I am pleased to present Fraser Health’s 2007-2010 Aboriginal Health Plan.

This strategic plan is the result of the past year’s collaborative working partnerships involving Fraser Health leaders and the representatives of our Aboriginal communities. It honours the wisdom shared through our Aboriginal consultations to date.

More than a year ago, Fraser Health’s Aboriginal Health Steering Committee recommended that Fraser Health form an Aboriginal Technical Advisory Group and a Mental Health and Addictions Technical Advisory Group with the purpose of creating this Aboriginal Health Plan. Representatives of the Steering Committee and both Technical Advisory Groups are to be commended for their exceptional leadership in the development of this plan. Their collective contributions will result in important health initiatives that will benefit Aboriginal people.

Additionally, Fraser Health acknowledges the work of the Aboriginal Graphic Design Working Group, consisting of members from the Aboriginal communities, who created the Aboriginal identifier displayed on the cover of this plan. This Working Group’s vision was to design a visual identity that conveys a culturally-inclusive and caring organization. The symbolism within the identifier includes an Aboriginal hummingbird which symbolizes health, the Métis Nation’s Infinity Flag, and the Inuit people’s inukshuk. This imagery is shown within the imagery of a medicine wheel and drum. The medicine wheel symbolizes balance, representing the four elements of life, including mental, emotional, physical and spiritual health. The drum symbolizes the heart beat of the Aboriginal nation.

Fraser Health’s Aboriginal Health Plan is closely aligned with the 2005 Transformative Change Accord and B.C.’s recently-released First Nations Health Plan. Fraser Health plans to establish an Aboriginal Health Advisory Committee which will play an instrumental role in implementing the 2007-2010 Aboriginal Health Plan. All participants are to be commended for their vision and commitment towards the creation of this plan.

Sincerely,

Betty Ann Busse
Executive Vice President
Health Promotion and Community Programs

1 The Term “Aboriginal” includes First Nations Governments with a land base, Métis Nation Communities, Urban Aboriginal People (Status and Non-Status), and Inuit.
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EXECUTIVE SUMMARY

This document sets out an updated Fraser Health Plan directed at improving the health of Aboriginal peoples living in Fraser Health communities and reserves. The Aboriginal Health Plan is an important initiative which is consistent with a series of high-level political decisions, all targeting improved health and well-being for British Columbia’s Aboriginal people.

Reviewing the current environment during the planning process provided a profile of Fraser Health’s approximately 46,000 Aboriginal residents and their health status:

- In general, Aboriginal demographics are significantly different from the provincial population as a whole, in that they are younger and have larger families.
- Lack of education in early years translates to lower incomes and higher rates of unemployment than for non-Aboriginal residents of Fraser Health.
- Centuries of disadvantage show up in significantly poorer mental and physical health, and ultimately earlier death. For example, in the north region of Fraser Health (formerly Simon Fraser), Status First Nation residents will die an average of 16.5 years before other residents.
- Poverty, smoking, alcohol and drug abuse, high rates of accidental deaths, increasing rates of HIV/AIDS and poor management of chronic conditions all work against the health and well-being of Aboriginal people.

Driving the increasingly determined effort to resolve both economic and health issues for Aboriginal people were a number of political policy decisions. In common with them all was a commitment to partnership, action and results. British Columbia will use two benchmarks to measure progress: improved infant mortality and life expectancy rates. All Health Authorities are moving forward on these issues.

Two major issues challenge progress in Fraser Health:

- Barriers to accessing health services include distance from available services, gaps in culture and knowledge, high incidences of substance abuse, and funding shortfalls for new or expanded programs/services.
- The currently complex maze of funding arrangements for Aboriginal health care—significantly different from funding for the general health system—impedes provision of care in an efficient and effective way.

Driven by carefully-articulated values and guiding principles, the planning team recommends three strategic priorities for the coming years as a means to driving to a vision of “Healthy Self, Healthy Families, Healthy Communities and Healthy Nation”.


1. Improving health outcomes for Aboriginal people

Specific actions to achieve this priority include:

- Enhance the collaboration with Aboriginal communities in planning and implementation of health promotion and prevention activities. This initiative will focus on healthy lifestyle choices, chronic diseases, HIV/AIDS, and injury prevention.
- Improve the Mental Health and Addictions continuum of care for Aboriginal individuals and families.

2. Improving access to culturally-appropriate services

Specific actions to achieve this priority include:

- Increase access to primary care services.
- Increase Fraser Health employee knowledge and understanding of Aboriginal terminology, theories and practice.
- Increase the number of Aboriginal health care providers hired by Fraser Health.

3. Strengthening relationships and community capacity-building

Specific actions to achieve this priority include:

- Increase partnerships and linkages with Aboriginal communities.
- Increase dissemination of knowledge, information and evaluation between Fraser Health and Aboriginal communities.
INTRODUCTION

Canada’s Aboriginal\(^2\) people, in partnership with the Federal and Provincial governments, are taking a more proactive and involved approach to resolving the health status inequities facing their communities and improving the health status of Aboriginal peoples.

A variety of specific initiatives, such as the National, Provincial and Aboriginal Health Blueprints and the 2005 Transformative Change Accord, have formalized the National determination to improve the health of Aboriginal communities.

Fraser Health has, in recent years, greatly increased its focus on building and nurturing relationships with Aboriginal residents in its regions, encompassing Status and Non-Status First Nations, Métis and Inuit. This is an essential step in the process which will ultimately produce measurable improvements in the health status of local Aboriginal people. At the same time, Fraser Health has dedicated a larger proportion of its resources to programs and services targeting the health of local Aboriginal communities.

This strategic plan marks one point in an ongoing formal planning process. As with all effective plans, it is a work in progress. New relationships, greater understanding and regularly evaluating progress will in turn refine and expand the initiatives outlined here.

This plan has demonstrated what can be achieved when everyone is committed to the development of an inclusive process. The Technical Advisory Group leading this process\(^3\) has had representation from many Aboriginal groups: it is thanks to their efforts that priority next steps can be identified and acted upon. These individuals served as essential links to their communities, to facilitate a two-way flow of information and feedback. Their role was essential in developing these priorities, but the relationships established during this process must continue if we are to achieve success.

\(^2\) See Appendix A for clarification of cultural terms used in this strategic plan.

\(^3\) See Appendix B for a complete list of those involved in creating this strategic plan.
FRASER HEALTH ABORIGINAL COMMUNITIES: A GENERAL PROFILE

Building a profile of Aboriginal communities in Fraser Health draws on a large variety of statistics from many sources. In some instances, data refers to all Aboriginal people, while other data has been collected exclusively about First Nations Status individuals.

The current estimate of Aboriginal (First Nation, Inuit and Métis) residents of Fraser Health puts the number at 46,025, of which approximately 17,000 are Métis. Table 1 summarizes the distribution of this population by region.

Table 1: Distribution of Fraser Health Aboriginal Population by Region (2001)

<table>
<thead>
<tr>
<th>REGION</th>
<th>ABORIGINAL POPULATION OF REGION</th>
<th>% OF ABORIGINAL POPULATION IN FRASER HEALTH</th>
<th>NON-ABORIGINAL POPULATION OF REGION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simon Fraser</td>
<td>10,315</td>
<td>22.4</td>
<td>312,414</td>
</tr>
<tr>
<td>Burnaby</td>
<td>4,020</td>
<td>8.7</td>
<td>188,246</td>
</tr>
<tr>
<td>South Fraser</td>
<td>17,305</td>
<td>37.6</td>
<td>588,708</td>
</tr>
<tr>
<td>Fraser Valley</td>
<td>14,385</td>
<td>31.3</td>
<td>222,310</td>
</tr>
<tr>
<td>TOTAL</td>
<td>46,025</td>
<td>100</td>
<td>1,311,675</td>
</tr>
</tbody>
</table>

Although Fraser Health was previously divided into three regions (North Fraser, South Fraser and Fraser Valley) most statistics used in this plan refer to four regions:

- Simon Fraser: Coquitlam, Maple Ridge, New Westminster, Pitt Meadows, Port Coquitlam, Port Moody
- South Fraser Valley: Delta, Langley, Surrey, Tsawwassen, White Rock
- Fraser Valley: Abbotsford, Agassiz, Boston Bar, Chilliwack, Hope, Mission
- Burnaby

Some sources of data may include Burnaby as part of the Simon Fraser Region.

It is important to note that the actual Aboriginal population is reputed to be higher than reported here. There are a variety of reasons for this, including changes in Federal legislation, inconsistent answers to the ancestry question in census questionnaires, and incomplete enumeration of some reserves.

In addition to the absolute number of Aboriginal residents of Fraser Health, one must also consider their First Nations affiliation, whether they live on- or off-reserve, and their distance

---

4 Source: Statistics Canada, 2001 Census.
from existing major health services. The enumerated population of these First Nations communities is 7,456 and approximately 45% of these live on-reserve.

Three main First Nations tribal groupings are part of Fraser Health. Coast Salish lands extend from Burnaby to Spuzzum and South to the U.S. border; St’át’imc is located near Lillooet in the Interior, and Nlaka’pamux is in the Thompson Fraser Canyon, extending from Hope to Boston Bar.

Within the tribal groupings, there are 35 First Nations communities with 456 separate Reserves. All but three are served by Fraser Health.

Other tribal groupings are important to health planning in Fraser Health, specifically non-Status First Nations, Métis, Inuit and First Nations people from other regions who are physically located within Fraser Health. No useful census or health status data is available for these groups. It is clearly understood that if data were available, similar health concerns and issues would emerge.

This Aboriginal Health Plan addresses the needs of the total Aboriginal population (First Nation, Inuit and Métis) in Fraser Health, living both on- and off-reserve.

The map below gives a clear picture of the scattered and often remote locations of some First Nations Reserves.

**Figure 1: First Nations Bands in Fraser Health**

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6 Three Bands physically located in Fraser Health—Samahquam, Skatin and Douglas—are served by Vancouver Coastal Health Authority because washed out bridges result in their only access being through Pemberton.

7 [http://www.gov.bc.ca/arr/img/maps/map_2.htm](http://www.gov.bc.ca/arr/img/maps/map_2.htm)
DEMOGRAPHICS OF FRASER HEALTH ABORIGINAL POPULATION

Before considering the health status of the Fraser Health Aboriginal population, it’s important to consider some more general statistics. In many instances, these point to issues relating to the determinants of health, as well as factors relevant to health service planning.

Age

The Status First Nations population in both the province as a whole and Fraser Health is younger compared to all other B.C. and Fraser Health residents. Points of note include:

The largest population group is 1 to 14 years, in which males slightly outnumber females.

Among adults, the largest population group is made up of people between the ages of 30 and 44. Females outnumber males in the 30 to 44 age bracket.

- Seniors, age 65 year or older, were estimated as the smallest group among Status First Nations. At this time, there are more senior Status First Nations age 75 and over than those who are between ages 65 to 74.

Education

Basic literacy and higher education are key determinants of health and well-being. Education affects employment opportunities and is directly correlated with income. Higher education leads to higher-paying jobs, more job options and greater employment. Some facts illustrate circumstances facing Aboriginal people in Fraser Health:

- Individuals living on-reserve have lower levels of education than the provincial average.
- In Fraser Health, less than one-half who enrol in Grade 8 go on to graduate with a high school diploma within six years.
- In the New Westminster and Burnaby school districts, only 25% of Aboriginal children achieve a high school diploma; 14% of the Aboriginal population aged 15 years and over have some university education.
- Communities in the eastern part of Fraser Health generally have a higher proportion of residents with less than Grade 9 education while having a lower proportion of residents with university education than their counterparts in the northern and southern communities of Fraser Health.

---

8 A Profile of Aboriginal People in Fraser Health, November 2002.
Income and (un)Employment

Aboriginal people with paid employment earn less than the Provincial average; this may be due in part to the part-time or part-year work among Aboriginal people.

Not surprisingly, with lower levels of education among Aboriginal people in the eastern part of Fraser Health, a parallel pattern emerged during the 1996 census relating to unemployment. At that time, the communities in the eastern region of Fraser Health had higher unemployment rates for both the Aboriginal people and the total non-Aboriginal population of Fraser East (19% and 9%, respectively). For example, nearly a quarter of the Aboriginal residents in Hope, Chilliwack and Agassiz/Harrison communities were unemployed.

The higher unemployment rates are reflected in the lower average incomes for the Aboriginal population.

- An Aboriginal male 15 and over earned on average $25,680 annually while a male in the general population earned $32,581.
- Aboriginal females, on average, earn less than their male counterparts.
- Only 6% of the total B.C. Aboriginal population earns more than $40,000.9

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9 “Honouring our Health”, op. cit.
ABORIGINAL HEALTH – STARTING FROM BEHIND

The many factual and anecdotal reports of Aboriginal health show few instances where health status is the same or better than the health of the general population. This situation is rooted in history. Colonialism, racism, disease, the residential school system, loss of cultural and political institutions, as well as loss of traditional lifestyles all served to create powerlessness, dependency and ill health. It is only in relatively recent years that the need to resolve these situations has turned the corner to meaningful action with the potential for positive results.

ABORIGINAL HEALTH – THE NUMBERS

The inequity of health status faced by Fraser Health’s Aboriginal population is enumerated in Appendix C\(^1\).

These points highlight major issues embedded in the statistics:

- A Status First Nation person in B.C. is expected to live 7.5 fewer years than a non-Aboriginal B.C. resident born in the same period. This gap varies widely in Fraser Health:
  - In Simon Fraser, Status First Nations people will live to 63, an average of nine years fewer than the provincial Status First Nations average, the lowest life expectancy among all Status First Nations in B.C.
  - Status First Nations in Simon Fraser have an average life expectancy of 16.5 years less than the general provincial population.
  - In Fraser Valley, life expectancy for Status First Nations exceeds the provincial Status First Nations average by one year.
- Fraser Health’s Status First Nations birth rate for 1996-2000 was 28 per 1,000, compared to 12 per 1,000 for all other residents. South Fraser had the highest rate of live births both in Fraser Health and the Province.
- The Status First Nations premature birth rate (1996-2000), compared with all other residents, was higher both regionally and provincially.
- Three of the Fraser Health regions—Simon Fraser, South Fraser and Fraser Valley—rated in the top five regions in the province for teen pregnancy for Status First Nations.

\(^{1}\) The health statistics used in this plan identify the regions of Fraser Health as: Burnaby, South Fraser Valley, Fraser Valley, and Simon Fraser.
Only the Fraser Valley had a better average than the B.C. First Nations population for infant mortality. Infant mortality rates generally are trending lower, and this trend has been more pronounced in the Status First Nations population.

Statistics related to smoking tell their own story:

- Smoking is a major contributor to three of the five leading causes of death for Status First Nations.
- Smoking is a direct contributor to low birth weight and SIDS.
- B.C. Aboriginal people, both adults and youth, are twice as likely to smoke as the general population.
- Simon Fraser, Burnaby and South Fraser ranked in the top four regions for smoking-attributable deaths for all Status First Nations in B.C.

Alcohol-related deaths are increasing and are also more than six times the rate for the general population. Simon Fraser had the highest rate in this category.

While HIV/AIDS death rates in the general population are declining, the trend is going in the opposite direction for Status First Nations, thus increasing the health status gap.

Injury deaths are a significant factor in the potential years of life-lost statistics, and account for one quarter of Status First Nations deaths.

Status First Nations patients are three times more likely than the general population to be admitted for manageable chronic conditions such as diabetes, asthma, hypertension, neurosis, depression and alcohol and drug abuse.

One negative trend is the increasing numbers of Aboriginal children taken into care. For example, as of March 2002, Aboriginal children made up 30% of the total children in care in Fraser Health.

PROGRESS - YES AND NO

In spite of the discouraging picture portrayed by the health statistics, the B.C. First Nations Regional Health Survey (1997)\(^\text{11}\) respondents (First Nations people living on-reserve) reported noticeable progress in five areas:

- Cultural awareness in schools
- Use of elders
- Educational opportunities
- Traditional ceremonies

Water and sewage facilities.

While these could all be categorized as among important determinants of health, they did not translate into many positive outcomes. The same report identified the top five trends showing the least progress, three of which were directly related to health:

- Fighting alcohol and drug abuse
- Little increase in the number of First Nations health professionals
- Lack of training in health field.
EXTERNAL INITIATIVES: DRIVERS FOR ACTION AND CHANGE

The early years of the 21st century have seen major initiatives by key political stakeholders, all determined to resolve the challenges facing Canada’s Aboriginal population.

Most notable among formal policy developments are:

THE FEDERAL ABORIGINAL HEALTH BLUEPRINT

This federal commitment, articulated at a Health Care Summit in 2004, spells out the intention to ensure Aboriginal people receive the same health care as the general population. Each Provincial and Territorial government in turn worked with their Aboriginal citizens to develop a parallel regional initiative. An important priority identified in this process was to reduce the inequity of health outcomes experienced by Aboriginal people.

THE B.C. ABORIGINAL HEALTH BLUEPRINT

The 2005 draft document, British Columbia’s Input into the Aboriginal Health Blueprint – Making Medicine, identified and built on health initiatives for Aboriginal people and contained actions for:

- Delivery and Access
- Sharing in Improvements to Canadian Health Care
- Promoting Health and Well-Being
- Monitoring Progress and Learning as We Go
- Clarifying Roles and Responsibilities between Governments and Organizations
- Developing Ongoing Collaborative Working Relationships.

THE B.C. FIRST NATIONS BLUEPRINT

The First Nations Leadership Council\(^ {12} \) of British Columbia developed its response to the Provincial document\(^ {13} \), First Nations Health Blueprint for British Columbia. The First Nations document expanded on the six theme areas in the Provincial document and outlined actions for a distinct yet interdependent health system for Aboriginal people in B.C.

THE NEW RELATIONSHIP

This March 2005 government-to-government framework resulted from collaboration between the Provincial Government and the B.C. First Nations Leadership Council. The New Relationship framework commits the B.C. government to involve First Nations leaders in public

\(^ {12} \) The B.C. First Nations Leadership Council is comprised of leaders from the First Nations Summit, the Union of B.C. Indian Chiefs, and the B.C. Assembly of First Nations.

policy work that affects the lives of Aboriginal people, while committing First Nations to work transparently with government as partners. The preliminary work of the New Relationship led to the development of the Transformative Change Accord and the New Relationship Trust Act\(^{14}\).

**TRANSFORMATIVE CHANGE ACCORD**

In late 2005, First Ministers and Aboriginal Leaders met to discuss how First Nations can be full partners in the success and opportunities of the province. This effort resulted in the Transformative Change Accord which identified priority goals in education, health, housing and economic opportunities. Establishing a new relationship based upon mutual respect and recognition was a key priority.

**INDIAN RESIDENTIAL SCHOOLS SETTLEMENT AGREEMENT**

Between 1861 and 1984, Indian Residential Schools operated in British Columbia. A 1922 amendment to the *Indian Act* made residential schooling mandatory and parents were fined or jailed if they did not relinquish their children. Extensive abuse at the schools brought about loss of health, language and culture, and became a pattern for subsequent generations. This is one the most significant factors leading to ill health in Aboriginal people.

In 2006, the Indian Residential Schools Settlement Agreement established restitution to former students of the residential school system.

**B.C.’S PRIORITIES**

Close collaboration between most B.C. and Federal ministries, Aboriginal organizations and Health Regions (to mention just some of the key players) has resulted in B.C.’s Ministry of Health articulating a priority strategy to improve the health status of Aboriginal peoples. Two important benchmark measures will be used to evaluate progress:

- Improved Status First Nations infant mortality rates
- Improved Status First Nations life expectancy rates.

While these involve specific targets, the Provincial Government has a long-term goal of achieving a comparable health status for Aboriginal and non-Aboriginal people in B.C.

At a program level, existing and new initiatives continue to focus on major threats to Aboriginal health, namely:

- Tobacco
- Alcohol and drugs

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\(^{14}\) The New Relationship Trust Act (Bill 11) was enacted in March 2006. It established a $100-million fund to help First Nations build institutional and community capacity.
HEALTH PROMOTION AND PREVENTION SERVICES
ABORIGINAL HEALTH PLAN 2007 – 2010

- Fetal Alcohol Syndrome
- SIDS
- Teen suicide
- Injuries
- Mental health
- HIV/AIDS
- Diabetes.

One significant benefit of more focused initiatives will be the creation of current and meaningful health statistics and trends for the Fraser Health Aboriginal population.

A COMBINED EFFORT: ABORIGINAL HEALTH IN OTHER B.C. HEALTH AUTHORITIES

Fraser Health and the Aboriginal residents of this area are working collaboratively. The collective energy of a vast array of federal and provincial organizations is increasingly directed to improving health status for all Aboriginal people, regardless of status and residence.

Within B.C., all Health Authorities are moving ahead with concrete efforts in the area of Aboriginal health. Health promotion and increasing the culturally-appropriate component of services are high priorities for all other Health Authorities, as well as Fraser Health. Table 2 captures the priorities of other Health Authorities.

Table 2: Provincial Health Authorities and their Aboriginal Health Priorities

<table>
<thead>
<tr>
<th>HEALTH AUTHORITY</th>
<th>NEAR-TERM PRIORITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial Health Services</td>
<td>HIV/AIDS, Maternal health, Aboriginal patient liaison, Aboriginal mental health</td>
</tr>
<tr>
<td>Vancouver Coastal Health Authority</td>
<td>Infant mortality, Improving life expectancy, Improving relationships and partnerships, Increased service access, Improved evaluation</td>
</tr>
<tr>
<td>Interior Health Authority</td>
<td>Identifying health issues, Establishing focused priorities, Recruiting Aboriginal staff, Maximizing mental health results</td>
</tr>
<tr>
<td>Vancouver Island Authority</td>
<td>Increasing collaboration, Creating a customized definition of Aboriginal health, Improve access, Build community capacity</td>
</tr>
<tr>
<td>Northern Health Authority</td>
<td>Increase knowledge leading to more informed governance and decision-making, Improving partnerships for prevention programs, Increasing working relationships, Community-specific action plans</td>
</tr>
</tbody>
</table>

15 Priorities for other Health Authorities’ Aboriginal Health plans, from conversation with the Aboriginal Health Director, Ministry of Health.
FRASER HEALTH INITIATIVES

FRASER HEALTH AT A GLANCE

Fraser Health Authority provides health care services to more than 1.48 million\textsuperscript{16} residents from Burnaby to Boston Bar. This is B.C.’s largest Health Authority by population. Between 2006 and 2010, the population is expected to increase by approximately 100,000 people to total 1.58 million. Fraser Health represents 22 municipalities and a large number of communities ranging in size from small rural communities such as Hope, to large, rapidly-growing suburban centres such as Surrey.

As already noted, the Aboriginal population is comprised of more than 46,000 Aboriginal people, including Status and Non-Status First Nations, Métis and Inuit. The diverse nature and size of our communities and the distances between them create challenges for health service delivery from the perspective of quality of care, equity in access, and efficiency. This is a major consideration for delivery of health care services to many Fraser Health Aboriginal communities in rural and isolated remote areas.

\textbf{Figure 2: Fraser Health Communities}

\textsuperscript{16} B.C. STATS, B.C. Ministry of Labour and Citizens' Services, PEOPLE 30 (July 1, 2006 projection).
PREVIOUS PLANS

This strategic plan draws from two prior projects, starting with the Fraser Health Aboriginal Health Profile, released in 2002. That was followed by a first Aboriginal Health Plan\(^\text{17}\) which focused on health promotion, prevention and chronic disease management, along with some mental health and addiction services.

FRASER HEALTH INITIATIVES: PROGRESS TO DATE

Creating a clear picture of existing services to Aboriginal residents of Fraser Health is linked to the ongoing process of taking inventory of services. In the meantime, it is worthwhile to note how many positive initiatives are already in place:

- A number of Maple Ridge, Pitt Meadows, Langley and Surrey agencies, along with the Canadian Cancer Society and Maple Ridge Public Health, have formed an integrated health team with the goal of providing services to the Katzie First Nations.

- Mission Indian Friendship Centre, To’o Housing and Mission Public Health collaborate closely, including providing health teaching on diabetes, healthy hearts and chronic disease prevention.

- Seabird Island partners with Chilliwack Hospital on chronic disease management, especially diabetes. It also has a focus on early childhood development, which includes Fetal Alcohol Syndrome Disorder (FASD) prevention.

- Over the past four years, Mission Mental Health and Aboriginal communities have collaborated on an annual cultural awareness education day for Fraser Health staff and other agencies.

Telehealth video-conferencing is a technology that will contribute to reducing access issues. This initiative is currently getting underway and one of the mandated First Nations communities to participate is the Stó:lô Nation in Fraser Health.

- Fraser Health and the Ministry of Children and Family Development (MCFD) are increasingly collaborating on both Aboriginal and non-Aboriginal interlinked issues. For example, Early Childhood Development hubs address basic health and safety as well as opportunities for healthy child development.

- Mission Mental Health, Stó:lô elders and other members of the community produced a DVD depicting the struggles with mental illness and drug and alcohol abuse resulting from experiences at residential schools.

- Fraser Health has also provided health promotion and prevention resources for youth and their families. Examples include:

\(^{17}\) Fraser Health Authority (2003), Aboriginal Health Plan 2003/04 – 2005/06.
- Seabird Island and Stó:lō received funding for workshops on the prevention of crystal methamphetamine use
- Kla-how-eya received funding for youth and family education workshops
- Stó:lō Nation received funding for alternative healing for youth.

- Co-sponsorship or collaborative arrangements with Aboriginal communities and Fraser Health is common. Again, some examples:
  - A health conference co-sponsored with Mission Indian Friendship Centre and Stó:lō Nation
  - A health fair with Seabird Island
  - HIV/AIDS awareness and prevention with Mennonite Central Committee
  - A collaborative arrangement for pediatric physician services with Stó:lō Nation
  - An Elders Assisted Living Centre with Stó:lō Nation.

- Maxxine Wright Community Health Centre opened in 2005 to address the complex needs of pregnant and parenting women who have a number of challenges with drugs and alcohol. In the first six months, approximately 40% of the clients were Aboriginal women. The Centre also hires Aboriginal service providers.

While this plan focuses on specific Aboriginal issues and initiatives, it’s important to remember that in the more populated areas of Fraser Health, Aboriginal people are routinely using mainstream health services. In these instances, the issues of cultural sensitivity and available Aboriginal health service providers are foremost.
ISSUES AFFECTING PROGRESS

Two main issues compound the challenge of improving Aboriginal health outcomes:

- Funding complexity, and
- Access barriers.

FUNDING COMPLEXITY

Delivering appropriate health services to Fraser Health Aboriginal people faces the added issue of negotiating through the complex process of allocating funds. While all are tax dollars, their route from taxpayer to an Aboriginal individual receiving care is often circuitous and can be a barrier to progress. In addition, an individual’s Status, location and the type of health care required are factors involved in when, where and how they receive services.

In some instances, services are provided and funded federally; in other cases, the service is handled provincially. The funds for services can be transferred, in some circumstances, to Fraser Health, and in other circumstances directly to a particular community. In general, there is a trend to move dollars as closely as reasonably possible to the service provider.

Readers who need or desire to understand this peripheral yet very complex issue can increase their understanding by referring to Appendix D.

ACCESS BARRIERS

A survey of health services yielded a greater understanding of services available to each Band locally, through Fraser Health or through collaboration with other organizations.

In addition to providing general service availability information18, respondents provided their comments on barriers to accessing services and what Fraser Health could do to alleviate some of their more pressing issues.

Barriers to improving health outcomes include:

- Geography

  Health planning sessions have shown that both rural and urban Aboriginal people must travel long distances to see particular specialists to obtain diagnosis and treatment. In addition, in some cases, even non-specialty services are unavailable at the community level. One example is that limited physician services are available for many rural and remote communities, especially those in the Fraser Canyon area.

18 See Appendix E for the results of the service inventory survey.
Culture and knowledge

While mainstream providers are well aware of the need to improve cultural awareness and sensitivity, Aboriginal communities too suffer from lack of communication and information that might assist their access to services. This lack of effective communication between Aboriginal leaders and mainstream service providers can contribute to misunderstandings, which in turn leads to limited responses to health-related messages and services.

Mental health, alcohol and drugs

Alcohol and drug-related issues present a barrier to achieving success among Aboriginal people and thus compound the issue of ill health. The many years Aboriginal children were separated from their families while attending residential schools is a prime factor here.

Funding issues

Over a period of five years, the population of Aboriginal people has grown in Fraser Health from 37,800 (1996 census) to 46,025 (2001 census). This is a 24% increase, without a corresponding increase in funding and services.

Some surveyed communities indicated that lack of funding increases also contributed to the difficulty of delivering programs, especially those dealing with mental health, drug and alcohol issues, and elders support programs.

The Provincial Health Officer’s 2001 report\(^\text{19}\) also addressed this issue. Aboriginal people clearly indicated that health programs and services must be delivered in their communities in order to be positively effective. Along with this is the need to make sure that services are culturally appropriate, while efforts to recruit and retain local Aboriginal health professionals is equally important.

\(^{19}\) The Health and Wellbeing of Aboriginal People in British Columbia, op cit.
MEETING THE HEALTH NEEDS OF ABORIGINAL RESIDENTS OF FRASER HEALTH

The Technical Advisory Group’s hard work, collaboration and research had a single purpose: to identify how Fraser Health can better serve the health needs of Aboriginal residents. This effort has led to a much greater understanding of the inequities of health status for Aboriginal people as well as recognizing where health services in Fraser Health must be adapted or expanded to start resolving this situation.

During the planning process, the team identified its Mission, Vision, Values and Principles. By doing this, the strategic priorities and action plans could be tested for appropriateness and consistency.

THE VISION
- Healthy Self, Healthy Families, Healthy Communities and Healthy Nation.

THE MISSION
- Inuit, Métis and First Nations (regardless of Status) partner with Fraser Health Authority and other service agents to meet primary health care and wellness needs and together build on cultural strengths enhancing communities of care.

THE VALUES
- Guided by traditional healing and spirituality.
- An inclusive partner when planning, implementing and delivering services.
- Build better relationships that support the capacity of the Aboriginal service providers to deliver service.

THE GUIDING PRINCIPLES
- Respect that Aboriginal culture, language and traditions are important to Aboriginal healing.
- Aboriginal well-being and healing needs to be determined by Aboriginal people.
- Fraser Health Authority is moving forward in full partnership with Aboriginal communities.
STRATEGIC PRIORITIES, OBJECTIVES, AND ACTIONS

Three main areas of improvement will have our priority attention during the coming three years and for the foreseeable future. These are:

1.0 Improving Health Outcomes for Aboriginal People

1.1 Enhance the collaboration with Aboriginal communities in planning and implementation of health promotion and prevention activities through:

Act Now B.C.\textsuperscript{20}

- Include Aboriginal leaders and healthcare providers in Fraser Health working groups and skills training related to Healthy Choices in Pregnancy (FASD prevention), tobacco reduction, community food security, healthy weights and physical activity.
- Connect Aboriginal communities to mainstream services: e.g., local Early Childhood Development hubs and related perinatal services (e.g., pre-registration, perinatal depression).
- Collaborate with Aboriginal nurses regarding immunization, dental, hearing, and vision screening.
- Link Fraser Health tobacco reduction coordinators with Aboriginal Honouring Our Health\textsuperscript{21} and brief intervention initiatives.

Performance Measures:

- Reduce the number of births to teen mothers towards the average teen birth rate for B.C.
- Reduce the Aboriginal post-neonatal mortality rate toward the B.C. average.
- Reduce the smoking rate for Aboriginal young adults 19 to 24 years from 61\% (2001) toward the B.C. average of 31\% (2001) for the general population of the same age group.

Chronic Disease

- Develop partnerships with Aboriginal experts to deliver chronic disease prevention workshops, and educational sessions to health providers and clinics.
- Invite key experts (Aboriginal and non-Aboriginal) to discuss and educate communities regarding communicable disease.

\textsuperscript{20} Act Now B.C. is a government-led, partnership-based health promotion initiative aimed at helping British Columbians live healthier lives by being more physically active, eating healthy foods, living tobacco-free and making healthy choices in pregnancy.

\textsuperscript{21} “Honouring Our Health”, op. cit.
- Provide information and support related to chronic disease management and self care.
- Link and refer to diabetes clinics.

**Performance Measures:**
- Decrease in the gap in life expectancy between Aboriginal and non-Aboriginal B.C. residents.
- Increase in the percentage of Aboriginal patients who receive follow-up services after being diagnosed with diabetes.
- Decrease preventable admissions for Aboriginal people toward the preventable rate for other residents in Fraser Health.

**HIV/AIDS**
- Partner with Aboriginal communities to provide additional or new HIV/AIDS programs as needed.
- Link Fraser Health HIV/AIDS nurses and support workers to Aboriginal health workers.
- Hire an Aboriginal Case Worker to liaise with Aboriginal communities and link to Fraser Health HIV/AIDS nurses and support workers.
- Collaborate with Aboriginal partners (e.g., Red Roads, Healing Our Spirit\(^\text{22}\) elders and case workers) to provide education and awareness programs to Aboriginal youth (e.g., the connection between injection drug use and HIV/AIDS; sexually transmitted diseases; self-esteem skills).

**Performance Measure:**
- Reduce the HIV/AIDS rate for Aboriginal people toward the HIV/AIDS rate in the B.C. general population.

**Injury Prevention**
- Collaborate with external partners to provide education and awareness programs to young parents regarding safety restraints (e.g., ICBC and RCMP).
- Link with Fraser Health initiatives related to falls prevention for the elders.
- Collaborate with Aboriginal communities to establish teen programs on drinking and driving.

\(^{22}\) Red Roads Aboriginal HIV/AIDS Network and Healing our Spirits Society are two provincial organizations providing culturally-inclusive support to Aboriginal people dealing with the many issues related to HIV/AIDS prevention and care.
Performance Measure:

- Reduce alcohol-related deaths of Aboriginal people by 5% toward the alcohol-related death rate for other residents of Fraser Health.

1.2 Improve the Mental Health and Addictions continuum of care for Aboriginal individuals and families.

- Provide a culturally-safe environment for all Aboriginal people to access mainstream services.
- Increase the number of Aboriginal Mental Health Liaison positions to link Aboriginal people to Mental Health and Addiction services.
- Establish a working group with mainstream services providers and Aboriginal leaders to identify the needed linkages, coordination, standardization of services and protocol development.
- Explore opportunities and plan for a “one-stop-shop” where a combination of services are provided, such as home-based alcohol recovery, an Aboriginal treatment program, Aboriginal house of healing for pre- and post-treatment, certification of Aboriginal workers by Fraser Health, and a single point of entry.
- Complement and enhance Federal counselling services for Aboriginal communities providing outreach Case Workers.
- Educate mental health providers of the impact of the residential school settlement process on Aboriginal communities and mental health service provision.

Performance Measure:

- Increase the percentage of Aboriginal people receiving mental health services.

2.0 Improving Access to Culturally-Appropriate Services

Culturally-appropriate services depend heavily on partnerships, communication and collaboration between Aboriginal communities and Fraser Health. Ongoing research will identify additional gaps and drive new initiatives to resolve them. Recruitment of Aboriginal people to work in all phases of the continuum of care is essential to success in this area.

2.1 Increase access to primary care services.

- Participate in planning to provide access to services where geographical barriers such as transportation and cultural barriers exist; e.g., Telehealth videoconferencing, mobile health units with physician, nurses, and Aboriginal outreach workers.
- Integrate culturally-appropriate services within existing health services; e.g., use elders, healers, and spiritual supports in the health service delivery.
- Develop protocols with acute care facilities for discharge planning, referral, and follow-up.
- Increase the number of Hospital Liaison positions in Fraser Health.
- Share information on data collected or new programs or initiatives with Aboriginal care providers.
- Obtain ongoing feedback on how to improve services from Aboriginal people (e.g., Aboriginal gatherings, focus groups, etc.).

**Performance Measure:**
- 80% of Aboriginal people who receive a health service in FH report receiving culturally-appropriate services.

2.2 Increase Fraser Health employee knowledge and understanding of Aboriginal terminology, theories and practice.
- Collaborate with Aboriginal experts to plan for and implement cultural competency training for Fraser Health employees.
- Blend best practices with best traditions in all programs and services; e.g., traditional healers, cultural events, elders.
- Explore ways to apply traditional knowledge and understand what is meant by “gap” and “need” for Aboriginal people.
- Collect qualitative and quantitative baseline data through pilot projects in order to better learn about Aboriginal people.
- Consult with Medical Health Officers regarding statistics and accuracy of data.

**Performance Measures:**
- 100% of Health Promotion and Prevention employees receive cultural competency training.
- 80% of Aboriginal people report satisfaction with public health nurses and emergency room service.

2.3 Increase the number of Aboriginal health care providers hired by Fraser Health.
- Develop a plan with the Ministry of Aboriginal Relations and Reconciliation (Aboriginal Employment Partnership Initiative) to integrate Aboriginal culture into recruitment of employees.
- Develop a process for recruitment and job-shadowing for Aboriginal students at health fairs.
- Create an Employee Selection Committee that represents the diversity of Aboriginal stakeholders’ interests, including those of their local health centre and community.
Target recruitment of Aboriginal employees.

**Performance Measure:**
- Increase the number of Aboriginal employees toward a target rate equivalent to the proportion of people in Fraser Health who are Aboriginal.

### 3.0 Strengthening Relationships and Community Capacity Building

Quality relationships are the foundation of progress. They lead to mutually-respectful collaboration and partnerships. They create awareness and sharing of valuable knowledge and they facilitate the ability to continually plan and to measure progress—to evaluate results and support any need to adapt plans to create more success.

#### 3.1 Increase partnerships and linkages with Aboriginal communities.
- Invest Fraser Health resources into successful partnerships and urban models that currently exist (e.g., Mission Indian Friendship Centre and Kla-how-eya).
- Build on the expertise of the technical committees and create an Aboriginal Health Advisory Committee to identify capacity issues and advise Fraser Health on service delivery.
- Create opportunities to partner with First Nation Inuit Health, the Ministry of Health, and Aboriginal communities to plan and deliver service.

Partner with Aboriginal communities to create local capacity and share service delivery (e.g., purchase service from Aboriginal communities, rent space for future service).

#### 3.2 Increase dissemination of knowledge, information and evaluation between Fraser Health and Aboriginal communities.
- Invite Aboriginal health professionals to share skills, knowledge and expertise.
- Develop a continuous communications link (e.g., newsletters and an Aboriginal website).
- Develop a framework to evaluate the progress and the achievement/outcomes of projects and communicate the results (e.g., Potential Years of Life Lost (PYLL), infant mortality, injury prevention).
- Develop a database of services.

**Performance Measures:**
- Increase in the number of partnerships established with Aboriginal communities.
- 100% of Aboriginal communities report satisfaction with partnership initiatives with Fraser Health.
This action plan must be complemented by a corresponding determination to measure outcomes and identify positive, as well as unsatisfactory, results. The outcomes and performance measures component is provided in detail in Appendix F.
CONCLUSION

The Aboriginal Health Plan is a living document, developed in partnership with Aboriginal groups and intended to be collaboratively monitored and evaluated. It provides a blueprint for programs and services that will contribute to closing the gap in health between Aboriginal people and other British Columbians.

The document will be widely shared with Aboriginal communities and groups for ongoing feedback.

The next steps in the process involve continued consultations to monitor the implementation of the plan and consideration of issues as they arise. An annual report will be prepared based on mutual evaluation of performance in relation to the strategic priorities. Regular evaluation will contribute to greater understanding and refinement of the initiatives and success in achieving our shared goals.
## APPENDIX A: CULTURAL DEFINITIONS

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>Aboriginal People</td>
<td>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.</td>
</tr>
<tr>
<td>Band</td>
<td>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.</td>
</tr>
<tr>
<td>First Nation</td>
<td>The term First Nation refers to the Indian people of Canada, both Status and Non-Status, who were the original people to inhabit Canada, or “First Nation”.</td>
</tr>
<tr>
<td>First Nations Community</td>
<td>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.</td>
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<tr>
<td>Inuit</td>
<td>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. “Inuit” has replaced the term “Eskimo”.</td>
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<tr>
<td>Non-Status First Nation</td>
<td>A person of Aboriginal ancestry who is not registered under the Indian Act.</td>
</tr>
<tr>
<td>Métis</td>
<td>A person of Aboriginal ancestry whose history dates back to the days of the fur trade when First Nations people married people of European descent. The blending of European and First Nations cultures gave rise to a distinct language, culture and identity known today as the Métis Nation. The Métis have been recognized as Aboriginal people under the Canadian Constitution. Unlike Status First Nations, the Federal Government does not presently acknowledge a fiduciary responsibility for Métis people.</td>
</tr>
</tbody>
</table>
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, usually in towns near their home reserves or in cities far from them.
APPENDIX B: THE TECHNICAL ADVISORY GROUP

In development of the Aboriginal Health Plan, one of the earliest and highest priorities was to make the process as inclusive as possible. With this in mind, members of the Technical Advisory Group were drawn from Aboriginal communities throughout Fraser Health. Not only were these individuals instrumental in working on this plan, they also greatly assisted in sharing the plan with members of the Aboriginal communities to obtain additional feedback on future initiatives.

Aboriginal members included:

Jennifer Bobb Spuzzum First Nation
Lorana Clairmont Mission Indian Friendship Centre
Terri-Ann Davidson Boothroyd First Nation
Ida John Chawathil First Nation
June Laitar Kla-how-eya
Susan Miller Tsawwassen First Nation
Carolyne Neufeld Seabird Island
Chief Dolores O’Donaghey Boston Bar First Nation
Carol Peters Stó:lō Nation
Virginia Peters Chehalis Indian Band
Patricia Raymond-Adair Kla-how-eya
Patty Rosvold North Métis Association
Leslie Schroeder Kwantlen First Nation
Doreen Sinclair Kla-how-eya
Brian Williams Stó:lō Nation

Fraser Health members included:

Linda Bachmann Health Promotion and Prevention
Stephanie Bale Communications
Frank Fung Mental Health and Addictions
Linda Hebel Planning & Development, Population Health
Margaret Wilson Aboriginal Health, Health Promotion and Prevention
Mental Health and Addictions Technical Advisory Group

A sub-group, focusing exclusively on issues related to mental health and addictions, augmented the work of the Technical Advisory Group.

Aboriginal members included:

Stuart Cadwallader Kla-how-eya
Carrie Dan Women’s Resource Society of the Fraser Valley
Janit Doyle Aboriginal Child and Youth Mental Health, MCFD
Wally La Vigne North Fraser Métis Association
Darryl Lucas Mission Indian Friendship Centre
Susan Miller Tsawwassen First Nation
Bill Mussell Sal’I’shan Institute Society
Brian Muth Stó:lō Nation
Carolyne Neufeld Seabird Island Band
Chief Dolores O’Donaghey Boston Bar Band
Carol Peters Stó:lō Nation
Virginia Peters Chehalis First Nation
Pat Reid Kla-how-eya
Doreen Sinclair Kla-how-eya

Fraser Health members included:

Frank Fung Mental Health and Addictions
Margaret Wilson Aboriginal Health, Health Promotion and Prevention
APPENDIX C: FRASER HEALTH ABORIGINAL PEOPLE – HEALTH STATISTICS

Extensive health statistics are available for Status First Nations in Fraser Health. These are broken down into four distinct regions:

- **Simon Fraser:** Coquitlam, Maple Ridge, New Westminster, Pitt Meadows, Port Coquitlam, Port Moody
- **South Fraser Valley:** Delta, Langley, Surrey, Tsawwassen, White Rock
- **Fraser Valley:** Abbotsford, Agassiz, Boston Bar, Chilliwack, Hope, Mission
- **Burnaby:** Burnaby

Note that, depending on the source of data used, the regional breakdowns sometimes vary, in that some reports include Burnaby in the Simon Fraser region23.

This ability to study data from specific Fraser Health regions will assist Fraser Health in its planning processes to continue to improve Aboriginal health.

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23 The statistics in this Appendix are drawn from the 2001 Provincial Health Officer’s Report on Aboriginal Health.
Life Expectancy

Life expectancy has long been regarded as a reliable indicator of the overall health of a population. Life expectancy tends to be higher for females, for the wealthy, and for married couples\textsuperscript{24}.

A Status First Nation person in B.C. is expected to live 7.5 fewer years than a non-Aboriginal B.C. resident born in the same period. This gap varies widely in Fraser Health:

- In Simon Fraser, Status First Nations will live to age 63, an average of 16.5 fewer years than the general population, the lowest life expectancy among all Status First Nations in B.C.
- In Fraser Valley, life expectancy for Status First Nations exceeds the provincial Status First Nations average by one year.

Mortality Rates

Simon Fraser had the highest mortality rate for the province, with 414.5 per 10,000, whereas the comparable statistic for all non-Aboriginal residents of B.C. was 103.3 per 10,000. The longer-term trends show that the mortality patterns have been shifting from pneumonia and perinatal conditions in the 1960’s compared to today, when accidents are the main cause of death. However, circulatory diseases and cancer combined account for 40% of deaths in Status First Nations people.
Potential Years of Life Lost

Simon Fraser ranked second and South Fraser Valley ranked fourth in all regions of B.C. for the potential years of life lost for Status First Nations people.
Birth Rates

The Fraser Health Status First Nations’ birth rate for 1996-2000\textsuperscript{25} was 28 per 1,000 Status First Nations population, over twice the rate of 12 per 1,000 in all other residents. The South Fraser had the highest rate of live births that were Status First Nation (38.5) in Fraser Health as well as in the province.

Premature Births


![Pre-term Births as Percentage of Total Births for Status First Nations 1991-1999]

Premature or pre-term births are those with a gestational age of less than 37 weeks. From 1996 to 2000, there were a total of 230 premature births out of about 2,800 total births in the Fraser Health Status First Nations population. The Status First Nations' premature birth rate compared with the all other residents was higher across Fraser Health as well as the province.
**Births to Teenage Mothers**

Simon Fraser, South Fraser Valley and Fraser Valley ranked in the top five in the province for teen pregnancy for Status First Nations.
Infant Mortality

Fraser Valley ranked sixth in the province for infant mortality for Status First Nations, which was the only region that was ranked higher than the average for all Status First Nations in B.C.

Provincial data show that infant mortality continues to decline for both the Status First Nations population and the total population; however, this decline has been much more substantial in the Status First Nations population.
Low Birth Weight

Burnaby was ranked second in the province for low birth weights for Status First Nations. Simon Fraser and Fraser Valley were ranked fifth and sixth respectively.
Post-Neonatal Mortality

Status First Nations babies in the past have had higher rates of post-neonatal death, usually from Sudden Infant Death Syndrome. The deaths usually occurred from one month to one year of age. Since 1990, this has been on the decline as there has been a reduction of smoking around babies, increased incidence of babies sleeping on their backs, and an increase in the number of babies who are breastfed.
Smoking-Attributable Deaths

Tobacco use is generally considered to be the number one preventable cause of death and disease. Smoking is a major contributor to three of the five leading causes of death for Status First Nations and it is also a direct contributor to low birth weight and Sudden Infant Death Syndrome (SIDS).

In 1997, an Angus Reid Group survey found that Aboriginal people in B.C. are twice as likely to smoke as are other residents of B.C. The average age for Aboriginal people to begin smoking is 14 years as compared to 15.7 years for other British Columbians.

According to the McCreary Centre, twice as many Aboriginal youth in B.C. are current or regular smokers compared to non-Aboriginal youth. Of the Aboriginal youth who are current smokers, 73% say that they have tried to quit smoking in the past six months. Of the those youth who are non-smokers, 29% say that they are exposed to second-hand smoke every day at home.

Simon Fraser, Burnaby and South Fraser regions ranked in the top four for smoking-attributable deaths for Status First Nations in B.C.
Alcohol and Drug-Related Deaths

Alcohol-related deaths among Status First Nations are more than six times the rate of the standard population (21.7 per 10,000). This is an increasing trend. Alcohol-related deaths account for 23.5% of mortalities among Status First Nations in B.C. In Fraser Health, both Simon Fraser and Burnaby regions were above the provincial rate, with Simon Fraser region being ranked second highest.

Alcohol and drug addictions play a major role in reducing the health of Aboriginal people. The misuse of these substances reflects the difficulty of managing above-average social, cultural and economic pressures faced by Aboriginal people.
**HIV/AIDS Deaths**

HIV/AIDS death rates in the general population are declining. However, HIV/AIDS deaths are increasing within Status First Nations and are one of the areas where the health status gap is increasing.
Injury Deaths

More than 40% of potential years of life lost and one-quarter of all Status First Nations deaths result from injuries. The most common causes of injury deaths are motor vehicle crashes, accidental poisoning, suicides, falls, fires and drowning. Simon Fraser ranked second in the province for injury deaths.
Preventable Admissions

According to the Provincial Health Officer’s Report, Status First Nations are three times as likely to be admitted for diabetes, asthma, hypertension, neurosis, depression or abuse of alcohol and/or drugs. These conditions could usually be managed within the community and without hospitalization. However, Fraser Health regions have lower rates of preventable admissions than the provincial average.
APPENDIX D: FUNDING ARRANGEMENTS FOR ABORIGINAL PEOPLE

First Nations Inuit Health (FNIH) Funding

Health care services for Aboriginal people can often be confusing in terms of provincial and federal jurisdictions, whether an individual has Status or not, whether the individual resides on-reserve or off-reserve, and the type of health service that is required.

Premiums for insured medical health services provided by the Province are paid by the Federal Government for Status First Nations, whereas non-Status First Nations and Métis must pay their own coverage.

Status First Nations may have the following services available to them, funded by First Nations Inuit Health Benefits, within strict guidelines: dental care, pharmaceutical drugs, medical supplies, optical needs, environmental health services, mental health and crisis intervention, patient transportation for medical appointments, and preventative community dental programs.

Over the last five years, Health Canada has been transferring control of health programs and services to First Nations communities to develop community-based programs within FNIHB guidelines.

The transfer process involves a number of phases of planning, consulting, negotiating and implementation. There are also integrated community agreements, allowing a community to jointly administer some or all of the first-level community-based programs. Integrated agreements are designed for smaller communities with populations between 100 to 450 people.

Programs that may be transferred from FNIHB to a First Nations community include:

- Community Health Services (Nursing and Community Health Representatives)
- Home and Community Nursing
- Aboriginal Diabetes Initiative
- National Native Alcohol and Drug Abuse Program (NNADAP)
- Health Careers Program
- First Nations Health Information Systems
- Brighter Futures/Building Healthy Communities Initiative
- Canada Prenatal and Nutrition Program
- Non-Insured Health Benefits.

The transfer of programs can occur at four levels:

Level 1 – Community Transfer (Community Health Representatives, NNADAP Workers, Brighter Futures/Building Healthy Communities and local patient transportation).
Level 2 – Zone Transfer (mental health crisis management, nursing supervision, and environmental health services).

Level 3 – Regional Transfer (health careers, regional newsletters, capital and facilities management and professional supervision/Medical Health Officer).

Level 4 – Non-Insured Health Benefits Transfer (pharmaceuticals, medical supplies, equipment, dental care, vision care, crisis intervention, mental health counselling, and health care premiums).

Aboriginal Health Transition Fund

The Aboriginal Health Transition Fund (AHTF) is a federal fund introduced by Health Canada in the spring of 2005 with the purpose of further closing the gap between Aboriginal and non-Aboriginal Canadians. It was intended to support First Nations and Inuit Communities in the integration of existing federally-funded health systems within First Nations and Inuit communities, with provincial and territorial health systems. Further, it was intended to adapt existing provincial and Territorial health services to better meet the needs of Aboriginal people including First Nations, Inuit, Métis, both on- and off-reserve. Currently, the Province and Aboriginal communities are awaiting decision regarding these funds.

Ministry of Health Funding Transfer

Similar to First Nations Inuit Health, the Provincial Ministry of Health transferred funding to Health Authorities in 2001 for Aboriginal health services. Direct service funding was provided for ongoing services and Aboriginal Health Initiative Program (AHIP) funding was provided for time-limited projects. The AHIP funding targeted Aboriginal community-based projects that focused on mental health and addictions and chronic diseases. Although the intent was that the AHIP funding was subject to application on an annual basis, this process did not happen in Fraser Health. Currently, Fraser Health is conducting an AHIP evaluation to determine how to allocate this funding in the future.
# APPENDIX E: INVENTORY OF SERVICES

<table>
<thead>
<tr>
<th>FIRST NATIONS BANDS (32)</th>
<th>FUNDING BODY</th>
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<td>Health Canada: First Nations Inuit Health</td>
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<td>Scowlitz</td>
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</table>

26 Fraser Health services are available to all Aboriginal people. This table identifies Fraser Health services that are developed in partnership with Aboriginal people.

27 Honouring Our Health funding aimed at smoking cessation for youth is part of the provincial tobacco prevention program.

28 New Westminster Band presently has no land base in the New Westminster area, but there are a small number of registered Band members.

29 Stó:lō Tribal Council and Stó:lō Nation are organizations that represent several Bands for the purposes of transfer of funding from Health Canada and delivery of programs.
<table>
<thead>
<tr>
<th>FIRST NATIONS BANDS (32)</th>
<th>FUNDING BODY</th>
<th>Fraser Health</th>
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<td>Skowkale</td>
<td>Dental Care and Children’s Oral Health</td>
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<tr>
<td>Yakweakwioose</td>
<td>Fetal Alcohol Spectrum Disorder Program</td>
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<td>Tzeachten</td>
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<td>Skawahlook</td>
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<td>Popkum</td>
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<td>Leqamel</td>
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<td>Matsqui</td>
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<td>Sumas</td>
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<td>Soowahlie</td>
<td>Community Health Services</td>
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<td></td>
<td>Dietician</td>
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<td>Elder Coordinator</td>
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<td></td>
<td>Alcohol and Drug Program</td>
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<td>Semiahmoo</td>
<td>Community Health Services</td>
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<tr>
<td></td>
<td>Alcohol and Drug Program</td>
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<td></td>
<td>Brighter Futures</td>
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<td></td>
<td>Prenatal Program</td>
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<td>Tsawwassen</td>
<td>Community Health Services</td>
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<td></td>
<td>Home and Community Care</td>
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<td>Union Bar</td>
<td>Incomplete</td>
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<tr>
<td>Yale</td>
<td>Incomplete</td>
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</table>

30 Stó:lō Tribal Council and Stó:lō Nation are organizations that represent several Bands for the purposes of transfer of funding from Health Canada and delivery of programs.
<table>
<thead>
<tr>
<th>URBAN ABORIGINAL GROUPS</th>
<th>FUNDING BODY</th>
<th>MINISTRY OF HEALTH: ABORIGINAL HEALTH</th>
<th>FRASER HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kla-how-eya</strong> Surrey Aboriginal Cultural Society</td>
<td>MCDF and Corporate and Community Partnerships</td>
<td>Education/Vocational Assessment and Training Culinary Arts Program, Including Community Kitchens and Youth/Family Nights</td>
<td>Health Promotion and Prevention: North Surrey Public Health Immunization Clinic Outreach AHIP: Prenatal/Elder Nutrition Education/Chronic Disease Prevention</td>
</tr>
<tr>
<td><strong>Mission Indian Friendship Center &amp; To’o Housing</strong></td>
<td>Ministry of Health: Aboriginal Health</td>
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<tr>
<td><strong>North Fraser Métis Association</strong></td>
<td>Tobacco Prevention Program</td>
<td>AHIP: Chronic Disease Management</td>
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</table>

31 Fraser Health services are available to all Aboriginal people. This table identifies Fraser Health services that are developed in partnership with Aboriginal people.
### APPENDIX F: OUTCOMES AND PERFORMANCE MEASURES

<table>
<thead>
<tr>
<th>STRATEGIC PRIORITY</th>
<th>OBJECTIVE</th>
<th>OUTCOMES</th>
<th>MEASURES</th>
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</thead>
<tbody>
<tr>
<td><strong>Improving health outcomes for Aboriginal people</strong></td>
<td>1. Enhance the collaboration with Aboriginal communities in planning and implementation of health promotion and prevention</td>
<td>Reduced FASD in babies&lt;br&gt;Reduction in infant mortality&lt;br&gt;Increased physical activity&lt;br&gt;Nutritious food is accessed by families&lt;br&gt;Healthy weights are achieved&lt;br&gt;Agencies are working collaboratively to improve service&lt;br&gt;Reduction in tobacco use&lt;br&gt;Decreased incidence of diabetes&lt;br&gt;Reduced hospitalization due to complications of chronic disease&lt;br&gt;Improved collaboration and linkages to Fraser Health&lt;br&gt;Improved continuity of care, treatment and support&lt;br&gt;Safety restraints in use&lt;br&gt;Decreased death and indirect deaths related to falls&lt;br&gt;Increased utilization of mainstream services&lt;br&gt;Improved service&lt;br&gt;Improved continuity and referral process</td>
<td>FASD rate&lt;br&gt;Post neonatal mortality rates&lt;br&gt;Physical activity rates&lt;br&gt;Childhood obesity rates&lt;br&gt;Progress on collaborative initiatives&lt;br&gt;Smoking rates&lt;br&gt;Diabetes rates&lt;br&gt;Hospitalization rates&lt;br&gt;HIV/AIDS rates&lt;br&gt;Injury deaths&lt;br&gt;MVA deaths&lt;br&gt;Hospital utilization due to falls&lt;br&gt;Satisfaction survey</td>
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<td></td>
<td>2. Improve the Mental Health and Addictions continuum of care for Aboriginal individual and families</td>
<td>Coordinated single point of entry achieved&lt;br&gt;Established MH&amp;A committee&lt;br&gt;Established Aboriginal healing centre</td>
<td>Increase in mental health liaison positions&lt;br&gt;Improved continuity of care for mental health patients: community follow up in 30 days&lt;br&gt;Decrease in waiting lists for Aboriginal people&lt;br&gt;Progress of committee&lt;br&gt;Progress in establishing a healing centre</td>
</tr>
<tr>
<td><strong>Improving access to culturally-appropriate services</strong></td>
<td>1. Increase access to primary care services</td>
<td>Increased outreach to Aboriginal communities in need&lt;br&gt;Increased utilization of primary care services&lt;br&gt;Cultural integration of services achieved&lt;br&gt; Increased skill level with health providers</td>
<td>Progress in providing outreach services&lt;br&gt;Progress in integrating cultural and spiritual traditions in services&lt;br&gt;Satisfaction survey</td>
</tr>
<tr>
<td>STRATEGIC PRIORITY</td>
<td>OBJECTIVE</td>
<td>OUTCOMES</td>
<td>MEASURES</td>
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</tbody>
</table>
| 2.                 | Increase Fraser Health employee knowledge and understanding of Aboriginal terminology, theories and practice | Cultural competency training provided  
Aboriginal definitions of health, gap and need are understood  
Baseline data developed for monitoring  
Increased understanding of data | Percentage of Fraser Health employees receiving cultural competency training  
Percentage of employees who attend education re: residential school settlement agreement  
Progress in establishing baseline data |
| 3.                 | Increase the number of Aboriginal health care providers hired by Fraser Health | Integration into corporate HR policy achieved  
Linkages with universities and colleges to identify Aboriginal students is achieved  
Increased Aboriginal employees recruited | Progress on job shadowing  
Progress on hiring Aboriginal health professionals |

**Strengthening Relationships and Community Capacity Building**

<table>
<thead>
<tr>
<th>STRATEGIC PRIORITY</th>
<th>OBJECTIVE</th>
<th>OUTCOMES</th>
<th>MEASURES</th>
</tr>
</thead>
</table>
| 1.                 | Increase partnerships and linkages with Aboriginal communities | Increased capacity in urban Aboriginal services  
Established regional network  
Improved partnerships and relationships  
Enhanced services | Progress in expanding urban Aboriginal services  
Increase linkages with new hospital liaison positions  
Progress in establishing new innovations and services |
| 2.                 | Increase dissemination of knowledge, information and evaluation between Fraser Health and Aboriginal communities | Increased partnerships and trust  
Shared learning achieved  
Improved knowledge of and access to services  
Framework developed and used  
Improved tracking | Progress in developing partnerships with Bands to deliver services  
Progress in shared learning opportunities  
Progress in tracking baseline data |