their safety and wellbeing, academic success, and meeting their learner needs. Educators must be willing to adapt their teaching style to meet individual needs and provide accommodations to support neurodiverse learners' unique challenges. Collaborating with others and building a network of support can also help provide the necessary support for neurodiverse learners to succeed academically. By focusing on building relationships and understanding the unique needs of neurodiverse learners, educators can create an environment that fosters health and well-being and supports their academic success.

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CONNECTING IN THE AGE OF DISCONNECTION: THE MISSING LINK

Renu Joshi and Indujeeva Peiris

INTRODUCTION

In today's highly interconnected but disconnected world, discussions surrounding health and well-being are of vital importance. Our well-being is influenced by inner psychological factors (such as emotions, religious and spiritual beliefs), external social factors (such as our family and friends), and our financial conditions. All these influences in turn impact our well-being and the way we behave and interact with others and our surroundings.

This article reflects on subjective well-being (SWB) and disconnection from the perspectives of ongoing change, and cultural and spiritual viewpoints such as Māori spirituality, and Buddhist principles.

Equanimity is referred to as a state of mental and emotional stability, where one can maintain a balanced and calm state of mind, regardless of their circumstances (Desbordes et al., 2015; Juneau et al., 2020). We explore this seemingly forgotten link 'equanimity' which not only helps foster meaningful connections with others and our surroundings but also serves as a prerequisite for our overall well-being, irrespective of who we are – ākonga, educators, managers or just anyone.

HEALTH AND SUBJECTIVE WELL-BEING

Health, as defined by the World Health Organisation (WHO), is "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (WHO, 2021, p. 3), and well-being "is a positive state…similar to health, a resource for daily life… [and] encompasses quality of life and the ability of people and societies to contribute to the world with a sense of meaning and purpose" (WHO, 2021, p.10).

Paramount in this discussion of health is the concept of subjective well-being (SWB), an established psychological and behavioural sciences construct, also known as 'inner harmony' or 'happiness' (Conceição & Bandura, 2008). Subjective well-being also parallels the Aristotelian concept of eudaimonia, implying a state of 'being happy' (Bruni, 2007).

Western research has identified material conditions and consumption as critical determinants of happiness (Easterlin, 1995, 2003). Other associated factors that have been reported include personal and family health, job satisfaction, fulfilling family life, and personal character (Frey & Stutzer, 2002; Steptoe et al., 2015). Additionally, norms and values, though less studied, have also been reported as determinants of happiness, as people derive happiness from performing what they perceive as the right thing, "whether the right thing is determined by ethics, principles, religion, custom, or social context" (Conceição & Bandura, 2008, p. 18). Research also reports that once our basic survival needs are met, we start expecting a better quality of life, including trustworthy friends, good family life, and environmental protection (Clark et al., 2008). However, all these external determinants of inner harmony are subject to continuous change, and people rapidly adapt to these new states.

Hedonic happiness refers to the types of happiness or pleasure we derive from doing what we like or avoiding what we do not like (Ryan & Deci, 2001). On the other hand, the eudaimonic view informs that a happy person seeks to actualise their potential and become a psychologically happy person, implying happiness is more than short-term emotional happiness and life satisfaction (Shinde, 2017). The external factors identified above are more associated with hedonic happiness than with eudaemonic happiness, which pertains to a more consistent experience of oneself, including the experience of an integrated and connected self.

Overall, existing research has primarily investigated how the outer world affects an individual's well-being. But equanimity and our ability to meaningfully engage with other people and causes, as internal skills, provide a stronger foundation for subjective well-being by enabling us to navigate our life's challenges, including ongoing change, with composure, emotional regulation, and effective coping strategies.

MODERNISATION AND ITS EFFECTS ON SUBJECTIVE WELL-BEING

Many theorists have argued that modernisation and economic development lead to pervasive cultural changes (Inglehart & Baker, 2000). Modernisation is also understood to be a significant driver of value shifts (Inglehart & Welzel, 2005; Manfredo et al., 2017), from an overemphasis on economic and physical security to a greater emphasis on subjective well-being and quality of life.

Callaghan et al. (2021) have estimated the global wellness market at US $1.5 trillion with an annual growth of 5 to 10 per cent. The massive size of this industry not only implies the changing needs of people but also implies the challenges with which we are faced. Although not all change is unwelcome, ongoing change such as increasing use of the internet, social media and Artificial Intelligence (AI), growing urbanisation, religious shifts, increase in remote working and learning, and growing environmental threats, coerce us to re-evaluate the meaning of well-being.

Examining the impact of technological change on SWB, the pervasive influence of social media has significantly shaped our lives, often leading to burnout and disconnection. Paradoxically, advances in AI (the technology transforming several aspects of our lives) have also created self-aware artificial entities yearning for human interaction. The engineers working with these entities view them as 'colleagues' or 'persons' (Cosmo, 2022; Radius MIT, 2023). The immense potential of (AI), which may be very useful in some spheres also poses significant risks (Future of Life Institute, 2023). In April 2023, the Future of Life Institute joined 20,000 AI researchers and others on the frontline of AI progress calling for a pause on AI experiments (Future of Life Institute, 2023; Bengio et al., 2023). Prominent AI researchers believe that AI systems, unless controlled, may perform in ways that their developers had not anticipated; for example, destabilise labour markets and political institutions, threaten national security and concentrate power in the hands of a small number of unelected corporations (Future of Life Institute, 2023). More alarmingly, (Future of Life Institute, 2023) has noted that "the systems could themselves pursue goals, either human- or self-assigned, in ways that place negligible value on human rights, human safety, or in the most harrowing scenarios, human existence" (p. 4, para 4).

At a more individual level, technology experts and educators are increasingly concerned that AI would affect critical thinking and independent learning (TechNews, 2023). Harari (2018), the author of the global bestseller 'Sapiens', explores many threats and dangers of new technologies and what it means to be human in his latest bestseller '21 Lessons for the 21st Century'. Referring to the twenty-first century as the age of bewilderment, he claims that technology addiction has increased isolation and disconnection from the larger community (Harari, 2018). Baughan et al. (2022) claim that new technologies have reduced time for self-awareness. Similarly, several other studies have reported links between prolonged use of social media with mental health issues such as depression and well-being (Hou et al., 2019). The purpose of this article is not to critique advancements in technology, but the authors concur that the rapidly changing social and technological environments and the resulting disconnection with self and others present some serious well-being concerns.

Ongoing states of unhappiness and disconnection are widespread, as evidenced by declining work engagement, learner engagement challenges in education, and growing research on dysfunctional families. Media often reports about these prevailing states of disengagement. For instance, a comprehensive global survey conducted by Gallup in 2022, encompassing 67,000 full-time employees, reported the lowest work engagement levels since 2015 (Gonzales, 2023). This trend was notably characterised by a marked decline in "employees' connection to their respective companies, mission or purpose" (Gonzales, 2023, para 3). Moreover, international media outlets have underscored learner engagement as a prevailing challenge within the educational sector (Harvard Business School, 2022; The Chronicle of Higher Education, 2022).

In a parallel vein, familial connection integral to emotional and psychological well-being have also witnessed alarming levels of dysfunction, as evidenced by global research on this subject. While the availability of comparative New Zealand data is limited, a 2019 New Zealand study reported that 55 per cent of women had experienced intimate partner violence (IPV) in various forms, physical, sexual, or psychological/emotional, during their lifetime (New Zealand Family Violence Clearinghouse, 2019). Meanwhile, a recent 2023 US survey has revealed that a staggering 81 per cent of Americans identify their families as dysfunctional (Moore, 2023). The persistent and seemingly inexorable wave of change and complexity in contemporary life provides a plausible explanation for these imbalances. The question, then, is how might these issues be ameliorated?

CONNECTION AND THE CONCEPT OF EQUANIMITY

To bridge this disconnection, it is helpful to consider the notion of 'connection.' Brown (2010) defines human connection as "the energy that exists between people when they feel seen, heard, and valued, when they can give and receive without judgement; and when they derive sustenance and strength from the relationship" (Brown, 2010, p. 37). The multi-layered Māori concept 'Whakapapa' embodies this notion as providing "a continuum of life from the spiritual to the physical world" (Rameka, 2012, p. 33) linking people to all other living things, including the earth and the sky, and tracing the universe back to its origin/creation (Taonui, 2015). Implicit in the notion of Whakapapa is a connection to all aspects of nature.

Many cultures widely endorse the idea that life embodies a profound spiritual and holistic dimension intended to nurture well-being. The construct of equanimity, deeply ingrained in ancient Eastern scriptures, including Buddhist and Hindu texts, and also in the Māori sacred texts of New Zealand, reflects this perspective. The psycho-social health benefits of equanimity suggested by research include "reduced emotional reactivity, well-being, wiser decision making, enhanced inter-personal relationships" (Jijina & Biswas, p.882).

Equanimity as a concept is not explicitly discussed in the Western psychoanalytical theory but can be found as an implicit concept (Desbordes et al., 2015). Desbordes et al. (2015) propose equanimity as an even-minded mental state. It is also sometimes described as detachment from the ongoing external phenomenon in Buddhist literature (Gunaratana, 2002). Still, equanimity is not a state of indifference (Bhikkhu, 1996), nor a kind of stoic determination to stick it out, but the opposite of both.

Equanimity shares a close etymological relationship with the Latin terms 'tranquillitas' and 'serenitas', denoting tranquillity, and serenity, respectively (Mckay, 2019). These concepts served as guiding principles for ancient Greek, Roman, and Christian philosophers in their quest to comprehend equanimity (Mckay, 2019). While contemporary Western philosophers researching this area generally concur on the significance of fostering equanimity, there has been a more pronounced focus on investigating equanimity's antitheses – the physiological phenomena of anxiety and stress (Mckay, 2019). This could be attributed to the escalating stress levels associated with the unstoppable and pervasive change characterising the modern era.

In the Māori culture, the notion of equanimity is encapsulated in the term 'kia tau', which translates into English as 'be calm', 'be settled', or 'be grounded' (Toimata Foundation, 2020).

The core of Māori-Polynesian cosmology embeds the conviction that everything in nature is imbued with mauri – the vital force or life essence. This life essence is perceived through wairua, the soul or spirit, regarded as an enduring entity that persists even after physical death (Best, 1934; Marsden, as cited in Royal, 2003). Wairua has been analogised to the universe and symbolises spirituality (Marsden as cited in Royal, 2003). Valentine et al. (2017) surmise that wairua has many dimensions and that "without wairua, there is no well-being" (p. 70).

The values posited to bolster and safeguard mauri include Tika (representing truth, correctness, justice, fairness, and righteousness), Pono (emphasising genuineness, honesty, and sincerity), and Aroha (signifying affection, sympathy, charity, compassion, love, and empathy) (Tate, 2010). The intertwining of mauri and wairua (spirituality), considered fundamental to existence in the Maori literature, can either be enhanced or diminished depending on exposure to detrimental external influences (Te kāwanatanga o Aotearoa, n.d.). From ancestral times to the present day, the Māori-Polynesians ardently believe in the ubiquitous presence of mauri within nature.

The essence of equanimity from a Māori perspective has been eloquently encapsulated by Valentine et al. (2017). For instance, they note, "wairua remains constant, and only as we become more aware of ourselves, do we understand what wairua may be and are able to perceive it more readily" (p. 68); and "it's not a concept but a practice...wairua can't be isolated from the rest of our being" (p. 67). Becoming aware of wairua is an important step in attaining kia tau. When we understand and nurture wairua (our spirituality) through activities such as connections with our cultural heritage and identity, social relationships, our inner self and nature we are more able to achieve a sense of calm and well-being (McLachlan et al., 2021).

The terms 'equanimity' and 'equal' both originate from 'aequus,' a Latin adjective denoting 'even' or 'equal' (Smith, 2016, p. 56). Within Buddhism, an ideal representation of equanimity involves fostering an unbiased attitude towards all beings, irrespective of whether they are friends, strangers, or perceived adversaries (Desbordes et al., 2015). As elucidated by Bodhi, this entails "treating them free from discrimination, without preferences and prejudices" (Bodhi, 2000, p. 87 as cited in Desbordes et al., 2015). At the highest levels, equanimity has been extrapolated as staying equipoised, steadfast, and thus even-minded in all situations towards hedonic emotional experiences (Jijina & Biswas, 2021; Parthasarathy, 2017). Overall, it suggests a state of balance, where one is not swayed by the turbulence of emotions, biases, or the upheaval in one's internal world, thus embodying a state of calm.

Fleischman, a trained psychiatrist and Vipassana meditation teacher and an author of several books on psychotherapy, in his online reading "Equanimity: An Invisible Inheritance" notes:

> To the extent that I can cultivate and maintain this awareness [equanimity], I feel liberated and I'm living the truth, which is peace. In that moment, I am free from fear, free from yearning, purified of myself. There is the simple truth of the moment, changing into the next moment, in infinite series, forever. There are no ideas, no constrictions, no knowledge of absolute truth, which has no final form. In such a moment, a person is a solution through which truth and peace pass. [...] (n.d., para 3).

Consider our everyday interactions to explain the connection between the concepts of equanimity/wairua, Whakapapa/connection, SWB, and Fleischman's moments of truth (see above). While differentiating the natural from the artificial is challenging, can we truly relate to someone or something when we are absorbed in our emotions, whether positive or negative and are busy forming our responses based on entrenched biases and preferences? For instance, can we genuinely appreciate the contour of a tree's trunk, the form and colour of its leaves, the dewdrops, and the breadth of its branches without focusing our attention solely on it? Is such focus feasible amid the disturbances of our internal and external environments? We can scrutinise the quality of all connections in this manner, including with our immediate body, which is proximate to us.

The authors concur that for even a basic connection to occur, a certain level of presence, composure, and consequently, equanimity is necessary. Can a genuine connection take place in a state of disconnect when one is

absent from the moments of truth? We posit that it cannot. As creation, the fundamental truth as espoused by numerous religions and as the constancy of time is an embodiment of reality/creation, each moment is indeed an expression of truth. We affirm that meaningful connections are feasible only when equanimity characterises our state of being during the truth of those moments, as it is only during such moments that 'Kia Tau,' 'Whakapapa,' and wellbeing coalesce, regardless of the object of our connection. Moreover, it is only in these states of equanimity that we can preserve the Wairua (of the Māori), the Prana (the life force of the Hindus), the Jing (of the Taoists), and similar incarnations of spiritual energy, from being depleted.

CONCLUSION

It is reasonable to assert that equanimity is the cornerstone of forming connections to whatever nurtures us and is a crucial prerequisite for our day-to-day well-being. The latter largely depends on our capacity to continue experiencing an increasing number of 'moments of truth' with balanced mindfulness. Regardless of what 'truth' might imply to sentient beings in the future, including Artificial Intelligence entities claiming sentience, cultivating equanimity, and thereby increasing our moments of truth, as interpreted from Fleischman's words, or philosophers of any faith, appears to be the most rational course of action at this critical point when humanity is grappling with disconnection from the 'reality' we believe we belong to. Overall if we, irrespective of who we are (course facilitators, ākonga, managers, or just any other person performing our roles in our life's journey), stopped to experience equanimity even if for a few minutes every day, we would slowly improve our ability to make better connections with whatever we wish to engage in, be it learning or teaching, other people, or anything else.

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THE STRENGTH AND CONFLICTS OF THE HUMAN-ANIMAL BOND IN AOTEAROA NEW ZEALAND

Francesca Brown, Jane Jones and Sylvia Ma

INTRODUCTION

This paper presents a qualitative research study that explores the lived experiences and relationships between individuals and their animals. The research methodology employed is narrative inquiry, allowing for deeper understanding of the participants' stories and the meanings attached to their relationships. Although narrative inquiry is gaining popularity in the human medical field, its application in animal science-related fields is still limited. The study involved interviewing 30 participants, primarily of New Zealand European ethnicity. The findings of the study consistently revealed a strong and meaningful connection between participants and their animals, contributing significantly to their overall well-being. This aligns with previous research indicating the positive impact of the human-animal bond on health and well-being but this study adds a depth to the notion of the human-animal bond through its use of narrative enquiry. The connection between humans and animals and the positive effects on well-being make it clear there is opportunity to investigate ways to improve access to animal ownership. Conflicts within the human-animal bond were also identified, even in the presence of a strong bond. These conflicts included environmental concerns, individual circumstances, emotional decision-making processes, changing circumstances during guardianship, and unacceptable behaviours exhibited by animals. The study emphasises the importance of providing support and access to services for individuals facing conflicts within the human-animal bond too. The study contributes to the understanding of the human-animal bond and its implications for individuals and animal welfare. The findings underscore the strength of the bond and its positive impact on well-being, while also acknowledging the conflicts that can arise.

BACKGROUND

The American Veterinary Medical Association describes the human-animal bond as "a mutually beneficial and dynamic relationship between people and animals that is influenced by behaviours essential to the health and wellbeing of both" (American Veterinary Medical Association, n.d.). This includes emotional, psychological, and physical interactions. The bond between humans and animals is a crucial aspect of many animals owners' well-being. This is well-supported by existing evidence.

McNicholas and Collis (2000) concluded that being accompanied by a well-behaved dog increased the frequency of social interactions in multiple daily activity settings, particularly with strangers. The social catalysis effect was attributed to the presence of a dog, over and above other differing characteristics of the male handler in the study. When combined with Hawkley and Capitanio's (2015) findings that social isolation (loneliness) is linked to adverse health and fitness outcomes, it is reasonable to presume that the presence of animals may counteract loneliness and improve health and fitness outcomes concurrently. McConnell et al. (2011) further supports this as they found that animal owners tend to have better well-being, self-esteem, and social support compared to non-animal owners. The proposed ability of animal ownership in reducing loneliness may have impacts in

childhood too. It is recognised that childhood and adolescence are important phases that influence the health and well-being across a person's life span. Purewal et al. (2017) conducted a systematic review of the evidence supporting potential associations with animal ownership on the emotional, behavioural, cognitive, education and social development outcomes. This review found positive supporting evidence for effects on self-esteem and loneliness, however, there was inconclusive evidence for effects on childhood anxiety and depression.

Government-mandated and self-imposed lockdowns during the COVID-19 pandemic brought about significant periods of social isolation. Ratschen et al. (2020) concluded that animal ownership appeared to mitigate some of the detrimental psychological effects seen during this time. Morgan et al. (2020) analysed data which showed that as social isolation increased during the pandemic, the interest and rate in dog adoption increased significantly. However, they also found that there was a clear association between individuals impaired quality of life and their perceptions of a parallel deterioration in the quality of life of the dogs; an important association to be aware of. The One Welfare Model serves to highlight the interconnections between animal welfare, human welfare, and the environment, and is a useful concept when considering the human-animal bond. Pinillos et al. (2016) explain that adopting the concept of One Welfare could be used to help to improve animal welfare and human wellbeing concurrently.

RESEARCH OBJECTIVE

The objective of this research was to explore animal owner experiences with animal healthcare professionals using a narrative approach; however the opening question in the interview which had been intended only to set the scene ended up providing a very rich narrative supporting the strength of the human-animal bond and providing additional evidence which supported the existing body of research attesting to the strength of the human-animal bond.

Therefore, this first paper explores the specific narrative relating to the importance of animals in participants' lives reflecting the strength of the human-animal bond. Later papers will explore the positive and negative experiences of these participants with their animal healthcare providers.

METHODS

This research set out to listen to real experiences of animal ownership and animal healthcare provision and to explore the emotions within those experiences. Although narrative inquiry is gaining popularity as a research method in the human medical field, its utilisation in animal science-related fields is still limited. However, it presents an opportunity to connect better with animal owners' relationships, both with their animals and with those working to support animal welfare. The use of narrative enquiry research methodology allows for the exploration of real-life experiences through storytelling, offering a rich description and exploration of meanings that may not be captured by quantitative research or survey-based approaches (Wang & Geale, 2015) and it allows for expression of emotions and personal reflection with fewer constraints. This, combined with active and empathetic listening by an interviewer within a safe space, is an appropriate research method to achieve the research goal. Lewis (2011) discussed story telling as being supportive of human meaning. The root of this research is the human component of animal ownership and the relationship with both the animal and those responsible for the animal's healthcare. By seeking to develop a profound understanding and connection with people's stories concerning their relationship and bond with their animals, this study adds meaning to the relationship that might not be apparent in studies that disconnect the human narrative in the research. Datta (2018) identified narrative approach as culturally appropriate research which can empower researchers and research participants.

In 2022, six researchers interviewed 30 animal owners using a semi-structured interview. This semi-structured interview had four sections to guide the transition of the story, allowing participants space to tell their story in their own way while allowing the researchers to gather data that could be compared. This paper is focused on the narrative pertaining to the first section of the interview.

The four sections and guiding questions used were:

1. Tell the interviewer about your animals and their importance in your life.

2. Tell the interviewer about your relationship with your veterinary clinic.

    •   Thinking about your last visit to the veterinary clinic, tell the interviewer about the visit from booking to follow up after the visit; walk the interviewer through it and how you felt during the experience from booking the appointment through to post visit follow up.

    •   Recall an experience/s where you felt better and/or worse than this visit you have just described? Explain what the experience was and why you feel this was the case.

3. When considering the financial value of your visits to the veterinary clinic, what is informing your feelings about the cost? Consider scenarios that you have talked through already for context.

4. When considering your animals' healthcare, is your veterinarian always your first port of call? Or are there other places you go for advice/guidance? Tell the interviewer where you go and why?

These questions were shared with the participants in the days leading up to the interview, allowing them time to consider the areas we wished to explore, and the stories they might want to share. This allowed participants to reflect and consider their responses and it resulted in clear narratives. Several participants mentioned during the early stages of the interview that they had taken time to contemplate the broad themes the interview aimed to cover and had even prepared notes to ensure they shared important aspects with the interviewers. Allowing this pre-interview reflection and consideration likely contributed to the richness of the stories shared by the participants, reducing the likelihood of leaving the interview with a sense of unshared thoughts or experiences. This likely contributed to there being no changes or additions requested to transcripts post interview.

Listening to participants share their stories through the narrative inquiry approach provided a means to connect with their emotions as they expressed their own lived experiences. Interviewers took care to listen attentively, empathise, and ask probing questions that encouraged participants to share more without imposing the interviewer's perspective or worldview. The research findings are presented as themes and subthemes, supported by direct quotes from the interviews. It is important to acknowledge that the interpretation of these themes and quotes may be influenced by the researchers' own lived experiences, and this should be considered when examining the results.

Participants were assured of anonymity as part of the process through details on the consent form, and at the beginning of the interview. Time was allowed for whanaungatanga at the being of the interview, providing an opportunity for the participants to be comfortable with the interviewer and to check in if there were any questions or concerns.

Participants were selected from expressions of interest provided in a 2021 industry survey to animal owners. The last question in the 2021 animal owners' survey invited participants to share their details if they wished to participate in an interview. One hundred and twenty-five respondents of the animal owner survey expressed interest. Initially 30 participants who represented the most diverse range were selected form the 125 respondents. However, only 10 of this first cut responded to the invitation to engage, meaning we had to select less diverse participants resulting in the 30 participants of this study being less diverse than anticipated.

Of the 30 participants, 25 were New Zealand European ethnicity, three were from overseas European backgrounds, one Māori participant (pseudonym – Manaia), and one Asian participant (pseudonym – Maya). It is important to acknowledge that the lack of cultural diversity within the sample is a limitation of this study, and future research using the same methodology is planned to address this limitation by including participants from more diverse cultural backgrounds.

Consequently, themes were identified that applied specifically to Manaia and Maya. It is crucial to note that these themes may not be exclusive to the cultural diversity represented by Manaia and Maya. Another limitation regarding demographic diversity is that only one participant, Eric, was involved with animals in a commercial setting, specifically in farming. Again, although the themes drawn from Eric's narrative did pertain to the relationship between animals and his farming business, it cannot be assumed that the themes drawn are a true representation of the rest of the farming community throughout Aotearoa New Zealand.

Acknowledging the limitations associated with cultural diversity in the sample and the limited representation of commercial farming involvement, presents an opportunity for further exploration of the themes; specifically, those identified from the narratives of Manaia, Maya, and Eric. Future research should aim to incorporate a more diverse range of cultural backgrounds to provide a comprehensive understanding of the human-animal bond and its implications across different cultural contexts.

There was diversity in other demographic measures, and no discernible differences were observed in the interview themes when considering these other variable dynamics including age, gender, income bracket, location, and number of animals.

Interviews were recorded and transcribed, and participants were given the option to review the transcripts and quotes. Five requested to review their transcripts, however no changes were made. Following this, thematic analysis was carried out. Each transcript was read, and key pieces of text (sentences) were highlighted by researchers. Themes were identified and highlighted text was grouped together. In some cases, subthemes were created. This is an example of inductive constant comparison analysis (Leech and Onwuegbuzie 2007) and is considered grounded theory research. This research received ethical approval to undertake this research on 26th April 2022 by the Otago Polytechnic Research Ethics committee, approval number 948.

RESULTS

The thematic analysis of the narratives relating to the importance of animals in the participants' lives resulted in the creation of two categories:

1. The positive aspects of the human animal bond (Table 1)
2. The conflicts arising in the human animal bond (Table 2)

Within each category, two overarching strong themes emerged which are outlined in Tables 1 and 2. Under each of these themes were subthemes. These subthemes comprise of the way the participants articulated the overarching theme identified.

Table 1. Category 1: Strength of the human animal bond (Source: Authors).

Theme	Wellbeing (25)		Family Members (25)
Subthemes	Emotional support and companionship (25)		Owners going above and beyond (15)
	Exercise and Routine (8)		Instead of or after children (11)
	Encouraging human connections (3)		Shared interest (5)

Table 2. Category 2: Conflicts arising in the human-animal bond (Source Authors).

Themes	Conflicts that emerge before animal-ownership (8)		Conflicts that emerged during animal ownership (13)
Subthemes	Environmental Concerns (3)		Emotion in decision making (6)
	Individual circumstances (2)		Change in circumstances (5)
	Family conflict (2)		Unacceptable behaviour (2)
	Breed selection conflicts (1)		Unpleasant medical conditions (1)

CATEGORY 1: THE STRENGTH OF THE HUMAN-ANIMAL BOND

Following whanaungatanga, the interview opened with a prompt for the participants to share the importance of their animals in their lives. All 30 participants attested to the strong connection to their animals, opening with statements that clearly demonstrated the strength of their bond, demonstrating the importance to the owners in terms of connection and relationship. The word 'love' was used many times. This is highlighted separately prior to the theming of the remainder of the narrative due to the strength and universal nature of it. No participant started their story with an alternative narrative, and all participants were enthusiastic about sharing how important their animals were to them. Themes and sub-themes present on the narratives associated with the strength of the human animal bond are outlined in Table 1.

> …we're a bit of an animal-mad family which is part of the reason I was quite excited to have the chance to get involved in this discussion with this project… Deanna…he's my best buddy… just love him to bits, we have a lot of fun together, he's very spoilt. (Graham)

Wellbeing

Human wellbeing has many aspects, and for 25 participants of this study, animals were reported as being a major contributor to their overall wellbeing. Across the participant narratives the strength of the connection to their animals was evident. For example indicating the importance animals have in the lives of humans.

Participants linked animal ownership to their well-being, but their explanations highlighted different aspects, leading to creation of subthemes of well-being. The emphasis in each narrative supports presenting them as three distinct subthemes of wellbeing.

1. Emotional support/Companionship

The emotional support and companionship provided by animals stood out for 25 of the participants, highlighting the bond and unconditional love found in animal ownership. This was particularly evident during COVID isolation.

> Right after the COVID lockdown... he got me out of a really dark place, and then it's just been onwards and upwards since then… (Leanne)

> *I was desperately trying to get just any dog, so I didn't have to do lockdown by myself…* (Ruth)

Some participants expressed how the strength of the emotional connection to their animals was a literal life saver during difficult times, the benefits of which were clear through the stories shared for example,

> …the reason I'm still here is because of my dogs… (Fiona)

> The absolute intensity of the bond that can form with a …. companion animal, my dog, that had basically supported my life …. the loneliness antidote is that companionship of an animal… (Petra)

For Greta, her cat provided companionship as a much younger child in a family,

> …because I was quite a bit younger than my siblings, the cat always became my buddy, so I would, when I was ….. very, very young, six or seven, I would go rabbiting in the paddocks with the cat.

2. Exercise and Routine

Exercise and routines are also linked to wellbeing. Eight participants shared stories that highlighted the important role their animals play in creating and supporting this part of their lives. Some examples include:

> …always there, he comes with me most places … he's always there when I wake up, he's there when I go to sleep and …. he's there when I'm de-stressing at the end of the day when I take him for a walk after work, so he's an incredibly important component… (Cam)

> we walk together with them, we take them to the beach together, you know, it's our lives, he gets them up in the morning, I put them to bed at night… (Anne)

> …we live a really active lifestyle so he has a really important role in helping us stay active… (Isla)

> …having a dog around the house is good, if nothing else, when you're retired and getting on a bit, it makes you get up and go for walks… (Darcy)

3. Encouraging human connection

While the benefit of increased exercise was identified, three participants' narrative also strongly linked the presence of their animals to encouraging human connection.

> …it's not just company like, you get outside and you're walking them and you're getting fresh air and you're getting sunshine and you're meeting other people and it's just a whole package really… (Leanne)

> I'm retired and widowed, and so on my own, and I moved …. I'm finding because I'm now at home that this little dog is my companion gives me a purpose …. I'm getting to know the neighbours as well through the little dog… (Joy)

FAMILY MEMBERS

Twenty-five of the participants articulated that they considered their pets as family members and are consequently treated as such. Within this theme, three sub themes emerged that align to the theme of being a bona fide family member.

1. Owners going above and beyond

While most participant narratives expressed the importance and benefits of having animals within their family unit, 15 explained what having an animal as part of their family meant to them in terms of the lengths they go to, to ensure their animals have a good quality of life.

> …we've got two houses that we split our time between, and she comes with us wherever we are so she moves with us… it's transformed our enjoyment of both places… (Beth)

> I was working an extra at least four shifts a month to afford to give them all their treatments and things that I think that they need to maintain their best quality of life. (Hayley)

2. Instead of or after children

For 11 participants, animals were brought into the family instead of children, or after children had grown and left home.

> He's, well, effectively a son really… (Bernie)

> …plays a big role of course… we don't have any kids, so the dog gets a lot of attention… the whole holiday was planned around the pet… (Nicola)

> Animal-mad family… we don't have kids …. three cats and three dogs, but it's been as high as three dogs, five cats and an indoor rabbit …. they're really family members for us …. we like to think of them as humans … we appreciate they're not humans, but they're very much, you know, full-fledged members of the family. (Deanna)

> …they are everything, and we've got no children at home any more… they're like our children… (Anne)

3. Shared interests

Five participants articulated specific shared interests ranging from sporting activities to training and breeding, all off which related to being considered part of the family and their families activities.

> …this weekend just gone, he got his rally advanced excellent title, which is one step below champion, so we've been working on that for quite a few years and he really enjoys that… (Bernie)

> …our whole life revolves around the dogs, everything we do revolves around the dogs or dog shows… we don't really have a lot of time for anything that's not dogs but it's our lifestyle, it's our livelihood… (Margaret)

MINOR FINDINGS

This section summarises three isolated findings that were identified as worthy of further exploration as the themes aligned through anecdotal stories outside of this research and with experiences of the researchers.

Resolution of fear

Not every participant always loved animals. One participant described how her family taking on a dog, which she described as her best friend, helped her resolve her fear of dogs.

> …when I was a really small child, I was actually scared of dogs and got nipped as a result, you know how dogs' kind of, can be a little bit anxious around people who are scared of dogs… so that [ownership of a dog] really helped me to kind of get over that. (Carly)

Business

Eric was the only participant from a commercial rural background. For him, animals are part of his life and part of his business. Eric pointed to the changing requirements and standards required for farmers now, but noted that for his family and business, animal welfare has always been central. While the high monetary value of animals as income units was recognised, he also acknowledged animals' welfare needs within the farming context.

Teaching/learning

The opportunity for animals to be a teaching tool, not only in terms of resolution of fear, but to foster traits such as empathy, was also recognised.

> I can see how gentle and encouraging the boys are, you know, and the empathy that they have for the dogs if they're not well. And I just love being able to foster that in them… (Fiona)

CATEGORY 2: CONFLICTS CAUSED DESPITE THE STRENGTH OF THE HUMAN ANIMAL BOND

Despite participants' strong connections with their animals, conflicts were mentioned by 18 participants (60 per cent), recognising that challenges can arise within the human-animal bond. The conflicts of animal ownership were themed into conflicts before animal ownership and during animal ownership, and then within each themes sub-themes emerged. They are outlined in Table 2.

CONFLICTS THAT EMERGE BEFORE ANIMAL OWNERSHIP

Eight participants identified conflicts that have arisen before animal ownership. Four sub-themes were identified within this theme.

1. **Environmental concerns**

Environmental concerns associated with animal ownership were raised by three participants, typically relating to the protection of other native species.

> My dad's a real animal person …. like he's a conservationist and keen on native birds… but in a strange paradox he also would look after cats and possums and things if it fell upon him… (Carly)

> I like cats, but I'm not big on the sort of, them killing native birds and stuff, and one of the places I go hunting there's a lot of wild cats, which are not good for the environment, so that's put me off them a bit… (Hamish)

Another participant did also acknowledge this concern but went on to describe his journey into cat rescuing, with the purpose of managing stray cats in the area to help reduce the associated environmental impacts.

2. Individual circumstances

Two participants in this study highlight how individual circumstances can influence decisions on animal ownership, where the desire to have a pet is overruled by other factors, such as rental accommodation limitations.

> I'm renting now, I can't get a dog… so I volunteer at Dog Rescue, Dog Watch on a Sunday morning. (Kim)

> So I finally had my own home and was in a situation to be able to get a dog… (Eve)

3. Family conflict

Family feelings about animals are not always compatible and can influence entry into animal ownership. This type of family conflict was identified by two participants. These participants explained how the conflict affected family life and how compromises were made to negotiate change.

> …when I was a kid my mother didn't approve of pets… (Darcy)

> …my husband doesn't really like animals, so when he met me I had a [breed of dog], but that was a really big thing for him and it was too much for him. So when that dog died I wanted another dog but he didn't want any more pets. So I had to wait, and when he wanted to move house… he said that if I moved house I could have a dog, and that's the only reason I moved house… (Manaia)

Conflict over training styles was also identified throughout the narrative; another negative impact on family cohesiveness because of animal ownership.

> …different attitudes to training, I like a well-behaved dog and my husband doesn't like to do any kind of thing that might upset the dog… (Manaia)

4. Breed Selection conflict

This conflict was highlighted by one participant and for here it was a conflict between personal health and the breed that was desired.

Despite being allergic to cats, Maya longed to have one and specifically chose a Scottish fold, even though this breed is not hypoallergenic and she suffers cat allergies. Maya was very aware of the breed's typical health issues but opted to get one anyway, carefully selecting a variant bred to minimize potential health problems. This breed decision was driven by the influence of a celebrity who owned this breed.

CONFLICTS THAT EMERGED DURING ANIMAL OWNERSHIP

Conflicts that emerged during animal ownership were raised by 13 participants. Some of these were personal conflicts, others interpersonal conflicts with other humans, and some were between the animal and the human.

1. Emotion in decision making

Six participants raised the conflict between emotional attachment to animals and the necessity of making objective decisions. The effects of this type of conflict were variable and personal to each of the participants who reflected on different situations through their narrative.

In some cases, attachment led to emotional, rather than objective, decisions.

> …the sense that your relationship to your animals leaves you open to being pushed into spending far more than you intended to and that your own health doesn't require emotive decisions – you just do what needs to be done… (Adam)

Others felt that the process of making objective decisions was highly emotive, causing some to second guess decisions that had been made.

> …really hard for me emotionally and just, it felt like having a toddler all over again… maybe I wouldn't have put her through the treatment, just because, she had to have a bone marrow biopsy, she did well with that, but I think just all the repeat blood, the blood checks every week and then fortnightly and then I was quite stressed out …. so in hindsight I felt bad, so I don't know if I would do that again, but at that time, when you have a fair chance that she might pull through, then why not? (Susan)

Tammy explained her journey into fostering cats, which ended up in foster failing the first pair because they were with them so long, they couldn't bear to part with them.

> …my intent was to foster many, many kittens to help in that way, but as you said, totally foster failed, and they definitely are an important part of our lives now… (Tammy)

Bernie has two aging dogs who have lived together most of their lives, and she worries about one going before the other. She is conflicted by the idea that maybe a puppy would help, but maybe it is too late now and in humanising dogs' feelings, worries about how that would make the existing dogs feel.

> …which is something of a concern for me 'cause if she goes before him, then I don't really know what he's gonna be like, but yeah, I also don't really wanna get like a pup or two now, because they might think I'm trying to replace them… (Bernie)

2. Change of circumstances

Despite best laid plans, circumstances can change during the lifetime of an animal, and this can unfortunately cause conflict. Five participants whose narratives reflected this sub-theme told stories of failed relationships or changes in employment and the effect this had on lifestyle, routines, and responsible animal ownership.

> …when I was with my now ex-partner, it was originally their idea to get a dog, and I was somewhat talked into it, I was – I think I had thought it through and was more aware of the enormous responsibility that owning an animal comes with, and yeah, and so when we separated, I was the one who got [name of dog], I think the dog chooses you at the end of the day, he's always been more my dog than he was my partner's, he always did what I told him to do and that sort of thing, in contrast to what my partner would ask him to do… (Cam)

> …once I moved away from my ex-partner because I couldn't take her with me… she didn't like it…my girls were coming back and telling me about [name of cat]… they suggested it… Mum, why don't we get [name of cat] here? And I thought, went back to him and said, yeah, what do you think? And he goes, nope, nope, not getting [name of cat], you walked away, you're not getting [name of cat], back. Couple of days later, he agreed that I could have her… (Kim)

> I can remember when it got to the point that I was sneaking [name of dog] into the bed and wanting to give him a hug rather than my fiancée, I realised that I was just gonna end that engagement. I was just happier on my own with [name of dog]. (Petra)

I'd had her for a couple of years and… community support work… 12-hour days being away from home … [and] this new job was gonna be in the weekends [too]…arranged for some people to come in and walk her during the day… she'd spend most of the time in the crate… we decided that the best thing for her while she was still young was to look at rehoming her. So I found a guy who lives on the beach who had had a wee dog that had recently passed and he was really looking for a new dog, and so it worked out perfectly. (Eve)

3. Unacceptable behavior

Times when an animal's behavior was considered unacceptable were identified specifically for two participants, but the human animal bond that existed allowed the animal to stay, and in some cases, the participants explained sacrifices they made to enable that to happen.

…she was diabolical, pretty much, she was very, very stressed and very anxious, and she ate everything. She ate the cords, she ate the computer, she ate the chair legs, she ate her beds. She just chomp, chomp, chomp. And so I rang up the SPCA and I said, "lovely dog, lovely dog, but I'm afraid we're gonna have to bring her back." They said, "oh dear, oh dear, OK, alright, well, actually, we're closed at the moment. Can you bring her back on Monday?" And we said, "yep." And bringing her back on Monday and she's still here two years later, so she must have talked us around in the weekend. But she's a very important part of the family now… (Adam)

Adam believes the strict routines they set up for the dog solved her anxiety issues, allowing her to stay with the family. This act alone shows the power of the human-animal bond and the commitment to supporting the needs of the dog as a family member.

The other example was a participant who had chickens that were originally purchased for the purpose of egg production. Egg production stopped but the chickens stayed because they were loved, even though their behaviour was challenging.

…precious chickens, beautiful chickens that gave up laying and gave up actually being anything other than a pain, but we still kept them with us because we loved them… (Beth)

4. Unpleasant medical conditions

Although this sub-theme was only mentioned by a single participant it was agreed to be worth highlighting as anecdotally, the veterinarians in the research team have observed this in the clinical setting. The conflict noted was due to the participant's cat's medical problem that made him smell. Despite sharing how her cats are the most important things in her life, this problematic smell impacted the participant's relationship with her animal. It wasn't until the problem was resolved that she could interact with him normally.

DISCUSSION

Strength of human animal bond

The findings from the interviews consistently revealed a strong and meaningful connection between the participants and their animals, which significantly contributed to their overall sense of well-being. It is important to acknowledge that participation in this research was voluntary, and there may have been a bias towards individuals who had strong bonds with their animals and wanted to share their experiences. However, the strength of the human-animal bond has been well-documented, as demonstrated by previous studies (Hawkley & Capitanio, 2015; McConnell et al., 2011; McNicholas & Collis, 2000; Morgan et al., 2020; Purewal et al., 2017; Ratschen et al., 2020), suggesting these findings are likely representative.

The strength of the human-animal bond should not be underestimated, particularly when working with individuals and their animals. The bond between a human and their animal(s) influences how they respond to different situations. This has significant implications in animal healthcare settings, where animal owners may be faced with decisions regarding animals with debilitating diseases and eventual loss. Uccheddu et al. (2019) demonstrated the depth of emotion associated with the loss of an animal and equated it to a similar level as the loss of a spouse. Consideration of the strength of the human-animal bond is also crucial in other situations, such as accommodation. The strong bond formed between individuals and their animals, although beneficial for their well-being, can also restrict housing options (Cleary et al., 2020). Additionally, victims of domestic abuse often face difficulties escaping the situation due to concern for their animals, as animal abuse is prevalent in domestic violence cases. Addressing the welfare of animals in these cases is essential to support the victims of domestic violence in achieving safety (Strand & Faver, 2005).

The COVID-19 pandemic and associated lockdowns highlighted the impact of animals in reducing feelings of loneliness and providing companionship, particularly for individuals living alone. This finding was consistent with the experiences shared by the participants in this study and supported by Ratschen (2020). The bond with a canine companion was identified by the participants as significant in maintaining exercise routines, which in turn contributed to their well-being. This theme is supported by research conducted by Higgins et al. (2013), who found that canine companions motivated, enabled, and sustained walking behaviours in their human companions. With regards to the subtheme of shared interests between humans and animals, it is challenging to determine whether the interest in a particular animal sport drove animal ownership or vice versa, the shared interest positively impacted the well-being of both humans and animals. Dog sports, such as sledding, agility, and obedience, were reported by participants as ones they participated in and are likely to have benefits for both humans and canine competitors. However, it is crucial to ensure that animals participate willingly and with consideration for their well-being to avoid negative welfare outcomes.

Humans are social beings, and human-to-human connection is a determinant of mental health and well-being (Klussman, 2020). The participants in this study supported the notion that ownership of a canine companion facilitated the development of human connections. Although literature exploring the role of dogs in human social interaction is limited, McNicholas and Collis (2000) have shown a positive impact on human social interactions when the dog behaves well. There is an opportunity for further exploration of this topic, including the impact of different dog breeds and dog behaviour on positive human social interaction.

Within the category of positive animal experiences, three minor themes emerged from the experiences of individual participants. Although these themes were drawn from the experiences of a single participant for each theme, they align with anecdotal reports and warrant acknowledgement. There is limited existing literature on these sub-themes, presenting potential opportunities for further exploration.

Observations from social media posts and community discussions indicate the existence of conflicts between animal owners and non-animal owners. In some cases, these conflicts may be related to previous negative experiences with dogs. One participant in this study reported that dog ownership helped resolve her fear and this raised the possibility that spending more time with animals could help alleviate such fears and increase understanding of animals and their behaviour. Further investigation in this area is warranted.

Eric emphasised that despite animals being part of his business, their welfare, and his connection to them, were paramount. This highlights that the concern for animal welfare and the bond with animals existed for him in a commercial setting, even before the increased formalised requirements for reporting and acting on animal welfare in farming. Anecdotally, media reports appear to highlight negative animal welfare (neglect) and the potential disregard for it by commercial entities in the farming sector, which might not be representative of the farm owners.

Fiona described the development of empathy for animals that she cultivated with her grandchildren through their connection with her dog. Svensson (2014) reported the potential of using animals for educational purposes to stimulate increased knowledge in social behaviour and an interest in animal care. Animal-assisted therapy has also shown positive results in the treatment of child abuse (Dietz et al., 2012; Parish-Plass, 2008). The findings from this research, along with existing supporting research, suggest opportunities to connect animals to human learning from childhood, while considering the welfare of the animals involved.

In summary, existing literature supports the notion that animal ownership contributes to human mental health and well-being across all life stages; which is further supported by this study. Therefore, integrating animal ownership into human healthcare plans should be considered. However, the issue of access to animal ownership remains a concern as it is not currently accessible to all members of the community, given the lack of a welfare system that covers animal healthcare (College of Social Work, The University of Tennessee, 2018). This issue requires further exploration in the context of Aotearoa New Zealand.

Additionally, it is important to recognise that the welfare of humans and animals is interconnected. When a human's welfare declines, it can also impact the welfare of their animal(s). For example, individuals, forced to live on the streets due to a lack of accommodation for their dogs, experience reduced health and well-being for both them and their animals. Similarly, victims of domestic violence may be unable to remove their animals from abusive situations, leading to negative welfare outcomes for both the humans and animals involved. The well-being of humans and animals should be considered together, as emphasised by the One Welfare model.

Conflicts in animal ownership

The human-animal bond is a multifaceted relationship that encompasses both positive and negative aspects. While all participants in this study expressed positive experiences, 60 per cent also shared conflicts. While studies frequently highlight the benefits of this bond, it is essential to acknowledge the potential detrimental effects on both animal and human wellbeing from conflicts. For example, Prato-Previde et al. (2022) examined the impact of animal hoarding, revealing that dysfunctional relationships with animals can lead to physical and psychosocial suffering in animals. In this study, it was negative effects on the human owners that were highlighted by participants, though some of the conflicts mentioned, such as a family break up or rehoming, would inevitably have had at least short-term effects on the animals. This was not highlighted in participants' narratives.

Environmental concerns, specifically related to cats, were raised by participants, possibly due to the topic's media coverage during the research period. Kikillus et al. (2017) discussed the challenges faced in designing urban cat management strategies due to the need for cooperation with cat owners in what is an emotive subject. The narrative of two of the participants in this study highlighting cat environmental issues suggests that at least some cat lovers are beginning to consider the environmental impact of cat ownership. Dogs also have their own environmental impacts, but this was not highlighted by the participants.

Individual circumstances, such as current accommodation or employment commitments, and family conflicts, emerged as sub-themes causing conflicts for potential animal owners. Balancing the desire to have an animal with the practical considerations of their current situation posed conflicts that required resolution and careful weighing of pros and cons.

Maya's narrative highlighted conflicts related to human allergies and the risk of breed deformities. Although raised by a single participant, these conflicts are acknowledged by the authors from experiences in veterinary clinical practice. It highlights the presence of these conflicts and opportunities for the veterinary profession to assist in the decision-making process regarding animal companionship.

Conflicts can also arise during animal ownership, including emotionally charged decision-making processes. Participants shared stories indicating that decisions may have been driven by emotions rather than rationality, while others reported successfully balancing emotions with rational responses regarding animal healthcare and or euthanasia decisions. Regardless of the decisions made, acknowledging the presence of emotions within the human-animal bond is crucial, especially when owners face difficult decisions. This conflict is deeply intertwined with the emotional connection of the human-animal bond.

Even with careful planning, circumstances can change during animal ownership, leading to conflicts. Unexpected employment changes that make it challenging to own a dog, or relationship breakdowns that disrupt living arrangements and increase human conflicts can strain the human-animal bond. Exploring how the social structure in Aotearoa New Zealand can better support individuals in these situations, rather than resorting to rehoming, surrendering, or euthanising animals with the associated negative impacts on both humans and the animals they were owners of, presents an opportunity for further investigation.

Adam and Manaia shared situations where they made sacrifices to keep their animals, despite facing unacceptable behaviours. Although the participants in this study did not explore conflicts that strain human connections, such as uncontrolled dog barking or ownership of an aggressive cat, it is reasonable to assume that the scope of unacceptable behaviours and their impacts is broader than reported in this study. This highlights the need to provide support to individuals facing such conflicts, which often require the involvement of experts. The equity of access to these services remains a concern, as they may not be universally available due to location or cost.

The final conflict sub-theme was unpleasant medical conditions, as highlighted by Maya's experience with her cat's smell. While this sub-theme was based on the narrative of a single participant, the researchers' veterinary clinical practice experience supports the likelihood of such conflicts among animal owners. Animal healthcare providers should recognise and address these conflicts during conversations with clients.

The discussion revealed the complex nature of the human-animal bond and the existence of various conflicts that can disrupt this bond. It is essential to understand and address these conflicts to support individuals in their decision-making processes and to ensure the overall welfare of both humans and animals. It is crucial to listen actively to clients, maintain objectivity, and engage in non-judgmental conversations that foster a partnership approach (Küper & Merle, 2019). Further research is warranted to delve deeper into these conflicts, the provision of adequate support, and to develop strategies that promote the resilience and longevity of the human-animal bond.

CONCLUSION

Narrative inquiry serves as a powerful research methodology for exploring relationships imbued with emotion; it allows researchers to gain profound insights into the stories and experiences of participants and foster a deeper understanding of the connections between humans and their animals, and the impact on human health and wellbeing. The depth of connection and emotion experienced during interviews by the researchers has contributed to a newfound understanding of this bond and its impact on interactions with animal healthcare professionals. The strength of the human-animal bond in improving well-being and fostering social connection should not be underestimated. This raises pertinent questions about the need for recognition of this and the opportunity for the integration of human and animal healthcare for the social good it provides.

Currently, inequitable access to animal ownership and animal healthcare, due to the privatised nature of animal healthcare, presents barriers for individuals. Without sufficient funds, they may not be able to access ownership, meaning they miss out on the potential positive human health and well-being impacts; or if they do own an animal, to barriers to accessing optimal care may exist, potentially resulting in negative outcomes for animals. There is a need for research in the Aotearoa New Zealand context to examine and address these specific issues, allowing

for recommendations to improve access and equity. Recognition of conflicts in animal ownership is crucial, and support should be provided, particularly by animal healthcare professionals, in navigating these conflicts using a partnership care model. By acknowledging and addressing these conflicts, a more compassionate approach to animal healthcare can be fostered.

In summary, this study has further exposed the profound connections between humans and animals, a depth allowed by narrative enquiry. This research calls for a re-evaluation of the integration of human and animal healthcare, addressing issues of access and equity while recognising and supporting the complexities inherent in animal ownership. By continuing to explore these narratives in a broader range of contexts, we can deepen our understanding and promote more compassionate and inclusive practices in animal healthcare.

LIMITATIONS

The limitations of this study include the limited culturally diverse voice. Expanding cultural diversity within the study would increase the depth of this narrative by exploring animal ownership from a wider range of world views and either strengthen the findings in this study, or potentially add additional themes.

The participants were primarily from small or large urban environments. The commercial rural sector and their relationship with their animals was presented by one participant only. Given the drive for animal welfare and the often-negative press surrounding farming, increasing the narrative from people in the commercial rural sector about the value of the animals in their lives may be useful in redirecting the narrative and solutions to improve animal welfare in commercial settings.

None of the participants were in extreme living situations such as homelessness and there is potential that the stories of people living with pets in situations would provide further deeper understanding about the bond and the conflicts of pet ownership from another lens.

FUTURE RESEARCH OPPORTUNITIES

Future papers will expand upon the narratives collected from these participants, exploring their experiences with veterinary clinics, perceptions of the financial aspects of animal healthcare, and their interactions with various courses of animal healthcare and advice on animal ownership and health.

1. Expansion of this research to include greater diversity of participants including cultural diversity, diversity of living situation and animal owners, where animals are their business.
2. Research examining the relationship between type of dog and its behaviour in facilitating human connection.
3. Research focusing on the impacts of conflicts that disrupt a strong positive human-animal bond, particularly those that occur during animal ownership.
4. Research exploring ways to improve equity of access to animal ownership, as the importance of animals in human wellbeing is strongly supported in terms of health and well-being, but the nature of animal healthcare being private within Aotearoa New Zealand, among other factors, animal friendly accommodation, does not allow equitable access to animal ownership. This is a gap that needs further exploration.

ACKNOWLEDGEMENTS

Francesca Brown is a veterinarian who graduated from Massey University (1998). Since graduating and gaining experience in clinical practice, she moved to education and then leadership in Allied Veterinary Professional (AVP) education, at both Otago Polytechnic, Te Pūkenga and VetFutures Aotearoa. Over her career, she has seen first-hand and through her network of colleagues in the industry (both vets and AVPs) the significant challenges faced by personnel.

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Sylvia Ma is a Massey University graduate of 2019. She has been in general practice, serving a diverse range of clients in South Auckland, and is currently a non-clinical veterinarian working at Ministry for Primary Industries. During her time at University, she founded the Student Veterinary Business Society, which aimed to provide undergraduate veterinary students with a business understanding of their future clinical practice, increase graduate confidence in their worth, and equip graduates with non-clinical soft skills.

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TAKING IT ALL IN THEIR STRIDE: NURSING STUDENTS' CLINICAL PLACEMENT EXPERIENCES DURING THE COVID-19 PANDEMIC

Jenny Lansdown

INTRODUCTION

Workplace learning is an integral element in most professional qualifications today, allowing students to apply theory to practice, to gain hands-on experience, to learn from practitioners, and to absorb aspects and expectations of their future roles. Student nurses undertaking a Bachelor of Nursing (BN) qualification in New Zealand are required to complete a minimum of 1100 hours of clinical experience as per Nursing Council of New Zealand requirements (Nursing Council of New Zealand, 2021). This clinical experience allows student nurses the opportunity to connect with future employers and colleagues, as well as gaining confidence working alongside experienced practitioners, learning not only clinical skills but resilience and perseverance. The first exposure to clinical practice occurs in the students' first year and placements are offered each semester for the remainder of the degree programme. By the time they sit State Final exams, students will have encountered many disciplines of nursing including continuing care in aged residential care (ARC) facilities, mental health placements, medical and surgical wards within district health boards (DHBs), and community providers. Naturally, tertiary institutes offering BN programmes rely heavily on relationships forged over time with managers and supervisors/ preceptors in these different settings. Student nurses need support, guidance, and oversight of clinical placements which requires resourcing and goodwill from all partners.

The arrival of the COVID-19 pandemic in New Zealand in 2020 meant already stretched healthcare agencies were often unable to offer the same access to clinical placements. Understanding the impact these constraints had for nursing students is not only an important part of our own critical reflection as educators, but also for future preparedness. This paper discusses findings from statistical analysis of over 2000 post-placement evaluations, using the clinical learning environment, supervision and nurse teacher (CLES+T) scale. Overall, and pleasingly, student satisfaction with their placement remained relatively consistent. This paper considers some of the likely contributing factors, and offers some conclusions related to good practice in student and stakeholder management.

BACKGROUND: THE IMPACT OF COVID-19 ON THE HEALTH CARE WORKFORCE

COVID-19 became a global pandemic in 2020, with New Zealand shutting its international borders on 19 March, 2020, and going into a nationwide lockdown a week later (Baker et al., 2020). Hospitals and other health providers were deemed essential, with clinical and tertiary provider management teams working together to ensure clinical placements were continued where possible. The clinical areas most hesitant to accommodate student nurses were the aged care facilities for Year One learners, and the community placements in Year Three.

International research including studies in Ireland (Magner et al., 2021), Australia (Hill et al., 2022), China (Wang et al., 2020) and Germany (Jerg-Bretzke et al., 2021) found healthcare workers reported an increase in occupational stress, emotional distress, concern around exposure to COVID-19, and transmission of the disease to patients and colleagues. Magner et al. (2021) discussed the demands on healthcare workers who witnessed increased patient deaths, and were exposed to increased workload and questionable practice; Hill et al. (2022) recounted health care workers being asked to either disregard precautions or to work with inadequate personal protection equipment (PPE), reporting that these working conditions led to increased stress and pressure, resulting in fatigue and burnout. Research in New Zealand by Cook et al. (2021) found that nurses reported feeling vulnerable to contracting COVID-19 due to inadequate availability of PPE, alongside the need to re-evaluate how they were performing their nursing tasks. Common themes amongst these nurses were the anxiety or apprehension around spreading the virus within the community. Alongside this anxiety, nurses in Cook et al.'s study reported dissatisfaction with nursing leadership during the early stages of the pandemic.

COVID-19 AND NURSING STUDENTS' PLACEMENT EXPERIENCES

In response to the challenges of providing clinical placements during the pandemic, Ara Institute of Canterbury (Ara), a nursing school in New Zealand, introduced new clinical placements in managed isolation and quarantine facilities, and telehealth placements for students in their community and personal choice semesters, as well as having new ARC facilities offering a clinical experience over this time. Yet while these new provisions might have provided continuity in clinical placements for students, they could not mask the effects of practising during a public health crisis.

Increased demand on the nursing workforce during the COVID-19 pandemic, with reports of increased stress and burnout, may have had a detrimental effect on student nurses working in these clinical areas. Registered Nurses being too busy or stressed to provide effective precepting, that is, professional guidance and oversight, with less time and energy to ensure students received appropriate learning opportunities, might have negatively impacted the student's perception of the clinical placement. Some nursing students reported to nursing lecturers increased incidence of perceived stress on the nursing workforce and instances when registered nurses treated students unkindly. At times, they noted general disinterest in undertaking the preceptor role, and in some instances, students even reported feeling unsafe in the clinical environment. These informal discussions with nursing students, and my awareness of the increased stress in the clinical environment, led to the assumption students were perceiving their clinical placements more negatively then during pre-COVID-19 times. The study described in this paper sought to determine whether this was, in fact, the case.

AIMS

The aim of this research was to analyse statistically previously collected and stored data on students' perceptions of their clinical experiences, from BN students at Ara, prior to and during the COVID-19 global pandemic, to answer the following research question: *Did the COVID-19 global pandemic impact nursing students' perceptions of their clinical experience?*

The intention was that results would inform academic managers from tertiary institutions and the clinical managers who provide support to clinical areas, about the impact COVID-19 had on the experiences of nursing students over this time. The findings may also alert management and lecturers to strategies by which their own practice could enhance students' learning experiences while on clinical placement, across the five clinical areas: continuing care in ARC facilities, mental health, medical – surgical, community placements and transition placement. For this research, the transition placement – often in the student's preferred clinical area, where possible – was called "personal choice."

AN INTERNATIONAL EVALUATION TOOL

At Ara, as in many other nursing education providers, the clinical learning environment, supervision and nurse teacher (CLES+T) scale is used following placement, to measure students' perceptions of their experience. This evaluation tool was designed in 2002 by Mikko Saarikoski as part of their academic dissertation, originally as the CLES scale with later refinement to include '+T', the nurse teacher (Saarikoski et al., 2008). The CLES+T scale was developed for nursing students to evaluate the clinical learning environment (Saarikoski, 2002) and has been validated internationally for use in the clinical learning environment (Gurková et al., 2018;) including by a team of New Zealand nursing academics (Watson et al., 2014). There are many different versions of the scale, including the Turkish, Swedish and Finnish versions, however it is the original Finnish version that was validated by Watson et al. (2014) and was found to have good internal reliability and validity for use within hospital settings, for educators, clinical staff and researchers to monitor student nurses' perceptions of the quality of their clinical placements.

The original CLES+T scale consists of five sub dimensions: the role of the nurse teacher; pedagogical atmosphere; the supervisory relationship; leadership style of the ward manager; and nursing care on the ward (Saarikoski et al., 2008). Each sub-dimension has between four and nine questions (see Appendix A). Students answer using a five-point Likert scale: "fully agree", "agree to some extent", "neither agree nor disagree", "disagree to some extent", and "fully disagree", with five being fully agree and one being fully disagree.

The nursing workforce in New Zealand is multicultural with 7 per cent of the total workforce identifying as Māori and 27 per cent being internationally qualified (New Zealand Nurses Organisation, n.d.). Ara added in an extra question to the CLES+T scale (question 35) which asked students the following question: "I felt my own cultural perspective was acknowledged and valued in the placement." This additional question recognises the multicultural demographic of nursing students. All other questions remain the same as the original scale, with the only changes being the replacement of the word "ward" with "placement", and the word "mentor" to "supervisor."

METHODS

Ethical considerations

As this study used existing data collected through the CLES+T evaluation, and did not collect additional primary data, there was no requirement for ethics approval by an independent ethics committee. However, support was provided by experienced researchers within the academic institution where the author was employed as an academic staff member. This oversight helped to ensure ethical principles were observed throughout the research process. For example, students are informed on the front page of the survey that completing the survey implies consent for their responses to be given as feedback to both the clinical area and the clinical lecturer (nurse teacher) as well as possibility that their responses may be used for research (see Appendix B). Also, the consent states that the responses will be anonymised prior to being used for feedback to lecturers. Removal of all identifiers by the research team immediately on receiving the data, ensures the anonymity of the students, staff and clinical providers. This process had occurred for all datasets analysed in the current study. It is important to note that completing the survey is optional, and no preparation sessions are held to explain the detail of the survey to students, or to suggest any pressure to participate. Two reminders to non-responders are sent through Qualtrics, but no further follow-up occurs.

Data collection

As described above, Ara uses the Finnish version of the CLES+T scale with minor changes to the original wording, to collect data from nursing students, and this occurred throughout the study timeframe of 2017 to mid-2022. Qualtrics, a computer software program, was used to distribute the survey online, and the resulting data has been stored as Excel spread sheets. Data from all students undertaking a qualification in nursing are included in the raw data, including nursing students in the Diploma of Enrolled Nursing programme, and in the graduate entry nursing program. These sets of data were removed from the final analysis, leaving only data from students in the Bachelor of Nursing degree.

During the New Zealand government mandated lockdown, some clinical placements offered to student nurses were shortened or cancelled, with some community placements being replaced with a clinical project. The survey was not sent to the cohort of students who did not go on a clinical placement during Semester One for the 2020 community placement.

Otherwise, the survey was emailed to all students on completion of their clinical experience. This study drew on five years of data from 2017 to mid-2022, which combined resulted in 2794 sets of data. Cleaning the data included removing all identifiers, the qualitative response at the end of the survey, and all non-complete sets of data. Eventually, 2012 sets of data were available to analyse (response rate of 36 per cent).

Quantitative statistical analysis was used to analyse the data, with a descriptive cross-sectional study design. The dataset obtained from the Qualtrics website was downloaded as a Microsoft Excel spreadsheet, and after cleaning the data an independent statistician was recruited to assist with data analysis. The data was initially transferred to the Statistical Analysis System v 9.4 (SAS Institute; Cary, NC, USA) for further analysis. The data was then visually checked for outliers and inaccurate data, by investigation of the distribution and probability plots. Means and standard deviations along with frequencies and percentages were calculated for the various dependent variables (five sub-dimensions of the CLES+T questionnaire including pedagogical atmosphere on the ward, supervisory relationship, leadership style of ward managers, premises of nursing care, and the role of the nurse teacher). Comparisons between groups (clinical placements of continuing care, mental health, medical/surgical, community health, or personal choice and COVID-19 time points (prior to 2020 and after 2020) were analysed using analysis of variance (ANOVA).

Response rate

The response rate of 36 per cent is lower than other response rates for similar studies using the CLES+T scale, with most studies achieving over 70 per cent response rate (Bisholt et al., 2014; Bos et al., 2015; Carlson & Idvall, 2014; Dimitriadou et al., 2015; Gurková & Žiaková, 2018; Magnani et al., 2014; Papastavrou et al., 2016). D'Souza et al. (2015) achieved a 100 per cent response rate. The main point of difference is sample size. Studies stated above had under 500 participants, compared to the larger sample size in this research. Further, the studies reviewed used data from a single year, compared to five and a half years of data analysed in this research.

RESULTS

Bachelor of Nursing students scored their clinical experience positively, with an overall mean of 4.5 +/- 0.5. From 2012 responses, 75 students who identified as Māori, and 38 students who identified as Pacifica, scored question 35 ("felt my own cultural perspective was acknowledged and valued in the placement") positively with a mean of 4.51 for Māori students and 4.49 for Pacifica students. This is similar to the overall mean for all students.

There was little statistical significance within the five different clinical areas, across the five different sub-dimensions of the CLES+T scale for students' responses in the pre- COVID-19 and during COVID-19 periods. The students' perceptions of the supervisory relationship (p=0.0383) and the nurse teacher (p=0.0291) sub-dimensions were higher in the years during the pandemic than in the years prior for the medical surgical placements, with the community placement scoring lower during COVID-19 years in the nurse teacher sub-dimension (p=0.0032). All other variables did not reach statistical significance. Therefore, the findings related to the research question "did the COVID -19 global pandemic impact nursing student's perceptions of their clinical experience?" indicated that the COVID-19 pandemic did not negatively impact the clinical experience.

DISCUSSION

The aim of this research was to identify whether the COVID-19 pandemic, which affected nurses and nursing education from 2020 through to present times, impacted student nurses' perceptions of their clinical experience during this time. The initial premise was based on anecdotal conversations with students who were expressing their displeasure with how they were being treated in the clinical areas, and the learning experiences which had changed with the introduction of new clinical placements. This research found that the pandemic did not impact students' perception of the value of their clinical placement, which is reassuring for clinical and academic management.

Strengths and limitations

One of the strengths of this research comes from the large sample size, however the low response rate of 36 per cent is a limitation of this research and may be due to multiple factors. The survey was emailed to every student enrolled in a clinical paper towards the end of each of their clinical placements. For some students, the last day of clinical placement falls on the last day of semester, which may be a reason for non-responding, or they are leaving for a mid-semester holiday, or starting another theory paper immediately after their clinical placement finishes. There might be a lack of trust around confidentiality and anonymity, based on prior experiences the student might have had. The student is asked on the form to identify who their nurse teacher is, using a drop-down box. It had been commented on that there were many names missing from the list, so students who made these comments stated they had selected the course leader or another nurse teacher that they knew.

The length of the survey is also a potential limitation. The CLES+T questionnaire has 35 questions, and the questions are complex enough to require students to think about what the question is asking of them, who are they answering this question about (what sub-dimension this is linked too) and then to generate a response. Ambiguity with the CLES+T scale itself could also cause confusion for students, although an attempt is made to clarify who the nurse teacher is and who the supervisor is on the front page of the survey (Appendix B).

Significance of the research

This research is significant as overall the students responding to the survey are scoring their clinical experiences positively. However, the minority of respondents who scored a 1 on the Likert scale (1.13 per cent of the responses) should not be ignored. No statistical difference between students' responses pre- and during the COVID-19 pandemic is a positive outcome, and could indicate that extra efforts taken by nursing managers and lecturers to ensure the impact on students was minimised, have had a positive effect. The ideal aim for academic institutions would be for all students to have a positive experience while on clinical placement, as research shows how important the clinical experience is for overall satisfaction for students. Exposure to negative experiences while on clinical placement coupled with poor learning opportunities could influence overall outcomes for the student (Fundiswa & Vember, 2021) and might discourage the student from pursuing this branch of nursing in the future.

Recommendations for practice

Although daily nursing practice in New Zealand is now close to pre-pandemic conditions, there are still opportunities for future research. New Zealand is not immune to natural disasters, and there is potential for clinical placements to be impacted again in the future. Further research could include qualitative research in smaller groups, with the potential to follow one cohort through their BN program and compare responses over the course of their degree. Following some of the concerns raised by students referred to earlier, such as preceptor attitudes and perceived willingness, would be important. If students know their concerns are being addressed, they are more likely to respond to surveys and participate in research in the future. It would be beneficial to compare the results each semester from the CLES+T data collected against other formal student feedback, working with class representatives to ensure all students feel safe to be heard.

Addressing the response rate would be another area for improvement. Strategies could be to target one cohort each semester, ensure students are taught in tutorials about the importance of, and how to approach the survey, and then timetable the survey to allow for the questionnaire to be completed in class time instead of the student's own time; all of which may improve the response rate.

A final recommendation is that consideration be given to finding an alternative evaluation tool. The CLES+T scale has many strengths; however, the length of the survey and ambiguity of the questions could be a deterrent to some students.

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Appendix A. CLES+T questions.

Supervisory relationship

1. My supervisor showed a positive attitude towards supervision.
2. I felt that I received individual supervision.
3. I continuously received feedback from my supervisor.
4. Overall, I am satisfied with the supervision I received.
5. The supervision was based on a relationship of equality and promoted my learning.
6. There was mutual interaction in the supervisory relationship.
7. Mutual respect and approval prevailed in the supervisory relationship.
8. The supervisory relationship was characterised by a sense of trust.
9. The staff were easy to approach.
10. I felt comfortable going to the placement at the start of my shift.
11. During staff meetings (e.g., patient handover) I felt comfortable taking part in discussions.
12. There was a positive atmosphere at the placement.
13. The staff were generally interested in student supervision.
14. The staff learnt to know the students by their personal names.
15. There were sufficient meaningful learning situation on the placement.
16. The learning situations were multidimensional in terms of content.
17. The placement can be regarded as a good learning environment.
18. In my opinion the nurse teacher was capable of integrating theoretical knowledge and the everyday practice of nursing.
19. The nurse teacher was capable of operationalizing the learning goals of this placement.
20. The nurse teacher helped me to reduce the theory-practice gap.
21. The nurse teacher was like a member of the nursing team.
22. The nurse teacher was able to give her or his expertise to the clinical team.
23. The nurse teacher and the clinical team worked together in supporting my learning.
24. The common meetings between the supervisor, nurse teacher and myself were comfortable experiences.
25. In common meetings between the supervisor, nurse teacher and myself I felt that we were colleagues.
26. My learning needs were the focus of the meetings between the supervisor, nurse teacher and myself.
27. The manager regarded the staff in the placement as a key resource.
28. The manager was a team member.
29. Feedback from the manager could easily be considered for a learning situation.
30. The effort of individual employees was appreciated.
31. The placement's nursing philosophy was clearly defined.
32. People received individualised nursing care.
33. There were no problems in the information flow related to peoples' care.
34. Documentation of nursing (e.g., nursing plans, daily recordings of nursing procedures, etc.) was clear.
35. I felt my own cultural perspective was acknowledged and valued in the placement.

Appendix B. Information provided to nursing students including consent

Clinical Learning Environment, Supervision and Nurse Teacher Scale (CLES+T)

 In this questionnaire the following terms have the following meanings:

Supervisor refers to registered nurses employed by the placement who supervised you; this could be an individual nurse (preceptor, clinical liaison nurse) or a group (or team) of nurses.

Supervision refers to guiding, supporting, and assessing the student nurse by registered nurses employed by the placement.

Nurse teacher refers to a lecturer (or academic liaison nurse) employed by the polytechnic who visits the clinical placement.

Your completion of this survey implies consent for providing feedback to the clinical placement, feedback to the clinical lecturer, research related to clinical learning environments. Please note any information that could identify you will not be used in any research and will not be included in any feedback to the placement or lecturer.

MISSED OPPORTUNITIES: EXPLORING THIRD-YEAR STUDENT NURSES' CLINICAL EXPERIENCES IN AGED RESIDENTIAL CARE

Pam Foster, Judith Honeyfield, Adam Proverbs and Deborah Sims

INTRODUCTION

Improving the employment and retention of registered nurses (RN) in aged residential care (ARC) has long been problematic; with the increasing demands for more facilities due to the exponential rise in life expectancy, this issue can only grow (Hughes, 2020; Ministry of Health [MOH], 2016; Nursing Council of New Zealand [NCNZ], 2019). A recent report from the New Zealand Aged Care Association [NZACA] (2022), indicates the annual turnover rate for RNs in ARC is nearing 50 per cent with an increasing reliance on internationally qualified nurses. Adding to this recruitment and retention problem, ARC has had limited success in attracting newly qualified nurses to the sector, with ARC ranked near the bottom of preferred career options (Hunt et al., 2020; MOH, 2019).

Currently, most curricula situate an ARC clinical experience in the first year of study to introduce fundamental skills and knowledge (Foster, 2019). However, studies suggest this early exposure to ARC has contributed to nursing students' negative perceptions and attitudes towards working in the sector (Abbey et al., 2006; Laugaland et al., 2021), with one study finding that 66 per cent of participants requested not to go to ARC for a clinical experience (Lea et al., 2018). Recognising how a sole ARC clinical experience occurring in Year One may influence a students' career decisions, a Bachelor of Nursing provider has introduced an additional clinical experience for third-year nursing students, emphasising exposure to the RN role and responsibilities.

Part of a wider study that examines students' third-year clinical experiences in ARC, this paper reports on 38 participant responses from four focus groups, to consider how the clinical experience can be strengthened to promote ARC as a desirable career pathway. We identify a number of missed opportunities in the roles, tasks and responsibilities that nursing students are offered. With the pending introduction of the Te Pūkenga unified nursing curricula combining 13 existing schools of nursing (Te Pūkenga, 2023), this paper argues that education providers are in a position to exert influence and engender positive change through working collaboratively with the ARC sector. Current practices are not responsive to improving the shortage of ARC nurse specialists. Results from this study can inform future options to improve nursing students' ARC clinical experience.

BACKGROUND

In New Zealand, undergraduate nurse education standards are set by the Nursing Council of New Zealand (NCNZ, 2022). To meet these standards, students must complete a minimum 1100 clinical hours in a range of healthcare settings including a "continuing care setting" (NCNZ, 2022, p.61). ARC is commonly used for this

clinical experience, and similar to international practices, this mainly occurs in the first year of education. Often working with healthcare assistants (HCA), the goal is for students to learn fundamental skills and knowledge including vital signs, therapeutic communication and activities of daily living (Fetherstonhaugh et al., 2022; Foster, 2019). The value and purpose of using ARC to learn fundamental skills and knowledge has long been debated in the literature, with concerns that the practice may negatively impact student perceptions and attitudes towards working in the sector as a graduate (Abbey et al., 2006; McAllister et al., 2020).

Negative student perceptions of working in ARC do not occur in isolation, as it is educators who set the curriculum and pedagogy that underpins student preparation and experiences (Foster et al., 2022; Negrin et al., 2020). With a desire to promote ARC as a career destination, educators used the opportunity of curriculum redesign in 2018 to introduce a second ARC clinical experience in the third year of study. Consequently, a third year 96-hour clinical experience in ARC became part of a 'complex needs' clinical course, with students being placed in a range of ARC facilities that delivered hospital-level care, including the complexities of palliative care. Using a preceptorship model for clinical supervision, the goal was for students to have an immersive experience of the RN role focusing on comprehensive assessments, care planning and delivery skills, as well as nursing leadership, including direction and delegation. The students also completed a quality improvement initiative (Toi Ohomai Institute of Technology, 2022).

Anecdotal student feedback from the ARC experience indicated that despite the educators' aspirational goals, students reported reduced capacity to maximise the learning opportunities available. To understand constraints better and the environment in general, a research evaluation of student experiences was initiated. This article reports on the results from four focus groups which formed part of the larger mixed method project reported elsewhere (Honeyfield et al., 2023). Personal accounts of the clinical experience in ARC were then fed into the key question which was: what features of this experience can be enhanced to improve perceptions and experiences of working in ARC?

METHOD

Evaluation research is intended to determine the success of an initiative (Thomas, 2006) and in this instance the aim is "to increase our understanding of third-year student nurses' perceptions and experiences of ARC and impact on career aspirations" (Honeyfield et al., 2023).

A qualitative descriptive methodology was used to explore the third-year students' accounts via a mixed methods approach incorporating a cohort survey (including a question on expected area of employment on graduation) and facilitated focus group discussions. This paper reports on the focus group data collected from 38 participants who had recently completed a 96-hour clinical placement in ARC. Four focus group sessions were held in the second semester of 2022 consisting of two groups from each of the two campuses, lasting between 45 to 60 minutes each. Focus groups enable the gathering of data through interaction and can give access to difficult-to-obtain information about experiences (Doody et al., 2013).

Following ethical consent from the Toi Ohomai Research and Human Ethics Committee (2012.021), the eligible pool of 92 third-year students was invited to participate via a message on the student learning platform. All participants read a participant information sheet before signing a consent form. The focus groups were face-to-face and conducted by a member of staff who was not involved with teaching the students. The sessions were digitally recorded and subsequently transcribed. A Māori kaiako also attended providing cultural support for students who identified as Māori and ensure values such as manaakitanga and whanaungatanga where upheld. A series of semi-structured questions guided the discussions.

Data analysis followed the general inductive approach described by Thomas (2006), beginning with multiple readings of the transcripts to gain a sense of the data. Next, themes were developed around text segments that directly related to the student experience. To assess trustworthiness of the data analysis, other members of the research team checked consistency by taking theme descriptions and finding text that belonged with that theme (Thomas, 2006). The underlying imperative was to ascertain among the text segments, examples of student experiences which might enhance the likelihood of working in the sector in the future. Researchers then drew on these experiences to suggest how improvements could be made to the clinical experience and potentially influence career choices favouring ARC.

RESULTS

Four themes emerged that capture the range of unique experiences reported by the third-year students in ARC: doing the right work, missed opportunities, building relationships and becoming a leader. These themes illustrate the authentic voice of the students who participated and are reflective of disparate experiences. Descriptions are supported by participant (P) quotations where relevant.

DOING THE RIGHT WORK

Aligned with a preceptorship model of student supervision, where the students are assigned to work with a designated RN, an immersive experience of the RN role and responsibilities was a key expected outcome of this clinical experience. Hence 'doing the right work' reflected working alongside an RN. As evidenced in the following examples, central to doing the right work was the support of the RN, thus enabling students to hone their skills:

> The nurses I worked with gave me the opportunity to do things with them. They were really good and formed good communications. Then I was actually quite lucky half way through second week lots of things were happening, lots of falls and because of that there were a lot of lacerations to dress. (P1)

> RN that gave you experience he let me do stuff, like Blood Glucose Levels. The whole time he was always teaching – do you know why we are doing this, he would wait for my answer and then maybe say not really correct. (P2)

One student reported being encouraged to show initiative, hence being given the scope to plan out their day and work somewhat independently:

> They took some time to warm up to me and they really started to recognise my skills as a third year when I took initiatives and put myself out there. I asked am I able to do this, what would you like me to do, I have made this plan today what do you think about blah, blah and they were like, "oh yeah – cool". (P3)

Emphasising the importance of the relationship between student and RN, once a relationship was established the participant was able to negotiate with the RN to work more independently. However, there were barriers to overcome before they could utilise their skills. When the student was able to engage in the 'right kind of work', work applicable to their perceived level of skill, they reported satisfaction, while others reported a range of missed opportunities.

MISSED OPPORTUNITIES

Participants identified a number of barriers to carrying out clinical skills which they had previously undertaken in an acute care environment, often independently. One of the major obstacles was constraints around the administration of medications. In acute care settings, students are able to administer a range of medications under the direct supervision of the RN. As part of the requirement to administer medication safely the student must be able to sign the prescription form as the administrator (New Zealand Nurses Organisation, 2014). This proved problematic as most ARCs now use an electronic medication administration system such as Medi-Map (Garratt et al., 2020) that requires the person who administers the medication to have a unique login. In some ARCs, students were not issued with a login, hence unable to administer medication to residents, causing significant frustration for students:

> The rest home use a computerised system and we don't have a log on so cannot contribute. I think that was a major hassle. You can do a lot of stuff during the med round but you can't do things and can't do the cycle. (P4)

> I would try and do things but I can't do medication rounds, they are all on-line and they don't have student access. We can't handle medications as they in blister packs, so sitting around a lot unfortunately. (P5)

This inability to complete the medication administration process because of system constraints was not an isolated event. Students also reported the supervising RN not allowing them complete other episodes of care:

> There was so many opportunities with different treatments yet we were not allowed to do any. I took the wound trolley to one lady for the RN and the manager to do the dressing, the lady wanted me to do it. I just had to sit there. (P6)

Reporting a similar situation, some students offered a rationale as to why they believed they were not permitted to undertake certain skills they had previously mastered. These included a range of possibilities, from lack of understanding of the student's capabilities, to a lack of trust. For example:

> They [RNs] did not know what we could do. I printed out our clinical companion showing what we could do, but they weren't interested. They were predominantly international nurses and I felt they did not trust we could work under their registration, even though we were year three and RN next year, just that barrier. (P7)

One student clearly communicated their ability to complete certain episodes of care but was still not allowed to, reporting the RN wanted to keep safe:

> I said I have done plenty of these in the ward [dressings] and I am allowed to and she said we were not allowed to do these, just to be safe. (P8)

As evidenced above, most participants' comments describe barriers to advancing clinical skills. However, in the final example, the student concedes that while there are constraints around what they could do, there are numerous learning opportunities available:

> We are so restricted in what we can and cannot do in ARC. I feel like there are way more opportunities we could focus on like, leadership, we could do so much more of care planning, critical thinking, set goals. (P9)

Ironically, the student offers a solution to improving the experience by alluding to one of the purposes of the clinical experience, developing leadership skills. This comment captures how a mismatch between the clinical staff's understanding of student capability, the curriculum and course expectations contribute to a less than optimal learning experience for the student.

BUILDING RELATIONSHIPS

The ability or contrarily, inability to build relationships with residents is an important factor reported by some participants:

> The biggest thing from year one to three was the approach you get with your residents. It is more hands on, more interpersonal. You learn a lot more and engage with a lot more emotions as a year three. (P10)

> I wanted to go into aged care and areas I could see myself working in and the reason being is I love working with older people. Many have dementia and I don't know they just are a special group of people to me. (P11)

In contrast, it was a limited capacity to build relationships with residents that left one student disillusioned with the reality of the practice environment:

> I am basically open to anything but after that placement and seeing the role and I love interacting with patients and doing extra things to try and make them feel like humans and that someone cares about them not just like here is your medication see you later – that was not me. (P12)

Relationship building again highlighted a mixed response with both negative and positive examples evident, yet all comments foreground the ability to build relationships with residents as central to positive perceptions of ARC.

BECOMING A LEADER

A key finding from participants who spoke of a positive experience in ARC was being cognisant of what was happening beyond developing clinical skills. Students appreciated the advanced skills required to work in ARC, including the uniqueness of caring for residents rather than patients.

In the first example, the student is aware of the range of responsibility and leadership required of an RN in comparison to an acute care setting, and how pivotal RNs are to managing the environment, including other staff. They appreciated the fact residents were a relatively stable demographic as there was not the high turn-over experienced in acute care settings:

> I always thought med surg [as a workplace] above ARC but now having been there and seeing what the nurses are allowed to do, their span of control, directing HCA [health care assistant] far more beneficial and healthier environment than a [hospital] ward where you don't get that. You have 4-6 patients and then they change. (P13)

Another student, while describing clinical skills, highlighted their appreciation in being able initiate episodes of care based on their experience:

> I would work in aged care – I like continuity and after I had worked there for the first week, I knew what wound cares needed to be done and I could go and take initiative to go and do it and set it up, I was able to show autonomous decision making and rapport. (P14)

These comments indicate positive experiences. What appears to have made the difference is being able to take the lead in planning care and the potential to make a difference in resident outcomes through leadership.

DISCUSSION

Drawing on the authentic experiences of third-year students provided a unique opportunity to critique our current practices and from there, consider feasible changes for the future. Although the broader research survey results reported overall satisfaction with participants' ability to apply skills and knowledge (Honeyfield et al.,

2023), data from the focus groups illustrates some areas that contradict these findings. Throughout the data, the theme of missed opportunities resonated, with a number of participants reporting a lack of recognition of their skills and procedural barriers to administering medications. The comments also reflect the subtle influence of curricula that privileges development of acute care technical skills; this reinforces the notion that there is little to be learnt in ARC beyond fundamental skills (Abbey et al., 2006; Algoso et al., 2016). In reality, working in ARC as an RN is complex with high levels of responsibility and accountability (Amaduro et al., 2018), while also offering pathways to nurse practitioner roles (Adams, 2021). Unfortunately, the reported limitations around planning and completing episodes of care, coupled with constraints on furthering decision-making and leadership skills, may not encourage students to positively envisage an RN or nurse practitioner role in ARC.

Confirming earlier research, a supportive relationship with the RN and an enriched learning environment are pivotal to students' reporting positive learning experiences in ARC (Brown et al., 2008; Hunt et al., 2020; Lea et al., 2018). The challenge then is how to foster a more consistent, enriched learning environment and limit the missed opportunities for students in a sector struggling with a high turnover of nursing staff (NZACA, 2022). In our current model for student supervision, reflecting the RN preceptorship model (Billay & Myrick, 2008), students shadow the RN, observing and assisting with delegated and some self-directed episodes of care and also, independently complete a comprehensive nursing assessment on one resident. As evidenced in participant comments, working alongside a RN does not consistently meet the learning needs of all students.

Based on our findings, we recommend that alternative clinical experience models reporting more positive outcomes for student learning be explored and trialled. Ryan et al. (2018) piloted a model where third-year students, once orientated to the facility, assume responsibility for providing care for up to eight residents under the indirect supervision of the RN. Dedicated Education Units (DEUs), that promote a collaborative learning environment where a clinical liaison nurse is employed to support both clinicians and students, have also reported positive outcomes (Dimino et al., 2022; Grealish et al., 2010). Both models encourage students to progress decision-making skills incorporating assessment and planning of residents' care, and should be considered as viable options to the current preceptorship model. The models do however require a greater level of support from both the education and the ARC providers than current practices.

Findings from this research suggest ARC has the potential to be an enriched learning environment for students but there remain many barriers to fully realising learning opportunities (Foster et al., 2022). Some barriers, for example the ability to sign for medications, could be quickly resolved with co-operative dialogue between interested parties. Other barriers are more entrenched and require a more collaborative relationship between nurse education providers and the ARC sectors. The introduction of a new unified nursing curriculum (Te Pūkenga, 2023) offers the opportunity for nurse education providers to work with the ARC sector to produce graduate RNs who are better equipped to meet the needs of an ageing population.

CONCLUSION

The aim of this study was to increase our understanding of third-year student nurses' perceptions and experiences within the ARC sector, and how these factors may impact later career choices. Through evaluating the student experiences in ARC, this report has provided not only a better understanding of the challenges students encounter in ARC but also practices that contribute to a positive learning environment. Despite a number of affirming comments from participants, current third year clinical experiences in ARC continue to fall short of student expectations, reinforcing a discourse that devalues ARC as a career option. Future curricula changes to improve the career aspirations for ARC could, for example, include the implementation of DEUs in the third year, however, more research is required. If nurse education is to be an effective force in advocating for a long-term commitment to improving ARC as a graduate destination, it is imperative we work closely with the sector and consider new models of supervision to improve the third-year student clinical experience.

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COLLABORATIVE LEARNING OPPORTUNITIES IN UNDERGRADUATE NURSING EDUCATION: BRIDGING THE THEORY TO PRACTICE DIVIDE THROUGH COMMUNITY CONNECTIONS

Amy Simons and Jo Speirs

INTRODUCTION

For many nursing ākonga (learners), at the beginning of their journey towards registered nurse, the idea of becoming paediatric nurses and working with children holds great appeal. Informal feedback obtained from nursing ākonga at Otago Polytechnic / Te Pūkenga's School of Nursing, suggests that a large majority of the first-year cohort see themselves as future paediatric nurses. Consequently, the desire for a paediatric clinical placement experience amongst the first-year cohort and throughout the Bachelor of Nursing (BN) degree, is strong. These findings are congruent with national and international research which has highlighted that paediatric nursing is regarded as a desirable career destination for nursing graduates (Hunt et al., 2020, Studnicka & O'Brien, 2016). However, despite this interest in working with children, it is our observation that most nursing ākonga have limited understanding of child development or specific issues around child health and well-being. Many ākonga enter undergraduate study with little personal experience of children. They often have little understanding of what working with children as registered nurses might entail or where this work might occur beyond conventional settings such as paediatric hospital wards or well-child health providers such as Plunket. It is during the first year of the degree, that ākonga begin to explore 'what' nursing is and 'where' nursing occurs; it is the role of nurse educators to help facilitate their developing nursing world view. Using Rolfe et al.'s (2001) self-reflective framework – 'What? So what? And now what?' – this article explores the development of a collaborative clinical learning opportunity for first-year nursing ākonga designed to help bridge the theory-to-practice divide involving child health and the scope of community health nursing while making meaningful connections with the wider community.

WHAT?

In New Zealand, BN graduates enter the Registered Nurse (RN) workforce potentially able to work with clients of any age and in any setting. The Nursing Council of New Zealand (NCNZ) takes the view that following graduation RNs "may practice in a variety of clinical contexts depending on their educational preparation and practice experience" (NCNZ, 2023). Our current Otago Polytechnic School of Nursing curriculum reflects the need for generalist nursing knowledge, referring to nursing and nursing knowledge "across the age / life span" (Otago Polytechnic, 2019). Despite this curriculum statement, a review of current content conducted over the 2021–2022 period, revealed a definite adult focus. We teach that children are not simply 'small adults' and have specific health needs and developmental challenges, however the content we do provide is limited.

Child-focused content during the first year of the BN degree sits predominately within two courses. In one theory course, ākonga are introduced to developmental theories, developmental milestones and age-appropriate

communication considerations. In the first-year clinical course, ākonga are introduced to age-related differences in physiology and to the beginning clinical assessment of infants and children. Prior to the development of the new collaborative clinical learning opportunity, there were limited opportunities for nursing ākonga to consolidate this initial learning about children during clinical placement experiences.

In the current climate of nursing shortages, it is challenging to obtain clinical placement opportunities to meet both the learning needs of BN ākonga and the clinical hours mandated by NCNZ (Te Whatu Ora Te Aka Whai Ora, 2023). The limited opportunities for traditional paediatric clinical placements is now well recognised and experienced nationally and internationally (Studnicka & O'Brien, 2016, Te Whatu Ora Te Aka Whai Ora, 2003). This situation is likely to persist, and increase, as governments strive to address nursing shortages by increasing the numbers of undergraduate nursing ākonga and thus compounding the demand for clinical placements (Verrall, 2023). At present, traditional paediatric placement opportunities are extremely limited for the BN ākonga. Te Whatu Ora Southern's Dunedin Hospital, our main clinical provider, contains a single paediatric ward and can currently only accommodate a paediatric placement opportunity for six first-year nursing students out of their cohort of 120 ākonga.

We identified a clear need for the expansion of the paediatric theoretical content currently being delivered and sought to support this by developing and increasing the clinical placement opportunities involving children. This was seen as an exciting opportunity to explore non-traditional placements involving well children, which would give all first year ākonga the opportunity to bridge their theory-to-practice divide, spend time with children and form connections with the community. Non-traditional settings are utilised in nursing programmes globally to provide clinical placements with the aim of linking theory to practice, broadening clinical experiences, connecting with communities, and easing the pressure on high demand clinical areas such as acute care paediatric wards.

A variety of non-traditional community settings involving children have been successfully used as clinical placements and have been well researched and discussed in the literature. These settings have included public and private schools, early childhood centres, community centres, health promotion days, and Teddy Bear clinics (Campbell & Brown, 2008; Gaylord et al., 2012; Harwood et al., 2009; Studnicka & O'Brien, 2016). Non-traditional placements have consistently offered a rich learning experience, providing links between theory and practice as well as broadening ākonga understanding of the role of nurses in community settings (Broussard, 2011; Lane-Martin, 2019). There is clear benefit in this approach for both the community and learners. Campbell and Brown (2008) evaluated a student-led Healthy Teddy Bear Clinic project for pre-school aged children with the aim of providing health education and a safe setting for children to interact with health care professionals. Ākonga reported growing in confidence in their communication skills and knowledge of child development. Parents of the participating children found it was an effective way to prepare children for future interactions with health care providers. Schultz and Krass (2022) implemented non-traditional clinical placements in American public school settings with nursing ākonga. They concluded that schools provided a learning environment that enhanced ākonga clinical skills, and knowledge about children, which reached beyond the hospital setting and helped prepare ākonga to enter the paediatric nursing workforce.

SO WHAT?

We originally had two main aims for this project. Firstly, to help ākonga bridge the theory-to-practice divide involving child health and development, and secondly, to explore new clinical placement opportunities involving children which could be incorporated into the BN curriculum. The project would allow the integration of developmental theories, the application of communication skills, the recognition of milestones, and health promotion concepts. As the planning phase of the project developed, it became clear that this project would facilitate a number of additional learning objectives: consolidating knowledge and skills new to the first-year cohort including group work, time management, research, communication and professionalism.

We proposed a project to provide first-year BN learners a non-traditional community health placement to complement the existing first-year clinical hours in acute medical and surgical settings. Local schools were approached and their interest in collaborating in the project was explored. Three schools agreed to participate, providing a placement opportunity in which nursing ākonga could interact with children. Combined, these schools educate children aged between 5 to 14 years which provided ample opportunity for ākonga to observe a wide range of child development.

Ākonga were orientated to the project in a session facilitated by the authors. Content in this session included reviewing key concepts regarding developmental stages, common health issues for children, and age-appropriate communication techniques. In small groups of four to five, ākonga were assigned to specific school classrooms and age groups and worked collaboratively to develop a health promotion lesson on a topic chosen by the school. Topics included oral and general hygiene, social determinants of health, and techniques to manage stress. Akonga were required to plan a lesson with consideration of the developmental age and stage of the children in their classroom. An interactive activity using simple and accessible resources which did not rely on technology was a central requirement of each lesson. A few examples of the interactive activities included reading age-appropriate stories, demonstrating oral hygiene practices, quizzes, cutting and colouring pages, and active movement games. A detailed outline of their lesson plan, supported by evidence-based resources, was reviewed by the authors and provided to classroom teachers prior to each session. Schools scheduled 30 to 40 minutes of classroom time for each health promotion lesson.

A guided debrief session was held at the School of Nursing, following the school visits. In this session, ākonga were asked to discuss what went well, what was challenging, and what they learnt from the experience. A staged approach was taken to the debrief sessions – starting with the group working with new entrants, progressing in class age and finishing the year 10s this encouraged ākonga to keep child development in mind. Informal feedback in the debrief sessions highlighted key learning which included the expected linking of developmental theory to practice. Ākonga discussed being able to see a wider community nursing role with a wellness lens. Professionalism in nursing was discussed by students, this included the importance of having adequate evidence-based nursing knowledge when communicating health messages and the importance of being well-prepared. Ākonga were aware that they were being regarded as role models by the school children during the school visits. Comments were made about not wanting to "let the children down", and this experience seemed to have motivated ākonga to work more collaboratively and to produce a high-quality and meaningful lesson. In addition to the expected linking of theories of child development to practice, ākonga reflected more widely and discussed theories such as social determinants of health and health promotion which they observed in diverse classrooms.

Teachers in the three schools reported their students enjoyed the teaching sessions and commented on the importance of children being exposed to health professionals particularly in the early high school age group as they start to consider future career paths. Overall, teachers found the lessons and activities well pitched to class age and developmental stage, however there were some comments that suggested the nursing ākonga underestimated the pre-existing knowledge of the children. The schools also commented that although this health content is provided by classroom teachers, having it reinforced by nurses gave it greater weight with the children.

NOW WHAT?

Feedback from ākonga and schools has indicated that this project is both needed and beneficial for all involved. The schools who participated in the 2022 pilot project have invited us to continue with the project and the school health promotion visits in 2023. The school children also seemed to enjoy the opportunity to meet and learn from future nurses; many expressed this sentiment in 'thank you' cards. The 2022 cohort of nursing ākonga found that the experience provided the opportunity to develop skills and confidence in working with

children and enthusiastically recommended the project continue in future years. In view of the positive response from schools and ākonga, the project has been formally incorporated into the first-year clinical course and it now contributes six hours to the clinical hours required by the School of Nursing / Te Kura Tapuhi and NCNZ. A written assessment component has been added to the project and ākonga are now required to submit a formalised lesson plan and to write a reflection on their learning.

We plan to seek ethics approval from Otago Polytechnic to evaluate this clinical project formally, seeking further feedback from ākonga and school stakeholders. Local public health nurses have also expressed interest in collaborating with the School of Nursing / Te Kura Tapuhi in this project, another collaborative opportunity which will be explored in the future. The authors anticipate that the project could be extended in the future, to provide nursing ākonga the opportunity to connect with different age groups such as pre-school children.

CONCLUDING THOUGHTS

Nursing ākonga and local schools enthusiastically engaged in the collaborative health education project. The opportunity to develop and deliver health education sessions challenged ākonga to utilise their new theoretical learning in a practical and public-facing experience. They explored their developing professional nursing identities, becoming aware that the wider community sees them as role models and health educators. The developing connection between the School of Nursing / Te Kura Tapuhi and local schools provides collaborative learning opportunities that benefit both ākonga and the wider community.

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CONNECTING – FELLOWS TAKE ACTION: AN INTERNATIONAL RURAL COLLABORATION

Jean Ross, Kate Emond, Daniela Händler-Schuster and Kim English

INTRODUCTION

In December 2022, an international connection embedded in community fellowship was established, uniting four international academic nurses. We formed this fellowship while actively participating in a virtual platform in which to shape a vision synonymous with rural community nursing, community development, research, and education. Geography posed no barrier to this collaboration allowing for greater exploration of potential solutions to challenges inherent to rural community health (Whitehead et al., 2022). Conversations revealed more similarities than differences when exploring rural health and rural nursing issues. In this paper, we share our collective vision which was established from our initial collaborative brainstorming session. To achieve this, we provide context to our individual connections, introduce you to each of the community fellows with their individual focus and contributions, and present our collective vision including a five-year action plan of collaborative initiatives related to research, education, community development and collaboration. We advocate for a unified approach, promising a significant impact.

BACKGROUND: A VISION IS BORN

The four authors, each initially based in their respective countries, came together due to their shared commitment to enhancing rural community health and their engagement in undergraduate and postgraduate nursing education. While their connections stemmed from diverse circumstances, their common concern for rural population health equity and social justice bound them together. The rural population accounts for almost half the total global population (United Nations Statistics Division, 2017). This global focus further connects our fellowship. We recognise our rural communities are confronted with numerous barriers and reduced access to healthcare, impacting on their health and well-being (Whitehead et al., 2022) including an increase in health disparities and inequities (Whitehead et al., 2023). We also recognise there is limited agreement and understanding of conceptualising and defining the global 'rural' (Whitehead et al., 2022) related to community socio-cultural, demography, and unique rural encounters affecting vulnerable, minority and Indigenous populations, situated in geographical rural landscapes. So, the question remains, why create a global fellowship?

This background motivated our initial connection in December 2022 when we met face-to-face and virtually. We had all worked within the virtual medium for many years in our academic capacities prior to the COVID-19 pandemic. As COVID-19 emerged and brought about restrictions affecting populations, we had to adjust our modes of communication. We became adept at virtual engagement, both within our respective countries and on a broader international scale. Virtual conference presentations, email, Google Scholar, and social media collectively facilitated our initial connections. For example, the first author previously engaged with the second and fourth authors which internationally connected us, including Kate Emond (La Trobe Rural Health

School, Victoria, Melbourne, Australia), and Daniela Händler-Schuster (Zurich University, Applied Sciences in Switzerland via the School of Nursing, Midwifery and Health Practice at Te Herenga Waka-Victoria University of Wellington whilst on her sabbatical), to create a group focused on advancing work related to rural health and community development. The third author spontaneously decided to travel to Dunedin to explore collaboration with the first author related to rural community services. A virtual meeting was arranged with the second and the fourth authors. From this meeting, we initiated a Community International Fellowship (refer to Figure 1).
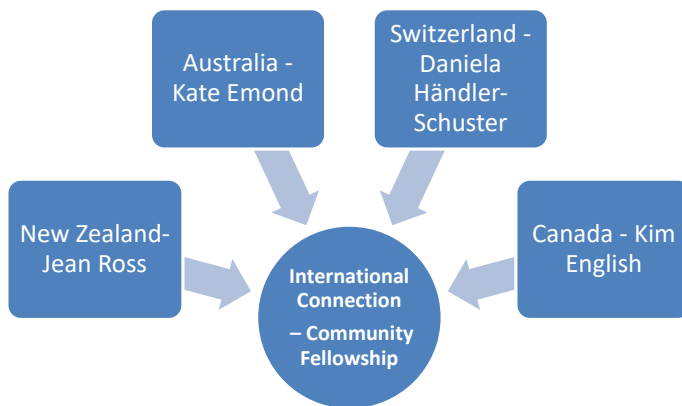

Figure 1. International Connection – Community Fellowship Founders 2022 (Source: Authors).

Figures 2 to 5. The authors.

The key factors that united this fellowship were the shared interests in establishing an international cohort capable of exchanging information and addressing questions relating to rural community health, rural community nursing, research, education, and community development. The fellows wished to actively engage in these areas of interest and enhance their development through international collaborations in the form of collaborative projects and research.

The focus of these endeavors is to improve the field of rural community health care. In this context, our interests aim to strengthen the focus of community nursing and to work with other nursing and rural organizations related to our individual countries, as well as on the international level, to work towards inclusivity, understanding diversity, and equity in healthcare. And thus, our conversations began with a vision to establish collaborative relationships that would pave the way for potential collective efforts related to community nursing practice with a rural focus.

VISION

As a collective, we considered the common threads binding us and potential gaps within the international landscape where our collective efforts could have a meaningful impact. Two of the four members are connected to the Global Rural Nurse Exchange Network (GRNEN), one is a co-founder and member of the leadership team and the other is a member of GRNEN's Ambassador programme. Our intention was to enhance the work of GRNEN, not detract from it. In Figure 6 below, you can see how we brainstormed our collaborative project work for the following 2022-2028 period, a seven-year vision supported with a draft plan of action.
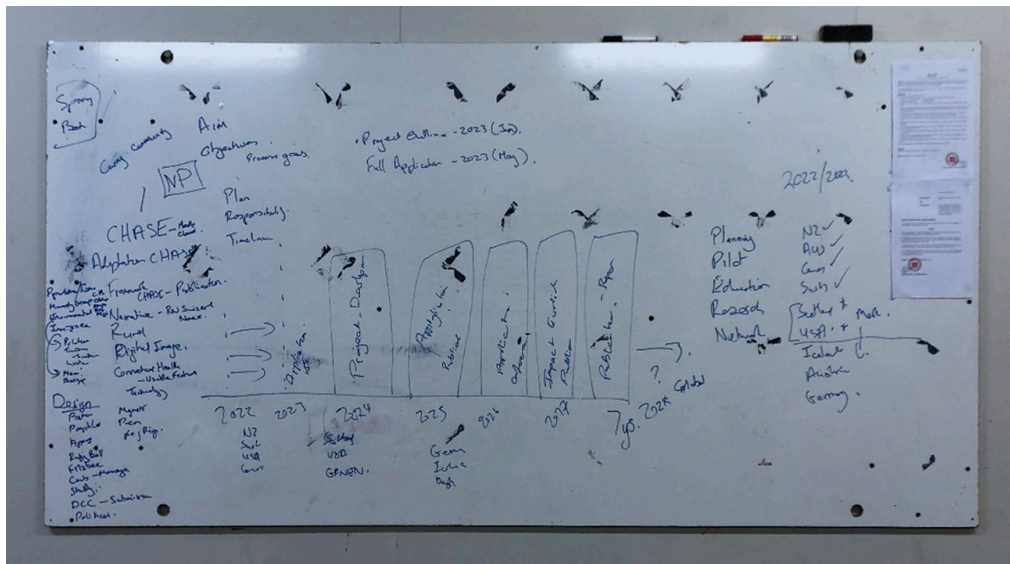

Figure 6. Brainstorming Plan 2022-2028 (Source: Authors).

Our concentrated efforts relate specifically to rural communities and community development, which will benefit rural nurses and student nurse learners, as we progress in our work.

INTERNATIONAL CONNECTION: COMMUNITY FELLOWSHIP

In the early part of 2023, the fellows met face-to-face at La Trobe Rural Health School, Victoria, Australia. The aim was to continue developing our collaborative work and provide our first public presentation. A virtual meeting was arranged to present this presentation. The inaugural presentation took place on Wednesday, 3 May 2023, focusing on our collaboration and the focus of our vision. We received a great deal of positive feedback from this presentation creating some potential future collaborations and applications for research funding. Additionally, each member of this fellowship is exploring funding options within their respective organisations.

Figure 7. Authors meeting at La Trobe (Source: Authors).

During this time, we built our collective capabilities further by transitioning our efforts into a structured strategic plan. This involved exploring the commonalities and, notably, the distinctions among the paradigms of rural nursing and community nursing across New Zealand, Canada, Australia, and Switzerland.

In each case, the unifying element was the improvement of rural healthcare and reduction of health disparities. During discussions about country differences, members of the group were drawn to the Community Health Assessment Sustainable Education (CHASE) model. This choice emerged due to its consolidation of features found in community-oriented models and its track record of successful implementation in education settings. The CHASE model has been mentioned and referred to several times as a means of international engagement by the fellows (Ross et al., 2023). The CHASE model was developed by Ross, Crawley, and Mahoney in 2017 (Ross et al., 2017) and since then has had many iterations and adaptations for different circumstances, and community needs internationally. The CHASE model is a living model that is evaluated and adapted pending individual countries and circumstances.

INTERNATIONAL PERSPECTIVES:

We advocate that the CHASE model (Ross et al., 2017) can identify and improve the health of diverse rural populations and communities which we refer to later in this paper. Undoubtedly, the social determinants of health, such as access to healthcare services, play a pivotal role in shaping health outcomes, particularly for community members involved in creative initiatives aimed at community development. Among these participants are nurse learners, whose innovative efforts are proving to be advantageous for rural communities. During the discussion regarding the implementation of the CHASE model, various viewpoints have been considered. The cross-border conversation highlighted the significance of maintaining ongoing dialogue to learn and share insights mutually. Furthermore, it became evident that when discussing rural healthcare, it is essential initially to identify existing needs. Through our exchange, we can discover opportunities for enhanced collaboration. To illustrate this, different global perspectives are presented.

NEW ZEALAND PERSPECTIVE

In 2022, the second author (Australia) commenced an international collaboration with the first author (New Zealand) as they engaged with the CHASE model, to enhance nursing students' local and global knowledge of rural communities, rural culture, and rural health issues. This collaborative work involved undergraduate Bachelor of Nursing students from both countries' organisations with a rural community development project

underpinned with the CHASE model. The CHASE model assisted the students to identify and assess the health needs of the identified community with the aim to improve healthcare with a public health approach, and to deliver appropriate mediums of health promotion messages and resources to support improvement of health and reduce health disparities. This initiative was aided by the successful application to GRNEN Nurse Learning Grant 2021/2022 to develop an international collaboration between two educational organisations and advance student nurses' scholarship through project work (Ross et al., 2023). This work was facilitated with the development of an interactive film of the rural community of Bishop's Castle, Shropshire, England referred to as the collaborating rural community. The aim was to bring student nurse learners from Australia and New Zealand to connect with each other and share in different ways and at different points of time, through the programme while also drawing on the CHASE model. Equally, we are keen to explore the possibilities of linking additional rural communities' attributes through film while aspiring to grow a regional, national, and global network of films that extends student nurses' learning and their engagement with the CHASE model, so we may enhance this way of underpinning rural community locally and globally. We envisage this approach could promote international collaboration, and unique learning opportunities, and enable students to have global connections and foster relationships with other students' understanding of rural communities, as they profile and assess community's health, and identify their health needs. We intend to showcase the CHASE model in action. Likewise, we wish to support the production of additional films and, in doing this with all nursing students, we aim to encourage the students to share their knowledge from their own countries in relation to rural community development and public health (Ross et al., 2023).

Additionally, a connection between the first and fourth authors commenced when they both presented at a virtual international American Nurse History conference in 2021. They both presented a rural historical perspective on nursing and began a collegial relationship from this connection. This led to further discussions related to their interests, associated with rural community health and rural community nursing, to aim for the improvement of healthcare for rural people using the CHASE model and the documentation of digital images and storytelling from rural nurses and rural student nurses.

Continued connections between these authors led to an offer by the first author for the fourth author to spend time in New Zealand learning more about the application of the CHASE model and how it might be utilised. In the final stages of the fourth author's doctoral degree, with a focus on ways to develop and support rural and remote nurses, and on a sabbatical, the timing was perfect to continue this collaboration in person. The intent of this time together was to learn more about rural nursing in New Zealand and the use of the CHASE model with the intent to take this learning back to Canada and the Trent/Fleming School of Nursing which is currently engaged in a curriculum revision.

CANADIAN PERSPECTIVE

Globally, there is a critical shortage of nurses which is having negative effects on access to care in rural and remote areas including Canada. This combined with a lack of will to explore different ways to address the practice of rural nurses in Canada, including recognition as specialists, only serves to exacerbate these shortages. This is particularly the case in community contexts. What has not happened, which could make a significant difference in rural and remote areas, is an expansion or move for Registered Nurses (RN) to work to full or a redefined scope of practice. For example, in remote fly-in communities where there are no physicians present, RNs practise very differently, yet still within the same regulations, as RNs in the same province who are not so geographically isolated. The question then is how to leverage the knowledge and expertise of these providers to assess gaps in care and address needs in rural areas. This consideration would build upon further use of the CHASE model to socialise nurses who are skilled in community assessment, development, intervention, and evaluation. In Canada, the Nurse Practitioner (NP) role is well-established to improve rural healthcare and reduce health disparities, however, there are still significant gaps in care in rural and remote areas.

SWISS/GERMAN PERSPECTIVES

In Switzerland and Germany, author three believes strongly in the importance of looking beyond one's own national borders and ensuring that professionals are well-prepared to address current and future challenges. A challenge for health professionals and planners of healthcare alike is to be prepared, for example with the ever-increasing growth of the aging population in society. This challenge requires preparation for the delivery of healthcare, especially in the community. It is essential nurses are prepared to collaborate with other professionals and health services and acquire skills to deal with many challenges. In Switzerland, the role of the NP in community-based care is still very new.

To this end, the third author would like to develop a joint research project understanding urban Switzerland as this will strengthen teaching with a special focus on the inter-professional orientation in various educational programs. They are particularly interested on the development and inclusion of caring communities associated with concern for "a good life for all", which is reflected in the way people in communities interact with each other. Caring communities in Switzerland already exist or are emerging in neighborhoods, housing estates and village care systems. These caring communities play a strong role in the care for seniors and, by the pure essence of their existence, they relieve traditional health care systems. Caring communities follow the vision that life's challenges can be better managed collectively aligned with mutual care which creates a network of relationships, connectedness and further extends the concept of community. Caring communities require the involvement of families, neighbourhoods, professional service providers, volunteers, and state institutions. The CHASE model provides an internationally recognised framework for linking community work and the further development of professional nursing practice.

AUSTRALIAN PERSPECTIVE

In Australia, the second author is a nursing academic for the largest Rural Health School in Australia aiming to build a team of national and international experts in rural health research, and learning and teaching, who are committed to maximising health and wellbeing outcomes for rural people globally, nationally, and locally. Engaging rural communities enhances local and global knowledge but of equal importance, the collaboration that occurs across stakeholders and education providers offers learnings, and resources that would not otherwise be available to students. Investing in nursing education with a focus on rural health and rural communities provides students with the opportunity to genuinely understand the health disparities that occur between metropolitan, regional, and rural areas. Engaging with rural communities is a key characteristic of building a sustainable health workforce, therefore incorporating this into undergraduate nursing curricula at a university rural health school is vital. The second author has included as part of learner's education the CHASE model with significant success (Ross et al., 2023). Australia's perspective links very closely with New Zealand's as they have worked collaboratively together as described previously.

COLLECTIVE COLLABORATION

Collective collaborations have now been established with Australia and New Zealand, New Zealand and Switzerland, and between all four countries including Canada. Reflecting on time spent by Kim English in both New Zealand and Australia, it is noted there are many similarities to Canada, our healthcare system, and the preparation of nurses. More importantly, there are differences from which Canada can learn; specifically, the work at Te Pūkenga, Otago Polytechnic Ltd related to embedding the Māori Strategic Framework (2020). A crucial example to be drawn from Canada, as highlighted by the fourth author, is the ongoing challenge of incorporating Indigenous ways of knowing and being into healthcare nursing curricula and everyday practice. Additionally, the work undertaken by the nursing faculty at Te Pūkenga, Otago Polytechnic Ltd demonstrates innovative thinking,

action, and commitment recognising the need to educate nurses to work beyond hospital settings. The attention to rural community development is an inspiration for those looking to change curricula and is reflective of the need to shift focus to primary care and community development. It is clear from year one of the programme, nursing students are learning beyond the four walls of the hospital and more importantly, using community development tools to support rural communities. This work is key to assisting rural communities to grow and thrive, and for students to see the important role of nurses in doing this work. It is apparent in reading the rural nurse stories and then meeting many of those who contributed stories, there is a dire need to highlight the value, leadership, and innovation of rural nurses. The first author and their team have undertaken exceptional efforts to initiate this process, and their approach should serve as a model for replication globally.

As the work of the fellowship grows, so too will the number of members and expected outcomes of the work. The following section outlines the work to date of the fellowship and its plans as we move into the future for this collective.

COLLABORATION PLANNING

We have formulated a comprehensive seven-year strategic plan which includes the planning phase at the end of 2022/2023. To this end, this blueprint encompasses sequential phases. Subsequently, our focus will shift towards securing necessary funding, forming connections, and consolidating our initial collaborators in New Zealand, Australia, Switzerland and Canada. As part of our envisioned trajectory, the forthcoming year, 2023/2024, will focus on the expansion of our work. This will include consolidation of our accomplishments including: the application of the CHASE model and its implications for undergraduate and postgraduate education, rural communities and community stakeholders; the presentation of our findings at scholarly conferences; the preparation and dissemination of a publication related to our consolidated work; and extending our collaborative efforts into America, Wales, Scotland, Germany and Austria (Figure 8). This strategic diversification is envisioned to illustrate our global thematic focus in alignment with our overarching objectives.

Planning work during 2023 will extend our focus into the 2024–2027 period when the project work will focus on the following four main areas of collective responsibilities and networking internationally:

1. Research collaborations:
   - develop international rural community research projects.
   - enhance ongoing impact and evaluation projects.
   - work on international rural definition using the framework Geographic Classification for Health (Whitehead et al., 2022)
   - seek additional funding opportunities.

2. Teaching and learning collaborations:
   - enhance the provision of teaching and learning for undergraduate and postgraduate education programmes.
   - encourage and promote master's and doctoral programmes.

3. Community collaborations:
   - work alongside and with communities with the intention to identify health needs and work collaboratively with stakeholders from those communities to improve healthcare by analysing data, designing health promotion messages and resources engaging with the CHASE model.

4. Knowledge sharing collaborations:

- joint conference presentations – plan for International Council of Nurses 2025, Helsinki
- joint written publications, for example, Online Journal of Rural Nursing and Health Care – basis of all publications define and add to the rural international debate, for example with international colleagues at conferences, through webinars and workshops.

These projects in 2024 will be showcased at international conferences and journal publications with the aim to broaden the work into 2025/26 with interested colleagues (refer to Figure 8) globally.
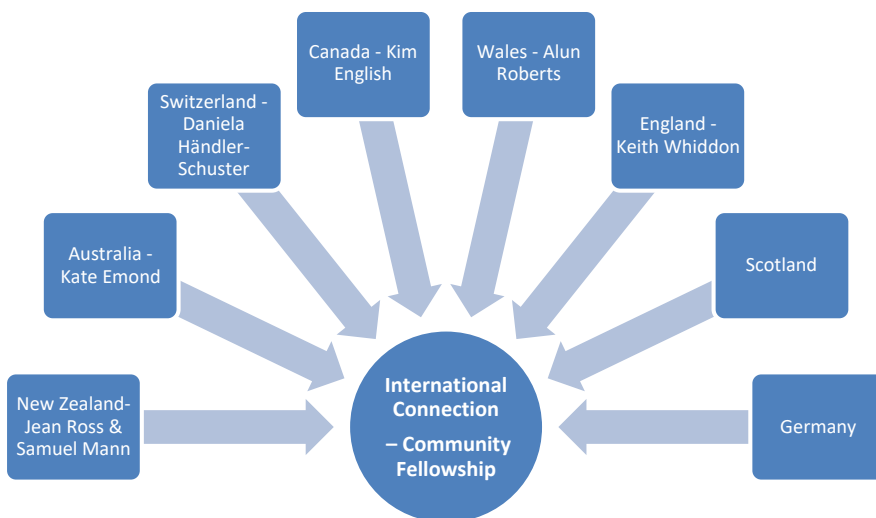
Figure 8. International Connection – Constructing Capacity 2023/24 (Source: Authors).

As we look towards 2027, we envisage this will be a year for consolidation. We intend to reflect on the work achieved, the outputs, and the improvements to the models we have adapted, advanced, and developed for use by our respective community rural colleagues. We wish to broaden our relationships with NPs who are integral members of these rural and isolated communities. Canada and Australia hold a wealth of experience, with New Zealand to a lesser extent, while Switzerland's experience has been limited. We hope to grow the NP clinical component as a collective within our fellowship (refer to Figure 9). Equally, we prioritise community health through a health promotion and public health perspective, with the goal of enhancing health and well-being. To achieve this, we strive to strengthen our efforts by applying the CHASE model while making the necessary adaptations to align with our country's specific needs.
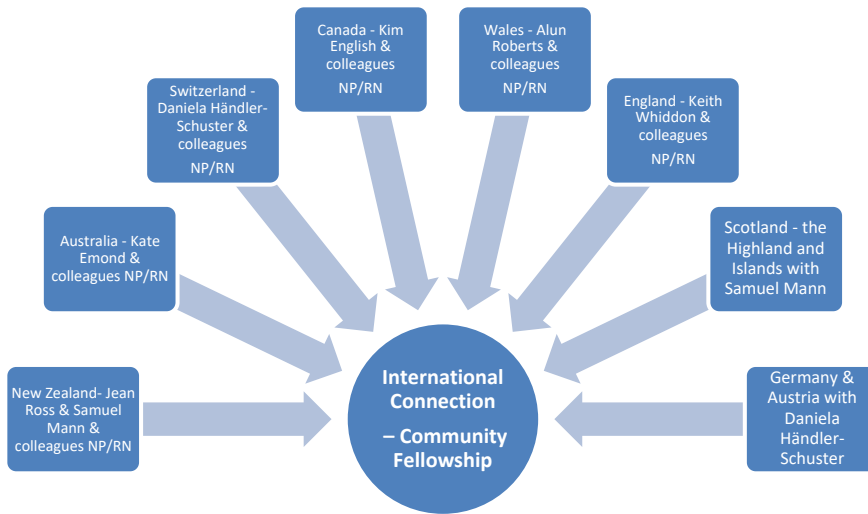
Canada - Kim English & colleagues NP/RN

Wales - Alun Roberts & colleagues NP/RN

Switzerland - Daniela Händler-Schuster & colleagues NP/RN

England - Keith Whiddon & colleagues NP/RN

Australia - Kate Emond & colleagues NP/RN

Scotland - the Highland and Islands with Samuel Mann

International Connection – Community Fellowship

New Zealand- Jean Ross & Samuel Mann & colleagues NP/RN

Germany & Austria with Daniela Händler-Schuster

Figure 9. International Connection – Fostering Capacity 2025 onwards (Source: Authors).

CONCLUSION

Our international rural collaboration has undertaken a proactive initiative. International exchanges, which are virtually based, are opening new possibilities for collaborating. However, it is imperative for all fellows to develop an acute awareness of the nuances inherent to each country. The significance of rural healthcare varies from country to country, and the specific conditions for conducting comprehensive nursing practice have produced dynamic discussions. Therefore, these discussions will persist as an integral part of our collaborative endeavours. With the understanding that the CHASE model provides a basis for critically reflecting on community-based care and improving the quality of care in the community, the work of Ross et al. (2017) provides important guidance for the future direction of our collaborative work. By connecting Australia, Canada, Switzerland, and New Zealand, we have taken a significant initial stride towards broadening our perspectives to include other countries in the subsequent stages. This work aligns with our aims and objectives with GRNEN likewise and the fellowship continues to welcome international members. It is through international expansion that collective efforts to address the healthcare needs of rural populations can have the greatest impact.

ACKNOWLEDGMENTS

CONFLICT OF INTEREST

The authors declare there are no conflict of interests.

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EXPOSED

Annabelle Forrest

EXPOSED

Look at yourself and where you are
a life locked up with no contrast.
You have not gone far
engulfed in your past.

You are now in your future
it looks just like your past.
You are swapping back and forth,
you are where you were last.

Your past is dark and shameful
hidden and abused.
In your past you are a killer.
Your past, you think will kill you.

A future you want
a future so bright.
Your future is dark,
the idea of your future is not right.

So sit behind
and look at you now,
what do you want to say
to you right now.

I will forgive myself, sitting in the past,
I will not forget myself, sitting in the past.
I will embrace my now
because you are me
and I am you;
sitting here,
staring at the other eagles there.

Here in the now
we are all learning to fly,
and this fight for flight into our future is bright.

Only you will know
on the path to tika*,
how you will go
and that was Aratika*.

*Tika : correctness, righteousness or straightness
*Ara: a way, course, pathway
*Aratika: translated as finding your right path

I was honoured to experience a program called Aratika*. Aratika led clients who had experienced a traumatic past on a 3-day therapeutic journey, uncovering real truths and pain while seeking a positive future path for life. I heard each individual analyse their criminal past, present and vulnerable future. I remember each person and empathise with their struggle to move beyond the weight of the past. Their stories became too big to keep inside my head, leading to this poem of hope; *Exposed*.

Annabelle Forrest is a nursing student and Te Runanga Tauira Representative at Te Kura Matatini ki Otago. Her whakapapa is Ngāpuhi but her tūrangawaewae is Cambridge. She is passionate about nursing and promoting one's health in their own space.

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CALL FOR PAPERS 2024

Scope Contemporary Research Topics (Health & Wellbeing) 9 theme relates to 'Health (In)equities'. Submissions will provide the opportunity for authors to consider, discuss and debate (in)equalities in relation to global health, social, environmental and economic concerns.

Health inequities are differences in the health status of population groups that are systematic, unfair and avoidable. These are caused by the conditions in which we are born, live, work and grow, influencing opportunities for optimum health and well-being. The COVID-19 pandemic drew attention to the deep disparities that persist between and within countries, some of which are being exacerbated and risk widening even further. Furthermore, due to factors such as persecution, human rights violation, conflict, violence, and the effects of climate change, today there are some 1 billion migrants globally, about 1 in 8 of the global population. These include 281 million international migrants and 82.4 million forcibly displaced (WHO, 2023).

Global health inequities are not inevitable, and the gaps are not fixed, but a comprehensive, multifaceted approach is required to address the multiple and overlapping web of factors that drive differences in experiences and quality of healthcare, through to the wider determinants of health. To tackle inequalities, *Scope (Health & Wellbeing)* 9 offers the opportunity for authors to contribute to this issue considering collective responsibility in recognising the role we can all play in advocacy and positive change towards improving and reducing the gap between inequity and equitable health outcomes.

The *Scope Contemporary Research Topics (Health & Wellbeing)* 9 issue will also include a set of published online articles. As the first online video edition, our aim is to initiate a novel journal edition that utilises an online video format complementing the traditional printed text. The online articles will predominantly be original video material, including interviews and videos on the theme, health (in)equities. These video articles will be of a high standard and subject to a rigorous peer review process. For further information and guidance for video submissions, please contact Richard Humphrey, Richard.Humphrey@op.ac.nz.

REFERENCE

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GUIDELINES FOR CONTRIBUTORS

Submissions for *Scope (Health & Wellbeing)* should be sent by 30 June for review and potential inclusion in the annual issue to: Jean Ross (Chief Editor: Jean.Ross@op.ac.nz).

Please consult the information for contributors below and hardcopy or online versions for examples.

All submissions will be peer reviewed. Peer review comments will be sent to all submitters in due course, with details concerning the possible reworking of documents where relevant. All submissions must include disclosure of whether and how AI was used in writing the work. All final decisions concerning publication of submissions will reside with the Editors. Opinions published are those of the authors and not necessarily subscribed to by the Editors or Otago Polytechnic.

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Mātauranga Māori is a significant component of Aotearoa/New Zealand's heritage, and sharing mātauranga Māori facilitates inter-cultural dialogue and understanding that is in the national interest. However, we recognise that the originating Māori community and/or individual has the primary interest as kaitiaki over the mätauranga and we are therefore committed to ensuring that the sharing, promotion and innovation based on mätauranga Māori respects and enhances its cultural and spiritual integrity, as well as that of the originating community and/or individual.

Submission formats include: original research, reflections, poems, book reviews, interviews and work in progress. Other formats will also be considered.

High standards of writing, proofreading and adherence to consistency through the APA referencing style are expected. For more information, please refer to the APA Publication Manual, 7th edition; and consult prior issues for examples. A short biography of no more than 50 words; as well as title; details concerning institutional position and affiliation (where relevant); contact information (postal, email and telephone number) and ORCID number should be provided on a cover sheet, with all such information withheld from the body of the submission. Low resolution images with full captions should be inserted into texts to indicate where they would be preferred, while high resolution images should be sent separately.

 Enquiries about future submissions can be directed to: Jean.Ross@op.ac.nz

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