



Beyond awareness: Towards a critically conscious health promotion for rheumatic fever in Aotearoa, New Zealand

Anneka Anderson^{a,*}, Julie Spray^{b,1}

^a Te Kupenga Hauora Māori, Faculty of Medical and Health Sciences, University of Auckland, Private Bag 92019, Auckland, 1142, New Zealand

^b Anthropology, School of Social Sciences, Faculty of Arts, University of Auckland, Private Bag 92019, Auckland, 1142, New Zealand



ARTICLE INFO

Keywords:

Indigenous health
Rheumatic fever
Health promotion
Māori health
Pacific health
Racism
Structural violence
Equity

ABSTRACT

Since 2014, the Rheumatic Fever Prevention Programme has targeted communities in Aotearoa, New Zealand affected by high rates of rheumatic fever (RF): namely, Māori and Pacific families. Initiated with the aim of reducing ethnic health disparities, the Health Promotion Agency attempted to use culturally appropriate approaches by engaging in consultative processes with Māori and Pacific communities and health leaders in developing the intervention. However, these consultations largely focused on evaluating strategies for reaching “priority” audiences with the message to get sore throats checked and on changing health-seeking behaviours. There was little regard for what the structural roots of RF in Aotearoa might suggest about equitable interventions, nor for the potentially harmful effects of the messages and their presentation.

The concept of structural violence can be a useful analytical tool to critically evaluate such interventions which attempt to address health disparities but do not meaningfully attend to equity. Drawing on three ethnographic studies with: 1) Northland Māori families (Anderson et al., 2015); 2) North Island Māori and Pacific families (Anderson et al., 2017); and 3) Māori and Pacific children at a South Auckland school (Spray, 2020), we show how recategorising RF disparities as expressions of violence reveals how, despite including cultural consultation, interventions may still inequitably distribute responsibility. In particular, by responsabilising communities affected with the highest rates of RF, the intervention creates collateral damage of stigma, internalised blame, emotional suffering and hypervigilance that reproduces structural violence. We suggest that attending to how families experience public health messaging in the context of their daily lives may guide a more critical and culturally safe health promotion that looks beyond awareness and behaviour and towards equity.

1. Introduction

Māori, the Indigenous people of Aotearoa, New Zealand (henceforth, Aotearoa) and Pacific peoples, a group representing diverse Pacific Island populations (Ministry of Social Development, 2016), suffer disproportionately high rates of rheumatic fever (RF) compared to non-Māori or non-Pacific people (Webb and Wilson, 2013). Closely linked to the unequal distribution of overcrowding and poverty (Jaime et al., 2008, 2011), these ethnic disparities are grounded in the colonial and migrant histories of Māori and Pacific populations, and compounded by contemporary forms of institutionalised racism which privilege European New Zealanders while disadvantaging Indigenous people through educational, medical and political systems (Borell et al., 2009; Reid et al., 2019).

Despite the structural roots of health disparities, Aotearoa health

policy remains focussed on isolating diseases within ‘at-risk’ bodies, in the case of RF, through targeted media campaigns and throat swabbing programmes. In response to the rapid rise of RF in Aotearoa over the last two decades, in 2011 the government initiated a Rheumatic Fever Prevention Programme (RFPP) with the goal of a two-thirds reduction in RF rates by 2016 (Ministry of Health, 2019b). The RFPP involved free throat swabbing at clinics and schools, and a mass-media health promotion aimed at raising parent awareness of RF and the risk of sore throats. These approaches included little emphasis on primordial prevention, meaning the inequitable conditions producing RF disparities continued unabated. Furthermore, the programme has not moved beyond strategies for promoting awareness and behaviour to consider broader issues of how health promotion inequitably distributes responsibility. Yet, through signalling its intentions to address health disparities, the state frames the RFPP as benevolent care, and the

* Corresponding author. Private Bag 92019, Auckland, 1142, New Zealand.

E-mail address: a.anderson@auckland.ac.nz (A. Anderson).

¹ Washington University School of Medicine in St. Louis, Campus Box 8100, St. Louis, MO 63110, U.S.A. (present address).

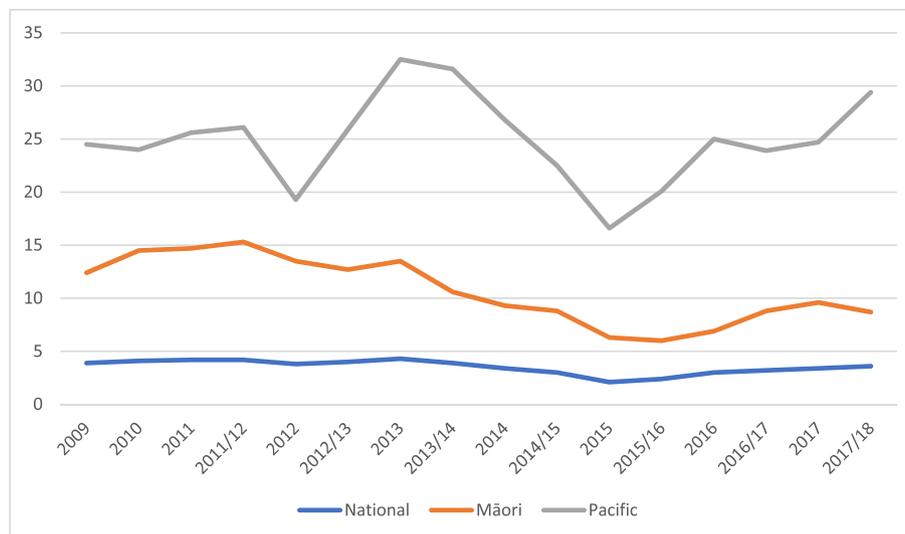


Fig. 1. First episode rheumatic fever hospitalization rate (per 100,000 total population) 2009–2018. Data source: Ministry of Health.

intervention appears to be founded in good intentions.

Structural violence can be a useful analytical tool for critically evaluating such interventions which attempt to address health disparities but do not meaningfully attend to equity. A term often attributed to Johan Galtung (1969), structural violence acknowledges that harm is not limited to individual agents and intentions, but can be enacted through social systems and structures, manifesting as unequal power and unequal life chances. Structural violence has been used to reframe individual suffering as inevitable outcomes of broader global “machinery of oppression” (Farmer, 2004, 307) including the lasting effects of colonisation, slavery, economic systems and trade policies. The concept enables analysis of the unequal distribution of illness through political-economic systems far removed from individual sufferers (Farmer, 2006, 2001; Bourgois, 1995), and of how hegemonies, ideologies, and processes of naturalisation function to justify or conceal the injustice of the status quo (Holmes, 2013).

Structural violence has been critiqued for being too broad a concept, unable to distinguish between variable and intersecting forms of harm or inform how harms can be inherited or compounded (Parsons, 2007; Winter, 2012). However, as a tool for evaluating interventions aimed at addressing inequalities, the utility of structural violence is in its transformative power of recategorisation; suffering becomes reclassified as *harm*. Structural violence can reveal the violence of omission—not just of commission—by broadening categories of violence from discrete, intentional acts of harm by a specific agent to include hunger, poverty and subordination as forms of violence enacted by a system (Farmer, 2004; Winter, 2012). That this is called *violence* matters, because despite the ambiguity of perpetrator, the language of violence shifts inequality from the category of unfortunate but natural suffering to the category of unnatural and unjust harm. “Violence” suggests liability, even while the invisibility of the violator is part of what makes structural forms of harm so insidious and intractable.

Beyond that liability exists, structural violence has little to say about how responsibility should be allocated, as not all are equally implicated in the reproduction of inequality (Winter, 2012). However, by showing us where liability does *not* lie—i.e., with the victims—structural violence can enable us to critique how state interventions distribute responsibility for addressing disparities. For example, though health disparities are widely acknowledged by state of Aotearoa, these are generally linked to causes such as poverty, poor housing, and overcrowding, a framing which recognises suffering, but not *harm*. Recategorising disparities as expressions of *violence* can therefore reveal problems with interventions that may have good intentions, but do not consider how responsibility for care is inequitably distributed.

Our analysis of RF policy in Aotearoa therefore shows that structural violence not only operates through the structures of colonialism and related medical approaches, but remains even in health interventions designed with good intentions and with cultural appropriateness in mind. We draw data from three ethnographic studies of RF in Aotearoa to illustrate how an intervention that is focused on raising awareness and changing behaviours of those ‘at risk’ inadvertently creates additional burdens of responsibility and suffering for the communities whose disease burden is caused by structural violence. The resulting distribution of responsibility for suffering suggests that it is not enough to consult communities. Instead, intervention design must be rooted in recognition of historical and contemporary harms, in order to shift beyond awareness and towards a critically conscious health promotion.

1.1. RF in Aotearoa

Rheumatic fever is an auto-immune response to group A streptococcus (GAS) infection and mainly affects children aged 5–14 (Milne et al., 2012b). Often preceded by strep throat or skin infections, RF causes cardiovascular inflammation which can lead to rheumatic heart disease (RHD) and valve damage that may require cardiac surgery (Parks et al., 2012). Children who develop RF are at high risk of recurrence, therefore initial hospital treatment is usually followed by at least ten years of prophylactic penicillin, usually delivered every 21–28 days by nurses (Lennon et al., 2014). Though RF is rarely fatal, the heart damage that may follow is a significant cause of premature mortality for the communities affected (Wilson, 2010; Milne et al., 2012a).

After decades of decline, RF rates in Aotearoa began to rise in the 1980s and remained relatively constant until 2015, when there was a brief decline in rates that have since increased (Fig. 1) (Ministry of Health, 2019b). The highest rates of RF are found among Māori and Pacific children, comparable to some of the highest in the world (Jaime et al., 2008). Jaime et al. (2011) calculated incidence rates by ethnicity from 1996 to 2005 and reported rates of 0.8 for New Zealand Europeans, 8.0 per 100,000 for Māori, and 16.6 for Pacific peoples. Recent reports have shown that these disparities are widening particularly among young Pacific people in Aotearoa (Ministry of Health, 2019b).

Though studies suggest susceptibility to RF may be genetic (Bryant et al., 2009), the proportion of individuals who are susceptible to RF/RHD does not differ substantially from one population to another (Carapetis et al., 2000). Instead, the current incidence rates among Māori and Pacific populations are likely explained by social inequities. Socioeconomic deprivation and household crowding have been shown

to be strongly associated with RF in Aotearoa (Webb and Wilson, 2013). Overcrowded homes can increase the risk of infectious disease transmission, particularly for GAS, where the cross-infection rate is between 15% and 50% within a household (Jaime et al., 2011).

1.2. *Suffering as violence; care as responsabilisation*

As an outcome of ethnic inequities, RF may be seen as a product of historical and contemporary structural violence for Māori and Pacific peoples. For Māori, this violence began with the events of colonisation, the effects of which included wide-scale loss of guardianship and spiritual connection to land and associated economic industries, and degradation of Māori language, identities, cultures and health (Reid and Robson, 2007). Though these traumas have historical roots, the effects of collective disenfranchisement are transmitted inter-generationally, reinforced by colonial structures and contemporary forms of institutional racism (Reid et al., 2019; Pihama et al., 2014).

Pacific peoples in Aotearoa too have a history of marginalisation and racism with roots in the colonisation of much of the Pacific. After waves of Pacific migrants arrived from the colonial territories of Aotearoa and other Pacific Islands to meet the country's needs for horticultural or manufacturing labour, Pacific peoples were blamed for the 1970s economic recession (Aanae, 1997). This persecution included random street checks of anyone who 'looked' Polynesian, exacerbated by the media and political parties who aired racist advertisements projecting hostility towards Pacific migrants. The racist attacks culminated in the dawn raids, where police targeted suspected 'overstayers' with early morning ambushes on women and children (Liava'a 1998). These experiences were deeply traumatic for Pacific people who remembered them with distress decades later (Aanae, 1997).

Māori and Pacific peoples therefore share historical experiences of colonial trauma under a European imperialist Aotearoa. Though the specific nature of these traumas vary across ethnic groups, they indicate shared racial marginalisation as "brown" ethnic minorities in a white dominated society (McCormack and Burrows, 2015). Marginalisation of Māori and Pacific people was further compounded from the 1980s, where neoliberal economic policies ushered in an age of diminishing state influence and free-market housing, disproportionately affecting Māori and Pacific peoples who were more likely to be employed in low-wage manufacturing or labour and more likely to occupy state housing (Murphy and Kearns, 1994; Cheer et al., 2002). As rental costs rose as much as 104%, it became common for two or even three families to occupy a single household (Howden-Chapman, 2000). Such inequities, which included a threefold rise in child poverty rates between 1980 and 1990, were reframed by the State in terms of neoliberal notions of personal choice and responsibility (Boston, 2014). The early 1990s also marked the beginnings of the rise of RF for Māori and Pacific children, the outcome of violence enacted through the state's inaction to address the historical roots of inequities and state adoption of neoliberal economic policies that reinforce the legacies of historical injustices.

But what of state care? In considering what structural violence tells us about care, we draw upon Lisa Stevenson's conception of care as 'the way someone comes to matter' (2014, 3). Stevenson recounts that for the Arctic Inuit, Canadian State care was concerned only with protecting physical survival of anonymous Indigenous bodies, its measure of success only the absence of death, not quality of life. The New Zealand State, meanwhile, has in rhetoric become increasingly concerned with ethnic disparities in health outcomes, where Māori and Pacific peoples are disadvantaged in comparison to non-Māori and non-Pacific on almost every major health indicator (Robson and Harris, 2007). The State claims a duty of care particularly to Māori, who hold rights to equitable health outcomes deriving from the United Nations Declaration on the Rights of Indigenous People, and Te Tiriti o Waitangi (the Treaty of Waitangi), the founding document between Māori and the Crown in Aotearoa (Reid and Robson, 2007). Signed in 1840, Te Tiriti o Waitangi allowed for the establishment of government and laws in Aotearoa and

a guarantee that Māori would receive 'good' governance and health services and outcomes equal to that of the crown (Came and Tudor 2017; Reid, 2013). Under Te Tiriti o Waitangi, Pacific peoples, although not considered Indigenous to Aotearoa, are recognised as Crown citizens and are thus entitled to fair, ethical and just health governance by a state that is a signatory to crucial human rights conventions (Reid et al., 2017).

Yet rhetoric aside, under the neoliberal Aotearoa State, people come to matter primarily in economic terms, with forms of care selected on the basis of cost-effectiveness. Despite recognising the link between overcrowding and RF, and evidence that improving housing conditions would improve a range of health issues (New Zealand Guidelines Group (NZGG) 2011), the State opted for the "low-complexity, low-cost" option of raising awareness and improving sore throat management (Ministry of Health 2013, 14). Thus, by placing responsibility for prevention onto families, the State offsets future cost of RF hospitalisations, surgeries, and subsequent morbidities with minimal investment and without making any structural change.

This approach is justified through what is commonly described as the "responsibilisation" of individuals for their own health status, whereby governments reorganise the provision of care to encourage or require individuals to manage their own health (Trnka, 2017; Baum and Fisher, 2014; Rose, 1999). Like other countries operating under neoliberal policies, responsabilisation is ubiquitous in Aotearoa health promotion, targeting Māori and Pacific communities with messages about behaviour change while ignoring root causes of health inequities. Such individual-focused approaches tend to inflate perceptions that individuals have power over their own health without recognising the structures constraining communities, therefore implying that people are to blame for detrimental outcomes (Guttman and Salmon, 2004; Bond, 2002).

Viewed through a lens of structural violence then, Aotearoa claims an obligation to address inequities, but crucially, claims no liability for inequities, instead shifting responsibility for health onto the very populations who experience the greatest burdens of the disease. People are not cared for as sufferers of violence, but responsabilised to care for their own structural victimisation. As can be seen in the RFPP, a lack of acknowledgement of the structural roots of health disparities has consequences for how state care is designed and delivered, meaning that even care aimed to address inequity becomes inequitable in and of itself.

2. Methods

Our analysis draws data from three Aotearoa-based anthropological studies: a Northland ethnography (Anderson et al., 2015); a national qualitative study on recurrent RF and RHD (Anderson et al., 2017); and a school-based ethnography in South Auckland (Spray, 2020) (Table 1).

The former two projects were with Māori and Pacific families and included perceptions of families and health providers using a Kaupapa Māori approach. "Kaupapa" can be loosely defined in English as a foundation, and represents a platform to apply, reproduce, and transform Māori philosophies, epistemologies and paradigms to research (Smith, 1999). As a critical Indigenous framework, Kaupapa Māori operates under a decolonising lens by simultaneously critiquing colonial structures of power and employing Māori ways of being, knowing and doing (Mahuika, 2008; Barnes, 2000). Kaupapa Māori methodology prioritises Māori world views, places Māori at the centre of the study and rejects cultural deficit explanations (Walker et al., 2006). Anderson et al. (2017) also used two Pacific methodologies: talanga ('Ofanoa et al., 2015) which facilitates sharing of stories and perspectives, and kakala (Thaman, 1997) which draws on symbolism to elicit experiences in ways that align with participants' cultural world views.

Spray's (2020) study involved a year of ethnographic research at a primary school where a throat-swabbing clinic had been established as part of the RFPP. This project took a child-centred approach, seeking to

Table 1
Data sources from three Aotearoa based projects.

Project	Project Title	Site	Research focus	Participants	Research approach, methodologies & analysis
Northland Ethnography (Anderson et al., 2015)	Whānau ^a experiences of the diagnosis and management of Acute Rheumatic Fever for tamariki in Te Tai Tokerau, Aotearoa.	Northland (Te Tai Tokerau)	Family experiences of ARF, including pathways to and through ARF diagnosis and treatment	Māori with RRF/RHD and families (n = 36)	Kaupapa Māori approach. Participant observation, whānau (family) focus group/individual interviews. General inductive thematic analysis.
National Qualitative RRF/RHD Project (Anderson et al., 2017)	Māori and Pacific Whānau Experiences of Recurrent Rheumatic Fever and Unexpected Rheumatic Heart Disease in New Zealand	Seven District Health Board (DHB) regions: Northland, Auckland, Waitematā, Counties Manukau, Waikato, Hutt Valley, and Capital and Coast.	The lived experiences of Māori and Pacific people living with recurrences of RF and unexpected RHD	Māori and Pacific children and adults under age 40 who had been diagnosed with ARF/RRF/RHD and their families (n = 80) Health professionals involved in the care of patients with RRF/RHD (n = 33 (9 interview/24 focus group))	Kaupapa Māori with two Pacific approaches: talanga and kakala. Whānau focus group or individual semi-structured interviews. General inductive thematic analysis
School-based Ethnography (Spray, 2020)	The Children in Child Health	Tūrama School ^b , South Auckland	Children's experiences of health and illness	Māori (70%), Pacific (25%), and other (5%) children aged 8–12 (n = 82/38 interviewed) Family members (n = 6) School staff (n = 7)	Child-centred approach. Participant observation, interviews. Thematic analysis.

^a Whānau loosely translates in English to 'family'.

^b Name of school, and participants in all studies, are pseudonyms.

mitigate adult dominance over children's representation by bracketing adult-centric assumptions and positioning children as subjects, rather than objects of research (Christensen and James, 2000). This approach views children as active participants in social life, listening for their experiences and perspectives while being mindful of generational power imbalances in research relationships. These approaches all share an aim of understanding lived experiences from participants' particular socio-cultural perspectives, while turning critical lenses onto the mechanisms of power which work to constrain options and generate marginalising discourses.

Data were collected and analysed through a range of ethnographic and other qualitative methods. Anderson et al. (2015) used participant observation and semi-structured interviews with 36 Māori affected by RF or RHD and their families. Anderson et al. (2017) also conducted semi-structured interviews with 80 Māori or Pacific family members and 33 health providers. Spray (2020) used participant observation with 82 consenting children aged between 8 and 12 years old, and as semi-structured interviews with 38 children, seven school staff, and six family members. Importantly, while Anderson's research focused on families who had experienced RF/RHD, Spray's community-situated research mostly involved families who were targeted as 'at risk' but did not have a child who had experienced RF. Combining data from these projects therefore allowed comparison of impacts of health promotion messaging for families who had and had not already been affected by RF.

3. Results

Across narrative data from the three studies, we found three forms of harm experienced by families as a consequence of the RF intervention: internalised blame; emotional burdens; and stigma. Bundled together, we characterise these harms as "collateral damage": the inadvertent and unrecognised but harmful effects that accompany care designed to address suffering but not violence. Below, we consider how the RFPP's narrow focus on "awareness" produces social consequences, followed by narratives detailing the impacts of this collateral damage for families.

3.1. Limits of awareness: collateral damage

Perhaps recognising the harms of colonial approaches to public health in the past, the RFPP design involved collaboration with Māori and Pacific health professionals and substantial consultation and engagement with Māori or Pacific led associations. The RF Guideline (Lennon et al., 2014) that underpins the programme lists endorsements by Pacific Islands Heartbeat, Te Hotu Manawa Māori, and Te Ohu Rata o Aotearoa/Te Ora Māori Medical Practitioners Association. Likewise, the Aotearoa Health Promotion Agency attempted to use culturally appropriate approaches to health promotion by engaging in consultative processes with Māori and Pacific communities and health leaders. However, based on evaluation reports, these consultations appear to have focused on assessing strategies for reaching "priority" audiences with the message to get sore throats checked and on changing health-seeking behaviours (Allen + Clarke, 2015; TNS New Zealand Ltd. 2015). Evaluation of the campaigns focused on 'value for investment' as measured by *knowledge*—the proportion of the targeted audience who reported awareness of the campaign messages—and of *actions* (engaging with health care) taken as a result. There was little critical consideration of the social consequences of the messages and their presentation for Māori and Pacific families.

Because RF is almost exclusively a disease of poverty, the RFPP targeted low-socio-economic Māori and Pacific families in several ways: throat swabbing is offered through schools in low socioeconomic areas with high Māori and Pacific enrolments; 'at-risk' children are entitled to free throat swabs at primary care clinics and pharmacies; and the mass-media campaign featured Māori and Pacific families of a child with RF



Fig. 2. Still shot from Rheumatic Fever Prevention television ad campaign, Winter 2015.

and prioritises advertising space in the geographical locations with highest RF rates. These efforts saw a slight reduction in RF rates between 2012 and 2018, but only one region, Northland, achieved the goal of a two-thirds reduction (Ministry of Health, 2019b).

While impacts on RF rates have been largely unsuccessful, this form of health care has seen other positive effects. Spray (2020) observed that from children's perspectives, clinic staff gave them a warm and affective interpersonal experience of care, and generally the programme was positively viewed as a moral 'good' by children, parents, and teachers. None of the children in this cohort contracted RF during the period of fieldwork, although nationally fewer than 200 children develop RF each year, so it is not possible to infer effectiveness at a micro-level. However, narratives from participants in all three studies revealed collateral damage which, given the minimal effects of the RFPP on RF rates for Pacific in particular, could be considered as iatrogenesis in clinical terms—where harm from a treatment is more detrimental than leaving the condition untreated (Guttman and Salmon, 2004).

Importantly, due to the targeted nature of the RFPP, these harms primarily impact Māori and Pacific families, and furthermore, are experienced *collectively*. This ethnic targeting created experiences and constructed identities for whole communities, not only families of children who had RF. Specifically, we note that by responsabilising families for identifying children's sore throats, these messages work to burden families with the role of monitoring a subjective symptom, while reinforcing stereotypes of the *irresponsible* "brown" parents, creating stigma, shame, anxiety or guilt. Importantly, these harms are almost exclusively experienced by Māori and Pacific peoples, exacerbating, rather than mitigating, the inequitable distribution of suffering in Aotearoa.

3.2. Responsibility and internalised blame

The key messages of the RF campaigns included directives for parents to take children's sore throats seriously, to "take them to the doctor or nurse straight away to get it checked," and the guilt inducing imperative to "do it for them" (TNS New Zealand Ltd. 2015). The decision to focus on sore throats, rather than inequitable conditions, shifts responsibility for RF onto Māori and Pacific parents, who became tasked with managing what was both a very common and subjective symptom of childhood illness.

Monitoring children for a sore throat is easier said than done as it requires children to identify their sore throat and tell a parent. Spray (2020) found many children reported sore throats on a weekly basis, but also that children had much broader understandings of sore throat than the throat swabbing was intended for. Some children believed a sore throat meant "sneezing" or "allergies", others reporting to the school clinic for sore throats relating to "talking too loudly" or "eating scratchy food" (p76). The presence of the school clinic meant that at least during the school term these varied "sore throats" could be easily

checked without inconvenience for families. However, for families whose children did not have access to a school clinic, the campaign messaging created stress as they struggled with the practicalities of getting their children to a doctor for every sore throat, which often required taking time off work. Anderson et al. (2017) reported that many families most vulnerable to RF also lived complex and transient lives, juggling the stresses of employment, housing, and parenting from positions of financial insecurity. Given that most families had more than one child, the expectation that they should take each child to the doctor for every sore throat was simply untenable.

Yet families whose child had developed RF were left dealing with the messaging's implication that they did something wrong. In the same way that Wang (1992) suggests injury prevention campaigns stigmatise those who have been injured—the disabled—the RF campaign stigmatises parents whose child developed RF by implying they did not take action to prevent the disease. This internalising of blame was modelled in the advertising campaigns, where a mother of a boy who developed RF wipes tears from her eyes as she berates herself for not taking her son to the doctor (Fig. 2). The mother laments:

"It makes you think, only if I had, only if I had taken him to the doctor when he had a sore throat, six months ago, and got some antibiotics to get rid of any sort of infection. He'd be okay. Open heart surgery, penicillin shots until he's 30 years old, these are all things that could have been avoided if we had just taken him to the doctors at the time when he got a sore throat. ... It's not cool to the take the risk of 'oh I'll see if it's okay tomorrow, I'll see what happens tomorrow'. As soon as your kid gets a sore throat, then you need to go to the doctors. We all need to go to the doctors to get it checked."

Similarly, it was common for families in Anderson's studies to blame themselves for their child's RF. One mother, Rata, reflected that prior to RF diagnosis her daughter:

"... was with a lot of people because we had the ah the tangi [funeral] after that aye? It was three days and that would have been mixing, sleeping with people, whether that had anything to do with it? ... I was like 'oh my God' that was my fault because I knew that it [RF] comes from a sore throat, they [doctors] said um, 'well you just didn't pick it up that she had a sore throat' and I was like 'Oh my God'. You feel like you're ah, (pause) ... you feel like a terrible parent cause you just missed all this stuff." (Anderson et al., 2015, 19)

Here Rata not only blames herself, but also the cultural practice of co-sleeping at the marae [communal area used for cultural functions] for a tangihanga [funeral], an internalising of racist attitudes which blame the cultural 'other' for their ill health. Perhaps the greatest violence here though is that as the doctor blamed Rata for not picking up her child's sore throat, there was no mention that up to two thirds of RF episodes are not preceded by a known sore throat event (Robin et al., 2013; Veasy et al., 1987). Families have been tasked with monitoring a polysemic symptom that children may never even experience. Furthermore, Anderson et al. (2017) also found that even when parents did get their child to a doctor because they had a sore throat, a large number of doctors were not following sore throat guidelines by swabbing sore throats or providing appropriate antibiotic treatment.

Yet parents took this responsibility very seriously; in Spray's data, the mother of a nine-year old who had experienced three bouts of strep throat that year explained:

"We don't want any of these diseases that we could have prevented by just educating ourselves or just you know listening to certain things like taking the medicine for the strep throat every day. This is our third time so, we really want to beat this. We want to beat this."

3.3. Emotional burdens

The burden of responsibility was accompanied by anxiety, guilt and shame for families who concluded that their child became ill because they did something wrong. However, families who did not have a child with RF also bore an additional emotional burden of anxiety and fear. Anna, the mother of a nine-year old who regularly attended the school clinic to be swabbed, grew visibly anxious as she described her growing awareness of RF:

“So when it started to be more familiar as in people were talking about it like rheumatic fever, oh my gosh if you get a sore throat you can end up with rheumatic fever. What, oh my God, I know what rheumatic fever is ... Man if we didn't have that check at school, I would be at the doctors all the time I'm like oh my God, oh my God, oh my God.”

While it was not uncommon for health promotion efforts to deliberately play on emotions of guilt or fear in order to capture public attention, many scholars argue these tactics are ethically problematic, especially as they often involve misrepresenting risks or amplifying statistics and may cause maladaptive responses such as anxiety (Guttman and Salmon, 2004; Hastings et al., 2004; Peng et al., 2018). The RF campaigns feature dramatic death language and imagery, including a wide-eyed child sitting in a hospital surgery with the tagline “I almost died.” (Fig. 3) The prominence of death in these advertisements portrayed RF as much more deadly than the reality; though heart surgeries carry risk, it is rare for a child to die of acute RF, and the bigger risk is early mortality to RHD later in life. Yet the children watching these advertisements saw a common, even inevitable progression from sore throats to death. Intended to mobilise parents, the images of vulnerable children with large scars from heart surgery inadvertently targeted children who identified with the Pacific boys playing rugby and joking with their siblings. Nine-year-old Chloe described her response to the RF advertisements:

“Cause when you watch the ads you're like, you get kind of scared and panicky. That you might die from it so you're like, and you tell them you think that you should do it (go to get swabbed), even though you're shy.”

This combination of responsibility for RF and anxiety created a

further burden of vigilance for Māori and Pacific families. At the school where Spray conducted fieldwork, teachers asked children daily if they had a sore throat; as a consequence children appeared to have a heightened awareness of sore throat, and large numbers of children visited the school clinic on an almost weekly basis, but rarely tested positive for GAS. One 10-year-old, Mila, explained that she never felt a sore throat, but would visit the clinic just in case, “so the nurse can check if I have a sore throat” (Spray, 2020, 78). Another boy became confused and distressed when he was not called to have his throat checked because he had already been swabbed earlier that week. Such vigilance demands energy and attention from the people already under greatest stress, while middle-class New Zealand European families are largely immune, compounding pre-existing inequities.

3.4. Targeting and stigma

Health targeting means tailoring resources and services to the particular needs, beliefs, values, practices, identities, or geographical locations of subgroups, and may be seen as an ethical dimension of social justice whereby resources are directed towards groups that need them to achieve more equitable health outcomes (Guttman and Salmon, 2004). Despite its health equity aim, health targeting can have the inverse effect, particularly because of the way it allocates responsibility for ill health onto whole groups of already marginalised people. In countries like Aotearoa, targeting operates as a neoliberal tool for optimising resources under a mantra of ‘efficiency’ (Carlos, 1996). In such cases, targeting may be superficially addressing inequities, by only attending to the effects of the inequities and not the causes, thus masking injustice as care.

Furthermore, by delivering a message only to certain subgroups, targeting contributes to the construction of social identities. Targeted promotion adopts marketing principles which operate on the mechanism of homophily, whereby targeted consumers are more persuaded when they infer similarity between themselves and characteristics of the advertisement. This process results in “felt targetedness,” where the viewer believes they are the intended audience for the advertisement (Grier and Kumanyika, 2010, 4). However, if messages are not positive, they reproduce notions of what kind of people “one should not become” (Wang, 1992, 6), leading to stigmatisation (Goffman, 1963). The RF campaign targeted Māori and Pacific people through



Fig. 3. Campaign posters for Rheumatic Fever Awareness. Health Promotion Agency, 2016.

images of “brown” socially assigned ethnicity (Harris et al., 2013) with messages implying not only is it bad to have a child with RF, it is bad to be Māori or Pacific because these are the people who suffer this disease. Moreover, targeting subgroups is particularly problematic for addressing issues of disease because of what Schiller et al. (1994, 1138) describe as “an ancient, explanatory paradigm that attributes lethal, transmissible disease to groups seen as culturally different from the mainstream population, and defines those who are sick as culturally different.” In other words, since disease is implicated in the maintenance of ethnic boundaries, then health promotion that links disease to marginalised subgroups reinforces stereotypes of those groups as dirty, poor, irresponsible, or deviant, perpetuating their social oppression. As well as being socially harmful, stigma can be embodied as poorer health, for example affecting access to health care because of patient shame or embarrassment, causing misdiagnosis or poorer quality of care, or through the stress caused by discrimination and shame (Krieger, 2011).

Health promotion concerned with addressing inequities should therefore be sensitive towards how stigma is created through targeting. Unfortunately, this is not the case for the RF campaign, where Anderson et al. (2017) found that families felt that they were portrayed as “the problem” and stereotyped as irresponsible, unhygienic and uneducated, as poor parents and as living in poverty and overcrowding. For example, Kōwhai, the mother of a child with RF explained:

“Yeah, well just from what I have seen, probably really more the TV adverts that I have seen, and because my children are Māori/Pacific Island, we get sort of upset ... That assumption that like, it's a Māori Polynesian problem, and poor people get it, you know. And almost sort or poor parenting, poor care of kids.”

The Health Promotion Agency's intention here is to direct health messages to those most affected in order to protect at-risk families. However, the message framed Māori and Pacific as poor and diseased, reinforcing stereotypes, while disregarding the injustices underlying risks of RF (Bond, 2005; Moewaka Barnes, Borell, and McCreanor, 2014; Reid and Robson, 2007).

4. Discussion

Approaches to RF prevention by the Aotearoa state have the hallmarks of good intentions, including an ambition to address health disparities, consultation with Māori and Pacific health leaders, and attempts to target care towards those who most need it. However, we argue that applying a lens of structural violence to an analysis of state care enabled us to do what the concept does best: reveal the concealed and situate health disparities within a discriminating, temporal chain of unequal environmental conditions. RF in Aotearoa can be temporally traced back from present day neoliberal ideologies of personal responsibility, to the neoliberal reforms on housing and social welfare of the 1990s, through the racist employment and immigration policies of the mid-20th century, to the original displacement and disenfranchisement of colonisation. As an embodiment of the compounding adversity, stress, and neglect of these eras, RF represents a violence dealt by the structures of Aotearoa society, sometimes purposefully, sometimes through neglect, but almost exclusively to Māori and Pacific populations.

Through structural violence we can consider efforts to address contemporary disparities in terms of a politics of recognition: how someone comes to matter (Stevenson, 2014). We argue that the Aotearoa state recognises suffering, but not violence; it recognises disparities, but not its own liability. This is a prevention policy predicated on economic investment, rather than social justice, and moreover, in how these interventions distribute responsibility for care. The approach to primary prevention of RF has been based in a deficit frame which ultimately burdens Māori and Pacific families with responsibility for monitoring and seeking antibiotic treatment for sore throats— adding

unrealistic burden to family life and resulting in shame and stigma. This means that in addition to almost exclusively carrying the weight of RF morbidity, Māori and Pacific peoples also bear the burden of RF prevention. By targeting GAS with pharmaceuticals, rather than addressing socioeconomic inequities as the root of the epidemic, the RFPP represents another vehicle for structural violence, protecting the status quo, reframing narratives of State neglect as State care, and holding the victims of structural violence responsible for their own illness. Thus, by failing to recognise liability for harm, the State compounds the structural violence of the past with new forms of suffering.

The harms wrought by the RFPP are concealed by the ambivalent experiences of Māori and Pacific families with the interventions themselves. Delivered through affective care, the school throat swabbing is presented as a comforting antidote to the fear and anxiety provoked by the programmes' campaign. Giving a generation of disadvantaged children a positive early experience of health care is a good thing, so long as we do not ask why these children need additional health care in the first place. Yet in its ambiguity lies its power, as the interpersonal care of community health workers serves to conceal that state care is merely surveillance, and not reparation for the violence that exposes some populations of children to greater risk than others.

Frustratingly, these are not newly identified issues. These are ethical tenets of health promotion repeatedly identified over the last three decades, particularly by social scientists after the HIV/AIDS crisis of the 1980s and 1990s. For example, Houkamau and Clarke (2016) found that health targeting of Māori in Sudden Unexplained Death in Infancy (SUDI) health-promotion programmes created discourses of blame and risk for Māori impeding their service engagement while ignoring the role of socioeconomic determinants in health through its focus on culture. Brough et al. (2004) caution against targeting culture in health promotion, particularly within Indigenous health contexts, arguing that “health-promotion needs to be aware of its own potential to utilise the culture concept superficially, “explaining” unhealthy behaviours in reference to a series of stereotypical cultural traits drawn from the popular culture” (p. 216). Moreover, there is little evidence of effectiveness of ethnic targeting for changing health behaviours (Mosdøl et al., 2017), though well-resourced services and messages developed by Māori to benefit Māori are more culturally appropriate, culturally safe and effectively delivered (Tipene-Leach et al., 2000). Evidence suggests that alternative approaches such as empathy-based messaging are both less harmful and more effective than those which use fear (Peng et al., 2018).

Deferring responsibility from the state to populations who experience the greatest burdens of the disease, and the continued inequities evident in health outcomes for Māori compared to non-Māori, also violate both human rights and articles of Te Tiriti o Waitangi. Responding to these breaches, in 2016 the Waitangi Tribunal (a permanent commission of inquiry that makes recommendations on claims of Te Tiriti o Waitangi violations) commenced an inquiry into health services and outcomes for Māori in Aotearoa: the ‘WAI 2575’ inquiry (Ministry of Health, 2019a). Initiated in 2019, the inquiry will hear over 200 claims relating to grievances with legislation and policy frameworks within primary health (Waitangi Tribunal, 2019). The commencement of WAI 2575 could indicate, if not a shift in the State's deferral of responsibility, at least a formal recognition of the State's role in influencing poor health outcomes for Indigenous people.

These findings highlight the limitations of consultation—especially if those consulted are not equipped to critically evaluate the social effects of public health approaches. Although the RFPP invested in substantial consultation with Māori and Pacific health leaders, and tested health promotion interventions with Māori and Pacific families, the focus here was still on promoting awareness and behaviour, with little attention to how families and children experience public health messaging in the context of their daily lives, and how these messages construct community identities in damaging ways. Reid et al. (2017) argue that for research to achieve beneficial health outcomes for Māori, it

must operate under a rights-based and equity approach and be responsive to Māori through consultation alongside the application of *critical indigenous frameworks and promotion of Māori voice*. We have additionally highlighted the value of ethnographic methods for guiding a more critical and culturally safe health promotion (Spray, 2018). This strongly supports promotion of social science training and critical indigenous approaches alongside clinical training for health professionals, as well as the inclusion of children and youth-centred approaches into health interventions and policies. Equity must be considered more broadly than simply numbers of hospital admissions. For a socially responsible health promotion, the means, not just the end, must also be equitable.

5. Conclusion

We have considered what a lens of structural violence can reveal about state attempts to address health disparities through targeted care. Though high rates of RF affecting Māori and Pacific populations are often discussed in terms of inequitable environmental conditions, placing the disease into historical and structural context repositions RF as an embodiment of violence dealt by legacies of colonisation and systemic racism. When applied to state care, RF prevention policies are revealed to acknowledge suffering but not violence; they are concerned with economic costs to the state rather than social justice. By using an approach which responsabilises Māori and Pacific in Aotearoa for their health, the state in fact inadvertently causes further harm to families through the collateral damage of stigma, vigilance, and emotional suffering. Moreover, by directing attention and resources from addressing the inequitable conditions that are the root causes of the illness disparity, the emphasis on secondary prevention actively conceals harm through the appearance of action. Thus, in this context, care represents a new form of structural violence. We argue that when a marginalised group already carries the greatest burden of disease, an equitable public health policy needs to ensure they do not also carry the greatest consequences of prevention.

Authors' contribution statement

Both authors independently undertook research projects, as primary investigators-from conception to completion that informed this paper.

Both authors co-wrote the paper and combined their respective research narratives through agreement.

Acknowledgements

We offer our grateful acknowledgement to all the participants in the research, our co-researchers, the journal reviewers, and the research funders- The University of Auckland and The Ministry of Health.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.socscimed.2020.112798>.

References

- Anae, Melani, 1997. 'Towards a NZ-born Samoan identity: some reflections on "labels"'. *Pac. Health Dialog* 4 (2), 128–137.
- Anderson, Anneka, Mills, Clair, Eggleton, Kyle, Henare-Toka, Te Ami, Palmer, Jim, 2015. Northland District Health Board Research Report: Whānau Experiences of the Diagnosis and Management of Acute Rheumatic Fever for Tamariki in Te Tai Tokerau, Aotearoa. University of Auckland, Auckland, New Zealand.
- Anderson, Anneka, Ofanoa, Malakai, Leversha, Alison, Peat, Briar, Malungahu, Gemma, Burgess, Hannah, Wade, Julie, Naisali, Suamelie, Sims, Allyn, 2017. Māori and Pacific Whānau Experiences of Recurrent Rheumatic Fever and Unexpected Rheumatic Heart Disease in New Zealand. University of Auckland, Auckland, New Zealand.
- Barnes, H.M., 2000. Kaupapa Maori: explaining the ordinary. *Pacific Dialog* 7 (1), 13–16.
- Barnes, Moewaka, Helen, Borell, Belinda, Tim McCreanor, 2014. 'Theorising the structural dynamics of ethnic privilege in Aotearoa: unpacking "this breeze at my back"'. *Int. J. Crit. Indig. Scholarsh.* 7 (1), 1–14.
- Baum, Fran, Fisher, Matthew, 2014. Why behavioural health promotion endures despite its failure to reduce health inequities. *Sociol. Health Illn.* 36 (2), 213–225. <https://doi.org/10.1111/1467-9566.12112>.
- Bond, Chelsea, 2002. Beyond the dotted drawings-the aboriginal health worker and health promotion practice. *Aborig. Isl. Health Work. J.* 26 (6), 16.
- Bond, Chelsea, 2005. A culture of ill health: public health or aboriginality? *Med. J. Aust.* 183 (1), 39.
- Borell, Belinda AE., Gregory, Amanda S., McCreanor, Tim N., Jensen, Victoria GL., Moewaka Barnes, Helen E., 2009. "It's hard at the top but it's a whole lot easier than being at the bottom": the role of privilege in understanding disparities in Aotearoa/New Zealand'. *Race/Ethnicity: Multidiscip. Global Contexts* 3 (1), 29–50.
- Boston, Jonathan, 2014. Child poverty in New Zealand: why it matters and how it can be reduced. *Educ. Philos. Theor.* 46 (9), 962–988. <https://doi.org/10.1080/00131857.2014.931002>.
- Bourgois, Philippe, 1995. *In Search of Respect: Selling Crack in El Barrio*. Structural Analysis in the Social Sciences. Cambridge University Press, Cambridge; New York.
- Brough, Mark, Bond, Chelsea, Hunt, Julian, 2004. Strong in the city: towards a strength-based approach in indigenous health promotion. *Health Promot. J. Aust.* 15 (3), 215–220.
- Bryant, Penelope A., Robins-Browne, Roy, Carapetis, Jonathan R., Curtis, Nigel, 2009. Some of the people, some of the time susceptibility to acute rheumatic fever. *Circulation* 119 (5), 742–753.
- Came, Heather, Keith, Tudor, 2017. Unravelling the Whāriki of crown Māori health infrastructure. *N. Z. Med. J.* 130 (1458), 42–47.
- Carapetis, Jonathan R., Currie, B.J., Mathews, J.D., 2000. Cumulative incidence of rheumatic fever in an endemic region: a guide to the susceptibility of the population? *Epidemiol. Infect.* 124 (2), 239–244.
- Carlos, Vilas, 1996. Neoliberal social policy managing poverty (somehow). *NACLA Rep. Am.* 29 (6), 16–25. <https://doi.org/10.1080/10714839.1996.11722877>.
- Cheer, Tarin, Kearns, Robin, Murphy, Laurence, 2002. 'Housing policy, poverty, and culture: "discounting" decisions among pacific peoples in Auckland, New Zealand'. *Environ. Plan. C Govern. Policy* 20 (4), 497–516. <https://doi.org/10.1068/c04r>.
- Christensen, Pia Haudrup, James, Allison, 2000. Researching children and childhood: cultures of communication. In: Christensen, Pia Haudrup, James, Allison (Eds.), *Research with Children: Perspectives and Practices*. Falmer Press, London; New York, pp. 1–8.
- Clarke, Allen, 2015. Evaluation of the 2015 Rheumatic Fever Awareness Campaign. Ministry of Health, Wellington, N.Z. <http://www.health.govt.nz/publication/evaluation-2015-rheumatic-fever-awareness-campaign>.
- Farmer, Paul, 2001. *Infections and Inequalities: the Modern Plagues*. University of California Press.
- Farmer, Paul, 2004. An anthropology of structural violence. *Curr. Anthropol.* 45 (3), 305–325. <https://doi.org/10.1086/382250>.
- Farmer, Paul, 2006. *AIDS and Accusation: Haiti and the Geography of Blame*. University of California Press.
- Galtung, Johan, 1969. Violence, peace, and peace research. *J. Peace Res.* 6 (3), 167–191.
- Goffman, Erving, 1963. *Stigma Notes on the Management of Spoiled Identity*. J. Aronson, New York.
- Grier, Sonya A., Kumanyika, Shiriki, 2010. Targeted marketing and public health. *Annu. Rev. Public Health* 31, 349–369.
- Guttman, Nurit, Salmon, Charles T., 2004. Guilt, fear, stigma and knowledge gaps: ethical issues in public health communication interventions. *Bioethics* 18 (6), 531–552. <https://doi.org/10.1111/j.1467-8519.2004.00415.x>.
- Harris, Ricci, Cormack, Donna M., Stanley, James, 2013. The relationship between socially-assigned ethnicity, health and experience of racial discrimination for Māori: analysis of the 2006/07 New Zealand health survey. *BMC Public Health* 13 (1), 844.
- Hastings, Gerard, Stead, Martine, Webb, John, 2004. Fear appeals in social marketing: strategic and ethical reasons for concern. *Psychol. Mark.* 21 (11), 961–986.
- Holmes, Seth, 2013. *Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States*. University of California Press, Berkeley and Los Angeles, CA.
- Houkamau, Carla A., Clarke, Kathrine, 2016. Why are those most in need of sudden unexplained infant death (SUDI) prevention information the least likely to receive it? A comment on unconscious bias and Māori health. *N. Z. Med. J.* 129 (1440), 114–119.
- Howden-Chapman, Philippa, 2000. *Social Inequalities in Health: New Zealand 1999*. Ministry of Health, Wellington, New Zealand.
- Jaine, Richard, Baker, Michael G., Venugopal, Kamalesh, 2008. 'Epidemiology of acute rheumatic fever in New Zealand 1996–2005'. *J. Paediatr. Child Health* 44 (10), 564–571. <https://doi.org/10.1111/j.1440-1754.2008.01384.x>.
- Jaine, Richard, Baker, Michael G., Venugopal, Kamalesh, 2011. Acute rheumatic fever associated with household crowding in a developed country. *Pediatr. Infect. Dis. J.* 30 (4), 315–319.
- Krieger, Nancy, 2011. *Epidemiology and the Peoples' Health*. Oxford University Press, New York, NY.
- Lennon, Diana R., Peat, Briar, Kerdemelidis, Melissa, Sharpe, Norman, Liddel, Rachel, 2014. *New Zealand Guidelines for Rheumatic Fever Group A Streptococcal Sore Throat Management Guideline: 2014 Update*. Heart Foundation New Zealand, Auckland.
- Liava'a, S., 1998. 'Dawn Raids: when Pacific Islanders Were Forced to Go "Home"'. University of Auckland, Unpublished MA thesis.
- Mahuika, Rangimarie, 2008. *Kaupapa Māori theory is critical and anti-colonial*. *Mai Review* 3 (4), 1–16.
- McCormack, J.V., Burrows, L., 2015. The burden of Brown bodies: teachings about

- pasifika within public health obesity research in Aotearoa/New Zealand. *Cult. Stud. Methodol.* 15 (5), 371–378.
- Milne, Richard J., Lennon, Diana R., Stewart, Joanna M., Vander Hoorn, Stephen, Scuffham, Paul A., 2012a. Mortality and hospitalisation costs of rheumatic fever and rheumatic heart disease in New Zealand. *J. Paediatr. Child Health* 48 (8), 692–697.
- Milne, Richard J., Lennon, Diana R., Stewart, Joanna M., Vander Hoorn, Stephen, Scuffham, Paul A., 2012b. Incidence of acute rheumatic fever in New Zealand children and youth. *J. Paediatr. Child Health* 48 (8), 685–691. <https://doi.org/10.1111/j.1440-1754.2012.02447.x>.
- Ministry of Health, 2019a. Health Services and Outcomes Kaupapa Inquiry. Ministry of Health, Wellington. <https://www.health.govt.nz/our-work/populations/maori-health/wai-2575-health-services-and-outcomes-kaupapa-inquiry>.
- Ministry of Health, 2019b. Rheumatic Fever. Ministry of Health, Wellington. <https://www.health.govt.nz/our-work/diseases-and-conditions/rheumatic-fever>.
- Ministry of Social Development, 2016. The Profile of Pacific Peoples in New Zealand. Ministry of Social Development, Wellington. <https://www.pasefikaproud.co.nz/assets/Resources-for-download/PasefikaProudResource-Pacific-peoples-paper.pdf>.
- Mosdøl, Annhild, Lidal, Ingeborg B., Straumann, Gyri H., Vist, Gunn E., 2017. Targeted Mass Media Interventions Promoting Healthy Behaviours to Reduce Risk of Non-communicable Diseases in Adult, Ethnic Minorities. *The Cochrane Library*.
- Murphy, L., Kearns, R.A., 1994. Housing New Zealand Ltd: privatisation by stealth. *Environ. Plan.* 26 (4), 623–637. <https://doi.org/10.1068/a260623>.
- New Zealand Guidelines Group (NZGG), 2011. RapidE: Rheumatic Fever: A Systematic Review of the Literature on Health Literacy, Overcrowding, and Rheumatic Fever. <https://www.health.govt.nz/publication/rheumatic-fever-systematic-review-literature-health-literacy-overcrowding-and-rheumatic-fever>.
- Parks, T., Smeester, P.R., Steer, A.C., 2012. Streptococcal skin infection and rheumatic heart disease. *Curr. Opin. Infect. Dis.* 25 (2), 145–153.
- Parsons, Kenneth A., 2007. Structural violence and power. *Peace Rev.* 19 (2), 173–181.
- Peng, Lulu, Shen, Lijiang, Vanderbilt, Rachel Reymann, Kim, Youllee, Foley, Kasey Ann, 2018. The impact of fear versus state empathy on persuasion and social stigma. *Media Psychol.* 1–24. <https://doi.org/10.1080/15213269.2018.1535321>. 0 (0).
- Pihama, Leonie, Reynolds, Paul, Smith, Cheryl, Reid, John, Smith, Linda Tuhiwai, Te Nana, Rihi, 2014. 'Positioning historical trauma theory within Aotearoa New Zealand'. *AlterNative. Int. J. Indig. Peoples* 10 (3), 248–262.
- Reid, Papaarangi, 2013. Good governance: the case of health equity. In: Tawhai, V., Gray-Sharp, K. (Eds.), *The Treaty of Waitangi and Public Policy*. Hui (NZ) Ltd, Auckland, pp. 63–84.
- Reid, Papaarangi, Robson, Bridget, 2007. Understanding health inequities. In: Robson, Bridget, Harris, R. (Eds.), *Hauora Maori Standards of Health IV: A Study of the Years 2000–2005*. Te Popu Rngahau Hauora a Eru Pomare, Wellington, pp. 3–10.
- Reid, Papaarangi, Paine, Sarah-Jane, Curtis, Elana, Jones, Rhys, Anderson, Anneka, Willing, Esther, Harwood, Matire, 2017. Achieving health equity in Aotearoa: strengthening responsiveness to Māori in health research. *N. Z. Med. J.* 130 (1465), 96–103.
- Reid, Papaarangi, Cormack, D., Paine, Sarah-Jane, 2019. Colonial Histories, Racism and Health—The Experience of Māori and Indigenous Peoples. *Public Health*. <https://doi.org/10.1016/j.puhe.2019.03.027>.
- Robson, Audrey, Mills, Clair, Tuck, Roger, Diana, R., Lennon, 2013. The epidemiology of acute rheumatic fever in Northland, 2002–2011. *N. Z. Med. J.* 126 (1373).
- Robson, Bridget, Harris, R., 2007. *Hauora: Maori Standards of Health IV: A Study of the Years 2000–2005*. Te Ropu Rangahau Hauora a Eru Pomare Wellington, New Zealand.
- Rose, Nikolas S., 1999. *Powers of Freedom: Reframing Political Thought*. Cambridge University Press, Cambridge, United Kingdom ; New York, NY.
- Schiller, Nina Glick, Crystal, Stephen, Lewellen, Denver, 1994. Risky business: the cultural construction of AIDS risk groups. *Soc. Sci. Med.* 38 (10), 1337–1346.
- Smith, Linda Tuhiwai, 1999. *Decolonising Methodologies. Research and Indigenous Peoples*. University of Otago Press, Dunedin.
- Spray, Julie, 2018. The value of anthropology in child health policy. *Anthropol. Action* 25 (1), 29–40.
- Spray, Julie, 2020. *The Children in Child Health: Negotiating Young Lives and Health in New Zealand*. Rutgers University Press, New Brunswick, N.J.
- Stevenson, Lisa, 2014. *Life beside Itself: Imagining Care in the Canadian Arctic*. University of California Press, Oakland, CA.
- Thaman, K.H., 1997. Kakala: a pacific concept of teaching and learning.
- Tipene-Leach, David S. Able, Haretuku, Riripeti, Everard, Carole, 2000. The Maori AIDS prevention programme: challenges and implications of Maori health service development. *Soc. Policy J. N. Z.* 65–77.
- TNS New Zealand Ltd, 2015. 2014 Rheumatic Fever Campaign Evaluation. Health Promotion Agency, Wellington.
- Tribunal, Waitangi, 2019. *Health Services and Outcomes Inquiry*. <https://waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/>.
- Trnka, Susanna, 2017. *One Blue Child: Asthma, Personal Responsibility, and the Politics of 21st Century Patienthood*. Stanford University Press, Stanford, CA.
- Veasy, L., George, Susan E., Wiedmeier, Garth S., Orsmond, Herbert D., Ruttenberg, Mark M., Stephen J Roth, Boucek, Vera, F., Joel A, Tait, Judy A Daly, Thompson, Kaplan, Edward L., 1987. Resurgence of acute rheumatic fever in the intermountain area of the United States. *N. Engl. J. Med.* 316 (8), 421–427.
- Walker, Shayne, Eketone, Anaru, Gibbs, Anita, 2006. An exploration of Kaupapa Maori research, its principles, processes and applications. *Int. J. Soc. Res. Methodol.* 9 (4), 331–344.
- Wang, Caroline, 1992. Culture, meaning and disability: injury prevention campaigns and the production of stigma. *Soc. Sci. Med.* 35 (9), 1093–1102. [https://doi.org/10.1016/0277-9536\(92\)90221-B](https://doi.org/10.1016/0277-9536(92)90221-B).
- Webb, Rachel, Wilson, Nigel, 2013. Rheumatic fever in New Zealand. *J. Paediatr. Child Health* 49 (3), 179–184.
- Wilson, Nigel J., 2010. 'Rheumatic heart disease in indigenous populations—New Zealand experience'. *Heart Lung Circ.* 19 (5), 282–288.
- Winter, Yves, 2012. Violence and visibility. *New Political Sci.* 34 (2), 195–202.
- Ofanoa, Malakai, Percival, T., Huggard, P., Buetow, S., 2015. Talanga: the Tongan way enquiry. *Sociol. Study* 5 (4), 334–340.