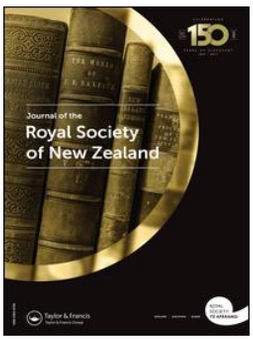

Journal of the Royal Society of New Zealand

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/tnzr20

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To cite this article: Susanna Trnka , Nicholas J. Long , Pounamu Jade Aikman , Nayantara Sheoran Appleton , Sharyn Graham Davies , Antje Deckert , Edmond Fehoko , Eleanor Holroyd , Naseem Jivraj , Megan Laws , Nelly Martin-Anatias , Michael Roguski , Nikita Simpson , Rogena Sterling & Laumua Tunufa'i (2021): Negotiating risks and responsibilities during lockdown: ethical reasoning and affective experience in Aotearoa New Zealand, Journal of the Royal Society of New Zealand

To link to this article: https://doi.org/10.1080/03036758.2020.1865417

Published online: 13 Jan 2021.

JOURNAL OF THE ROYAL SOCIETY OF NEW ZEALAND
https://doi.org/10.1080/03036758.2020.1865417

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RESEARCH ARTICLE

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Negotiating risks and responsibilities during lockdown: ethical reasoning and affective experience in Aotearoa New Zealand

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ABSTRACT

Over forty-nine days of Level 4 and Level 3 lockdown, residents of Aotearoa New Zealand were subject to 'stay home' regulations that restricted physical contact to members of the same social 'bubble'. This article examines their moral decision-making and affective experiences of lockdown, especially when faced with competing responsibilities to adhere to public health regulations, but also to care for themselves or provide support to people outside their bubbles. Our respondents engaged in independent risk assessment, weighing up how best to uphold the 'spirit' of the lockdown even when contravening lockdown regulations; their decisions could, however, lead to acute social rifts. Some respondents – such as those in flatshares and shared childcare arrangements – recounted feeling disempowered from participating in the collective management of risk and responsibility within their bubbles, while essential workers found that anxieties about their workplace exposure to the coronavirus could prevent them from expanding their bubbles in ways they might have liked. The inability to adequately care for oneself or for others thus emerges as a crucial axis of disadvantage, specific to times of lockdown. Policy recommendations regarding lockdown regulations are provided.

ARTICLE HISTORY
Received 20 August 2020
Accepted 12 December 2020

HANDLING EDITOR
Gabrielle Jenkin

KEYWORDS
Aotearoa; collective responsibility; COVID-19; ethical reasoning; lockdown; moral experience; New Zealand; pandemics; risk

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Supplemental data for this article can be accessed https://doi.org/10.1080/03036758.2020.1865417

Introduction

Aotearoa New Zealand's responses to COVID-19 has been hailed as exemplary across the globe. The World Health Organization lauded the approach of acting 'early and hard' and a November 2020 Bloomberg Covid resilience ranking ranked Aotearoa as 'the best … place to be in the coronavirus era' (World Health Organization 2020; Chang et al. 2020). Yet an analysis of how residents across Aotearoa experienced the first national lockdown that was the centre-piece of the New Zealand government's preliminary COVID-19 response presents a more complicated picture. This article focuses on the way that these unprecedented 'stay home' regulations were interpreted, embraced, and recast by the general public, with a view to informing not only scholarly debate over how best to analyse public behaviour during the COVID-19 crisis, but also future pandemic preparedness in Aotearoa and beyond.

On the morning of March 26, 2020, Aotearoa experienced its first nation-wide state of emergency and first national 'lockdown'. Schools, government offices, and nonessential businesses across the nation were closed. The public was ordered to 'stay home' under threat of legal sanction, unless seeking essential food supplies or medical care, exercising, or travelling to and from work in essential services. Initially anticipated to last four weeks, Level 4 lockdown lasted 33 days, followed by 16 days at Level 3 (Table 1).

The government made a concerted effort to put a positive spin on the 'stay home' regulations, depicting a unified, national 'team of 5 million' whose determination citizens could be proud of through slogans such as 'we're all in it together' and 'unite against COVID-19' (Trnka 2020a). Civic duty and public health outcomes were emphasised. Simultaneously, there was widespread awareness that the lockdown and associated economic downturn might negatively impact people's mental and physical wellbeing. The government had to make hard choices about how to balance these needs against mitigating the virus' spread. So too did those living under lockdown.

Enforcing lockdown over Aotearoa's 268,021 square kilometres was potentially difficult. At the start of the lockdown, police described their role as focusing on 'educating' the public, rather than necessarily enforcing the law. Their presence was, however, differentially felt across various constituencies, particularly amongst groups with long histories of racialized police harassment (Aikman 2020a, 2020b; Jamieson 2020; Jones 2020). Nevertheless, with relatively few arrests (there were only 629 prosecutions for lockdown breaches at Level 4) and no overt displays of large-scale force, a successful lockdown resulted from citizen participation (Trnka 2020a, 2020b; see also Appadurai 2020). But does participation simply mean adherence to the rules (whether motivated by fear of punishment, fear of contagion, or civic duty)? An assumption that it *does* certainly pervades the often punitive public cultures of the COVID-19 pandemic (see Benson 2020; Coetzee and Kagee 2020; Fitzgerald 2020). Those who deviate from physical distancing guidelines are frequently labelled 'selfish' or 'irresponsible' and subject to shaming, scolding, and other acts of 'everyday authoritarianism' in which the public become 'the state's partners in punishment' (Ibrahim 2018, p. 221).

In this article we advocate a more nuanced approach than assessing compliance/non-compliance, suggesting the citizenry takes an active role in determining how lockdown regulations are enacted, going above and beyond simply conforming (or not) to 'the rules'. Our analysis reveals people individually or collectively determined the utility of

Table 1. An overview of COVID Alert Levels in Aotearoa New Zealand.

Summary of Alert Levels (March - May 2020) as compiled from https://covid19.govt.nz/assets/resources/tables/COVID-19-alert-levels-summary.pdf				
Level	4	3	2	1
Label	"Lockdown"	"Restrict"	"Reduce"	"Prepare"
Risk Assessment	Sustained and intensive community transmission occurring	Multiple cases of community transmission occurring	Limited community transmission could be occurring	Isolated local transmission could be occurring
Personal movement	Must stay at home in bubble except for essential personal movement	Must stay at home in bubble, except for essential personal movement. Bubble can expand but must remain exclusive.	No restrictions; physical distancing should be observed wherever possible	No restrictions; record-keeping encouraged
Gatherings	All gatherings cancelled	Up to 10 people allowed, but only for weddings, funerals, and tangihanga	Up to 100 people allowed	No restrictions; record-keeping encouraged
Work	All workplaces closed except for essential services and lifeline utilities	People must work from home unless that is not possible	Workplaces can open with record-keeping and physical distancing in place; alternative ways of working encouraged where possible	Workplaces open; must operate safely
Education	All facilities closed	Facilities open up to Year 10, but only with limited capacity - e.g. for children of essential workers	All facilities open; appropriate safety measures must be in place	All facilities open; must operate safely
Retail	All shops closed, except for essential services	Shops can open but may not physically interact with customers	Shops can open; physical distancing must be observed in-store	No restrictions; record-keeping encouraged

specific physical distancing regulations and adjusted behaviour accordingly. Such determinations occurred across members of different ethnic groups, genders, economic statuses, and regional locations. They involved individuals drawing upon government information about COVID-19, assessing the necessity of state regulations against their perceptions of risk and affective ties, prioritising amongst competing responsibilities to care for themselves, loved ones, and the nation. While such assessments could lead people to contravene regulations, they generally viewed their actions as upholding 'the spirit of the law'.

Personal responsibility / collective risk

Late liberal countries have been described as 'risk societies,' drawing on a term employed by Beck to characterise modern societies' 'systematic way of dealing with hazards and insecurities induced and introduced by modernisation itself' (1992, p. 21). One of the key functions of contemporary societies is the management of widespread disasters, such as environmental crises, pollution, and chronic illness, which are themselves often products of globalised processes such as industrialism, market capitalism, and environmental degradation (Beck 1992; Brown 2007; Fassin 2012). There is a well-established social science literature on how individuals who live in risk societies - including Aotearoa - assess and attempt to mitigate risks to themselves and family members (e.g. Robertson 1999; Park 2000; Rose 2007; Dupuis and Thorns 2008; Adams et al. 2009; Trundle 2011; Fitzgerald et al. 2015).

A strong focus of the medical anthropology, medical sociology, and public health literature has been on health-related risks, including examinations of how 'informed' patients (or potential patients) mitigate personal or familial risks of developing diseases such as cancer (Gibbon 2008; Dumont 2012), Huntington's (Novas and Rose 2000), or asthma (Trnka 2017; 2018). Nonetheless, there are areas of disease management where attentiveness to collective risk must remain paramount. Mass vaccination and environmental health campaigns are two such instances, both involving intensive public debate over collective versus individual rights and responsibilities (Casiday 2005; Brown 2007; Phillips 2015; Sobo 2015). Moreover, despite recent emphasis on the individualising characteristics of advanced liberal societies (e.g. Rose 2007), citizens carry a variety of interpersonal responsibilities and obligations to the State, requiring navigation through a range of 'competing responsibilities' of different forms and scales (Trnka and Trundle 2017). In the area of health, and beyond, risk and responsibility frequently require attentiveness to responsibilities to oneself and one's family or whānau [extended family], and interpersonal/collective obligations and desires, as responses to COVID-19 illustrate.

Measures taken to mitigate the threat of COVID-19 provide an opportunity for understanding how societies react to novel national and global health threats characterised by uncertain prognosis and rapidly evolving understandings of the spread and aetiology of pathogens. Examining this situation via qualitative inquiry can shed light on how citizens engage with the curtailment of civil liberties during states of emergency where the actual extent of the threat remains indeterminable: insights that stand to inform policies governing both future health crises and the management of national emergencies (see Teti et al. 2020).

Many people in Aotearoa responded to the March-May 2020 lockdown with a generally positive appreciation of the need to halt the virus' spread but nonetheless took it upon themselves to determine when and which aspects of lockdown legislation should be deemed 'negotiable'. Rather than following the law as they understood it, reasoning about personal and collective risks and responsibilities led to personal choices about how to proceed. This occurred across all levels of the lockdown. We refer to this form of decision-making, whether highly reflective or ad hoc, as 'ethical reasoning' to highlight how steps are taken to resolve competing motivations (e.g. strong compulsion to visit a sick relative while also wanting to uphold the lockdown) in ways deemed by the determiner(s) as 'right,' 'good,' 'justified,' 'necessary,' or ethically sound.

Anthropologists have shown how those affected by illness often individually or collectively make critical medical decisions, including risk management, by un/consciously drawing upon government and scientific information alongside everyday resources such as cultural and religious values, social and economic capital, institutional norms, and the opportunities and limits determined by bureaucratic processes (Kaufman 2005; Das 2006; Biehl 2013; Laidlaw 2014). While some acts of ethical reasoning may constitute moments of profound (self-)reflection or ethical turning points (Zigon 2007), others take place within, and informed by, the flow of everyday life, as people continuously weigh up choices presented to them as well as creating new ones (Brodwin 2013; Das 2015; Keane 2017). Affective ties and relations of care — to known and unknown others, as well as to the State — often play a central role in such decision-making (Mol 2008; Trnka and Trundle 2017). Ethical reasoning is thus integral to social and political life. To speak of the ethical in this way is not to detract from its profound importance, but rather to focus attention to ethics as part and parcel of the constitution of daily life (Brodwin 2013; Lambek 2015), even in times of acute uncertainty or state emergency (Das 2006; Fassin 2012).

Methods

This article uses anthropological approaches to examine ethical reasoning and affect as part of people's lived experiences of lockdown. Our analysis is based on qualitative analysis of responses to three online nation-wide surveys, released at Levels 4, 3 and 2 (for specific dates and other details, see Table 2). Respondents were recruited via a digital marketing campaign on Facebook, Messenger and Instagram, complemented by requests for participants to share the survey through their social networks. 105 respondents to the Level 3 survey also consented to join an online panel and respond to additional open-ended questions in writing or via audio recordings. The full schedule of questions is listed in a Supplemental Annex.

Table 2. Overview of participation in our three research surveys.

Survey	Dates on which the survey ran	Total number of valid responses	Respondents answering one or more open-ended questions
Level 4	6–26 April 2020	1770	996
Level 3	28 April–13 May 2020	1338	1143
Level 2	21 May–6 June 2020	536	440
Total		3644	2579

Table 3. Demographic breakdown of survey respondents.

Gender	All respondents	Respondents answering one or more open-ended questions	Highest level of education	All respondents	Respondents answering one or more open-ended questions
Woman	2726	2129	No qualifications	72	45
Man	565	364	Completed high school	576	374
Non-binary	48	40	Undergraduate degree or professional qualification	1509	1173
Not specified / prefer not to say	305	46	Postgraduate degree	1132	913
Total	3644	2579	Not specified/prefer not to say	355	74
			Total	3644	2579
Ethnicity	All respondents	Respondents answering one or more open-ended questions	Age	All respondents	Respondents answering one or more open-ended questions
European New Zealand/Pākeha	2611	2070	18–30	523	331
Māori	128	76	31–40	685	509
Asian	169	83	41–50	854	686
Pacific	36	22	51–60	570	466
Middle Eastern, Latin American, African (MELAA)	34	15	61–70	293	250
Mixed	101	81	71 and above	104	86
Other	205	136	Not specified/prefer not to say	615	251
Not specified / prefer not to say	360	96	Total	3644	2579
Total	3644	2579			

As is common for survey research in Aotearoa (Houkamau and Sibley 2019), our self-selected sample skewed heavily towards women, Pākehā (New Zealanders of European descent), and university graduates (Table 3). Moreover, respondents not only needed online access, but the time and inclination to complete a survey. Rather than developing a quantitative analysis, or making claims to representativeness, this article draws on the answers to our open-ended survey questions, in which respondents could freely describe their thoughts. 2579 of the 3644 respondents answered at least one such question (see Tables 2 and 3). We also draw on responses to the open-ended questions sent to the online panel. These responses were subjected to qualitative analysis using a grounded theory approach (Urquhart 2013), affording an overview of the range of ways the nation's lockdown was experienced, whilst also identifying dynamics that, having been mentioned by respondents of multiple demographic backgrounds, could be reasonably understood as having been widespread.

Lockdown experiences were undoubtedly differentiated along historic axes of exclusion and disadvantage: tikanga Māori (customary practice) was jeopardised through restrictions on marae gatherings (Dawes et al. 2020); East Asian bodies were figured as hotbeds of contagion; shop closures left Muslims struggling to obtain halal meat (Curtis 2020; Long et al. 2020, pp. 17–19). Inequities in policing meant some communities had to be more vigilant in going about their daily lives than others (Aikman 2020a). Such inequalities notwithstanding, however, all survey respondents had to navigate the question of how to reconfigure their sociality in the light of government mandates to 'stay in your bubble'. Even as respondents drew on diverse practices and traditions of ethical reasoning to grapple with this challenge (cf. Fitzgerald et al. 2015), certain key concerns and issues recurred in their answers, several of which we examine below. We then turn to the way our analysis revealed patterns in respondents' moral experiences of lockdown. Some found it to be a time of growth and flourishing, others found it fraught, and others still found it profoundly disempowering. By examining their accounts, this article reveals how additional axes of disadvantage, compounding already existing discrimination based on class, sexual identity, and ethnicity can emerge as a direct result of physical distancing regimes (see also Aikman 2020a; Long 2020a, 2020b; Napier 2020).

'Stay in your bubble'

Instead of being told to limit physical contact to members of their own household during lockdown, people were instructed to stay within their 'bubble'. The bubble scheme was introduced in recognition of the need for flexibility beyond the boundaries of distinct households. For example, those who lived alone could become 'buddies' with another single-person household; those with complex childcare needs could receive assistance; and children in joint custody arrangements could, when in close enough proximity, move from house to house. At Level 3, the rules were further relaxed, enabling bubbles to be 'slightly extended' to 'reconnect with close family/whānau, bring in caregivers, or support isolated people'.[1]

On the surface, the demand to 'stay in your bubble' appeared relatively straightforward. In reality, public health and other government explanations and even regulations about bubbles evolved throughout the lockdown (Long et al. 2020, p. 22). So too did

people's interpretations of what was required, as well as what constituted risky or responsible behaviour. While nearly everyone who answered our surveys supported the lockdown as a public health measure, they did not simply stay within their bubbles; they looked up the latest information to glean answers to tricky questions, came up with their own sense of what was too risky and what was probably alright, and determined for themselves how to act responsibly and ethically. Two factors contributed to their decision-making: adherence to the law, and balancing independent assessments of risks with personal, interpersonal and national needs.

Following the letter of the law

Many respondents entered lockdown strongly motivated to comply with physical distancing guidelines, convinced that this was the 'right' thing to do. However, as Zigon and Throop (2014, p. 9) observe, the cornerstone of moral experience is often not rule-following *per se*, but rather 'attuned concern for … relationality'. Respondents did not necessarily follow the rules *because* they were 'the rules' but because doing so was 'a small price to pay to protect us and others', allowing them to feel they were 'part of something good (doing our bit)' (Pākehā man, no age given). Such feelings were often grounded in strong affective relationships with the nation and its government:

> Take 1 day at a time, be kind to everyone and remember we are all in this together! – Māori woman (no age given)

> I am feeling blessed to be able to live with my family in a country with efficient leader. BTW thank you Jacinda Ardern and probably your hubby who supports you totally. – Asian woman (age 37)

Compliance was also grounded in deference to risk assessments made by government experts (cf. Sibley et al. 2020). A Pacific-Pākehā woman (age 46) explained she would support reductions in the COVID-19 Alert Level 'if the scientists believe we are in a position to do so. I do trust their logic given the information they currently have on COVID-19'.

A few respondents emphasised the simplicity of following physical distancing and bubble regulations, suggesting all one needed to do was follow the letter of the law. Some highlighted the strength and clarity of Aotearoa's regulations, writing: 'I appreciate the strict rules for [sic] the government as they are clear and easy to follow' (Asian woman, no age given); and 'The decisions have been sound and communications clear. It has been easy to adhere to the restrictions because we can understand the "why"' (Pākehā woman, no age given).

Other respondents, however, struggled to ascertain exactly what the rules permitted. A Pākehā woman in her thirties described taking her children to cycle around a school playground when 'a woman on the street said school was out of bounds in [Level 4]. I knew [public] playgrounds were, but not the school itself'. Upon returning home, she searched but 'never found any material online suggesting we couldn't be there'. Others were certain they had followed government regulations despite their accounts suggesting otherwise: one Pākehā woman (age 60) wrote, 'Although we have observed lockdown rules, our bubble has included the other 2 households on our driveway. We have met on driveway for drunks [sic] or in our home each day'.

Amidst confusion over the rules, there were also complaints against those thought to be 'flouting' them. A 41-year-old Māori man described why he thought some people 'burst' their bubbles:

> [It's] just selfishness. So many people complaining about this and that, and not following the guidelines. At the end of the day it is better to do it tough and get it right the first time rather than prematurely making the wrong call and seeing another spike in COVID-19 and having to start over at Level 4 lockdown again. Just be patient, think about others, not just yourself and do the right thing.

Perhaps unsurprisingly, essential workers were particularly concerned about noncompliance, since their jobs often required interaction with others. A Māori supermarket clerk (age 57), noted, 'I work in a supermarket, in the aisles where you have to rely on the public to follow the physical distancing protocols, they don't'. A Pākehā teacher (age 38) described the lack of physical distancing at his school: 'I work with primary school children. I can stay a safe distance from colleagues, but this is nearly impossible with young children'. A Māori health worker (age 54) highlighted the impossibility of staying a 'safe distance' from others: 'providing personal care such as showers, bowel or catheter care, as well as wound management & skin integrity cares made it impossible. Made harder by the lack of face masks that our employer refused to provide us until week 2 of the Level 3'. Such difficulties were not unusual and, as discussed later, resulted in significant stress and interpersonal tension.

Independent risk assessment

Even when well informed of the 'rules,' many respondents described making their own, independent assessments of risk. Such assessments largely focused on the likelihood of the virus' presence and potential for transmission, and how deleterious infection might be to specific populations such as the elderly or immunocompromised. These assessments were mostly based on widely propagated health promotion campaigns and social media alerts. A few respondents recounted their fears of the virus compelled them to adopt more stringent measures than those promoted by government; despite not belonging to specific risk categories, they chose to self-isolate before it was required and continued to do so after restrictions were lifted. When asked about the upcoming shift to Level 3, a Pacific woman (age 48), remarked, 'Frankly I'm reluctant to leave my bubble until the virus is completely eradicated from NZ'.

Respondents typically portrayed their fear or discomfort as part of a reasoned response to what was and was not likely to be safe in various situations. High risk was determined by: their own or another's vulnerability; fears of interacting with those thought to be more likely to be exposed (e.g. essential workers); and, among essential workers, concerns over potentially transmitting SARS-CoV-2 to others. Thus, those who were happy to go to the supermarket or interact with neighbours would refrain from visiting older relatives lest they expose them to the virus. There were consequently specific groups who found themselves frequently shunned by others, sometimes with painful consequences. A 27-year-old Māori nurse recounted:

> I … felt that my family were too frightened to see me … when I returned [from living overseas], I had to stay away from family (I arrived about 2 days before the mandatory

> quarantine) and then once I started working as a nurse again to help us out financially, I still couldn't be in the same room as anyone else or share spaces. I feel really angry and hurt even though I understand why.

A 48-year-old Pākehā woman working in customer service at a gas station revealed, 'I feel like a criminal because I had to interact with others for my job'.

A similar sense of being cast out due to others' fears of potential contagion – in this case, inflected by racist imaginaries of 'East Asians' – was expressed by a 27-year-old Asian man who had been thrown out of his home:

> a few days prior to March 20, I was informed by the people I was boarding with, I was no longer allowed to stay with them. This was after I informed them that I returned from Auckland after meeting people who arrived from Korea.

Some of those at heightened risk of contracting and transmitting COVID-19 took extra steps to protect others: 'We're getting bored of only having each other to play the same board game with. But as healthcare workers, even with relaxed rules we'll likely still isolate until Level 2,' explained a 39-year-old European man. However, assessments of risk did not run unilaterally – bubbles could be composed of both those with a higher likelihood of being potential vectors and those at high risk due to health vulnerabilities. A 38-year-old Pacific woman outlined some of the stress living in such a household caused:

> I have two high-risk people in my bubble, two other people who are essential workers, working outside of the home, and then we have a designated shopper. Having these 3 people leave our bubble every day is stressful enough, having any other person, even if they live alone, enter our bubble [at Level 3 would cause] me stress.

Indeed, while many respondents' decisions over whether and how to expand their bubbles at Level 3 were in line with government regulations, they were primarily informed by independent judgements of risks and responsibilities inherent in particular relations. What was done was not so much what was *allowable* according to government regulations as what felt *right* in terms of limiting exposure while maximising support and engagement. Such assessment of risk was articulated by a Pākehā man (age 50), who explained why he did not expand his bubble despite being asked to do so: 'We decided the risk was too great with elderly relatives – most of the data are clear that the virus is dangerous to them, but not especially to us. This was a difficult process'.

In general, respondents did not allude to flouting or disregarding regulations, but they sometimes spoke of complying to an extent that seemed *reasonable* or *possible*. Their sense of what felt possible was, inter alia, dependent on their personal circumstances; some were at greater disadvantage in terms of the composition of their households, their extended care obligations, childcare or custody arrangements, or their or other household members' employment status (Trnka and Davies 2020; Keddell and Beddoe 2020). Faced with these and other challenges, they complied with what several respondents referred to as 'the spirit of the law', rather than the law itself.

Such decision-making often fell into two categories. The first encompassed cases where respondents considered the risk of catching or spreading coronavirus to be lower than the government suggested, and so returned to more typical behaviour patterns before regulations allowed. A Pākehā woman (age 49) expressed this attitude

succinctly: 'After Level 3 [ended], we went back to work and pretty much abandoned social distancing, as being pointless'. The second was where respondents described bending rules, rather than disregarding public health concerns altogether: 'Birthday gathering outdoors with social distancing, all food and drinks byo. 10 people [at Level 4]' (Pākehā man, no age given). Such rule-bending was rarely habitual, however. Far more common were occasional deviations from official guidance in the face of fraught assessments of how to 'do the right thing' when faced with competing needs and obligations.

Competing responsibilities

According to those surveyed, while they did everything possible to act for the greater good, they sometimes compromised on regulations to address a personal or interpersonal need. Their position was, in other words, one of being caught between *competing responsibilities* to themselves, to others they cared for, and to the nation (Trnka and Trundle 2017). In such cases, respondents often felt the need to justify their actions, either detailing the reasoning behind them or presenting motivations that would seemingly be hard for others to refute.

Some breaches occurred due to compelling personal needs. 'My grandmother died yesterday,' a 36-year-old Pākehā woman stated. 'I could not go to her passing. I cannot go to her funeral. I have kept my sanity by driving to bushwalks during last two weeks. Last night when I found out I drove 40 mins to [the] beach. I know [this is] breaking [the] rules but it has been [a] super shit time'. In addition to self-care, respondents recounted needing to extend care to friends, partners, or family members due to a sense of responsibility and/or the desire to alleviate emotional suffering. A 25-year-old Māori woman explained why she contravened lockdown regulations to meet a friend: '… they were living alone and were sad'. A Pākehā woman (age 61) spoke of providing support by staging a 'short visit with [an] adult child not living with me who was having [an] exceptionally difficult time with isolation'.

Reference was often made to supporting one's own and others' mental health needs. A Māori woman (age 49) recounted that at Level 4, 'People are sneaking to check up already. Mental health and physical checks on loved ones'. On the possibility of holding outdoor gatherings in contravention of lockdown regulations, a Pākehā woman (age 51) explained: 'I think a lot of people did this anyway. Better for mental health'.

The explicit and implicit evocation of *need* across these accounts is striking. A few respondents explicitly reflected on the nature of need, outlining the difference between *wanting* to and *needing* to. A 69-year-old Pākehā woman described how her son had visited her twice at Level 3, and while it had been 'great to have a hug and share a cuppa' she had not yet seen her daughter-in-law or grandchildren because that was 'a want not a need'. In some cases, trying to assess what truly was 'a need' became a point of deep reflection. A 31-year-old Pākehā woman described why her mother-in-law broke lockdown and debated whether it was 'essential':

> My mother-in-law helped her friend get to the hospital for urgent care related to a terminal illness. She drove her friend and his adult daughter from his home to the nearest hospital. … It's hard to fit this kind of care into the criteria of 'essential' – his daughter probably could've physically done this on her own and not caused their bubbles to be burst by coming into

> contact with each other, but it would've been pretty awful for her friend's daughter to be in a car alone with someone in end-of-life cancer pain, unable to give her father all of her attention. I think it would've also been really hard for my mother-in-law to cope with not actively, physically helping her friend at that time.

Faced with such conundrums, respondents often erred on the side of providing care where it felt *necessary*, as without it the probable outcome would have been worse than the risk of spreading coronavirus. Indeed, the lack of social support available for people struggling with circumstances such as terminal illness, pregnancy, bereavement, or rehabilitation following hospital discharge was one of our respondents' most frequently articulated critiques of lockdown. Nevertheless, these relational concerns did not lead to the wholesale rejection of public health imperatives; rather, many respondents described devising ways of supporting struggling loved ones whilst minimising coronavirus transmission – such as by only meeting outdoors, maintaining physical distancing, or wearing gloves (see also Long et al. 2020, p. 47). Such strategies, they hoped, would allow them to safely balance competing responsibilities.

Thriving and struggling

As our analysis demonstrates, respondents overwhelmingly acted in what they considered a responsible manner, proportionate to estimates of risks posed by the pandemic. Efforts were made to adhere to the perceived 'spirit' of lockdown, even when 'bending' the rules. Understanding lockdown life as a complex moral balancing act allows us to move beyond simplistic dichotomies of 'compliance' versus 'non-compliance', or 'selfishness' versus 'selflessness'. It also helps us understand the diverse affective experiences of lockdown. Some respondents found lockdown to be a time when stark differences over how to weigh up their desires and needs, the needs and desires of others, as well as their relationship to the State, were thrown into sharp and sometimes painful relief. For others, their abilities to honour their most pressing commitments made the experience positive.

Several respondents noted that Levels 3 and 4 forced them to strip back commitments and realise what matters most. An Asian woman (age 59) explained that lockdown had given 'perspective on what's most important in life. Looking back at Level 4, I think we did our world a favour by reducing so much pollution. We did our family a favour by reconnecting so much with each other'. Indeed, and in keeping with Zigon and Throop's (2014) observation that attuned care for core relationships lies at the heart of moral flourishing, many found the slower pace and opportunity to focus time and energy on relationships with loved ones to be a source of personal revitalisation:

> I found joining my wife in the Northland region, as I live and work in Auckland, was very good for my wairua (spiritual) aspect. Having two of my mokos (grandchildren) enhanced this as well. We got to do alot of things together like building a chooky pen and a piggy pen. My mokos being able to ride the quad bike in the paddock or take that to the creek for a swim. – Māori man (age 62)

Importantly, for those who thrived during lockdown, caring for core relationships was not in tension but aligned with fulfilling other duties. Rather than juggling competing responsibilities, these respondents were able to fulfil multiple parallel obligations whilst staying in their bubbles. That they could do so reflects their own good fortune that their relationships outside the bubble could be successfully cared for remotely,

and that relationships inside the bubble were not unduly strained by mutual confinement.

For those who had to negotiate competing responsibilities that stretched beyond their bubble, the moral experience of lockdown could be more fraught. Even when the expansion of bubbles was allowed at Level 3, some households were faced with invidious choices over who to support:

> I was conflicted. We ended up including our flatmate's girlfriend who had previously been in another bubble. … We had a hard job weighing up whether that was the best way to expand our bubble, or whether my two grown children should be able to see their dad. We knew we could only choose one of those things. In the end we made the decision because we felt our flatmate's mental health was starting to be badly affected by lockdown and it would help her a lot to have her girlfriend here. It was tough on the kids' dad though. – Māori woman (age 52)

In other cases, conflicts arose over who would discharge caring responsibilities to a particular individual. A Pākehā woman (age 58) described, 'My sister and I fought over having our elderly father in our bubbles as only one of us was allowed'. As these examples show, the disjuncture between the complex webs of relationships in which respondents were embedded and the requirement that bubbles be small and exclusive could lead to feelings of guilt, regret, and sometimes interpersonal tension.

Rifts also stemmed from differences in interpretation over what was within the 'spirit' – or indeed the 'letter' – of the law. Respondents described being subject to zealous informal policing by members of their communities, even when abiding by government guidelines. A Pākehā man (age 68) described queueing to enter a grocery store when 'the person in front of me perceived I was too close and told me to back off (rudely I thought); I was actually far enough away'. A Māori essential services worker (age 28) received abuse when seen leaving her house: 'My neighbour … yelled at me for going to work one afternoon but calmed [down] when I told her I had to'. In some cases, such 'everyday authoritarianism' deterred people from taking advantage of policies designed to support them. A Pākehā solo mother (age 35) explained how she would 'have loved for there to be greater discussions around single parents being able to join with another bubble [at Level 4]'. Despite being allowed to do so, she didn't – 'out of fear of being reported by neighbours, etc'.

In such an anxious and heavily moralised climate, bending rules to meet one's multiple responsibilities raised the unappealing prospect of being viewed as irresponsible or selfish by people with different views on what was a reasonable and proportionate response to the risks of catching or transmitting coronavirus. Careful negotiation was thus required. A 22-year-old Māori woman summed up the process as inherently fraught: 'Everything is too wary at the moment. All social norms have gone out the window and no one knows how close they should get but they also don't want to offend'.

In some cases, differences of opinion were viewed with compassion, understanding and acceptance: 'My auntie died and I wanted to be with my cousin who lives in a house with flatmates in their own bubble but I wasn't allowed to visit. I did understand them, though,' stated an Asian woman (age 30). Yet even ostensibly 'successful' negotiations could be unpleasant: a 19-year-old Māori man described 'feeling terrible' about 'having to explain the rules' on bubbles to his parents after they invited him over for takeaways on the first night of Level 3.

Some relationships suffered serious damage from disagreements over what was appropriate. A 29-year-old Pākehā non-binary person described the end of their relationship during lockdown: 'I believe I lost respect for my boyfriend when he steadfastly refused to abide by lockdown restrictions, attempted to intimidate me into ignoring lockdown and was generally arrogant and ignorant to the importance of the situation'. Even rule-bending motivated by urgent care needs could attract moral censure, straining previously harmonious relationships. A 56-year old Pākehā woman described how a close friend of twenty years had 'scolded' her for 'breaking lockdown rules' when taking her mother to the hospital during Level 4, and had been unwilling to hear her side of the story. The friendship was now 'shattered'.

As noted earlier, bubble expansion was sometimes marred by stigma against essential workers whose workplace exposure led them to be seen as 'high-risk' contacts. 'I turned away my sister and her family [from my bubble]. She is an essential worker and my daughter has lung and heart problems. I don't think [my sister] has forgiven me,' reported a Pākehā woman (age 33). Even when essential workers had internalised similar views, it was clear that their status as essential workers was limiting them – and those they lived with – from enjoying the practical support that bubble expansion could bring, and from being physically present for loved ones in need.

Disempowerment

Aotearoa's lockdown presented significant challenges to those for whom pressing relational obligations extended beyond the confines of a single bubble. Not only did they face intrinsically unpalatable dilemmas, even as they attempted to navigate these in ways that seemed reasonable and proportionate, they made themselves vulnerable to judgement or censure by others – something that could itself jeopardise relationships that mattered. Despite these difficulties, many respondents seemed to take comfort in feeling they had done *the right thing*. By contrast, the lockdown proved especially challenging and frustrating for respondents who were precluded from acting as they would have liked because they were disempowered from making decisions about the configurations or boundaries of their bubbles.

Sometimes this sense of disempowerment stemmed from the specificities of respondents' living arrangements. The government recognised the need for persons in situations of domestic violence to be able to change residences. With this exception, legislation seemed to operate on the assumption that most people lived in situations in which they had some agency over the configuration of their bubble, as well as over its adherence to physical distancing guidelines. Indeed, much government and media rhetoric surrounding bubbles (e.g. TV One's campaign to 'love your bubble') assumed that co-residence implied a unified household, which in turn, often equated to bonds of kinship. But many people's living situations belied such a simple mapping of family onto household onto co-residence (Trnka and Davies 2021). Whether living in shared accommodation with relatively unknown others, or belonging to families that spanned multiple households, many people found their co-habitation arrangements led to complicated webs of inter-relationality that could deprive them of the ability to determine the constitution, expansion, or behaviours of their bubble. This left them feeling powerless:

> I live in a mixed household in a flatting situation (like most Aucklanders) which did not allow for visits by close friends nor partners. That has been the toughest part of the lockdown; not allowed physical contact with my chosen family and partners who do not live in the same house as I do. – Asian man (age 38)

> Expanding our bubble was dictated to us due to a shared care arrangement with 2/3 of our children with their mother. She expanded her bubble during Level 4 to a man (and his three-year-old also in shared care) she has recently started dating and exposed the children, therefore there is now no leeway for us to expand our bubble any further. A very upsetting and hurtful experience. – Mixed ethnicity woman (age 45)

Others were not entirely disempowered, but still struggled to align their complicated relationalities with the official mandate to keep bubbles exclusive and small:

> I'm in the midst of a separation and my initial Level 4 bubble was kind of strange: my ex-husband, with whom I still live, my two children, and my ex-husband's girlfriend and her daughter, who live separately to my ex-husband and my two boys and me. My partner and his son were not in our initial bubble as my partner is an essential worker and had to continue working … However, once we reached Level 3, I decided to add [them] into our bubble, as my ex-husband and his girlfriend were also returning to work. Also, the girlfriend's other daughter and daughter's boyfriend were added to the bubble … I do feel that this bubble is nowhere near as exclusive as I'd like it to be, but I also have all of our mental health to think about and the reality is there are not many cases of COVID here, so I've had to reconcile myself to a less-than-ideal bubble – Pākehā woman (age 45)

The 'less-than-ideal bubble' is an image that runs through several respondents' accounts. Bubbles appeared 'less-than-ideal' either because of actions people felt compelled to take (often to ensure emotional or mental wellbeing) or situations thrust upon them, about which they simultaneously felt resentful and resigned. Meanwhile, respondents who deemed the law 'less-than-ideal' often found ways to subvert emergency regulations, particularly if they determined their activities to be innocuous (e.g. because 'there are not many cases of COVID here').

Conclusion

A few days into lockdown, an activist banner declaring 'Do It Right NZ!' was displayed in the small suburban community of Green Bay, Auckland. On prominent display throughout Levels 4 and 3, the banner spoke to one of the key issues discussed in this paper – the desire by many people to do their 'part' in the national effort. Footage of the banner was incorporated into a TV commercial for AMI Insurance; another representation of the 'team of 5 million,' the commercial, which ran in May 2020, highlighted visions of a nation 'united against COVID-19'.

As we have underscored, though, there was significant variance and even dispute over what exactly it meant to 'do it right'. Moreover, even when people felt clear on what one *should* do, other needs and obligations sometimes compelled them to act differently. Our analysis shows that the people who answered our survey generally described their activities as attentive to public health concerns. Nevertheless, the stress of having to navigate competing moral imperatives, together with the risk of censure from those who objected to such 'bending' of the rules, could mar their experience of lockdown. Rather than castigating such people as 'noncompliant', it is more productive to consider various forms of disadvantage, stemming from the ways their relationality diverged from the self-reliant

nuclear household arrangements that allowed others to thrive. Further disadvantage was experienced by those whose working, living or childcare arrangements connected them to such large numbers of people that they could not in good conscience give or receive in-person support, even when this was permitted during Level 3. Clearly, neither these people (most typically essential workers, co-parents, and those flatsharing) nor their loved ones were well-served by existing lockdown regulations. However, their struggles – a result of policy choices – risk going unrecognised in celebratory discourses of Aotearoa's approach to COVID-19.

Our analysis thus suggests four priorities when planning for future pandemics or similar national-level crises:

(1) Funding for health promotion and education should be increased in recognition of how many people will make their own determinations of health risks. This should include greater focus on the broad range of factors that impact on risk, e.g. economic deprivation, large households, disabilities, etc.
(2) Government communications should be more proactive in addressing the concerns and needs of people with personal obligations that span multiple households and/or who share residences with non-family members. These communications should:
    a. provide more detailed and accessible information on the risks of chain transmission associated with transferring children between households, opening bubbles to the elderly, etc., since our survey indicates that many people actively used government information as part of their decision-making;
    b. offer concrete suggestions for how best to establish multi-household care arrangements that will mitigate the spread of the virus;
    c. publish advice on how best to reach collective decisions regarding such arrangements and how to address any tensions or interpersonal rifts that may result from them.
(3) There should be greater flexibility of bubble regulations with respect to distressing situations – for example, allowing limited provision to change residences or have visiting rights due to deaths in the family, kin with terminal illness, etc.
(4) Limited provision should be made for people to meet safely outdoors with people beyond their bubbles, if doing so is necessary to keep them or others safe and well. People could, for example, be allowed to meet with one other person at a two-metre distance outdoors in a public place. While of potential benefit to everyone, these provisions should be a particular priority for those least able to give or receive care in bubble arrangements, such as essential workers or those living in flatshares. Government messaging should outline precautions that will minimise such meetings' epidemiological risks.

These recommendations respond to some of the specific challenges reported by our survey respondents, but they also reflect a broader analytic framework that our research indicates should be adopted when examining people's behaviour during the COVID-19 pandemic in Aotearoa – and beyond. To date, much sociological and anthropological literature on how individuals actively mitigate 'risk' has focused on the 'neoliberal' imperative to craft optimal selves, particularly in terms of actively protecting one's health against potential threats (e.g. Rose 2007; Adams et al. 2009; Dumont 2012). However, while

respondents to our survey were, understandably, concerned about safeguarding their own health, this was by no means their sole or overarching imperative. Indeed, their answers indicated that a more pertinent approach to understanding practices of ethical reasoning during Aotearoa's COVID-19 lockdown can be drawn from recent scholarship on relational moralities. As this literature argues, even in societies and amongst individuals who wholeheartedly embrace neoliberal ideologies, the needs of others and of 'society at large' (however it may be imagined) may, in various contexts, be deemed paramount, or at least lend themselves to tricky 'competing responsibilities' that pull actors in multiple directions (Trnka and Trundle 2017; cf. Adam 2005; Zigon and Throop 2014; Hookway 2018). If we are to better understand people's behaviour during lockdown, let alone develop public health interventions that will leave people feeling better supported during any future situations in which widespread physical distancing is required, it is thus essential to acknowledge their multiple obligations and engage seriously with their forms and practices of ethical reasoning.

Note

1. https://covid19.govt.nz/assets/resources/tables/COVID-19-alert-levels-summary.pdf

Acknowledgements

We would like to thank all the participants in our survey for candidly sharing with us a snapshot of their lockdown experiences. We would also like to thank the four anonymous reviewers for their very constructive feedback, and the journal's editors for their support. We are grateful to Brodie Quinn for feedback on the final draft. Ethics approval for this research was granted by the London School of Economics and Political Science Research Ethics Committee [refs. 11.08; 11.08b] and the Auckland University of Technology Ethics Committee [ref 20/142], and ratified by the University of Auckland Human Participants Ethics Committee.

Funding

The cost of administering the surveys was supported by Nicholas Long's annual London School of Economics and Political Science Staff Research Fund allowance. Research assistant support was covered by Susanna Trnka's University of Auckland PBRF grant and Sharyn Davies' Auckland University of Technology PBRF grant.

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