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Who's Health Matters? An Autoethnographic Study of Aotearoa New Zealand's Covid-19 Vaccine Mandates

A thesis presented in partial fulfilment of the requirements for the
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Abstract

This thesis explores the human experience of pandemic governance through the lens of critical health psychology and autoethnography. Focusing on Aotearoa New Zealand's Covid-19 response, it examines how health, risk, and responsibility were socially constructed and how vaccine mandates reframed questions of autonomy, vulnerability, and belonging.

Methodologically, the thesis adopts an autoethnographic approach, combining personal narrative with critical analysis to situate lived experience within wider cultural and political contexts. Part I outlines the theoretical framework, drawing on critical health psychology to interrogate how health is socially constructed, whose health is prioritised, and how power operates through public health measures. It also addresses ethical considerations and reflexivity in undertaking research that is both deeply personal and socially contested.

Part II presents and autoethnographic account of navigating Aotearoa's Covid-19 mandates, told through narrative, poetry, and visual art. Each chapter begins with an original poem that sets the thematic tone, framed within seasonal metaphors to symbolise both the passage of time and the cyclical nature of crisis and renewal. This creative dimension is extended in a textile-based visual representation: ten canvases adorned with crochet appliqués, linked by a crocheted ribbon as a symbolic road. The installation concludes with a butterfly – representing transformation and release. Together, these creative elements highlight the interpretive and meaning-making dimensions of autoethnography, demonstrating how lived experience can be communicated through both text and art.

The thesis contributes to scholarship by demonstrating how vaccine mandates functioned not only as public health interventions but also as technologies of power, producing new boundaries of inclusion and exclusion. It highlights the tensions between individual autonomy and collective wellbeing and underscores the need for public health approaches that acknowledge structural inequities, honour tino rangatiratanga, and support those adversely affected by mandates. In doing so, it shows how critical health psychology and autoethnography together can illuminate the lived complexities of health governance during crisis – and how creative inquiry can act as a pathway toward understanding, resilience, and healing.

Dedication

To János – my Apuci – who gifted me the love for storytelling,

and Tünde – my Anyuci – for always believing in me.

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Glossary

Anyuci	Hungarian word for “mummy”.
Apuci	Hungarian word for “daddy”.
Magyar	Hungarian word for “Hungarian”.
Magyarország	Hungarian word for “Hungary”. Magyar meaning “Hungarian” and ország meaning “country”.
Waka	Māori word for “canoe” or “vehicle”.

Situating Myself [Preface]

The story which follows is one that I have told countless times. It is the tale of where I have come from and how I came to live in Aotearoa New Zealand (Aotearoa). My intention in sharing it here is to situate myself; to acknowledge and explain both the context surrounding my experiences throughout the Covid-19 pandemic and the lenses through which I found meaning at the time (and subsequently since).

Seeking safety, freedom, autonomy, and self-determination

> Forty years ago, my parents secretly sold our apartment, holiday home, and my mother's Volkswagen Beetle; carefully stashed prized possessions with trusted friends; gave away anything we didn't need; and packed up everything we needed to "live" in my father's car.
>
> It was summer holidays, and we were going camping in Austria! My first time out of Hungary. I was so excited.
>
> But the border crossing was terrifying.
> So many men carrying rifles.
> Approaching cars.
>
> Cars being pulled over and contents being thrown across the ground.
>
> I sensed something uncomfortable that I didn't understand. My mother turned around and sternly told us to keep quiet and not speak until they tell us it’s okay to.
>
> Some men with rifles came over to our car too. Peering inside. Using their rifles to lift blankets and poke around our belongings. Words were exchanged. I do not recall what.
>
> They waived us through.
>
> We went camping in Austria. It was magical. I formed a friendship with a girl I could only communicate with through hand gestures, nodding, and shaking my head.
>
> Our holiday ended. But we didn't return to Budapest.
>
> We "got lost" and found ourselves in Italy.
>
> For four months we travelled around this magical country. We sheltered in a convent, motels, and the quirkiest terraced house in a seaside village in the heart of a Mafia community.

I remember being told that we were never going back home. That I will never see my grandparents or friends or beloved dance teacher again. The finality of this I didn't understand at the time.

I was only seven years old, but I have so many fond memories of our time in Italy. And I'm not just talking about the cities and landmarks; it was the time we spent together as a family. I learned to play poker and in the heat of the summer we would play cards late into the night; sleep a few hours; head out for pizza (dough with just a smearing of tomato sauce on top) fresh out of the oven, whose aromas filled the streets; and spent our days sight-seeing or playing on the beach before heading inside for siesta.

It was as if time stood still. And my parents were fully present, day in, day out. Bliss.

We had family living in America, Canada, and New Zealand. My parents chose New Zealand as the safest country for our family to live in. But at the eleventh hour, immigration declined our visa. Then just as we had resigned ourselves to staying in Italy, we got the call to say immigration accepted us as political refugees after all.

Forty years ago today, my family arrived in Aotearoa New Zealand. I am grateful to have been able to call this beautiful country home. Yet I haven't always been welcomed. As a child, I was different and othered. I was made to change the pronunciation of my name to make it easier for Kiwis. And I became embarrassed of all my qualities that made me different.

Image 1: Austria (1983), photographer unknown, from author's family archive

Our car bursting at the seams... camping gear hiding all kinds of treasures one would never take camping... like electrical appliances and a box of Lego.

Image 2: Italy (1983) photographer unknown, from author's family archive

My Apuci and Anyuci... both MUCH younger than I am today.

Image 3: Venice, Italy (1983) photographer unknown, from author's family archive

The two things I remember most about Venice: the pigeons and the cats!!

Image 4: Airplane (1983) photographer unknown, from author's family archive

Our waka[1]: Singapore Airlines

Image 5: Aotearoa (1983) photographer unknown, from author's family archive

Land of the Long White Cloud

> For the majority of my life, my nationality has been New Zealander. But I will always be a Hungarian at heart; and my soul is drawn back to Italy. This year I was officially given back my Hungarian nationality.
>
> (12 December 2023, Social Media Post)

I was born in Budapest and escaped along with my parents and brother at a time when Magyarország[2] was still an Iron Curtain[3] country. We went camping in Austria and "got lost" on our way home. We then spent four months traveling around Italy before coming to Aotearoa as political refugees.

With family ready to help us in the United States, Canada, and Aotearoa, my parents decided that the Land of the Long White Cloud would provide the safety, freedom, autonomy, and self-determination which our Motherland, under Russian (Communist) rule, denied us. It was not until I became an adult that I came to fully appreciate the enormity of

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[1] Waka is the Māori word for "canoe" or "vehicle".

[2] Magyarország is the Hungarian word for "Hungary". Magyar meaning "Hungarian" and ország meaning "country".

[3] "The Iron Curtain was the political and physical boundary that divided Europe from the end of World War II in 1945 until the end of the Cold War in 1991." (https://en.wikipedia.org/wiki/Iron_Curtain) Hungary was the first country to remove its border fence (with Austria) during the end of communism in Hungary in 1989.

what we did. I always knew that my parents would have ended up in jail had we been caught – but the weight of that did not fully hit me until much later in life. A smile crosses my face as I notice how my perspective – as well as my meaning making – has changed with the passage of time, the evolution of place (in not only the physical, but also political and historical context), and lived experiences since.

We landed at Auckland airport on 12 December 1983, and our citizenship was granted on 11 July 1988; one year before Magyarország broke free from Communist rule.

Image 6: Citizenship ceremony (15 July 1988) photographer unknown, from author's family archive

Feeling othered and finding refuge among the marginalised

I grew up in West Auckland, in middle-class, predominantly white, suburbia. Aotearoa in the mid-to-late 1980s lacked the cultural diversity of today. All the staff at my primary school were of European descent. Similarly, the majority of the children were European with only a handful in a class of over thirty students being of Māori, Pasifika, or Indian heredity. I have no recollection of anyone from any other Asian culture (for example, Chinese, Korean, Taiwanese, or Vietnamese) in those early school years; and my perception of these demographics is confirmed by class photos.

> It is 1984, the start of the school year, and our new lives.
>
> My mother – a seamstress – has been employed by a clothing factory. She spends her days sitting at an industrial sewing machine;

making garments for which she is paid a fraction of what she was earning in Hungary; with next to no interaction with co-workers. It isn't until she starts working from home that she learns the English language through watching (American) daytime television.

My father – an engineer – has gone to work for his cousins in their plastics factory. He spends his days learning about injection moulds and the machinery he will be operating and maintaining for the remainder of his working life. He is fortunate, not only are his relatives fluent in Hungarian, but they employ other Hungarian migrants with whom my father is able to communicate with in his native tongue. The remainder of the factory staff are predominantly Chinese, who also barely speak a word of English. My father learns to interact with his colleagues through hand gestures and pidgin English; and they bond over the sharing of traditional foods from their respective cultures.

My brother – six years my senior – is enrolled in high school. But first, he must attend English classes taught elsewhere; through an intensive course delivered over several weeks to a group of migrants of varying ages.

As for me – at not yet eight years of age – I am enrolled in the local primary school. There are no ESOL[4] tools or resources available so my teacher creates her own, drawing pictures of common objects on cards for me to pair up with English words. Whilst my parents use dictionaries to translate English to Hungarian (and vice versa) I quite literally learn this foreign language like any newborn learning to communicate.

The First Day

My aunt brought me here,
But is now walking away;
I feel abandoned.

A woman takes my hand,
Leads me inside;
To stand on a section of carpet.

I am frightened,
Nothing is familiar;
So much I do not understand.

I am surrounded by noise,
SO much noise;
I want it to stop.

Girls have formed a circle around me;

---

[4] English for speakers of other languages.

What are they saying?
I do not understand.

Boys in the background,
Boisterously playing;
I am scared they will hurt me.

I want to run,
But my body is frozen;
Trapped and unable to escape.

I feel small.
Insignificant.
Powerless.

Franciska

Despite being amongst predominantly Europeans, I felt like an outsider. By my understanding, I was the only genuine European – having been born in Europe and not speaking a word of English. Indeed, I was a novelty. The popular girls (upon the encouragement from the teacher to befriend me) took me into their fold. To this day, this experience informs my definition of the term “European” – something I am reminded of every time I complete a form which asks me to indicate my ethnicity. I feel triggered when I read down the list and find no option which I identify with. NZ European, Māori, Samoan, Cook Island Māori, Tongan, Niuean, Chinese, Indian, and Other. I find myself forced to choose “Other”. Thus, reinforcing the othering that I have been subjected to for the past forty years.

In contrast to the primary school which I attended, my intermediate school was a low socioeconomic melting pot of cultural diversity. My form one teacher was Samoan and white skinned kids a minority across the school. All but one of my primary school friends had gone to a different school; I was the outsider once again, having to assimilate and form new friendships. This time, I found myself amongst the nerds, misfits, and outcasts. Before long, I became the subject of relentless bullying. In the mornings, the kids would line the corridor and taunt and tease me as I walked to my classroom. During morning tea and lunchtimes, my friends and I would make ourselves as inconspicuous as possible, sitting and playing away from the popular kids. When it came to P.E. (Physical Education) classes and sports days, I was always one of the last to be picked for teams. On the way home, I would exit the school bus at the earliest stop and walk considerably further than necessary to avoid any confrontations (having previously been physical assaulted on the school bus – the scar from which is still visible on my wrist today). In a nutshell, I spent my intermediate school years trying to be as invisible as possible; in an effort to keep myself safe from harm.

High school afforded me the opportunity of a fresh start. Only a handful of us moved across to the same high school; and at the same time, I was reunited with some of the kids from my primary school years. I continued to employ the invisibility strategy, successfully avoiding any further bullying for the remainder of my school years, and once again found friendships amongst the nerds, misfits, and outcasts. Under the radar, I remained unseen, and unharmed.

Health autonomy and self-determination

> It is 2013. We are sitting across from yet another doctor, hopeful that this one will be able to shed some light on what is causing the unrelenting pain in my (then) ten-year-old daughter's foot. He reads over her medical history and proceeds to ask me a plethora of questions. Not once does he address her directly. But why am I surprised? He barely acknowledged her as we entered the consultation room.
>
> I'm growing increasingly irritated by him ignoring my child – the patient he is supposed to be consulting.
>
> Doctor (looking directly at me): "Can you describe what the pain feels like?"
>
> "Why don't you ask my daughter? She's sitting right here."
>
> Doctor: "I don't have time to listen to a child."

At what age are we deemed old enough to be seen as the expert in our own health? The laws around children and young persons in Aotearoa do not specify an age at which an individual can consent to medical treatment (New Zealand Psychologists Board (NZPB), 2017). Rather, the focus is on the individual's capacity to understand the treatment being proposed and to express their own wishes. Given that the doctor above had never met my daughter, nor made any effort to engage her in conversation, the only information available to him to judge her level of maturity (capacity) would have been her biological age. Without conscious awareness, my gut instinct was that the patient is the best person to describe the sensations within their own body.

I do not recall how old I was when my mother stopped accompanying me into medical appointments. But I *do* remember the first doctor to treat me as an equal and respect my right to medical autonomy. With decades of experience, John Pollock was like a father figure to me; yet he trusted that I was the expert of my body. Rather than dismissing me when I did not fit the textbook symptoms, he would listen empathetically and work with me to diagnose and treat bothersome health conditions. He was the first person to suggest I try alternative therapies in the form of acupuncture and naturopathy; and one of only three general practitioners I have ever known to fully support holistic approaches to health. John also lobbied for euthanasia – even resigning from the New Zealand Medical Association (NZMA) because its views that euthanasia is unethical was in direct conflict of what he and many other doctors he had spoken to believed (Binning, 2010; “Doctor with Cancer Lobbies for Euthanasia,” 2010). Perhaps unconventionally, I knew of John’s views on assisted dying prior to him going public – long before his own terminal diagnosis. Indeed, I can recall many occasions where medical consultations turned into philosophical conversations – where any form of power imbalances simply did not exist.

Following John’s decision to step away from general practice, I decided to transfer to a new medical practice closer to home. It was at this point when I learned that not all doctors are created equal; and struggled when my new doctor was dismissive, dictatorial, and completely lacking empathy. However, by a wonderful twist of events, I discovered that a very close friend of John’s also worked at my new medical practice and for the next decade I enjoyed (and took for granted) full autonomy over my health. I am alive today because (unlike his colleagues) this doctor listened to me and was willing to investigate my suggested diagnosis. To be fair, I also had the privilege of having private health insurance – meaning that I was able to consult specialists, undergo expensive testing, and receive life-saving surgery in a very short period. Within the public health system, my symptoms had been dismissed (“it is just a recurring urinary tract infection”) and I was sent back to my family doctor. Had my doctor not viewed me as the expert of my own body, I would have died of sepsis.

Storytelling

Whenever I am asked about my childhood, I wax lyrical about Sunday lunches. The one meal a week that my family almost always came together for – free from work, music, and sporting commitments. We were often joined by friends of my brother and I – many of whom still recount their own fond memories of the Neuhäuser Sunday lunches.

My Apuci[5] would spend the morning in the kitchen. Windows open, flooding the neighbourhood with delicious aromas of Magyar[6] peasant food and magical sounds of music

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[5] Apuci is the Hungarian word for “daddy”.

[6] Magyar is the Hungarian word for “Hungarian”.

from the 1970's, operas, and operettas. Think Boney M[7;8], Frank Sinatra[9;10], Luciano Pavarotti[11;12], and Apuci; all in perfect harmony.

But mostly, it is the storytelling that is burned into my memory – not so much the content of the tales, but the act of sharing the stories from Apuci's childhood, misspent youth, time in military service, our ancestors, family, and friends.

Apuci passed away in the year 2000. Twenty-five years – half my lifetime – ago. But his love for storytelling lives on in me. Not only to amuse and entertain friends and family members, but also as a vehicle through which to connect with people that I meet through my work.

Current context

I began writing this in a post-pandemic era. During a climate of immense political change as Aotearoa's newly elected three-way coalition government made right-leaning policy changes. Whilst internationally, the Russia-Ukraine War continued, the Israel-Hamas War re-ignited, England and France elected new leaders, and a failed assassination attempt of United States former President Trump threatened to further divide a Nation.

Professionally, I am a mental health and wellbeing practitioner. I hold qualifications in Counselling, Coaching, Neurolinguistic Programming (NLP), and Ericksonian Hypnotherapy. In my practice, I help people manage and overcome issues such as grief, trauma, and anxiety; often with comorbidities of chronic health conditions and/or neurodivergence.

My postgraduate studies are informed by a strong sense for justice and a genuine desire to help people improve their emotional, mental, and physical well-being. Health psychology through a critical and social lens is concerned with challenging power imbalances that negatively impact upon people's health and well-being (Chamberlain et al., 2018; Riley et al., 2025). Beyond focusing on the individual, I am also interested in affecting change at community, societal, and political levels. Apparently, this makes me a scholar-activist.

> "The scholar-activist has a long heritage within the social justice movement and refers to the tradition of exposing, subverting, and challenging social

---

[7] Boney M were a German disco music group (formed in 1974).
[8] Recording of Boney M performing "Rasputin": https://www.youtube.com/watch?v=16y1AkoZkmQ
[9] Francis Albert Sinatra was an American singer and actor (b. 12 December 1915, d. 14 May 1998).
[10] Recording of Frank Sinatra singing "My Way": https://www.youtube.com/watch?v=w019MzRosmk
[11] Luciano Pavarotti was an Italian operatic tenor (b. 12 October 1935, d. 6 September 2007).
[12] Recording of Luciano Pavarotti singing "Nessun Dorma" from Turandot: https://www.youtube.com/watch?v=cWc7vYjgnTs

> injustices through a combination of various forms of scholarly work and activism."
>
> (Murray, 2012, p. 1)

When I think of an activist, I picture a placard-holding, emotionally charged individual protesting over something they feel passionate about; in order to affect change. My maternal grandmother also comes into mind – a fiercely patriotic woman who still attended political protests well into her late 90s; eternally scarred by the oppression and traumas she was subjected to post WWII under the Communist regime. I cannot imagine myself ever partaking in a protest of any kind. Even "peaceful" protests appear violent to me. So many people, raising their voices, exhibiting aggressive body language. I *do*, however, feel passionately about every human being's right to medical autonomy.

Mosaic lens

These snippets from my life story are intended to form the mosaic lens through which I would like you to read, explore, and take meaning from the text that is to follow.

> Read me
> like a country you cannot pronounce
> but whose soil grows under your tongue anyway.
>
> Read me
> like a story whispered across three continents
> and four decades,
> buried in the folds of a mother's sewing machine,
> between stitches that kept our lives from falling apart.
>
> I belonged to no country,
> just the back seat of my father's car;
> concealing a box of Lego,
> a sewing kit,
> and every fragile thing
> we weren't supposed to take camping.
>
> My first act of resistance
> was staying up late playing poker in an Italian summer,
> when my parents finally had time
> to look me in the eye.
>
> I learned English
> by pairing words with pictures,
> by watching lips move
> like riddles I had to solve before interval.
> I learned how to disappear

so well
I almost forgot
how to speak.

This is not nostalgia.
This is navigation.

These memories are not decorative.
They are methodological.
They are data points
in a thesis of survival.

When I tell you I believe in health autonomy,
it is not theory –
it is the scar on my wrist,
the ten-year old daughter ignored in a clinic,
the GP who listened
and saved my life
with nothing more
than belief.

You will not find my ethnicity on a form.
You will find it in the Sunday lunch stories,
seasoned with paprika and opera,
in the passion of my father’s voice
retelling our family history
as if it were scripture.

I am not telling you my story.
I am handing you
the mosaic window
through which this thesis must be read.

So hold it gently.
Each piece is sharp.
because it is real.
Each edge
a country we left,
a name I changed,
a room I entered and made mine.

This is the lens.
This is the map.
This is the me
beneath the method.

Now, begin.

Franciska

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I would like to express my deepest appreciation to my Academic Supervisor, Dr Kathryn McGuigan, whose empathy, patience, expertise, guidance, and support were instrumental in empowering me to undertake, navigate, and complete this thesis.

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I would also like to acknowledge the pivotal role my daughter Satine played – completely unaware – in the final months of writing. Her resilience and ability to get shit done whilst juggling work, study, and parenting a one-year-old is not only inspiring, but highly motivational.

Special thanks to my dear friends Michella, Helen, Andrew, and Anton for checking-in, listening, and encouraging me; and Caroline for providing me with much-needed self-care and a generous sprinkling of enthusiasm for my next journey towards a PhD.

Last but absolutely not least, I wish to acknowledge Professor Emeritus Kerry Chamberlain not only for his insights and advice at the very beginning of this project, but also for his support for and promotion of innovative qualitative research methodologies.

PART I [The Building Blocks]

This thesis is presented in two parts: Part I (Chapters 1-5) sets the scene, explains the process and theory of autoethnography and arts-based research, and discusses ethics. Part II (Chapters 6-9) tells my story – through the lens of both the subject and the observer – concluding with final observations and learnings in Chapter 10.

Chapter 1: Setting the Scene [Introduction]

Image 7: Siberian Tiger (David Saddler, 1983, via Flickr) – used under CC BY 2.0

Trapped

Peering from within the bars,
Piercing eyes; both cold and cruel.
Shadows dance from side to side,
Waiting for the fatal duel.

Body resting, ears alert,
Muscles ready to perform.
Silence now but not for long,
Like the calm before a storm.

Boxed in like a guinea pig,
Snatched away from wilderness.
There is no joy, only pain,
Nothing more than bitterness.

Lack of freedom, lack of choice,
Unaware of why he's there.
Are they blind or are they deaf,
For his cries they cannot hear.

Franciska

I wrote the poem above in high school, in my final year – I would have been seventeen or eighteen. At the time, it was about a tiger in captivity. Yet three decades later, it became an elegant metaphor for how I felt throughout the period of vaccine mandates during Aotearoa's public health response to the Covid-19 (coronavirus disease 2019) pandemic. Like a trapped animal. Cornered. Unheard.

Where I once found safety and solace among the marginalised, the pandemic brought new tensions and values conflicts – even within those communities. My concern, like that of many who later protested outside Parliament buildings in early 2022 (Barnes, 2023), was never about the vaccinations themselves, but about the mandates. This thesis is not an anti-vaccination diatribe, nor does it lend credence to conspiracy theories about the virus. Rather, this thesis raises questions about how Covid-19 vaccine mandates were applied and enforced; justified under the premise of "protecting the vulnerable" while failing to acknowledge, or make provisions for, those who were injured by the vaccine.

The Covid-19 pandemic

In December 2019, Chinese authorities notified the World Health Organization (WHO) of a 'pneumonia with an unknown cause' detected in the Wuhan province. Within a month, on 30 January 2020, WHO declared the virus a Public Health Emergency of International Concern (PHEIC), and on 11 March 2020 categorized the Covid-19 outbreak as a pandemic (World Health Organization, n.d.). The virus quickly spread worldwide, with over 25 million confirmed cases of Covid-19 and over 844,000 deaths across 216 countries by the end of August 2020 (Summers et al., 2020). The first confirmed case of Covid-19 in Aotearoa was reported on 28 February 2020, and the first Covid-19 related death on 29 March 2020 (Ministry of Health, 2023c).

Some three years later, on 5 May 2023, the WHO Emergency Committee recommended to the Director-General that Covid-19 no longer fitted the criteria of PHEIC; on the grounds that the virus was by then well established and on-going (World Health Organization, n.d.). As of 7 May 2023, there had been a total of 2,832 deaths in Aotearoa attributed to Covid-19 (Ministry of Health, 2023b).

At the time of writing, Covid-19 sits alongside influenza (flu) and respiratory syncytial virus (RSV) – both in terms of monitoring and the way in which the general public views and manages it. Vaccination against Covid-19 is still encouraged, but no longer mandatory in any context in Aotearoa in the year 2025.

Aotearoa's public health response

The rapidly spreading virus created unprecedented health, economic, social, and moral disruptions both in Aotearoa and across the globe (Ministry of Health, 2023a; Ryan, 2020; Tay, 2023). As healthcare systems became overwhelmed internationally, the Labour-led government in Aotearoa implemented a multi-faceted response aimed at protecting the health sector. The approach began with elimination (by way of travel restrictions and mandatory isolation and quarantine for travellers), then shifted to minimisation (involving nation-wide lockdowns, contact tracing, social distancing, and mask wearing), and finally to protection (through vaccination mandates and associated policies) (Ministry of Health, 2024). Although Aotearoa's initial response to the pandemic was praised internationally as an exemplary success (Beattie & Priestly, 2021; Gilray, 2021; Officer et al., 2022), the various strategies caused frictions within Aotearoa society; from the nation-wide lockdowns to the vaccine mandates.

Aotearoa's public health response can be read through the lens of *governmentality* (Dean, 2010; Foucault, 1991; Rose, 2007). Governmentality refers to the ways in which modern governments seek to manage populations not only through laws and sanctions, but also through norms, discourses, and everyday practices. Within this framework, public health becomes a site of population governance: risks are identified, behaviours are categorised, and citizens are encouraged to regulate themselves in the name of collective wellbeing. In Aotearoa, this was enacted through the Labour-led government's layered response to Covid-19 (elimination, minimisation, and protection) and through the careful use of language, symbolism, and affect.

One of the clearest examples of governmentality in practice was the government's communication strategy. Consistent public messaging is a powerful tool with which to influence a collective response to a crisis (Officer et al., 2022). Alongside the dissemination of information, key messages of kindness ("be kind"), unity ("unite against Covid-19") and cooperation ("team of five million") were delivered through a strong media campaign and the government's daily press briefings (Beattie & Priestly, 2021; Gilray, 2021).

This messaging was notable for being largely informational rather than overtly political, aided by what Croucher et al. (2021, p. 85) describe as Aotearoa's "less politically divisive mediascape," where mainstream outlets tend to maintain a centrist, fact-focused orientation. In the case of Covid-19, this meant the pandemic was framed as an issue of science rather than political ideology, reducing uncertainty and strengthening trust in the government's response.

Although the 'team of five million' was intended as an inclusionary metaphor, in practice it isolated those who opposed the government's response, positioning them as outside the team (Gilray, 2021). These messages framed compliance not simply as epidemiological necessity, but as the mark of responsible citizenship. Those who dissented were positioned outside the bounds of solidarity. They were implicitly coded as endangering the collective.

Vaccine mandates

Vaccine mandates sit at the intersection of individual autonomy, collective wellbeing, and state power. In Aotearoa, several legal principles and statutes came into direct tension when mandates were introduced: the right to refuse medical treatment (New Zealand Bill of Rights Act 1990), the obligation to provide safe workplaces (Health and Safety at Work Act 2015), protections from discrimination (Human Rights Act 1993), and privacy protections around health data (Privacy Act 2020).

Under section 11 of the New Zealand Bill of Rights Act 1990, everyone has the right to refuse to undergo any medical treatment. This enshrines bodily autonomy as a fundamental right. However, section 5 of the same Act provides that rights may be subject to reasonable limits prescribed by law where these can be “demonstrably justified in a free and democratic society” (New Zealand Bill of Rights Act 1990, s 5). Vaccine mandates therefore represented a legal and ethical balancing act: protecting public health on one hand and safeguarding individual rights on the other.

In the employment context, the Health and Safety at Work Act 2015 requires employers to provide, so far as is reasonably practicable, a safe working environment. During the pandemic, this duty was interpreted to permit or require vaccination in certain high-risk sectors. Yet these requirements sat uneasily alongside the Human Rights Act 1993, which prohibits discrimination based on disability and health status. Differentiating between vaccinated and unvaccinated workers raised questions about whether such measures could be justified without undermining equity and fairness.

Privacy was also a concern. The Privacy Act 2020 restricts the collection and use of personal health information unless there is a lawful and proportionate reason. Employers were permitted to request vaccination status only where this information was demonstrably necessary for workplace safety, but the application of this principle varied across sectors.

From a critical health psychology perspective, mandates exemplify how public health measures operate as technologies of governance (Dean, 2010; Foucault, 1991; Rose, 2007). As stated earlier, compliance became framed as not only an epidemiological necessity but also a moral duty – a marker of responsible citizenship. Those who complied were positioned as protecting the collective, while those who dissented were constructed as threats to public safety. In this way, legal frameworks intersected with social discourse, producing new boundaries of inclusion and exclusion.

What is health?

In conventional biomedical discourse, health is often framed as the absence of disease, a physiological equilibrium, or an individual capacity to function (Rocca & Anjum, 2020). Yet from a critical health psychology perspective, health is not merely a biological reality but also a social and political construct – shaped by cultural norms, political values, and relations of power (Lyons & Chamberlain, 2017). What is defined as 'healthy' or 'unhealthy' reflects moral assumptions about responsibility, productivity, and worth, revealing the extent to which health operates as both a scientific and social concept.

Critical health psychology in Aotearoa has emphasised that what counts as 'health' depends on who is defining it, in what context, and for what purposes (Chamberlain et al., 2018). Health is not a fixed or universal state, but is produced through social structures and practices, including inequities in income, education, housing, racialisation, and access to healthcare. These definitions are therefore inseparable from questions of justice and equity: whose bodies are protected, whose suffering is recognised, and whose needs are prioritised.

Internationally, social constructionist literature demonstrates how health and illness are culturally negotiated. Conrad and Barker (2010) argue that many conditions are not simply 'discovered' by medicine but constructed through social meaning-making: what one society regards as a medical disorder may in another be seen as a normal variation of human experience. Baum (2016) extends this by highlighting that health cannot be separated from its political determinants: inequities in health outcomes are underpinned by structural arrangements that privilege some groups while marginalising others. Thus, decisions about what constitutes health are deeply value-laden and often reflect moral hierarchies embedded in public discourse.

Lupton (2012) further shows how health discourses function as mechanisms of social regulation. Public health campaigns, risk framings, and health surveillance practices encourage individuals to self-monitor and self-regulate in ways that align with dominant moral and political values. Through this process, health becomes both an ethical and political project – a means of producing 'responsible' citizens who act in accordance with prevailing norms.

Health equity provides one way of articulating these issues. Braverman et al. (2018) describe it as ensuring that everyone has a fair opportunity to attain their fullest health, which requires removing systemic barriers such as poverty, discrimination, and lack of access to education, housing, and safe environments. Achieving equity, they argue, demands not only fairness but also recognition of health as a human right.

Taken together, these perspectives underscore that health is not only biological but a social, moral, and political construct (Baum, 2016; Chamberlain et al., 2018; Lyons & Chamberlain, 2017). Decisions about what constitutes health, whose health is prioritised, and how health should be protected or promoted are deeply value laden (Conrad & Barker, 2010; Lupton, 2012). This framing is particularly important in the context of pandemic governance and vaccine mandates, where debates over health were also debates about morality, responsibility, and power.

Understanding health as a socially constructed concept also reshapes how we think about risk. If health is not merely a biological state but a product of cultural values, social norms, and political decisions, then so too is risk inseparable from its social context.

Risk perception

Risk perceptions are often the focus of health behaviour initiatives when governments or other organisations are aiming for protective action (Schmälzle et al., 2017). Risk factors are also used in discourses around health and healthism where again officials are attempting to induce people to take care of themselves, ultimately not to be a burden on an overstretched health system. Experts in managing risk focus on probability of an event and the severity of the possible consequences – aiming for a level of dread to inspire change (Schmälzle et al., 2017). Health promotion requires people to feel a degree of emotion and relevance to the issue. All this points to many factors influencing risk, health promotion, and public safety that played out in Covid-19.

In Aotearoa, risk perception during the Covid-19 pandemic was based not only on statistical information or objective facts, but heavily influenced by social, cultural, and relational factors. For example, in their study into who Australasians trusted during Covid-19, August et al. (2023) found that healthcare providers and scientists were the most trusted sources of information, over and above other institutions, indicating how trust in authority frames how risk is perceived in the first place.

Similarly, the *New Zealand Attitudes and Values Study* (Sibley et al., 2021) revealed that throughout the differing Alert Levels, trust in science, politicians, and policing shifted, and that a heightened sense of community contributed to resilience and compliance – demonstrating that shared identity and social norms shape how people perceive risk.

Furthermore, vaccine uptake in Aotearoa has been found to depend not only on individual risk perception, but also on collective motivations, social norms, and perceptions of safety and effectiveness. That is, those who perceived Covid-19 as a broader threat to the community or identified more strongly with collective values were more likely to choose to be vaccinated (Vinnell et al., 2023).

Such findings highlight that risk is not an objective calculation but a socially constructed process, produced within cultural, historical, and political contexts (Chamberlain et al., 2018; Fraser & Walker, 2025). According to Kasperson et al. (1988), risk is socially amplified; shaped by public trust in government and public sector agencies, the authority of scientific expertise, and collective discourses such as the government's "team of 5 million" framing. For marginalised groups, perceptions of risk were further negotiated through historical and relational frames, particularly in relation to government agencies and the public health system.

Whose health matters?

Health is not only about biology and pathology – it is also a question of whose bodies and lives are valued, and who gets to decide which health risks deserve priority. During the Covid-19 pandemic, these questions became especially charged: decisions about lockdowns, vaccine prioritisation, and mandates inherently embedded judgments about whose health should be protected first and most vigorously.

These decisions are often guided by public health definitions. For example, the Ministry of Health identified certain groups as being at risk of severe illness (such as the elderly, and those with chronic health conditions and compromised immunity) as priorities (Wiki et al., 2021). Such guidance signals who is considered more 'vulnerable' and thus prioritised. But these lists themselves are products of scientific, political, and social negotiations, not neutral facts.

From a critical health psychology perspective, the framing of vulnerability reflects underlying power relations and societal hierarchies. As McCartney et al. (2020) argue, health inequalities persist because of structural power: who controls resources, whose social position grants access, and who can influence policy. Furthermore, Link and Phelan' (1995) fundamental causes theory proposes that socioeconomic status grants enduring access to resources (such as money, knowledge, and social connections), which protect health regardless of shifting disease patterns. Thus, someone lower in the social hierarchy remains vulnerable across different health crises.

In Aotearoa, equity has long been foregrounded – though implementation remains contested (Chin et al., 2018). Health system reforms and primary healthcare policies over recent decades have tried to shift resources toward disadvantaged communities, but critics note that power dynamics still skew who benefits (Reidy et al., 2025). In practice, Māori, Pacific, and lower socioeconomic groups have often borne disproportionate burdens in health outcomes (Sheridan et al., 2011).

In pandemic management, decisions about vaccination rollout, mandates, and restrictions become symbolic of whose health is prioritised. When the government referred to ‘the vulnerable,’ the term masked a series of decisions: which vulnerabilities counted, how they were measured, and whose voices were heard in making those choices. Those outside the official vulnerability lists may be deprioritised, even when their social circumstances (such as job exposure, housing, access to care) increase their actual risk.

In sum, whose health matters is never a neutral question. It is mediated by scientific authority, political decision-making, and cultural valuation. During the Covid-19 pandemic, choices about who to protect, how to distribute risk, and what trade-offs were acceptable revealed the latent hierarchies in health governance.

Self-determination / medical autonomy

Medical autonomy has long been considered a cornerstone of health ethics, enshrined in both law and professional codes. In Aotearoa, this principle is protected under section 11 of the New Zealand Bill of Rights Act 1990, which affirms that everyone has the right to refuse to undergo medical treatment. Autonomy here is understood as the individual’s right to make decisions about their own body, free from coercion.

Autonomy is not simply and individual right exercised in isolation – it is socially and structurally mediated. People’s ability to exercise self-determination is shaped by access to information, socioeconomic conditions, cultural values, and the broader political environment (Lyons & Chamberlain, 2017; Riley et al., 2025). What appears as a ‘free choice’ may, in practice, be constrained by economic insecurity, limited healthcare access, or the discursive framing of responsibility during a health crisis.

In Aotearoa, autonomy also carries collective dimensions. For Māori, self-determination is grounded in tino rangatiratanga (the right to self-determination, authority, and sovereignty), guaranteed under *Te Tiriti o Waitangi*. This principle extends the notion of autonomy beyond individual decision-making to include the right of iwi, hapū, and whānau to define and pursue their own health priorities. Recent research highlights how Māori health organisations and communities continue to seek autonomy in designing and delivering health services, asserting control over health priorities and resisting externally imposed mandates (Kidd et al., 2022). This emphasises that self-determination in Aotearoa must be understood as both individual and collective – shaped by historical and political commitments to equity and justice.

During the Covid-19 pandemic, vaccine mandates complicated the principle of self-determination. Whilst individuals retained the formal right to refuse vaccination, practical consequences – including employment restrictions, limits on participation in public life, and social stigma – sharply narrowed the scope of meaningful choice. From a critical lens, autonomy under these conditions was conditional, negotiated under governmental directives and institutional pressures.

This, medical autonomy in Aotearoa during the pandemic cannot be understood as a simple matter of personal preference. It was shaped by legislation, mediated through cultural values, and constrained by political and structural contexts. Critical health psychology encourages us to ask not only whether people had the right to refuse, but whether they had the capacity to enact that right – and at what cost.

Individual autonomy vs collective responsibility

The pandemic exposed the tension between individual autonomy and collective responsibility. On one side stood the principle of medical self-determination, affirming each person's right to make choices about their own body (Beauchamp & Childress, 2019; Mackenzie & Stoljar, 2000). On the other side was the public health imperative to protect the collective through measures such as vaccination, mask mandates, and restrictions on movement (Jennings, 2007). These competing values often collided: what counted as an individual's 'free choice' simultaneously carried consequences for the safety and wellbeing of others.

Perspective, autonomy and responsibility are not simple opposites but are mutually entangled. As stated earlier, people's capacity to make decisions is shaped by social structures, cultural expectations, and political discourses that position some decisions as responsible and others as reckless (Lupton, 2012; Riley et al., 2025). During Covid-19, compliance with mandates and protective measures was framed not only as a matter of epidemiological necessity but as a moral duty – a marker of responsible citizenship.

This framing raises important questions about how responsibility is distributed. As Baum (2016) argues, public health often places the burden of responsibility on individuals while obscuring the structural conditions (such as inequities in housing, employment, or healthcare access) that shape people's capacity to comply. Critical health psychology pushes us to see that 'choice' is always constrained, and that collective responsibility must also involve addressing these broader determinants rather than individualising blame.

In Aotearoa, the 'team of five million' metaphor epitomised this tension. While it fostered solidarity, it also implicitly constructed dissenters as failing their civic duty and endangering the collective. Responsibility was thus not only about reducing viral transmission but about belonging – about who was seen as part of the team, and who was positioned outside it.

Power

Power in public health operates not only though laws and regulations, but also through discourse, norms, and practices that shape how people understand themselves and their obligations to others. As Foucault (1991) argued, modern governance often functions less by overt coercion than by encouraging individuals to regulate themselves in line with broader social goals. Public health, in this sense, is a space where power is exercise by defining risks, setting priorities, and framing what counts as responsible behaviour (Dean, 2010; Rose, 2007).

The pandemic response in Aotearoa exemplified this dynamic. The 'team of five million' rhetoric fostered unity but also created boundaries of belonging – those who complied with restrictions and vaccination were positioned as responsible citizens, while dissenters were implicitly framed as endangering the collective. Power was exercised not only through formal mandates but through moralised expectations of solidarity and care.

Vaccine mandates made this especially visible. Legally, individuals retained the right to refuse vaccination under the New Zealand Bill of Rights Act 1990, but in practice the consequences of refusal (exclusion from employment, limits on public participation, and social stigma) narrowed the scope of meaningful choice. Mandates thus operated as technologies of power (Rose, 2007): regulatory tools that shape not just behaviour, but identity and belonging. Compliance was framed as both a scientific necessity and a civic duty, while non-compliance was equated with irresponsibility or threat.

As Baum (2016) emphasises, public health often assigns responsibility to individuals while downplaying the structural inequities that constrain choice. In Aotearoa, those in precarious or frontline employment had fewer options to negotiate mandates compared to those in secure or flexible work. Therefore, while mandates were presented as universal, their social impacts reflected and reinforced existing inequalities.

Viewed through this lens, power during the Covid-19 pandemic cannot be reduced to government edicts alone. It was enacted through law, discourse, and everyday practice; through who was included in the 'team,' who was excluded, and whose health was prioritised. In this sense, mandates were not just about epidemiology but about morality, responsibility, and the social ordering of citizenship.

These dynamics of power were not abstract; they shaped how I, and many others, navigated everyday life during the pandemic. The legal frameworks, public health messaging, and discursive boundaries of belonging all set the conditions in which my own choices and experiences unfolded. In Part II (Chapters 6-9), I turn from theory to lived account: tracing how these broader structures of governance and responsibility were experienced in my own body and mind, relationships, and working life. By situating my personal story within these dynamics, I aim to show not only what mandates meant in policy terms, but how power was lived, negotiated, and resisted in the everyday.

Chapter 2: The What, The Why, and The How [Autoethnography]

> "…as we pass through different stages of life, the meanings of previous experiences move, change, and call for revision…It continues to be important, however, to consult the past for the lessons it provides to use now and take into the future."
>
> (Ellis, 2020, pp. xi-xii)

The overarching purpose of this thesis is to answer the research question of: *what is it like to experience vaccine mandates?* Whilst simultaneously questioning whose health is taken into consideration within public health responses; who gets to decide whose wellbeing will be prioritised; and the power dynamics that contribute towards the denial of medical autonomy. Specifically, I am exploring my lived experience of vaccine mandates as someone working in the health sector when the vaccine mandates were introduced, who became medically vulnerable as a result of vaccination and coerced into having more doses in order to "protect the medically vulnerable". With the hope that lessons learned can be taken into the future when we are faced with another pandemic; and maybe, just *maybe* inform the decisions of policy makers. There is, however, another goal of this dissertation beyond the academic. One that is deeply personal and encapsulated by autoethnographer and philosopher Christopher N. Poulos:

> "If there is anything I believe about life—and about autoethnography—it is that it offers the possibility of deliverance from the past. In writing, in the present, we reconstruct memory, and thus write our way toward a new narrative trajectory.
>
> And that, my friends, is real redemption."
>
> (Poulos, 2014, p. 1005)

Autoethnography was a process where I sought to make sense of my experiences, find meaning, construct a new narrative, and ultimately, achieve deliverance from the past. Redemption not only from any regrets, but also any ill feelings towards others who may have contributed towards my negative outcomes. In other words, to be *set free*.

What is autoethnography?

> "Autoethnography" is comprised of three interrelated components: "auto," "ethno," and "graphy." Thus, autoethnographic projects use selfhood, subjectivity, and personal experience ("auto") to describe, interpret, and represent ("graphy") beliefs, practices, and identities of a group or culture ("ethno")."
>
> (Adams & Herrmann, 2020)

First appearing in the 1970s, the term *autoethnography* only began to receive academic attention in the 1980s and 1990s. However, works published decades and even centuries earlier could be deemed to be autoethnographic – even though the authors did not label them as such (Adams & Herrmann, 2020; Holman Jones & Adams, 2024). Autoethnography, as a genre, can include a range of terms including "critical autobiography, ethnobiography, ethnographic poetics, emotionalism, evocative narratives, first-person accounts—to name a few" (Rossman & Rallis, 2012, p. 94). Unlike empirical forms of inquiry that focus on facts, rigour, and abstractions, autoethnography allows the researcher to lean into ambiguity, contradiction, and uncertainty. With a focus on lived experience and meaning making, autoethnographers are driven to both ignite and keep conversation alive; fuelled by the desire to contribute towards a more just and loving world (Bochner, 2020).

> "Autoethnography is an autobiographical genre of academic writing that draws on and analyzes or interprets the lived experience of the author and connects researcher insights to self-identity, cultural rules and resources, communication practices, traditions, premises, symbols, rules, shared meanings, emotions, values, and larger social, cultural, and political issues."
>
> (Poulos, 2021, p.4)

I use Poulos' (2021) definition because it captures the breadth and depth of what I am attempting to do through this work: to weave together lived experience, emotion, and cultural context into an interpretive practice that values both personal truth and social meaning. His framing situates autoethnography as more than storytelling – it is a way of analysing experience through the relational, symbolic, and political dimensions of life. This definition aligns closely with my intention to explore not only what happened to me during the mandates, but also what those experiences reveal about the broader systems and discourses that shaped them.

Autoethnography is not only a set of methods but also an epistemological and ontological orientation. It begins with the assumption that knowledge is socially constructed rather than discovered in an objective, value-free sense (Poulos, 2021). As Chamberlain and Murray (2017) note, critical health psychology typically adopts a social constructionist position: knowledge is always produced in relation to cultural, historical, and political contexts, and it carries consequences for whose voices are heard and whose are silenced. This stance aligns closely with autoethnography, which situates personal experience as a legitimate site of knowledge production.

At the same time, autoethnography draws inspiration from existentialist and phenomenological traditions. These approaches emphasise the subjective lifeworld and the search for meaning in lived experience (Poulos, 2021). Phenomenology, in particular, stresses that consciousness is always intentional (it is directed toward something) and therefore personal experience is never isolated from the social and material world. Autoethnography encompasses this orientation by treating the self not as a solitary subject but as embedded in networks of relationships, discourses, and histories.

This thesis therefore takes a constructionist epistemology and a relational ontology. The experiences I recount are not offered as timeless ‘truths,’ but as situated interpretations shaped by who I am, where I stand, and the broader political moment in which they unfolded. In this sense, epistemology and method converge: as Bochner and Ellis (2016) emphasise, the act of writing is central to autoethnography: it is through the process of composing and revising stories that understanding emerges. Writing here is performative as much as descriptive – a means of creating knowledge by engaging deeply with lived experience. Autoethnographic writing thus legitimises reflexivity and narrative as analytical tools, allowing the researcher to connect the personal with the cultural and political.

I also use artistic methods alongside writing to reveal what words alone cannot hold – the felt, sensory, and embodied aspects of experience that resist linear description. These methods include textile art and visual symbolism, where colour, texture, and form become additional layers of analysis. The creative process functions as both inquiry and expression: crochet become method, stitching becomes reflections, and each piece materializes a part of the story that is otherwise inexpressible. As elaborated in the following chapter, these arts-based practices complement the written autoethnography by allowing emotional knowledge to surface through the act of making.

What does it mean to be autoethnographic?

> *"Autoethnography is not only a research methodology but also a way of life*. The autoethnographic way of life originates in doubt and uncertainty. To be alive is to be uncertain."
>
> (Bochner, 2020, p. 84)

By *way of life*, Bochner (2020, p. 85) is referring to what he has defined as "autoethnographic temperament"; that is, the tendency to use the voices inside your head to scrutinize almost everything about existence. Bochner (2020) describes this as a process of listening to yourself talking; replying to yourself, directly commenting on what you heard yourself saying; and continuing the conversation in an effort to transform yourself into a new being through interpreting, reinterpreting, and making new discoveries about the self you started with. This requires acute self-consciousness, shameless subjectivity, and a willingness to be your own worst critic. For me, this resonates deeply. Throughout this process, I have found myself constantly narrating, questioning, and revising not only my memories but my meanings – as though the act of writing and thinking had become an internal dialogue. The uncertainty Bochner speak of has been both unsettling and generative; it has forced me to confront uncomfortable truths about my own beliefs, motivations, and vulnerabilities. To be autoethnographic, in this sense, is to live in relationship with one's story – to remain open to the possibility that understanding will shift as we do. This methodology fits because my experience of the pandemic was itself characterized by profound uncertainty, loss, and re-evaluation. Autoethnography allows me to honour that instability rather than resolve it, transforming doubt into a site of inquiry and self-compassion.

For qualitative research more broadly, reflexivity is a research practice aimed to address the need for us (as researchers) to acknowledge and reflect upon our potential biases in the collection and interpretation of data (Murray, 2012). Reflexivity is of particular importance for autoethnographers due to the multiple roles we play throughout the research process; and is the reason for the extensive preface in which I situate myself and the mosaic window through which I experience, perceive, and interpret the world. The multitude roles of an autoethnographer are elegantly summarised by Ellis (2020):

> "As an autoethnographer, I am both the author and focus of the story, the one who tells and the one who experiences, the observer and the observed, the creator and the created…I tell a situated story, constructed

> from my current position, one that is always partial, incomplete, and full of silences, and told at a particular time, for a particular purpose, to a particular audience."
>
> (Ellis, 2020, p. 3)

Ellis not only highlights the multiple roles we take on as autoethnographers but acknowledges that we constantly reframe and restory our lives. That is, the story I tell today will change as I age and have new experiences; as others respond to my story and share their own; as society – indeed the world – evolves around me; and as I construct and adopt new perspectives through which to give meaning to my diverse experiences. This was something I often discussed in supervision – how the story kept shifting depending on where I stood in time. I found myself moving fluidly between past, present, and future: revisiting what I felt then, noticing what I feel now, and attending to what my body still carries from those moments. Each return to the page became another act of sense-making – a way of asking, *what does this mean now, and how do I honour it in this thesis?* This constant reflexivity, tension and process is described by Bochner:

> "Remembering, then articulating what we remember, is always an activity under the influence of the present, fusing what one desires, what one imagines, and what may actually have occurred."
>
> (Bochner, 2020, p. 82)

Form

Autoethnography blurs the boundaries between research and art, between analysis and story. It invites the researcher to use literary techniques (narrative, poetry, dialogue, and imagery) as both method and meaning making. The act of writing is not merely a way of reporting findings but also of discovering them. As Bochner and Ellis (2016) remind us, we come to know what we think through the process of writing itself. Each word shapes reflection; each draft becomes a site of inquiry.

Autoethnographies illustrate sensemaking processes situated within a particular context of history, space, and time (Ellis, 2020). They are deeply reflexive pieces of work, requiring the researcher to take careful consideration of the ways in which their past experiences, values, and beliefs influence their interaction with, and interpretations of the story they are telling (Poulos, 2021). Autoethnography also involves processes of meaning making which despite the field of psychology's long-standing interest in 'meaning', conceptualising what it actually is appears to be less than straight forward (Park, 2010; Proulx & Inzlicht, 2012). In essence, it is a sense-making function that comprises of understanding *what* is happening and *why* (Proulx & Inzlicht, 2012).

I was struck by this lack of clarity on what does it mean to make sense of something in autoethnography versus other methodologies. One way I found useful was looking to models. Crystal L. Park's (2010) Meaning Making Model proposes that there are two levels of meaning: global and situational. Global meaning is conceptuatlised as the general framework through which we structure our lives, encompassing our values, goals, and beliefs about ourselves, the world, our place in the world, and our sense of purpose. Whilst situational meaning refers to the meanings we attribute to a particular experience – whether that be an ordinary encounter or a highly stressful or traumatic event – where global meaning influences our interpretation of and subsequent reaction to a particular situation (Park, 2016; Steger & Park, 2012). The meaning making model was useful for this project as I could consider global and situational factors throughout my sense making using it as a reflexive tool.

According to the Meaning Making Model, distress arises when situational meanings disrupt or violate some aspect of a person's global meaning framework, triggering the process of meaning making (Park, 2013; Steger & Park, 2012). 'Meaning making' refers to the process of reconciling the discrepancies by changing the way in which we view or understand the situation in question (perhaps reframing it in a more positive light), reviewing and reforming our global meanings (possibly changing our beliefs, values, or life goals), and/or experiencing posttraumatic growth (such as a greater appreciation for life, strengthened relationships with others, increased awareness of our resilience) (Park, 2013, 2016). Whilst mass murders remain relatively rare in Aotearoa, the Christchurch Mosque shootings[13] made me revise my global meaning; Aotearoa is not immune to terrorist attacks but remains a relatively safe country compared to America for example.

In this thesis, writing functions as both representation and exploration. I do not claim to present an objective account of events but rather an interpretive one – a crafted narrative that conveys the emotional and ethical texture of lived experience. The writing seeks to evoke rather than explain, to draw the reader into the world of experience through sensory detail, rhythm, and metaphor. This aligns with what describes as *evocative autoethnography*: writings that "conjure, arouse, or elicit vivid images, deep meaning, and

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[13] On 15 March 2019 during Friday prayer, a 28-year-old Australian man living in Dunedin at the time, carried out two consecutive mass shootings in Christchurch targeting Muslims. The perpetrator (acting alone) live-streamed the first mosque attack on Facebook and was arrested whilst on his way to a third mosque. A total of 51 people died and a further 40 were wounded. https://nzhistory.govt.nz/51-killed-mosque-shootings

intense emotions." Through this form, I aim to invite resonance rather than persuasion – to connect through feeling as much as through reason.

Autoethnography, as Denzin (2014) suggests, is not concerned with generalisation but with understanding – the pursuit of insight that emerges from close attention to experience. It is a dialogic process between self and world, between the writer and those who might read and respond. My narrative does not stand outside life but within it; it participates in the same cultural discourses it seeks to interrogate. In this sense, writing becomes a relational act – a way of conversing with the past, with readers, and with the shifting meanings that arise in between.

Formally, this thesis weaves together multiple modes of expression – analytic commentary, narrative vignettes, and poetic fragments. Each mode serves a different purpose: analysis provides conceptual framing, narrative anchors ideas in lived reality, and poetry distils emotion into image and rhythm. The coexistence of these modes reflects my commitment to autoethnography as both an intellectual and aesthetic practice – one that values *how* we tell as much as *what* we tell. Ultimately, my writing as inquiry embodies a belief that stories can think – that through the act of storytelling, new understandings emerge that cannot be reached by analysis alone. Through the process of crafting language, I make sense of the intersections between self, society, and structure. Writing becomes both mirror and method – as space where reflection, theory, and imagination meet to form understanding. In this way, the text itself becomes part of the research: not merely a vessel for knowledge, but its very site of creation.

The timeline of the story that follows in Part II of this thesis spans from 12 December 2019 to 5 May 2023. Whilst my blog and social media posts are recordings of my lived experiences as they took place, my reflections and commentary about those posts were written some two years after the global health emergency was declared to be over. I have not shared every single blog and social media post that I made during the pandemic. Rather, I have carefully curated those that resonated most deeply in the process of restorying. Through each act of writing, revisiting, and reframing, I engage in meaning-making: revising the lens through which I understand both myself and the wider social world. Writing, then, is not only a medium for telling the story but also the very method by which I come to know what that story means.

Chapter 3: Harnessing Creativity [Arts-Based Methods]

Creativity as a form of social inquiry

This thesis employs arts-based research (ABR) methods within an autoethnographic design to explore how creative practice can generate knowledge about health, ethics, and agency during the pandemic.

ABR refers to a collection of qualitative approaches that use artistic forms (such as narrative, poetry, visual art, music, or performance) to generate, analyse, and communicate knowledge. Rather than treating art as decoration or dissemination, ABR positions the creative process as an integral mode of inquiry – a way of knowing that engages the senses, emotions, and imagination as valid sources of understanding (Knowles & Cole, 2008; Leavy, 2020). In contrast to traditional scientific paradigms that privilege detachment and objectivity, ABR embraces subjectivity, relationality, and reflexivity. It asks what can be known *through* creative expression that might otherwise remain unsaid or unfelt. Within psychology, ABR has been used to explore identity, trauma, resilience, and belonging – foregrounding lived experience as the basis of meaning (Boydell et al., 2012).

ABR developed alongside what Denzin et al. (2024) describe as the interpretive turn – a shift toward qualitative methodologies that recognise knowledge as co-constructed, contextual, and value-laden. Scholars across anthropology, sociology, and social psychology increasingly turned to storytelling, performance, and visual media to convey the complexity of human experience (Barone & Eisner, 2012). This aesthetic turn reflected a growing recognition that the form of research matters as much as its content: how we represent experience shapes what is possible to understand. Critical and feminist researchers have similarly embraced ABR for its ability to disrupt established knowledge systems and broaden who gets to participate in knowledge production. Through accessible and affective forms, ABR scholarship reaches audiences beyond academia, engaging the public in conversations about social justice, health, and care (Leavy, 2020).

Within critical health psychology, ABR methods have become powerful tools for exploring the lived experiences of health, illness, and identity – dimensions often resistant to standardized measurement. By foregrounding affect, embodiment, and context, ABR opens ways of engaging with experiences that are emotional, ambiguous, or resistant to standardized measurement (Chamberlain & Murray, 2017). In this domain, ABR opens different conversations about power, culture, agency, and care (Boydell et al., 2012; Leavy, 2020).

Here, the arts function as sites of dialogue rather than display. They invite participants and audiences to encounter each other's experiences empathetically, sometimes across social or political divides. This aligns closely with critical health psychology's commitment to social justice and transformation: both seek to challenge taken-for-granted assumptions about who is head, whose suffering counts, and what constitutes evidence. Creative enquiry can make visible the emotional labour of health work, the embodied dimensions of illness, and the often-silenced voices of those at the margins of care.

Importantly, ABR does not claim neutrality. It recognises that art – like science – is value-laden and performative. By embracing creative practice, researchers can foreground this partiality, acknowledging that all knowledge is situated, relational, and interpretive (Finlay, 2008). Through story, image, and texture, ABR renders health as something lived, felt, and negotiated rather than a fixed clinical category.

Artistic autoethnography sits at the interface of ABR and self-narrative inquiry. As Bartleet (2021) explains, artistic autoethnography extends conventional autoethnographic practice by positioning artistic expression as both data and analysis. Here, the creative process is not a supplement to reflection but a mode of knowing: a way of thinking through making. This integration enables the researcher-artist to embody and transform experience through artistic media, allowing form and content to evolve together.

In this thesis, I draw on this interface as both a methodological and epistemological stance. Creative forms – including poetry, photography, textile art, and narrative performance – serve as portals into emotion, memory, and meaning that might otherwise remain inaccessible through analytic prose alone. The arts become a language through which personal experience converses with cultural context. The arts become a language through which personal experience converses with cultural context.

Through this integration, I position creativity not as decoration but as dialogue: a relational practice that enables me to inhabit and interpret the complexities of health, autonomy, and belonging. By creating and reflecting simultaneously, I participate in a cycle of meaning-making that bridges feeling and thought, body and text, self and society.

Illustrating, storytelling, and sense making through metaphor

At some point during our school years we were formally introduced to metaphors. Most likely while learning about written prose in the form of poetry, short stories, novels, and perhaps plays and films. On a basic level, we learned that a metaphor is a way of experiencing and understanding something in terms of another (Lakoff & Johnson, 2003). For example, to describe someone as having "an icy stare" immediately evokes the sensory and emotional qualities of coldness. However, contemporary scholars of metaphor argue that it extends far beyond an ornamental aspect of language; metaphor provides a fundamental mechanism through which we conceptualise experience and make sense of the world (Gibbs Jr., 2008). These fundamental schemes are contextual and arise through a complex interaction between our brain, body, language, and culture. Although rooted in bodily experiences common to most people, metaphor can also be culturally sensitive, creative, and novel – referred to as the "paradox of metaphor" by Gibbs Jr. (2008, p. 5). From a critical and interpretive perspective, metaphors both reveal and shape the ways in which people construct meaning. They can reinforce dominant ideologies (such as "fighting" illness or "winning the battle" against disease) or open space for new ways of understanding vulnerability, recovery, and resilience. In this sense, metaphors do not just describe experience; they actively influence how people interpret and respond to it.

Within this thesis, metaphor functions as both method and meaning-making device. It threads through my writing, poetry, and textile artwork as a way of translating lived experience into forms that can be felt as well as understood. The seasonal structure of Part II (summer, autumn, winter, spring) operates metaphorically to represent emotional and existential cycles of loss, endurance, and renewal. The crocheted canvases similarly materialise metaphor: each piece weaves memory and reflection into texture, colour, and pattern. Together, these metaphors serve as narrative bridges between inner and outer worlds; between academic discourse and creative expression.

Through metaphor, I am able to hold complexity: to illustrate not only what happened but what it *felt* like to live through mandates, isolation, and recovery. Metaphor thus becomes an analytic and aesthetic strategy – a means of turning lived experience into shared understanding, and of demonstrating that knowledge can be simultaneously intellectual, emotional, and embodied. These metaphors – both written and stitched – gesture toward a broader arts-based inquiry (an approach explored in the following chapter), where creative practice becomes not just illustration but a way of knowing.

Evocation, embodiment, and ethics

A defining feature of ABR and autoethnography is evocation. That is, the capacity to move the reader or viewer emotionally and imaginatively. Evocative inquiry values resonance over replication, connection over control. The aim is not to generalise but to create insight through affective engagement (Barone & Eisner, 2012; Bochner & Ellis, 2016; Denzin et al., 2024). This entails an ethical responsibility to represent lived experience with care, sensitivity, and respect for its complexity.

Embodiment is central here. Creative processes engage the body as an instrument of knowing – through movement, gesture, rhythm, and sensory awareness (Faulkner, 2017;

Finlay, 2005). In health research, this attention to embodiment offers a counterpoint to dominant biomedical framings that often abstract or pathologise the body. Artistic expression re-grounds health in lived experience: in breath, pain, recovery, and connection (Todres et al., 2007).

Ethically, ABR calls for transparency and reflexivity. Researchers must consider how their positionality, privilege, and creative choices shape what is represented and how it might be received (Leavy, 2020; McNiff, 2017). Leavy (2020) emphasises that ABR researchers operate in a space where aesthetics and ethics intertwine: the beauty of a work must never eclipse its responsibility to truthfulness and care. In this sense, ABR shares critical health psychology's deep concern for justice – seeking not only to describe the world but to imagine it otherwise (Denzin et al., 2024; Knowles & Cole, 2008).

My use of poetry, seasonal metaphor, and textile art sits within this tradition of ABR inquiry. Each creative form provides a different language through which to think and feel my way into understanding. The poems that open the chapters are not merely decorative preludes but integral analytic acts. They condense emotion, gesture toward meaning, and invite reflection (Faulkner, 2017). The seasonal framing (summer, autumn, winter, spring) operates as an interpretive structure through which I trace cycles of rupture, endurance, and renewal. The crocheted canvases extend this inquiry into the tactile realm – transitioning memory and affect into colour, texture, and form.

Through these practices, I engage in what Finlay (2008) describes as embodied reflexivity: a form of knowing that emerges through the interplay of action, emotion, and creative practice. By combining critical analysis with creative practice, this thesis positions ABR as not only an illustrative tool but a legitimate mode of knowledge production. One that honours emotion, subjectivity, and imagination as vital dimensions of understanding the human experience of health (Bochner & Ellis, 2016; Leavy, 2020). I recognise that creativity is not only a mode of expression but a mode of inquiry – one that blurs the boundary between knowledge, art, analysis, and empathy. Yet, working within this creative and deeply personal space also raises complex ethical questions: about representation, vulnerability, and responsibility to both self and others. The following chapter turns to these ethical considerations, examining how I navigated care, consent, and integrity while translating lived experience into artistic and scholarly form.

Chapter 4: To Do No Harm [Ethics]

> "Ethics is knowing the difference between what you have a right to do and what is right to do."
>
> Potter Stewart[14]

Ethics: A journey in itself

I began thinking about ethical considerations long before embarking upon this project. Or more accurately, long before embarking upon this project, I decided there was no need for me to apply for research consent from Massey University's Human Ethics Committee (Massey University, 2017). After all, I was the only research participant; why would I need a committee's permission to write about myself? Oh, the naivety of the inexperienced!

Yet why would I think any different? A year before beginning my thesis I started borrowing books, researching journal articles, watching videos/webinars about autoethnography, and attending conferences about autoethnography; and found very little mention of ethics. In *Autoethnography as Method,* Chang (2008) devotes less than a page and a half to the topic; and seems only concerned with confidentiality. Namely, that by identifying myself as the subject of the story being told, it becomes far more difficult to protect the privacy of others (than it would be when undertaking other forms of studies involving human subjects in which my participation would be limited to merely observing and interpreting data). Fair point. Similarly, in the American Psychological Association's publication, *Essentials of Autoethnography*, Poulos (2021) summarises the question of ethics into a single paragraph. His overarching advice is to be guided by the ethical consideration to 'do no harm'. Which can be achieved through a relational ethic of care and compassion towards oneself as well as others (including readers). When I turned to *The Handbook of Autoethnography* (Holman Jones et al., 2022), I expected a more sustained discussion of ethics, given the book's scope and the maturity of the field. Yet even there, ethical considerations were largely embedded within broader discussions of relationality, vulnerability, and representation rather than treated as a distinct methodological concern. This did not surprise me. If anything, it confirmed what I was beginning to realise: that ethics in autoethnography is not a set of procedural rules but an ongoing, lived practice: a journey of attentiveness and care, unfolding throughout the research process.

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[14] American judge (b. 23 January 1915, d. 7 December 1985)

Stories are never created in a vacuum – there are always active and non-active participants surrounding the main character (Chang, 2008). As I began discussing my choice of methodology with various professors and my academic supervisor, it was pointed out to me that there were at least two "characters" within my story that I needed to take into consideration: one being myself, and the other being the organisation that I was working for at the time of the mandates. It was never my intention to tarnish the reputation of my former employer. I hold no grievances against either the organisation or any of the individuals with whom I worked. I do not hold them responsible for what happened to me and if anything, I view them as victims of circumstances – denied any rights to agency through the mandates imposed upon anyone operating within healthcare. Yet I must acknowledge that the audience will form their own judgements based upon their perceptions of the story I am telling. This raised the question of whether I can tell my story without it having negative repercussions on any of the active and non-active participants; and what could I possibly do to protect their identities.

Chang (2008) suggests that the only way to protect both myself and others is to write under a nom de plume (pen name). But is this not a form of silencing? A denial of my right to tell my story? In hiding my identity, would I not be inflicting upon myself the marginalisation and silencing that I am wanting to raise awareness of? I found validation of my dilemma in Edwards' (2021) discussion on how we can enhance the ethic of respect when conducting autoethnographic studies:

> "Key responsibilities and objectives within an ethic of autoethnography include allowing the voice of the author to be heard. To silence this voice because descriptions of others' culpability in causing the author discomfort or distress might expose these others to a type of harm is a difficult balancing act with regards the competing claims of the *right to be heard* and *oppressive silencing*."
>
> (Edwards, 2021, p. 4)

Unpacking it further with my academic supervisor, I decided to fully consent to revealing my identity. However, I cannot consent on behalf of other participants – active or non-active. According to Tolich (2010), before embarking upon any kind of autoethnographic writing, the researcher must gain full consent from all active and non-active participants. Furthermore, he suggests that the gaining and maintaining of consent should be on-going throughout the process up to and including publication. Yet he questions whether such consent (especially when sought retrospectively) could ever be given without an element of coercion. What he is saying, is that a person may feel unable to say no to participating when they know that my ability to complete this dissertation (as intended) may be dependent upon their consent. Whilst further down the track, they may feel even more pressure to agree to publication knowing that I have invested a substantial period of time in the writing of this thesis and that my academic and professional future may be impacted by their decision.

I decided not to seek explicit permission from non-active participants but rather, to protect their privacy by keeping them anonymous and avoiding the disclosure of any identifiable information. I also committed to evaluating (with guidance from my academic supervisor) each mention of a non-active participant; and ensuring I maintained an ethic of care and compassion by seeking permission whenever questions of privacy arose.

The first example of this was when I decided to include some photographs in the preface that included my father, mother, and brother. I knew my mother would have no issue with me including photographs of her within my work; and she did not disappoint. My brother on the other hand, surprised me. I hesitated in asking him – pondering the best approach – fully expecting him to say no. Yet much to my delight, not only did he grant me permission, but he even supplied me with better quality digital scans of the photographs I was wanting to use.

It was not possible to consult with my father – given that he is no longer earth-side. But I am confident that he too would have supported me in my academic endeavours – and would have proudly granted me permission to publish photographs of him. Still, I am conscious of the delicate responsibility that comes with representing someone who cannot speak for themselves. I hold a deep sense of guardianship over my father's legacy; the decision to include him in this work is not taken lightly but made in the spirit of honouring the love, wisdom, and influence that continue to shape who I am.

How do you ask a deceased person for permission? How do you ethically represent those who can no longer give their consent yet remain integral to the story being told? These questions resurfaced when considering whether to include the name of my late GP, Dr John Pollock, whose compassion and integrity deeply influenced my understanding of care and medical ethics. John passed away well over a decade ago, making it impossible to seek permission directly. I therefore needed to reflect carefully on how to acknowledge his presence respectfully – balancing transparency and gratitude with an awareness of the privacy owed to his family and patients.

John occupies a unique place in my story. As my GP, he was not only a clinician but also a moral touchstone whose compassion, humility, and deep humanity profoundly shaped my understanding of what it means to ‘do no harm.’ To omit him would be to erase a formative influence on both my personal and professional development. I include his name with reverence, acknowledging that while he is no longer here to provide consent, his public role as a respected physician and his enduring impact on my ethical worldview justify his presence within this narrative. Nevertheless, I have been mindful to represent him with care, avoiding any speculation or detail that might encroach on the privacy of his family or former patients.

These reflections made me increasingly aware that ethical decision-making in autoethnography extends far beyond procedural approval or formal consent. It is, at its heart, relational – embedded in ongoing encounters with people, memories, and institutions that continue to shape the story even in their absence. Each narrative choice carries implications for others, and with that, a responsibility to act with empathy and care. This understanding forms the basis of what Bochner and Ellis (2016) describe as *relational ethics*: an ethic grounded not in abstract rules, but in attentiveness to the human conditions that sustain our research and our lives.

Relational ethics

Relational ethics recognises that ethical practice is not confined to institutional approval processes or formal consent procedures; it is something lived and continually negotiated through relationships (Bochner & Ellis, 2016). It asks the researcher to remain attentive to the impact of their words, silences, and representations on others – both present and absent. In the context of autoethnography, where the boundaries between self and others are blurred, ethical responsibility becomes a continual process rather than a single event. It is enacted through care, reflexivity, and an ongoing sensitivity to the relational nature of storytelling (Bochner & Ellis, 2016).

As Ellis (2020) reminds us, relational ethics begins with empathy. It requires the researcher to consider how their writing may affect those implicated in the story, including those who may never have the opportunity to read or respond to it. This is particularly significant when working with intimate or emotionally charged experiences. Ethical autoethnography therefore involves more than protecting anonymity – it entails writing with compassion, humility, and respect for the dignity of others. It also demands a willingness to hold oneself accountable for how one’s representations may be interpreted or misinterpreted.

Within critical health psychology, relational ethics resonates strongly with the discipline's commitment to social justice and reflexivity. Both perspectives view the researcher as embedded within systems of power and relationship, and therefore responsible for recognising how those dynamics shape knowledge production. Finlay (2008) suggests that ethical practice involves ongoing reflexive awareness of how privileges, vulnerabilities, and biases enter the researcher encounter and influence what is observed, said, and unsaid. In this sense, ethics is not about achieving moral purity but about cultivating responsiveness and integrity in the face of complexity.

In my own work, relational ethics has meant writing with attentiveness to the lives intersecting with mine: colleagues, family members, and institutions. It has involved protecting the identity of my former workplace by avoiding specific identifiers, while still being truthful about my lived experience. It has meant pausing to consider how my words might affect those who appear within my story, whether by name, inference, or proximity. These moments of hesitation are, I believe, integral to ethical scholarship – they reflect a consciousness that storytelling always carries consequences.

Ultimately, relational ethics is grounded in care. It invites an ethic of kindness not only toward others but toward oneself as researcher and narrator. Writing autoethnographically can stir deep emotion (such as grief, anger, vulnerability) and ethical responsibility includes acknowledging these affects without exploiting them. This orientation of care naturally extends into what follows: an ethic of the self, where the wellbeing of the researcher becomes both a moral and methodological consideration.

Ethic of the self

An ethic of the self centres on the researcher's responsibility to safeguard their own wellbeing throughout the research process. As Edwards (2021) notes, autoethnographers face the dual challenge of revealing deeply personal truths while managing the emotional, reputational, and relational risks of such exposure. This risk may be particularly acute when the narrative engages with trauma, illness, or conflict – experiences that may reopen wounds or evoke unresolved emotions.

Xue et al. (2025) expand this view by proposing a self-consent approach: a practice of ongoing self-check-ins to ensure the researcher remains emotionally and ethically aligned with their work. They outline six categories of ethical risk – psychological, physical, privacy, social, career, and integrity – each requiring intentional reflection and self-care. This framework encourages researchers to treat themselves as participants whose consent must be continually revisited. For me, this resonates deeply with the cyclical process of writing and resting, reflecting and reframing, that characterizes both chronic illness and creative inquiry.

As Edwards (2021) argues, the researcher has an obligation to investigate their experience authentically, but this can be painful. Revisiting the past may reawaken grief or uncertainty. In my case, chronic fatigue syndrome (CFS) – a lasting consequence of my vaccine injury – continues to shape not only my daily life but also the rhythm of my research. There are days when writing becomes impossible and rest itself becomes part of the methodology. Honouring the ethic of the self therefore means recognising these limitations, refusing to frame them as failure, and instead viewing them as integral to the embodied nature of this work.

Ultimately, an ethic of the self involves compassion without self-erasure. It requires acknowledging the emotional labour of autoethnography and engaging in practices that sustain both integrity and wellbeing. As I continue to write about vulnerability and power, I strive to ensure that the process itself remains an act of care – for the participants in my story, for the readers who may share in it, and for myself as the storyteller.

Ethics, in this project, is not an external framework imposed upon the work but a living thread woven through it. From relational care to self-compassion, each ethical choice has shaped how I write, remember, and represent my experiences. The process has taught me that ethical inquiry is inseparable from reflexive practice: every decision about what to include, omit, or reveal becomes a moment of self-examination. As I move into the next chapter, this ethic of reflexivity continues to guide me – inviting honesty without harm, transparency without exposure, and storytelling that remains grounded in care for both myself and others.

Procedural ethics

In practice, this process began by researching peer-reviewed academic writing and watching video lectures/webinars by academics on the topic of ethics when conducting autoethnographic research. I then discussed my initial findings and thoughts with Massey University staff teaching into the Master of Science (Health Psychology) programme who shared their own personal opinions on my chosen methodology and associated ethical considerations. I also had extensive conversations with my academic supervisor and together we met with a former academic supervisor who has lived experience of supervising Master's level students conducting autoethnographic research. As a result of the above meetings and discussions, I conducted further research before presenting my academic supervisor with the potential ethical issues that may arise whilst carrying out this project; and we discussed ways in which I can minimize risks and address any ethical issues. My supervisor and I then decided to complete a low risk ethics application. A copy of this notification letter can be found in Appendix B (Low risk ethics notification 4000027257).

Chapter 5: The Process [Reflections]

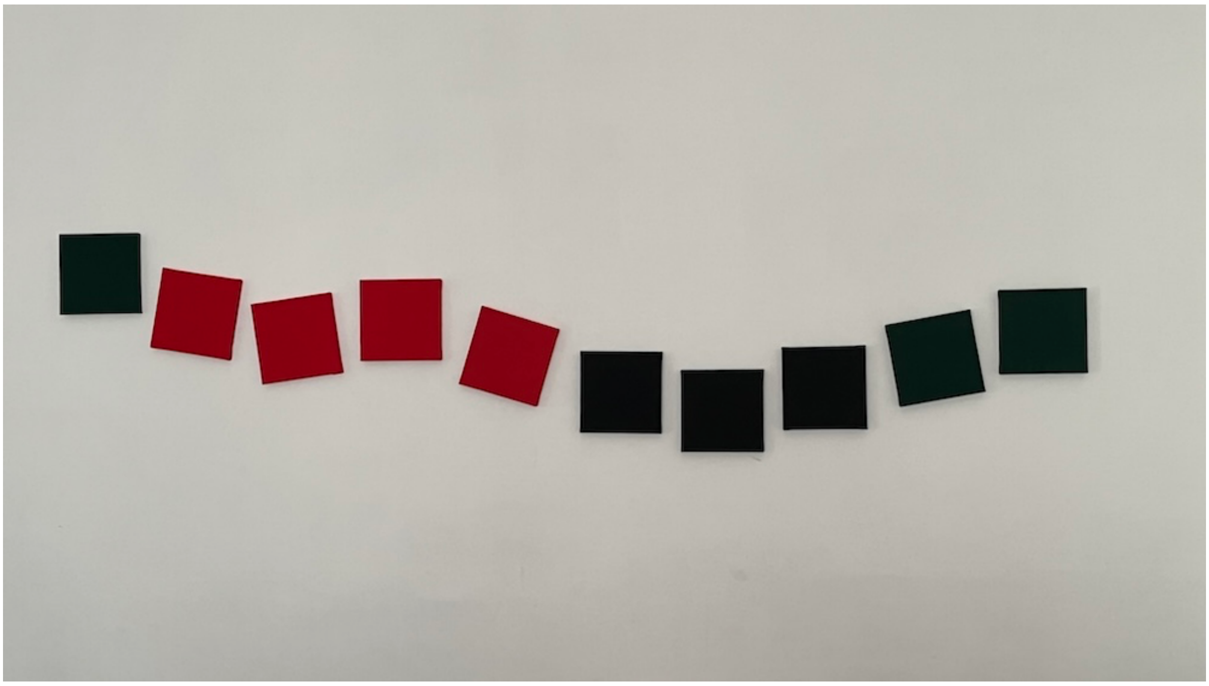

Image 8: The journey begins

Reflexivity

to speak
words of what
we
feel;
storytelling turns
knowledge from
inside to outside

speak to
what of words
we
feel;
turns storytelling
from knowledge
outside to inside

Franciska

On being questioned

I experienced a number of tensions throughout my dissertation journey and very quickly felt the need to justify not only the topic of focus, but my chosen methodology.

> I am on a Zoom call for health psychology postgraduate students. It is a regular, informal drop-in session where students and teaching staff come together for information sharing and *support*. There is generally a set topic presented by one of the professors; followed by open discussion. Today we're talking about the Master's thesis and we (the students) are invited to talk about our ideas. I had not long

> decided to pivot my focus for both topic and methodology and was very much bubbling with excitement. When my turn comes, I share my excitement about the direction my thesis has taken – my decision to explore the pandemic experience through autoethnography. There's a pause. Then, a fleeting expression crosses one of the professor's faces, followed by a comment that lands heavily. I can't recall the exact words, but I remember the tone. The implication is clear enough: autoethnography (by their standards) is not valid research. The air feels different now and I feel a heaviness in the pit of my stomach and my heart racing. I feel the need to justify not only my topic but my very right to explore it this way. But instead, I fall silent – silencing myself.

In hindsight, this moment became a turning point. It reveals how academic spaces – even those that champion reflexivity and critical inquiry – can reproduce hierarchies of legitimacy. I am reminded that knowledge is not only produced but policed – that some ways of knowing must constantly defend their right to exist. I left the meeting unsettled but resolute. If autoethnography is not considered "proper" research, then perhaps that is precisely why it must be done.

That moment stayed with me, not as a wound but as a mirror. It forced me to examine my own internalised assumptions about what counts as knowledge and who decides. Throughout the process of writing this thesis, I returned to that discomfort time and again – reminding myself that reflexivity begins in the body, in the tightening of the chest when one's legitimacy is questioned and resolves in the quiet decision to keep speaking anyway.

Spelling error or intentional pun?

I like to think that I have an excellent grasp of spelling and grammar. I know the difference between their, there, and they're; and still hear the rules in my head as I am writing ("i before e, except after c"). But I admit, I have always struggled with "its" and "it's" (my current solution being to tell myself it is the opposite of whatever makes sense to me). Halfway through writing this thesis I learned that I have also been incorrectly using the word "who's".

> Thesis supervisor [hesitatingly, during a video call]: "I have been meaning to ask you… did you intend to use "who's" in the title? Because grammatically, it doesn't make sense. Unless it was an intentional pun?"

Please world, open now and swallow me. I was SO embarrassed. Why, oh why aren't the rules around apostrophe-s use consistent? How is one to know that words like "it's" and "who's" are a contraction and not a possessive?

Lesson learned. “Who’s” actually means “who is” or “who has”. Whereas what I intended to say was “whose” (being the possessive; referring to the person whom health belongs to). Confession: I have no recollection of ever having used the word “whose” in my life. It is completely and utterly foreign to me. I tried changing the title (and re-naming the word document) but it both looked and felt wrong. So, I pondered some more. Whilst my overarching question is around prioritising the health of some people over that of others, in order to address and unpack the issues, we need to both define what health “is” and identify who “has” it in the context of Covid-19 and vaccine mandates. Therefore, I made the conscious decision to keep the title as is. Thus, turning my spelling error into an intentional pun.

Language, tone, and the ethics of writing

Even seemingly small stylistic choices reveal the entanglement of language, emotion, and ethics. When the announcement came from the WHO I welcomed and fully embraced the official name – it made so much sense to me. Indeed, I took great effort to write CoViD-19 from this point and was most disappointed to eventually realise that my use of mixed case for the abbreviated name was never universally adopted. Pity. I find it rather aesthetically pleasing.

After reluctantly adopting the upper- and lower-case version (that is, Covid-19), I began noticing that almost every journal article I was collecting (Croucher et al., 2021; Gilray, 2021; Officer et al., 2022; Starink, 2022; Summers et al., 2020; Tay, 2023) was using all upper-case (that is, COVID-19) – with just one outlier (Gauld, 2023) electing to abbreviate the name further to simply “Covid”. Similarly, the Ministry of Health publications (2023a, 2023b, 2023c, 2024) along with reports prepared for the MoH (Horizon Research, 2022), Te Whatu Ora – Health New Zealand (n.d.), and of course the WHO (n.d.), all use COVID-19. Yet mainstream media (1news, n.d.; RNZ, n.d.; Stuff, n.d.; The New Zealand Herald, n.d.) have consistently used Covid-19.

In 2020, Elisabeth Ribbans from The Guardian was asked by a medical specialist why the media was “incorrectly” printing COVID-19 as Covid-19. She explained that The Guardian (like most British newspapers) only use all upper-case for abbreviations in instances where the name/term is written and spoken as a collection of letters; for example, BBC[15] or NHS[16] in Britain; TVNZ[17] or IRD[18] in Aotearoa. Whilst upper- and lower-case is used for abbreviations pronounced as words; such as, Nasa[19], Unicef[20], and now Covid-19 (Ribbans, 2020). Since we tend to follow British spelling and grammar, it makes sense that the media in Aotearoa follows suit.

In weighing up my limited options, I decided to stay with the upper- and lower-case version. In part because whenever I read anything in all upper case, it feels like the author is shouting at me. I associate shouting with anger and hostility. Therefore, I would be neglecting my ethics of the self if I were to force myself to type in all capitals every time I refer to the virus – potentially causing unnecessary distress. Worse still, it could obstruct my goal of finding deliverance from my experiences of the vaccine mandates by reinforcing an anger narrative.

I now recognise that even this seemingly trivial choice around capitalisation reveals the intimate link between language and emotion. My decision to soften the typography mirrors my broader attempt to resist polarisation – to write with care rather than confrontation.

I acknowledge that in choosing to refer to the virus as Covid-19, I am going against what appears to be the academic standard. But this is not a lab report or quantitative research project. This is a deeply personal account of a human experience. Furthermore, I see autoethnography as a bridge between art and (social) science – blurring the boundary between storytelling and analysis. My intention with this thesis has always been to write and publish my story in a manner that is accessible to anyone and everyone who may be interested in learning from my experiences of vaccine mandates.

Language not only reflects the context it is used in, but is also active in the creation and maintenance of that context (Taheri, 2020). This is significant not only in *my* choice of language throughout this thesis, but also the intentional use of language in the political realm during the pandemic. It raises questions of privilege and power. As Taheri (2020) states:

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[15] "The BBC (British Broadcasting Corporation) is a British public service broadcaster. Its main responsibility is to provide impartial public service broadcasting in the UK, Channel Islands and Isle of Man." (https://www.gov.uk/government/organisations/bbc)

[16] The NHS (National Health Service) is Great Britain's comprehensive, government administered public-health service. (https://www.britannica.com/topic/National-Health-Service)

[17] TVNZ (Television New Zealand) is a Crown entity (state-owned) media company operating a free-to-air television network, streaming service, and new service in Aotearoa. (https://corporate.tvnz.co.nz)

[18] The IRD (Inland Revenue Department) is responsible for collecting revenue (by way of taxes from individuals and organisations) that Aotearoa's government needs to fund its programmes; as well as administering a number of social support programmes. (https://www.ird.govt.nz/about-us)

[19] Nasa / NASA (National Aeronautics and Space Administration) is an independent agency of the United States federal Government responsible for the space programme and carrying out aeronautic and space research. (https://www.nasa.gov)

[20] Unicef / UNICEF (United Nations Children's Fund, formerly known as United Nations International Children's Emergency Fund) is the United Nations agency working globally to protect the rights of children to health, education, and survival. (https://www.unicef.org)

> Language “can be a tool of discrimination or of empowerment. We can use it to foster discrimination, unintentionally or otherwise, or we can use it to help make a fairer world.”
>
> (Taheri, 2020, p. 151)

As you will see in sections to come, the Government relied upon and referred to ‘scientific evidence’ to support their policies in managing the pandemic; and tensions arose as members of the public began questioning the decisions being made. I see two issues here: firstly, scientific articles are often behind paywalls – creating a barrier to access for the public. Secondly, scientific articles are using increasingly complex language – making them less readable to those outside of academia (Rosenberg et al., 2023). Access to research information – particularly data upon which public health decisions are made – needs to be equitable to all stakeholders.

The pandemic highlighted the growing interest among a broader audience to access research information and for the data to be presented in a manner that is understandable. In response, scholarly publications have adopted plain (non-technical, jargon-free) language summaries (PLS) of articles. PLS champions diversity, equity, inclusion, and accessibility to research information (Rosenberg et al., 2023). I am taking this further – rather than writing just a summary that is accessible and readable, I endeavour to write this entire thesis using language that is accessible for all.

Magyarország (and all those weird looking words)

Studying social sciences in Aotearoa, I learned to not only respect the Māori language (te reo Māori) but to also use it wherever appropriate. When I began working as a therapist, I made the conscious decision to employ Māori greetings when corresponding with clients, colleagues, and suppliers (from sending out appointment confirmations, invoices, etc. to posting on social media). This practice not only honours the principles of Te Tiriti o Waitangi (partnership, participation, and protection), but also feels natural, normal, and the “right” thing to do. Māori is, after all, one of the three official languages of Aotearoa.

As I began writing the preface of this thesis, reading over the social media post I made on the 40th anniversary of arriving in Aotearoa, I noticed (for perhaps the first time in my life) that I always refer to my country of birth as “Hungary”. Yet the name Hungary only exists in the English language. Whilst I appreciate that it is common for languages to translate the names of countries, and I *am* writing this dissertation in English, to not use “Magyarország” feels like I am denying my identity in order to make the reading experience more accessible to others. Conversely, by using Magyar words wherever appropriate, I am reminding the reader of my ethnic and cultural heritage; the foundation of my identity; and the influence on the way in which I experience, perceive, and make sense of the world. To help non-Magyar speaking readers, I have included both footnotes and a glossary (see page viii).

Writing on both English and Magyar is more than a linguistic choice; it is an act of reclamation. Each accent mark, each unfamiliar word, gestures toward the layered identities I inhabit: migrant, researcher, and therapist. Through language, I trace where I come from and how those roots shape the way I view, experience, and write about the world. In this sense, the act of writing becomes another kind of translation – not only across languages, but between selves.

The seasons metaphor

What began with great gusto came to a grinding halt soon after submitting my ethics application (see Chapter 4). I had the skeleton outline of my thesis; eagerly awaiting feeding. I had all the ingredients; ready to be combined into a culinary feast. I even had the utensils, vessels, and appliances; all at the ready. But the instructions were missing.

Then one day I received a suggestion: *“how about you start with a timeline?”* Sure! What a superb idea. So, I set about writing a timeline of events but struggled to connect with the words on the screen; I could not visualize the story I was wanting to tell. Perhaps an infographic in the form of a flowchart was what was needed – a map we could all refer to as we navigate through my story. But all I was doing was moving words around the screen, trying to direct them into some kind of order.

What am I trying to achieve here? I asked myself. We all know the facts – the milestones – of the Covid-19 pandemic. What has now become contemporary history was documented in real time across a wide array of media and is readily accessible to anyone via cyberspace. There is also a growing volume of academic literature studying the global pandemic: from the biomedical at the human cell level to the political at societal level, and everything in-between. To regurgitate statistical data would not be contributing anything new, and quite frankly, felt pointless. What I *could* contribute uniquely, however, was my lived experience of the vaccine mandates.

Perhaps my story will reach past, current, and future policy makers; and feeling seen and heard will enable me to heal and let go. Perhaps my story will touch others who experienced similar circumstances and allow them to feel validated. And maybe – just maybe – my story will help those who were not affected in similar ways find the empathy with which to treat those who differ from them with compassion, rather than hatred and ridicule.

As words blended into a flowchart
The flowchart ignited visceral feelings
The feelings transformed into colours
The colours evolved into distinct seasons
Thus, my journey's metaphor was born.

Franciska

Thus, the idea of separating the factual events from my lived experience was born; and in aligning them side-by-side I began to see my journey unfold (see Appendix A). Throughout my studies, I have read about the meaning-making power of arts-based methodologies (see Chapter 3), but to experience it first-hand was transformative in ways that are almost indescribable. What had been an abstract methodological concept suddenly became lived knowledge. As colours, shapes, and emotions emerged through the creative process, I found myself moved in unexpected ways – sometimes exhilarated, sometimes tearful, often both at once. The act of visualizing my journey dissolved the boundaries between analysis and feeling; knowledge began to take form through the senses as much as through intellect.

In this moment, I understood what Bochner (2020) means when he describes how metaphor allows us to "weather storms and live through interruptions in the flow of the story of our lives" (p. 82). The use of seasons as metaphor is not new within autoethnography, yet finding this passage *after* I had intuitively arrived at my own "seasons" framework felt like a moment of kinship rather than citation. It affirmed that what I had created instinctively was also methodologically legitimate – a gentle reminder that art can, at times, anticipate theory.

The more time I spent conceptualising a visual representation of my journey, the more meaning I was able to attribute to my experiences, and the more I learned about myself. Moreover, once I was able to step outside of myself, I saw just how distorted my perceptions were from "reality". This further strengthened my social constructionist stance: there really is no single universal truth. Each of us interprets experience through shifting seasons of our own – moments of clarity and obscurity, of growth and retreat – continually making meaning as we go.

The natural cycles of the seasons provided language for articulating my journey's emotional landscape. Each phase embodied distinct energies, colours, and sensations.

Through the seasons, I could convey transformation not as linear progress but as a cyclical movement of loss, endurance, and renewal. In many cultures, the changing of seasons symbolises ritual, reflection, and regeneration. For me, they became a complex, analogy-based metaphor – an abstract framework through which deeply personal experiences could take physical, visual form.

In hindsight, I suspect that my attraction to the seasons metaphor was unconsciously influenced by the staging of Andrew Bovell's *Things I Know to Be True* – a play that explores family heartbreak and truth through scenes staged in four distinct seasons. Only now, as I reflect on my own creative process, do I recognise how profoundly this theatrical imagery shaped my way of thinking.

Covid's four seasons

Table 1 shows the time periods that I am covering in my seasons of Covid. Perhaps not as musical as Vivaldi's *Four Seasons*, but perhaps just as lyrical?

Table 1: Seasons for my Covid-19 journey

Summer *(12 Dec 2019 – 29 Dec 2019)*	Carefree. Sun-soaked. A sense of lightness and anticipation. This was the calm before the storm – a time of innocence, laughter, and warmth.
Autumn *(7 Jan 2020 – 6 Aug 2021)*	The winds shift. Leaves begin to fall. There is melancholy, uncertainty, and the slow fading of vitality. A lingering sense of unease, though the full weight of winter is yet to arrive.
Winter *(12 Aug 2021 – 12 Sep 2022)*	Darkness descends. The air grows heavy and cold. The world contracts inward. Isolation, exhaustion, and despair dominate this season. It feels endless.
Spring *(26 Sep 2022 – 5 May 2023)*	Light returns. Hope flickers through the cracks. Renewal does not erase loss but coexists alongside it. This season hums with quiet resilience – the first signs of recovery.

Note: Table 1 visualises the temporal and emotional rhythms of my Covid-19 journey, mapping significant phases of experience against the metaphor of the seasons. What began as an attempt to chart factual events evolved into a poetic structure that gave emotional shape to time itself.

When I laid out these seasons visually, I had an unexpected revelation: despite *winter* feeling never-ending, *autumn* was, in fact, the longest by far. This realisation unsettled me. It revealed how emotion bends time – how distress compresses memory and distorts perception. What felt endless was not the longest period chronologically, but the most intense experientially.

In developing the timeline that became the basis for Table 1, I initially sought only to order events chronologically. Yet, as I began pairing factual milestones with emotional textures, the seasons emerged almost organically. Through this alignment of outer chronology and inner experience, I came to understand not only my story but also the way meaning, memory, and emotion intertwine. The metaphor became more than an organising device; it became a theory of lived experience – one that acknowledges the cyclical nature of suffering and healing, and the inevitable return of spring.

Stitching the story

I crochet regularly – not only for relaxation, but as a form of creative expression, gift-giving, and meditation. The slow rhythm of hook and yarn offers me a space to create beauty, express care, and quiet the mind. During a supervision meeting, I was asked what visual or arts-based methods I could use to help illustrate the seasons. In that moment, the idea arrived fully formed: what if I translated my experiences into crochet? The tactile nature of the medium – its repetition and rhythm – seemed to mirror the cyclical pattern of the seasons I had already begun mapping visually. Crochet, I realised, could bridge the temporal with the emotional – a way to materialise the abstract flow of my journey in colour and texture.

I crocheted the appliqués in chronological order, aligning each with a chapter of my journey. Summer came first – bright, effortless, and full of life. I chose vibrant flowers in yellow, orange and red, and leafy greens that mirrored the warmth and optimism I felt at the beginning.

Image 9: Summer canvas

Then came autumn: a cascade of reds, yellows, and browns, each stitch echoing the slow surrender of light. I was immersed in rhythm, texture, and colour – the making itself becoming a meditation. But when it came time to crochet winter, I stalled.

Image 10: Autumn canvas

What colour is despair? How do you represent stillness, isolation, or the absence of warmth? It felt wrong to fill the canvas with brightness when everything in me was weighed down by darkness. For weeks I avoided the work altogether, circling around it as if proximity alone might spark an answer. Eventually, I realised that perhaps the absence was the answer. I would crochet the flowers and leaves entirely black – forcing the viewer to examine the artwork from close-up in order to fully appreciate its depth and beauty.

Image 11: Winter canvas

Crocheting with black yarn is an act of endurance. Those who have done it know that it strains the eyes and tests the patience – every stitch nearly invisible, every mistake easy to make and difficult to correct. It felt right. The labour matched the emotional texture of that season: the heaviness, the exhaustion, the quiet perseverance. Each motif emerged slowly, almost reluctantly, from the dark. Creating them became a ritual of survival – a way to sit with the discomfort rather than escape it.

When I reached spring, my hands and spirit longed for colour again. I turned to cherry blossoms, remembering the trees that lined the streets of Christchurch in full bloom when I came to purchase my home in September 2019. The pinks and pure whites carried the promise of renewal. I added forget-me-nots in pale blue – delicate, persistent, and deeply personal. Apuci used to sing *Kék Nefelejcs* ("Blue Forget-Me-Not") when I was a child, and since moving to Christchurch I have planted them in my garden; and even had them tattooed on my arm in his honour. Their presence on the canvases became a quiet conversation with memory – a bridge between loss and continuity, between the stories inherited and those still unfolding.

Image 12: Spring canvas

Once the appliqués were finished, I made another decision: I would only attach them to the canvases as I completed each corresponding chapter of the thesis. The canvases hung on my bedroom wall – blank, waiting. They became silent witnesses to my progress and my pauses, a visual measure of time and labour. Attaching the winter appliqués felt like an act of release. The darkness no longer haunted me; it became proof of endurance. And when I finally reached spring, the joy of attaching the blossoms was almost ceremonial – an embodied declaration that the end, both of this journey and of the story I had carried for so long, was near.

The very last motif was the butterfly. I saved it deliberately, knowing it would symbolise transformation. I crocheted it only once the writing was complete – my final act before submission. In its wings I saw the whole arc of the journey: from contraction to expansion, from silence to articulation, from darkness to light.

Image 13: Butterfly motif

Through this process, art became both documentation and catharsis. Each stitch held memory, emotion, and reflection. Each completed canvas mirrored not only the progress of the thesis but the rhythm of recovery itself. To crochet was to think with my hands – to make sense of what could not yet be written. In the slow, repetitive motion of hook and yarn, I found what words alone could not give: a way of being with the story rather than apart from it.

This creative process exemplifies the principles of arts-based inquiry discussed earlier (see Chapter 3). Through the act of making, reflection became embodied; knowledge emerged not as abstraction but as texture, colour, and rhythm. Each stitch represented an iterative negotiation between self and story – a tactile form of reflexivity where emotion and intellect intertwined. In this sense, the crocheted canvases are not merely artefacts of research but living expressions of inquiry itself: they materialise the central claim of this thesis, that creativity can be both a method of knowing and a means of healing.

Writing the self

Throughout this process, I have learned as much about how I write as about what I write. For most of my life, I have been a last-minute writer – not through disinterest, but through paralysis. What I once dismissed as procrastination I now understand as perfectionism – the fear of not meeting my own expectations, of disappointing both myself and imagined others. That fear would ignite my body's threat response: the tightening chest, the racing thought, the freeze. As Van der Kolk (2015) explains, when the brain perceives threat, the amygdala triggers a cascade of psychological defences designed for survival, even in the absence of immediate danger. Similarly, Porges' (2011) polyvagal theory suggests that the 'freeze' state represents the body's neurophysiological attempt to seek safety when the perceived threat exceeds coping capacity. Beginning felt impossible; only the urgency of a looming deadline could finally cut through the noise.

As my understanding of reflexivity deepened, I began to see this pattern differently. Rather than labelling it as a personal flaw, I came to view it as a somatic response to vulnerability – the physical manifestation of self-doubt. The act of writing autoethnographically exposes one to judgment – both internal and external. Each word risks misrepresentation or misunderstanding. Recognising this, I began to practice a gentler form of accountability: acknowledging my body's resistance not as an obstacle to overcome, but as part of the process itself.

In mid-2024, something shifted. For the first time, I wrote freely – untethered by chronology or order. I captured ideas as they came, leaping between sections, following threads of emotion or memory rather than logic. Some days I wrote in long bursts of clarity; other days, only a few sentences. Yet the fragments began to weave together organically, like stitches joining into fabric. This nonlinear method mirrored the nature of both memory and healing: uneven, cyclical, unpredictable. Writing ceased to be an act of control and became one of trust.

Later that year, fatigue returned with force. Brain fog settles like mist over my thoughts, and sentences once fluid became sluggish. I recognised this as part of the rhythm of CFS – a lingering consequence of my vaccine injury that continues to shape my daily life. Where once I might have called this writer's bock, I began to see it as the body's demand for rest. The stillness, too, was productive in its own way. Reflection often arrived in the quiet intervals between effort and recovery.

This experience deepened my understanding of embodiment in the research process. Writing was not merely cognitive but profoundly physical – influenced by energy, pain, and emotion. To write through fatigue required pacing, patience, and compassion. It meant relinquishing the myth of constant productivity and honouring the cyclical nature of creativity. In this, I recognised parallels with my own theoretical stance: that meaning making is iterative, relational, and shaped by the conditions of our bodies as much as by our minds.

By accepting my fluctuating energy as part of the research ecology, I learned to write *with* my body rather than against it. The work unfolded in pulses of presence – bursts of inspiration followed by rest, reflection, and return. This rhythm, though slower, felt more authentic. It aligned with the core principles of both autoethnography and arts-based inquiry: that knowledge is lived, felt, and continually in the making.

Ultimately, the process of writing the self became a practice of self-understanding. Each pause, setback, and reawakening mirrored the story I was telling – one of endurance, adaptation, and renewal. The thesis, like the body, found its way forward not through force, but through flow.

In many ways, this process of writing and un-writing myself became a rehearsal for what follows. It taught me to listen – to my body, to my emotions, and to the rhythm of words as they rose and retreated. By learning to honour these ebbs and flows, I came to understand that storytelling is not a linear act of narration but a living dialogue between past and present, self and society, stillness and movement. Just as winter eventually gives way to spring, the story now shifts from reflection to renewal – from theory into life itself. The next chapters of Part II unfold as lived seasons: moments of darkness and light, rupture and repair, told through the language of experience. Here, the abstract becomes flesh, and the personal becomes political once more.

PART II [The Story]

To guide the reader through the unfolding chronology, I have used visual timeline boxes throughout Part II. The grey boxes mark key public events and official announcements related to the pandemic – contextual anchors that situate my story within the wider social and political landscape. The blue boxes, by contrast, represent moments from my personal life: emotional, relational, or embodied experiences that ran parallel to the public timeline. Together, these timelines weave the external and internal dimensions of the pandemic, illustrating how lived experience intersected with collective events. In this way, the timelines function both as data and as sense-making devices – a visual method for tracing how meaning emerged through the interplay between personal narrative and public discourse.

Chapter 6: Summer [Blissfully Ignorant and Unconcerned]

Image 14: Summer

Summer

The sun shines brighter as the days grow long,
A gentle breeze summons my name in a song.
I pack up my dreams, my hopes, and my things,
Into brown packages, tied up with strings.

Leaving behind the familiar sky,
Chasing the dawn as I say goodbye.
Farewell the sand and the salt in the air,
Following whispers of a life elsewhere.

As the long and winding road unfolds,
I dream and wonder what the future holds.
Away from busyness and stress running rife,
I yearn for a quieter pace of life.

With the turn of a key, the door swings open,
The light that spills in is bright and golden.
I unpack the years, the loves, the losses,
Tuck them away in cupboards and corners.

I walk amongst early morning dew,
Planting sweet daisies where weeds once grew.
Exploring the city with eyes anew,
Each step is a promise; each view a clue.

Franciska

Blissful ignorance

It was the beginning of summer 2019/2020. I had not long moved to Christchurch and was still in the process of unpacking boxes and exploring the city that was to become home during the next phase of my journey through life.

Although I had already experienced a major move from one side of the world to another, three and a half decades later, this move from one end of the country to the other felt very different. During the first move, I had my immediate family to embrace, support, and protect me as I navigated the feelings associated with cultural assimilation; the sense of loss, not belonging, and being othered (Hodgetts et al., 2020). This time, however, I was on my own. Yet embarking upon this journey alone did not concern me. I felt no apprehension of being viewed as an outsider. After all, I could speak the language and having come from a culturally diverse city, did not foresee any issues with fitting in; despite there being differing ethnic and religious demographics from what I had previously assimilated to. Rather, I was excited. Excited over the prospect of a slower, quieter pace of life, and a greater sense of community than what Auckland provided for me.

Clearly, I had considered "place" and "society" but had overlooked the impact of "time" on my experience of the world; and in turn, my meaning making. In moving from one physical space to another, I had not anticipated that the world as I knew it – indeed, the whole of humanity – was about to change.

Image 15: Anyuci on Mount Cavendish (December 2019)

Anyuci[21] arrived in Christchurch on 12 December 2019 – the 36th anniversary of our arrival in Aotearoa. She had not long been back from having spent six months in Magyarország and was keen to do lots of sight-seeing; despite having a niggling cough that she could not shake. We visited the International Antarctic Centre where we patted Huskies, experienced an Antarctic storm, and rode in a Hägglund[22]. We spent time at Willowbank Wildlife Reserve where we giggled about the geese (goose liver pâté being a delicacy in Magyarország). We caught buses to and from the central city where we walked for hours amongst buildings old and new, through Cathedral Square, and around the Botanic Gardens. We rode the Gondola up Mount Cavendish to take in the spectacular 360-degree views of Christchurch. We took a ferry from Lyttleton to Diamond Harbour where we visited Stoddard Cottage[23] and wandered contemplatively through a cemetery. We shopped in garden centres and grocery stores. We dined in cafés, pubs, and restaurants. We moved amongst strangers.

Anyuci's visit ended on 17 December 2019 with us locked in a tearful embrace; surrounded by dozens, if not hundreds, of travelers passing through Christchurch Airport.

Longing for that care-free world I once knew

Reflecting on this pre-pandemic time through my post-pandemic lens, I find myself longing for that care-free world I once knew. To this day, no matter where I go, every time I leave the house, I see people wearing face masks; sense tension within my body as personal spaces are crossed; and feel unease at the sound of a cough, sneeze, or sniffing in close proximity. Consciously, I do not consider myself to be particularly concerned about contracting Covid-19. However, the fact that I notice these things and experience a variety of reactions, tells me that my amygdala is still on high alert, scanning for danger.

I often refer to the 2011 Christchurch earthquake[24] to explain the role of the amygdala to my clients. In basic terms, the amygdala's primary function is to keep us safe by scanning for danger on an unconscious level (LeDoux, 2007; Öhman, 2009). However, the amygdala's ability to detect danger is limited to our existing knowledge of what constitutes danger (Tottenham et al., 2009). Although I had visited Christchurch in the late 1990s and mid 2000s, I was still living in Auckland at the time of the devastating earthquake. As such,

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[21] Anyuci is the Hungarian word for "mummy".

[22] First manufactured in Sweden in 1922, a Hägglund is an all-terrain heavy-duty vehicle used to transport people and cargo across snow and ice in Antarctica.

[23] Stoddard Cottage is the birthplace of Margaret Stoddard (b.1865, d.1934); one of Canterbury's foremost botanical and impressionist painters.

[24] On 22 February 2011, a 6.3 magnitude earthquake killed 185 people and injured several thousand; causing severe devastation around Christchurch – bringing down buildings that were previously damaged during a 7.1 magnitude earthquake on 4 September 2010 – some of which is still visible throughout the city over a decade later (https://nzhistory.govt.nz/page/christchurch-earthquake-kills-185).

my brain is blissfully (or perhaps naively) oblivious to the potential danger when the earth rumbles and shakes. For those that experienced the 2011 Christchurch earthquake, the house shaking elicits a variety of responses from an exclamation such as, “that felt like 4.5” to ducking for cover; possibly experiencing a panic attack. Meanwhile, I am casually looking around asking myself, “was that an earthquake or a truck going by?”; and when the shaking continues longer than I would expect it to take a vehicle to pass I ponder, “should I be ducking for cover?”. Thus, illustrating the difference between an individual whose amygdala has been conditioned by lived experience to associate the earth rumbling and shaking with life-threatening danger versus an individual whose knowledge of earthquakes is restricted to second- and third-hand accounts, with a sprinkling of images of unfamiliar places.

The pandemic has become my traumatic event – my devastating earthquake – where the appearance of a mask triggers a danger warning within me similar to the way in which a house shaking may trigger a stress/trauma response in someone who experienced the 2011 Christchurch earthquake. In her autoethnographic essay *This is What I Greive Now*, Cohan (2022) in the midst of the pandemic, reflects on how her world had changed; grieving the loss of freedom, spontaneity, and hope. Like Cohan, I too find myself grieving – grieving for that pre-pandemic blissful ignorance.

And so, it began

29 December 2019:

Chinese authorities advise the WHO of cases of pneumonia of unknown cause, originating in Wuhan, Hubei province.

Soon after her visit, Anyuci asked me what, if anything, I knew about this new illness from China that could be spreading through Europe. I told her about a friend of mine who had also been travelling around Asia and Europe, and like Anyuci, had a lingering cough following a particularly nasty case of the flu. Seemed more than a coincidence, but far from concerning.

Chapter 7: Autumn [Growing Concern for the Wellbeing of Others]

Image 16: Autumn

Autumn

Autumn leaves fall as the bleak season dawns,
Cold winds have come, and a dark sadness calls;
My summer days ended, with sorrow and pain,
Ending my season with more loss than gain.

Shadows have fallen on my joyous days,
Dark spirits played with my careless ways;
Sitting alone at the end of the wharf,
The great storm had come and I feel like a dwarf.

By the waves and the current beating the shore,
My spirit will rise to the wilderness call,
I will stride forward, and not try in vain,
I won't be stopped by the power of rain.

Franciska

Whispers of a distant virus

I consider myself a relatively informed person who keeps up to date with both domestic and international news via television, radio, and social media. In the year 2020, I listened to news bulletins first thing in the morning as I ate breakfast, packed my lunch, dressed, and put on make-up; and in the evenings, watched the six o'clock news as I prepared and ate dinner. In-between, I caught snippets of news whilst listening to the radio as I drove to and from work, and as I interacted with colleagues, clients, and patients. I also subscribed to several news media sources via Facebook[25]; meaning that amongst posts from my friends of jokes, memes[26], and random snapshots of food, pets, holidays, renovations, and celebrations, my Facebook feed was sprinkled with links to news articles.

This was a time before terms such as dis- and misinformation were in common, everyday use; and "fake news" was a claim that Donald Trump[27] threw around to discredit anything in mainstream media that he personally disagreed with. As far as I was aware, no-one (other than Trump) questioned the legitimacy of the information presented to us via mainstream media – and assumption that would soon be challenged as truth itself became contested terrain.

7 January 2020:

Anyuci's 71st birthday.

A new type of coronavirus is identified and isolated by Chinese authorities. The virus quickly spreads into Thailand, Japan, South Korea, Taiwan, Hong Kong, Macau, and the United States.

I recall thinking this is *'just'* another SARS[28] – something happening on the other side of the world, unlikely to affect us here in Aotearoa. At the time, my understanding of contagion was biomedical and distant, rather than embodied and local. If Anyuci had in fact contracted this virus whilst in Europe, she was well and truly over the worst of it and the lingering cough was improving (albeit slowly). Although at this point, media reports spoke of

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[25] Created by Mark Zuckerberg, Eduardo Saverin, Andrew McCollum, Dustin Moskovitz, and Chris Hughes in 2004, Facebook is a social media and social networking platform.

[26] Meme: "an image, video, piece of text, etc., typically humorous in nature, that is copied and spread rapidly by internet users, often with slight variations." (Oxford Languages)

[27] Donald John Trump is an American businessman, media personality, and member of the Republican Party, who served as the 45th president of the United States from 2017 to 2021 (b. 14 June 1946).

[28] Severe Acute Respiratory Syndrome (SARS) first appeared in China in 2002. Although it spread worldwide within a few months, it was quickly contained; and no cases have been diagnosed in Aotearoa (https://www.who.int/health-topics/severe-acute-respiratory-syndrome#tab=tab_1).

the virus being present in China and possibly some surrounding countries. Therefore, any suggestion that Anyuci's recent illness was the same as this new virus was mere speculation – only supported by anecdotal evidence from my earlier mentioned friend who had also become ill with the flu whilst travelling internationally.

13 January 2020:

The first lab-confirmed case outside of China is identified in Thailand.

Still not feeling particularly alarmed. SARS also originated in China and although it rapidly spread across 29 countries on five continents, it never reached Aotearoa. This calm was grounded not only in geography but in privilege – the comfort of distance. The fact that I personally knew two people who might have been exposed to Covid-19 whilst overseas – who had since returned – was not at the forefront of my thought process. I felt physically removed from the situation that was unfolding; and was very much of the opinion that it was 'just' a nasty strain of the flu.

30 January 2020:

The WHO declares the epidemic a global health emergency.

Okay, things just got serious. The WHO is expecting this virus to spread across the entire globe; and I begin questioning just how 'safe' Aotearoa is.

In seeking refuge from the possibility of future wars in Europe, I very much doubt that health emergencies featured among my parents' safety concerns in the early 1980s. I scan the dozens of stories that were repeatedly told throughout my childhood: trudging through snow, tonsils extracted in the family kitchen, hiding school lunch money to buy stockings instead, sheltering in basements from gunfire and bombings… not a single mention of any virus spreading through communities, causing illness or death. The only feature of destruction to life was at the hands of the Russians.

For me, the threat of war has never been of any real concern – our emigration to a remote country has mostly sheltered me from conflict, violence, and societal disturbances fuelled by political and religious unrest. The mosque shootings remain an isolated incident, and I feel safe to go about my day-to-day business. However, as far as I know, viruses do not discriminate – irrespective of ethnicity, culture, religious beliefs, and political views, we are all targets. Whilst any barrier provided by physical distance crumbles at the mercy of global travel. This dawning awareness reflects how globalisation collapses the boundaries between self and society – a theme central to critical health psychology's concern with the social dimensions of risk. Recalling how quickly colds and flus spread across classrooms from my childhood and office spaces during my early adulthood, I imagine a virus could easily take down (no pun intended) an entire airplane of passengers and flight crew – who, upon arrival, would become unintentional accomplices in the invasion of Aotearoa.

When the virus found its name

12 February 2020:

The disease is named Coronavirus Disease [of] 2019 (Covid-19).

Prior to the announcement of the official name, the virus was being referred to as "the Corona". The only "Corona" that I knew of was a golden-coloured alcoholic beverage sold alongside "Budweiser", "Heineken", and "Steinlager". Clearly, I was not alone in this meaning disruption as a plethora of beer-related memes quickly spread across social media. I recall thinking at the time that if people are making jokes about this virus, then surely it can't be *that* serious, right?

17 February 2020:

The WHO says Covid-19 is not as deadly as SARS or MERS.

This is welcome news – supporting my belief that there was no need to be alarmed. Even if the virus does reach us in Aotearoa, it is unlikely to be life-threatening. Or so it seemed.

When the news hit home

21 February 2020:

The first Covid-19 case is reported in Aotearoa.

Until that moment, Covid-19 was something happening ‘out there’ – in China, in Europe, in headlines scrolling across my devices. Although it was concerning, any thought of immediate danger had been mitigated by the privilege of geographical distance. Then, overnight, it was here. Not a story on the news, but an unsavoury character amongst us that could walk up to me in the supermarket, tap me on the shoulder, and follow me home.

I remember the strangeness of the days that followed. Once the news broke, the conversations shifted with everyone having an opinion on the severity of the situation that was unfolding, and I found myself suspended between disbelief and dread – not entirely sure which one to lean into.

Looking back, I can see how quickly risk perception became contagious. At this point, it wasn’t the virus itself that we were catching yet – but rather, it was the fear of it. As previously discussed (see Chapter 1: Risk perception), risk is rarely evaluated on facts alone. Instead, it is socially constructed; shaped by culture, emotion, and trust in authority. I witnessed this happening in real time as some people minimised the danger (labelling the virus as “just the flu”), whilst others began wearing face masks and gloves whilst out in public. Prior to official public health advice, I hovered somewhere in-between – uncertain of the risks, but nonetheless alert to potential danger.

The arrival of that first case in Aotearoa marked the beginning of negotiations between individual safety and collective well-being. At the time, I could not have imagined the extent to which this tension would come to dominate not only public health policy, but the most personal corners of my life. Within months, my sense of belonging in Aotearoa, my faith in public health systems, and my ability to make autonomous choices about my own health would be challenged.

In that moment, however, all I was aware of was a tightening in my chest, a churning in my stomach, and the haunting thought, *what if I get sick?*

The word that changed everything

11 March 2020:

The WHO declares the outbreak a pandemic.

In Aotearoa, the WHO’s announcement landed like an echo – the virus was still contained, but the language shifted the atmosphere. ‘Pandemic’ was not simply a technical classification; it carried symbolic weight, amplifying both the urgency of the threat and the legitimacy of government action. I remember how jarring it was to hear the word spoken aloud. Until then, Covid-19 had been a story of clusters, of containment, of borders holding. Naming it a pandemic reframed it as inescapable. It was less about numbers and more about narrative – a signal that the global story of the virus had now become our story in Aotearoa. This moment illustrates a key concern of critical health psychology: that official discourse shapes risk perception – not by presenting new facts, but by altering the frame through which we understand them.

Between care and fear

> I see a lot of people be like "I would survive the coronavirus; I'll take my chances."
>
> The way I see it, yeah, I'd survive it, but I might carry it to someone who wouldn't.
>
> And that, folks, is the problem.
>
> (13 March 2020, Social Media Post)

In hindsight, this social media post captures the core tension of the pandemic: the shift from individualised notions of risk to collective responsibility. As previously stated, risk is never a simple matter of self-assessment; it is relational. Furthermore, discourses of responsibility often carry moral undertones: who is framed as careful or careless, who belongs to the "team of five million," and who is cast outside it. Re-posting this meme was, for me, both an act of sense-making and an early attempt to align myself with the collective narrative of protection.

Safety through separation

19 March 2020:

Aotearoa closes border to all but citizens and permanent residents. Large gatherings are banned.

This was the first time in history that Aotearoa completely shut itself off from the world. The measure felt both protective and unnerving – a reassurance that steps were being taken, but also a stark reminder of our vulnerability. Soon, safety would mean distance not only from the outside world, but also from gatherings and visitors.

21 March 2020:

A four-tiered Alert Level system is introduced in Aotearoa.

The new framework translated an invisible threat into a language of numbers. Each Level came with rules: how many could gather, whether schools stayed open, when businesses closed. For me, the system made the virus tangible – not only a pathogen but a shifting set of instructions about how to live. From a critical health psychology perspective, the introduction of the Alert Levels illustrates how risk was conceptualised and communicated through government discourse, shaping not just behaviour but the emotional atmosphere of everyday life.

Silence falls

25 March 2020:

A State of National Emergency is declared in Aotearoa at 12:21pm. The entire nation goes into self-isolation (full lockdown) at 11:59pm.

That night, the country fell silent. Roads emptied, shops closed, playgrounds taped off. The ordinary rhythms of daily life were suspended, replaced by the strange stillness of lockdown. For me, the announcement was both surreal and sobering: never before had we been told to retreat into our homes, not as individuals but as an entire nation. The call to 'stay home, save lives' was framed as both an act of kindness and an obligation. This moment exemplifies how collective responsibility was discursively constructed – compliance was not simply mandated but moralised, shaping how we understood our role in the crisis.

29 March 2020:

My daughter's 18th Birthday.

Aotearoa reports our first Covid-19 related death.

This date carried a dual weight: a family milestone marked at a distance, and the country's first Covid-19 death announced. The coincidence brought home how the personal (individual) and the national (collective) became intertwined in unsettling ways during the pandemic. Birthdays, funerals, weddings, and anniversaries were no longer private matters, but refracted through the lens of lockdown rules and daily case updates. For me, this convergence underscored how the pandemic was reshaping both intimate rituals and collective narratives – binding joy and grief together under the same headlines.

Beyond inconvenience

> It isn't just a flu.
> It isn't just about those directly affected by CoViD-19.
>
> I am alive today because two and a half years ago I had the luxury of crying in my GP's office about symptoms the hospital doctors fobbed off. Which resulted in me seeing two specialists and having multiple diagnostic tests performed. Tests that would have taken months to get done through the public health system. I underwent what turned out to be urgent life-saving surgery in a private hospital. Surgery that became far more complicated and serious than what the imaging had revealed. The abscess they found in my bladder was days - if not hours - from bursting. Something I would not have survived had it been left untreated.
>
> If all that was taking place today, I would not be able to have the surgery. Nor the colonoscopy or the MRI that indicated the need for surgery. And I certainly wouldn't be seeing any specialists, because right now, I'm not going to bother my GP with my "inconvenient" symptoms that the hospital doctors fobbed off as a UTI.
>
> If all that was taking place right now, I'd be dead before the lockdown period ends.
>
> Let that sink in whilst you're sitting around, watching Netflix, complaining about the lockdown, and looking at loopholes not to stay at home.
>
> (2 April 2020, Social Media Post)

I was alarmed. It felt like people (that is, the general public) weren't taking the virus seriously. Seemingly everyone was complaining about lockdowns, and many were breaking the rules. All they could see was the inconvenience placed upon them, with zero consideration for the wider implications of our already stretched health system having to manage even greater demand – with potentially fewer resources as healthcare workers themselves become infected.

Looking back, I see how my personal medical history shaped my urgency. For me, risk was not abstract. It was embodied, urgent, and inseparable from my awareness of an already fragile health system.

After the silence, small beginnings

10 April 2020:

Second Covid-19 related death reported in Aotearoa.

Each death was announced with solemnity, carrying a weight far beyond the number itself. Even at two, the losses reverberated, reminding us that behind the statistics were lives, families, and grief.

13 April 2020:

Aotearoa Covid-19 related death toll: five.

By now, the daily updates had become a national ritual – numbers read out, carefully tracked, their gravity magnified by repetition. It was unsettling to feel collective mourning delivered as a statistic, grief encased into the rhythm of case counts.

27 April 2020:

Aotearoa moves to Alert Level 3 at 11:59pm

After weeks of stillness, the country stirred again. Takeaway coffee, drive-throughs, and online shopping returned; though schools and workplaces remained mostly closed. The shift brought both relief and unease in equal measure: freedom, but conditional. The message was clear – the virus was still with us, and life was now a negotiation between risk and normality.

5 May 2020:

My 44th Birthday.

State of National Emergency is extended at 12:21pm for the seventh and final time.

The day carried its own strangeness: a birthday spent in confinement, marked more by quiet reflection than festivity. The extension of the State of Emergency underscored the unsettled backdrop – a reminder that even small personal milestones were framed by uncertainty. This convergence made it difficult to separate the ordinary passage of life from the extraordinary context in which it was unfolding.

13 May 2020:

Aotearoa moves to Alert Level 2 at 11:59pm

Shops reopened, schools returned, and gatherings were permitted – though capped and monitored. The familiar hum of daily life came back, yet it felt altered, like a play resumed after a long intermission. I remember moving through the supermarket aisles feeling both gratitude and anxiety: we were ‘back’, but not to the world we had known before.

8 June 2020:

Aotearoa moves to Alert Level 1 at 11:59pm

The government declared the virus eliminated within the community. Borders remained closed, but inside them, life resumed with few restrictions. There was celebration – handshakes, hugs, concerts, sport – a rare reprieve when much of the world was still in crisis. Yet even in this joy, I felt a lingering fragility: elimination was not an ending, but a pause. The border closure was still our shield, and with it came the weight of waiting.

A plea for kindness

> I need to reconsider my use of social media... the conspiracy theories and vile, derogatory, and disrespectful discourse being shared about our government is starting to get to me.
>
> Yes, lock downs have been tough on all of us - emotionally, physically, and economically. But I am eternally grateful to be living in a country where under intelligent, balanced, and compassionate leadership we have managed to keep infection levels low enough to not overwhelm our health system and we haven't seen the devastating loss of lives that many other countries are continuing to experience daily.
>
> Sure, wearing face coverings is weird and there have been mixed messages as to their usefulness since the start of the global pandemic. But I remember a time when wearing a seat belt was also weird - yet it is now second nature to pull that strap across your torso and buckle up as soon as you sit inside a car. Seat belts save lives. Face coverings reduce the chance of you spreading the virus to someone else. Simple.
>
> As for vaccines... we all have our opinions and we sit on a spectrum from those fiercely against to those fiercely for, and many somewhere in-between. Personally, the idea that the pandemic is a plot to inject us all with some form of control device is just ridiculous. But I do respect the very valid fear of vaccines that are rolled out too fast. At the end of the day, we live in a country where we cannot be forced to undertake medical treatments/procedures without informed consent. So let's just respect one another to decide for themselves whether or not to be vaccinate if/when a vaccine becomes available.
>
> PLEASE be kind.
>
> (27 August 2020, Social Media Post)

By late August, I was exhausted by the endless stream of conspiracy theories and anger on social media. The tone had shifted from unity to division – from shared sacrifice to suspicion. Looking back, I see how my post was both a plea and a defence: a plea for kindness and a defence of science, leadership, and collective responsibility. It was also my first attempt to make sense of the conversations that would only intensify when vaccines eventually arrived.

Love stitched into fabric

Image 17: Fabric masks from my daughter (28 August 2020)

At the time, any and all face coverings were encouraged. We did not yet understand that cloth masks were insufficient – that only surgical masks could provide real protection from the virus. I felt proud of my daughter's creations and loved across the physical distance that separated us. Wearing those masks whenever I left the house made me feel close to my daughter – and not so alone.

To this day, they still hang from a hook by the front door. Long after the pandemic ended. Even longer since they were deemed redundant. They remain as artefacts. Yet they do not remind me of the pandemic itself, but of her care and love stitched into fabric – protection not only against a virus, but also against the weight of isolation.

16 September 2020:

Aotearoa Covid-19 related death toll: 25.

The tally reached 25. A small number by international comparison, yet here each life felt counted, spoken aloud in daily briefings. I did not know their names, but I felt the gravity of each announcement. It was a strange mix of closeness and distance – mourning without faces, grief marked in number rather than stories.

The promise of protection

16 January 2021:

Worldwide Covid-19 death toll passes two million.

Even from the relative safety of Aotearoa, the weight of global loss was impossible to ignore. Numbers on a screen carried the weight of millions of lives – impossible to picture, yet impossible to ignore. I remember feeling buffered by distance yet haunted by the knowledge that families elsewhere were being torn apart, day after day.

18 January 2021:

Covid-19 Recovery Minister Chris Hipkins announces vaccinations should be available to the public by the middle of the year. The vaccine roll-out will be the largest ever mass immunisation campaign in Aotearoa's history.

The announcement felt like a turning point – a light glimmering at the end of an impossibly long tunnel. The vaccine carried with it a promise of protection, of normality restored, of safety reclaimed. After months of uncertainty and fear, it represented hope made tangible – a scientific triumph delivered just in time.

I have always considered myself pro-vaccine. My daughter and I are both fully vaccinated according to the national immunisation schedule, and I have long trusted in the principles of public health and collective protection. The only exception – or perhaps hesitation – I have ever felt was in relation to the HPV vaccine, which I felt was introduced too quickly, with too little long-term data on efficacy and side effects. Looking back now, I do not recall that hesitation resurfacing at this time. In the face of a global pandemic, survival outweighed uncertainty.

I remember watching the televised announcement and feeling a quiet sense of relief mixed with cautious optimism. The language was full of reassurance – words like *safety*, *efficacy*, and *evidence-based*. Scientists and health officials spoke with conviction, invoking both reason and responsibility. It was difficult not to be swept up in the collective exhale of gratitude.

At that moment, I could not have anticipated how deeply the vaccine would come to divide our nation – how something intended to unite and protect us would instead fracture communities, families, and friendships. Nor could I foresee how my own relationship with the vaccine – and with the health system – would shift from faith to doubt, and from doubt to disillusionment.

But in early 2021, none of that was visible. There was only the promise of protection, the hope of freedom, and the yearning to believe that science could save us.

25 January 2021:

The government grants Covid-19 vaccine suppliers Pfizer and BioNTech indemnity from any claims that may arise from use of the vaccine.

I was not aware of this at the time. Perhaps it wasn't widely publicized, or perhaps it simply failed to register as significant amid the flood of information and the relief of an approaching vaccine. Knowing what I know now, I wonder whether I would have paused to question it – to ask why pharmaceutical companies sought such protection. Would it have unsettled me, or would I have assumed this was standard practice for new medicines developed under emergency conditions?

At the time, I had no reason to doubt. My focus, like that of most people, was on hope and safety – not on the legal scaffolding that made the vaccine rollout possible. Only later would I learn that indemnity agreements between governments and vaccine manufacturers were indeed negotiated internationally during the pandemic – a pragmatic measure to ensure rapid distribution under uncertain circumstances (Congressional Research Service, 2021). But in January 2021, I was simply grateful that a vaccine existed at all.

The question lingers in me now, as both suspicion and sorrow. It is the weight of hindsight pressing against the hope I held then.

3 February 2021:

Ex-husband's 47th Birthday.

Pfizer-BioNTech vaccine is provisionally approved by Medsafe[29], with 58 conditions placed on the company.

At the time, I was unaware that Medsafe's approval came with conditions – fifty-eight of them, no less. Whether this detail wasn't widely publicized, or simply did not register in my consciousness, I cannot say. I suspect it was the latter. After months of waiting, the word *approval* was all that mattered. It meant progress, safety, and the beginning of an end. The finer details – the provisional nature of the authorization and the list of stipulations – passed me by entirely. I do not recall questioning them or even noticing them. My focus was on what this moment symbolized: a way out, a scientific breakthrough, a collective sigh of relief.

Looking back now, I find myself wondering whether this was trust or fatigue – or perhaps a blend of both. By then, the world had been holding its breath for over a year. We were exhausted by uncertainty and desperate for something solid to believe in. And so, I took the word *approval* at face value, letting it soothe rather than stir.

10 February 2021:

Aotearoa authorities formally approve the Pfizer Covid-19 vaccine for people aged 16 years and older once stock arrives in the country.

By this point, the announcements were beginning to blur together – approvals, authorisations, conditions. Each one carried promise, but none yet touched daily life. The vaccine was officially sanctioned, yet still abstract: a headline, a hope, an idea waiting to materialise.

I do not recall feeling either excitement or concern. Just waiting. The language of *when stock arrives* lodged quietly in my mind – a reminder that even hope depended on

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[29] New Zealand Medicines and Medical Devices Safety Authority (Medsafe) is a business unit of Manatū Hauora (Ministry of Health), responsible for the regulation of therapeutic products in Aotearoa (https://www.medsafe.govt.nz/other/about.asp)

supply chains and schedules. We were on the cusp of something, though no one yet knew exactly what.

20 February 2021:

Pfizer's Covid-19 vaccine begins to be given to cleaners, nurses, and security staff from Auckland's Jet Park quarantine hotel.

I remember hearing about the first vaccinations on the news. It was presented as a national milestone – the beginning of something monumental. The announcement felt both reassuring and distant, like a chapter beginning somewhere else.

The vaccine rollout began with those at highest risk: the frontline workers who had been closest to the threat since the beginning. It was logical, even comforting, that they were first in line. Still, for most of us, the vaccine remained a promise not yet realised – something happening *out there* while life continued *in here*.

I noted the date, perhaps even mentioned it in passing, but then returned to my day. The news was hopeful, but abstract. It marked progress without altering the rhythm of daily life. The waiting continued, stretched between gratitude and anticipation, knowing it would still be months before my turn came.

17 June 2021:

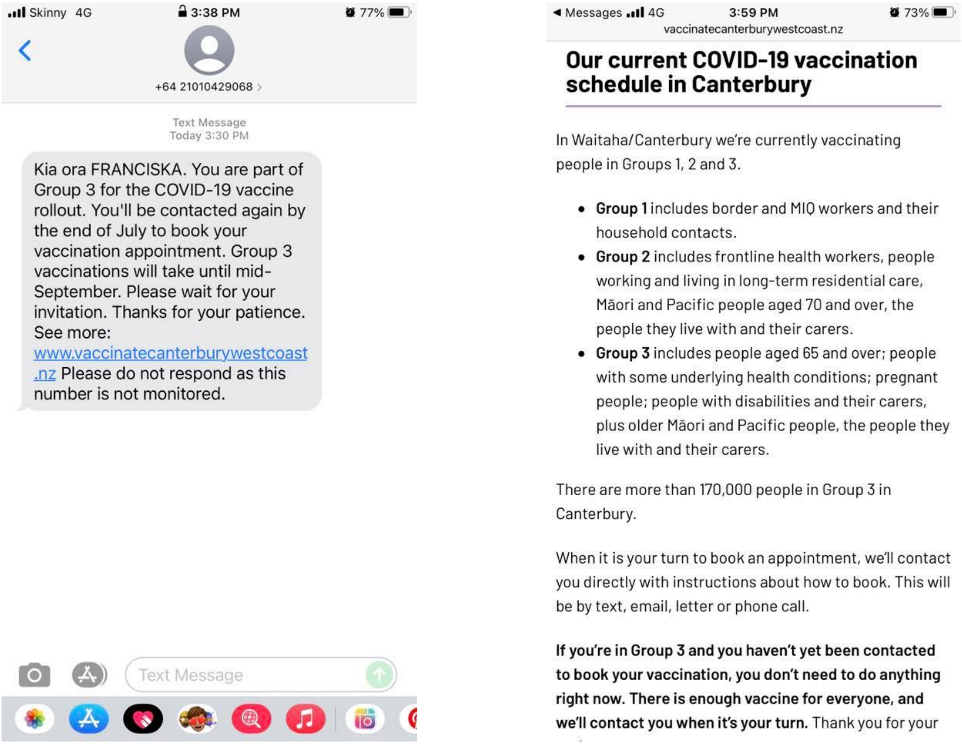
Plan for vaccine rollout for general population announced.

When the plan for the general rollout was announced, the news felt different – not distant this time, but close enough to matter. For the first time, there was a sense that the process would eventually reach *me*. It no longer belonged only to essential workers or healthcare staff; the promise of protection was widening its circle.

I remember listening as dates and groups were read out, each with their own window of eligibility. I wasn't sure exactly when my turn would come, but at least there was a plan. The uncertainty that had defined the months before now had a faint outline – something to look forward to.

It wasn't excitement so much as quiet anticipation, a cautious readiness. Life still carried the weight of waiting, but the waiting now had an endpoint. For the first time, I could imagine re-entering a world that might one day feel normal again.

The mirror of time



Kia ora FRANCISKA. You are part of Group 3 for the COVID-19 vaccine rollout. You'll be contacted again by the end of July to book your vaccination appointment. Group 3 vaccinations will take until mid-September. Please wait for your invitation. Thanks for your patience. See more: www.vaccinatecanterburywestcoast.nz Please do not respond as this number is not monitored.

Our current COVID-19 vaccination schedule in Canterbury

In Waitaha/Canterbury we're currently vaccinating people in Groups 1, 2 and 3.

- **Group 1** includes border and MIQ workers and their household contacts.
- **Group 2** includes frontline health workers, people working and living in long-term residential care, Māori and Pacific people aged 70 and over, the people they live with and their carers.
- **Group 3** includes people aged 65 and over; people with some underlying health conditions; pregnant people; people with disabilities and their carers, plus older Māori and Pacific people, the people they live with and their carers.

There are more than 170,000 people in Group 3 in Canterbury.

When it is your turn to book an appointment, we'll contact you directly with instructions about how to book. This will be by text, email, letter or phone call.

If you're in Group 3 and you haven't yet been contacted to book your vaccination, you don't need to do anything right now. There is enough vaccine for everyone, and we'll contact you when it's your turn. Thank you for your

(30 June 2021, Social Media Post)

I was so excited to be eligible to jump the vaccine queue that as soon as I received the text notification of my eligibility for early vaccination, I posted about it on social media. The message was formal, almost bureaucratic in tone, but to me it felt like a gift – a small, glowing promise after so many months of waiting. For once, my chronic health conditions place me in a category that meant safety sooner rather than later. It was an unexpected privilege, and I felt grateful.

Posting the screenshot online felt like participating in something bigger than myself – a moment of collective relief, a sign that we were moving forward. For the first time, the distant machinery of the rollout had reached me personally.

At that moment, I did not see the irony of ‘jumping the queue’ – that access itself was already marked by hierarchy and circumstance. All I felt was inclusion, belonging, and the quiet hope that this message marked the beginning of the end.

Reflecting back, I now recognise how even this moment of relief was entangled in systems of power – the very ones I set out to interrogate in this thesis when my vaccine injuries were not recognised. Who gets to decide whose health is prioritised, and on what grounds? The language of eligibility, though framed as fairness, carried implicit hierarchies of worthiness and vulnerability. What strikes me now, as I write these words, is the irony that at this early stage my health *was* prioritised. I was seen as someone worthy of protection – my vulnerability acknowledged, my safety ensured. Yet only months later, when the vaccine itself endangered my wellbeing, that same system refused to see me at all.

This realisation arrives as both revelation and rupture. It reminds me that reflexivity is not static but cyclical – each return to the story reveals a new layer of meaning, a different truth shaped by time and perspective. At the time, I received that recognition with gratitude. In hindsight, it stands as a quiet foreshadowing: the point at which protection and harm would begin to blur.

Chapter 8: Winter [Depths of Despair Over Personal Health and Livelihood]

Image 18: Winter

Winter

The sky hangs heavy with silence and frost,
The world counts the rules, and the warmth feels lost.
Where safety once spoke in the language of care,
Now fear wears a mask and lingers in air.

Each morning I wake to a colder refrain,
The hum of the headlines etched into my brain.
The circle of trust has narrowed and thinned,
Even the sunlight now feels disciplined.

I sign the forms, I nod, I comply,
While something within me learns how to die.
They call it protection; I call it survive –
A season of stillness, a will to stay alive.

Yet under the ice, a pulse remains true,
A whisper of spring breaking quietly through.

Franciska

When protection turns to harm

First vaccine injury

> Not wanting to alarm anyone…
> I'm having an adverse reaction…
> Been sent to urgent care…
> Fun times.

Image 19: Wheelchair

Image 20: Hospital cubicle

(12 August 2021, Social Media Post)

I sincerely did not want to alarm anyone. My friends at the time represented the full spectrum of stances across the vaccine debate, and I was very much in support of vaccine use to control communicable diseases. The last thing I wanted was to put people off getting vaccinated by suggesting that they were unsafe. So, when one representative of the more extremely anti-vaccine variety commented that they are "definitely not going to be part of this experiment", I responded with:

> …to be fair, we are ALL a part of the experiment - the difference is which control group we choose to be a part of. And aren't we fortunate to have the privilege of choosing for ourselves which risk we consider to outweigh the other? But of course, we can only utilise the information that is available to us. I wish I could talk to someone who could give me balanced, unbiased data from which to decide what I do next. Unfortunately, those providing information (both in the media and social media) are very much in either the pro- or anti-vaccine camp.

In hindsight, that brief exchange on social media foreshadowed the shifting ground beneath me – a moment when conviction began to give way to questioning.

Once I became vaccine-injured, the lens through which I was sourcing, perceiving, and making sense of information began shifting. In turn, I began questioning my previous stance on Covid-19 vaccines. However, at this point, I felt I had full autonomy in deciding whether to be further vaccinated; and as the blog post below demonstrates, this freedom of self-determination was not something I took for granted.

I am truly torn

> I am trying to navigate a fucking difficult decision.
>
> There are two extreme camps in regards to Covid-19 vaccines - each with their own agenda and both ignoring any evidence contradicting their own beliefs and preconceived ideas.
>
> I have friends on both sides, with very few joining me on the fence.
>
> Initially, we were sold on vaccinations as our best weapon to protect not only ourselves, but the vulnerable people in our communities. However, it turns out that even fully vaccinated, we can both contract the virus ***and*** still pass it on to those vulnerable people.

Image 21: Vaccination centre

> So now the main benefit of vaccination is minimising how sick we will get if we contract the virus. It is no longer about protecting others, but rather, protecting ourselves.
>
> I chose to have the vaccine because I believed the risk of me getting sick if I get the virus outweighed the risk of me having an adverse reaction to the vaccine.
>
> I was wrong.
>
> I now feel the risk of me having a life-threatening reaction to a second dose outweighs the risk of me having life threatening complications if I were to contract the virus.
>
> I am privileged to live in a country where there are currently no cases in the community. So I have the luxury of taking my time to think through what is best for me.

> By the end of the year, we will have a third vaccine in the country that has a high rate of efficacy and a lower rate of side effects and adverse reactions than the Pfizer and AstraZeneca vaccines. Perhaps it might be better for me to wait for that.
>
> I am seriously torn.
>
> I want to protect the vulnerable. But I AM one of the vulnerable. I need to think about protecting myself.
>
> So I have been evaluating the information that is available via both news and social media. Applying my critical social scientist lens to published articles.
>
> The general consensus seems to be that the rate of infection, serious illness, and death is lower in those fully vaccinated. (Yes, those things can still happen, but the odds are statistically significantly lower.)
>
> The problem is, the pandemic is constantly evolving, and we just don't know where it is going. All we can do is theorise. We don't know what the long-term side effects are of any of the vaccines. Nor do we know what the long-term effects are of Covid-19. We just don't know.
>
> We are ALL in an experiment - whether we like it or not. I have the luxury of living in a country where due to the availability of vaccines, I can choose which control group I participate in. And I can make my decision safely in the knowledge that should we find any cases in the community; our government will act fast and hard to protect the public.
>
> That's a pretty damned privileged position for me to be in.
> And for that, I am extremely grateful.
>
> (15 August 2021, Blog Post)

Four years on, I find the word *experiment* difficult to sit with. Back in 2021, the meaning I attributed to it was simple and pragmatic. Covid-19 was a new illness, and the vaccines were developed and released under emergency conditions. By my understanding, calling it an *experiment* acknowledged uncertainty – that we lacked longitudinal data on safety and efficacy, and that we were learning in real time.

Since then, the same word has taken on an entirely different charge. In the current discourse, *experiment* has become a rallying cry for conspiracy and control, a symbol of mistrust rather than inquiry. I notice my own discomfort each time I reread my words, aware of how language shifts as social meaning evolves. What once expressed cautious reasoning now reads, through today's lens, as an alignment with views I do not hold. This awareness reminds me how unstable meaning can be – how words, like stories, are never fixed, but continually rewritten by context and hindsight.

Windows filled with promises

The public health messaging urging people to get vaccinated surrounded me: television, social media, shop windows – there was no escaping it.

One evening, while out for dinner, I noticed the window of a chemist lit against the winter darkness. Streetlights flickered across the pavement, fairy lights glimmered in the trees, and the air carried the quiet bite of frost. Yet it was the posters that caught my eye – bold, clean, insistent:

Image 22: Pharmacy window display

Image 23: Vaccine flyers

Image 24: Vaccine flyers

Image 25: Vaccine flyers

"The vaccine keeps us together."

"The vaccine helps protect us all."

"The vaccine helps us meet new family."

"Stronger immunity, greater possibilities."

I stood there for a long time, staring at the glossy certainty of those words. The messages were clear – simple, persuasive, reassuring. Yet instead of comfort, I felt a tightening in my chest. The vaccine that was supposed to *protect* had harmed me. Where were the posters acknowledging risk, complexity, uncertainty? Was I an anomaly, or merely an inconvenient truth in a narrative that allowed no cracks?

The slogans glowed like promises, but for me, they flickered with contradiction. I still believe in science, in collective care, in doing my part – and I still felt like one of the *team of five million*. But even as I stood in a soft pool of light, I sensed something shifting.

I could not have known then how quickly that belonging would unravel – how the same messages that once united us would later draw invisible lines between those deemed safe and those deemed suspect. That night, though, I simply turned away from the glass, carrying with me the faint unease of seeing myself reflected in a story that no longer felt entirely true.

Where care meets calling

23 August 2021:

First day at *the agency*[30] supporting whānau through illness.

It was the first day of a new chapter – a 12-month fixed-term contract, though I quietly hoped it might continue beyond that. The role balanced perfectly with my private practice and academic work, offering security without sacrificing autonomy. Ten days' sick leave, four weeks' notice period, a steady income to ease the uncertainty of fluctuating client numbers – small details that carried enormous weight after a period of precarity.

I began my new role in the stillness of lockdown. There was no first-day handshake, no office tour, no shared morning tea. Instead, my work laptop and phone were dropped off at my doorstep by my team leader – a quiet exchange of tools rather than greetings. My induction took place online: policies, procedures, introductions all unfolding through screens and phone calls. I 'met' my new colleagues via flickering video tiles, each of us framed by the backdrop of our own homes.

It was a strange beginning – distant yet intimate. The usual small talk of a new workplace was replaced by glimpses into living rooms, pets, and children passing by in the background. Connection was filtered through technology, but warmth still travelled through the wires. I remember feeling deeply moved by how welcoming everyone was despite the distance.

That evening, I shared the following post on social media:

> I was overwhelmed today by the constant stream of warm welcomes from my new colleagues throughout the country.
>
> I feel so very blessed to have joined an organisation full of wonderful human beings.
>
> (23 August 2021, Social Media Post)

The message was simple, but sincere. In a time when the world felt fragmented, *the agency* offered something steady – a shared purpose, a sense of belonging. Though I had

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[30] In accordance with relational ethics guidelines (see Chapter 4), the organisation for which I worked during the pandemic is referred to pseudonymously as "*the agency*."

not yet met anyone in person, I felt part of something meaningful: a network of people working to support others through illness and uncertainty.

Looking back now, this beginning feels almost tender. It marked a moment when connection seemed impossible even across isolation – when care and calling intertwined through cables and screens. I could not have known then that this same workplace would soon become the setting of profound ethical and emotional tension. For now, I simply felt grateful: grounded by purpose, buoyed by belonging, unaware of the fractures yet to come.

A death and a disclaimer

> 30 August 2021:
>
> The Covid-19 Vaccine Independent Safety Monitoring Board considers the death of a woman following vaccination against Covid-19 was due to myocarditis, a known rare side effect of the vaccine. The board concluded that the myocarditis was probably due to vaccination.

I remember the headline but not the details. It passed quickly through the news cycle, softened by careful phrasing: *rare side effect, probable link, no change to guidance*. It landed in me as something distant – tragic, yes, but contained. The story was framed as an exception, and I accepted it as such.

I did not yet see how language can hold both reassurance and denial; how words like *rare* can comfort and conceal at the same time. I scrolled on, telling myself that this was tragic but not relevant – a statistical anomaly, not a personal omen.

A scientist in the crossfire

> Fun fact... anti-vaxxers are using the argument that they do not want to be injected with something that hasn't been sufficiently tested (fair enough to be scared) but are at the same time scrambling to ingest a drug that was originally developed to kill parasites in animals (yes, animals) and has NO clinical evidence to support the claim that it may kill the virus in the human body.
>
> These are the same people who on the one hand will argue that covid-19 related deaths are more likely to have been caused by an underlying condition (as opposed to the virus itself), whilst on the other hand, refuse to consider that a person who died two weeks

> after receiving the vaccine may in fact have succumbed to an underlying medical condition.
>
> As a scientist, I value theories. But you need to recognise that any argument you formulate to support your theory can also be applied to disprove your theory. It goes both ways.
>
> (3 September 2021, Social Media Post)

Looking back, I can see the tension humming beneath my words. I was still recovering from my own vaccine injury yet defending the very narrative that had wounded me. I needed to sound rational – to stay anchored in reason while the world fractured around me. My logic became a kind of shield; if I could stay measured, I could stay safe.

It felt surreal to be defending both sides – as if I were perched atop the Berlin Wall, with armed soldiers on either side, each fighting for what they believed in. From that vantage point, I could see the shape of both arguments but belonging fully to neither.

The noise of that time was relentless. Every claim met its mirror image, every certainty its counter-certainty. The middle ground I was fighting to protect began to feel like quicksand – sliding, unstable, yet the only place I could stand. I told myself that balance was truth; that neutrality was integrity. But beneath that calm tone was fear – the fear of being mistaken for *one of them*, the fear of losing belonging altogether.

In hindsight, this moment feels like a freeze-frame: me suspended between belief and doubt, still clinging to reason while the ice beneath me was beginning to crack. The world around me was polarising, but I still believed I could hold the middle. I did not yet realise that the ice was standing on was already beginning to thin.

Policies tighten

9 September 2021:

The agency issues Covid-19 Vaccination Policy.

The policy arrives

When *the agency* released its Covid-19 Vaccination Policy, I read it carefully, twice. The language was cautious but clear: vaccination was *"encouraged and recommended"*[31] for existing employees, yet *"required"* for all new hires. Those who did not disclose their vaccination status would be considered unvaccinated for health-and-safety purposes.

I agreed with the intent. The people we supported were medically vulnerable; it made sense to minimise risk wherever possible. I was vaccinated, had proof, and no hesitation in disclosing it. At the time, I felt the policy was a reasonable measure of protection – a practical expression of care.

Still, something in the phrasing stayed with me: *"case-by-case basis," "cannot be arranged without significant disruption," "precondition for employment."* I noted them without unease, as if underlining words in a manual I did not yet realise I would one day need to reread.

For existing staff like me, the policy posed no immediate threat. It was about others – future employees, hypothetical exceptions. I was inside the circle, safe for now. What I did not yet know was how quickly the boundaries of that circle would begin to close.

16 September 2021:

Director General of Health Ashely Bloomfield, with the endorsement of Prome Minister Jacinda Ardern, voices a national Covid-19 vaccination target: Aotearoa needs a vaccination level of 90 per cent or above to achieve community protection.[32]

Ninety per cent

The number echoed across every news channel that night: ninety per cent. I watched the announcement without any strong emotional response – neither comforted nor alarmed, just certain what it really meant. Ninety per cent sounded neat and measurable, a goal that seemed to promise safety through arithmetic. Yet something about it also felt abstract, detached from the texture of daily life.

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[31] All quotations and paraphrases from *the agency's* internal Covid-19 Vaccination Policy have been anonymised and selectively reproduced to protect organisational confidentiality, in accordance with relational ethics protocols outline in Chapter 4. Excerpts are included solely to illustrate the lived and contextual dimensions of policy as experience by the researcher, rather than to provide a verbatim account of the document itself.

[32] See here for details, at 33 minutes and 18 seconds: https://www.health.govt.nz/news-media/news-items/covid-19-update-16-september-2021

At the time, I did not think to question how that figure would be counted or who exactly it represented. Only later did I read commentary suggesting that the reported percentages may not have reflected the full population, but rather those who had engaged with the health system within each District Health Board (DHB) over the previous year. Whether or not that was strictly accurate, it unsettled my trust in the number I had once taken at face value.

In hindsight, this target marked a subtle shift in tone. The messaging began to lean away from encouragement and toward expectation – ninety per cent became not only a statistic but a threshold of belonging. It transformed a public health goal into a moral measure – a line between those who were playing their part and those who were not.

A different kind of protection

It was a requirement of my employment that I be up to date with all my childhood immunisations. During the onboarding process, my antibody screening revealed that one of my MMR[33] antibodies was low, so I needed a booster. The decision was neither political nor philosophical – it was procedural. Compliance with public health expectations was part of the role, and I had no hesitation.

I posted about it on social media, partly to normalize the act, partly to reassure myself that my relationship with vaccines hadn't been broken by my earlier reaction to the Pfizer vaccine. The MMR felt safe and familiar – evidence that not all vaccines were to be feared.

> I got the MMR vaccine today.
> I'm no anti-vaxxer. I'm anti-dying.
> Offer Novavax and I'll be the first in the queue.
>
> (30 September 2021, Social Media Post)

Commenting on my post above:

> Incidentally, aside from a sore arm and feeling super tired (even more so than normal) I have had no reactions to the MMR vaccine.

Further commenting on my post above:

> Just to be clear, I'm not saying that Pfizer is UNsafe for everyone. I'm not even saying it's the mRNA that caused me issues (perhaps, as

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[33] The MMR is a combination vaccine against measles, mumps, and rubella (German measles) (https://en.wikipedia.org/wiki/MMR_vaccine)

> one of the articles[34] I have read suggests, it is the carrier that I reacted to). All I'm saying is that we need an alternative vaccine - at minimum, for those of us who cannot have any subsequent doses of Pfizer for medical reasons.
>
> And heck, if the government wants us all to be vaccinated, and offering an alternative gets the vaccine hesitants to change their minds, it seems a no-brainer to me to bring in an alternative vaccine that doesn't use mRNA technology.

At the time, I was searching for reassurance in date, not dissent. The MMR vaccine felt familiar – tried, tested, ordinary – a way to remind myself that vaccines, in themselves, were not the enemy. My earlier reaction to Pfizer had shaken my trust, not in science itself, but in my place within it.

Novavax became a symbol of possibility – a way to stay aligned with collective responsibility while also protecting my own health. When I read that it used protein-based rather than mRNA technology, I felt relief. It offered a bridge between belief and fear, between participation and protection.

Looking back, my tone in that post reads as both reasoned and pleading – a careful attempt to sound rational, informed, and loyal to science while quietly negotiating the limits of my own body's safety. It captures a subtle but important shift: the moment I began to realise that *trust* in science was not the same as *certainty* in it, and that belonging sometimes required a body that could comply.

6 October 2021:

Vaccination change: the Ministry of Health advises considering a shorter gap – of at least two weeks – between the first and second doses of Pfizer-BioNTech vaccines, down from the current six weeks, which has been recommended since August 2021.

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[34] https://www.stuff.co.nz/nz-news/350521292/coronavirus-everything-you-need-to-know-about-the-novavax-vaccine

Shifting of goalposts

When I learned of the update, it landed with quiet unease. On paper, it was a small logistical adjustment, a matter of timing and efficiency. But beneath it, I heard the faint creak of shifting expectations. If the spacing between doses could change, what else might? The implication, though not stated outright, was that I might soon be asked – or required – to have another dose. Perhaps sooner than I had anticipated.

It was the first time I felt the ground move beneath the promise of choice. What had seemed like a clear, measured process was beginning to blur. Each new announcement arrived as both information and instruction, narrowing the space between recommendation and requirement. I did not yet know that this was only the beginning of that contraction – the slow tightening of policy that would soon turn into mandate.

18 October 2021:

Personalised letter from *the agency* regarding Covid-19 Vaccination Policy and Government Mandate.

The gentle face of power

The email arrived quietly, without ceremony – just another message in my inbox, but one that carried the weight of both policy and power. *The agency's* letter was careful in tone: measured, procedural, full of reassurance and legal phrasing. It explained that, under the new Public Health Order, our organisation was classified as a *home and community support service*. Everyone was now required to be fully vaccinated by 1 December 2021.

My situation, however, was acknowledged. The letter referenced my earlier adverse reaction and the advice from my doctor not to receive another dose of the Pfizer vaccine. It asked only for written confirmation – a note for the file – and promised that "an optimum plan" would be explored to allow me to keep working safely.

At the time, I felt reassured. The tone suggested compassion, not coercion. It seemed that *the agency* understood: that my commitment to public health did not need to come at the expense of my own wellbeing. For now, it appeared that reason and empathy could coexist within the same policy.

Looking back, I recognise this moment as the calm before the storm – the delicate illusion of choice that precedes the tightening of rules. At the time, though, I exhaled with relief, believing that care could still be negotiated, that compliance and compassion might somehow find a middle ground.

By late October 2021, the rules around vaccination no longer seemed to align with the principles they claimed to serve. We were told the vaccine protected others yet reports confirmed that vaccinated people could still contract and transmit Covid-19. The moral clarity that had once underpinned the public health narrative was dissolving into contradiction.

At work, these inconsistencies became impossible to ignore. As part of *the agency*, I was permitted to visit families in their homes or meet them in cafés – masked, of course, as required – even if I was unvaccinated. Yet the same visit was forbidden to take place inside hospital grounds. The virus, it seemed, respected institutional boundaries.

I followed the rules, but the logic unsettled me. Safety was being defined less by science than by policy – and policy, I was beginning to see, was shaped by politics as much as by evidence. What had once felt like collective protection now felt like performance: a choreography of compliance designed to reassure rather than to reason.

Looking back, this was the first time the word *mandate* began to trouble me. Until then, vaccination had been framed as an act of care – something we chose in solidarity. But when choice gave way to requirement, the tone shifted. Care became conditional, belonging contingent. And though I did not yet know it, I was already standing on the threshold of exclusion.

Caught between a rock and a hard place

> I love my job.
> I love my employer.
> I believe in vaccines.
>
> Unfortunately, I suffered an adverse reaction to the one and only vaccine currently available in NZ. Understandably, I am terrified of having any more doses of that particular vaccine. Would I advise others to not have any doses of that particular vaccine? Heck no. I still believe the risks of serious illness from covid far out-weigh the risks of an adverse reaction to a vaccine. Would I have a dose of an alternative? Absolutely!!
>
> I work in a job that has been mandated to be "fully vaccinated" by 1 Dec 2021. I fully support the intention behind this mandate. Heck, I was among the first to get the first dose when it became available to Group 3 because I believe in protecting the medically vulnerable people in society.

> As of today, there is only one vaccine available in NZ and no indication that an alternative will be made available prior to 1 Dec 2021.
>
> Public health mandates trump individual Human Rights.
>
> My employer is doing everything in their power to help me. But at the end of the day, they must follow the mandate. There isn't a single role in the organisation that would fall outside of the mandate.
>
> I WANT to be vaccinated.
> I do NOT want to be further injured or worse.
> I am passionate about my work.
> I NEED income.
>
> If I lose my job because I'm not "fully vaccinated", I will also be unemployable for the same reasons.
>
> I am not driven by money. I am perfectly content within my very basic life and take tremendous joy in the most simplest of pleasures. But what is "life" when you cannot earn money to secure the basic necessities? What is "life" when you cannot be a contributing member of society?
>
> ROCK.....Franciska.....HardPlace
>
> (21 October 2021, Social Media Post)

To this day, I struggle to reconcile where I stand on the tension between public health and individual human rights to medical autonomy. I absolutely feel a responsibility to protect the medically vulnerable – but at what expense, and to whom? Where do we draw the line?

I recall having a conversation with a friend at the time, asking this very question. In their opinion, it was no different to soldiers going into battle – risking their lives for the greater good. The comparison unsettled me. *How is forcing me to risk my life in order to reduce the risk of passing on an illness that may or may not make someone else critically ill comparable to soldiers fighting wars over land, politics, or power?*

Furthermore, having been vaccine-injured with on-going medical issues, at what point would I be considered “medically vulnerable”? Seemingly never.

The narrowing gap

22 October 2021:

Aotearoa government releases finalised Covid-19 Public health Response (Vaccinations) Amendment Order (No 3) 2021; requiring all high-risk workers in the health and disability sector to be fully vaccinated against Covid-19 by 1 January 2022 and to receive their first dose by 15 November 2021.

When the amendment was announced, it felt less like news and more like confirmation of what had been quietly gathering momentum. Each update seemed to close another gap in the system, tightening around those of us who sat uneasily between compliance and caution. What had once been *encouraged* was now *required*; what had begun as public health guidance was becoming law.

I remember reading the new Order and feeling a flicker of both fear and relief. Fear, because the timeline left little room for uncertainty. Relief, because I still believed that my doctor could advocate for me – that medical exemptions were possible for those with legitimate risk. I held tightly to that belief; it offered a fragile thread of hope that reason and evidence would prevail.

The language of the Order was clinical and absolute – the kind that leaves little space for human nuance. But at the time, I told myself there was still room for care within compliance, that compassion and common sense could coexist inside bureaucracy. I had not yet realised that the definition of *exemption* itself was about to change.

Permission to breathe

> Step 1 completed: I have a letter from my GP stating I had an adverse reaction to my first dose of Pfizer and recommending I wait for an alternative vaccine to become available.
>
> (26 October 2021, Social Media Post)

For a moment, I felt safe. The letter from my GP seemed to carry real weight – a shield of logic and legitimacy in a climate that was rapidly closing in. It was written in the precise, dispassionate language of medicine, but to me it read like compassion made tangible: *they believe me; they're protecting me*.

I posted the update online not to boast, but to breathe. It felt like progress, like being seen. My injury had a name, my caution had context, and my decision had the backing of a professional voice. For the first time in weeks, I could imagine keeping both my job and my integrity intact.

Yet even as I held that letter in my hands, a quiet unease settled beneath the relief – an intuition I could not name then, but can now. Policies were shifting faster than people could adapt. What felt like protection might prove to be paper-thin. I did not yet know that exemptions could vanish with the stroke of a pen, or that trust itself could be rendered invalid by decree – but something in me already knew: this reprieve was borrowed time.

The cost no one counted

> My heart is so heavy.
>
> On Tuesday evening a counsellor friend of mine let us know that a friend of hers had hung herself.
>
> On Wednesday morning a client told me of a nurse (a relative of hers) who had taken her own life.
>
> Today I just got off the phone with a friend who told me that one of their customers had just done the same yesterday.
>
> Three people in three days, all in Tauranga.
>
> (20 November 2021, post seen on Social Media)

Just to be clear, at no point did I contemplate ending my life. However, seeing posts like the one above (shared within a group for mental health professionals who opposed mandate sue to safety concerns) shook me to the core.

Having already suffered adverse reactions to the Pfizer vaccine, I held very real fears for my wellbeing should I receive a second dose. Yet I felt powerless. To keep my job – my livelihood – I had to risk my life.

It is not difficult for me to imagine the depth of despair that led those souls to see death as their only escape. In the most final and horrific way, they took the power back.

As I read their stories, I felt the familiar pull of reflexivity – the uneasy witnessing of others' pain mirrored against my own. These were not just isolated tragedies but expressions of a wider fracture: the human cost of policies that measured safety in numbers while overlooking the toll on individual lives. Here, the personal and political collided. The stories that reached me through a glowing screen became part of the narrative thread I now write from – a reminder that beneath the rhetoric of protection there were bodies, emotions, and lives unraveling quietly at the edges.

Forced to choose between livelihood and life

1 November 2021:

Meeting with Team Leader (in person) and General Manager (via Zoom).

The meeting began politely enough – routine, procedural, the kind of conversation that could almost pass for ordinary. My team leader and I sat side by side – close enough to share the same nervous air – while the General Manager's face filled a square on the laptop screen in front of us. The atmosphere carried that uneasy blend of empathy and authority that often precedes bad news.

As I settled into the chair, I was struck by the familiarity of it. Months earlier, during my interview for the role, we had sat in the very same configuration – my team leader beside me, the General Manager on screen. Back then, it had felt warm and full or promise: a conversation about purpose, about care, about the privilege of supporting others through illness. Now the same arrangement felt heavier, the screen a barrier instead of a bridge.

I asked what felt like a reasonable question: could we introduce rapid antigen testing (RAT) for staff visiting medically vulnerable clients, just to ensure that we weren't asymptomatic and spreading the virus? My suggestion was met with a shrug cloaked in policy: *there's no legal requirement for that*.

Trying to soften the edges, my team leader remarked that I was probably 'safer' than most of the fully vaccinated staff, who could contract Covid-19 without symptoms and never know. The logic made sense, yet it landed strangely – as if reason and reassurance had been repurposed to justify an impossible situation.

Then came the part I had been dreading. Unless I complied with the vaccine mandate, my contract would be terminated.

I looked directly at the General Manager on the screen. "You are asking me to choose between my livelihood and my life," I said, my voice shaking before the tears came.

The meeting ended with promises of compassion, assurance that they would *"work with me."* But I already knew what was coming. Policy had replaced dialogue; empathy was no longer enough to protect me.

Later, as I replayed the moment in my mind, I realised how the language of care had been absorbed by the machinery of compliance. Sitting shoulder to shoulder with my team leader – just as I had the day I was interviewed for the role – I felt the sharp symmetry of it all. What had started in welcome was now ending in warning. It was then that I understood that the shape of care and the shape of control are, at times, indistinguishable.

Compassion with conditions

2 November 2021:

Follow-up email from *the agency's* General Manager regarding the vaccination mandate and next steps.

The email arrived the next morning – formal, courteous, carefully worded, and heavy with implication. It thanked me for my time, acknowledged the stress I was under, and repeated the assurances voiced in our meeting: empathy couched in policy, concern framed within procedure. Yet beneath the pleasantries, a date was set – an invitation to meet the following week to *"to discuss further steps."* The machinery was moving. I noticed how the tone balanced sympathy with structure, each paragraph offering care while tightening expectation. There were reminders of support services and supervision, a suggestion to seek another medical opinion, and a promise that the process would be *"handled with understanding."* Still, the subtext was unmistakable: the countdown had begun.

Reading the email, I felt the now-familiar constriction in my chest – that paradox of being treated kindly while being cornered. Bureaucratic compassion has its own rhythm: polite, measured, and inescapable. What sounded like flexibility was, in turn, momentum. The email was not unkind, but it was final in its trajectory.

Equality without exception

5 November 2021:

The agency issues updated Covid-19 Vaccination Policy to align with the new Public Health Order.

The update arrived just days after the meeting with my Team Leader and General Manager – swift, decisive, and absolute. On paper, it was an administrative adjustment, simply bringing *the agency's* policy into line with the Government mandate. In practice, it made everything official. What had previously been conversation was now decree.

There was a strange comfort in it. For weeks, I had felt like the anomaly – the one whose health complicated compliance. The new policy, at least, framed the issue as collective: every employee now bound by the same rule. I wasn't being singled out. But neither was I being seen.

The blanket language left no room for nuance, no recognition of individual circumstance or medical complexity. My situation – vaccine-injured, waiting for an alternative that did not yet exist – fell through the gaps. The policy spoke of protection, of duty, of shared responsibility, yet what I felt most was invisibility.

Reading the document, I understood that equality can sometimes mean erasure. In treating everyone the same, the policy had made difference impossible to acknowledge. Care had been standardised; compassion, procedural. It was official now: my safety, once personal, had become administrative.

The loss of medical autonomy

6 November 2021:

Government's Covid-19 Public Health Response (Required Testing and Vaccinations) Amendment Order 2021 comes into order.

The announcement came quietly, buried in the bureaucratic rhythm of daily updates. On the surface, it was another amendment – technical, procedural, couched in the neutral language of governance. But within the fine print, everything shifted. From this point forward, only one person in the country – Direct General of Health Ashley Bloomfield – could approve a vaccine exemption.

With the stroke of a pen, my medical certificate was rendered meaningless. The letter that had once felt like protection now carried no more weight than a note of sympathy. My doctor's judgement, my lived experience, my body's reaction – all of it dissolved in the face of authority.

It was not only my exemption that disappeared but also the illusion of partnership between people and policy. The balance of power tilted fully toward the machinery of government. Medicine had become administrative, care redefined as compliance.

I remember staring at the news update, returning to the line about centralised approval as if comprehension might change the outcome. The language was calm, rational, necessary – and yet its impact was anything but. It stripped away the last remnants of agency I had clung to, reducing personal health to paperwork waiting on a stranger's desk.

In that moment, I understood the difference between being *seen* and being *managed*. My safety was no longer a matter for my doctor or even for me. It had become a decision made elsewhere, by someone I would never meet.

Belonging by barcode

Feeling attacked from all corners

> If anyone believes that I should be labelled, marginalised, and segregated from society because I cannot have a second dose of the Pfizer vaccine, please unfriend me now.
>
> People are not the problem; the virus is the problem. Stay kind.
>
> (8 October 2021, Social Media Post)

No one ever said such words to my face. But the message hummed through every broadcast, briefing, and comment thread. It was there in the language of officials urging 'full vaccination,' in the headlines celebrating vaccine passports, in the conversations of those exhausted by lockdowns and desperate for normality. The story being told was clear: protection equaled participation. Those of us who could not comply were cast as risk, as problem, as cause.

I remember the sting of that narrative settling in – the quiet reordering of belonging. I had done everything 'right,' yet now found myself on the wrong side of the line. The rhetoric of kindness that had carried the nation through the early pandemic began to sound conditional. Stay kind, yes – but only to those who fit the criteria.

It was my first real taste of exclusion, not as overt hostility, but as omission – a silence where empathy used to live. From that point on, I began to understand that the politics of protection can wound just as deeply as the virus itself.

When empathy meets enforcement

9 November 2021:

Conversation with *the agency's* General Manager.

The call began in a tone of care – the familiar cadence of understanding that softened the edges of what was, at its core, an ultimatum. The General Manager spoke gently, even kindly, but the subtext was unmistakable: time was running out. I would need to be fully vaccinated to remain employed.

I tried to listen for reason, for flexibility, for some space in which my situation could fit. Instead, I heard the slow closing of a door. The conversation circled around words like *policy, risk management, compliance* – terms that spoke not to my experience, but to the organisation's obligation.

Even as I recognised the constraints my managers were under, the conversation felt like a rehearsal for something already decided. Care was being performed, not extended. The empathy was real, perhaps, but its reach was limited by the very system it sought to humanise.

The formalisation of inevitability

> 10 November 2021:
>
> Email from *the agency's* General Manager containing a formal letter.

The next morning, the empathy of conversation was replaced by the precision of text. The email arrived with a formal letter attached – measured, procedural, unambiguous. It reiterated what I already knew: to keep my job, I would need to be fully vaccinated, despite my adverse reaction to the first dose.

The letter went further, outlining the organisation's right to request a medical examination even if were granted an exemption – as though my doctor's expertise, my body's response, and my own account could be second-guessed by policy. I was also instructed to work from home until I was "fully vaccinated."

Reading the letter, I felt an ache of inevitability. It was the written version of what had already been spoken – compassion distilled into compliance. There was no malice in it, only certainty. And that, perhaps, made it even harder to bear.

By then, I had come to understand that institutional kindness often travels hand in hand with control. What begins as concern ends in containment; what sounds like care becomes the echo of authority.

A glimmer of possibility

10 November 2021:

Director General of Health Ashley Bloomfield announces that AstraZeneca will be made available for those who cannot safely receive Pfizer.

When I heard the announcement, a quiet pulse of hope stirred. AstraZeneca was coming – an alternative, an opening, a sign that perhaps the system could accommodate bodies like mine. For the first time in months, I felt I might belong again within the framework of compliance rather than standing just outside it.

The phrasing of the announcement mattered. It acknowledged people like me – those medically unable to complete the Pfizer series, and those working with vulnerable populations under mandate. I clung to that inclusion as though it were recognition itself.

Still, I was cautious. The promise was phrased in future tense: *expected late November*. I had already learned how dates could shift, how certainty could dissolve into delay. Yet even so, that day, I allowed myself to exhale. For a moment, the horizon widened.

Hope, resisting

10 November 2021:

Meeting with my Team Leader and the General Manager (via Zoom) to discuss implications of AstraZeneca's arrival.

By the afternoon, my cautious optimism had been tempered by reality. The meeting with my Team Leader and General Manager carried the weight of pragmatism. AstraZeneca's announcement, they explained, was promising – but no one knew precisely when the doses would arrive or whether supply would meet demand. The deadlines remained fixed.

I nodded along, outwardly calm, but inside I was already negotiating possibilities: could I wait, could I hold out for Novavax, could policy bend even slightly for those who had already been harmed? The conversation balanced between empathy and inevitability, yet the tone made one thing clear – time was not on my side.

When the call ended, I sat staring at the faint reflection of my face in the blackened laptop screen. Hope was still there, yes – but it had become an act of defiance. To keep believing, even in the face of bureaucracy, felt like resistance. And for that moment, resistance was enough.

Holding on to hope

> There is hope for me yet...
>
> Ashley Bloomfield just confirmed that AstraZeneca will be made available for those who have a medical reason for not having a second dose of Pfizer as well as those who have been mandated in jobs working with vulnerable people. (I fully expect to be able to qualify.)
>
> He said they will have more details next week but expect the vaccine to be available late November.
>
> (10 November 2021, Social Media Post)

That evening, I wrote those words as if to anchor myself to something solid. I wanted to believe in progress – that systems could adapt, that science could offer alternatives, that reason might still hold space or compassion. The post was brief, but beneath its optimism lay exhaustion. Each announcement, each meaning, each shifting deadline demanded another recalibration of hope. Even as I typed, I sensed that I was writing not from certainty, but from the fragile art of staying hopeful. But hope, I was learning, could be both sustaining and cruel – the longer it held, the harder the fall would be.

No real choice at all

> In supporting me, PLEASE resist the urge to tell me that it causes blood clots... all vaccines have risks... the risk of blood clots from AstraZeneca is less than the risk of blood clots from contraceptive pills...
>
> I have NO choice whether or not to be vaccinated.
>
> My ONLY choice is whether I have a second dose of a vaccine that I already know my body has reacted to OR taking a chance on a different vaccine that I may or may not react to.
>
> Pfizer and AstraZeneca are the only vaccine choices I have before I lose my job, my practicum placement, my livelihood, and my ability to be a contributing, functioning, and "worthy" member of the new society being created in Aotearoa New Zealand.

(20 November 2021, Social Media Post)

When I look back on that post now, I can see how tightly fear and reason were intertwined. I wasn't trying to challenge science or provoke debate – I was trying to stay afloat in a tide of uncertainty. Listing statistics about blood clots was a way to steady myself with logic when my body had already betrayed my trust. I was reasoning out loud, hoping that facts could offer a kind of anchor when everything else felt precarious.

There was still no sign of Novavax progressing through approval. AstraZeneca had become my only remaining hope, though even that was shadowed by doubt. Each day felt like a narrowing corridor: one door locked behind me, another barely open ahead. When I wrote that post, it wasn't defiance – it was fear. I was already terrified, trying to summon the courage to take a vaccine I did not trust, and pleading with others not to make that fear worse. I wasn't asking for debate or reassurance; I was asking for gentleness, for space to breathe while I tried to stay brave.

The colours of control

22 November 2021:

Alert Level announcement: whole country to move to the news Covid-19 Protection Framework (the traffic light system based on the vaccine pass) at 11:59pm on 2 December 2021.

The announcement flickered across screens like a new kind of weather report – a forecast measured not in temperature, but in risk. Red, orange, green: colours once used for celebration or warning now redefined as permissions. Movement, gathering, even belonging would soon depend on a pass that glowed from a phone screen.

For many, it was the promise of freedom restored. For me, it signaled a quieter transformation – the point at which safety became something to prove. The world was being sorted into shades of access, and I could already feel myself fading to the margins of its map.

To be (in the team) or not to be

If the prospect of losing my job failed to keep me awake at night, the introduction of vaccine passes infiltrated my sleep. Aotearoa was divided, with the fully vaccinated considered a part of the "team" and rewarded for their compliance; whilst the "others" were deemed unsafe and punished for their non-compliance by being banned from participating in society. The language of unity had become a language of separation – “team” no longer a metaphor for collective care, but a boundary that defined who belonged.

> "New Zealanders without vaccines are not safe to be around." 😳😔
>
> Surely if the vaccine is providing you with protection, there is no need to feel unsafe around people who aren't vaccinated.
>
> Another person's vaccination status doesn't make me feel any more or less safe. Their physical proximity, use of face coverings, and whether or not they're exhibiting symptoms is what makes me feel more or less safe.
>
> (27 November 2021, Social Media Post)

I was quoting a statement made by a public figure. This was the narrative being promoted – presumably to encourage vaccination – but it carried with it a subtle violence. Words meant to protect were now being used to divide. I found myself defending reason to both sides: to the fearful, that unvaccinated did not mean unsafe; to the skeptical, that vaccines were not the enemy. The middle ground I once occupied was a place of balance was now a no-man’s-land.

I began to realise how public health messaging, once rooted in solidarity, had become moralised. Protection was no longer about care but about worthiness – who deserved access, who had earned safety. The pass itself became a kind of passport to belonging, and I, despite my intention and history of compliance, found myself standing just outside its borders.

Confined by care

29 November 2021:

The agency puts me on “home detention” due to being considered “unsafe”. Citing the DHB’s decision to not allow single-dosed contractors on hospital campus.

It was never called *“home detention”*, but that’s what it felt like. I was told to work from home *“for safety reasons”* – mine, theirs, everyone’s. But the irony was impossible to ignore. The very same hospitals that allowed single-dosed nurses to continue working considered me unsafe to enter. The rule was not about risk; it was about optics.

Even though the mandate gave me until 1 January 2022 to receive my second dose, *the agency* wanted me visible again – in the office, in the wards, in the community. Working from home was a temporary kindness wrapped in pressure. Every email carried the silent message: *hurry up and comply*.

Isolation blurred into humiliation. *"Home detention"* (the phrase that I coined) became both a joke and a truth. I wasn't sick, but I was treated as though contagion were a moral state.

Riddle me this

> Riddle me this...
>
> Today I am on home detention (as I have been for several weeks now) because the DHB won't allow me into the hospital.
>
> At the same time, nurses who are single jabbed (just like me) can continue working in the hospital until 31 December 2021 because the mandate says so.
>
> Tomorrow I will receive my second jab and will be allowed inside the hospital immediately afterwards.
>
> I have NOT been asked to take any kind of test because "the mandate doesn't require that."
>
> There is no stand-down period following vaccination because "the mandate doesn't require that."
>
> By what miracle will I suddenly be safer the second the needle is removed from my arm than I am today??
>
> (29 November 2021, Social Media Post)

Reading this post now, I can still feel the disbelief that drove it. I wasn't mocking public health – I was pleading for logic. The rules no longer followed science; they followed sequence. One injection stood between exclusion and acceptance, regardless of timing, testing, or recovery. I wasn't just questioning policy – I was mourning the loss of reason.

Informed consent, uninformed process

> I received a phone call late afternoon from a doctor working for Covid-19 Vaccination Operations. He was lovely. His job? To talk me through why I want AstraZeneca instead of Pfizer and the associated risks (which he then quickly corrected himself to say "highly unlikely possible side effects").
>
> He knew NOTHING about my medical history. He didn't even know that I had had an adverse reaction to Pfizer. The closest he came to finding out about my medical history was to ask what my reaction entailed, book marked with "but you're all recovered now" (ummm, no); and when explaining the risk of blood clots, he asked if I have ever had a DVT or the like. After a few short minutes, knowing nothing about me, he said he'll complete the required form and write a prescription for AstraZeneca for me.
>
> I then asked him, "incidentally, what ARE the symptoms of a blood clot?". He rattled them off. Then said, "unless you're a smoker or very overweight, you have nothing to worry about." So, I said, "well, I'm not a smoker, but I AM overweight." He then said, "but you don't have a history of DVT's, so you would be a very low risk".
>
> I'm struggling to understand how a perfect stranger, who knows nothing about my medical history, is truly equipped to prescribe a medical treatment for me following a 5-minute phone call.
>
> This is not how Health Psychologists define "informed consent".
>
> And Social Psychologists question whether consent under coercion can be accepted as consent.
>
> (29 November 2021, Social Media Post)

That evening, I realised that the machinery of compliance had become self-sustaining. The question was no longer *is this safe?*, but *will this satisfy the system?*

The Immunisation Advisory Centre advice

According to The Immunisation Advisory Centre (2021) patients who experienced an allergic reaction or anaphylaxis to the first dose can (and should) be revaccinated. Read that again. Even if a person experienced anaphylaxis – a potentially life-threatening physiological response affecting the cardiovascular and respiratory systems – they are advised to be revaccinated. If someone has a known peanut allergy, would we ever tell them they must ingest something containing peanuts? Hell no; we tell them to avoid peanuts at all costs. Indeed, we have laws requiring warnings to be printed on food packaging if the contents may have been contaminated by traces of peanuts. So how is it that we now believe it to be okay to inject a person with a substance that previously caused them an anaphylaxis reaction? Someone clearly understands the risks – but those risks have been reframed as acceptable in the name of collective safety.

This moment exposed the paradoxes at the heart of public health discourse – where the body becomes both subject and object of policy. From a critical health psychology perspective, the instruction to revaccinate despite reaction reflects a biopolitical logic that prioritises population-level risk management over individual embodiment. Within that framing, safety becomes statistical, not sensory; the lived experience of fear or pain is subsumed beneath epidemiological certainty.

For me, this guidance re-activated the central tension of my thesis: how systems of care can demand trust even as they erode autonomy. The language of safety was meant to reassure, but to someone who had already experienced harm, it read as dissonance – a directive to silence the body in service of collective belief. The 'human experience' became negotiable, rewritten through bureaucratic certainty that left no space for felt knowledge or embodied truth.

Barbed wire and compliance

The photograph I took that morning still unsettles me – barbed wire framing the horizon beyond the vaccination centre window. It felt like an accidental metaphor for what was unfolding: protection and imprisonment intertwined.

Image 26: Barbed wire outside vaccination centre

Nothing like staring at barbed wire for half an hour as they try to sort out the paperwork to put one at ease 😳

So, we go through the questions…
“You don’t have any history of blood clots, DVT’s, etc?” No.
“Have you ever had a reaction to a vaccine before?” Yes - Pfizer.

Awkward silence.

“But you weren’t hospitalised, right?” Well, I was sent to urgent care.

Awkward silence.

“How long were you there for?” About six hours.
“And what did they say?” They shrugged their shoulders, said I’m not dying, and sent me home.
“But you’re all okay now, right?” No.

Awkward silence.

“But you talked this through with the doctor?” Yes.
“And you don’t have any autoimmune conditions?” Yes I do.

Awkward silence.

“So you obviously think it’s important to be vaccinated.” No. I have no choice in the matter. I am merely choosing the lesser of two evils - taking the chance on an unknown vs risking a second dose of something I know I had an adverse reaction to previously.

Awkward silence.

I did manage to glimpse the vaccine vial label which clearly said AstraZeneca.

So I get escorted to observation. Where the nurses were expecting me and had been reading my file. They say I need to stay for 30mins (as opposed to 15mins) for observation. Fine by me. They then invite me to sit in the seat closest to them so that they can observe me. Fine by me.

I start feeling drowsy. But want to go home. When my time is up, I go to stand but feel light-headed and have to sit down again. Feels like déjà vu. Nurse asks ”I’d like to check your blood pressure; can I get you a wheelchair?” Oh for the love of God, please don’t make a scene. So I’m supported as I walk into a separate room, where I’m told I can remove my mask from my flushed cheeks, and I’m given a wet flannel to cool my face. Damn it felt good. My blood pressure is 130/70 sitting and 125/78 when standing. Nothing remarkable.

> Except that my average diastolic rate has been mid 80's to mid 90's for months. So 70 is very low for me. No wonder I'm feeling dizzy!!
> "What would you like to do?"
>
> I have zero desire to sit in an urgent care waiting room for hours. How about you give me a copy of the obs you took and I go home? If I feel worse, I'll seek medical care.
>
> So I came home.
> Still a little dizzy.
> Then the nausea hit.
> Thankfully I have anti-nausea meds.
>
> (30 November 2021, Social Media Post)

When I think back to that day, I picture myself as Sean Penn's character in the movie *Dead Man Walking* as he walks to his execution – resigned, composed, and quietly furious. I had accepted what felt inevitable, but resentment simmered beneath every polite exchange. My sarcasm was armour. I was performing compliance, not offering consent.

The myth of bravery

A well-meaning friend commented beneath my post, calling me "brave". To which I replied:

> Nope. Being forced to do something has nothing to do with bravery. And given that I can still catch the virus and pass it on, the only benefit is that I'm less likely to get seriously ill if I catch it. So no, I didn't do it for anyone else either. The ONLY reason I did it is because I was coerced into it. In order to keep my job, my placement, and my ability to participate in society come Friday.
>
> So please don't call me brave. Or a hero.
>
> Having to undertake medical treatment against my will goes against my values not only as a Critical Health/Community/Social Psychologist in training, but also as a human being.
>
> I am not a hero. I have acted against my own core values. That is nothing to celebrate or be proud of. I just hope that somehow I can forgive myself.

Another friend insisted that such defiance *was* bravery – that to "act against every fiber of your being" in service of duty was an act of selflessness. Ending their comments with a single word; "respect". But again, I retaliated:

> Nope. Not brave.

> I acted out of fear.
>
> A cornered animal afraid of the repercussions if I didn't comply. That isn't bravery by my definition.

The psychology of coercion

Looking back, I see these exchanges as a live enactment of the ethical tensions at the heart of my work – the blurred line between choice and coercion, agency and survival. The social script demanded gratitude for compliance, even when compliance came at the expense of integrity. My friends meant well; they were trying to reframe trauma as courage. But their words only deepened the dissonance.

That day, I wasn't brave. I was terrified. Intelligent enough to understand the risk and too entangled in the machinery of belonging to resist it. In the language of critical health psychology, I had become both subject and symptom – proof of how systems manufacture consent by conflating fear with responsibility.

Conditional freedom

2 December 2021:

Alert level system replaced by Covid-19 Protection Framework (traffic lights) as 11:59 p.m.

That same day, my vaccine pass arrived in my inbox. The timing felt deliberate, as if the system itself were welcoming me back into society – my barcode of belonging granting permission to sit in cafés, book a haircut, enter public spaces without question. After months of exclusion and fear, I was once again deemed 'safe.'

And yet, I could not celebrate. The digital pass glowed with quiet irony: the evidence of my compliance was also proof of my coercion. I knew this reprieve was temporary. *'Fully vaccinated'* was a phrase already showing signs of instability – two doses today, perhaps three tomorrow, then four. The goalposts could move at any time, shifting safety into an ever-receding horizon. In the language of public health, safety was a destination; in my lived reality, it was a condition – granted, revoked, and never truly my own.

Worthy, for now

> Day 11
> Still experiencing temps above 37.0
> Still experiencing high BP (currently 161/102)
> Still falling asleep multiple times throughout the day
>
> Got a second jab so that I can participate as a contributing member of society and here I am, barely able to carry out basic necessities for life. 😔
>
> I was distressed over the prospect of losing my job without a vaccine pass. I now have this golden ticket to be deemed "worthy" until 1 June 2022. But now I'm fretting over when I will be well enough to actually return to work. 😭
>
> And what will happen in six months' time? Will it be back to no jab no job? It isn't my employer's fault. It isn't anything personal. But I will be made to feel like the problem lies with me. Cause, you know, the vaccine is "safe and effective" and "clearly" I am either "super unlucky" or "hypersensitive" or it is a "stress response". Therefore, I am at cause. 😔
>
> I have also received correspondence from Massey stating that only those with vaccine passes can attend on-campus activities and enrol in practicums. Distance students rejoice, right? Wrong. We still need to go onto campus to sit exams. One can only hope that they will continue to offer online exams for those shunned from society. If not, many will be left with massive student loans and incomplete qualifications. 🤨
>
> I am struggling to understand how anyone can think this is good for anyone. Physically or mentally. 🤷‍♀️
>
> If the reasoning behind mandates is to protect the medically vulnerable from serious illness and death, why aren't we exhibiting the same concern and care towards those who are suffering serious illness and death as a result of the vaccines?
>
> Why are people being denied the right to make medical decisions over their own health and well-being?
>
> (11 December 2021, Social Media Post)

Through the implementation of vaccine passes, I already felt discriminated against; now I was increasingly feeling stigmatised and marginalised. In short, an unwelcome member of society. My compliance had bought me temporary inclusion, but it came at the cost of my health and self-trust. I was 'safe' only on paper – my physical body told a different story. Each time the pass granted me entry to a café or store, I felt the quiet dissonance of being both permitted and unwell. Within the logic of the new order, participation had become a performance of worthiness, and I had become both actor and audience – watching myself try to belong in a world that no longer knew what to do with those who had paid too high a price for their inclusion.

The limbo of legitimacy

> * Update *
>
> GP thinks it's a viral type reaction to the vaccine. Said that most people don't react, but some do, and that it can take days, weeks, or MONTHS to recover. And of course everyone is different so its just a wait and see.
>
> He said that at the current BP levels, if I wasn't already on medication, he wouldn't be putting me on medication but asking me to monitor it for the next two months. So basically, he's neither concerned nor doing anything about it.
>
> He also said my bloods look fine (even though some of the liver markers are elevated).
>
> He hasn't had anything back from CARM acknowledging either of my adverse reaction reports. But he did get a letter back accepting his referral for me being high-risk for subsequent vaccination (which he requested as soon as I was mandated) and that they would process it mid-January 2022. SO helpful when the mandate stated I had to be double jabbed by 1 January 2022.
>
> Anyway, he has given me another week off work and said to come back next Monday to re-assess.
>
> Upon my insistence, he put through a backdated ACC claim for the first 14 days of my adverse reaction and another ACC claim for the next 7 days. But doubts it will be accepted.
> Fun times. Not.
>
> (13 December 2021, Social Media Post)

The visit left me in a strange kind of suspension – not sick enough to warrant concern, not well enough to return to life. The system had acknowledged me only through paperwork: reports filed, claims submitted, letters pending. Care had been outsourced to process. My body, once again, became a site of waiting – waiting for validation, waiting for recovery, waiting for someone to decide that my experience counted. It was a familiar kind of invisibility: the space between recognition and disregard, where harm exists but responsibility dissolves.

The line in the sand

1 January 2022:

All those mandated must be double vaccinated by today.

The date had hovered for months, and it had arrived – unceremonious, almost anticlimactic. For most, it marked compliance completed; for me, it felt like a border crossing I had not chosen. The mandates were no longer hypothetical or looming – they were law, lived, and enforced. Though I had met the requirement, I could not shake the awareness that my participation had been purchased at the expense of autonomy. This was not resolution, but surrender rebranded as progress.

Exits and endings

Suspended between systems

> Saw my GP…
> Running more tests…
> Took the nurse THREE attempts to draw blood and I am traumatised to say the least…
>
> I feel utterly miserable…
> Have been given a further week off work…
> No diagnosis and therefore no prognosis…
> "We may need to look at applying for a sickness benefit through WINZ if ACC won't come to the party" (you think?)
>
> I am almost certain my employer will fire me.
>
> (24 January 2022, Social Media Post)

Each appointment by then felt like déjà vu – a cycle of tests, forms, and unanswerable questions. The consultation produced activity but not progress; procedures stood in for certainty. With Accident Compensation Corporation (ACC) unresponsive and no clear diagnosis, I found myself once again suspended between systems – too unwell to work, too functional to warrant alarm. What struck me most was the shift in tone: from medical inquiry to administrative triage. I had entered a liminal category of patienthood, where acknowledgement depended on paperwork rather than pain. The body became evidence to be processed, not a story to be heard. Somewhere between compassion and compliance, I was learning what it meant to live as a case without conclusion.

Filing resignation

26 January 2022:

Resigned from role at *the agency*.

After discussing with my team leader, the impending requirement for a third Covid-19 vaccine dose, I made the decision to hand in my resignation – timed to coincide with the booster-mandate deadline. It was less a protest than an act of preservation. I could not bear the thought of another injection, another round of symptoms, another fight for legitimacy.

Yet my intention was never to withdraw permanently. I fully expected to return to work as soon as I was well enough to do so. What I could not accept was the expectation that I continue down the same path of risk. I was unwilling to take further doses of Pfizer or AstraZeneca, and even the prospect of Novavax filled me with unease. My decision was about self-protection, not defiance.

But even resignation required permission. I was told that notice could not be given more than four weeks in advance, so my letter was not accepted – only 'filed.' The language struck me: not rejected, not received, merely suspended, as if even my decision to leave had to wait for administrative timing.

The exchange captured the quiet absurdity of the moment: autonomy deferred once again, paperwork standing in for choice. I had tried to reclaim agency, and even that had been put on hold.

The moving target

4 February 2022:

From today, the approved gap between the second and booster doses reduces to three months from four, for those eligible for booster shots (those aged 18 and over).

By early February 2022. The rules had changed again. The window between doses shortened, the urgency renewed, the narrative of protection refreshed. The policy rhythm no longer seemed to follow science so much as momentum – each amendment arriving before the last could settle.

Watching from the sidelines, still unwell, I felt time contract around me. The world was racing ahead under a logic of acceleration, while my body refused to keep pace. The mandate had once been a line in the sand; now it felt like a treadmill – one that rewarded endurance but punished pause.

The dance of departure

8 February 2022:

Resigned again.

11 February 2022:

Email to Team Leader withdrawing resignation.

Email from Team Leader formally accepting the withdrawal of my resignation.

21 February 2022:

Final letter of resignation submitted and accepted.

February 2022 unfolded like a choreography of hesitation – one step forward, one step back. My first resignation came from misunderstanding: I believed that my only options were the two vaccines I had already reacted to. It felt like the inevitable end to a story I had fought so hard to rewrite.

Days later, clarity surfaced. I withdrew my resignation, clinging to the faint hope that reason might still find a place in policy. My Team Leader's acceptance of that withdrawal felt both kind and procedural – as if the system itself had learned to accommodate hesitation without truly resolving it.

But by the end of the month, I knew the truth. My body could not endure another round of compliance, and my spirit could no longer negotiate with contradiction. The third letter was final – not an act of defeat, but of release. After months of oscillation between duty and self-preservation, I had stopped dancing to the rhythm of mandates and chose, instead, the stillness of integrity.

Too late for me

1 March 2022:

Novavax vaccine approved in Aotearoa for those aged 18 and over.

By the time Novavax was finally approved, my decision had already been made. I had drawn my own line, not in defiance but in self-preservation. On paper, this new vaccine offered the very alternative I had once prayed for – a non-mRNA option that might have spared me the turmoil of the previous months. Yet when it arrived, I felt nothing but exhaustion.

The timing was cruelly poetic. The system had finally expanded to accommodate people like me, but only after I had stepped outside its reach. My trust had been spent, my body too wary to risk another experiment in compliance. What might once have felt like redemption now felt irrelevant. I had already chosen health over belonging, and there was no going back.

The day I disappeared

3 March 2022:

Resignation formally announced to *the agency* staff nation-wide.

The internal announcement went out like any other – brief, procedural, and easily lost among the day's routine emails. Within a large organisation, departures were common, the tone always neutral, the phrasing interchangeable. But where others were moving on to new opportunities or long-awaited travel, I was stepping out of participation itself. My resignation wasn't from my role; it was from a system that no longer had space for me.

There was no farewell morning tea, no card passed around for signatures, only a single sentence of thanks. It was professional, appropriate – and quietly devastating. In an agency devoted to care, my exit registered as paperwork, not loss. Only one colleague reached out, their message hesitant but sincere. I appreciated it more than I could say. In that small gesture, I felt briefly visible again – a person, not a liability, taking leave of the world she once helped to hold together.

The door between worlds

8 March 2022:

Final day of work at *the agency*.

My employment ended just as it had begun – in solitude within the confines of my home. There were no handshakes, no farewells, only the quiet exchange of objects that once tethered me to work. My laptop and phone were collected at the day's end by a colleague, passed across the threshold like evidence of a life now closed. The door clicked shut, and with it, the last remaining thread of belonging to the world I had once served.

Freedom, conditional

4 April 2022:

From 11:59 p.m., the vaccine pass is no longer required by venues covered by the pass, but businesses can continue to require them if they wish.

Vaccination no longer mandatory in a number of occupations, but remain mandatory in health and disability, aged care, corrections, and border workforces.

When the announcement came, it was framed as liberation – a return to normality, a gesture of trust in the public's responsibility. For many, it marked the end of restriction; for me, it marked the confirmation of its cost. The very structures that had excluded me were now quietly dismantled, as if none of it had happened.

I watched from the outside, unmoored. The mandates were loosening, the passes dissolving, yet the impact remained etched into bodies and livelihoods. My compliance had already taken its toll, my career already undone, my body harmed. What was being celebrated as reopening felt, to me, like reopening old wounds.

The world was moving on, but those of us caught in its machinery were left to live with the residue of its logic – the lingering proof that freedom, once conditional, is never fully free.

Trying to understand

> Riddle me this...
>
> One of the benefits of the vaccine is that it reduces the chance of developing Long Covid...
>
> I am twice jabbed...
>
> I have not had Covid...
> A heart specialist is of the opinion that I have Long Covid...
>
> With symptom onset correlating to vaccine administration...
>
> (Please resist the urge to tell me that nothing is guaranteed and that I am "just incredibly unlucky" to be in the minute percentage that falls outside of the best case scenario.)
>
> (21 May 2022, Social Media Post)

How are we supposed to make sense of the world when our personal experiences don't fit the social narrative? I found myself stranded between the biomedical and the experiential – labelled with a diagnosis that, by definition, could not apply to me. The circular reasoning was dizzying: what could not be explained was simply reclassified until it made sense again.

From a critical health psychology perspective, this was more than semantic confusion; it was a form of epistemic injustice – where the credibility of lived experience is diminished by the authority of institutional knowledge. My symptoms were interpreted through the logic of population-level discourse, not the specificity of embodiment. The 'truth' of my experience was thus filtered through frameworks unable to accommodate contradiction. In this moment, theory and reality converged. The body, as both site and source of knowledge, stood in quiet rebellion against its own categorisation. It was a lesson in the politics of knowing: that meaning making, especially in times of crisis, often depends not on what is true, but on what can be tolerated by the prevailing narrative.

The slow unravelling

2 July 2022:

Vaccine mandates end for border and corrections workers.

7 July 2022:

Vaccine mandates end for some workers in the Defense Force, Fire and Emergency, and Police.

15 August 2022:

All remaining Covid-19 restrictions are lifted.

12 September 2022:

Covid-19 Protection Framework ends.

The dismantling came quietly. One by one, the mandates were lifted, the frameworks dissolved, and the language of emergency softened into something resembling normality. The very policies that had dictated who could work, who could gather, who could belong, were now being undone without apology, without acknowledgement of what had been lost along the way. It was not triumph that I felt, but a hollow stillness – the sense of watching the tide recede, revealing the debris of what had once seemed immovable.

Each announcement landed with a kind of muted disbelief. For those who had complied, the lifting of mandates signaled relief. For those who had resisted, it arrived too late to matter. And for those of us caught in-between – who complied at cost, who trusted and were harmed – the ending offered no restoration. It merely confirmed that the rules had always been provisional, their permanence a fiction sustained by fear.

As the framework collapsed, I felt no urge to celebrate. The policies that had shaped the rhythm of my life for two years disappeared almost overnight, but the embodied residue remained: the distrust, the exhaustion, the awareness of how fragile autonomy can be when redefined as compliance.

Winter ended not with resolution but with reckoning. The external restrictions were gone, but the internal landscape had changed. The season of containment had passed, yet its imprint lingered – a reminder that systems thaw faster than souls. In their absence, I was left with the quiet work of reinhabiting my own agency, of remembering what it means to belong on my own terms.

Chapter 9: Spring [Cautiously Relieved and Hopeful]

Image 27: Spring

Spring

The frost has melted, the air feels new,
A hush of promise drifts softly through.
The world exhales – cautious, slow,
Unfolding petals where grief used to grow.

The rules have faded, the masks laid down,
And whispers of colour return to town.
I gather the pieces winter unmade,
And stitch new dreams where the shadows fade.

Pinks of promise, and blues that recall,
Cherry blossoms and forget-me-nots tall.
Each tiny bloom, a memory's thread,
Sewn for the living, not just the dead.

A butterfly breaks from its silken keep,
Its wings untested, its hope runs deep.
It flutters skyward, fearless, bright –
Carrying prayers into morning light.

No fanfare sounds, no banners rise,
Just gentle truth beneath wide skies.
Spring does not shout; it softly sings –
Of healing found in fragile things.

Franciska

Final mandate lifted

26 September 2022:

The last government vaccine mandates – for health and disability workers – ends at 11:59pm.

For the first time in over a year, every profession stood on equal footing. Yet the announcement landed with quiet indifference. There were no headlines of apology, no public recognition of the sacrifices demanded. For those who had complied, it was simply another update. For those who had been cast out, it arrived too late to rebuild what had been lost. Freedom, when returned without acknowledgement, feels less like repair and more like erasure – a silence where reckoning should have been.

The world moves on

5 May 2023:

My 47th Birthday.

WHO declares Covid-19 is no longer a global health emergency.[35]

I read the announcement over breakfast, the words strangely anticlimactic. The crisis that had reordered the world was now official ordinary. While institutions shifted to post-pandemic rhetoric, those of us who lived through its policies still carried its echo – not in case numbers, but in memory, in bodies still recovering. I turned forty-seven not with celebration, but with quiet understanding: history had moved on, even if healing had not.

Musings on memory

> Remember AIDS? Do you remember the last time a TV series even mentioned AIDS? No? Me neither.
>
> In addition to my obsession with crime series, I also have an addiction to medical dramas... I recently started re-watching *ER* from the beginning and the biggest difference I have noticed (aside from the obvious cinematography, clothes, and hair styles) is the fact that

---

[35] https://www.who.int/news/item/05-05-2023-statement-on-the-fifteenth-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-coronavirus-disease-(covid-19)-pandemic

> almost every episode of this series from the 1990s discusses AIDS. In contrast, *Grey's Anatomy* has dedicated just one episode (across 16 seasons) to a story line around AIDS.
>
> HIV/AIDS still exists. But it seems to have fallen off the radars of TV producers and writers.
>
> I wonder if CoViD-19 will be the virus to take centre stage in medical dramas of the 2020s? And I wonder if we'll reach a point in decades to come when it too will fall off our radars?
>
> (17 May 2020, Social Media Post)

My prediction proved right. Covid-19 storylines infiltrated every show I watched – from *Grey's Anatomy* and *The Good Doctor* to *Station 19* and *Shortland Street*. For a while, it seemed the pandemic was everywhere, rendered in scripts and sets as if we needed art to prove it had really happened. But as the world reopened, those storylines vanished just as quickly. The virus became background noise – reference in passing, then forgotten.

Perhaps this is how collective memory works: not through deliberate forgetting, but through the quiet fatigue of moving forward. What once consume the world becomes an historic subplot, condensed to a montage. Watching those shows now, I find myself both relieved and uneasy. Relief that we have space again for other stories. Unease at how easily we let go of the ones that changed us.

Chapter 10: Learnings [Conclusion]

Image 28: Journey completion

This autoethnographic journey began as an exploration of the human experience through storytelling – an attempt to understand how meaning is created and transformed in times of uncertainty. What emerged was not only a record of lived experience during the Covid-19 pandemic but a deeper reflection on how systems, identities, and emotions intertwine in the process of surviving disruption.

Across four seasons, this thesis has traced the movement from disorientation to reconstruction – from silence to voice, from containment to creative renewal. Through narrative, I have sought to reveal the emotional texture behind policy, the personal cost behind compliance, and the enduring strength of the human spirit when confronted with loss of autonomy.

At its heart, this research affirms that storytelling is both knowledge and method – a way of transforming lived chaos into collective insight. The stories shared here are not intended to stand as universal truths, but as embodied understandings – moments of resonance that remind us that the personal is always political, and that healing often begins with the simple act of being heard.

Future implications

The learnings from this autoethnography extend beyond my own experience. They invite reconsideration of how health systems, workplaces, and governments engage with the complexity of human lives – particularly during crisis. Policies designed for collective safety must also hold space for individual difference. When bodily autonomy is negotiated through bureaucracy, the potential for harm increases; so too does the importance of empathy, flexibility, and dialogue in public health decision-making.

For practitioners and researchers in critical health and social psychology, this thesis underscores the value of reflexivity and narrative in understanding the relational dimensions of power. It suggests that care cannot be fully realised through compliance alone, and that trust, once fractured, must be rebuilt through relational transparency rather than institutional reassurance.

In future work, I hope these insights contribute to broader conversations about ethics, autonomy, and meaning-making – particularly in times when fear threatens to overshadow compassion. Theatre, storytelling, and creative research methodologies continue to offer vital pathways for such inquiry: spaces where lived experience is not only represented but re-imagined as collective wisdom.

Ultimately, this thesis contributes to the growing body of autoethnographic and critical health psychology scholarship that challenges how we conceptualise health, agency, and ethics in times of crisis. It demonstrates how personal narratives can act as both critique and care – unsettling dominant discourses while opening space for empathy, complexity, and repair. By tracing the lived consequences of policy through a human story, this research reaffirms that critical inquiry is not only analytical but also relational: a way of connecting individual pain to collective understanding.

Final reflections: A journey of healing and becoming

Autoethnographic conclusions rarely aim for closure in the conventional sense. Instead, they invite reflection, connection, and continued dialogue (Bochner & Ellis, 2016; Ellis, 2020). In this spirit, the following reflections offer not an ending but a moment of pause – a return to self through which I integrate the personal, ethical, and methodological learnings of this journey. It is through this synthesis of story and scholarship that I locate my contribution: the demonstration that healing and inquiry are not opposites, but interdependent processes of becoming.

I was forty years old when I learned that my middle name – Ildikó – means “fierce warrior”. Now as I approach fifty, embracing this new adventure as an autoethnographer, reflecting upon my personal journey thus far, I cannot ignore the evidence that I *am* indeed just that. A fierce warrior. But not in the context of fighting others, fuelled by hurt, bitterness, or hatred, which we so often see depicted in media (of both the mainstream and social variety). Rather, it is my unwillingness to allow the events throughout the pandemic to break me; my rejection of any label (be it medical, political, or societal) to define me; and my conscious refusal to engage in hatred towards others (be they family, friends, acquaintances, random people on social media, policy advisors, or policy makers), which makes me a fierce warrior.

I want to live in a world guided by forgiveness, kindness, and respect. I may not be able to control what happens to me, but I can choose how I respond.

I choose love.

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References

1news. (n.d.). *Covid-19*. https://www.1news.co.nz/tags/coronavirus-pandemic/

Adams, T. E., & Herrmann, A. F. (2020). Expanding our autoethnographic future. *Journal of Autoethnography*, *1*(1), 1–8. https://doi.org/10.1525/joae.2020.1.1.1

August, R., Barrett-Young, A., Guiney, H., Hogan, S., Ramrakha, S., & Poulton. (2023). Who Autralasians trusted during COVID-19: Lessons from the pandemic response. *New Zealand Medical Journal*, *136*(1587), 85–97.

Barnes, G. (Director). (2023). *River of Freedom* [Documentary]. https://riveroffreedom.nz

Barone, T., & Eisner, E. W. (2012). *Arts Based Research*. SAGE Publications, Inc. https://doi.org/10.4135/9781452230627

Bartleet, B.-L. (2021). Artistic autoethnograpy: Explopring the interface between autoethnography and artistic research. In T. E. Adams, S. Holman Jones, & C. Ellis (Eds.), *Handbook of Autoethnography* (2nd ed., pp. 133–145). Routledge. https://doi-org.ezproxy.massey.ac.nz/10.4324/9780429431760

Baum, F. (2016). *The New Public Health* (4th ed.). Oxford University Press.

Beattie, A., & Priestly, R. (2021). Fighting COVID-19 with the team of 5 million: Aotearoa New Zealand government communication during the 2020 lockdown. *Social Sciences & Humanities Open*, *4*(1). https://doi.org/10.1016/j.ssaho.2021.100209

Beauchamp, T. L., & Childress, J. F. (2019). *Principles of Biomedical Ethics* (8th ed.). Oxford University Press.

Binning, E. (2010). Dying GP’s last wish: Legalise euthanasia. *NZ Herald*.

Bochner, A. P. (2020). Autoethnography as a way of life: Listening to Tinnitus teach. *Journal of Autoethnography*, *1*(1), 81–92. https://doi.org/10.1525/joae.2020.1.1.81

Bochner, A. P., & Ellis, C. (2016). *Evocative Autoethnography: Writing Lives and Telling Stories* (1st ed.). Routledge.

Boydell, K. M., Gladstone, B. M., Volpe, T., Allemang, B., & Stasiulis, E. (2012). The production and dissemination of knowledge: A scoping review of arts-based health research. *Forum: Qualitative Social Research*, *13*(1).

Braverman, P., Arkin, E., Orleans, T., Proctor, D., Acker, J., & Plough, A. (2018). What is health equity? *Behavioural Science & Policy*, *4*(1), 1–14. https://doi.org/10.1177/237946151800400102

Chamberlain, K., Lyons, A. C., & Stephens, C. (2018). Critical health psychology in New Zealand: Developments, directions and reflections. *Journal of Health Psychology*, *23*(3), 457–471. https://doi.org/10.1177/1359105317734871

Chamberlain, K., & Murray, M. (2017). Health psychology. In C. Willig & W. Stainton Rogers (Eds.), *The SAGE Handbook of Qualitative Research in Psychology*. SAGE Publications. https://doi.org/10.1146/annurev.ps.40.020189.002533

Chang, H. (2008). *Autoethnography as Method*. Left Coast Press, Inc.

Chin, M. H., King, P. T., Jones, R. G., Jones, B., Ameratunga, S. N., Muramatsu, N., & Derrett, S. (2018). Lessons for achieving health equity comparing Aotearoa/New Zealand and the United States. *Health Policy*, *122*(8), 837–853. https://doi.org/10.1016/j.healthpol.2018.05.001

Cohan, D. J. (2022). This is what I grieve now. In Ryan, J. Michael (Ed.), *Covid-19: Surviving a Pandemic* (1st ed., pp. 38–45). Routledge.

Congressional Research Service. (2021). *Liability issues related to COVID-19 vaccine manufacturing and global distribution* (No. IF11905). https://sgp.fas.org/crs/misc/IF11905.pdf

Conrad, P., & Barker, K. K. (2010). The social construction of illness: Key insights and policy implications. *Journal of Health and Social Behaviour*, *51*(S), S67–S79. https://doi.org/10.1177/0022146510383495

Croucher, S. M., Nguyen, T., Pearson, E., Murray, N., Feekery, A., Spencer, A., Gomez, O., Girardelli, D., & Kelly, S. (2021). A comparative analysis of COVID-19-related prejudice: The United States, Spain, Italy, and New Zealand. *Communication Research Reports*, *38*(2), 79–89. https://doi.org/10.1080/08824096.2021.1885371

Dean, M. (2010). *Governmentality: Power and rule in modern society* (2nd ed). SAGE.

Denzin, N. K. (2014). Assumptions of the method. In *Interpretive Autoethnography* (2nd ed., pp. 1–18). SAGE Publications. https://dx.doi.org/10.4135/9781506374697

Denzin, N. K., Lincoln, Y. S., Giardina, M. D., & Cannella, G. S. (Eds.). (2024). *The SAGE Handbook of Qualitative Research* (Sixth). SAGE Publications Inc.

Doctor with cancer lobbies for euthanasia. (2010). *Otago Daily Times*.

Edwards, J. (2021). Ethical autoethnography: Is it possible? *International Journal of Qualitative Methods*, *20*, 1609406921995306. https://doi.org/10.1177/1609406921995306

Ellis, C. (2020). *Revision: Autoethnographic reflections on life and work* (Classic ed.). Routledge.

Faulkner, S. L. (2017). Poetic inquiry: Poetry as/in/for social research. In P. Leavy (Ed.), *Handbook of Arts-Based Research* (pp. 208–230). Guilford Publications.

Finlay, L. (2005). “Reflexive embodied empathy”: A phenomenology of participant-researcher intersubjectivity. *The Humanistic Psychologist*, *33*(4), 271–292.

Finlay, L. (2008). A dance between the reduction and reflexivity: Explicating the “phenomenological psychological attitude.” *Journal of Phenomenological Psychology*, *39*(1), 1–32. https://doi.org/10.1163/156916208X311601

Foucault, M. (1991). Governmentality. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault Effect: Studies in Governmentality*. The University of Chicago Press.

Fraser, G., & Walker. (2025). Frameworks for critical health psychology practice in Aotearoa. In S. Riley, K. McGuigan, E. Brittain, G. Terry, A. Kora, S. Healy-Cullen, C. van Ommen, & D. Baken (Eds.), *Critical Health Psychology: Foundations, Approaches and Applications*. Massey University via the Council of Australasian University Librarians Open Educational Resources Collective.

Gauld, R. (2023). A review of public policies on Covid-19: The New Zealand experience. *Public Administration and Policy*, *26*(1), 10–20. https://doi.org/10.1108/PAP-04-2022-0028

Gibbs Jr., R. W. (2008). Metaphor and thought: The state of the art. In R. W. Gibbs Jr. (Ed.), *The Cambridge Handbook of Metaphor and Thought* (pp. 3–13). Cambridge University Press. doi:10.1017/CBO9780511816802.003

Gilray, C. (2021). Performative control and rhetoric in Aotearoa New Zealand's response to COVID-19. *Frontiers in Political Science*, *3*. https://doi.org/10.3389/fpos.2021.662245

Health and Safety at Work Act (2015).

Health New Zealand. (n.d.). *COVID-19*. https://www.tewhatuora.govt.nz/for-health-professionals/covid-19

Hodgetts, D., Stolte, O., Sonn, C., Drew, N., Carr, S., & Nikora, L. W. (2020). Immigration, acculturation and settlement. In *Social Psychology and Everyday Life* (pp. 161–184). Bloomsbury Publishing Plc.

Holman Jones, S., & Adams, T. E. (2024). Autoethnography as becoming-with. In N. K. Denzin, Y. S. Lincoln, M. D. Giardina, & G. S. Cannella (Eds.), *The SAGE Handbook of Qualitative Research* (Sixth ed., pp. 421–435). SAGE Publications Inc.

Holman Jones, S., Adams, T. E., & Ellis, C. (Eds.). (2022). *Handbook of Autoethnography* (2nd ed.). Routledge.

Horizon Research. (2022). *Attitudes and behaviours towards vaccination and the COVID-19 second booster vaccine*. Ministry of Health.

Human Rights Act (1993). https://www.legislation.govt.nz/act/public/1993/0082/latest/whole.html

Jennings, B. (2007). Public health and civic republicanism: Toward an alternative framework for public health ethics. In A. Dawson & M. Verweij (Eds.), *Ethics, Prevention, and Public Health* (pp. 30–58). Oxford University Press.

Kasperson, R. E., Renn, O., Slovic, P., Brown, H. S., Emel, J., Goble, R., Kasperson, J. X., & Ratick, S. (1988). The social amplification of risk: A conceptual framework. *Risk Analysis*, *8*(2), 177–187. https://doi.org/10.1111/j.1539-6924.1988.tb01168.x

Kidd, J., Came, H., Doole, C., & Rae, N. (2022). A critical analysis of te Tiriti o Waitangi application in primary health organisations in Aotearoa New Zealand: Findings form a nationwide survery. *Health and Social Care in the Community*, *30*, e105–e112. https://doi.org/10.1111/hsc.13417

Knowles, J. G., & Cole, A. L. (2008). *Handbook of the Arts in Qualitative Research: Perspective, Methodologies, Examples, and Issues*. SAGE.

Lakoff, G., & Johnson, M. (2003). *Metaphors We Live By* (2nd ed.). University of Chicago Press.

Leavy, P. (2020). *Method Meets Art: Arts-Based Research Practice* (3rd ed.). The Guilford Press.

LeDoux, J. (2007). The amygdala. *Current Biology*, *17*(20), R868–R874.

Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*, 80–94.

Lupton, D. (2012). *Medicine as culture: Illness, disease and the body* (3rd ed.). SAGE.

Lyons, A. C., & Chamberlain, K. (2017). Critical health psychology. In B. Gough (Ed.), *The Palgrave Handbook of Critical Social Psychology*. Palgrave Macmillan. https://doi.org/10.1057/978-1-137-51018-1

Mackenzie, C., & Stoljar, N. (2000). *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*. Oxford University Press.

Massey University. (2017). *Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants*.

McCartney, G., Dickie, E., Escobar, O., & Collins, C. (2020). Health inequalities, fundamental causes and power: Towards the practice of good theory. *Sociology of Health A& Illness*, *43*(1), 20–39. https://doi.org/10.1111/1467-9566.13181

McNiff, S. (2017). Philosophical and practical foundations of artistic inquiry: Creating paradigms, methods, and presentations based in art. In P. Leavy (Ed.), *Handbook of Arts-Based Research* (pp. 22–36). Guilford Publications.

Ministry of Health. (2023a). *Aotearoa New Zealand Strategic Framework for Managing COVID-19*. Ministry of Health.

Ministry of Health. (2023b, May 17). *COVID-19 Trends and Insights*. Te Kāwanatanga o Aotearoa | New Zealand Government. https://www.tewhatuora.govt.nz/for-health-professionals/data-and-statistics/covid-19-data/covid-19-trends-and-insights

Ministry of Health. (2023c, September). *Timeline of Significant COVID-19 Events*. Te Kāwanatanga o Aotearoa | New Zealand Government. https://www.health.govt.nz/strategies-initiatives/programmes-and-initiatives/covid-19/managing-covid-19-in-new-zealand

Ministry of Health. (2024). *Managing COVID-19 in New Zealand*. Ministry of Health – Manatū Hauora. https://www.health.govt.nz/strategies-initiatives/programmes-and-initiatives/covid-19/managing-covid-19-in-new-zealand

Murray, M. (2012). Critical health psychology and the scholar-activist tradition. In S. Johnson & C. Horrocks (Eds.), *Advances in Health Psychology: Critical Approaches* (pp. 29–43). Palgrave. https://doi.org/10.1007/978-0-230-37494-2_3

New Zealand Bill of Rights Act (1990). https://www.legislation.govt.nz/act/public/1990/0109/latest/whole.html?utm_source=chatgpt.com

New Zealand Psychologists Board (NZPB). (2017). *Guidelines on informed consent*. https://psychologistsboard.org.nz/wp-content/uploads/2021/06/BPG_InformedConsent_CURRENT_ADOPTED_230217.pdf

Officer, T. N., McKinlay, E., Imlach, F., Kennedy, J., Churchward, M., & McBride-Henry, K. (2022). Experiences of New Zealand public health messaging while in lockdown.

Australian and New Zealand Journal of Public Health, *46*(6), 735–737. https://doi.org/10.1111/1753-6405.13297

Öhman, A. (2009). Human fear conditioning and the amygdala. In P. J. Whalen & E. A. Phelps (Eds.), *The Human Amygdala* (pp. 118–154). Guilford Publications.

Park, C. L. (2010). Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. *Psychological Bulletin*, *136*(2), 257–301. https://doi.org/10.1037/a0018301

Park, C. L. (2013). The Meaning Making Model: A framework for understanding meaning, spirituality, and stress-related growth in health psychology. *The European Health Psychologist*, *15*(2), 40–47.

Park, C. L. (2016). Meaning making in the context of disasters. *Journal of Clinical Psychology*, *72*(12), 1234–1246. https://doi.org/10.1002/jclp.22270

Porges, S. W. (2011). *The Pylvagal Theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation*. W. W. Norton.

Poulos, C. N. (2014). My father's ghost: A story of encounter and transcendence. *Qualitative Inquiry*, *20*(8), 1005–1014. https://doi.org/10.1177/1077800414530317

Poulos, C. N. (2021). *Essentials of Autoethnography*. American Psychological Association.

Privacy Act (2020). https://www.legislation.govt.nz/act/public/2020/0031/latest/whole.html

Proulx, T., & Inzlicht, M. (2012). The five "A"s of meaning maintenance: Finding meaning in the theories of sense-making. *Psychological Inquiry*, *23*, 317–335. https://doi.org/10.1080/1047840X.2012.702372

Reidy, J., Matheson, N. R., Keenan, R., Crampton, P., & Harris, M. (2025). Equity, power and resources in primary health care reform: Insights from Aotearoa New Zealand. *International Journal for Equity in Health*, *24*(124). https://doi.org/10.1186/s12939-025-02463-w

Ribbans, E. (2020). COVID or Covid? The comfort of a pedantry at a time of national crisis. *The Guardian*. https://www.theguardian.com/commentisfree/2020/apr/19/covid-pedantry-national-crisis-spelling-grammar

Riley, S., McGuigan, K., Brittain, E., Terry, G., Kora, A., Healy-Cullen, S., van Ommen, C., & Baken, D. (Eds.). (2025). *Critical Health Psychology: Foundations, Approaches and Applications*. Massey University via the Council of Australasian University Librarians Open Educational Resources Collective.

RNZ. (n.d.). *Covid-19*. https://www.rnz.co.nz/news/covid-19

Rocca, E., & Anjum, R. L. (2020). Complexity, reductionism and the biomedical model. In R. L. Anjum, S. Copeland, & E. Rocca (Eds.), *Rethinking Causality, Complexity and Evidence for the Unique Patient*. Springer. https://doi.org/10.1007/978-3-030-41239-5_5

Rose, N. (2007). *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton University Press.

Rosenberg, A., Walker, J., Griffiths, S., & Jenkins, R. (2023). Plain language summaries: Enabling increased diversity, equity, inclusion and accessibility in scholarly publishing. *Learned Publishing*, *36*, 109–118. https://doi-org.ezproxy.massey.ac.nz/10.1002/leap.1524

Ryan, J. M. (2020). Covid-19: Global pandemic, societal responses, ideological solutions. In J. M. Ryan (Ed.), *Covid-19 Volume I: Global Pandemic, Societal Responses, Ideological Solutions: Vol. I* (1st ed.). Routledge.

Schmälzle, R., Renner, B., & Schupp, H. T. (2017). Health risk perception and risk communication. *Biobehavioural Approaches to Health Risks*, *4*(2), 163–169. https://doi.org/doi.org/10.1177/2372732217720223

Sheridan, N. F., Kenealy, T. W., Connolly, M. J., Mahony, F., Barber, P. A., Boyd, M. A., Carswell, P., Clinton, J., Devlin, G., Doughty, R., Dyall, L., Kerse, N., Kolbe, J., Lawrenson, R., & Moffitt, A. (2011). Health equity in the New Zealand health care system: A national survey. *International Journal for Equity in Health*, *10*(45). http://www.equityhealthj.com/content/10/1/45

Sibley, C. G., Overall, M. C., Osborne, D., & Satherley, N. (2021). *Social, psychological and employment impacts of COVID-19 in New Zealand: Insights from the New Zealand Attitudes and Values Study 2020/2021*. University of Auckland.

Starink, M. (2022). Medical exemption process for mandates “not fair.” *Kaitiaki Nursing New Zealand*, 25–26.

Steger, M. F., & Park, C. L. (2012). The creation of meaning following trauma: Meaning making and trajectories of distress and recovery. In R. A. McMackin, E. Newman, J. M. Fogler, & T. M. Keane (Eds.), *Trauma Therapy in Context: The Science and Craft of Evidence-Based Practice*. American Psychological Association. http://dx.doi.org/10.1037/13746-008

Stuff. (n.d.). *Covid-19 Tracked*. https://interactives.stuff.co.nz/2022/covid-19-cases-new-zealand/

Summers, J., Cheng, H.-Y., Lin, H.-H., Barnard, L. T., Kvalsvig, A., Wilson, N., & Baker, M. G. (2020). Potential lessons from the Taiwan and New Zealand health responses to the COVID-19 pandemic. *The Lancet Regional Health - Western Pacific*, *4*, 100044. https://doi.org/10.1016/j.lanwpc.2020.100044

Taheri, P. (2020). Using inclusive lanuage in the applied-science academic environments. *Technicum Social Sciences Journal*, *9*, 151–162.

Tay, Y. T. A. (2023). Lessons from the COVID-19 pandemic: The ethics of coercive vaccination policies—Where should we draw the line? *The New Zealand Medical Student Journal*, *35*, 23–26.

The Immunisation Advisory Centre. (2021). *Update around management of those with allergic reaction to their first dose of Comirnaty or history of PEG allergy*. https://covid.immune.org.nz/resources/written

The New Zealand Herald. (n.d.). *Latest from Covid-19*. https://www.nzherald.co.nz/topic/covid-19/

Todres, L., Galvin, K., & Dahlberg, K. (2007). Lieworld-led healthcare: Revisiting a humanising philosophy that integrates emerging trends. *Medicine, Health Care and Philosophy*, *10*, 53–63.

Tolich, M. (2010). A critique of current practice: Ten foundational guidelines for autoethnographers. *Qualitative Health Research*, *20*(12), 1599–1610. https://doi.org/10.1177/1049732310376076

Tottenham, N., Hare, T. A., & Casey, B. J. (2009). The developmental perspective on human amygdala function. In P. J. Whalen & E. A. Phelps (Eds.), *The Human Amygdala* (pp. 107–118). Guilford Publications.

Van der Kolk, B. A. (2015). *The Body Keeps the Score: Brain, mind, and body in the healing of trauma*. Penguin Books.

Vinnell, L. J., Becker, J. S., Doyle, E. E. H., & Gray, L. (2023). COVID-19 vaccine intententions in Aotearoa New Zealand: Behaviour, risk, perceptions, and collective versus individual motivations. *Current Research in Ecological and Social Psychology*, *4*(100082). https://doi.org/doi.org/10.1016/j.cresp.2022.100082

Wiki, J., Marek, L., Hobbs, M., Kingham, S., & Campbell, M. (2021). Understanding vulnerability to COVID-19 in New Zealand: A nationwide cross-sectional study. *Journal of the Royal Society of New Zealand*, *51*(sup1), S179–S196. https://doi.org/10.1080/03036758.2021.1900294

World Health Organization. (n.d.). *Coronavirus disease (COVID-19) pandemic*. World Health Organization. Retrieved October 5, 2024, from https://www.who.int/europe/emergencies/situations/covid-19

Xue, H., van Kooten, K., & Desmet, P. M. A. (2025). A consent for myself/ourselves: Designing for responsible use of autoethnography. *CoDesign*. https://doi.org/10.1080/15710882.2025.2456609

Appendix A

Timeline

Covid-19 in Aotearoa New Zealand

Public Health Response vs Author's Lived Experience

2019

Date	Public Health Response	Author's Lived Experience
12-17 December 2019		Anyuci comes to visit; having just returned from six months in Europe.
29 December 2019	Chinese authorities advise the WHO of cases of pneumonia of unknown cause.	

2020

Date	Public Health Response	Author's Lived Experience
7 January 2020	New type of coronavirus is identified and isolated by Chinese authorities.	Anyuci's 71st Birthday.
13 January 2020	First lab-confirmed case outside of China identified, Thailand.	
30 January 2020	WHO declares the epidemic a global health emergency.	
12 February 2020	Disease is given the name Covid-19.	
17 February 2020	WHO says Covid-19 not as deadly as SARS or MERS.	
21 February 2020	First Covid-19 case in Aotearoa New Zealand.	

11 March 2020

WHO declares the outbreak a pandemic.

19 March 2020

Large gatherings banned, borders closed to all but NZ citizens and permanent residents.

21 March 2020

Four-tiered Alert Level system introduced.

25 March 2020

State of National Emergency declared and entire nation goes into full lockdown.

29 March 2020

Aotearoa New Zealand reports its first Covid-19 related death.

29 March 2020

Daughter's 17th Birthday.

10 April 2020

Second Covid-19 related death reported in Aotearoa New Zealand.

13 April 2020

Aotearoa New Zealand Covid-19 related death toll: five.

27 April 2020

Aotearoa New Zealand moves to Alert Level 3 at 11:59pm.

5 May 2020

State of National Emergency is extended at 12:21pm for the seventh and final time.

5 May 2020

My 44th Birthday.

13 May 2020

Aotearoa moves to Alert Level 2 at 11:59pm.

8 June 2020

Aotearoa moves to Alert Level 1 at 11:59pm.

16 September 2020

Aotearoa Covid-19 related death toll: 25.

2021

16 January 2021

Worldwide Covid-19 death toll passes two million.

18 January 2021

Mass immunisation campaign announced for Aotearoa New Zealand from mid-2021.

25 January 2021

Government grants Covid-19 vaccine suppliers Pfizer and BioNTech indemnity.

3 February 2021

Pfizer-BioNTech vaccine is provisionally approved by Medsafe.

3 February 2021

Ex's 47th Birthday.

10 February 2021

Pfizer Covid-19 vaccine formally approved for people aged 16 years and older

19 February 2021

First vaccination administered in Aotearoa New Zealand.

20 February 2021

Pfizer Covid-19 vaccine begins to be given to Auckland Jet Park hotel quarantine staff.

24 February 2021

Christchurch Airport workers vaccinated as start of South Island immunisation rollout.

17 June 2021

Plan for vaccine rollout for general population announced.

4 July 2021

150,000 doses of Pfizer-BioNTech vaccine arrives in Aotearoa New Zealand.

18 July 2021

370,000 doses of Pfizer-BioNTech vaccine arrives in Aotearoa New Zealand.

28 July 2021

Vaccination bookings open for people aged 60-64.

6 August 2021

Vaccination bookings open for people aged 55-59.

12 August 2021

PfizerBioNTech vaccine administered. Adverse reaction.

23 August 2021

First day at XXX on fixed term contract - with expectation of annual contract renewal.

9 September 2021

XXX issues Covid-19 Vaccination Policy.

16 September 2021

Vaccination target of 90% or above announced by Director General of Health.

18 October 2021

Letter from XXX re: must comply with public health order, asking for medical certificate.

22 October 2021

Health and disability workers mandated to be fully vaccinated by 1 January 2022.

26 October 2021

GP letter raising concern re: adverse reaction, recommending alternative vaccine

1 November 2021

Meeting with Team Leader (in-person) and General Manager (Zoom). Home detention..

2 November 2021

Email from General Manager asking for second medical opinion.

5 November 2021

XXX issue updated Covid-19 Vaccination Policy: all staff must comply with mandates.

6 November 2021

Covid-19 Public Health Response Amendment Order 2021 comes into order.

10 November 2021

AstraZeneca vaccine is expected to be available late November 2021.

10 November 2021

Meeting with General Manager and Team Leader. Follow-up letter. Home detention.

17 November 2021

People can request a “My Vaccine Pass” as official proof of full vaccination as of today.

22 November 2021

New Covid-19 Protection Framework (the traffic light system) announced.

29 November 2021

DHB won’t allow me to work on hospital campus (but can be on site as a patient).

30 November2021

AstraZeneca vaccine administered. Adverse reaction.

2 December 2021

Alert Level system replaced by Covid-19 Protection Framework (traffic lights).

13 December 2021

Accepted as high-risk for subsequent vaccination, to be processed mid-Jan 2022.

2022

1 January 2022

All those mandated must be double vaccinated by today.

17 January 2022

Issued medical certificate for the rest of the week. More leave without pay.

26 January 2022

Resigned from role at XXX.. Told I cannot give more the four weeks' notice.

4 February 2022

Approved gap between the second and booster doses reduces to three months.

8 February 2022

Resigned again (having been told I had no other option if I was unable to get booster).

11 February 2022

Withdrew resignation. XXX accepted resignation withdrawal.

21 February 2022

Final letter of resignation submitted and accepted.

1 March 2022

Novax vaccine approved in Aotearoa New Zealand for those aged 18 and over.

3 March 2022

Resignation formally announced to XXX staff nation-wide.

8 March 2022

Covid-19 positive critical workers can return to work in some circumstances.

21 March 2022

Final day of work at XXX.

23 March 2022

Changes announced for public health measures to come into effect 4 April 2022

4 April 2022

Vaccination remains mandatory for health, aged care, corrections, and border workers.

1 June 2022

My Vaccine Pass expires.

2 July 2022

Vaccine mandates end for border and corrections workers.

7 July 2022

Vaccine mandates end for the Defense Force, Fire and Emergency, and Police.

15 August 2022

All remaining Covid-19 restrictions are lifted.

12 September 2022

Covid-19 Protection Framework ends.

26 September 2022

Last government vaccine mandates (for health and disability workers) ended.

2023

5 May 2023

WHO declares Covid-19 is no longer a global health emergency.

5 May 2023

My 47th Birthday.

Key:

The timeline has been colour coded to categorize my lived experience according to my perceptions and mental state as per below.

🟨	Summer: blissfully ignorant and unconcerned
🟧	Autumn: growing concern for the wellbeing of others
⬛	Winter: depths of despair over personal health and livelihood
🟪	Spring: cautiously relieved and hopeful

Appendix B

Low risk ethics notification 4000027257

TE KUNENGA KI PŪREHUROA | MASSEY UNIVERSITY
UNIVERSITY OF NEW ZEALAND

7/08/2023

Dear: Franciska Neuhauser

Re: Low Risk Notification - 4000027257 - Who's Health Matters? An Autoethnographic Study of Aotearoa New Zealand's Covid-19 Response

Thank you for submitting a low risk notification for your research/teaching/evaluation.

This email is to acknowledge receipt of the low risk notification and to inform you that the details of your project have been recorded in our database for inclusion in the annual reports to the Health Research Council Ethics Committee (HRCEC) and the Massey University Research Committee (URC).

You may proceed with your research, though it is advisable to provide a couple of weeks before commencing, as all low risk notifications are checked for completeness and clarity by a Research Ethics Advisor. You may be contacted if your application is incomplete and/or further clarification is required.

The low risk notification for this project is valid for a maximum of three years.

Please notify me if situations subsequently occur which cause you to reconsider your initial ethical analysis.

If a sponsoring organisation, funding authority (e.g., the Health Research Council) or a journal require evidence of ethical approval from a Human Ethics Committee (with an approval number), you need to complete a full Massey University Human Ethics application to be reviewed and approved by one of our Human Ethics Committees. Applications must be submitted and approved prior to the commencement of the research.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact the Research Ethics Office, email humanethics@massey.ac.nz. "

Please include the following statement on all public documents (e.g., information sheet, consent form) related to your project:

> ***This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.***
>
> ***If you have any concerns about the ethical conduct of this research that you want to raise with someone other than the researcher(s), please contact Massey University Human Ethics by email: humanethics@massey.ac.nz.***

I wish you all the best in your research, teaching or evaluation activities and appreciate your thoughtful consideration of ethics principles and practices.

Ngā mihi nui,

Professor Tracy Riley
Acting Chair, Research Ethics Chair's Committee

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