Aboriginal Health & Wellness Strategy

2010-2014

October 27, 2010

Interior Health
ABORIGINAL HEALTH

Acknowledgements

This Strategy draws from the contributions of numerous individuals dedicated to Aboriginal health. Participants at our health planning meetings included representatives from First Nations communities, Friendship Centres, urban Aboriginal health and social service organizations, Métis organizations, First Nations Health Council, Health Canada, Provincial Health Services Authority, academic institutions, and Interior Health staff and physicians. We appreciate the rich insight provided by all participants – thank you for generously sharing your time and expertise.

We would like to acknowledge the ongoing contributions of the Aboriginal Health and Wellness Advisory Committee (AHWAC) to health planning for Aboriginal peoples in the Interior Health region. AHWAC remains an important means by which we liaison with Aboriginal community members.

This Strategy distills what we have learned to date, and leads the way for our renewed direction in Aboriginal health.

This document was prepared by Geeta Cheema, Community Integration, Interior Health

Message from the Board Chair

On behalf of the Interior Health Board of Directors, I am pleased to present the Aboriginal Health & Wellness Strategy, 2010-2014. The Board is confident that this strategy provides a sound direction for Interior Health's continuing and evolving work to improve the health outcomes of Aboriginal peoples.

Interior Health is concerned that Aboriginal peoples' health lags behind other residents of our region. We recognize the barriers that Aboriginal peoples face in attaining good health, including challenges in accessing healthcare services. The health authority assumes responsibility for eliminating the barriers that we can control, and mitigating the barriers that we can influence.

The Board of Directors acknowledges the vital partnerships that we have with Aboriginal communities and organizations to ensure Aboriginal peoples' health needs are met. We are committed to local relationships as the foundation of our successful efforts, including Interior Health's role in implementing the Tripartite First Nations Health Plan.

I wish to extend my support to the Community Integration portfolio for its leadership in providing inclusive health services. The Board will be interested in learning about the outcomes of this strategy.

Norman Embree
Chairman of the Board, Interior Health
October 27, 2010

Message from the CEO

Interior Health is currently engaged in a significant restructuring process in order to achieve a vision of "One IH" – that is, an organization where consistently high quality healthcare services are provided across our vast geography in ways that ensure accessibility and responsiveness to patients' needs. This vision is particularly relevant to reducing the health inequities experienced by the Aboriginal population. As outlined in this Aboriginal Health & Wellness Strategy, we will ensure that Aboriginal peoples' health needs are integral to "One IH".

Local Aboriginal peoples have a deep rooted connection to the lands within the Interior Health region. Interior Health acknowledges the history of this area, and the special relationship that Aboriginal peoples have with Government. To counter the often-devastating experiences Aboriginal peoples have had within residential schools and healthcare facilities, and the effects of ongoing marginalization, we are committed to providing inclusive, culturally competent care.

With leadership from the Community Integration portfolio, Interior Health is accountable to our stakeholders for successful implementation of the Aboriginal Health & Wellness Strategy.

Dr. Robert Halpenny
President & Chief Executive Officer, Interior Health
October 27, 2010

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Executive Summary

Interior Health's Aboriginal Health & Wellness Strategy, 2010-2014, presents a strategic framework with the goal to improve the health of the Aboriginal peoples we serve. Our Strategy relies on a good understanding of the health issues faced by the Aboriginal population and the opportunities for improvement. Reflecting our renewed direction in Aboriginal health, this Strategy is consistent with the aims of the Tripartite First Nations Health Plan, and affirms the ongoing need to nurture locally-based relationships with Aboriginal peoples.

Aboriginal people – including First Nations, Métis and Inuit persons– constitute 6.7% of the population in the IH region (BC Stats, 2009), yet experience disproportionate rates of many diseases and injuries compared to other residents. For instance, there are wide disparities in the childhood dental surgery rates, cervical cancer mortality rate, and life expectancy for Status Indians in the IH region (BC Provincial Health Officer, 2009). Interior Health is committed to closing the gap on such health inequities.

The health system's impact on Aboriginal health outcomes can be amplified when the determinants of health are considered. In addition to commonly understood health determinants such as income, education, and access to health services (Public Health Agency of Canada, 2010), Aboriginal health determinants include colonization, cultural continuity, and self-determination (National Aboriginal Health Organization, 2006).

This Strategy supports the principle that healthcare for Aboriginal people is most effectively delivered through inclusion in all service streams across the continuum of care. Inclusion does not preclude the need for specialized approaches in order to meet the needs of Aboriginal clients.

With the aim for inclusion, this document presents 5 key strategies that define our renewed approach to Aboriginal health. They are:

1. Develop a Sustainable Aboriginal Health Program
2. Ensure Aboriginal Peoples' Access to Integrated Services
3. Deliver Culturally Safe Services across the Care & Service Continuum
4. Develop an Information, Monitoring and Evaluation Approach for Aboriginal Health
5. Ensure ongoing Meaningful Aboriginal Participation in Healthcare Planning

The Community Integration portfolio within Interior Health (composed of Promotion & Prevention, Mental Health & Addictions, Primary Healthcare, Community Care, and Aboriginal Health) assumes primary accountability and leadership for implementation of these key strategies. Community Integration will monitor implementation of the Strategy and report on Aboriginal health outcomes.

Having established inclusive services across their Care & Service Continuum, the Community Integration Leadership Team will be able to facilitate inclusion of Aboriginal health across other IH Programs.

Introduction

Interior Health's Aboriginal Health & Wellness Strategy, 2010-2014, presents a strategic framework with the goal to improve the health of the Aboriginal peoples we serve. Resulting from extensive stakeholder consultations, this document distills the key strategies for our renewed direction in Aboriginal health.

The health of Aboriginal peoples merits particular attention. While the Aboriginal population is a relatively small proportion of the entire regional population, we recognize that Aboriginal health is influenced by historical and contemporary determinants of health that have resulted in disproportionate rates of disease and injury. In order to close the gap in Aboriginal health status, we must pay special attention to these health determinants and collaborate with Aboriginal people to identify healthcare solutions that will meet their needs.

This Strategy acknowledges that for Aboriginal health gains to occur, efforts are required across the Care & Service Continuum (see Figure 1). As depicted within the Continuum, Interior Health's services are collectively directed towards "Staying Healthy", "Getting Better," "Living with Illness" and "Coping with End of Life". By providing a client-centered approach to health services, the Care & Service Continuum serves as a roadmap for health services integration.

This Strategy supports the principle that healthcare for Aboriginal people is most effectively delivered through inclusion in all service streams (i.e., Programs) across the Care & Service Continuum. This Strategy relays expectations for inclusive health planning and service delivery that will contribute to Aboriginal health. By ensuring services are accessible and responsive to all residents – and particularly those with the greatest health needs – Programs will direct their efforts to achieving population health gains and reducing health inequities. In the aim for inclusion, Aboriginal health will provide clear impetus for action. Successful approaches learned through experience in Aboriginal health will be applied to parallel initiatives across the health authority.

While this Strategy is based on the premise that Aboriginal health will improve through inclusive, integrated service delivery, this does not preclude the need for specialized approaches suited to the needs of Aboriginal peoples. For instance, the Aboriginal Health and Wellness Advisory Committee provides a vehicle for participation in Aboriginal health planning, and Aboriginal Patient Navigators are vital to ensuring cultural safety for Aboriginal clients. This Strategy affirms that inclusion will be supported through practices appropriate for Aboriginal people.

The Community Integration portfolio within Interior Health assumes primary accountability and leadership for implementation of the key strategies identified in this Strategy. Community Integration provides community-based health services in 5 program areas: Promotion & Prevention; Mental Health & Addictions; Primary Healthcare; Community Care; and, Aboriginal Health. Having established Aboriginal inclusion across their Care & Service Continuum, the Community Integration Leadership Team will be able to facilitate change across other IH Programs.

Interior Health is committed to having an impact on Aboriginal health. Community Integration will monitor and report on the implementation of this Strategy and key Aboriginal health outcomes.

Figure 1. ***Care & Service Continuum, Community Integration (CI)*** (source: IH Prevention Services, modified by the Central Okanagan Community Integration Managers)

Continuum of Care	STAYING HEALTHY			GETTING BETTER / LIVING with ILLNESS	COPING with END OF LIFE
	PRIMORDAL PREVENTION; PROMOTION	PRIMARY PREVENTION	SECONDARY PREVENTION	TERTIARY PREVENTION	
Goal	Preservation & promotion of healthy determinants & reduction of unhealthy determinants.	Prevent Individuals and groups from becoming "at risk." Modify risk factors & contexts.	Lower incidence of established cases of disease.	Eliminate or reduce long-term impairments, disabilities and complications.	Support comfortable and respectful end of life.
Pop'n	Whole Population	Whole Population – Universal & Targeted	At Risk Individuals & Groups	Individuals with established disease	Individuals nearing end of life
CI Programs	**Promotion & Prevention**				
	Mental Health & Addictions				
	Primary Healthcare				
	Community Care				
	Aboriginal Health				

Background & Context for Aboriginal Health

In order to take an inclusive approach to Aboriginal health, we rely on a good understanding of the health issues faced by the Aboriginal population and the opportunities for improvement. This section provides an overview of Aboriginal population health status and health determinants, identifies important developments in Aboriginal health policy, and highlights key aspects of IH's Aboriginal Health Program.

Aboriginal Peoples Served by IH

As embedded in Section 35 of the *Constitution Act* (1982), the term Aboriginal refers to people of First Nations, Métis and Inuit ancestry. Status Indian is a legal term that refers to a First Nations person registered with Indian and Northern Affairs Canada. These and other key terms are defined in Appendix A.

The service area of Interior Health is the traditional territory of many culturally distinct First Nations, and is also home to many Aboriginal people from other parts of the province, country and continent. Diversity among the Interior's Aboriginal peoples is marked by varying cultural practices, languages, residency (i.e., on- or off-reserve) and Status.

The 2006 Census enumerated 196,075 self-identified Aboriginal people in British Columbia (4.8% of the total provincial population); within the Interior Health region, there were 44,900 self-identified Aboriginal people (6.7% of the total regional population) (BC Stats, 2009).

In 2006, there were 27,475 First Nations people residing in the IH region, comprising 61% of the Interior's total Aboriginal population (BC Stats, 2009). 42% of First Nations people in the IH region reside on-reserve, in one of 53 First Nations communities (BC Stats, 2009). See Appendix B for further information about First Nations communities within the IH region.

58% of the First Nations population in our region reside off-reserve (BC Stats, 2009). Friendship Centres provide health and social services to 'urban' Aboriginal people, and there are seven of these organizations within the IH region. Appendix C provides further information about Friendship Centres in the IH region.

According to the 2006 Census, 16,200 Métis people reside in the Interior Health region, which constitutes 36% of the Interior's total Aboriginal population (BC Stats, 2009). There are 13 Métis Chartered Communities within the IH region (Métis Nation BC, 2009). Further information about Métis communities is provided in Appendix D.

An Overview of Aboriginal Health Status in Interior Health

The ability to profile the health status of Aboriginal people is limited. In most cases, provincial health data can only be sourced for the Status Indian population, because non-Status Aboriginal persons are not identifiable within the records. Population health surveys, such as the Métis Nation BC Survey, provide some information to supplement the available provincial data.

The BC Provincial Health Officer's 2007 Annual Report provides the most current analysis of health information for British Columbia Status Indians (BC Provincial Health Officer, 2009). In assessing population health changes that have occurred from 2001 to 2006, the Provincial Health Officer (PHO) states, "some progress has been made in improving both the determinants of Aboriginal health and health outcomes. Nonetheless, significant gaps in health status continue to exist" (p xxxi).

The PHO report provides an analysis of health indicators by regional health authority. For 48 indicators, the report presents the "gap" between Status Indians and Other Residents of the Interior Health region. Indicators where Status Indians fare *better* than or the *same* as Other Residents are:

- **All Cancers**
- **Lung Cancer**
- **Female Breast Cancer**
- **Prostate Cancer**
- **Ischemic Heart Disease**
- **Chronic Lung Disease**
- **Smoking Attributable Mortality**
- **Prescriptions for Cerebral Stimulants**
- **Preventable Admissions to Hospitals**

Status Indians fare *worse* than Other Residents for numerous indicators. Such indicators related to 'Healthy Beginnings' and 'Disease & Injury 'are presented in Table 1. Here, the last column ("ratio") shows the degree of the inequity. Because they are sometimes ambiguous to interpret, 'Health Services' indicators are presented separately in Table 2.

Table 1. ***PHO Indicators for Healthy Beginnings and Disease & Injuries, Status Indian vs. Other Residents, Interior Health (BC Provincial Health Officer, 2009)***

HEALTH INDICATORS	STATUS INDIAN	OTHER RESIDENTS	RATIO: STATUS INDIAN / OTHER RESIDENTS
Indicators for Healthy Beginnings			
Dental Surgery Rate, 0-4 years (per 1000)	47.2	10.8	**4.4**
Dental Surgery Rate, 0-14 years (per 1000)	21.5	6.1	**3.6**
Dental Surgery Rate, 5-9 years (per 1000)	20.6	7.9	**2.6**
Post-Neonatal Mortality Rate (per 1000)	2.9	1.2	**2.3**
Infant Mortality Rate (per 1000)	8.6	4.1	**2.1**
Neonatal Mortality Rate (per 1000)	5.7	2.9	**2.0**
Teen Pregnancy Rate (per 100)	3.7	1.8	**2.0**
Preterm Birth Rate (per 100)	9.4	7.4	**1.3**
Stillbirth Rate (per 1000)	9.0	6.8	**1.3**
Low Birth Weight Rate (per 100)	6.4	5.3	**1.2**
Indicators for Disease & Injuries Age Standardized Mortality Rate; per 10,000			
HIV Disease	0.6	0.1	**5.3**
Cervical Cancer	1.2	0.2	**5.2**
Alcohol Related Deaths	19.0	4.7	**4.1**
Digestive System Diseases	6.4	2.2	**2.9**
Unintentional Injuries	8.8	3.6	**2.4**
Motor Vehicle Accidents	3.6	1.6	**2.3**
Medically Treatable Diseases	0.9	0.4	**2.2**
External Causes	11.2	5.0	**2.2**
Colorectal Cancer	2.4	1.5	**1.6**
Pneumonia and Influenza	3.0	1.9	**1.6**
Respiratory Diseases	7.8	5.3	**1.5**
Accidental Poisoning	1.1	0.7	**1.5**
Cerebrovascular Diseases	5.2	3.7	**1.4**
Drug-Induced Deaths	1.4	1.0	**1.4**
Diabetes	2.4	1.9	**1.3**
Suicide	1.6	1.2	**1.3**
All Causes of Death	74.5	57.6	**1.3**
Endocrine / Nutritional / Metabolic	2.8	2.4	**1.2**
Circulatory System Diseases	18.6	17.5	**1.1**
Life Expectancy	75.2	79.8	**0.9**

Table 2. ***PHO Indicators for Health Services, Status Indian vs. Other Residents, Interior Health (BC Provincial Health Officer, 2009)***

HEALTH INDICATORS	STATUS INDIAN	OTHER RESIDENTS	RATIO: STATUS INDIAN / OTHER RESIDENTS
Indicators for Health Services			
Medical Services Plan Utilization (per 1000)	703.1	844.2	**0.8**
Prescriptions for Antimanic Agents (per 10,000)	12.3	29.5	**0.4**
Prescriptions for Anti-Infectives (per 100)	36.9	34.2	**1.1**
Prescriptions for Antidepressants (per 1000)	79.5	125.3	**0.6**
Prescriptions for Antipsychotics (per 1000)	18.1	23.4	**0.8**
Prescriptions for Antixiolytics (per 100)	7.0	10.8	**0.6**
Hospitalization Rates, Attempted Suicide/Suicide (per 100,000)	93.6	35.7	**2.6**
Hospitalization Rates, Attempted Homicide /Homicide (per 100,000)	137.5	41.0	**3.4**
Community Follow-up for Mental Health Clients (per 100)	67.5	81.5	**0.8**

Tables 1 and 2 demonstrate the magnitude of health inequities experienced by Status Indian people. This is one source of information that can be used to set priorities for the Aboriginal Health Program. It is also necessary to consider the number of people affected by the health issue, the impact on quality of life, the burden on healthcare utilization, and the ability of the healthcare system to intervene.

While not as extensive as the Status Indian data featured above, the 2006 Métis Nation BC Survey provides some perspective on Métis health status in BC based on survey responses from nearly 1500 Métis households. The results infer that the Métis population faces similar health disparities as those profiled for Status Indians. Commenting on the survey results, the Provincial Health Officer (2009) explains, "overall, Métis health indicators appear to be closer to the indicators for the Status Indian population rather than other residents" (p. xxxvi).

The three most commonly reported health concerns of the adult Métis survey respondents were Dental Care, Prescription Assistance, and Traditional Healing, while Métis youth cited Drug Addiction, Teen Pregnancy and Smoking as their most important health issues.

DETERMINANTS OF ABORIGINAL HEALTH

Health status indicators vividly convey the health inequities experienced by the Aboriginal population. In order to effectively address these inequities, it is vital to understand the determinants of Aboriginal health.

Health outcomes are related to a variety of factors and influences. It is estimated that the healthcare system contributes only 25% towards health outcomes (Senate Subcommittee on Population Health, 2009). As identified by the Public Health Agency of Canada (2010), the determinants of health are:

- **Income & Social Status**
- **Social Support Networks**
- **Education & Literacy**
- **Employment / Working Conditions**
- **Social Environments**
- **Physical Environments**
- **Personal Health Practices & Coping Skills**
- **Healthy Child Development**
- **Biology & Genetic Endowment**
- **Health Services**
- **Gender**
- **Culture**

The National Aboriginal Health Organization (2006) affirms the relevance of these determinants of health for Aboriginal people, but adds the following factors:

- **Colonization**
- **Globalization**
- **Migration**
- **Cultural Continuity**
- **Territory**
- **Access (remoteness)**
- **Poverty**
- **Self-Determination**

These health determinants imply that the health system's impact on Aboriginal health outcomes can be amplified when the broader determinants of health are considered.

Developments in Aboriginal Health Policy

The landscape of Aboriginal health policy in British Columbia has been shifting rapidly. The most substantial developments originate from the Transformative Change Accord: First Nations Health Plan (2006) and the subsequent Tripartite First Nations Health Plan (2007). The Tripartite First Nations Health Plan (TFNHP) is a 10-year agreement between the Government of Canada, the Province of British Columbia and the First Nations Leadership Council to close the gaps in health status between First Nations and other British Columbians.

The First Nations Health Council was created in 2007 as a coordinating body mandated to implement the TFNHP, and is composed of representatives of the First Nations political organizations in BC; however, the FNHC does not speak on behalf of First Nations in the region. IH works with a Community Development Liaison designated by the FNHC who facilitates engagement between IH and First Nations communities.

The TFNHP will result in significant changes to the delivery of health services to First Nations communities, and will require the involvement of health authorities in the development of strategies, plans and implementation. The IH Aboriginal Health & Wellness Strategy is consistent with the approaches and aims of the TFNHP.

The IH Aboriginal Health Program will also be connected to the provincial table on Community Integration, currently known as the "Tricouncil" (composed of Primary Healthcare, Community Care, and Mental Health & Addictions). Aboriginal Health will join membership of this group in early 2011, and a Work Plan will be developed provincially to guide Aboriginal Health Program delivery across the regional health authorities.

In addition to these provincial developments, IH's relationship with the Ktunaxa Nation continues to be guided by a Letter of Understanding signed in January 2008. This agreement establishes a collaborative process for planning and provision of health services within the Ktunaxa Nation's traditional territory (in BC).

Highlights of the Aboriginal Health Program in IH

The 2010-2014 Aboriginal Health & Wellness Strategy is the third cycle of dedicated Aboriginal health planning since Interior Health's inception in 2001. Following are a few key highlights of our efforts to work closely with Aboriginal patients, communities and organizations over nearly a decade:

Aboriginal Health Program Team. Led by a Program Director, this Program team is dedicated to closing the health status gap experienced by the Aboriginal population.

Aboriginal Health & Wellness Advisory Committee (AHWAC). AHWAC is a health planning advisory body that is composed of representatives from First Nations communities, Friendship Centres, and the Métis Nation BC, plus members of IH's Board of Directors and Aboriginal Health Program.

Aboriginal Patient Navigators (APNs). IH's seven Aboriginal Patient Navigators are located throughout the region, and act as a resource to patients and healthcare providers to ensure culturally competent care. APNs assist healthcare providers with needs assessment and discharge planning, and connect Aboriginal patients with community services.

Strategic Framework for Aboriginal Health

This Strategic Framework presents five key strategies. Together, these provide clear direction for Interior Health to close the health status gap experienced by the Aboriginal population.

1 Develop a Sustainable Aboriginal Health Program

Through Practice Leads, the Aboriginal Health Program will provide consultation to ensure that all Community Integration Program strategies are inclusive of Aboriginal Health. The Aboriginal Health Program will be sustained through stabilized funding and a positive working environment for staff.

2 Ensure Aboriginal Peoples' Access to Integrated Services

Access to health services requires a connection between patient and provider. The patient-provider connection will be facilitated through communication, community engagement, transportation, outreach and telehealth. Aboriginal Patient Navigators play a special role in connecting patients and providers. Accessibility also presumes the delivery of culturally competent care.

3 Deliver Culturally Safe Services across the Care & Service Continuum

Services are culturally safe when Aboriginal people experience culturally competent service delivery within welcoming environments. Cultural safety also considers continuity of care when Aboriginal people return to their home communities. Mechanisms to promote cultural safety will include Indigenous cultural competency training, culturally competent clinical practice (e.g., discharge planning), spaces for cultural/spiritual practice, and the services of Aboriginal Patient Navigators.

4 Develop an Information, Monitoring and Evaluation Approach for Aboriginal Health

Information on the health needs of Aboriginal people supports good service delivery, and monitoring and evaluation allows us to determine our effectiveness. Our approach will include monitoring key performance indicators through the Community Integration Dashboard, implementing the Aboriginal Self-identification Project, sharing information with Aboriginal communities, and evaluating selected initiatives.

5 Ensure ongoing Meaningful Aboriginal Participation in Healthcare Planning

Participation of Aboriginal people improves health planning. We will work with the Aboriginal Health & Wellness Advisory Committee and through the Letter of Understanding with the Ktunaxa Nation to provide meaningful opportunities for Aboriginal participation. Liaison with the First Nations Health Council will enhance our role in the implementation of the Tripartite First Nations Health Plan.

Implementation

The Community Integration portfolio within Interior Health assumes primary accountability and leadership for implementation of the key strategies identified in this Plan; this will occur under the guidance of the Community Integration Leadership Team.

Once inclusive services are established across the Community Integration Care & Service Continuum, the Community Integration Leadership Team will identify mechanisms to facilitate inclusion of Aboriginal health in other IH Programs.

Accountability related to this Plan will be demonstrated through two primary channels:

(1) Semi-annual dissemination of a newsletter highlighting accomplishments in Aboriginal Health, for internal and external stakeholders, and;

(2) Quarterly reporting of performance indicators identified within the Community Integration Dashboard, to Senior Executive and to the Aboriginal Health & Wellness Advisory Committee.

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APPENDIX A: Key Terms

Aboriginal People: Includes all indigenous people of Canada. The Canadian Constitution recognizes three groups of Aboriginal people, Status and Non-Status First Nations, Métis, and Inuit, each having their own unique heritages, languages, cultural practices and spiritual beliefs.

Band: Many First Nations communities have legally changed their name from "Indian Band" to "First Nation". A First Nation or "band" is usually made up of one or more land bases, more commonly known as reserves. Generally, First Nations identify themselves as communities and not bands.

Chartered Métis Communities: Communities of Métis citizens as registered through the Métis Citizen registry.

First Nation: A term that came into common usage in the 1970s to replace the word "Indian." Although the term First Nation is widely used, no legal definition of it exists. The term First Nation generally refers to the Indian people of Canada, both Status and Non-Status.

First Nations Community: For the purpose of this Aboriginal Health Plan, this is defined as Status First Nations people residing on-reserve. This definition facilitates the use of available statistics.

Inuit: The Inuit are people of Aboriginal descent in northern Canada who generally reside in the Northwest Territories, northern Quebec and Labrador with a small percentage living throughout the rest of Canada. The Inuit are officially recognized as Aboriginal people in the Constitution.

Non-Status First Nation: A person of Aboriginal ancestry who is not registered under the *Indian Act* but traces their ancestry back to a First Nation, Métis or Inuit person.

Reserve: "A tract of land, the legal title to which is vested in Her Majesty, that has been set apart by Her Majesty for the use and benefit of a band." *Indian Act*, 1876.

Status First Nation or Registered First Nation: Status First Nation or Registered First Nations persons are defined as" Indian" under the *Indian Act* and are usually members of a First Nation or Band. Prior to the mid-1960s, most Status First Nations lived on-reserve; however, recently a steady migration to urban centres has seen almost 50 per cent choosing to live off-reserve.

Métis: "Métis" means a person who self-identifies as Métis, is distinct from other Aboriginal peoples, is of Historic Métis Nation ancestry, and is accepted by the Métis Nation. The Métis have been recognized as Aboriginal people under the Canadian Constitution.

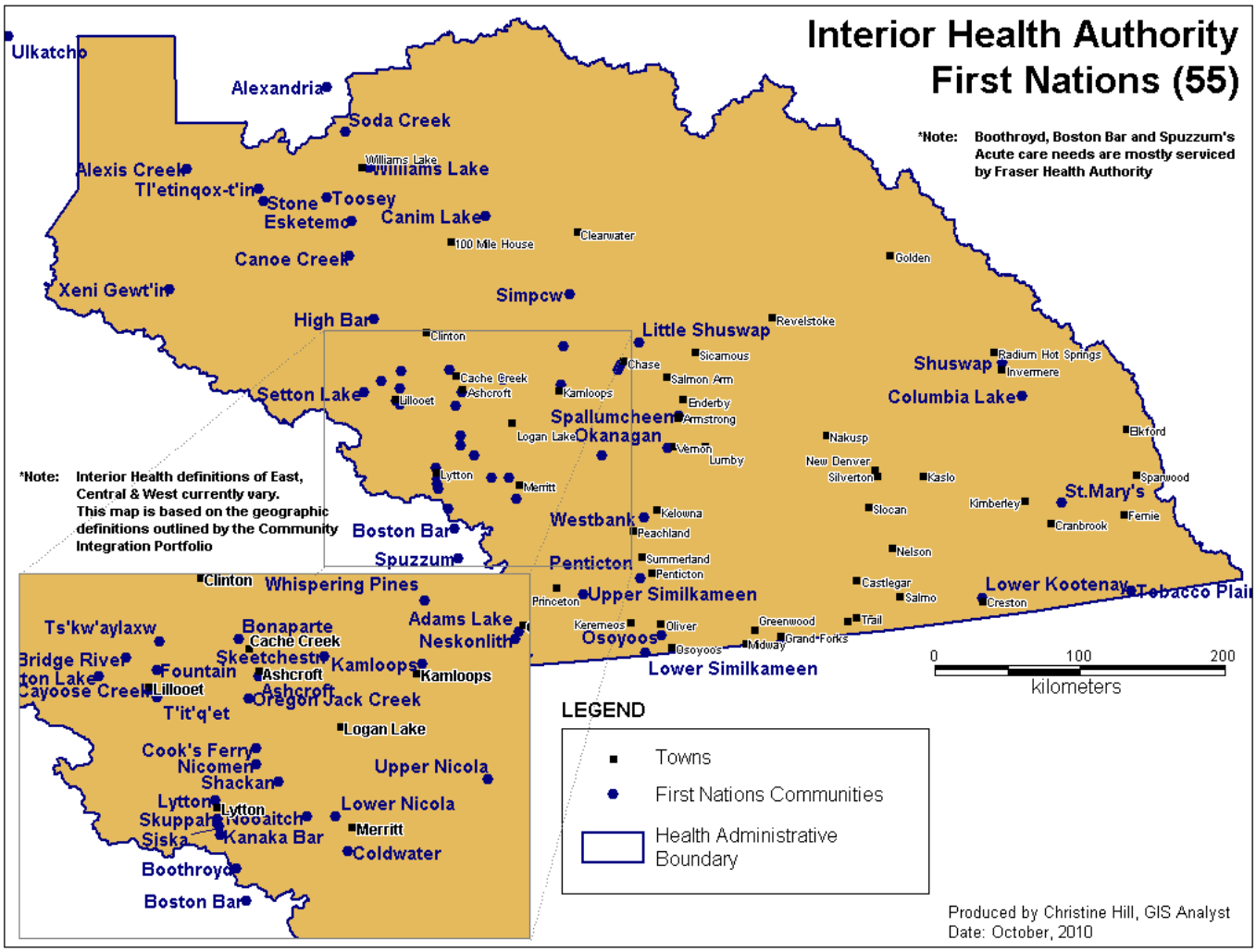
Defined Terms in National Definition of Métis:

i. "Historic Métis Nation" means the Aboriginal people then known as Métis or Half-breeds who resided in the Historic Métis Nation Homeland
ii. "Historic Métis Nation Homeland" means the area of land in west central North America used and occupied as the traditional territory of the Métis or Half-breeds as they were then known.
iii. "Métis Nation" means the Aboriginal people descended from the Historic Métis Nation which is now comprised of all Métis Nation citizens and is one of the "aboriginal peoples of Canada" within the meaning of s.35 of the *Constitution Act* 1982.
iv. "Distinct from other Aboriginal peoples" means distinct for cultural and nationhood purposes.
v. Métis identity and citizenship is established in the Métis Nation British Columbia (MNBC) in partnership with Indian and Northern Affairs Canada. Métis identity is verified through Métis ancestry. Genealogy review with supporting documentation, determines citizenship.

Urban Aboriginal People: The term "urban Aboriginal peoples" refers to Inuit, Métis and First Nations Peoples currently residing off-reserve. This may be in rural or urban areas.

APPENDIX B: First Nations Communities

First Nations Communities within the IH Region (Source: IH Information Support, 2010).



First Nations Communities Located within the IH Region

684 Adams Lake Band
709 Alexandria Indian Band
710 Alexis Creek/Tsi Del Del
685 Ashcroft Indian Band
686 Bonaparte Indian Band
700 Boothroyd Indian Band
701 Boston Bar First Nation
590 Bridge River Indian Band
713 Canim Lake Indian Band
723 Canoe Creek Indian Band
591 Cayoose Creek Band
464 Coldwater Indian Band
604 Columbia Lake Indian Band
694 Cooks Ferry Indian Bands
711 Estetemc (Alkali) First Nation
702 High Bar First Nation
688 Kamloops Indian Band
704 Kanaka Bar Indian Band
689 Little Shuswap Indian Band
606 Lower Kootenay Indian Band
695 Lower Nicola Indian Band
598 Lower Similkameen Indian Band
705 Lytton First Nation
690 Neskonlith Indian Band
696 Nicomen Indian Band
699 Nooaitch Indian Band
616 Okanagan Indian Band
692 Oregon Jack Creek Band
596 Osoyoos Indian Band
597 Penticton Indian Band
595 Seton Lake Indian Band
698 Shackan Indian Band
706 Siska Indian Band
691 Simpc
687 Skeetchestn Indian Band
707 Skuppah Indian Band
716 Soda Creek Indian Band
605 Shuswap Indian Band
600 Spallumcheen Indian Band
708 Spuzzum
602 St. Mary's Indian Band
717 Stone Indian Band (Yunesti'in)
593 T'it'q'et Administration
712 Tl'etinqox-t'in Government Office
603 Tobacco Plains
718 Toosey
594 Ts'kw'aylaxw First Nation
722 Ulkatcho First Nations
697 Upper Nicola Band
599 Upper Similkameen Indian Band
601 Westbank First Nation
702 Whispering Pines
719 Williams Lake Band
592 Xaxli'p First Nation
714 Xeni Gwet-in First Nations Government

APPENDIX C: Friendship Centres

Friendship Centres provide off-reserve services to Aboriginal peoples; these services may or may not include healthcare. Friendship Centres also act as a significant political voice for off-reserve/urban Aboriginal peoples.

There are seven Friendship Centres located in the IH region:

Kamloops	Interior Indian Friendship Centre
Kelowna	Ki-Low-Na Friendship Centre
Lillooet	Lillooet Friendship Centre
Merritt	Conyat Friendship Centre
Penticton	Ookanakane Friendship Centre
Vernon	First Nations Friendship Centre
Williams Lake	Cariboo Friendship Centre

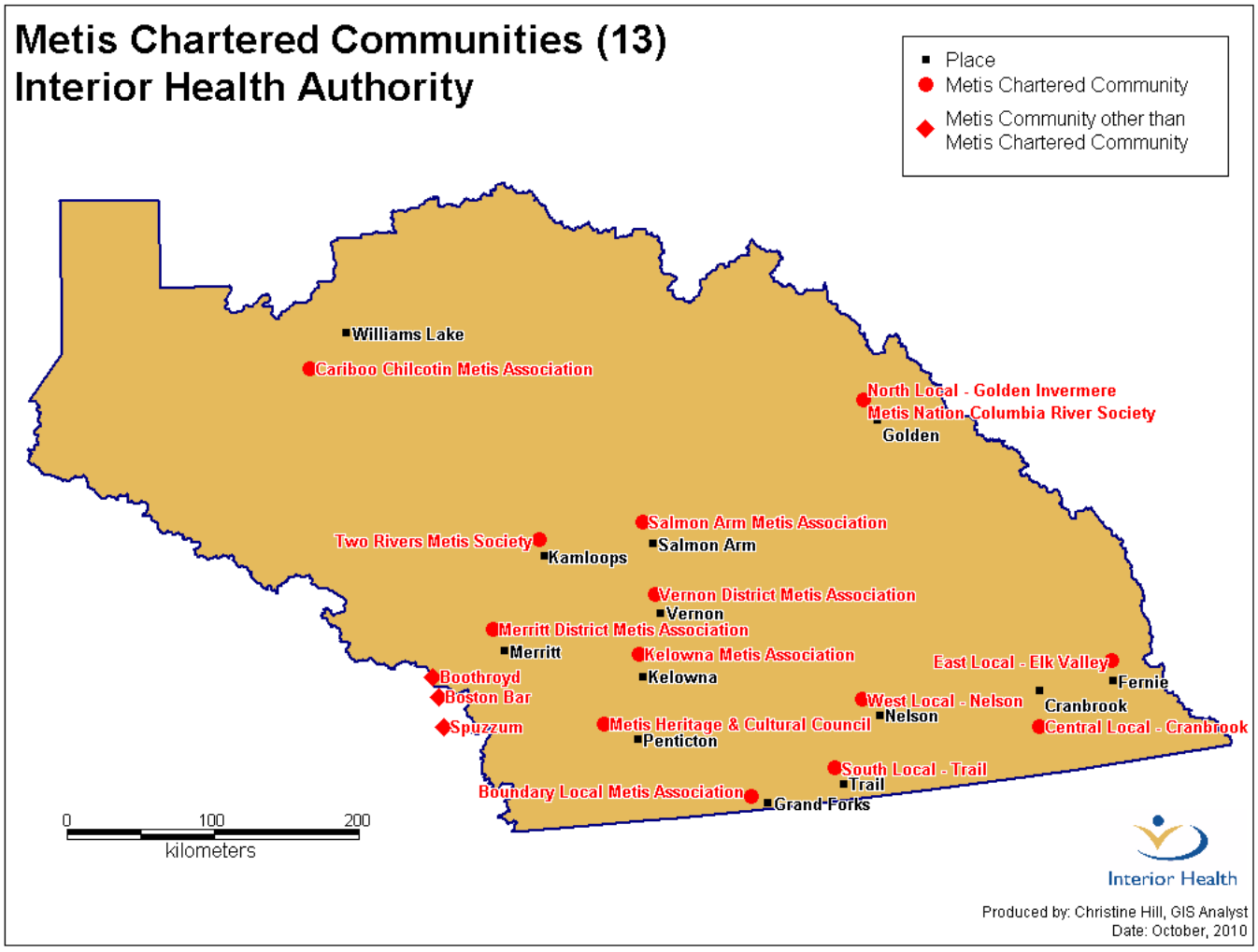
Besides Friendship Centres, Aboriginal people may access numerous other community organizations for off-reserve health and social services.

APPENDIX D: Métis Communities

The Métis Nation is governed by the Métis Provincial Council of BC, and is divided into seven Provincial governing regions. Region 3 (Thompson/Okanagan), Region 4 (Kootenays) and Region 5 (North Central) are completely or partially within the IH service area.

The IH region includes 13 Métis Chartered Communities, plus 3 non-Chartered communities.

Metis Communities, Chartered and non-Chartered, within the IH Region (Source: IH Information Support, 2010).



Charted and non-Chartered Métis Communities Located within the IH Region

- Boothroyd
- Boston Bar
- Cariboo Chilcotin Métis Association
- Central Local - Cranbrook
- East Local - Elk Valley
- Kelowna Métis Association
- Merritt District Métis Association
- Métis Heritage & Cultural Council
- Métis Nation Columbia River Society
- North Local – Golden Invermere
- Salmon Arm Métis Association
- South Local - Trail
- Spuzzum
- Two Rivers Métis Society
- Vernon District Métis Association
- West Local - Nelson