



September 2022

Why are Indigenous Affairs Policies Framed in ways that Undermine Indigenous Health and Equity? Examining Australia's Northern Territory Emergency Response

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Recommended Citation

Freeman, T., Townsend, B., Mackean, T., Musolino, C., Friel, S., McDermott, D., & Baum, F., (2022). Why are Indigenous affairs policies framed in ways that undermine Indigenous health and equity? Examining Australia's Northern Territory Emergency Response. *The International Indigenous Policy Journal*, 13(2). <https://10.18584/iiipj.2022.13.2.14012>

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Abstract

The 2007 Australian Northern Territory Emergency Response policy was harmful to the health of Aboriginal and Torres Strait Islander people. We thematically analysed 72 speech acts and reports from the three prominent perspectives: a Northern Territory government inquiry report, the Federal government, and an Aboriginal civil society coalition to examine how framings during the policy agenda setting phase constrained or supported scope for equitable health outcomes. The report authors and the coalition emphasised colonisation and other social determinants of Indigenous health. The Federal government used a discourse of pathology and white sovereignty. Our findings highlighted the need for Indigenous voice in policy making, and the need to address colonial assumptions underpinning policy framings to achieve Indigenous health equity.

Keywords

Indigenous, policy, agenda setting, social determinants of health, Australia

Acknowledgments

This work was supported by a Centre of Research Excellence grant from the Australian National Health and Medical Research Council (grant # APP1078046).

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Why are Indigenous Affairs Policies Framed in ways that Undermine Indigenous Health and Equity? Examining Australia's Northern Territory Emergency Response

In colonised countries, Indigenous people continue to be denied health equal to that of non-Indigenous people (Anderson et al., 2016), an inequity driven by social determinants of Indigenous health underpinned by historic and ongoing colonisation (Carson et al., 2007; Sherwood, 2013). One of the forms which ongoing colonisation takes is public policies that are enacted on Indigenous Peoples, that do not advance health equity for Indigenous people. Colonial policy making has been noted as a barrier to health equity for Indigenous Peoples in Australia (George et al., 2019; Henderson et al., 2007), New Zealand (Came, 2014; Came, Herbert, & McCreanor, 2019), the United States (McLeigh, 2010), and Canada (de Leeuw et al., 2010; Mitchell et al., 2019). This suggests public policymaking, agenda-setting, and power need to be examined (Harris et al., 2020; Kingdon & Stano, 1984).

This paper presents a policy agenda setting case study of an Australian Indigenous Affairs policy, the Northern Territory Emergency Response (NTER). This policy nominally addressed child sexual abuse in Aboriginal communities in one Australian territory. It outlined a series of draconian, punitive measures that was harmful to the health of Aboriginal and Torres Strait Islander people (Australian Indigenous Doctors' Association & Centre for Health Equity Training, 2010; Gray, 2015; National Aboriginal Community Controlled Health Organisation, 2017). These measures included increased policing, conditional welfare measures (where a cashless welfare 'Basics' card was introduced to control where welfare recipients could spend their money), the banning of pornography in particular communities, and government acquisition of Aboriginal townships. The NTER involved army operations to implement these measures, and required the suspension of the Racial Discrimination Act (Gray, 2015; O'Mara, 2010).

The study is part of a Centre for Research Excellence studying the full policy cycle across several sectors to understand how to improve public policy's contribution to health equity (Baum & Friel, 2017). Public policy plays a critical role in determining health equity in a population (Baum & Friel, 2017; Carey & Friel, 2015). Factors that affect how public policy supports or undermines health equity occur during the agenda setting, formulation, and implementation stages of the policy cycle (Baum & Friel, 2017; Carey & Friel, 2015). In the agenda-setting period, studying the underlying ideas and assumptions informing policymakers' approach is crucial to understanding how issues, including Indigenous affairs, are framed and whose problem definitions and solutions get advanced (or not) (Bacchi, 2009).

This case study sought to examine how framings of the policy agenda for the NTER supported or constrained the potential for the policy to improve or undermine Aboriginal and Torres Strait Islander health. While much has been written on the NTER itself, there is no published literature using an equity lens to examine how decision making in the development phase of the NTER was likely to affect the health of Aboriginal and Torres Strait Islander Peoples. This paper reports on a framing analysis of the dominant and competing frames that shaped the agenda-setting of the NTER policy. It seeks to identify how actors framed the problem, what assumptions informed their problematization, and thus the solutions they offered, and whether health equity was silenced or included in these frames.

Background: Australia's Northern Territory Emergency Response

In 2006, a nationwide series of television reports aired that described high levels of sexual abuse of Aboriginal children in the Northern Territory (NT), particularly in more remote Aboriginal communities. The NT government instigated an independent inquiry, resulting in the 'Ampe Akelyernemane Meke Mekarle: Little Children Are Sacred' report (Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse et al., 2007). The report examined the extent and nature of, and factors contributing to the sexual abuse of, Aboriginal children, and proposed recommendations to address child abuse and neglect in the NT. The Federal Government, particularly the then-Aboriginal Affairs Minister Mal Brough and Prime Minister John Howard, immediately criticized the report and the NT government, and launched the Northern Territory Emergency Response (NTER) a week later.

The top down, paternalistic and punitive approach of the NTER was criticized by a coalition of Aboriginal organisations in the NT ('Combined Aboriginal Organisations of the Northern Territory') in an open letter. The group then published an alternative 'Emergency response and development plan,' proposing a different approach to addressing child sexual abuse in Aboriginal communities in the NT, focused on improving services for the communities. Spokespeople from the coalition presented at the Senate public hearing for the NTER legislation on this alternative plan.

The timeline of events leading to the NTER are shown in Figure 1.

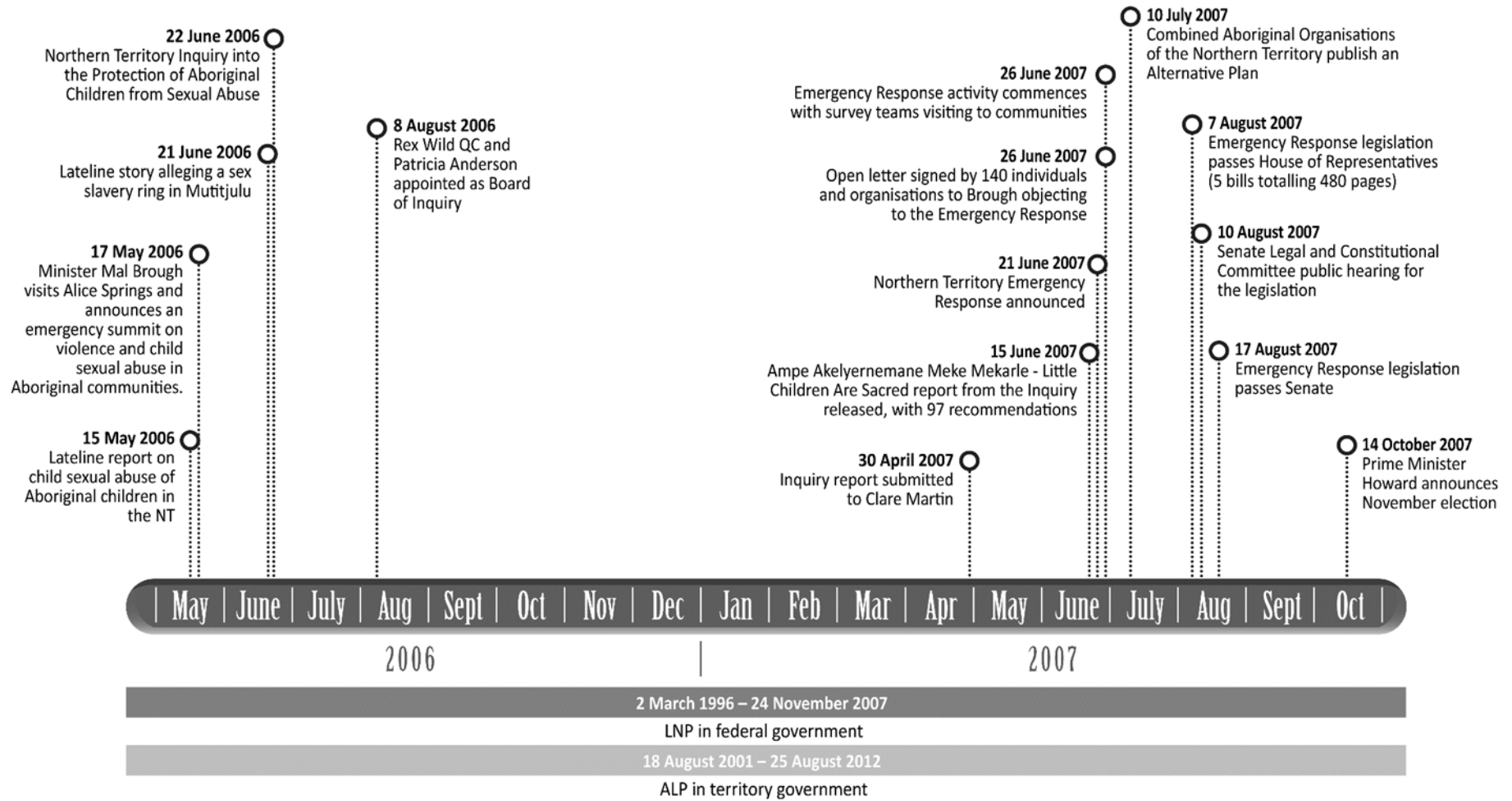


Figure 1. Timeline of events surrounding the Northern Territory Emergency Response. NT = Northern Territory. LNP = Liberal National Party. ALP = Australian Labor Party.

The lack of an evidence base and logic supporting the NTER measures as a response to child sexual abuse has been raised by other writers (Altman & Russell, 2012; Partridge, 2013). Child sexual abuse within Aboriginal and Torres Strait Islander communities was also not a new issue—there had been a number of reports from states and territories on this issue, and there was no data to support that child sexual abuse was more prevalent in the NT than elsewhere (Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse et al., 2007). These concerns make understanding the policy agenda setting period and the framings used particularly critical. The NTER is also important to study because it is such a uniquely extreme recent example of state intervention in Aboriginal and Torres Strait Islander affairs in Australia—its extremity demonstrated by the mobilisation of the army, and suspension of the Racial Discrimination Act (Altman & Russell, 2012).

The NTER and health equity

While the NTER was presented as a policy focused on a social welfare issue (child sexual abuse), research has indicated it had a negative effect on the health and wellbeing of Aboriginal and Torres Strait Islander people in the Northern Territory (Australian Indigenous Doctors' Association & Centre for Health Equity Training, 2010; Gray, 2015; National Aboriginal Community Controlled Health Organisation, 2017). The negative health effects are due to the social and psychological impact of the racial discrimination and heavily stigmatising approach of the NTER, the disempowerment of Aboriginal Peoples including weakening community control, decreased capacity for health due to the cashless welfare cards, and increased incarceration of Aboriginal people (Australian Indigenous Doctors' Association & Centre for Health Equity Training, 2010; Gray, 2015; National Aboriginal Community Controlled Health Organisation, 2017). Thus, our analysis of the case demonstrates that the policy was framed in a way that meant it would increase health inequities between Aboriginal and Torres Strait Islander people and non-Indigenous Australians.

We use Braveman and Gruskin's (2003) definition of health equity: the absence of systematic inequalities in the distribution of health caused by unfair distribution of resources or other unjust or unfair processes (e.g., racism and discrimination). The systematic health inequalities experienced by Aboriginal and Torres Strait Islander Peoples arise from ongoing colonisation, racism, and unfair distribution of power, control, and other social determinants of Indigenous health (Carson et al., 2007; Sherwood, 2013), and thus are clear, egregious health inequities. This is the case for many colonised countries, where the health of the Indigenous Peoples is inequitable (Walker et al., 2017). We use the term Indigenous when referring to peoples globally, Aboriginal and Torres Strait Islander when referring to Australia, and Aboriginal when referring to the communities and land specifically affected by the NTER.

The NTER is generally condemned by academics and commentators as having a negative effect on the health of Aboriginal and Torres Strait Islander Peoples (e.g. Australian Indigenous Doctors' Association & Centre for Health Equity Training, 2010; Gray, 2015; National Aboriginal Community Controlled Health Organisation, 2017). A Health Impact Assessment (Australian Indigenous Doctors' Association & Centre for Health Equity Training, 2010) concluded it would do more harm than good because of the detrimental effects of the NTER's punitive, controlling, and stigmatising measures. Gray's (2015) scorecard indicated the NTER failed to improve employment and economic participation, resulted in little change in education outcomes, increased rates of incarceration, and few improvements in health outside of decreasing child mortality. For one of the

key health interventions, child health checks, Bailie et al. (2008) found that without effective follow up systems in place, the checks would produce “little or no benefit” (p. 618). The main positive outcome cited from the NTER is the investment in primary health care services (Boffa et al., 2007; Sorensen et al., 2014; Tait, 2007).

Previous analyses of the framing of the NTER

We identified seven articles on the NTER that employed a discourse or framing analysis. Five focused on media, and two examined ‘speech acts’ (e.g. media releases, speeches, interviews, and press conferences; Macoun, 2011; Roffee, 2016). The media analyses highlighted the negative portrayal of Aboriginal communities, the use of racialized constructions of Aboriginal and Torres Strait Islander people, denial of their voices and agency, and how media coverage was dominated by individual responsibility and failed social policy framings (Dunne Breen, 2015; McCallum et al., 2012; McCallum & Waller, 2013; Mesikammen, 2016; Proudfoot & Habibis, 2015).

For the two analyses of speech acts, Macoun (2011) examined how Aboriginality was framed as primitive or savage, justifying colonialism and settler sovereignty. Roffee (2016) analysed then Indigenous Affairs MP Mal Brough and Prime Minister John Howard’s speech acts and concluded that they used the framing of a “state of emergency” (p. 138) to push consensus for the NTER and prohibit debate, and denigrated Aboriginal communities to justify government intervention.

Our analysis builds on these analyses by examining how the policy agenda setting period constrained or supported the potential for approaches positive for health equity in the final legislation and its implementation—an issue that has not yet been explored in the NTER literature.

Conceptual Framework

Three conceptual approaches informed our approach to analysing the documents: 1) framing, 2) social determinants of Indigenous health, and 3) white possessive logics.

Framing. Framing is an important ideational strategy that is used by policy actors to influence policymaking (Alasuutari, 2015; Bacchi, 2009; Panizza & Miorelli, 2013; Schmidt, 2010). Policy actors use frames to focus attention on issues and persuade others of their importance. How policies frame the problems, and therefore solutions, is critical to whether or not they are supportive of health equity (Bacchi, 1999; McInnes & Lee, 2012; Townsend et al., 2018). Bacchi (2009) cites the NTER as a ripe subject for analysis of framing of problems and solutions because the policy measures were not clearly linked to the problem, and because of the heavily paternalistic approach to Indigenous Affairs the policy signalled.

Social determinants of Indigenous health. The social determinants of health comprise the living circumstances and social, political economic, and corporate drivers that affect people’s health and wellbeing, and include but are not limited to housing, employment, income, racism and discrimination, and the health care system (Commission on Social Determinants of Health, 2008). The social determinants of *Indigenous* health (Anderson et al., 2007; Carson et al., 2007) extend on the social determinants of health (Commission on Social Determinants of Health, 2008; Donkin et al., 2018) to foreground often-overlooked drivers of Indigenous health, including cultural continuity and over-incarceration. They are a valuable lens through which to interrogate the framing of public policies that affect Indigenous Peoples (Fisher et al., 2019). The Australian Health Ministers’

Advisory Council (2017) argue that 39% of the gap in life expectancy between Aboriginal and Torres Strait Islander Peoples and non-Indigenous Australians is due to inequities in social determinants of Indigenous health.

White possessive logics. White possessive logics are the meanings, framings, and rationale that underpin, perpetuate, and are used to justify illegitimate non-Indigenous sovereignty over Australia (Moreton-Robinson, 2015). Moreton-Robinson (2015) argues that “[W]hite possessive logics are operationalized within discourses to circulate sets of meanings about ownership of the nation, as part of common-sense knowledge, decision making, and socially produced conventions.” (p. xii). One key strategy used to reproduce white sovereignty is the ‘discourse of pathology’ (pathologizing Aboriginal and Torres Strait Islander culture and Peoples), used as “a means to subjugate and discipline Indigenous people to be good citizens” (p. 155) and justify colonisation. Moreton-Robinson (2015) highlights the NTER as an example of such logics, that “patriarchal white sovereign right was exercised using the [Little Children Are Sacred] report as evidence to further regulate and manage the subjugation of Indigenous communities.” (p. 161). In conceptualising “white sovereignty” Moreton-Robinson draws on critical race theory on whiteness as “a form of power, as supremacy, as hegemony, as ideology, as epistemology and ontology” (Moreton-Robinson, 2015, p. xviii). Here, whiteness “is not just about bodies and skin colour” (Moreton-Robinson, 2004, p. 78) but an ingrained world view that shapes our society, structures, and culture in a way that privileges Western knowledge and interests and excludes Indigenous perspectives.

While Moreton-Robinson covers the NTER, she does not include analysis of documents or speech acts. This framing analysis provides an opportunity to examine available material to understand how the reproduction of white sovereignty and the discourse of pathology shaped the policy agenda setting in favour of or against health equity.

Research Questions

Our framing analysis examined the three main actor groups’ positions in the lead up to the NTER (see Table 1). These three groups were selected as they presented a collective proposal for a response to child sexual abuse in Northern Territory Aboriginal communities.

Table 1. Summary of the three most influential groups in the lead up to the Northern Territory Emergency Response (NTER)

Perspective	1. Little Children Are Sacred Report Authors	2. Federal coalition government	3. Combined Aboriginal Organisations
Activity	Produced the report that triggered the Federal government to respond with the NTER	Developed the NTER legislation	Argued against the NTER and produced an alternative plan
Key Actors	Pat Anderson, Rex Wild (and Clare Martin as Chief Minister of NT)	Mal Brough, John Howard	Pat Turner, Olga Havnen were key spokespeople
Aboriginal Leadership	Some Aboriginal leadership	No Aboriginal leadership	Full Aboriginal leadership

Two reports were critical sources. Firstly, the Little Children Are Sacred report was produced from the Northern Territory inquiry (Australian Health Ministers' Advisory Council, 2017), after an eight month, highly consultative process. The 320 page report reviewed international literature and evidence and brought this together with the findings from the consultations to form a complex picture of the drivers of child sexual abuse in the Northern Territory, and provided 97 recommendations. Secondly, the Aboriginal coalition's 30-page Alternative Plan (Combined Aboriginal Organisations of the Northern Territory, 2007) was drafted by a coalition of 40 Northern Territory Aboriginal and community sector organisations following the Federal government's announcement of the NTER. The coalition's plan outlined an alternative approach many of the issues the NTER addressed, including child safety, alcohol, welfare, education, housing, employment, and land tenure and permits, and endorsed the recommendations from the Little Children Are Sacred report.

We did not include the perspectives of individual commentators, who contributed to the debate (e.g., prominent Aboriginal activist, lawyer, and academic Noel Pearson), but did not provide a proposed policy agenda.

The research questions were:

1. How did the three positions frame the 'problem' of child sexual abuse in the Northern Territory?
2. To what extent were each of these three positions supportive of health equity?

Materials and Methods

Following Roffee (2016), we bounded the policy agenda setting period as beginning with the release of the Little Children Are Sacred (Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse et al., 2007) report on 15 June 2007, and ending with the passage of the NTER legislation (Parliament of Australia, 2007) through the Senate on the 17 August 2007 (see Figure 1).

Data collection

We searched Trove, the parliamentary record (Hansard), Google, and government websites (including pages for previous Factiva members of parliament) using the terms: “Little Children Are Sacred report”, “Northern Territory Emergency Response”, “A proposed Emergency Response and Development Plan”, “Combined Aboriginal Organisations of the Northern Territory”, and the names of key spokespeople of the three groups.

We searched for speeches in parliament or elsewhere, media releases, or media interviews with or quotes from key actors during the policy agenda setting period (15 June–17 August 2007). For the media articles, only direct quotes of key actors were used, to further our understanding of the contribution of key actors to framings of the policy agenda. How the media framed the issues has been the focus of other research (Dunne Breen, 2015; McCallum et al., 2012; McCallum & Waller, 2013; Mesikammen, 2016; Proudfoot & Habibis, 2015), and was not the central question for our analysis. Roffee (2016) argues the importance of examining pre-legislative speech acts as they seek to create consensus on the issue, often using persuasive imagery, and illuminate the interests of actors, and how language choice can be manipulated to drive the agenda. The Little Children Are Sacred report and the Alternative Plan were also included as key documents.

Data analysis

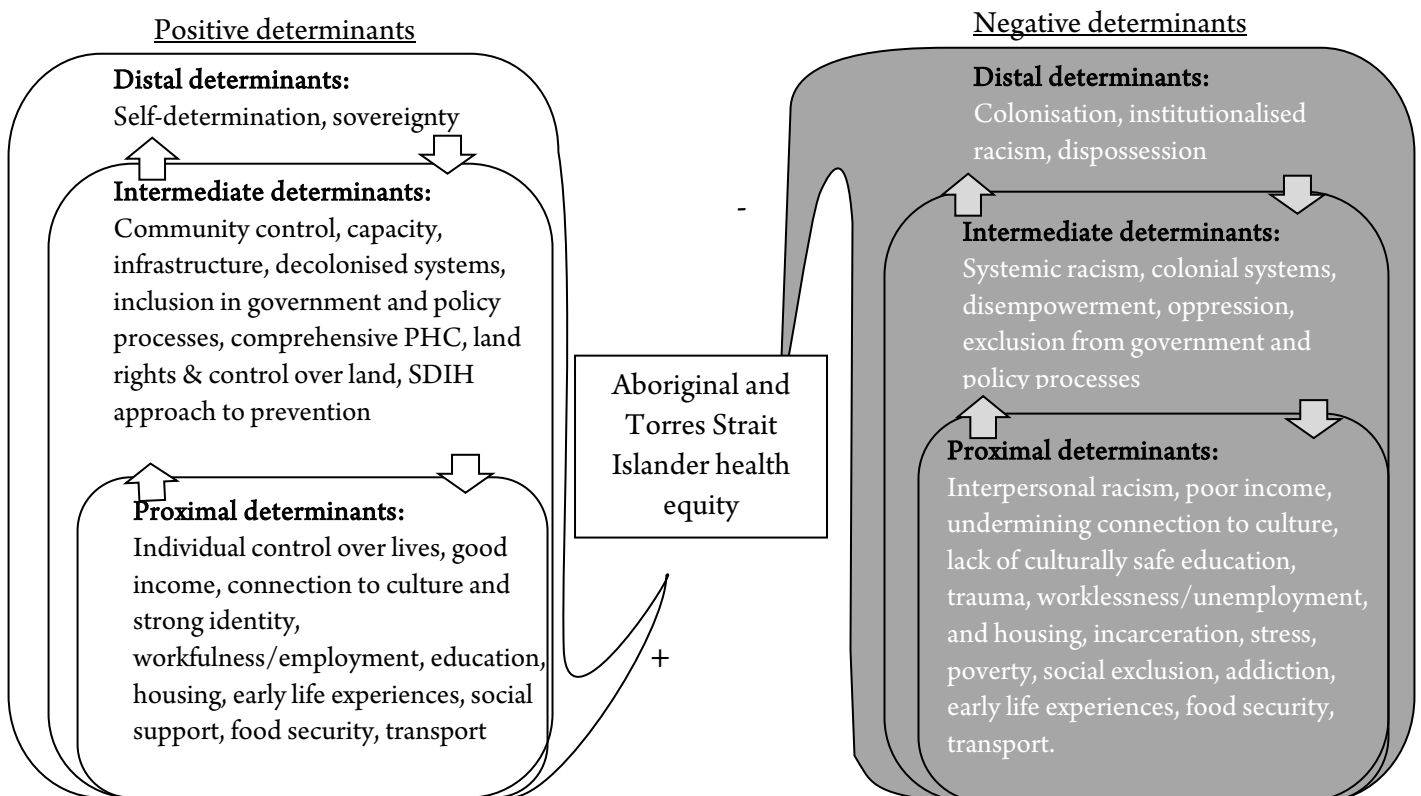
The three positions were evaluated through a framing analysis of speech acts by key actors from each of the three positions.

The 72 sources were imported into NVivo and categorised. Two non-Indigenous researchers (TF and BT) coded one to two documents from each of the three positions to develop a coding framework, which was then discussed with the wider team. Codes covered white possessive logics (e.g., reproducing white sovereignty, discourse of pathology), social determinants of Indigenous health, how the problem was framed (e.g., failure of Aboriginal governance, racism), solutions proposed (e.g., law and order), considerations of health or social equity, and the role of evidence. Aboriginal researchers, TM and DM, reviewed the coding framework, resulting in changes and addition codes. The coding framework was refined during coding by TF, BT, and CM, and workshopped with the research team to ensure coding was comprehensive, accurate, and theoretically justified.

As part of the analysis, codes were compared and contrasted between the three different positions to identify differences in how the policy issue was framed (Bazeley, 2013). Overarching frames for each of the three positions were elucidated in a team analysis workshop.

We analysed whether each framing was positive or negative for equity. We reviewed literature on the social determinants of Indigenous health, including key review texts (Anderson et al., 2007; Carson et al., 2007; Czyzewski, 2011; Devitt et al., 2001; World Health Organization, 2007), and constructed a diagram (see Figure 2) to identify policy factors that may increase or decrease Aboriginal and Torres Strait Islander health equity. TF, BT, and CM evaluated the three agenda setting framings using the social determinants of Indigenous health framework for whether it promoted positive action for equity, or whether it promoted action that would have a negative effect. Differences were discussed until agreement was reached.

Figure 2. Social determinants of Indigenous health that can support (left column) or constrain (right column) health equity for Aboriginal and Torres Strait Islander peoples. SDIH = social determinants of Indigenous health, PHC = primary health care.



Results

We found 72 sources from the three main perspectives (see Table 2).

Table 2. Sources included in the analysis

1. Little Children Are Sacred report authors	2. Federal coalition government	3. Combined Aboriginal Organisations
<ul style="list-style-type: none"> • 1 Report • 1 Media release • 10 media articles quoting Anderson and/or Wild 	<ul style="list-style-type: none"> • 15 media releases/press conferences • 2 public speeches • 10 Hansard speeches • 24 media articles quoting Brough and/or Howard 	<ul style="list-style-type: none"> • 1 Alternative plan • 1 media release • 6 media articles quoting Turner and/or Havnen • 1 Senate public transcript
Total: 12	51	9

The high number of Federal coalition government sources reflects their domination of the media coverage.

The analysis of the framings used by each of the three perspectives are outlined below, followed by an examination of differences and implications for equity.

1. Framings of the Problem

Little Children Are Sacred Report. The overarching frame in the Little Children Are Sacred report articulated child sexual abuse as an intergenerational problem stemming from colonisation. These forces were argued to have led to the most proximal determinants of child sexual abuse, such as poverty, overcrowded housing, and alcohol and other drug abuse. While the media coverage that instigated the report took an individual blaming approach (e.g. "Aboriginal people choose not to take responsibility for their own actions", Australian Broadcasting Commission, 2006, para 2), the report took a consciously contextualised approach that provided a complex nuanced frame of the causes of the causes of abuse. The report highlighted barriers to successfully addressing child sexual abuse

including disempowerment of Aboriginal people in the Northern Territory, Aboriginal people's lack of trust in authority, and a predominance of culturally unsafe, non-consultative policies and programs:

“The Inquiry believes there needs to be a radical change in the way government and non-government organisations consult, engage with and support Aboriginal people. ... many Aboriginal people felt disempowered, confused, overwhelmed, and disillusioned.”
(Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse et al., 2007, p. 50)

Federal Coalition Government. In contrast, the overarching frame in the Federal government's NTER articulated child sexual abuse as a result of dysfunction and breakdown of Aboriginal communities. The required response was thus government intervention in the form of increased policing, surveillance, and disciplining of Aboriginal people (particularly men), drawing on pre-existing race and gender stereotypes:

“The communities are completely dysfunctional and in order to offer them any long-term hope you have got to intervene in a root-and-branch way, you've got to grab control of the communities, you've got to pursue the perpetrators, you've got to provide medical help for the children, you've got to staunch the flow of alcohol and you've got to instil responsibility in the dispersal of welfare payments” (John Howard, then Prime Minister, in Coorey, Hartcher, & Peatling, 2007)

The discourse of pathology (Moreton-Robinson, 2015) and the reproduction of white sovereignty is very clear in the NTER speech acts, evidenced by phrases such as the need “to grab control of the communities” above.

Coalition of Aboriginal Organisations. The overarching frame in the Alternative Plan and surrounding speech acts was that child sexual abuse was a result of under-resourced services (including housing, health care, and schools) and adverse social determinants (including housing and joblessness). The response identified was the need for greater and sustained government funding in partnership with communities. For example, the Alternative Plan argued that any response to child sexual abuse “should also address community safety and access to essential services including housing, health care and education. A failure to also commit to addressing these underlying issues will ensure the current risk factors contributing to existing child abuse and neglect will remain.” (Combined Aboriginal Organisations of the Northern Territory, 2007, p. 3)

2. How supportive or unsupportive were the framings for health equity?

The three different framings led to different proposed solutions, which included extent of focus on law and order, resources for services, Aboriginal and Torres Strait Islander governance, and Aboriginal and Torres Strait Islander people's control. Consideration of temporality, equity, Northern Territory-Federal government roles, land, trust, rights, trauma, and the role of evidence differed across the three frames (see Table 3).

Table 3. Comparison of key framings and foci across the three perspectives, and whether the framing was positive (+), mixed or unclear (~), or negative (-) for health equity

Focus	Little Children Are Sacred report	NTER legislation	Alternate Plan
Law and Order	Culturally inappropriate policing/justice is the problem. Need to regulate industry (e.g., alcohol). Avoid overincarceration. Increasing Aboriginal and Torres Strait Islander Law and governance, and partnership between Aboriginal and Australian Law is a solution. (+)	Lack of law and order is the problem. Increase policing, plus army presence. No mention of incarceration. (-)	Lack of resources for community capacity e.g., community justice groups, community services is the problem (and culturally inappropriate policing). Avoid overincarceration. (+)
Temporality	Intergenerational, long term. (+)	Short term emergency response. (-)	Two tiers – emergency response then sustained resources for services. (+)
Resources for Services	Emphasis: High. (+)	Emphasis: Low, except health and policing. (-)	Emphasis: Very high. (+)
Aboriginal and Torres Strait Islander governance	Crucial that this is strengthened. Worst abuse is where Aboriginal and Torres Strait Islander law is weakest. (+)	Viewed as part of the problem and has failed. Government intervention to replace Aboriginal and Torres Strait Islander governance, including addressing permit system and government business administrators. (-)	Aboriginal and Torres Strait Islander governance of services vital. (+)
Aboriginal and Torres Strait Islander people's control	Increase through education and empowerment. (+)	Control affected by conditional welfare, and law and order measures. (-)	Increase through community-controlled services. (+)
Equity	Equity in terms of ongoing colonisation and need for culturally appropriate responses. (+)	Equity as 'colour blind', aim for sameness. (-)	Self-determination, with same rights as non-Indigenous. (+)
Northern Territory-Federal government roles	Needs to be priority for NT government and Federal government and they need to establish a collaborative partnership on the issue. Federal government actions not related to NT government's LCAS report. (+)	Child protection is a state and territory responsibility, but Federal government required to intervene due to lack of adequate action from NT government. (~)	NT and Federal governments need to jointly develop plan. Current responsibilities are patchy. Both governments need to partner with communities. (+)
Land	Land connection and ownership not mentioned. (-)	Government to regain control of land to enact law and order, open communities to scrutiny, fix housing, and encourage tourism economy. (-)	Connection to land supports health. Government ownership of land will weaken community capacity and violates hard won land ownership rights. (+)

Table 3. Comparison of key framings and foci across the three perspectives, and whether the framing was positive (+), mixed or unclear (~), or negative (-) for health equity (continued)

Focus	Little Children Are Sacred report	NTER legislation	Alternate Plan
Trust	Aboriginal and Torres Strait Islander peoples' mistrust of government contributes to not reporting, acting on child sexual abuse. Community led approaches rather than submitting offenders to mainstream system desired. "Relationships of trust" with Aboriginal and Torres Strait Islander communities are critical and require long term approaches. (+)	Establishing law and order will foster communities' trust. (~)	Respectful partnership with Aboriginal and Torres Strait Islander communities required to establish trust in government, police, child protection. (+)
Rights	International perspective on human rights, rights of the child. Cultural/ Indigenous rights need to be protected through cultural security. (+)	Rights of the child to safety. Other human or collective rights need to be withheld to ensure children's safety. Rights as a vehicle for emphasising individual responsibility, e.g., "the right to welfare comes with obligations" (-)	Land rights. Right to same benefits and services as other Australians. (+)
Trauma	Intergenerational trauma as key issue. (+)	No mention of trauma. (-)	Trauma and grief as "one of the most significant and frequent problems" (p.22)- need for services for trauma. (+)
Role of evidence	The report focused on building an evidence base in collaboration with Aboriginal and Torres Strait Islander people. Recommendations are linked to both pre-existing evidence and proposing further evidence gathering including ongoing monitoring and evaluation. (+)	Engages with some evidence but views more evidence gathering as not necessarily and inhibiting action. Predominantly non-Indigenous "survey teams" sent into communities to gather evidence and to explain the intervention to community members. (-)	Draws on the evidence reported on in the LCAS report, and other past reports. Community knowledge is key to solution. Including Aboriginal and Torres Strait Islander people living in the communities and the knowledge of service providers. Challenges NTER lack of evidence use and emphasises ongoing, independent monitoring and evaluation NTER. (+)

(+) = positive for health equity, (~) = mixed or unclear potential for health equity, (-) = negative for health equity

While the report calls for government action, they are framed as needed redress to inequities, rather than legitimising white sovereignty. There is repeated emphasis on the need for consultation and partnership. For example, the first recommendation of the report states:

“It is critical that both governments commit to genuine consultation with Aboriginal people in designing initiatives for Aboriginal communities.” (p. 22).

Federal Coalition Government. While there was some discussion of social determinants including school attendance, housing, and employment in the Federal Government’s framing, these were largely to advance the discourse of pathology, e.g.: “The cycle of unemployment and welfare dependency, alcohol abuse and violence needs to be broken so that we can go on to build sustainable, healthy communities.” (Brough, in Hansard 7 Aug 2007, p. 18). Any potential positives were heavily outweighed by the systemic racism inherent in the NTER framing, the ignoring of colonisation and intergenerational trauma, and the reduced control and stigmatisation of Aboriginal communities. This meant the framing advanced the negative determinants of health equity in Figure 2. Thus, we judged the framing to be very negative for health equity.

The discourse of pathology and white sovereignty necessitated a top-down policy approach that excluded Aboriginal and Torres Strait Islander people, seeing them as part of the problem and not as part of the solution. It led to solutions that increased white sovereign control over Aboriginal communities through removing permit systems and compulsory government acquisition of five-year leases of Aboriginal land, living areas, and town camps. The individual responsibility framing excluded consideration of contextual drivers such as colonisation and trauma, and resulted in punitive approaches such as income management. The racism inherent in the NTER is clearly demonstrated by the need to suspend the racial discrimination act to implement it.

Coalition of Aboriginal Organisations. The Alternative Plan’s focus on the social determinants of Indigenous health, particularly proximal determinants such as housing and education indicates it had the potential to improve health equity for Aboriginal and Torres Strait Islander Peoples. The plan was clear that loss of land and control were negative determinants of health, and there was a strong emphasis on community control. Thus, we judged the framing to be very favourable for health equity.

In contrast to the Little Children Are Sacred Report, the Alternative Plan was produced to provide an alternative to the NTER. The Alternative Plan also had the Little Children Are Sacred Report to build on, stating that “The response should build on the knowledge base already available to Government, starting with the recommendations of the Little Children are Sacred Report.” (p.3). This meant that while not contradicting the Little Children Are Sacred report, the framing in the plan particularly emphasised those areas to which the NTER presented a threat, such as Aboriginal community control. The plan was also more careful in how it articulated the role of government in its framing, as a provider of funds for services to its citizens. The framing had a strong focus on the provision and historic underfunding of services. These foci strengthened its capacity to be positive for health equity.

Discussion

Our analysis revealed that the three key perspectives informing the agenda setting period of the NTER policy presented conflicting narratives of the causes of child sexual abuse and the solutions

needed to address it. We found the different framings had a strong effect on how much the proposed responses supported or undermined health equity. Overall, the Little Children Are Sacred report and Alternative Plan were aligned with a health equity approach by addressing distal and proximate determinants of health. The Federal Government framing instead drew on racist and white supremacist framings of Aboriginal and Torres Strait Islander Peoples and conflicted with health equity.

These findings are an example of how policymaking in Australia is informed by underlying colonial and racist assumptions which detract from the evidence of what works for Aboriginal and Torres Strait Islander health equity: self-determination, community control, improving social determinants of health, and addressing colonial and racist structures (Anderson et al., 2007; Carson et al., 2007; Czyzewski, 2011; Devitt et al., 2001; World Health Organization, 2007). The Little Children Are Sacred report presented considerable evidence that this was the approach needed to effectively address child sexual abuse (Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse et al., 2007). The demonization of Aboriginal and Torres Strait Islander Peoples and communities, particularly men, is clear in the Federal government discourse, and is a commonly used colonial tool of control and division (Watson, 2009).

One clear difference was the extent of involvement of Aboriginal and Torres Strait Islander voices in the three frames. There were none in the Federal Government framing, while the Little Children Are Sacred report and the Alternative Plan had Aboriginal leadership, and were more conducive to health equity. This suggests firstly that the white colonial frames informing Australian policymaking need to be countered through narratives that emphasise historic and ongoing colonisation, and secondly, that Aboriginal and Torres Strait Islander Peoples need structural opportunities to have their voices heard and to lead policy that affects Aboriginal and Torres Strait Islander people. For example, Humpage (2017) has argued that the Māori Party in New Zealand has contributed to improved policy making for Māori people.

These two identified needs align with the 2017 Uluru Statement from the Heart, developed from a National Constitutional Convention of Aboriginal and Torres Strait Islander People. The Statement called for truth telling, enshrining the need for a voice in the Australian constitution, and treaties between governments and First Nations. The need for a structure for Aboriginal and Torres Strait Islander voices to be heard is particularly critical given the media was complicit in the racism in the NTER agenda setting, and the silencing of Aboriginal and Torres Strait Islander dissenting voices (Dunne Breen, 2015; Mesikammen, 2016; Proudfoot & Habibis, 2015). The truth-telling would reduce the opportunity for colonisation to be ignored in policy agenda framing, and a treaty or series of treaties would improve Aboriginal and Torres Strait Islander self-determination and foster more partnership approaches with government. It is clear the same discourses of pathology and white sovereignty continue in contemporary Australian policy, evinced by the high rates of incarceration and child removal (Finizio, 2018), the failure to act on evidence of human rights abuses of Aboriginal and Torres Strait Islander young people in detention (Anthony, 2018), the dismissal by the Federal government of the Uluru Statement from the Heart, and the failure to progress treaties.

This research was part of a broader Centre for Research Excellence on the Social Determinants of Health Equity that focused on the concern that evidence is not enough for healthy and equitable public policy. We found the NTER framing was not aligned with evidence on what works for health equity. Rather, the Federal government used the evidence in the Little Children Are Sacred report to

frame the issue of child sexual abuse as an emergency, and silence dissent (Roffee, 2016). This finding reinforces the need to understand what drives policies to address or be consistent with the evidence for health equity.

International implications

Our findings reinforce international literature that has argued that negative, deficit framings of Indigenous people, and institutional racism, has shaped public policies affecting Indigenous Peoples, including in New Zealand (Came, 2014; Came et al., 2019) and Canada (de Leeuw et al., 2010). Our study provides an empirical example of how such a deficit discourse framed a detrimental Indigenous affairs policy in Australia. Our findings also accord with calls for public policy affecting Indigenous Peoples to be based on Indigenous knowledges rather than colonial knowledges (Brown, 2016; Came et al., 2019; McLeigh, 2010).

This analysis adds to the international literature on agenda setting for the social determinants of health. A recent review of this literature identified the role of framing in shaping agendas away from or towards a social determinants of health approach, including the negative consequences of neoliberal framings, a biomedical disease focus, and 'othering' of Aboriginal and Torres Strait Islander communities (Baker et al., 2018). We add discourses of pathology wielded against Indigenous Peoples (and potentially other populations), and the reproduction of white sovereignty as underlying ideological frames that can shift policymaking away from a health equity approach.

Our framing analysis also revealed conflict between multiple levels of government, in this case a social conservative Liberal-National Federal Government portraying the Labor-led Northern Territory government as incompetent in Aboriginal and Torres Strait Islander affairs as a precursor to the militaristic Intervention. Multi-level governance is missing from the literature on social determinants and agenda-setting (Baker et al., 2018), but appeared to play an important role here. Many colonised nations are federated, with multi-level governance, including Australia, Canada, and the United States, adding complexity to the fight for Indigenous sovereignty and self-determination.

Limitations of the study

This analysis was conducted on available documents from the agenda setting period of the NTER. It does not answer the question of why the two perspectives that supported health equity were sidelined, and why the Federal government agenda proceeded to legislation and implementation almost unchanged. Understanding these power dynamics may aid public health advocates to change dominant framings to support health equity in policy.

Conclusion

Our analysis found that the two framings that did not succeed in influencing the NTER legislation both involved Aboriginal leadership and had the potential to support health equity for Aboriginal and Torres Strait Islander Peoples. The Federal government proceeded instead with an agenda underpinned by racist discourses pathologizing Aboriginal and Torres Strait Islander Peoples and reproducing white sovereignty and white supremacy. We argue that the recommendations in the Uluru Statement from the Heart need to be urgently implemented to improve future policy support for Aboriginal and Torres Strait Islander health equity. A greater understanding of how to challenge dominant policy framings that are not supportive of health equity is required, so that the vast

evidence on health equity can be better translated into public policy that fosters better population health and health equity.

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