Key Health Policy Narratives and Data Themes in Indigenous Services Canada Departmental Results Reports (2017-2021)

Hayden Rasberry, MPA candidate, University of Ottawa

Statement of Positionality: I feel it is important that I recognize my position as a Caucasian cis-gender scholar. I also wish to acknowledge my position as an ally but never the voice of Indigenous peoples.

September 7th, 2022

Student Number: 300209357

Abstract

Several Indigenous scholars have argued that deficit-based data and discourse pervades policy and research on Indigenous health. However, the influence of deficit discourse is not well understood and significantly under theorized in public policy contexts. This exploratory qualitative study consists of an analysis of departmental results reports to Parliament authored by Indigenous Services Canada between 2017-2021. The primary research focus was to identify what social policy narratives and data themes emerged in these reports and to determine if these narratives and themes were primarily deficit-based. Findings indicated that neutral language narratives and data themes were most prevalent in the reports rather than the deficit-based discourse that was predicted. The deficit-based narratives and themes that did emerge were consistent with the hypothesis in the literature that Indigenous health data is based on deficit, dysfunction, deprivation, disparity, and disadvantage. The challenge for governments is to document health disparities to help close health gaps without further alienating and marginalizing First Nations. I argue that deficit-based data and approaches are necessary to address health inequities but should be complemented by a strength-based approach. Additionally, engaging Indigenous stakeholders at every stage of the data life cycle, introducing more culturally relevant data indicators, and including a section on the historical context of the health data, are changes that could be made by ISC to make reports more inclusive and comprehensive.

Table of Contents

Abstract *2*

Abbreviations *5*

Introduction *6*

Theoretical Framework *7*

- Social Constructivism 7
- Policy Images 9
- Social Policy Narratives 10
- Theoretical Framework Limitations 11

Literature Review *12*

- Deficit-based Social Policy Narratives 12
- Strength-based Approaches and Social Determinants of Health 17
- Institutional Foundations and First Nations Statistics 21
- The “Recognition Gap” In Indigenous Statistics 25
- Research Questions 28

Methodology *28*

- Selection Criteria 28
- Data Collection 29
- Coding Method 30
- Classifying Social Policy Narratives 31
- Data Analysis 33

Results *33*

- Key Findings 33
- Key Neutral Language Policy Narratives and Data Themes 34
- Key Deficit-based Policy Narratives and Data Themes 38
- Key Strength-based Policy Narratives and Data Themes 41

Discussion *43*

- Principal Findings 43
- Neutral Language Narratives and Data Themes Were Most Referenced 45
- Deficit-Based Narratives/Themes Were Consistent with Findings from the Literature 45
- Strength-based Narratives/Themes were Inconsistent with Findings from the Literature 49
- Limitations of the Study and Future Research 53

Conclusion *54*

Annex *58*

- **Annex A – The Relational Worldview** 58
- **Annex B – Deficit-based Deductive Codes** 59
- **Annex C – Strength-based Deductive Codes** 61

References *63*

Abbreviations

ABS	Australian Bureau of Statistics
ACER	Australian Council for Educational Research
AFN	Assembly of First Nations
AG	Auditor General
AIDS	Acquired Immunodeficiency Syndrome
CIHI	Canadian Institute for Health Information
CIRNA	Crown-Indigenous Relations and Northern Affairs
FNHA	First Nations Health Authority
FNIGC	First Nations Information Governance Centre
IDS	Indigenous Data Sovereignty
INAC	Department of Indian and Northern Affairs
ISC	Indigenous Services Canada
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NCTR	National Centre for Truth and Reconciliation
NSOs	National Statistics Offices
NWAC	Native Women's Association of Canada
OAG	Office of the Auditor General
OID	Overcoming Indigenous Disadvantage
RCAP	Royal Commission on Aboriginal Peoples (1996)
RHS	Regional Health Survey
SCRGSP	Steering Committee for the Review of Government Service Provision
SNZ	Statistics New Zealand
STBBI	Sexually Transmitted and Blood Borne Infections

Introduction

Historically, research on Indigenous health was primarily disease focused, rooted in harmful stereotypes, and emphasized disparities between the health status of the Indigenous and non-Indigenous population (Anderson & Kukutai, 2016; Hyett et al., 2019; Russell, 2002). This historical conception of Indigenous health based on disparities and deficits persists in some deficit-based social policy narratives around Indigenous health (Kukutai & Walter, 2015; Walter, 2010). A deficit-based narrative is conceptualized as discourse that characterizes people or groups as inadequate, lacking, dysfunctional or different from the norm (Dinishak, 2016; Fogarty et al., 2018). A deficit view tends to overemphasize problems or weaknesses over strengths and problems are often conceptualized at the individual rather than societal level (Dinishak, 2016). Deficit-based narratives have been investigated in a variety of contexts including in health (Carpenter et al., 2021; Fforde, 2013; Fogarty et al., 2018; Hyett et al., 2019; Kukutai & Walter, 2015; Russell, 2002; Walter, 2010), education (Pollack, 2012; Sarra, 2011; Vass, 2012), sports (Bamblett, 2011), and in the media (Aldrich et al., 2007; McCallum, 2012; McCallum & Holland, 2010). However, the potential presence and impact of deficit-based social policy narratives is undertheorized in the Canadian public policy context. To begin to explore this area further, the present paper examines the concept of social policy narratives and data themes in the documentation of the health of First Nations in Canada.

The study consisted of an exploratory qualitative study comprised of a document analysis of Indigenous Services Canada Departmental Reports authored between 2017 and 2021. [1] To

---

[1] The period of analysis corresponds with dissolution of Indigenous and Northern Affairs Canada (INAC) in 2017 and the creation of two new federal departments: Crown-Indigenous and Northern Affairs Canada (CIRNAC) and Indigenous Services Canada (ISC). Since 2017, ISC has led Indigenous programming including service delivery while CIRNAC has been responsible for building Crown-Indigenous nation-to-nation relationships (Coburn, 2017). As part of the 2017 restructuring, responsibility for First Nations and Inuit health services was transferred from Health Canada to Indigenous Services Canada.

further narrow the scope, only descriptions of the health and wellbeing of First Nations were considered. Therefore, the term "Indigenous" in this report refers to First Nations in Canada and not Inuit or Métis populations. The primary aim of the study was to explore what key health policy narratives or data themes might emerge in Indigenous Services Canada departmental results reports on the health of First Nations in Canada. The secondary aim of the study was to examine if deficit and difference-based narratives were most common as predicted by a review of the literature (Carpenter et al., 2021; Fforde, 2013; Fogarty et al., 2018; Hyett et al., 2019; Kukutai & Walter, 2015; Russell, 2002; Walter, 2010).

To better understand the phenomena of social policy narratives and their consequences, the theoretical concepts of social constructivism and policy images are introduced. The present study adopts an ideas-based conception of public policy where policymaking is understood as a function of the *perceived nature* of the problems being dealt with (Rochefort & Cobb, 1994, p. 4). This theory of policy development helps explain the potential significance of social policy narratives around Indigenous health as policymakers, particularly those who are non-Indigenous, form their understandings of Indigenous peoples through narratives and images contained in quantitative research (Anderson & Kukutai, 2016). Thus, the narratives embedded in seemingly neutral data collected on Indigenous peoples have the potential to be deeply influential in shaping the policy process including problem definition (Ingram & Schneider, 1993).

Theoretical Framework

Social Constructivism

Analysis of policy narratives and data themes are well situated within the theoretical framework of social constructivism, which posits that there is not one objective social reality (Berger & Luckman, 1991; Ingram & Schneider, 1993; Müller, 2020). The social constructivist approach offers utility in exploring Indigenous health data by helping to shed light on the discourses or narratives that may surround the seemingly neutral presentation of statistics. Discourse is an important means of constructing and maintaining our subjective social realities according to this perspective (Berger & Luckmann, 1991). Subjective realities consist of concepts that do not need to be questioned or redefined in daily use since they come to be taken for granted (Müller, 2020, p. 17). Subjective realities over time may appear to represent an objective reality since they are rarely questioned or redefined.

In relation to the present study, statistics are often taken for granted as representing an objective reality and are sometimes interpreted as objective or neutral truths (Müller, 2020; Sismondo, 1993; Stone, 2021). However, according to the social constructivist understanding, knowledge, including data and statistics, are themselves a reflection of social processes. To count or measure something, we must first decide what to count (Stone, 2021). Thus, what is counted (or not counted) is not understood as a neutral rational choice but rather a reflection of cultural assumptions, personal judgements, and social norms (Ingram & Schneider, 1993; Müller, 2020; Stone, 2021). The way statistics are presented is also interpreted as a social process that may reflect particular social policy narratives or policy images around Indigenous health (Baumgartner & Jones, 1993).

A common misinterpretation is that social constructivism accepts that there is no objective reality. This is not the interpretation in most of the social science literature surveyed by Müller (2020) and Sismondo (1993). Most studies adopt the mild or contextual form of analysis where a distinction is maintained between what is known objectively and what subjects (subjectively) believe (Sismondo, 1993). For instance, the notion that disease exists as an independent objective reality is compatible with the social constructivist approach. What is more of a matter of social construction is the knowledge surrounding the disease (Bhattacahrjee et al., 2011; Müller, 2020). For instance, our collective understanding of mental illness has shifted considerably since the 18th century (Bhattacahrjee et al., 2011; Foucault & Khalfa, 2009). Mental illness was first conceptualized by clinicians as the result of individual pathology, but as knowledge of mental illness has increased, so has our collective understanding of the disease (Foucault & Khalfa, 2009). Now mental illness is also understood as being a result of larger structural forces such as discrimination and stigma (Foucault & Khalfa, 2009). The example of our shifting collective understanding of mental illness is given to demonstrate that social constructivist scholars are more concerned with how knowledge is socially constructed through discourse than with debates about the nature of reality.

Policy Images

The way statistics are socially constructed also connects to the role of 'image-making' in the policy development process. Baumgartner and Jones (1993) argue that policy development is impacted by public understandings (policy images) of policy problems. Different people can hold different images of an identical policy; proponents of a policy will tend to focus on one set of images while opponents will focus on another set of images or narratives. Baumgartner and Jones further posit that the creation of a policy monopoly is deeply intertwined with the creation and maintenance of a supporting "policy image" (p. 26). This theory offers value by explaining policy development in a way that is independent of notions of traditional political power.

According to this perspective, policymaking is understood as a function of the *perceived nature* of the problems being dealt (Rochefort & Cobb, 1994, p. 4). This theory of policy development has salience to Indigenous health policy as many non-Indigenous people form their understandings of Indigenous peoples through narratives and images contained in quantitative research (Anderson & Kukutai, 2016). Thus, the narratives embedded in the types of data collected on Indigenous people have the potential to be deeply influential in shaping the policy process including problem definition (Ingram & Schneider, 1993).

Social Policy Narratives

Narratives perspectives are well established in the policy research with seminal works emerging in the late 1980s and early 1990s (Blumm & Kuhlmann, 2019; Fischer & Forester, 1993; Hajer, 1993; Majone, 1989; Stone, 1989). Pursuant to this school of thought, ideas play more than a secondary role to interests and institutional structures by actively interacting with interests and institutions to shape the *very definition* of policy problems (Fischer, 2003). As such, there may not always be a clear link between social problems and corresponding policy responses (Fischer & Forester, 1993; Stone, 1989). According to this perspective, ideas, including narratives, stories, metaphors, and symbols, play an important role in the policymaking process (Blum & Kuhlmann, 2019; Fischer & Forester, 1993; Weible & Sabatier, 2017).

Policy narratives can be understood as an "argumentative form of language" that portrays or attaches meaning to an issue or sequence of events (Van Eeten, 2007, p. 254). Policy narratives often emerge when conditions are ambiguous, which allows for the emergence of multiple, and sometimes competing, explanations of a given condition (Shananan et al., 2018; Stone 1989). Policy problems are not always conceptualized as policy narratives, but most policy problems have a narrative structure including a beginning, middle, an end, and some change or transformation (Münch, 2016; Stone, 2012). Some policy narratives also contain some sort of hero, villain or an "innocent victim" (Stone, 2012, p. 158). These forms of character attributions are most common in narratives that assign blame or responsibility for a problem (Stone, 1989).

Policy narratives have salience in the policy process because policy narratives help determine how problems are defined, what policies are attached to them, and how both policy problems and solutions are contested (Stone, 2012; Van Eeten, 2007). In other words, policy narratives help shape the link between policy problems and policy solutions or the link from "description to prescription" (Van Eeten, 2007, p. 341). Narratives are also powerful because they have been theorized to play a central role in human cognition and communication (Jones & Song, 2013, Shannan et al., 2019). Narratives also help simplify issues and thus can serve as a heuristic device (Münch, 2016).

Analytically, policy narratives are usually studied at the micro or meso level, which typically refers to the specificity of the narrative or the unit of study (Aldrich et al., 2007; Bamblett, 2011; Gorringe et al., 2011; McCallum & Holland, 2010, Van Eeten, 2007). Micro narratives are typically short and specific or at the level of the individual whereas meso level narratives are broader or studied at the group level (Shanahan et al., 2019). Narratives may also be studied at the macro level, which is the most general narrative form and typically studied at the institutional or cultural level (Shanahan et al., 2019; Van Eeten, 2007). The present study considered narratives at all three levels: micro, meso, and macro.

Theoretical Framework Limitations

Social constructivism and ideas-based theories of the policy process fall short in explaining institutional factors that may shape policy development. For instance, the theory fails to explain how institutional constraints may shape the policy process. Perhaps a given policy is not adopted because of institutional barriers that are independent of social constructions of target populations. For instance, Indigenous health is a federal responsibility, and the federal government may face constraints due the limited scale of health services as compared to the provinces. It is also important to emphasize that it is difficult for one actor or institution to control the dominant policy image. In the case of Indigenous health policy, Indigenous groups have the power to create a *statistical counternarrative* by generating their own sets of statistics. Examples of this bottom-up form of statistical engagement include the Māori Plan for Tamaki Makaurau in New Zealand and the health surveys carried out by the First Nations Information Governance Centre in Canada (Anderson & Kuktai, 2016). Finally, one could make an argument that deficit-based data does not necessarily lead to deficit-based policy. For instance, deficit-based data is needed to identify socioeconomic gaps between groups. Evidence of these gaps may provide the rationale for meaningful social policy interventions.

Literature Review

The following section will consider examples of deficit-based narratives in the literature in Indigenous health but also in other areas including education, sports, and the media. Strength-based approaches will then be explored as examples of counter-narratives to a traditional Western deficit-based approach. Finally, to offer an institutional context, an overview of First Nations statistics in Canada will be presented along with the key organizations involved in producing these statistics.

Deficit-based Social Policy Narratives

Deficit-based social policy narratives and discourses within the area of Indigenous health have been studied both through historical and contemporary lenses (Carpenter et al., 2021; Fforde, 2013; Fogarty et al., 2018; Hyett et al., 2019; Kukutai & Walter, 2015; Russell, 2002; Walter, 2010). Social policy narratives have also been studied in the domains of education (Pollack, 2012; Sarra, 2011; Vass, 2012), sports (Bamblett, 2011), and in the media (Aldrich et al., 2007; McCallum, 2012; McCallum & Holland, 2010).

Historically, Indigenous peoples have often been identified in terms of what they lack in relation to the non-Indigenous ideal and studies on Indigenous health were primarily disease focused and rooted in harmful stereotypes (Anderson & Kukutai, 2016; Hyett et al., 2019; Russell, 2002). The colonial ideology relied on "constructed truths" (p. 164) about Indigenous people that were often underpinned by notions of deficiency (Fforde, 2013). In Canada, the federal government's agenda of assimilation relied on discourse that positioned the Indigenous subject as deviant and deficient, which justified government involvement in virtually every area of Indigenous life including health (De Leeuw, 2010).

Contemporaneously, deficit-based social policy narratives around Indigenous health have been studied in a variety of contexts. Carpenter et al. (2021) argued that Indigenous people are overrepresented in suicide statistics because of the present impacts of colonialism. Through an emphasis on narratives of disadvantage, Indigenous subjects "become the deficit subjects of their own making" (p. 542) requiring non-Indigenous intervention. Similarly, De Leeuw (2009) and Li (2007) argue that the construction of non-Indigenous governments and other agencies as helping, protecting, and benevolent forces aiming to 'improve' and transform Indigenous peoples 'for their own good' was a crucial colonial narrative that persists today. Indigenous scholar Maggie Walter (2010) has termed this phenomenon "the politics of the data" (p. 45), in which the production, analysis, and dissemination of Indigenous information is not interpreted as a neutral interpretation of numerical counts but rather a reflection of the "racialized terrain" in which the information is conceived. Anglo-whiteness is associated with the "highest value" while access is constrained by cultural, social, and economic capital (Walter, 2010, p. 48). Indigenous data politics in countries like Australia and Canada are most obvious in the statistical portrayal of deficit, difference, and dysfunction. According to the authors, the ubiquity of this form of

Indigenous population statistics is powerful because it makes up the evidentiary base for Indigenous public policy (Kukutai & Walter, 2015; Walter, 2010).

In the Australian context, through an analysis of a range of historical and contemporary reports authored by the Australian government, Fogarty et al. (2018) determined that the statistical portrayals of Indigenous Australians over the period of study were primarily deficit and difference based. The authors argue that deficit statistics and deficit data can create a narrative that paints Indigenous people in a monolithic way and as a problem to be addressed. Importantly, the study determined that Indigenous health policy was far from monolithic. Efforts were made, for instance, to understand how factors such as language and community played a role in health outcomes. Furthermore, Fogarty et al. (2018) stressed the challenge governments face to build policy that does not deny the structural inequalities in health between the Indigenous and non-Indigenous population but that also does not serve to further stigmatize the Indigenous population.

In the Canadian context, Tang and Brown (2008) examined how race and process of racialization operate in Canadian healthcare and considered the influence of race on health care access for Indigenous people in a Canadian urban centre. The researchers uncovered two separate and contradictory narratives between the perceived experience of racism by Indigenous patients and the narrative or liberal ideal of equality in access to healthcare. A common idea expressed by Indigenous patients interviewed in the study was concern related to discriminatory experiences in various health care settings. Conversely, many of the health providers interviewed who argued that the social or ethnocultural background of their patients had nothing to do with their quality of care (Tang & Brown, 2008). This study illuminates the power of narrative by demonstrating how the narrative of equal care for all patients played an ideological function in masking structural inequalities in everyday health care encounters. Fford et al. (2013) also argued that narratives and discourses around Indigenous health are of significance because of the link between discourse surrounding Indigeneity and health outcomes for Indigenous peoples. Their central argument is that this deficit discourse influences policy and health outcomes because it is both constitutive and productive: constitutive because it is a social action which frames and constrains understanding and productive as discourse also produces knowledge or understanding of a given subject (Fford et al., 2013). The authors concluded that the influence of deficit discourse is “significantly undertheorized” (p. 162) and is not well understood in public policy contexts.

Deficit-based social policy narratives and discourse have also been studied by scholars in the areas of education, sports, and the media. Vass (2012) presents an argument calling for increased critical awareness of narratives that surround Indigenous education. Vass argues that the dominant understanding of Indigenous education in Australia is shaped by deficit thinking, assimilationist ideologies, and race-based assumptions. Thus, the challenge for educators it to meet the needs of Indigenous students in ways that do not sustain a deficit-based perspective (Vass, 2012). Through a personal narrative and critical reflection, Pollack (2012) discusses the potential of negative or deficit-based narratives to miseducate and their contribution to perpetuation of educational inequities between the Indigenous and non-Indigenous population. The author argues that practitioners need to be aware of their own unacknowledged beliefs to challenge and reframe informal, deficit-based discourse.

In the area of sports writing, Bamblett (2011) analyzed sports writing since the 1960s and demonstrated how the “politics of recognition” (p. 5) can lead to a restricted or stereotyped view of Indigenous Australians. Specifically, discourses of deficit and victimhood were found to be established early on in writing about Indigenous Australians in sport (Bamblett, 2011). Deficit-based discourses have also been studied in the Australian context in the news media. McCallum et al. (2012) explored the connection between the representation of Indigenous peoples in public media and the development of Indigenous affairs policy. Although Indigenous public policy was often framed in negative terms, Indigenous voices were found to have had significant influence in the policy areas of primary healthcare and bilingual education programs (McCallum et al., 2012). McCallum & Holland (2010) and Aldrich et al. (2007) both analyzed the public statements of politicians to identify frames and discourses communicated by politicians as the beliefs of politicians were theorized to influence policy development by delineating acceptable policy options. Four primary discourses emerged from this research: (1) The competence and capacity of Aboriginal and Torres Strait Islander people to manage their own affairs; (2) The control of, and responsibility for, Aboriginal and Torres Strait Islander people's health; (3) Aboriginal and Torres Strait Islander people as 'other'; and (4) The 'problem' concerning Aboriginal and Torres Strait Islander health (Aldrich et al., 2007; McCallum & Holland, 2010).

It is clear from a review of the literature on Indigenous social policy narratives that deficit-based narratives pervade discourse not only in health but also in education, sports, and the news media. However, it is also clear that this is not a monolithic narrative and there are examples of counter-narratives that should not be overlooked (Fogarty et al., 2018; McCallum et al., 2012). The following section will explore more examples of strength-based approaches that serve as counter-narratives to the traditional Western deficit-based approach to Indigenous health. The social determinants of health model will also be an advanced as an alternative to the Western biomedical model of disease (Lines, 2020).

Strength-based Approaches and Social Determinants of Health

A deficit-based approach is reflected in the Western biomedical model of disease, where health is understood as the absence of mental or physical disease (Lines, 2020, p. 120). The Western model of health tends to individualize health problems through a focus on personal "risk factors" that make an individual more susceptible to disease (McKenzie et al., 2016, p. 386). For instance, the behavior of smoking cigarettes is identified as a risk factor for heart or lung disease. Community engagement in a Western deficit-based approach to health research is typically a top-down model where the researcher delivers a health solution to an individual or community (Bird-Naytowhow et al., 2017; Lines, 2020).

On the other hand, a strength-based approach is a more holistic approach, which tends to be solutions-focused and recognizes the existing elements that already contribute to the health of individuals or communities (Crooks, 2009; Lines, 2020). Employing a strength-based approach to health research typically involves working directly with study participants to support "their voice and power in research decisions" (Lines, 2020, p. 120). Utilizing a strength-based approach does not necessarily serve to minimize issues or "problem deflate" (Thurber et al. 2020, p. 2). Rather, the impetus of a strength-based approach to research and policy is to highlight the existing assets and strengths of individuals and communities to help overcome challenges (Lines 2020; Sasakamoose et al., 2017; Thurber et al., 2020). Another key element of a strength-based approach is a recognition of the context that surrounds the health of an individual, which is reflected in the social determinants of health model.

The social determinants of health model, although rooted in the bio-medical model, goes beyond the individual to incorporate the context of health disparities (Anderson, 2020; Greenwood et al., 2017; McKenzie et al., 2016). According to this perspective, addressing the social determinants of health of Indigenous people in Canada necessitates the recognition of broader social, economic, and political structures that impact health dynamics, including the present-day impacts of colonialism (Greenwood et al., 2017). The social determinants of health model has been modified by some researchers to include Indigenous-specific determinants (Anderson, 2020; McKenzie et al., 2016). This work accommodates strength-based approaches, which focus on protective factors, including the role of cultural practice, in Indigenous people's health and wellness (Anderson, 2020; Chandler & Dunlap, 2018; Currie et al., 2013; Pearce et al., 2015; Rowan et al., 2014). Although there is ample evidence of deficit-based Indigenous health research, there is a growing body of literature that employs a strength-based approach to Indigenous health and recognizes social determinants of health (Boulton & Gifford, 2014; Cross et al., 2011; Kant et al., 2013; Mark & Lyons, 2010; Priest et al., 2012; Rountree & Smith, 2016; Tingey et al., 2016; Witham et al., 2022).

Rountree & Smith (2016) conducted an international review of Indigenous community and strength-based wellbeing indicators based directly on original qualitative data collected from Indigenous community members. The authors found that Indigenous health indicators were aligned according to the Relational Worldview (see Annex A). The Relational Worldview is a framework for Indigenous wellbeing based on traditional medicine wheel teachings (Cross et al., 2011; Cross, 1997; Rountree & Smith, 2016). There are four quadrants that make up the wheel, where each circle represents four sets of elements that impact health and wellbeing. The four quadrants are: (1) context (including concepts of family, culture, community, environment, and history), (2) mind (including concepts of cognition, emotion, and identity), (3) body (including concepts oriented around physical and practical needs including financial needs), and (4) spirit (including spiritual concepts such as practices, teachings, dreams, and stories) (Frisen et al., 2014; Rountree & Smith, 2016). Two particularly important contextual elements of health that appear most frequently in the literature are environmental health and community health.

The environmental-health connection is an important element of health that isn't frequently incorporated into the Western biomedical model of disease. Kant et al. (2013) explored the contributions of social, cultural, and land use factors to Indigenous wellbeing and health based on data collected from two First Nations in Canada. One of the most significant findings was that land use, specifically the percentage of household meals on traditional diets and the impact of government regulations on land use, were the most important determinants of overall health (p. 462). Mark and Lyons (2010) also determined that land was one of the five key elements that helped support Māori health and wellbeing in addition to the health of the mind, body, spirit, and family.

Another key social determinant of health that emerged in the literature on strength-based approaches to Indigenous health was the health of the family and extended community. Boulton and Gifford (2014) described the findings from a series of qualitative studies consisting of semi-structured interviews that asked Māori participants to define the elements of family wellbeing (*whānau ora*). Findings indicated that participants defined family wellbeing well beyond their immediate family unit to include the health and wellbeing of their extended family, their sub-tribe, and tribe. Similarly, Witham et al. (2021), in assessing Indigenous Cancer Supports in Saskatchewan, determined that kinship served as a key protective factor during cancer treatments. Kinship and connection to community are also key elements of the approach employed by Priest et al. (2012) in their conceptual framework of child and health wellbeing. Connectedness to caring adults and school and peer connectedness has also been identified as a key preventative factor for substance use and suicide prevention in the strength-based model of Tingey et al. (2016).

Despite increasing calls for the use of strength-based methodologies to counter the dominant deficit-based discourse that pervades policy and research on Indigenous health, there is an absence of strength-based approaches employed by governments (Fogarty et al., 2018; Foley & Schubert, 2013; Gray & Oprescu, 2016; Thurber et al., 2020). Perhaps unsurprisingly, there is also an absence of literature on the practical application of strengths-based approaches to quantitative research that could be utilized by governments to guide the implementation of strength-based research methods (Thurber et al., 2020). Thurber et al. (2020), however, demonstrated that existing government data could be utilized in the application of a strength-based approach that retains the statistical significance seen with standard deficit-based approaches (p. 1). Utilizing a protective factors approach, the authors identified factors protective against negative health outcomes using data from a Longitudinal Study of Indigenous Children funded by the Australian Government Department of Social Services. One of the principal findings was that poor mental health was significantly less common among children whose caregivers were employed versus not employed (p. 4). Crucially, the strength-based approach retained the same statistical rigour as a deficit-based approach but had a “profound effect on the framing of results” (p. 6)

It is therefore not beyond the realm of possibility to leverage existing government data sources to produce strength-based analyses. The following section will provide a high-level overview of the source of First Nations information in Canada. First Nations were chosen as the key population for the present analysis and thus sources of information on Inuit and Métis are purposely omitted.

Institutional Foundations and First Nations Statistics

It is instructive to examine the institutional environment in which health policy narratives emerge as social policy narratives, and ideas more broadly, do not exist as independent social phenomena (Fischer, 2003). The following section provides a high-level overview of the key governmental and non-governmental institutions that are involved in First Nations health statistics.

There is a vast amount of data collected on Indigenous peoples, including First Nations, in Canada (Pyper et al., 2018; Symlie & Firestone, 2015; Trevethan, 2019). Health statistics on First Nations are drawn from several core population-level data sources including the census, vital registration systems, health utilization records, disease surveillance and registration systems, and national and regional health and wellbeing surveys (Symlie & Firestone, 2015; Walker et al., 2017). There are several organizations that collect additional First Nations data including statistical agencies, First Nations organizations and academic institutions across Canada, and government departments (Symlie & Firestone, 2015; Trevethan, 2019; Walker et al., 2017). The FNIGC notes that, although multiple sources of information on First Nations exist, few of these sources have been built based on Indigenous input. As such, existing data sources may provide a “fragmented and incomplete picture of the realities of Indigenous peoples in Canada” (FNIGC, 2019, p. 53).

There are statistical agencies, both governmental and non-governmental, that hold First Nations data. At the federal level, Statistics Canada, under the *Statistics Act* (1918), is required to collect, analyze, abstract, and publish statistical information relating to the commercial, industrial, financial, economic, and social activities and condition of the Canadian population (Statistics Canada, 2022; Trevethan, 2019). Through the population Census, the Aboriginal

Peoples Survey and others, Statistics Canada collects and holds data on First Nations, Métis, and Inuit people. All provinces and territories also have statistical agencies. Some statistical agencies use administrative data from other provincial departments, while some conduct their own surveys. Provincial statistical agencies thus represent another potential source of First Nations data (Green, 2018; Trevethan, 2019).

Non-governmental statistical agencies that collect First Nations data include the Canadian Institute for Health Information (CIHI), an independent, not-for-profit organization, as well as the First Nations Information Governance Centre (FNIGC) (FNIGC, 2019; Trevethan, 2019). The First Nations Information Governance Centre is the leading steward and source of information on First Nations in Canada. The FNIGC became an independent, incorporated non-profit organization on April 22, 2010. However, the origins of the organization trace back to 1996 when the federal government of Canada made the decision to exclude First Nations living on reserve from three major population surveys (FNIGC, 2021). Concern with this exclusion led the Assembly of First Nations to form a National steering Committee with the goal of creating a new First Nations health survey. These efforts culminated in the creation of a First Nations governed national health survey, the First Nations Inuit Regional Longitudinal Health Survey (RHS), which was first published in 1997 (FNIGC, 2021). In 2009, the Assembly of First Nations passed a resolution which mandated the creation of the First Nations Governance Centre, which was intended to be an independent, non-governmental organization. Though the FNIGC is independent from the federal government, budget 2018 earmarked $2.5 million over three years to support the First Nation Information Governance Centre in designing a national data governance strategy and efforts to establish regional statistical centres. This national governance strategy was published in 2020. Budget 2021 proposed to invest $73.5 million over three years, starting in 2021-2022, to continue work towards the implementation of the First Nations Data Governance Strategy (FNIGC, 2021).

Along with leading national data governance strategy, the FNIGC holds the copyright to OCAP® and provides data collection, analysis, and dissemination services (FNIGC, 2020). OCAP® is based on the principle that First Nations should have ownership, control, access, and possession over information about them (FNIGC, 2014). The Centre also supports capacity building by supporting First Nations at the local, regional, and national level to establish good data governance practices and processes (FNIGC, 2020).

Several Indigenous organizations in addition to the FNIGC gather data and conduct research on First Nations. Examples include, but are not limited to, the Assembly of First Nations (AFN), the Native Women's Association of Canada (NWAC), the National Centre for Truth and Reconciliation (NCTR), and the First Nations Health Authority (FNHA) (Gallagher et al., 2015; Trevethan, 2019). In addition to Indigenous organizations, First Nations bands, governments and Tribal Councils also collect and employ First Nations data. A notable example is the "Tui'kn Partnership", which is a health partnership between five Cape Breton First Nations, the district health authorities, the Nova Scotia Department of Health and Wellness, and Health Canada (Green, 2018; Tui'kn Partnership, 2018). The impetus behind the partnership is a client registration, which is owned and managed by the Unama'ki community and has been linked with provincial data sources to provide communities with health information (Green, 2018; Tu'kn Partnership, 2019). Finally, colleges and universities also conduct research on Indigenous peoples including First Nations and thus also possess Indigenous data (FNIGC, 2019).

Numerous federal departments other than Statistics Canada hold data on Indigenous peoples but the focus of the present research is Indigenous Services Canada (ISC). ISC was created in September 2017 along with Crown-Indigenous Relations and Northern Affairs (CIRNA) to replace the Department of Indian and Northern Affairs (INAC) (Indigenous Services Canada, 2020; Metallic, 2019). The change was made largely so ISC could focus on quality service delivery while CIRNAC could focus on nation-to-nation relationships (Metallic, 2019). CIRNAC is tasked with the governance renewal file and supporting Indigenous peoples to build capacity and support self-determination in northern Canada (CIRNAC, 2022). On the other hand, ISC's primary responsibility is service delivery to First Nations communities living on-reserve and under the Indian Act (OECD, 2020). Health services for on-reserve First Nations and Inuit were also transferred from Health Canada to Indigenous Services Canada as part of the 2017 restructuring.

The health and education services for First Nations, Métis and Inuit living off reserve falls under the responsibility of provincial and territorial governments (OECD, 2020). Indigenous Services Canada is subject to an annual reporting requirement to table a report in Parliament on the (a) socioeconomic gaps between the Indigenous and non-Indigenous population and what steps were taken to reduce those gaps, and (b) the progress made towards the transfer of responsibilities (Indigenous Services Canada, 2020; Metallic, 2019). Reducing socioeconomic gaps through quality service delivery is thus a key part of the department's mandate. It is also notable that ISC was created with the goal of one day being obsolete meaning service delivery be transferred completely to Indigenous communities (Metallic, 2019).

While healthcare is a provincial responsibility for the non-Indigenous population, the Indian Act of 1876 explicitly states that First Nations health and healthcare is a federal responsibility (Government of Canada, 2022a). Section 91 (24) of the Constitution Act also assigns the federal government constitutional responsibility for all areas of government activity as they relate to “Indians” (Government of Canada, 2022b). Indigenous Services Canada is thus the primary federal department responsible for service delivery, which includes health, education, and social services to First Nations (Richmond & Cook, 2016). Indigenous data is used to help deliver these programs and services, and most notable to the present research question, is also used to report on results.

The “Recognition Gap” In Indigenous Statistics

The final relevant theme in the literature is the ‘recognition gap’ between what Indigenous statistical functionality means to Indigenous peoples, and how it is understood by National Statistics Offices (NSOs) (Kukutai & Walter, 2015). This ‘recognition gap’ is partially attributed to the ongoing legacy of historical quantitative research (Anderson & Kukutai, 2016; FNIGC, 2014) as well the privileging of NSO’s informational needs over those of Indigenous peoples (Kuktai & Walter, 2015).

Historical quantitative histories of Indigenous peoples were primarily deficit and disease focused and rooted in harmful stereotypes (Epsey, 2002). This historical quantitative history, according to Anderson and Kuktai (2016), has served to “alienate Indigenous peoples further from their own stories” (p. 43) and has produced significant distrust in quantitative methods. Though some Indigenous scholars posit that statistical research sits in fundamental tension with Indigenous ways of knowing, Anderson and Kukutai argue that it is not statistical abstraction that has led to the production and legitimation of stereotypes about Indigenous communities. Rather, it is the absence of meaningful collaboration with Indigenous communities (both historically and presently) that has produced these outcomes. The authors argue for more

Indigenous involvement at every stage of the statistical lifecycle including in the creation, interpretation, and dissemination of information about them (Anderson & Kukutai, 2016).

Kukutai & Walter (2015) contrast the statistical practices of NSOs in Australia and New Zealand. This comparison offers insight into how different information prioritization practices by governments can lead to different choices about what type of data is collected.

In response to a lack of policy-relevant Indigenous data, the Australian Bureau of Statistics (ABS) developed the cross-sectional National Aboriginal and Torres Strait Islander Social Survey (NATSISS) (Australian Bureau of Statistics, 2016). The authors argue that the core objectives of the survey "clearly signal that the survey is first and foremost about meeting the government's informational needs" (Kukutai & Walter, 2015, p. 319). The objectives focus largely on disadvantage and social inclusion, and the data needed to report on the government's social inclusion agenda (Australian Bureau of Statistics, 2016). The data produced by the survey in existing form can't easily be leveraged by communities for planning and advocacy and are limited to tracking socioeconomic disadvantage (ibid).

Statistics New Zealand (SNZ) has been more successful in addressing the statistical needs of Indigenous peoples. Kukutai and Taylor posit that this might be partly due to the higher demographic visibility of the Māori but also likely reflects differences in political and social exclusion. The Māori Social Survey Te Kupenga, first conducted in 2013, represents a significant step forward in generating high-quality data on Indigenous cultural and institutional practice (Statistics New Zealand, 2020). Te Kupenga has generated nationally representative data that can be linked to Census records to provide a more complete evidence base on Māori social, economic, and cultural wellbeing (Kukutai & Walter, 2015). Te Kupenga is being employed in a variety of policy settings including the government's Families and whānau status report; the local government-focused Māori Plan in Auckland, and various SNZ informational products (Statistics New Zealand, 2020).

In summary, deficit-based narratives and discourses are prevalent within the area of Indigenous health and are often rooted in harmful stereotypes. Scholars have also identified deficit-based social policy narratives in the domains of education, sports, and in the media. Despite the prevalence of deficit-based narratives, there is a growing body of research that employs a strength-based approach to Indigenous health and wellbeing. A strength-based approach is more holistic, solutions-oriented, and recognizes the contextual elements that contribute to the health of individuals and communities.

Despite increasing calls for the use of strength-based methodologies to counter the dominant deficit-based discourse that pervades policy and research on Indigenous health, there is an absence of strength-based approaches employed by governments. However, although not directly related to health, ISC and CIRNAC identified a strength-based approach as a part of the Indigenous Community Development National Strategy (Government of Canada, 2021). There is also a vast amount of existing data on First Nations collected by governmental and non-governmental organizations that can be leveraged to produce strength-based analyses. It is important to caution that existing data sources may provide an incomplete picture of Indigenous health as most sources of First Nations data were not built based on Indigenous input. The lack of Indigenous input may help explain the “recognition gap” in Indigenous statistics, which describes the gap between what Indigenous statistical functionality means to Indigenous peoples, and how it is understood by National Statistics Offices (NSOs).

Research Questions

Federal Departmental Results Reports on Indigenous health offer a compelling case to explore what “hidden” health policy narratives may lie behind the seemingly neutral reporting of results. Thus, the research questions of the present paper are:

(1) What key health policy narratives or data themes emerge in federal reports on the health of Indigenous Peoples in Canada?
(2) Are deficit and difference-based narratives most common, as implied by the literature?

Methodology

This exploratory qualitative study was comprised of a document analysis involving the analysis of health policy narratives through an examination of departmental results reports. To bracket the data selection by time, a review of Indigenous Services Canada Departmental Results reports between 2017 and 2021 (a total of four reports) was conducted. This section will discuss the selection criteria behind the choice of cases, the qualitative coding methodology employed, the data collection process, and the analysis of data.

Selection Criteria

Since Indigenous health is a relatively broad topic, the first step was to determine a clear set of inclusion criteria to narrow the data set, which consisted of federal departmental results reports on Indigenous health. The inclusion criteria were: (a) First Nations were the primary population described, (b) the subject of the report related primarily to health outcomes, (c) the report type was a federal departmental results report, and (d) the report was recent (authored between 2017 and 2021). Indigenous Canada Departmental Results Reports between 2017 and 2021 were selected since these reports satisfied all four inclusion criteria. Departmental Results Reports are a type of estimate document. Estimate documents support appropriation acts, which outline the amounts and broad purposes of federal funding (Treasury Board of Canada, 2016). Departmental Results Reports report on a department's actual results against the expected results and priorities outlined in the Departmental Plan. Departmental Results Reports were selected for analysis because they are public-facing, reports are subject to review by the Auditor General, and inform both Parliamentarians and the Canadian public of actual results achieved by the department. Furthermore, Departmental Results Reports are consequential because they reflect the citizen focus of government programs and provide the link between the use of public resources and benefits achieved for Canadians and Canadian society (Public Services and Procurement Canada, 2013).

The period of the selected case corresponded with the creation of Indigenous Services Canada in November 2017, which allowed for a complete analysis of ISC departmental results reports (Indigenous Services Canada, 2018). Furthermore, these reports were data and results focused, which related directly to the focus of the research question on Indigenous health policy narratives and data themes.

Data Collection

The data set consisted of four Indigenous Services Canada Departmental Results Reports. The four reports were downloaded in PDF form from the Indigenous Services Canada website and uploaded to *NVivo12* (NVivo, 2022). The Departmental Results Report provided detail on actual results achieved and covered the most recently completed fiscal year (Indigenous Services Canada, 2022). As such, the last available report was for the 2020-2021 fiscal year. The first available report covered the 2017-2018 fiscal year. Given the broad scope of the report, sections were excluded if they were not directly relevant to the research question and did not make direct reference to First Nations health or First Nations health data. Sections on education, for instance, were excluded although education is recognized as a key social determinant of health (Shankar et al., 2013). After an initial scan of the reports to eliminate sections not relevant to the research question, the reports were ready for analysis in *NVivo12.*

Coding Method

A qualitative coding method was chosen to analyze the data. Coding is one way, among many, of analyzing qualitative data. It is not tied to one qualitative analytic practice and can be found in varying approaches ranging from critical discourse analysis and content analysis to different forms of ethnography (Maclure, 2013). A code in in the present analysis was defined as a term or phrase that "assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data" (Saldaña, 2021, p. 5). Patterns were identified as a salient source of evidence as patterns demonstrate habits, significance, and consequence in the social world (Saldaña, 2021). Data can be coded in several forms but for the purposes of the present paper, data sets were in the form of reports.

When conducting qualitative research by coding, codes can be generated inductively or deductively, or both. Coding deductively involves using a set of pre-determined codes, either developed by the researcher or based on pre-established concepts in the literature (Saldaña, 2021). Coding inductively is a data-driven approach where the analyst develops codes while engaged in the coding process. In other words, categories or themes emerge while actively coding as opposed to being pre-determined (Saldaña, 2021). In conducting the present analysis, codes were developed both deductively based on the literature and inductively based on the narratives, themes, and patterns that emerged in the reports analyzed. Codes were sorted into three categories of deficit-based social policy narratives, strength-based social policy narratives and neutral or neutral language social policy narratives.

The codebook of deductive codes (see Annex B & C) was created by reviewing the literature on Indigenous health measures. Walter (2010) advanced the hypothesis that Indigenous health data is '5D' based (deficit, dysfunction, deprivation, disparity, and disadvantage). This hypothesis, based on the literature, provided a set of deficit-based *a priori* codes employed in the analysis (see Annex B). A review of the literature was also conducted for possible strength-based codes related to Indigenous health and wellbeing, which provided a set of deductive strength-based codes (Boulton & Gifford, 2014; Cross et al., 2011; Kant et al., 2013; Mark & Lyons, 2010; Priest et al., 2012; Rountree & Smith, 2016; Tingey et al., 2016; Witham et al., 2022). Strength-based measures were selected as codes if they appeared at least twice in the literature (see Annex C).

Classifying Social Policy Narratives

A crucial aspect of the analysis involved classifying social policy narratives as either deficit-based, neutral, or strength-based. Although this work was subjective by nature, a clear definition of each approach helped differentiate between deficit-based, neutral, and strength-based narratives or themes. It is also important to note that any of these three narrative structures may be contained within the same passage; they are not always mutually exclusive categories.

A deficit-based approach or understanding was understood as discourse that characterized people or groups as inadequate, lacking, dysfunctional or different from the norm (Dinishak, 2016; Fogarty et al., 2018). A deficit view tends to overemphasize problems or weaknesses over strengths (Dinishak, 2016). A key component of a deficit-based approach is to conceptualize problems at the level of the individual rather than at a structural or societal level (Davis & Museus, 2019; Fogarty et al., 2018). In a health policy context, this may take the form of explaining health gaps based on differences between individual, family, or community traits rather than based on larger structural causes like colonialism (Fogarty et al., 2018). Another key component of a deficit-based is an implied deviation, either in excess or deficiency, from the mean or what is understood as normal (Dinishak, 2016). In the health policy context, this is most evident in the emphasis of health gaps between the Indigenous and non-Indigenous population where Indigenous health outcomes are presented as deviation from the mean or what is considered normal (Fogarty et al., 2018).

A strength-based approach or understanding has multiple meanings within the literature (Fogarty et al., 2018). For the purposes of the present paper, a strength-based understanding was understood as discourse that characterized people or groups according to their assets and capabilities (Jain & Cohen, 2013). A deficit-based approach focuses on needs whereas a strength-based approach emphasizes the resources and assets that individuals and communities already possess (Fogarty et al., 2018; Jain & Cohen 2013). In the context of health policy, an example of a strength-based approach to Indigenous health would be identifying “resilience attributes” in Indigenous communities that serve as a protective factor against disease (West et al., 2016, p. 349).

A neutral based approach or understanding was used to classify discourse that did not fit neatly into either a strength-based or deficit-based social policy narrative. Neutral-based narratives were understood as the absence of the characterization of people or groups according to deficits or strengths. In other words, neutral narratives do not attach a particular sentiment to people or groups. A good example of a neutral-based social policy narrative is one in which a department says they intend to increase access to services for Indigenous communities. Crucially, this narrative doesn’t characterize Indigenous communities according to their strengths or deficits but rather states a departmental goal.

Data Analysis

The analysis was conducted using *NVivo12*, a qualitative data analysis software tool that helps researchers organize, analyze, and find insights in unstructured or non-numerical data (NVivo, 2022). The software was used to manually code each departmental results report in the data set, which enabled the identification of narratives, themes, and patterns. To avoid proliferation, codes were employed repeatedly, and each code was incorporated within three broad categories: strength-based codes, neutral codes, and deficit-based codes. For instance, within the broader category of deficit-based codes were the sub-codes of “deficit”, “difference”, “dysfunction”, “disadvantage”, “disparity”, and “disease-focused.”

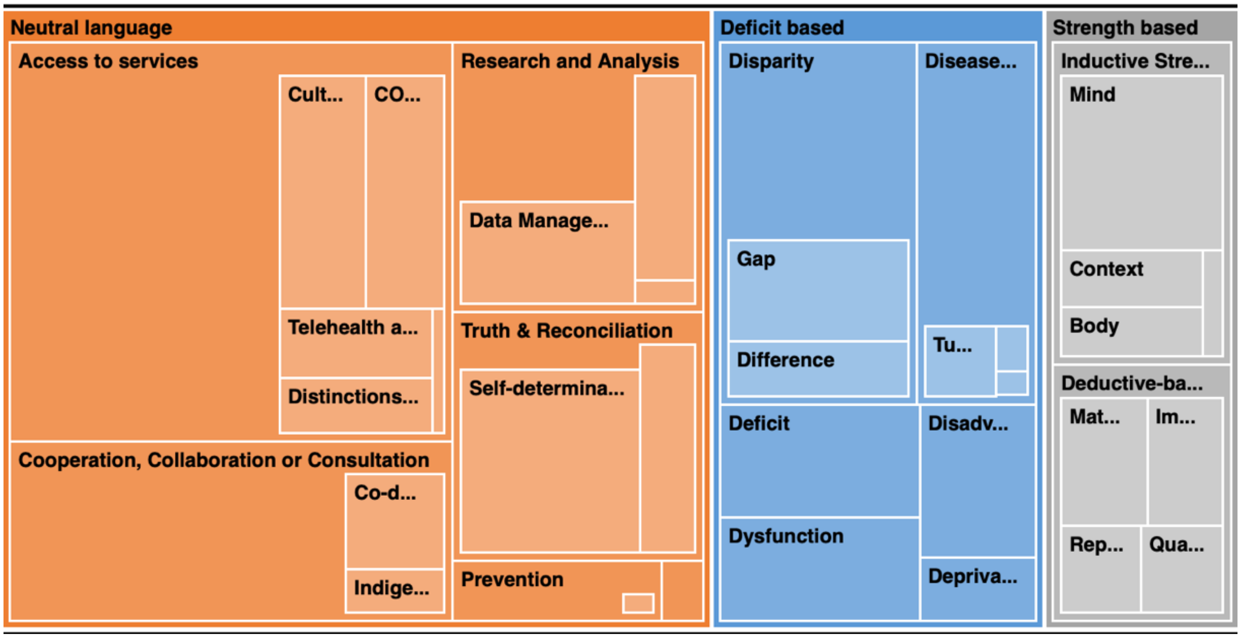
Coding was conducted in multiple waves. The first wave involved deconstructing all four ISC departmental results reports to identify the primary themes and concepts and to develop inductive codes. The second wave involved ensuring codes were applied consistently across all four reports and merging similar codes into broader categories to identify larger trends within the data. For instance, “self-determination” and “capacity building” were grouped under “truth and reconciliation.” In total, three principal health policy narratives or themes were identified in the analysis: (a) strength-based narratives (b) neutral language narratives and (c) deficit-based narratives. These themes are discussed in full in the following section.

Results

Key Findings

Neutral language was the most common narrative form surrounding Indigenous health and Indigenous health data across all four reports with a total of 416 references. Deficit-based narratives and data themes were the second most referenced form of code with a total of 195 references. Strength-based narratives and data themes were the least referenced form of code in all four reports with a total of 113 references. These were the results at the macro level, however, within each of the three narrative categories and data themes, more refined sub-themed emerged as demonstrated in figure 1.

Fig. 1 – Tree map of code references from all four reports



Key Neutral Language Policy Narratives and Data Themes

There were two neutral language health policy narrative most referenced across all four reports. The primary narrative was that Indigenous Services Canada had increased or was working to increase access to services for First Nations, Inuit, and Métis. The “access to services” narrative would typically begin with a description of the former insufficient state of service delivery, how Indigenous Services Canada worked to improve service delivery, and, in some cases, how the department was continuing work to improve service delivery. In this way, Indigenous Services was frequently depicted as a “helping” or benevolent actor addressing the health needs of “vulnerable” First Nations communities. The secondary narrative identified was that Indigenous Services Canada was working in active collaboration with Indigenous partners to design, manage, and deliver health services. This collaboration-based narrative centered around the idea that increased Indigenous involvement in service delivery would translate to an increase in the quantity and quality of health services. An assumption in this narrative is that Indigenous consultation will, in itself, lead to higher quality service delivery independent of other factors.

Starting with the primary narrative, there were numerous examples across all four reports of references to an achieved increase in health service delivery ranging from the general, such as: "Canada made significant progress to ensure that First Nations children have access to the health, educational and social supports they need" (ISC, 2018) to the more specific, "Provided increased access to Naloxone to help temporarily reverse the effect of opioid overdose" (ISC, 2018). Where an increase in access to services was not achieved, there were frequent references to plans to increase service delivery moving forward. For example, "We are working in partnership with First Nations organizations to support them in identifying, designing and delivering health service solutions that better meet the needs of their communities" (ISC, 2019) and "More work needs to be done to ensure First Nations, Inuit and Métis people have access to timely and culturally appropriate medical care and mental health services" (ISC, 2021). This narrative mostly had to do with ISC's account of its institutional responsibilities rather than a description or explanation of the state of health in Indigenous communities.

Within the access to services narrative, several sub-themes emerged involving "access to culturally relevant services," "distinctions-based" services, and "telehealth and digital health services." References to access to culturally relevant services increased over time with three direct references to culturally relevant services in the 2017-2018 report and 11 references in the final 2020-2021 report analyzed. The recognition of the importance of providing culturally relevant health services appeared to be amplified by the conditions of the COVID-19 pandemic:

> The effects of the COVID-19 pandemic highlighted the unique challenges faced by many First Nations, Inuit and Métis communities in accessing quality and timely health care services and benefits. It also underlined the need to provide these services in a way that is culturally relevant and results in improved outcomes. (ISC, 2021)

All four reports also contained references to "distinctions-based" services, which recognizes the distinction between First Nations, Métis, and Inuit, and how service needs may vary amongst these groups. For instance, "distinctions-based" services were referenced as part of the department's mandate in the 2019-2020 report, as follows: "As Minister of Indigenous Services, my mandate is clear: to ensure a consistent, high-quality and distinctions-based approach to the delivery of services to Indigenous Peoples" (ISC, 2020). "Distinctions-based" services were also referenced in relation to GBA+ analysis, "These discussions have laid the groundwork for ISC to support partners to further develop and advance the integration of Indigenous-first, distinctions based GBA+ approaches during the 2020-21 fiscal year" (ISC, 2020).

The final sub-theme identified within "access to services" was "telehealth and digital health services." Even before the COVID-19 pandemic, Indigenous Services Canada reported efforts to increase IT and digital health infrastructure:

> Where primary care services are provided by departmental nurses working in remote and isolated locations, IT infrastructure support has been provided for eHealth tools such as telehealth and digital health records in order to improve access and delivery of health services. (ISC, 2018)

A digital health strategy was also identified as a key component of increasing access to service delivery in remote communities:

> Investments in digital health innovation helped address fundamental components of quality health care in First Nation communities including improved connectivity and telehealth services. The ISC eHealth program increased access to pre-natal care and post-natal care and alleviated the burden of some women from leaving their community and families for extended periods of time. (ISC, 2020)

The second most common neutral language health policy narrative or theme that emerged in the reports was that Indigenous Services Canada was working in active collaboration with Indigenous partners to design, manage, and deliver health services. The implication of this narrative was that Indigenous involvement in service delivery would increase the quality of services moving forward. The code "cooperation, collaboration, or consultation" was developed to capture narratives related to this theme. As was observed with the "access to services" narrative, references ranged from the general (not related to specific policies and programs) to more specific references to examples of successful collaboration efforts. Examples of general references to collaboration included "The Department continues to work in partnership with First Nations, Inuit and Métis" (ISC, 2018) and "We are working in partnership with First Nations organizations to support them in identifying, designing and delivering health service solutions that better meet the needs of their communities" (ISC, 2019). Examples of more specific references included:

> Established an Indigenous Women's Well-being Advisory Committee made up of representatives from national Indigenous organizations, national Indigenous women's organizations, the National Aboriginal Council of Midwives, the National Aboriginal

> Circle Against Family Violence, and the Society of Obstetricians and Gynaecologists of Canada" (ISC, 2019) and "ISC began collaborative work with First Nations on the implementation of a longitudinal study of Food Environment Health and Nutrition of First Nations Children and Youth. (ISC, 2020)

Within the "cooperation, collaboration, or consultation" code, two main sub-themes were identified: "Co-develop" and "Indigenous-led". References to "co-develop" were more common and referenced health services that were delivered in collaboration with Indigenous communities. Examples included, "The Government has worked with the AFN and Inuit Tapiriit Kanatami (ITK) to engage their constituents in identifying their respective health priorities" (ISC, 2018) and "Continued working with Inuit partners, provinces and territories to develop a long-term Inuit-specific approach to help better address the unique health, social and education needs of Inuit children" (ISC, 2019). Conversely, the "Indigenous-led" code captured references to health service delivery that were primarily designed and executed by Indigenous communities. There were a total of six references across all four reports to "Indigenous-led" health services such as, "We have also increased access to mental wellness teams, suicide prevention initiatives and we continue to support community-led strategies to improve mental wellness" (ISC, 2019) and "Throughout the pandemic, Indigenous Services Canada's (ISC) first priority has been to provide Indigenous leadership with the resources they need to keep their communities safe" (ISC, 2021).

Key Deficit-based Policy Narratives and Data Themes

One primary deficit-based narrative and a secondary deficit-based data theme were referenced across all four reports. The primary narrative was a "disparity" narrative that emphasized the differences or gaps between the health outcomes of the Indigenous and non-Indigenous population. The key aspect of this narrative was an "othering" of the First Nations population through an emphasis on differences between the Indigenous and non-Indigenous population. “Othering” is conceptualized as a discursive process by which subjects are differentiated from the hegemonic subjects or those in powerful social positions (Thomas-Olalde & Velho, 2011). The secondary data theme was “disease-focused,” which centered on the documentation and management of disease within the Indigenous population.

As predicted by the literature, there were frequent references to “disparity” in each of the four reports. The core element of “disparity” narratives is an othering of the First Nations population through an emphasis on differences in health outcomes between the Indigenous and non-Indigenous population. The Indigenous population was almost always the target population with a health deficit or disparity compared to the non-Indigenous population. The conclusion from this narrative is that the “gap” between the two populations should be closed by government intervention. For example, “the program objective is to help improve the health status of First Nations and Inuit, to become comparable to that of the Canadian population over the long term” (ISC, 2018). Within the “disparity” narrative, two sub-themes emerged: “gaps” and “differences.” “Gap” narratives emphasized health gaps between the Indigenous and non-Indigenous population. For example, “ISC continued working with Indigenous partners to address public health concerns, including chronic and communicable diseases, and to respond to unacceptable health gaps” (ISC, 2020) and “[t]he pandemic has highlighted the socio-economic gaps that exist between Indigenous and non-Indigenous Peoples caused by colonization and decades of historic injustices” (ISC, 2021).

The other sub-theme within the “disparity” narrative was the “difference” narrative, which served to highlight the ways Indigenous health outcomes were deficient compared to the non-Indigenous population. There are no doubt differences between the Indigenous and non-

Indigenous population but this narrative paints differences in terms of deficits rather than strengths (Hyett et al., 2019). Examples were numerous across all four reports with examples such as, “Health services provided directly by ISC to First Nations and Inuit communities played an essential role in supporting health outcomes that are comparable to other Canadians” (ISC, 2020), and “There is a shorter life expectancy for Indigenous peoples compared to non-Indigenous peoples” (ISC, 2018).

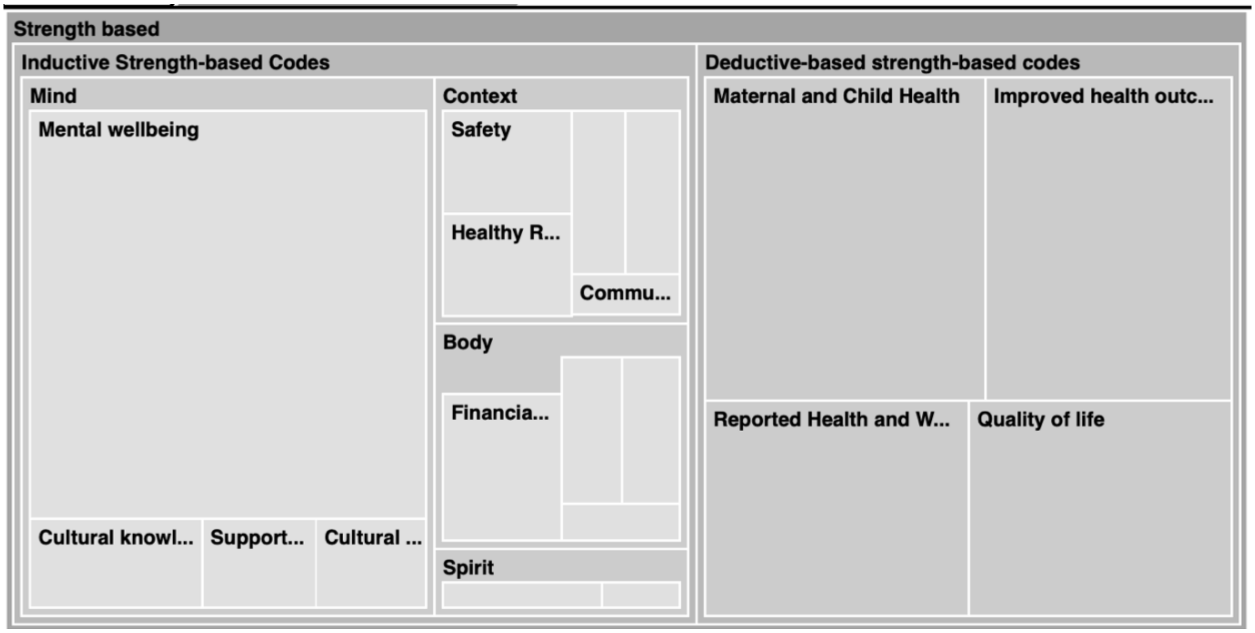
The secondary deficit-based data theme was “disease-focused,” which consisted of data indicators to measure disease transmission within the Indigenous population. The three most referenced data indicators of disease across all four reports were tuberculosis, HIV, and diabetes. References to these diseases included, “[worked] with First Nations and Inuit partners to reduce the unacceptably high rates of infectious diseases, including tuberculosis and sexually transmitted and blood-borne infections” (ISC, 2019) and “ISC continues to place focus on developing programs in high incident regions including Human Immunodeficiency Virus (HIV)/hepatitis C education (Ontario)” (ISC, 2020).

It is important to note that not all disease data indicators were deficit-based and there were exceptions in novel strength-based disease data indicators. For instance, when referring to diabetes, a new data measure was developed in 2020 to assess the “Percentage of First Nations adults with diabetes accessing newer, novel medications and not on insulin” (ISC, 2021). Indigenous Services Canada also referenced culturally appropriate or relevant models for the treatment of disease, “ISC supported education programming and awareness of sexually transmitted and blood borne infections (STBBI) through continued support of the Canadian Aboriginal Acquired Immunodeficiency Syndrome (AIDS) Network, Native Women’s Association of Canada, and Pauktuutit Inuit Women of Canada in their development of culturally safe models and frameworks to address STBBIs" (ISC, 2020). Therefore, although deficit-based narratives and "disease-focused" data themes were common, there were notable exceptions and strength-based narratives were found in all four departmental results reports.

Key Strength-based Policy Narratives and Data Themes

The most referenced strength-based Indigenous health policy narrative was that Indigenous Services Canada was working to improve the "mental wellness" of Indigenous communities. This narrative was referenced a total of 32 times across the four reports which represented twice the frequency of the second most referenced strength-based data theme of "child and maternal health" (see figure 2). The "mental wellness" narrative, in general terms, was that by increasing access to government sponsored mental health services, the "mental wellness" of Indigenous communities would improve. For example, Indigenous Services Canada made frequent reference to expanding access to emergency mental health supports: "45 new mental wellness teams were established (from 86 to 300 communities served)" (ISC, 2018) and "We have also increased access to mental wellness teams, suicide prevention initiatives and we continue to support community-led strategies to improve mental wellness" (ISC, 2019).

Fig. 2 – Tree map of strength-based code references



Within the "mental wellness" narrative there was a sub-theme of culturally relevant mental health services. For instance, Indigenous Services Canada referenced traditional healers and services, "Access to counselling was expanded through Non-Insured Health Benefits, including access to traditional healers" (ISC, 2018) and "ISC also expanded the mental health counselling benefit to include traditional healer services" (ISC, 2018). Indigenous Services Canada also referred to the tripartite Mental Health and Wellness Initiative with the First Nations Health Authority and British Columbia in the 2019-2020 report. This initiative is a partnership between the Government of Canada, the First Nations Health Authority and British Columbia to establish a new approach for federal and provincial investment in mental health and wellness services (First Nations Health Authority, 2022). This is a significant step in supporting Indigenous capacity to deliver culturally relevant mental health services for Indigenous communities by Indigenous communities (First Nations Health Authority, 2022).

“Maternal and Child Health” was a data theme that emerged inductively and was the second most referenced strength-based code. “Maternal and Child Health” references did not conform to a general narrative about Indigenous health and were thus classified and understood as a data theme. References to “Maternal and Child Health” included, “Made progress in ensuring First Nations and Inuit children had timely access to health services, with strengthened services in the areas of Jordan's Principle, Maternal Child health, Fetal Alcohol Spectrum Disorder, and midwifery” (ISC, 2019) and “The department continued to advance service provisions for both Maternal Child Health and Fetal Alcohol Spectrum Disorder programming” (ISC, 2020).

Discussion

The discussion begins with a high-level overview of the most significant results. This is followed by a critical analysis of the three principal findings, namely, (a) that neutral language narratives and data themes were the most referenced; (b) that deficit-based narratives/themes were consistent with those from the literature; and (c) that several of the key strength-based narratives/themes in the literature were infrequently referenced in the reports analyzed. The critical analysis situates the results within the literature and discusses policy implications. Finally, the limitations of the study are discussed followed by suggestions for further research.

Principal Findings

The first finding of significance was that neutral language narratives were the most referenced narrative category in all four reports and not deficit-based narratives as predicted by the literature (Kukutai & Walter, 2015; Walter, 2010). The principal narrative was that Indigenous Services Canada had increased or was working to increase access to health services for First Nations. The secondary neutral language narrative identified was that Indigenous Services Canada was working in active collaboration with Indigenous partners to design, manage, and deliver these health services.

Though neutral language narratives and data themes were the most referenced, deficit-based narratives themes materialized in all four of the departmental results reports. The deficit-based narratives and themes that emerged were consistent with the hypothesis in the literature that Indigenous health data is based on deficit, dysfunction, deprivation, disparity, and disadvantage (Kukutai & Walter, 2015; Walter, 2010). The primary narrative in the data analyzed was a disparity narrative that emphasized the differences or gaps between the health outcomes of the Indigenous and non-Indigenous population. The secondary deficit-based data theme was disease-focused, which centered around the documentation and management of disease within the Indigenous population. The deficit-based narrative and disease-focused data theme have potential policy implications, which will also be discussed.

Additionally, there were strength-based narratives and data themes in the reports that should not be overlooked. The most referenced strength-based Indigenous health policy narrative was that Indigenous Services Canada was working to improve the mental wellness of Indigenous communities. Maternal and Child Health was a data theme that emerged inductively. The strength-based narratives and themes that emerged were inconsistent with the themes from the literature, which is the third finding of significance. It will be instructive to examine how the strength-based narratives and data themes that emerged in the reports differ from the literature on strength-based approaches to health.

Neutral Language Narratives and Data Themes Were Most Referenced

The narrative of working to provide an increase in “access to services” was expected, given that the mandate of Indigenous Services Canada is to improve access to high quality services for First Nations, Inuit, and Métis (Indigenous Services, 2022). However, it is also an important narrative to consider in the context of capacity-building and self-determination. Indigenous people in Canada face systemic barriers to equitable healthcare access (Nguyen et al., 2020). Increasing access to services is an important step towards equitable access to services but access to services alone is not a sufficient condition to address the systemic barriers Indigenous peoples face in accessing culturally relevant services (Nguyen et al., 2020).

Simply increasing access to services in Indigenous communities also does little to build Indigenous service delivery capacity. Delivering high quality services to Indigenous communities is undoubtedly important but capacity building efforts should also be prioritized. If Indigenous Services Canada wants to be eventually obsolete, Indigenous communities will first need to be supported in building the capacity to deliver health services themselves. For instance, guaranteeing long-term, stable funding agreements so communities can build the health infrastructure required for service delivery. Arguably, it is also not sufficient to simply consult with Indigenous communities to improve the cultural relevancy of services if the intention is for Indigenous communities to eventually deliver services themselves.

Deficit-Based Narratives/Themes Were Consistent with Findings from the Literature

The deficit-based narratives and themes that emerged were consistent with the hypothesis derived from an interpretation of the literature wherein much of Indigenous health data is presented through a deficit and disparity-based lens (Carpenter et al., 2021; Fforde, 2013; Fogarty et al., 2018; Hyett et al., 2019; Kukutai & Walter, 2015; Russell, 2002; Walter, 2010).

One of the most salient themes in the literature is that the Indigenous population, both historically and contemporaneously, have often been identified in terms of what they lack in relation to the non-Indigenous ideal (Anderson & Kukutai, 2016; Hyett et al., 2019; Russell, 2002). This theme was consistent with the disparity narrative identified across the reports that emphasized differences or gaps in health outcomes between the Indigenous and non-Indigenous population. The challenge for the federal government is to document health disparities to help close health gaps without further alienating and marginalizing First Nations. An overemphasis on the deficits and deficiencies of the Indigenous population can create unintended policy consequences. At the same time, deficit data is an essential tool in holding government accountable to quality health services (Fogarty et al., 2018). The drawbacks and benefits of deficit-based statistics will be outlined in this section followed by a short case study of the Overcoming Indigenous Disadvantage report (OID) in Australia that incorporated both deficit and strength-based statistics (ACER, 2012; SCRGSP, 2014).

According to an ideas-based conception of public policy, the very definition of what constitutes a policy problem is a function of the *perceived* nature of the problem, and the qualities or data that define the problem are almost always contestable (Rochefort & Cobb, 1994, p. 4). The existing health data collected on First Nations, for example, reflects deliberate choices about what to count—and not to count (Stone, 2012). Comparisons of Indigenous and non-Indigenous populations produce knowledge about Indigenous peoples and constructs the category of Indigeneity. Negative discourse around failing to meet targets related to health, education, employment, and wellbeing can serve to emphasize what is wrong with Indigenous people (Pholi, Black & Richards, 2009, p. 9). Furthermore, this deficit data forms the basis of knowledge about Indigenous people, particularly among non-Indigenous individuals. In a policy context, this knowledge can orient strategic policy goals around "fixing" Indigenous people and can situate deficits within Indigenous communities (Fogarty et al., 2018; Pholi, Black & Richards, 2009). Crucially, this framing may "insulate existing institutions, systems, and power structures from an expectation to change…" (Pholi et al., 2009, p. 10). In other words, situating responsibility of deficits within Indigenous communities can serve to distract from a recognition of the structural issues such as colonial systems that perpetuate health deficits. The logic behind closing health gaps also fails to acknowledge that there may be differences in goals and values between populations around what is conceptualized as a good or healthy life (Altman, 2009; Bulloch & Fogarty, 2016).

At the same time, deficit statistics can do important political work by bringing attention to issues of health inequalities (Fogarty et al., 2018). Deficit statistics may serve to "politicise inequality" by drawing attention to areas where government is failing to provide adequate services (p. 32). Ideally, deficit and strength-based statistics could exist side-by-side. Strength-based approaches offer one way to counterbalance deficit discourse by highlighting individual and community strengths that can help overcome deficits. The Overcoming Indigenous Disadvantage (OID) report authored by the Australian government reports on a range of indicators related to Aboriginal and Torres Strait Islander health and wellbeing (ACER, 2012). Changes to the report in 2014 following criticisms of being overly deficit-based offer solutions that may be applicable to the Canadian context.

A 2012 review of the OID determined that the report was meeting its objectives of reporting on government performance (ACER, 2012; Fogarty et al., 2018). However, Indigenous stakeholders wanted to be represented less by gaps, deficit, and dysfunction and more in terms of achievements, strengths, and other "positive dimensions of Indigenous experience" (ACER, 2012, p. 5). In response to the 2012 recommendations, future reports adopted a focus on strength-based statistics and engaged Aboriginal and Torres Strait Islander people at all phases of the data cycle instead of simply after the report had been completed (SCRGSP, 2014). Greater attention was also paid to cultural indicators and some data indicators were shifted from negative to neutral or positive framings. For instance, “tooth decay” was replaced by “oral health” (SCRGSP, 2016, p. 12). Of note, both the 2014 and 2016 OID reports also included sections on the historical context of the health data presented. The 2016 report, for example, acknowledged how health disadvantages can derive from “both immediate social, economic and cultural determinants, and deeper underlying causes” (SCRGSP, 2016, p. 11). Deeper underlying causes referenced included the role of colonialism, dispossession, and racism that can lead to present day structural inequalities in health and wellbeing (Sherwood, 2013). Interestingly, the reports also recognized the implication of the Australian government in causing these disadvantages.

Deficit-based data can play an important political role by bringing attention to health inequities. However, deficit-based narratives and data themes can also further marginalize the populations they describe and contribute to deficit-oriented policy strategies. The OID reports offer an example of how strength-based and deficit-based data can be leveraged together to offer a more complete picture of Indigenous health (ACER 2012; SCRGSP, 2014, 2016). Changes made to the OID report offer potential changes that could be made by Indigenous Services Canada to departmental results reports. Engaging Indigenous stakeholders at every stage of the data life cycle, introducing more culturally relevant data indicators, and including a section on the historical context of the health data, are changes that could be made by ISC to make reports more inclusive and comprehensive.

Strength-based Narratives/Themes were Inconsistent with Findings from the Literature

Land use or the environmental-health connection, community health, and spiritual health were all salient themes in the strength-based literature but were referenced infrequently by Indigenous Services Canada in recent departmental results reports (Boulton & Gifford, 2014; Kant et al., 2013; Mark and Lyons, 2010; Tingey et al., 2016; Witham et al., 2021). The relationship between environmental health and human health was referenced only once in the 2021-21 report in the context of climate change adaptation (ISC, 2021-2021). Given that environmental health has been well documented as a key component of overall health according to the Relational Worldview, more data should be collected to better understand this relationship in the Canadian context. A better understanding of the environmental-health connection could be leveraged both by policymakers and First Nations communities to design interventions to improve both environmental and human health. For instance, Kant et al. (2013) determined that government regulations on land use was one of the most important determinants of overall health among two First Nations in Canada. Documenting the relationship between government policy on land use and overall health is an important first step in both problem definition and defining the types of policy interventions that could be feasible.

The relationship between personal health and community health is another salient theme in the strength-based approach literature that was referenced infrequently by Indigenous Services Canada apart from the “Average Community Wellbeing Index Score” (ISC, 2021). However, the OAG concluded in 2018 that the Community Wellbeing Index did not provide a comprehensive description of the wellbeing of on-reserve First Nations (Office of the Auditor General of Canada, p. 6). Launched in 2004, the index is based on socioeconomic data on education, employment, income, and housing where each indicator of wellbeing is assigned a numeric value between 0 and 100 and equally weighed against the other indicators (Guthro, 2021). According to the AG, the existing Community Wellbeing Index score omits several crucial aspects of First Nations wellbeing including environment, language, and culture (Office of the Auditor General of Canada, 2018). The index is also missing many of the key indicators of community health cited in the literature such as peer connectedness and the health and wellbeing of extended family (Tingey et al., 2016; Witham et al., 2021). Furthermore, the Auditor General concluded that Indigenous Services Canada did not meaningfully engage with First Nations to report on education and health gaps and made limited use of available data. For instance, data from the First Nations Information Governance Centre's Regional Health Survey on the presence of chronic health conditions reported by First Nations living on reserve was omitted (Office of the Auditor General of Canada, 2018).

The final theme that was present in the strength-based literature but referenced only sporadically by Indigenous Services Canada was the concept of spiritual wellbeing. Spiritual wellbeing is one of the four elements identified by Rountree & Smith (2016) in the Relational Worldview of Indigenous wellbeing. Though difficult to measure precisely, elements of spirituality refer to "spiritual forces and beliefs that promote wellbeing and are maintained through practice and ceremonies" (Rountree & Smith, 2016, p. 216). For the purposes of the present research, the spirituality indicators of "knowledge of and connection to ancestry," "spiritual wellbeing" and "spiritual practice/ceremony" were determined inductively based on a review of the literature (Boulton et al., 2014; Cross et al., 2011; Mark & Lyons, 2010; Rountree & Smith, 2016). Of these three indicators, only two were referenced by Indigenous Services Canada. "Spiritual wellbeing" was referenced twice across all four reports and "spiritual practice/ceremony" was referenced once. It is perhaps unsurprising that elements of spirituality were overlooked in the reports analyzed due to the difficulty of explaining and describing spirituality in quantitative research. However, it is promising that spiritual health was considered in the most recent departmental results report (ISC, 2021), which may indicate a growing awareness of the importance of spiritual wellbeing in the maintenance of overall health.

The lack of relevant data on environmental and spiritual health in addition to the fundamental measurement issues associated with the Community Wellbeing Index all serve as illustrations of the importance of meaningful Indigenous consultation and engagement on measures of health and wellbeing. Simply put, Indigenous Services Canada cannot accurately measure the well-being of Indigenous communities through top-down, Eurocentric, colonialist measurement standards (Guthro, 2021). According to proponents of Indigenous Data Sovereignty, higher quality data (including health data) on First Nations cannot exist without the recognition of the rights of First Nations to control the collection, ownership, and application of data about them (Rainie et al., 2017). A key aspect of respecting Indigenous Data Sovereignty is the application of the OCAP® principles, which have been described as “self-determination applied to research” (Schnarch, 2004, p. 80). These principles were created with an understanding of how past research on First Nations has inflicted great harm and with the goal of preventing these harms from occurring (FNIGC, 2014). OCAP® principles outline the rights of First Nations to own, control, access and possess First Nations Data (FNIGC, 2016, 2020).

First Nations can exercise data jurisdiction in several ways. First, privacy, OCAP® and access to information laws can be enacted in First Nations communities. Addressing how community information may be used and under what circumstances is key to establishing these laws (FNIGC, 2014). Policies and procedures can also be developed to provide guidelines on the protection of both personal and collective privacy. They can describe the requirements for data-sharing agreements with other governments, can help define relationships with outside contractors and researchers, and ensure that publication of data is a controlled and approved process (Kuktai &. Taylor, 2016, p. 153). Repatriation of data held by federal and provincial governments is also a possibility. Where this is not practical, data governance agreements or data-sharing contracts can be negotiated to ensure First Nations control over their data (Carroll et al., 2019; FNIGC, 2014; Kukutai & Taylor, 2016).

An excellent example of data sharing in action is the Unama'ki Client Registry in Nova Scotia. Completed in 2010, the Registry is a longitudinal population registry of the Tui'kn Partnership First Nations. It allows extraction of population-level data from provincial administrative and clinical registry systems for use by First Nations communities in their own health planning and in their planning efforts with other health organizations (Tu'kin Partnership, 2018). This is a promising initiative as it leverages existing data collected by governments to produce culturally-relevant policies and programs that are administered by First Nations themselves. Perhaps as governments, corporations, and entities that hold Indigenous data become more open to data repatriation or data-sharing agreements, the data on First Nations will become more comprehensive. In this process, indicators such as environmental health that have been identified as missing from mainstream wellbeing indicators might also be added. However, it is important to note that First Nations exercising the right to data sovereignty occurs within a larger data system in which other governments, corporations, and entities control Indigenous data. Thus, Indigenous data sovereignty efforts also require that non-Indigenous stakeholders incorporate Indigenous data sovereignty principles into their own data governance practices (Carroll et al., 2019, p. 11).

Limitations of the Study and Future Research

The principal limitations of the present study are that (a) the analysis is limited in scope; (b) the analysis is limited to the content of the reports; and (c) the results may not be highly generalizable. Each of these limitations also present opportunities for future research.

First, the primary limitation is the limited scope of the analysis. The departmental reports analyzed included those authored by Indigenous Services Canada. However, there are numerous other government institutions and non-governmental organizations that are also implicated in Indigenous health policy. For instance, several organizations collect First Nations data including statistical agencies, First Nations organizations and academic institutions across Canada, and several government departments (Symlie & Firestone, 2015; Trevethan, 2019; Walker et al., 2017). Future research could expand the scope of the analysis to include reports authored by non-governmental organizations such as the First Nations Information Governance Centre. It would be instructive to examine what social policy narratives and data themes emerge in these reports and how the results might differ from the present study. Could there be social policy narratives in non-governmental reports that are not present in federal reports?

The scope of the present analysis is also limited to 2017-2021. Further research could expand the time period to include reports authored by the department of Indian Affairs (INAC) before it split into Indigenous Services Canada (ISC) and Crown-Indigenous Relations and Northern Affairs (CIRNA). It would be particularly interesting to explore how social policy narratives and data themes might have evolved over time and to arrive at a more granular judgement of the impact of the 2017 restructuring of INAC. Given that there were notable changes in themes over the four-year period examined, there were likely many even more dramatic shifts in the conception of Indigenous health policy over the past three decades.

Another limitation of the present study is that analysis was limited to the content of the reports. The perspectives of the stakeholders involved in producing the reports were not considered. In future research, interviewing stakeholders involved in producing departmental results reports might uncover some of the internal logic behind the choice of data collected. Interviews would also be helpful to contextualize the results of the present study and to hear if the identified narratives and data themes are salient to the stakeholders involved in producing the reports analyzed. Future research could also explore the perspectives of Indigenous stakeholders and contrast these perspectives with federal government stakeholders.

The final principal limitation of the present study is that the subjective nature of the analysis, which might mean the results are not highly generalizable. Qualitative research is by nature a subjective process informed by the perspective and position of the researcher (Saldaña, 2021). One way to respond to this limitation is to establish intercoder agreement, where two or more analysts work independently to corroborate each datum. If at least two coders are largely consistent with their assignment of codes to the data, there is intercoder agreement. There is no standard agreement among qualitative research, but according the 80-90% range is a minimal benchmark to produce evidentiary statistics (ibid). It would be especially interesting to have an Indigenous scholar apply the same methodology as in the present study and see if the results are replicable or if key differences emerge.

Conclusion

Narrative language social policy narratives, and not deficit-based social policy narratives, were the most referenced narrative form in ISC departmental results reports. The primary narrative was that Indigenous Services Canada had increased or was working to increase access to services for First Nations, Inuit, and Métis. Although providing access to services is important, it was advanced that increasing Indigenous capacity to deliver health services should be equally prioritized.

The deficit-based narratives and themes that emerged were consistent with the literature wherein much of Indigenous health data is presented through a deficit and disparity-based lens (Carpenter et al., 2021; Fforde, 2013; Fogarty et al., 2018; Hyett et al., 2019; Kukutai & Walter, 2015; Russell, 2002; Walter, 2010). The primary deficit-based narrative in the data analyzed was a disparity narrative that emphasized the differences or gaps between the health outcomes of the Indigenous and non-Indigenous population. The secondary deficit-based data theme was disease-focused, which centered around the documentation and management of disease within the Indigenous population. An overemphasis on the deficits and deficiencies of the Indigenous population can serve to further marginalize the population they describe. In a policy context, this knowledge can orient strategic policy goals around "fixing" Indigenous people and may situate deficits within Indigenous communities (Fogarty et al., 2018; Pholi, Black & Richards, 2009). At the same time, deficit statistics play an important political function by bringing attention to inequalities and drawing attention to inadequate service provision. Strength-based narratives and statistics offer one way to counter deficit-based discourses by highlighting existing capabilities and strengths that can be leveraged to overcome deficits. Ideally, governments, including emerging Indigenous-based governance and administrative institutions, would consider both strength-based and deficit-based health statistics to offer a more comprehensive picture of health and wellbeing. Additionally, engaging Indigenous stakeholders at every stage of the data life cycle, introducing more culturally relevant data indicators, and including a section on the historical context of the health data are changes that could be made by ISC to make reports more inclusive and comprehensive.

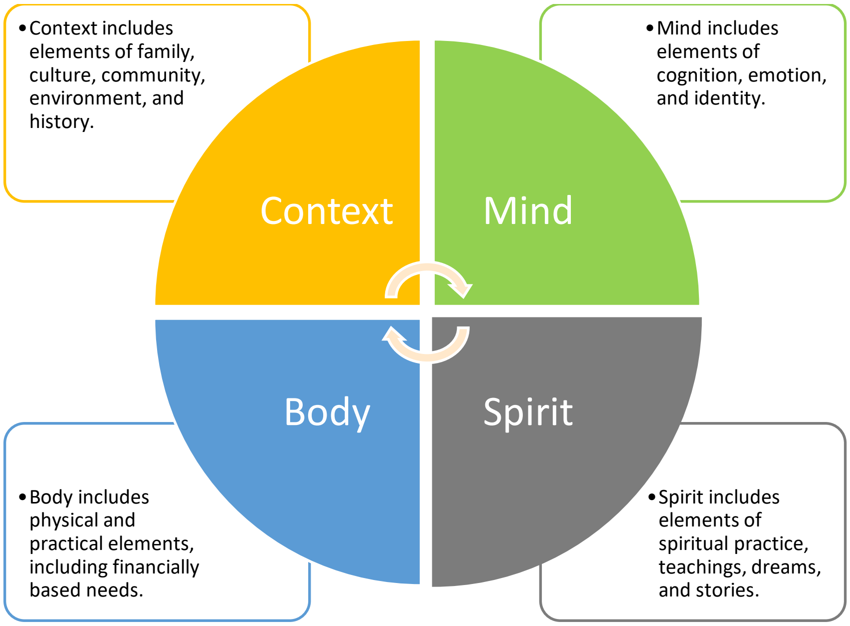
The most referenced strength-based Indigenous health policy narrative was that Indigenous Services Canada was working to improve the mental wellness of Indigenous communities. Maternal and Child Health was a data theme that emerged inductively. The strength-based narratives and themes that emerged were not reflective of the themes in the literature. Specifically, land use or the environmental-health connection, community health, and spiritual health were all salient themes in the strength-based literature but were referenced infrequently by Indigenous Services Canada in recent departmental results reports (Boulton & Gifford, 2014; Kant et al., 2013; Mark and Lyons, 2010; Tingey et al., 2016; Witham et al., 2021). It was argued that this lack of relevant data is partly a reflection of a lack of meaningful Indigenous consultation and engagement on measures of health and wellbeing. Indigenous data sovereignty was also advanced as a key factor that may impact the quality and cultural relevancy of First Nations data.

Limitations of the present study presented include the limited scope of the analysis, the analysis being limited to the content of the reports, and the potential lack of generalizability of the results. These limitations present opportunities for future research on Indigenous social policy narratives. Future research could expand the scope by expanding the time period to include reports authored by the department of Indian Affairs (INAC) and Health Canada before the 2017 restructuring. Interviewing stakeholders involved in producing departmental results reports might offer another avenue for future research and help uncover some of the internal logic behind the choice of data collected. Finally, future research could increase the generalizability of the results by establishing intercoder agreement. Two or more analysts could apply the same methodology as the present study and see if the results are replicable.

Language is powerful in the policy world. The way Indigenous social policies are presented and discussed can serve to frame the very definition of policy problems and what solutions seem desirable. Social policy narratives can therefore have tangible consequences for the individuals they describe, which is why these narratives merit further investigation.

Annex

Annex A – The Relational Worldview



- Context includes elements of family, culture, community, environment, and history.

- Mind includes elements of cognition, emotion, and identity.

- Body includes physical and practical elements, including financially based needs.

- Spirit includes elements of spiritual practice, teachings, dreams, and stories.

Annex B – Deficit-based Deductive Codes
Note: These themes are not mutually exclusive, as such, some codes may be referenced more than once within the same section of the report.

Code	**Selected Subcode(s)**	**Code Description**	**Data Sample**
Disparity	• Difference • Gap	Data themes or narratives that emphasize the difference or gap between the Indigenous and non-Indigenous population.	“ISC continued working with Indigenous partners to address public health concerns, including chronic and communicable diseases, and to respond to unacceptable health gaps” (ISC, 2020).
Deficit	**N/A**	Data themes or narratives that emphasize areas where Indigenous health is lacking or behind the health of the non-Indigenous population.	The dependency rate has decreased from 33.6 percent in 2013 to 30.5 percent in 2017 (ISC, 2018).
Disadvantage	**N/A**	Data themes or narratives that emphasize the adverse circumstances First Nations communities face rather than the unique strengths possessed by First Nations.	“Indigenous communities experience more barriers to services and are at greater risk for negative impacts from services that cannot support their needs” (ISC, 2021).
Deprivation	**N/A**	Data themes or narratives that emphasize the lack of available resources in First Nations communities to improve health outcomes.	“There were some factors that accelerated COVID-19 transmission, such as housing density; and other factors that were aggravated during the pandemic. This included social isolation, economic deprivation, food insecurity, family and

			gender-based violence, substance abuse and other mental health issues" (ISC, 2021).
Dysfunction	**N/A**	Data themes or narratives that emphasize the flawed or broken aspects of First Nations health services delivery.	"Challenges do remain, however, regarding retention and recruitment of nurses due to a variety of issues including the remoteness of the communities, high workload and connectivity difficulties (ISC, 2020).

Annex C – Strength-based Deductive Codes

Code	Selected Subcode(s)	Code Description	Data Sample
Context	• Community involvement • Environmental-health connection • Healthy relationships • Safety • Social Support • Traditional activities and practices	The context indicators include social support systems, community, as well as health as other factors external to the individual such as the environment. These factors can be current *and* historic factors (Cross, 1997; Rountree & Smith, 2016).	A reference to *positive community relationships and contributions* (Cross et al., 2011).
Mind	• Cultural identity • Self-esteem • Speaking of Indigenous languages • Cultural knowledge • Coping skills • Mental wellbeing	The mind indicators "represent the internal constructs that orient the individual toward the path of health and healing and the mental and emotional capacity to thrive" (Rountree & Smith, 2016, p. 213).	Rates of *educational achievement/attainment*.
Body	• Financial security • Good nutrition • Traditional foods	Body indicators represent the	Reference to *financial security*.

	• Access to (culturally competent) services • Healthy lifestyle/activities • Secure housing • Traditional healing practices	essential physical and economic elements that support wellbeing (Cross, 1997).	
Spirit	• Spiritual wellbeing • Spiritual practice/knowledge/ceremony • Knowledge of and connection to ancestry	Spirit indicators are often overlooked in mainstream approaches to well-being but consist of the spiritual beliefs and practices that promote wellbeing and are maintained through ceremony and practice (Cross, 1997; Rountree & Smith, 2016).	Reference to *spiritual knowledge*.

References

ACER. (2012). Review of the Overcoming Indigenous Disadvantage: Key Indicators report. https://research.acer.edu.au/indigenous_education/28

Aldrich, R., Zwi, A. B., & Short, S. (2007). Advance Australia Fair: Social democratic and conservative politicians' discourses concerning Aboriginal and Torres Strait Islander Peoples and their health 1972–2001. *Social Science & Medicine*, *64*(1), 125-137.

Altman, J. C. (2009). *Beyond closing the gap: Valuing diversity in Indigenous Australia*. Centre for Aboriginal Economic Policy Research.

Anderson, I. (2020). Understanding the processes. *Social Determinants of Indigenous Health*, 21–40. https://doi.org/10.4324/9781003117247-2

Andersen, C., & Kukutai, T. (2016). Reclaiming the statistical "native": quantitative historical research beyond the pale. In C. Andersen, & J. O'Brien (eds.), Sources and Methods in Indigenous Studies (pp. 55–62). New York, NY: Routledge.

Australia. Australian Bureau of Statistics. (2016). *National Aboriginal and Torres Strait Islander Social Survey*, *2014-15.* Australian Bureau of Statistics. Retrieved from https://www.abs.gov.au/ausstats/abs@.nsf/mf/4714.0

Bamblett, L. (2011). Straight-line stories: Representations and Indigenous Australian identities in sports discourses. *Australian Aboriginal Studies*, (2), 5-20.

Baumgartner, F. R., & Jones, B. D. (1993). *Agendas and instability in American politics*. University of Chicago Press.

Berger, P. & Luckmann, T. (1991). The social construction of reality. London: Penguin Books.

Bhattacahrjee, D., Singh, N. K., Rai, A. K., Kumar, P., Verma, A. N., & Munda, S. K. (2011). Sociological understanding of psychiatric illness: An appraisal. *Delhi Psychiatry Journal*, *14*(1).

Bird-Naytowhow, K., Hatala, A. R., Pearl, T., Judge, A., & Sjoblom, E. (2017). Ceremonies of relationship. *International Journal of Qualitative Methods*, *16*(1), 160940691770789. https://doi.org/10.1177/1609406917707899

Blum, S., & Kuhlmann, J. (2019). Stories of how to give or take – towards a typology of health policy reform narratives. *Policy and Society*, *38*(3), 339–355. https://doi.org/10.1080/14494035.2019.1657607

Boulton, A. F., & Gifford, H. H. (2014). Whānau ora; he whakaaro Ā whānau: Māori family views of family wellbeing. *International Indigenous Policy Journal*, *5*(1). https://doi.org/10.18584/iipj.2014.5.1.1

Bulloch, H., & Fogarty, W. (2016). Freeing the ‘Aboriginal Individual’: Deconstructing ‘development as freedom’ in remote Indigenous Australia. *Social Analysis, 60*(3). https://doi.org/10.3167/sa.2016.600305

Canada. (2016). *Report of the Royal Commission on Aboriginal Peoples*. Retrieved from https://www.bac-lac.gc.ca/eng/discover/aboriginal-heritage/royal-commission-aboriginal-peoples/Pages/final-report.aspx

Canada. Crown-Indigenous Relations and Northern Affairs Canada. (2022). *Government of Canada*. Canada.ca. Retrieved from https://www.canada.ca/en/crown-indigenous-relations-northern-affairs.html

Canada. (2022a). *Consolidated federal laws of Canada, Indian act*. Indian Act. Retrieved from https://laws-lois.justice.gc.ca/eng/acts/i-5/

Government of Canada. (2022b). *Consolidated federal laws of Canada, the Constitution Acts, 1867 to 1982*. Legislative Services Branch. Retrieved from https://laws-lois.justice.gc.ca/eng/const/page-3.html#docCont

Canada. (2021). *Indigenous Community Development National strategy*. Indigenous Community Development National Strategy. Retrieved from https://www.sac-isc.gc.ca/eng/1550512330682/1550512404487

Canada. Indigenous Services Canada. (2018). *Departmental Results Report 2017-18*. Government of Canada; Indigenous Services Canada. Retrieved from https://www.sac-isc.gc.ca/eng/1538147955169/1538148052804

Canada. Indigenous Services Canada. (2019). *Departmental Results Report 2018 to 2019*. Government of Canada; Indigenous Services Canada. Retrieved from https://www.sac-isc.gc.ca/eng/1562155507149/1562155526338

Canada. Indigenous Services Canada. (2020). *Departmental Results Report 2019 to 2020*. Government of Canada; Indigenous Services Canada. Retrieved from https://www.sac-isc.gc.ca/eng/1603722062425/1603722082047

Canada. Indigenous Services Canada. (2021). *Departmental Results Report 2020 to 2021*. Government of Canada; Indigenous Services Canada. Retrieved from https://www.sac-isc.gc.ca/eng/1631214245677/1631214394167

Canada. Indigenous Services Canada. (2020). *Annual Report to Parliament 2020*. Government of Canada; Indigenous Services Canada. Retrieved from https://www.sac-isc.gc.ca/eng/1602010609492/1602010631711

Canada. Public Services and Procurement Canada. (2013). *Departmental Results Reports.* Departmental results report / Department of National Defence and the Canadian Armed

Forces.: D3-41E-PDF - Government of Canada Publications - Canada.ca. Retrieved from https://publications.gc.ca/site/eng/9.833927/publication.html

Canada. Statistics Canada. (2022, February 17). *Raison d'être, mandate and role: Who we are and what we do*. Government of Canada, Statistics Canada. Retrieved from https://www.statcan.gc.ca/en/about/mandate

Carpenter, B., Harris, M., Jowett, S., Tait, G., & Scott Bray, R. (2021). Coronial inquests, indigenous suicide and the colonial narrative. *Critical Criminology*, *29*(3), 527–545. https://doi.org/10.1007/s10612-021-09578-w

Carroll, S. R., Rodriguez-Lonebear, D., & Martinez, A. (2019). Indigenous Data Governance: Strategies from United States Native Nations. *Data Science Journal*, *18*(1), 31. https://doi.org/10.5334/dsj-2019-031

Chandler, & Dunlop, W. L. (2018). Cultural wounds demand cultural medicines. In Greenwood, M., Leeuw, D. S., & Lindsay, N. M. (2018). *Determinants of indigenous peoples' health: Beyond the social*. Canadian Scholars Press.

Crooks, C. V., Chiodo, D., Thomas, D., & Hughes, R. (2009). Strengths-based programming for First Nations Youth in schools: Building engagement through healthy relationships and leadership skills. *International Journal of Mental Health and Addiction*, *8*(2), 160–173. https://doi.org/10.1007/s11469-009-9242-0

Cross, T. L., Friesen, B. J., Jivanjee, P., Gowan, L. K., Bandurraga, A., Matthew, C., & Maher, N. (2011). Defining youth success using culturally appropriate community-based participatory research methods. *Best Practices in Mental Health*, *7*(1), 94-114. Retrieved from http://www.pathwaysrtc.pdx.edu/pdf/pbBestPractices5.pdf

Cross, T. L. (1997). Understanding the relational worldview in Indian families. *Pathways Practice Digest*, *12*(4). Retrieved from http://www.nicwa.org/Relational_Worldview/

Davis, L. P., & Museus, S. D. (2019). What is deficit thinking? an analysis of conceptualizations of deficit thinking and implications for scholarly research. *NCID Currents*, *1*(1). https://doi.org/10.3998/currents.17387731.0001.110

De Leeuw, S., Greenwood, M., & Cameron, E. (2009). Deviant constructions: How governments preserve colonial narratives of addictions and Poor Mental Health to intervene into the lives of indigenous children and families in Canada. *International Journal of Mental Health and Addiction*, *8*(2), 282–295. https://doi.org/10.1007/s11469-009-9225-1

Dinishak, J. (2016). The deficit view and its critics. *Disability Studies Quarterly*, *36*(4). https://doi.org/10.18061/dsq.v36i4.5236

Espey, J. (2002). OCAP & Stewardship: A Discussion Paper for the First Nations Statistical Institute. First Nations Statistical Institute.

Fforde, C., Bamblett, L., Lovett, R., Gorringe, S., & Fogarty, B. (2013). Discourse, deficit and identity: Aboriginality, the race paradigm and the language of representation in Contemporary Australia. *Media International Australia*, *149*(1), 162–173. https://doi.org/10.1177/1329878x1314900117

First Nations Health Authority. (2022). *A new approach for tripartite investment in First Nation Mental Health and Wellness*. A New Approach for Tripartite Investment in First Nation Mental Health and Wellness. Retrieved from https://www.fnha.ca/about/news-and-events/news/a-new-approach-for-tripartite-investment-in-first-nation-mental-health-and-wellness

First Nations Information Governance Centre (FNIGC). (2021). *Our history*. The First Nations Information Governance Centre. Retrieved from https://fnigc.ca/about-fnigc/our-history/

First Nations Information Governance Centre (FNIGC). (2020). *Introducing a first nations data governance strategy*. The First Nations Information Governance Centre. Retrieved from https://fnigc.ca/news/introducing-a-first-nations-data-governance-strategy/

First Nations Information Governance Centre (FNIGC). (2019). First Nations Data Sovereignty in Canada. *Statistical Journal of the IAOS*, *35*(1), 47–69. https://doi.org/10.3233/sji-180478

First Nations Information Governance Centre (FNIGC). (2014). *Ownership, Control, Access, and Possession (OCAP): The Path to First Nations Information Governance* (pp. 1–49). Ottawa, ON: First Nations Information Governance Centre.

Fischer, F. (2003). *Reframing public policy: Discursive politics and deliberative practices*. Oxford University Press.

Fischer, F., & Forester, J. (Eds.). (1993). The argumentative turn in policy analysis and planning. Durham: Duke University Press.

Fogarty, W., Lovell, M., Langenberg, J. & Heron, M-J. 2018, Deficit Discourse and Strengths-based Approaches: Changing the Narrative of Aboriginal and Torres Strait Islander Health and Wellbeing, The Lowitja Institute, Melbourne.

Foley, W., & Schubert, L. (2013). Applying strengths-based approaches to nutrition research and interventions in Australian indigenous communities. *Critical Dietetics*, *1*(3), 11. https://doi.org/10.32920/cd.v1i3.600

Foucault, M., & Khalfa, J. (2009). *History of madness*. Routledge.

Friesen, B. J., Cross, T. L., Jivanjee, P., Thirstrup, A., Bandurraga, A., Gowen, L. K., & Rountree, J. (2014). Meeting the transition needs of urban American Indian/Alaska Native youth through culturally-based services. *Journal of Behavioral Health Services & Research*, *42*(2), 191-205. http://dx.doi.org/10.1007/s11414-014-9447-2

Gallagher, J., Mendez, J. K., & Kehoe, T. (2015). The First Nations Health Authority. *Healthcare Management Forum*, *28*(6), 255–261. https://doi.org/10.1177/0840470415600131

Gorringe, S., Ross, J., & Fforde, C. (2011). Gorringe, S., Ross, J., & Fforde, C. (2011). ‘Will the Real Aborigine Please Stand Up?’: Strategies for breaking the stereotypes and changing the conversation. *Australian Institute of Torres Strait Islander Stories, 28*.

Gray, M. A., & Oprescu, F. I. (2016). Role of non-Indigenous researchers in Indigenous Health Research in Australia: A review of the literature. *Australian Health Review*, *40*(4), 459. https://doi.org/10.1071/ah15103

Green, M. E. (2018). Innovation and Healthcare for Indigenous Peoples. *A Canadian Healthcare Innovation Agenda: Policy, Governance, and Strategy*, *195*, 95.

Greenwood, M., Leeuw, D. S., & Lindsay, N. M. (2018). *Determinants of indigenous peoples' health: Beyond the social*. Canadian Scholars Press.

Guthro, E. (2021). Measuring Indigenous Well-Being: What is Indigenous Services Missing? *The Yellowhead Institute*, (101), 1–4.

Hajer, M. (1993). Discourse Coalitions and the Institutionalization of practice: The case of acid rain in Britain. In F. Fischer & J. Forester (Eds.), The argumentative turn in policy analysis and planning (pp. 43–76). Durham: Duke University Press.

Hyett, S. L., Gabel, C., Marjerrison, S., & Schwartz, L. (2019). Deficit-based indigenous health research and the stereotyping of indigenous peoples. *Canadian Journal of Bioethics/Revue canadienne de bioéthique*, *2*(2), 102-109.

Ingram, H., & Schneider, A. L. (1993). Making distinctions: The Social Construction of target populations. Handbook of Critical Policy Studies, 259–273. https://doi.org/10.4337/9781783472352.00022

Jain, S., & Cohen, A. K. (2013). Fostering resilience among urban youth exposed to violence. *Health Education & Behavior*, *40*(6), 651–662. https://doi.org/10.1177/1090198113492761

Jones, M. D., & Song, G. (2013). Making sense of climate change: How story frames shape cognition. *Political Psychology*, *35*(4), 447–476. https://doi.org/10.1111/pops.12057

Kant, S., Vertinsky, I., Zheng, B., & Smith, P. M. (2013). Social, cultural, and land use determinants of the health and well-being of Aboriginal peoples of Canada: A path analysis. *Journal of Public Health Policy*, *34*(3), 462–476. https://doi.org/10.1057/jphp.2013.27

Kukutai, T., & Walter, M. (2015). Recognition and indigenizing official statistics: Reflections from Aotearoa New Zealand and Australia. Statistical Journal of the IAOS, 31(2), 317–326. https://doi.org/10.3233/sji-150896

Li, T. (2007). *The will to improve: Governmentality, development, and the practice of politics*. Duke University Press.

Lines, L.A. (2020). Reflecting on environment to understand diversifying health perspectives. *Health Science Inquiry*, *11*(1), 119–122. https://doi.org/10.29173/hsi296

MacLure, M. (2013). Classification or wonder? Coding as an analytic practice in qualitative research. *Deleuze and research methodologies*, 164–183.

MacMillan, H. L., Jamieson, E., Walsh, C., Boyle, M., Crawford, A., & MacMillan, A. (2010). The health of Canada's Aboriginal children: results from the First Nations and Inuit regional health survey. *International Journal of Circumpolar Health*, *69*(2), 158–167.

Majone, G. (1989). Evidence, argument, and persuasion in the policy process. New Haven: Yale University Press.

Mark, G. T., & Lyons, A. C. (2010). Maori healers' views on wellbeing: The importance of mind, body, spirit, family and land. *Social Science & Medicine*, *70*(11), 1756–1764. https://doi.org/10.1016/j.socscimed.2010.02.001

Marshall, S. G. (2015). Canadian drug policy and the reproduction of indigenous inequities. *International Indigenous Policy Journal*, *6*(1). https://doi.org/10.18584/iipj.2015.6.1.7

McCallum, K., Waller, L., & Meadows, M. (2012). Raising the volume: Indigenous voices in news media and policy. *Media International Australia*, *142*(1), 101–111.

McCallum, K., & Holland, K. (2010). Indigenous and multicultural discourses in Australian news media reporting. *Australian Journalism Review*, *32*(2), 5–18.

McKenzie, H. A., Dell, C. A., & Fornssler, B. (2016). Understanding addictions among indigenous people through social determinants of health frameworks and strength-based approaches: A review of the Research Literature from 2013 to 2016. *Current Addiction Reports*, *3*(4), 378–386. https://doi.org/10.1007/s40429-016-0116-9

Mehta, J. (2010). The Varied Roles of Ideas in Politics. *Ideas and Politics in Social Science Research*,23-46. https://doi.org/10.1093/acprof:oso/9780199736430.003.0002

Müller, A. (2020). What is constructivism? *Constructing Practical Reasons*, 6–32. https://doi.org/10.1093/oso/9780198754329.003.0002

New Zealand. Statistics New Zealand. (2020). *Te Kupenga: 2018 (final) – english: Stats NZ*. Te Kupenga: 2018. Retrieved from https://www.stats.govt.nz/information-releases/te-kupenga-2018-final-english

Nguyen, N. H., Subhan, F. B., Williams, K., & Chan, C. B. (2020). Barriers and mitigating strategies to healthcare access in indigenous communities of Canada: A narrative review. *Healthcare*, *8*(2), 112. https://doi.org/10.3390/healthcare8020112

NVivo. (2022). *NVivo Qualitative Research Data Analysis Software*. Download nvivo qualitative research data analysis software. Retrieved from https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/support-services/nvivo-downloads

OECD (2020). *Linking Indigenous Communities with Regional Development in Canada*, OECD Rural Policy Reviews, OECD Publishing, Paris, https://doi.org/10.1787/fa0f60c6-en

Office of the Auditor General of Canada. (2018). *Report 5-socio-economic gaps on First Nations Reserves-Indigenous Services Canada*. Report 5-Socio-economic Gaps on First Nations Reserves-Indigenous Services Canada. Retrieved from https://www.oag-bvg.gc.ca/internet/English/parl_oag_201805_05_e_43037.html#

Pearce, M., Jongbloed, K. A., Richardson, C. G., Henderson, E. W., Pooyak, S. D., Oviedo-Joekes, E., Christian, W. M., Schechter, M. T., & Spittal, P. M. (2015). The Cedar Project: Resilience in the face of HIV vulnerability within a cohort study involving young indigenous people who use drugs in three Canadian cities. *BMC Public Health*, *15*(1). https://doi.org/10.1186/s12889-015-2417-7

Pholi, K., Black, D. & Richards, C. (2009). Is' Close the Gap' a useful approach to improving the health and wellbeing of Indigenous Australians? *Australian Review of Public Affairs: Journal*, *9*(2).

Pollack, T. M. (2012). Unpacking everyday “teacher talk” about students and families of color. *Urban Education*, *48*(6), 863–894. https://doi.org/10.1177/0042085912457789

Poth, C. N. (2018). *Innovation in mixed methods research: A practical guide to integrative thinking with complexity*. Sage.

Priest, N., Mackean, T., Davis, E., Briggs, L., & Waters, E. (2012). Aboriginal perspectives of Child Health and Wellbeing in an urban setting: Developing a conceptual framework. *Health Sociology Review*, 1084–1099. https://doi.org/10.5172/hesr.2012.1084

Pyper, E., Henry, D., Yates, E. A., Mecredy, G., Ratnasingham, S., Slegers, B., & Walker, J. D. (2018). Walking the path together: Indigenous health data at ICES. *Healthc Q*, *20*(4), 6-9.

Reading, C. (2018). Structural determinants of aboriginal people’s health. In Greenwood, M., Leeuw, D. S., & Lindsay, N. M. (2018). *Determinants of indigenous peoples' health: Beyond the social*. Canadian Scholars Press.

Rochefort, D. A., & Cobb, R. W. (1994). *The politics of problem definition: Shaping the policy agenda*. University Press of Kansas.

Russell, L. (2002). *Savage imaginings: Historical and contemporary constructions of Australian aboriginalities*. Australian Scholarly Publ.

Rountree, J., & Smith, A. (2016). Strength-based Well-being Indicators for Indigenous Children and Families: A Literature Review of Indigenous Communities' Identified Well-being indicators. *American Indian & Alaska Native Mental Health Research: The Journal of the National Center*, *23*(3).

Rowan, M., Poole, N., Shea, B., Gone, J. P., Mykota, D., Farag, M., Hopkins, C., Hall, L., Mushquash, C., & Dell, C. (2014). Cultural interventions to treat addictions in indigenous populations: Findings from a scoping study. *Substance Abuse Treatment, Prevention, and Policy*, *9*(1). https://doi.org/10.1186/1747-597x-9-34

Saldaña J. (2021). After First And Second Cycle Coding Methods. In *The coding manual for qualitative researchers* (pp. 341–360), Sage.

Sarra, C. (2014). Strong and smart - towards a pedagogy for emancipation. https://doi.org/10.4324/9780203093191

SCRGSP (Steering Committee for the Review of Government Service Provision) 2014, Overcoming Indigenous Disadvantage: Key Indicators 2014, Productivity Commission, Canberra.

Shahram, S. (2015). The social determinants of substance use for aboriginal women: A systematic review. *Women & Health*, *56*(2), 157–176. https://doi.org/10.1080/03630242.2015.1086466

Shanahan, E. A., Jones, M. D., & McBeth, M. K. (2018). How to conduct a narrative policy framework study. *The Social Science Journal*, *55*(3), 332–345. https://doi.org/10.1016/j.soscij.2017.12.002

Shanahan, E. A., Jones, M. D., & McBeth, M. K. (2011). Policy narratives and Policy Processes. *Policy Studies Journal*, *39*(3), 535–561. https://doi.org/10.1111/j.1541-0072.2011.00420.x

Shankar, J., Ip, E., Khalema, E., Couture, J., Tan, S., Zulla, R., & Lam, G. (2013). Education as a social determinant of health: Issues facing indigenous and visible minority students in postsecondary education in Western Canada. *International Journal of Environmental Research and Public Health*, *10*(9), 3908–3929. https://doi.org/10.3390/ijerph10093908

Sherwood, J. (2013). Colonisation–It's bad for your health: The context of Aboriginal health. *Contemporary nurse*, *46*(1), 28–40.

Sismondo, S. (1993) Some social constructions. *Social Studies of Science, 23,* 515–553.

Smylie, J., & Firestone, M. (2015). Back to the basics: Identifying and addressing underlying challenges in achieving high quality and relevant health statistics for indigenous populations in Canada. *Statistical Journal of the IAOS*, *31*(1), 67–87. https://doi.org/10.3233/sji-150864

Stone, D. (2021). *Counting: How we use numbers to decide what matters*. Liveright Publishing Corp.

Stone, D. A. (1989). Causal stories and the formation of policy agendas. *Political Science Quarterly*, *104*(2), 281. https://doi.org/10.2307/2151585

Tang, S. Y., & Browne, A. J. (2008). 'Race' matters: Racialization and egalitarian discourses involving Aboriginal people in the Canadian Health Care Context. *Ethnicity & Health*, *13*(2), 109–127. https://doi.org/10.1080/13557850701830307

Thomas-Olalde, O., & Velho, A. (2011). Othering and its effects–Exploring the concept. *Writing Postcolonial Histories of Intercultural Education*, *2*, 27–51.

Thurber, K. A., Thandrayen, J., Banks, E., Doery, K., Sedgwick, M., & Lovett, R. (2020). Strengths-based approaches for Quantitative Data Analysis: A case study using the Australian Longitudinal Study of Indigenous Children. *SSM - Population Health*, *12*, 100637. https://doi.org/10.1016/j.ssmph.2020.100637

Tingey, L. (2016). Entrepreneurship education: A strength-based approach to substance use and suicide prevention for American indian adolescents. *American Indian and Alaska Native Mental Health Research*, *23*(3), 248–270. https://doi.org/10.5820/aian.2303.2016.248

Treasury Board of Canada. (2016). *Departmental Results Reports* . Canada.ca. Retrieved from https://www.canada.ca/en/treasury-board-secretariat/services/departmental-performance-reports.html

Trevethan, S. (2019). Strengthening the availability of first nations data. *Indigenous Services Canada & The Assembly of First Nations*.

Tu'kin Partnership. (2018). *About tui'kn*. Tui'kin Partnership | Because Health Belongs To All Of Us. Retrieved from http://www.tuikn.ca/about-tuikn/

Van Eeten, M. J. G. (2007). Narrative policy analysis. In F. Fischer, G. J. Miller, & M. S. Sidney (Eds.), *Handbook of public policy analysis. Theory, politics and methods* (pp. 251–269). Taylor and Francis.

Vass, G. (2012). 'So, what *is* wrong with Indigenous Education?' perspective, position and power beyond a deficit discourse. *The Australian Journal of Indigenous Education*, *41*(2), 85–96. https://doi.org/10.1017/jie.2012.25

Walker, J., Lovett, R., Kukutai, T., Jones, C., & Henry, D. (2017). Indigenous health data and the path to healing. *Lancet, 390*(10107), 2022–2023.

Walter, M. (2010). The Politics of the Data: How the Australian Statistical Indigene is Constructed. International Journal of Critical Indigenous Studies, 3(2), 45–56. https://doi.org/10.5204/ijcis.v3i2.51

Weible, C. M., & Sabatier, P. A. (Eds.). (2017). *Theories of the policy process* (4th ed.). Boulder, CO: Westview Press.

West, R., Foster, K., Stewart, L. & Usher, K. 2016, 'Creating walking tracks to success: A narrative analysis of Australian Aboriginal and Torres Strait Islander nursing students' stories of success', Collegian, 23(4):349–54. https://doi.org/10.1016/j.colegn.2016.08.001

Witham, S., Carr, T., Badea, A., Ryan, M., Stringer, L., Barreno, L., & Groot, G. (2021). Sâkipakâwin: Assessing indigenous cancer supports in Saskatchewan using a strength-based approach. *Current Oncology*, *29*(1), 132–143. https://doi.org/10.3390/curroncol29010012