Interior Regional Health and Wellness Plan

Interim Plan

June 4, 2014

Acknowledgements

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Thank you to the many **Elders, Chiefs, Council Members, Health Directors/Leads, community health staff and community members** who participated in the Nation Assemblies, meetings and other engagement sessions that contributed to the information and priorities included in this plan.

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Executive Summary

The *interim* Interior Regional Health and Wellness Plan is a joint plan developed through collaboration among the 7 Nations of the Interior - the Dãkelh Dené, Ktunaxa, Nlaka'pamux, Secwepemc, St'át'imc, Syilx and Tsilhqot'in - Interior Health Authority and the First Nations Health Authority. It establishes a common voice and perspective on health and wellness. It describes the Nations' overall direction regarding their vision and guiding principles; who the Nations are; and their Regional and Nation health and wellness priorities. This plan describes how the Nations and their partners will work together based on the 7 Directives , the guiding principles outlined in the *Indigenous Nations of the Interior Declaration of Unity* (2010), the Interior *Partnership Accord* (2012) and the Nation Letters of Understanding with Interior Health Authority.

The Interior Nations' priorities focus on improving health programs and services, bringing financial resources and decision-making closer to home and strengthening, maintaining and aligning capacity with communities and Nations through a system that is deeply rooted in the values, principles and cultures of the 7 Nations of the Interior. Governance structures and processes continue to evolve to support implementation of this vision and the iRHWP describes the various entities that the 7 Nations will establish, in partnership with Interior Health Authority and the First Nations Health Authority, to support technical work and decision-making. The iRHWP also sets the intention to further refine communication and engagement processes to ensure that everyone receives the information they need and have opportunities for engagement and to provide input and direction to the work moving forward.

Each of the 7 Nations have identified emerging health priorities and remain committed to developing Nation Health and Wellness Plans over the next year. Regional priorities, summarized below, have been identified based on the 7 Directives and the priorities shared among multiple Nations. In future planning cycles, Nation plans, which have been informed by community priorities, will be the basis of the Regional Health and Wellness Plan.

This interim plan is a living document that will be revisited and revised to reflect the structures and processes being developed and the further planning work that will be done throughout the year by the 7 Nations. This work will lay the foundation for the 7 Nations to continue to operationalize the 7 Directives and Unity Principles, and to transform the health system serving their people to one that is based in their values, principles and cultures and best supports the health and wellness of the people of the 7 Interior Nations.

Summary of Regional Priorities

1. Community-Driven, Nation-Based

1.1. Support each Interior community to have an up-to-date Community Health and Wellness Plan
1.2. Develop Nation Health and Wellness Plans in each of the 7 Nations
1.3. Conduct asset and service mapping and complete the Interior Region expenditure analysis to support planning processes

2. Increased First Nations Decision-Making and Control

2.1. Establish governance and technical structures and processes enabling regional and Nation-based decision-making
2.2. Identify and develop strategies and policies for topics that require a regional approach
2.3. Enhance regional data governance and processes ensuring data and research activities are conducted in accordance with Nation priorities, policies and protocols.

3. Improve Services

3.1. Improve the First Nations Health Benefits Program to better meet the needs of First Nations people
3.2. Promote mental wellness and reduce harmful substance use
3.3. Promote Elder wellness and increase supports enabling Elders to remain at home or close to home
3.4. Promote child and family wellness and improve services in collaboration with social service partners

Additional service improvement goals related to holistic wellness, improving access to high quality health services and infrastructure are included in the full document.

4. Foster Meaningful Collaboration and Partnership

4.1. Build a collaborative relationship with Interior Health Authority based on the Partnership Accord and Nation Letters of Understanding
4.2. Align Interior Health Authority First Nations and Aboriginal planning and investment with the Interior Regional Health and Wellness Plan
4.3. Explore mechanisms to resolve the issues of Nations whose territories encompass more than one Regional Health Authority

5. Develop Human and Economic Capacity

5.1. Increase the number of First Nations health professionals and staff working in each of the Interior Nations
5.2. Improve recruitment and retention of health service providers in First Nations communities
5.3. Explore economic opportunities that will support sustainability and build First Nation health sector capacity

6. Be Without Prejudice to First Nations Interests

6.1. Establish processes for engaging Métis and urban Aboriginal groups that respect and reflect the inherent rights and interests of First Nations peoples
6.2. The Interior Caucus will consider avenues for supporting self-determination and jurisdiction interests of the Interior Nations

7. Function at a High Operational Standard

7.1. Establish clear, consistent communication and information-sharing among partners within the Interior Region
7.2. Strengthen Interior Region processes for reciprocal accountability
7.3. Develop indicators enabling Nations to report from the perspective of their values, principles and understandings of wellness
7.4. Explore the potential for more effective and efficient use of existing resources

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Appendices

Message from the Interior Region Nation Executive

When the 7 Nations of the Interior signed a Unity Declaration in 2010 we called our ancestors to be present, to bless the work and set the stage for the work ahead. Four years on from the signing, the Nations of the Interior Region remain committed to the Nation model of working together "for the betterment of the health, safety, survival, dignity and well-being of all of our peoples." It is in this spirit of unity and cooperation that we celebrate the completion of a Community-Driven and Nation-Based *interim* Interior Regional Health and Wellness Plan (iRHWP).

In developing this plan we are guided by the directives provided by First Nations leadership in British Columbia through Consensus Papers 2011 and 2012. Consensus Paper 2012 mandated the development of regional teams and supports, regional planning (iRHWP) and the phase-in of regional funding envelopes. This interim plan provides a foundation, for in addition to identifying key emerging priorities for health service improvements, the iRHWP highlights the ongoing development of our regional governance structures and processes and the further planning that will be conducted by each of the 7 Nations to develop Nation Health and Wellness Plans over the next year. The iRHWP further builds on the Interior Partnership Accord and defines how we will begin to transform the relationship between our Nations and Interior Health Authority, leading to greater collaboration and joint efforts to ensure high quality and equitable services for our people.

Implementation of the priorities in the iRHWP will lay the groundwork for putting our Unity Declaration and the 7 Directives into practice and sets the stage for the transformative work we will be doing to establish a health system that is embedded in our values and principles and supports the health and wellness of our Nations.

Chief Zach Parker
Dãkelh Dené Nation

Chief Arthur Adolph
St'át'imc Nation

Gwen Phillips
Ktunaxa Nation

Mic Werstuik
Syilx Nation

Ko'waintco Michel
Nlaka'pamux Nation

Chief Bernie Mack
Tsilhqot'in Nation

Kukpi7 Wayne Christian
Secwepemc Nation

Introduction

At Gathering Wisdom for a Shared Journey IV (May 2011), BC First Nations leadership provided direction for each of the five health regions to develop a "Regional Health and Wellness Plan" that establishes a shared voice and priorities for health and wellness[1]. This *interim* Interior Regional Health and Wellness Plan (iRHWP) is the product of this direction. It builds on a significant amount of work accomplished to date by First Nations, federal and provincial government partners, and partners within the region. It establishes a common voice and perspective on health and wellness among the 7 Nations of the Interior Region, the Dãkelh Dené, Ktunaxa, Nlaka'pamux, Secwepemc, St'át'imc, Syilx and Tsilhqot'in. The iRHWP describes the Nations' overall direction regarding their vision and guiding principles; who the Nations are; and their Regional and Nation health and wellness priorities. This plan describes how the Nations and their partners will work together based on the 7 Directives, the guiding principles outlined in the *Indigenous Nations of the Interior Declaration of Unity* (2010), the Interior *Partnership Accord* (2012) and the Nation Letters of Understanding with the Interior Health Authority.

The iRHWP is an important milestone for the 7 Interior Nations in putting the Community-Driven, Nation-Based approach into practice and identifying the emerging priorities of the Nations. Additionally, stemming from the signing of the *Partnership Accord* between the 7 Nations and Interior Health Authority, this is the first time a planning process has been conducted jointly among the 7 Nations, the First Nations Health Authority (FNHA) and Interior Health Authority. This development of a joint plan will enable increased alignment and coordination of the work of the two Health Authorities with the priorities that have been identified by the Nations. The iRHWP will guide regional envelope decision-making and guide FNHA work in partnership with the Interior region and other population health and provincial scale initiatives. It will also inform the provincial work and planning processes of the First Nations Health Council (FNHC) and First Nations Health Directors Association (FNHDA). Overall, the iRHWP will support the delivery and transformation of high-quality health and wellness programs and services for First Nations in the Interior region.

This interim plan is a living document that will be revisited and revised to reflect the structures and processes being developed and the further planning work that will be conducted throughout the year. The Nations of the Interior remain committed to creating Nation Health and Wellness Plans[2] and, over the coming year, the foundations will be laid for a planning cycle whereby Community Health and Wellness Plans will inform Nation Health and Wellness Plans and these Nation Plans will be the basis of future Regional Health and Wellness Plans (see figure 1).

[1] See Consensus Paper: British Columbia First Nations Perspectives on a New Health Governance Arrangement (2011). Additional information on the history and context of the First Nations Health Transfer, foundational documents and governance structure are provided in Appendix B.
[2] See Interior Partnership Accord (2012).

Methodology to develop the *interim* Regional Health and Wellness Plan

The iRHWP was developed through a process of reviewing existing planning work already completed by the Nations[3] and holding discussions about the iRHWP and Nation priorities at Nation Assembly meetings conducted throughout February and March, 2014. Based on the discussions at the Nation Assemblies and further engagement within their respective Nations, the Community Engagement Hubs took the lead in gathering and refining the priorities and profiles of their respective Nations to be included in this iRHWP. In the Nation Assemblies and documents, common priorities among the 7 Nations emerged and these were identified as Regional priorities.

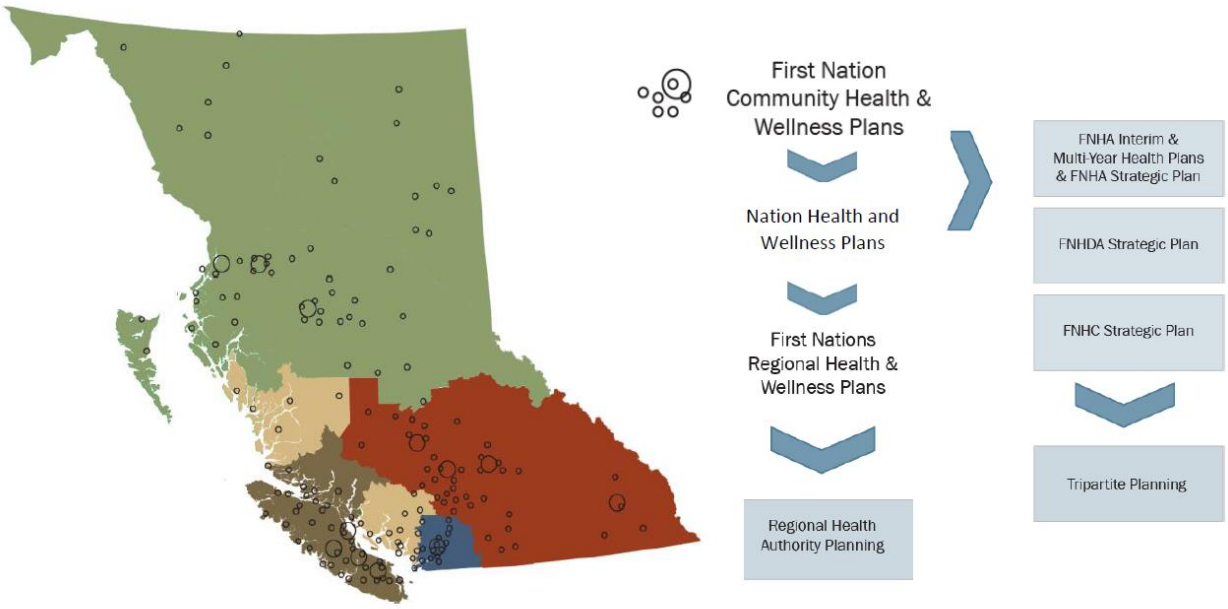


Figure 1: Health and wellness planning framework

> *"We need to move out of crisis mode and into proactive mode"*
> *Chief Zach Parker*

[3] See References for list of documents consulted.

Vision and Guiding Principles

Collective efforts of First Nations in BC are united and guided by a vision of "Healthy, Self-Determining and Vibrant BC First Nations Children, Families and Communities." The work toward achieving this overall vision is guided by the following shared values: Respect, Discipline, Relationships, Culture, Excellence, and Fairness[4]. First Nations in BC also set and agreed on the following 7 Directives:

- Directive #1: Community-Driven, Nation-Based
- Directive #2: Increase First Nations Decision-Making and Control
- Directive #3: Improve Services
- Directive #4: Foster Meaningful Collaboration and Partnership
- Directive #5: Develop Human and Economic Capacity
- Directive #6: Be without Prejudice to First Nations Interests
- Directive #7: Function at a High Operational Standard

"We need to incorporate our values and principles into this health initiative, that includes traditional foods and medicines"
Chief Art Adolph

[4] FNHA vision and values.

Declaration of Unity

The 7 Interior Nations' vision and guiding principles are based upon the *Declaration of Unity* (2010). This declaration confirmed the commitment of the 7 Nations of the Interior Region to work together in implementing the Tripartite First Nations Health Plan through a Nation to Nation model. In the Declaration, the Nations of the Interior committed to "respectfully work together, collaborating for the betterment of the health, safety, survival, dignity and well-being of all of our peoples". The *Unity Declaration* includes the following principles shared by the Interior Nations:

- Health and wellness outcomes and indicators will be defined by each Nation
- Partnerships will be defined by each Nation
- Agreements will be negotiated and ratified by the Nations
- No Nation will be left behind; needs are addressed collectively
- The federal fiduciary obligation must be strengthened, not eroded
- Services will be provided to all of our people regardless of residency/status
- Adequate funding will be provided for our corporate structure(s)
- Socio-economic indices will be incorporated into planning and projections – plan for 7 generations
- Negotiations will be interest based - not position based (Nations define)
- Community hubs will be linked to the health governance process
- Documents will be kept simple and understandable
- The Interior Leadership caucus will meet regularly
- Liability will be minimized; the Nations will inherit no liability from other entities
- Celebration will be included in all activities
- The speed at which development occurs will be determined by the Nations
- The authority to govern rests with each Nation, as does the responsibility for decision-making

Social and Cultural Context

Action on the Social Determinants of Health

The 7 Nations recognize that improving the health of their people will take more than the implementation of the Regional Health and Wellness Plan. Within a First Nations holistic perspective there is recognition of the significant impact that the social determinants have on health and wellness. Factors such as housing, employment opportunities, income and wealth, working conditions, education and experiences of colonization, residential schools and institutional racism all contribute to people's health and wellness. Addressing these complex issues challenges those working in health to reach out and build partnerships with other sectors to create and advocate for the supportive environments and public policy that will enable First Nations people to achieve the quality of life they are entitled to as an inherent right. This requires an approach that is collaborative and recognizes and builds upon the integral strengths and assets of the 7 Nations.

"We are a land based culture. In order for us to have healthy Nations and communities we need to look at ways to heal the land, in turn we will heal our people"
Chief Art Adolph

First Nations Perspective on Wellness

The First Nations Perspective on Wellness is a holistic health and wellness approach that provides a guide for health and wellness planning, program and service delivery throughout British Columbia. It builds on the recognition that health and wellness are intimately connected, and that they encompass emotional, mental, spiritual and physical health and well-being. It also recognizes how health and wellness is interwoven with the health and wellness of families, communities, Nations, Land, and other aspects of the contexts we live in. The First Nations Perspective on Wellness has been derived from a holistic perspective and concepts from traditional knowledge.

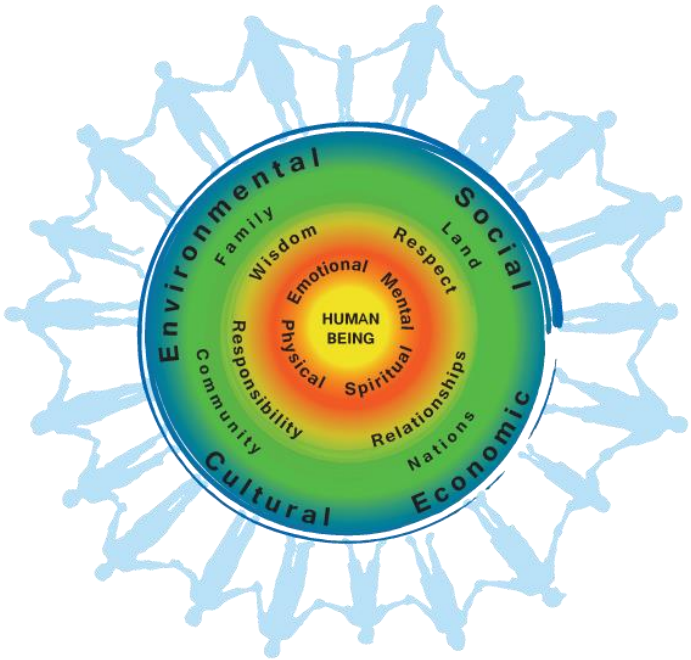


Figure 2. First Nations Perspective on Wellness

Interior Nations

The territorial land base of the Interior Region, as defined by BC Regional Health Authority boundaries, covers almost 216,000 square kilometres. For health planning purposes, there are First Nations communities included in the Interior Region that may lie outside this geographic boundary, creating unique jurisdictional complexities. It is also essential that planning take into consideration the diversity of the geography and climate in the region, the travel distances required and the effects of weather conditions.

According to Aboriginal Affairs and Northern Development Canada data (AANDC 2011), the First Nations population in the Interior Region is close to 30,000, representing 22% of the First Nations population in BC. The 54 Interior First Nations communities vary in size and include a number of small and isolated communities.

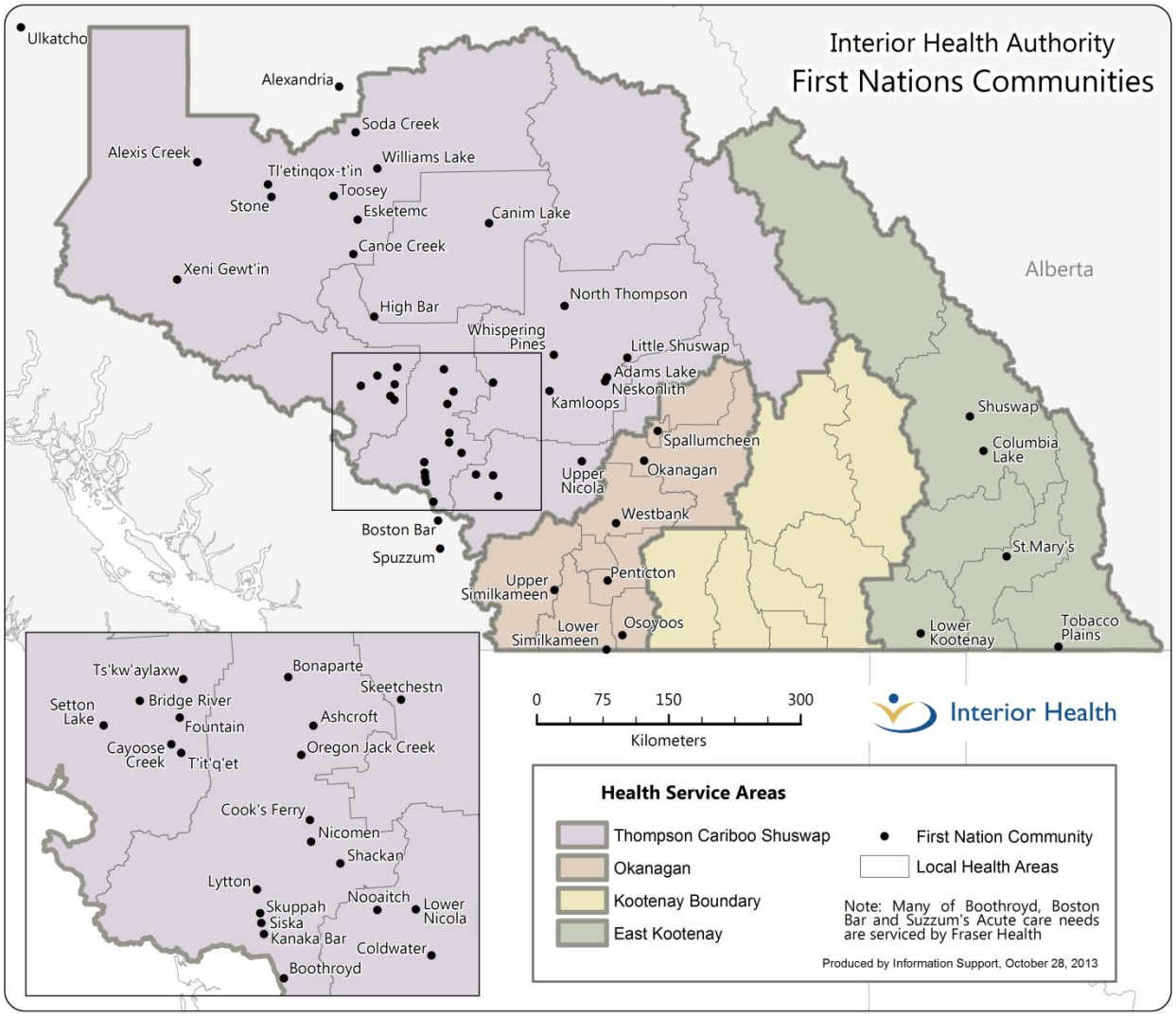


Figure 3. First Nations Communities in the Interior Region

Governance Structures and Processes

The First Nations of the Interior have formed the Interior Region Health Caucus, which serves as an engagement forum for the political (i.e. Chiefs) and technical leaders (i.e. Health Directors or Health Leads) relating to the implementation of the resolutions and consensus papers passed at Gathering Wisdom for a Shared Journey forums and the Tripartite Framework Agreement on First Nations Health Governance. The Caucus represents 54 First Nations of the 7 Nations: Dãkelh Dené, Ktunaxa, Nlaka'pamux, Secwepemc, St'át'imc, Syilx, and Tsilhqot'in.

The Interior Region Caucus Terms of Reference outlines the roles and responsibilities of the governance entities and technical advisory bodies that are being established to create the space for Nations to provide guidance and make decisions. The diagram and descriptions below outline the governance structures and processes involving the Interior Nations.

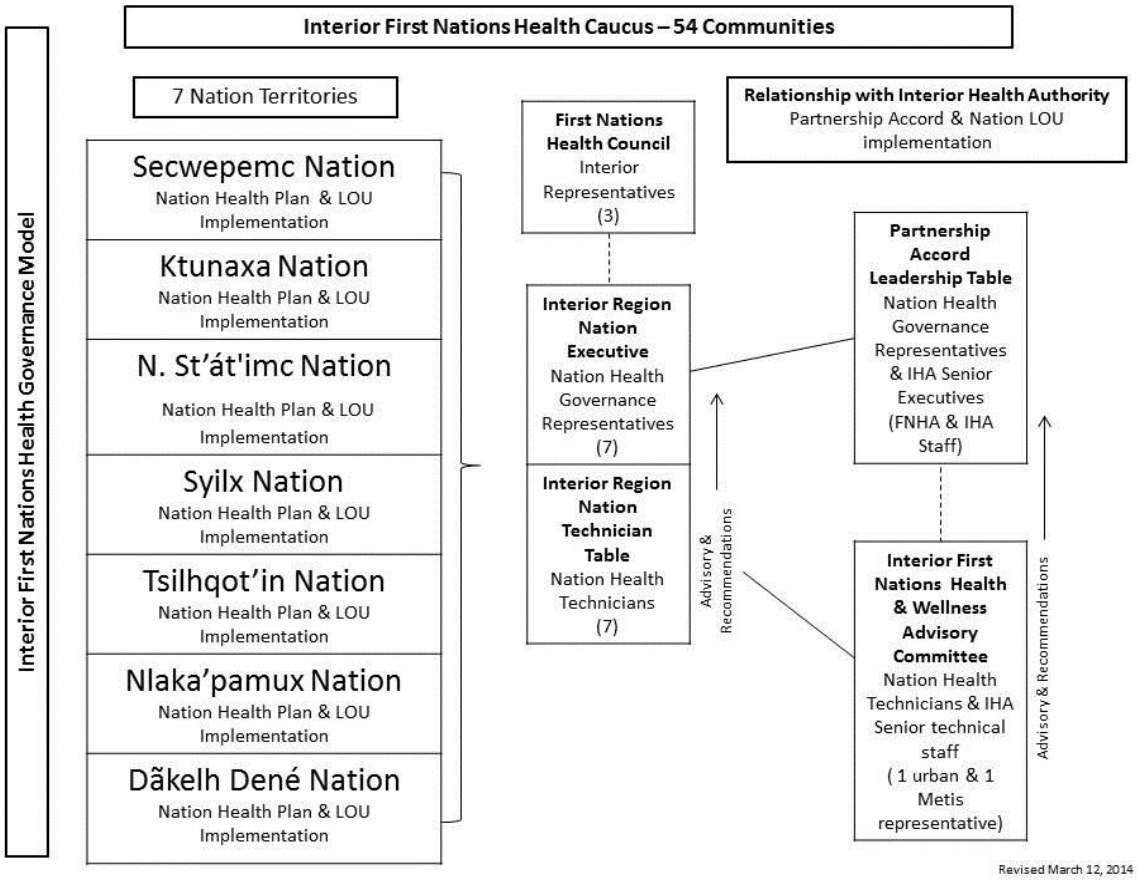


Figure 4. Interior First Nations Health Governance Pathways Model

Interior Regional Caucus

The Interior Region First Nations Community Health Caucus table provides a forum for the 54 First Nations of the Interior Region to engage with each other for purposes of planning, priority setting and decision-making related to regional health matters. The Health Caucus provides guidance to the Interior Region Nation Executive, Partnership Accord Leadership Table and provides advice and recommendations to the FNHC, FNHA and FNHDA along with approval of region specific documents.

7 Interior Nations

The province is broken down into five geographic regions for the purposes of health care service delivery. The Interior Region coincides with the boundaries of the Interior Health Authority and is comprised of 7 distinct Nations: Dãkelh Dené, Ktunaxa, Secwepemc, Syilx, St'át'imc, Tsilhqot'in and Nlaka'pamux. Each of the 7 Nations will develop a Nation Health Plan and negotiate a Letter of Understanding, or other agreement, independently with Interior Health. Issues or interests that are common to the Nations will be addressed in a collaborative manner.

Interior Region Nation Executive

The Interior Region Nation Executive Table is comprised of one representative from each of the 7 Nations of the Interior Region, and acts as an Executive body to the Interior Region Caucus, carrying out directions in between Caucus sessions. The Executive Table offers a more equitable decision-making capacity for Interior First Nations and gives regional direction to the First Nations Health Council.

First Nations Health Council Interior Representatives

The FNHC is comprised of 15 members, with 3 members appointed by the First Nations resident in each of the 5 geographic Health Authority regions of the province. The 54 First Nation Communities of the Interior Region, through the Caucus, appoint their 3 representatives to the Health Council from amongst the 7 Nation representatives who form the Interior Region Nation Executive.

Interior Region Nation Technicians Table

The Interior Region Nation Technicians Table is comprised of one representative from each of the 7 Nations of the Interior Region and acts as an advisory body to the Interior Region Nation Executive providing recommendations to the Interior Region Nation Executive Table on concerns common to the region.

Partnership Accord Leadership Table

The Partnership Accord Leadership Table is comprised of Senior Officials from Interior Health Authority along with the 7 Nation representatives of the Interior Region Nation Executive. The Partnership Accord Leadership Table is a decision-making body that provides direction and oversees the implementation of the Partnership Accord. The Table serves as a senior and influential forum for partnership, collaboration, and joint efforts on First Nation and Aboriginal priorities, policies, budgets, programs and services in the Interior Region.

Interior First Nations Health & Wellness Committee

The Interior First Nations Health & Wellness Committee is comprised of Senior Management from Interior Health Authority and First Nations Technicians appointed by the 7 Nations of the Interior Region. The Committee is an advisory body that provides recommendations to the Partnership Accord Leadership Table. Upon agreement from the Nations, space may be created for one Urban and one Métis representative.

"There are going to be growing pains but in the end we are going to have better health services"
Chief Percy Guichon

Interior Regional Team

The Interior Regional Team of the FNHA includes the Regional Director, the Regional Health Liaison, an Administrative Assistant and a collaborative relationship with the Nation Engagement Coordinators. This team also draws on support from teams throughout FNHA and will be evolving as regional processes continue to develop. This regional and matrix approach will be outlined in the regional team charter that is currently being reviewed and updated based on input gathered through the regional planning process.

Communication and Engagement

For effective health governance, engagement and communication must be community-driven and Nation-based. It must be inclusive and happen at every level. Communities can only give direction if communications are provided in clear and plain language, and they are given sound information upon which to base decisions.

There is currently a robust and dynamic communications and community engagement network to support both political and health service conversations, and specifically to support ongoing planning and implementation of plans in the Interior region. Leadership has recognized the need for this network to evolve in order to keep pace with the emerging governance and partnership structure, and the evolving role of the FNHA to enhance the delivery of quality health services to BC First Nations. The Regional Team supports regional efforts in communication, collaboration, and planning, and serves as a main contact for information within the region. Also, the Regional Team will work in partnership with Interior Health to streamline and integrate community engagement efforts.

> *"We need to make the plan unique to our Nation and unique to our communities. We need to be working together with our partners"*
> *Chief Joe Alphonse*

Communication has been identified as a key regional priority of the Nations and, as part of addressing this priority, an Interior communication plan will be developed and implemented. This plan will strive to ensure clarity, understanding and consistency around communications among all partners within the region and support communication and engagement on health and wellness issues, including priority areas identified in the iRHWP.

The process used in the development of the iRHWP, which involved engaging with health technicians and Chiefs at Nation Assemblies and other meetings occurring prior to the Regional Caucus will continue to be one of the key processes for communication and engagement. Ongoing, regular communication processes among the FNHA Regional Team, Interior Health Authority, Hub Coordinators, Health Leads and Governance Entities will also continue and be further refined in the communication plan that will be developed in the Region.

Strategic Challenges and Opportunities

In the work moving forward there are a number of opportunities for health service improvements and supporting increased health and wellness; however, there are also challenges that will be encountered, many of which are deeply entrenched and will require time and creativity to address.

Challenges

- Persistent health gaps
- Inequities facing First Nation communities compared to the non-First Nation population
- Limited resources
- Social determinants of health
- Historic and current government policy
- Jurisdictional complexities
- Cultural safety

> *"The most important priority is to get money to our community. That's us doing our job"*
> *Chief Jonathan Kruger*

Opportunities

- Improved planning for, and responding to, regional needs (including socio-geographic factors)
- Capacity, decision-making, policy-making and health care design and delivery closer to home
- Foster meaningful collaboration and partnerships regionally
- Maximize other revenue streams at the regional level
- Regional influence over investments
- Address region-specific information gaps

interim Interior Regional Health and Wellness Plan Goals

Long term goal

Bringing financial resources and decision-making closer to home and strengthening, maintaining and aligning capacity with communities and Nations in a health system that is deeply rooted in the values, principles and cultures of the 7 Nations of the Interior.

Goal 1: Design strong, sustainable health and wellness services that support community capacities

Goal 2: Improve health and wellness programs and services to better meet the needs of the Interior Nations

Goal 3: Align First Nations Health Authority and Interior Health Authority planning and investments with the Interior Regional Health and Wellness Plan

Goal 4: Improve access to high quality health services and infrastructure

Regional Priorities

To support the implementation of the goals of the Nations, and to make early improvements on priority health services, regional priorities have been identified and described below, in alignment with the 7 Directives[5]. Upon completion of the Nation Health and Wellness Plans that will be developed over the next year, the regional priorities will be revisited and updated to reflect the 7 Nations' priorities.

[5] Regional priorities were identified through analysis and synthesis of the discussions that occurred at Nation Assemblies that took place February through March, 2014, and the documents listed in the Reference section below.

1. Community-Driven, Nation-Based

The framework for planning that the Interior Nations will work towards is Nation Health and Wellness Plans informed by Community Health and Wellness Plans, and a Regional Health and Wellness Plan that is based on the Nation Plans. This planning process will lay the foundation for implementing the Community-Driven, Nation-Based approach and linking investment and supports with community and Nation priorities.

Priorities:

1.1. Support each Interior community to have an up-to-date Community Health and Wellness Plan

1.2. Develop Nation Health and Wellness Plans in each of the 7 Nations

1.3. Conduct asset and service mapping and complete the Interior Region expenditure analysis to support planning processes

"We worked on and signed health transfer so we could have better control and better options for our health care"
Kukpi7 Ann Louie

2. Increased First Nations Decision-Making and Control

The 7 Nations are in the process of developing and refining their health governance structures and the processes for how they will work together and make joint decisions. Establishing these structures and processes and strengthening Nations' policies will lay the foundations that will enable good governance and increased decision-making and control by the 7 Nations. Ensuring all people are included in decision-making and control, regardless of gender, age or status, is also an essential part of conducting this work in alignment with the values and principles of the Interior Nations.

Priorities:

2.1. Establish governance and technical structures and processes enabling regional and Nation-based decision-making

2.2. Identify and develop strategies and policies for topics that require a regional approach

2.3. Enhance regional data governance and processes ensuring data and research activities are conducted in accordance with Nation priorities, policies and protocols

"Data governance is having the information you need to tell the story"
Gwen Phillips

3. Improve Services

Systems transformation for service improvements will be a long term process as Nations look at strategies to incorporate holistic wellness perspectives and improve programs and services to ensure they are equal to or better than services provided in the provincial system. The Nation planning that will be taking place will provide an opportunity for Nations to identify their service improvement priorities. Emerging priorities within the region are listed below.

Priorities:

3.1. Improve the First Nations Health Benefits Program to better meet the needs of First Nations people

3.2. Promote mental wellness and reduce harmful substance use

3.3. Promote Elder wellness and increase supports enabling Elders to remain at home or close to home

3.4. Promote child and family wellness and improve services in collaboration with social service partners

Additional Goals:

Holistic Wellness	a. Incorporate the First Nations Perspective on Wellness into programs and services promoting health and wellness throughout the life cycle – infants, children, youth, mothers, fathers, families, adults and Elders b. Strengthen the role of traditional healers and medicines c. Collaborate with partners across sectors to protect the health of the land and environment and address the social determinants of health
Access to High Quality Services	d. Increase access to primary, community and home care service providers and linkages to specialist and acute care e. Increase and improve supports for chronic disease management f. Develop health service delivery models for rural and remote contexts g. Improve first responder services in rural and remote communities h. Improve transitions among service providers and across jurisdictions i. Work with the Provincial health system to increase resources for communities providing services to the off-reserve population j. Increase the cultural safety of health programs and services
Infrastructure	k. Develop the facilities, infrastructure and technology required to provide high quality health services l. Enhance health data and information management systems

4. Foster Meaningful Collaboration and Partnership

The signing of the Partnership Accord set the stage for fostering meaningful collaboration and partnership among Interior Health Authority and the 7 Nations. Nations have also been negotiating Letters of Understanding with Interior Health Authority and look to strengthen their relationship with the Health Authority through joint implementation of the work plans developed from these agreements.

Priorities:

4.1. Build a collaborative relationship with Interior Health Authority based on the Partnership Accord and Nation Letters of Understanding

4.2. Align Interior Health Authority First Nations and Aboriginal planning and investment with the Interior Regional Health and Wellness Plan

4.3. Explore mechanisms to resolve the issues of Nations whose territories encompass more than one Regional Health Authority

"We want to be recognized as intelligent, educated and experienced people and ensure that we have a voice at the table"
Sheila Dick, Health Director for Canim Lake

5. Develop Human and Economic Capacity

Bringing resources closer to home has been an overarching theme of the Interior Nations. As stated in the *Unity Declaration*, the Nations "desire to establish and maintain a desired level of capacity in the areas of health research, health career development, health service delivery (including traditional practices), information management and governance (health planning, administration, policy/program design and implementation and…), in order to achieve their individual and collective Nation visions."

Priorities:

5.1. Increase the number of First Nations health professionals and staff working in each of the Interior Nations

5.2. Improve recruitment and retention of health service providers in First Nations communities

5.3. Explore economic opportunities that will support sustainability and build First Nation health sector capacity

"Equal access to health services by recognizing our community clinics the same as those off reserve"
Jackie McPherson, Health Services Coordinator, Osoyoos Indian Band

6. Be Without Prejudice to First Nations Interests

As outlined in the *Consensus Paper* (2011), it is essential that there be no impact on Aboriginal Title and Rights or the treaty rights of First Nations, no impact on the fiduciary duty of the crown, no impact on existing federal funding agreements with individual First Nations, unless First Nations want the agreements to change, and is without prejudice to any self-government agreements or court proceedings.

Priority:

6.1. Establish processes for engaging Métis and urban Aboriginal groups that respect and reflect the inherent rights and interests of First Nations peoples

6.2. The Interior Caucus will consider avenues for supporting self-determination and jurisdiction interests of the Interior Nations

7. Function at a High Operational Standard

The newly established structures and processes among the Interior Nations will require processes, procedures and policies to enable them to function at a high operational standard in line with the principles of the Interior Nations. Additionally, data and research can be used to inform best practices.

Priorities:

7.1. Establish clear, consistent communication and information-sharing among partners within the Interior Region

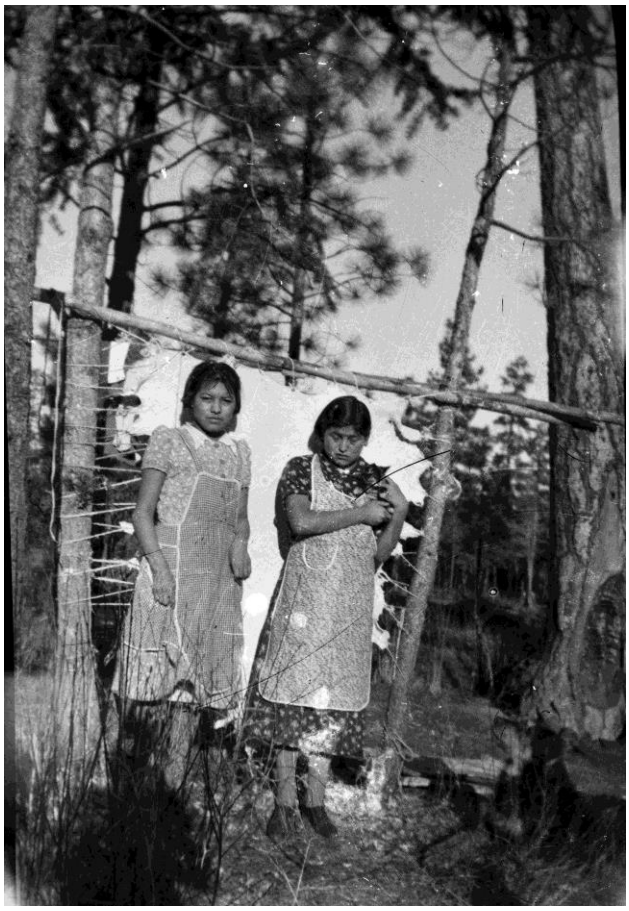
7.2. Strengthen Interior Region processes for reciprocal accountability

7.3. Develop indicators enabling Nations to report from the perspective of their values, principles and understandings of wellness

7.4. Explore the potential for more effective and efficient use of existing resources

Nation Priorities

This section contains a profile and emerging priorities of each of the 7 Nations in the Interior Region. These priorities were drawn from existing plans and community engagement reports provided by the Nations. Based on the discussions at the Nation Assemblies and further engagement within their respective Nations, the Community Engagement Hubs took the lead in gathering and refining the priorities and profiles of their respective Nations to be included in this iRHWP. As the Nations conduct further planning in the development of their Nation Health and Wellness Plans, these priorities will be updated and expanded.



"When we really look at our early teaching with rites of passage and our legends, we focused on the betterment of our communities"
Chief Art Adolph

Dãkelh Dené

1. Lhoosk'uz Dené Nation (receives services from Northern Health and at times Interior Health when members are referred)
2. Lhtako Dene Nation (receives services from Northern Health)
3. Ulkatcho (part of Vancouver Coastal Health but receives services from Interior Health through a Memorandum of Understanding)

The Southern Carrier territory is part of the Cariboo-Chilcotin Region in the interior of British Columbia. The Southern Carrier today are represented by the people of Red Bluff (Lhtako Dene Nation), Kluskus (Lhoosk'uz Dené Nation) and Ulkatcho. The Southern Carrier are a semi-nomadic people who migrate with the seasons. They are hunter gatherer people who depend on the land as their way of life. They have been able to maintain an independent, self-sufficient lifestyle based on hunting, trapping and fishing that provides them with the animals, fish, berries and plants for the medicines they may need throughout the seasons. Provisions are taken throughout the summer months to make sure there is enough food dried and stored away for the winter months.

Most Carrier call themselves Dãkelh, meaning "people who travel around by boat". The traditional Carrier way of life was based on a seasonal round, with the greatest activity in the summer when berries were gathered and fish caught and preserved. The mainstay of the economy was fish, especially the several varieties of salmon, which were smoked and stored for the winter in large numbers. Hunting of deer, caribou, moose, elk, black bear, beaver, and rabbit provided meat, fur for clothing, and bone for tools. With the exception of berries and the sap and cambium of the Lodgepole Pine, plants played a relatively minor role as food, though Carrier people are familiar with and occasionally used a variety of edible plants. Plants were used extensively for medicine. Winter activity was more limited, with some hunting, trapping, and fishing under the ice. Fish, game, and berries still constitute a major portion of the Carrier people's diet.

The Dãkelh Dené have developed a work plan and the priorities identified in this plan are summarized below:

1. **Community and Nation Wellness**
   1.1. Development of the RHWP
   1.2. Incorporate Elder and Youth representatives in the Health Committee

2. **Land and environmental health**
   2.1. Mold remediation of affected buildings

3. **Social determinants of health**
   3.1. Economic growth and reduced poverty
   3.2. Increase knowledge and educate and empower members

4. **Traditional medicine and healers**
   4.1. Identify and develop opportunities for increased participation and leadership of Elders in community health and wellness

5. Health services and programs

5.1. Achieving equity of service for on- and off- reserve individuals with special needs
5.2. Develop sustainable, ongoing Residential Survivor Programs
5.3. Develop and assess success of current or future men's, women's and youth support groups
5.4. Coordinate sharing of medical resources between local nations on and off reserve
5.5. Advocate for mandatory localized cultural competency training for service providers
5.6. Develop a plan to keep educated members in communities, retain staff, and access local expertise
5.7. Raise awareness about available mental wellness programs in community
5.8. Improve the First Nations Health Benefits Program
5.9. Improve and identify available or new options for medical transport to appointments
5.10. Improve first responder services

6. Health Authorities

6.1. Update information on Nation Territory Boundaries
6.2. Increase contact for review and assessment of services from FNHA, Interior Health Authority, Vancouver Coastal Health Authority and Northern Health Authority

7. Health Human Resources

7.1. Address ongoing issues related to retaining primary care staff (RNs)
7.2. Enhance the knowledge of nurses and other health care staff about First Nations health governance structures and processes and the First Nations Health Authority

8. Telehealth and ehealth

8.1. Develop and assess infrastructure for each community
8.2. Consult with FNHA to identify the best option for electronic medical records

9. Capital Projects

9.1. Develop and assess infrastructure for each community

10. Communication and Engagement

10.1. Assess current methods and efficiencies regarding Health Committee communication and relevant technical solutions (Skype / GoTo meetings, etc.)
10.2. Develop a plan for regular ongoing communication and accountability between Interior Health Authority, Vancouver Coastal Health Authority, Northern Health Authority, First Nations Health Authority and communities

11. Planning and Evaluation

11.1. Conduct health service mapping in all communities

12. Data and Research

12.1. Develop Nation wellness indicators

13. Governance Structures and Processes

13.1. Develop processes and procedures for developing a Nation Health Plan

Ktunaxa

1. Akisq'nuk
2. Lower Kootenay
3. St. Mary's
4. Tobacco Plains

Ktunaxa (pronounced ‘k-too-nah-ha’) people have occupied the lands adjacent to the Kootenay and Columbia Rivers and the Arrow Lakes of British Columbia, Canada for more than 10,000 years. The Traditional Territory of the Ktunaxa Nation covers approximately 70,000 square kilometres (27,000 square miles) within the Kootenay region of south-eastern British Columbia and historically included parts of Alberta, Montana, Washington and Idaho.

For thousands of years, the Ktunaxa people enjoyed the natural bounty of the land, seasonally migrating throughout our Traditional Territory to follow vegetation and hunting cycles. We obtained all our food, medicine and material for shelter and clothing from nature - hunting, fishing and gathering throughout our Territory, across the Rocky Mountains and on the Great Plains of both Canada and the United States.

European settlement in the late 1800s, followed by the establishment of Indian Reserves, led to the creation of the present Indian Bands. Ktunaxa citizenship is comprised of Nation members from seven Bands located throughout historic traditional Ktunaxa territory. Five Bands are located in British Columbia, Canada and two are in the United States. Many Ktunaxa citizens also live in urban and rural areas "off reserve".

The Ktunaxa language is unique among Native linguistic groups in North America. Ktunaxa names for landmarks throughout our Traditional Territory and numerous heritage sites confirm this region as traditional Ktunaxa land. Shared lands, a rich cultural heritage, and a language so unique that it is not linked to any other in the world, make the Ktunaxa people unique and distinctive.

Priorities that have been identified by the Ktunaxa Nation are as follows:

1. **Relationship building**
   - 1.1. Engagement with East Kootenay Aboriginal population and East Kootenay health care providers
   - 1.2. Expand and strengthen activities, relationships, linkages, and understanding through IHA Aboriginal Liaison and Aboriginal Patient Navigator
   - 1.3. Letter of Understanding implementation and Work Plan development

2. **Resource and capacity development**
   - 2.1. Evaluate and revise educational materials
   - 2.2. Build capacity in communities to train Aboriginal Health Care Providers
   - 2.3. Identify opportunities to increase capacity to provide comprehensive community care
   - 2.4. Increase supports enabling health care providers to provide high quality care

3. **Improved access**
   - 3.1. Assess the possibility of an Aboriginal community health centre in Cranbrook
   - 3.2. Explore options for rural nursing partnership initiatives
   - 3.3. Ensure the treatment centres address all social determinants of health

3.4. Work with FNHA to identify approved treatment centres that meet the needs of Aboriginal people

4. Health programs and services

4.1. Provide safe places and respectful services, information and supports for immunization and communicable disease control
4.2. Identify early childhood development clients and increase participation in services
4.3. Implement early interventions and prevention processes by increasing knowledge and service capacity
4.4. Expand and improve Aboriginal Health Information and Cultural Awareness
4.5. Develop opportunities for healthy activities and social connections
4.6. Enhance prevention and supports for conflict resolution and lateral violence
4.7. Improve the First Nations Health Benefits Program

5. Mental or emotional health

5.1. Establish an alternative mental health program to support the reconstruction of families and healing of individuals
5.2. Identify resources to re-introduce the CHIP program to address the needs of individuals affected by FAS/E. The loss of this program has significantly impacted communities
5.3. Develop and increase relevant mental health services through planning
5.4. Develop an accountability framework to align and deliver services considering best practices, gaps and barriers and local needs identified in the Mental Wellness Forum

6. Youth and Elder services

6.1. Expand and improve Elder care and needs assessment services
6.2. Expand the Elders Network and the Elders Roster to represent the 5 Nations the Ktunaxa/Kinbasket Child & Family Services Society serves
6.3. Expand and improve youth services and assessment of needs

7. Social determinants of health

7.1. Increase education and skill development activities to enhance employment opportunities for Aboriginal people - especially in health professions
7.2. Develop a plan and standards to address housing, water, mould, radon and other environmental health concerns
7.3. Work with partners and communities to support economic development
7.4. Increase the availability of transportation

8. Community wellness and revitalization of traditional knowledge and language

8.1. Organize family and community cultural activities, knowledge sharing and language learning
8.2. Promote Elder-Youth mentorship
8.3. Develop Permanency Plans for children in care where it is unlikely that they will return to their parents' care
8.4. Reinvigorate traditional food systems
8.5. Promote community participation and increase engagement with men, Elders and youth

9. Aboriginal Urban Services

9.1. Secure Federal Transfer funds to provide services to the Aboriginal Urban population
9.2 Increase access to mental health and substance use services for the Aboriginal Urban population

Nlaka'pamux

1. Ashcroft Indian Band
2. Boothroyd[6]
3. Boston Bar First Nation[6]
4. Coldwater Indian Band
5. Cooks Ferry
6. Kanaka Bar Indian Band
7. Lower Nicola Indian Band
8. Lytton First Nation
9. Nicomen Indian Band
10. Nooaitch
11. Oregon Jack Creek
12. Shackan
13. Siska
14. Skuppah Indian Band
15. Spuzzum[6]

The Nlaka'pamux Nation is an Indigenous Nation with title and rights held communally by the people of the Nation. What defines us is not a line on a map, but a way of life, a shared culture and a communal responsibility to future generations. The Nlaka'pamux Nation is located in the southern interior of British Columbia and extends into the state of Washington. The economic value within the Nation is its richness in natural resources. Water availability is perhaps one of the most significant natural resources available to the Nation. The area is inhabited by numerous species of wildlife, plants, medicines and natural foods. The natural diet of the Nlaka'pamux Nation members consists of fish, wild meats, berries, plants, roots and medicines. The Nations' people are resilient, strong and generous, sharing and trading their resources with other tribes. The traditions and culture of the Nlaka'pamux Nation members are valued assets transferred from past generations to the present.

Vision for regionalization:
1. Bringing services to community
2. Develop policy and rewrite policy that fits a First Nation perspective and values

Emerging Nlaka'pamux priorities are provided below**:**

1. Mental wellness and substance use

1.1. Communication at all levels
1.2. Honouring and utilizing cultural roles
1.3. Increase in professional health service providers
1.4. Shared resources and funding access
1.5. Nlaka'pamux cultural positions
1.6. Treatment and healing centres to be built within the community
1.7. Resolve access issues for the community
1.8. Collaboration of community resources
1.9. Rites of passage ceremonies
1.10. Culture and language camps
1.11. Transition out of treatment and aftercare
1.12. Case management and networking
1.13. Resolve access issues for the community by bringing services to the community

[6] Boothroyd, Boston Bar First Nation and Spuzzum are part of the Nlaka'pamux Nation but are within the Fraser Health Authority region.

1.14. Veteran post-traumatic stress disorder support and advocacy for services including defining how many veterans we have and coordinating services
1.15. Provide high quality, culturally safe care for residential school survivors and their families
1.16. Improving housing and reducing overcrowding

2. Healthy living and wellness

2.1. Increase opportunities for physical activity
2.2. Develop groups and programs for all age groups and genders
2.3. Provide programs on parenting and healthy attachment (inclusive of foster children)
2.4. Provide programs to address violence against woman (and by women)
2.5. Elder recreational activities

3. Chronic disease prevention, education and management

3.1. Enhance supports which incorporate the physical, mental, emotional and spiritual components of health in the prevention and management of chronic conditions such as diabetes, arthritis, asthma, heart/circulation and disabilities (e.g. community gardens)

4. Primary care & public health services

4.1. Improve the accessibility and equity of health services for on- and off- reserve members and members of other areas in the territory
4.2. Enhance programs and services supporting the health and wellness of infants and toddlers
4.3. Increased support and programming for Early Childhood Education
4.4. Enhance health promotion, screening and preventive services occurring in schools
4.5. Increase access to physician, nurse practitioner and nursing services
4.6. Improve access to x-ray and lab services
4.7. Enhance the availability of emergency services
4.8. Enhance aftercare and support for discharging and liaison with the Band/Health Centre
4.9. Address the unique issues of small and isolated communities
4.10. Support the development of community health and wellness plans
4.11. Address gaps in services in collaboration with FNHA and Interior Health Authority
4.12. Establish access to basic health services in all communities, including doctors, dentists and eye care

5. Social determinants of health

5.1. Strengthen partnerships with social service agencies to address issues related to the social determinants of health
5.2. Support economic development

6. Elder care

6.1. Assess Elder's facilities and programs and identify assets and priorities for improvement
6.2. Develop groups and programs for Elders such as healthy eating, safety and recreation

7. First Nations Health Benefits

7.1. Improve the First Nations Health Benefits Program to better meet the needs of First Nations
7.2. Develop and circulate clear descriptions of what Health Benefits coverage allowances are available (i.e. glasses, dental, etc.)

7.3. Programs for pharmaceutical drug misuse that are inclusive of:
  7.3.1. Doctor awareness and prevention
  7.3.2. Education on side effects of medication
  7.3.3. Counselling and prevention

8. Letter of Understanding implementation

8.1. Select a Nlaka'pamux representative for the Joint Committee

9. Housing

9.1. Collaborate with partners in the housing sector to address repairs, renovations and plans for new houses

10. Culture and Spirituality

10.1. Incorporate cultural and spirituality throughout all documents and programs

10.2. Support cultural and spiritual practices and traditional activities such as the gathering of traditional foods and medicines

11. Environment

11.1. Protection of the watersheds

11.2. Quality assurance of water samples within community by ensuring processes and standards of water safety are being adhered to for safe drinking water

11.3. Protection of the pollen bee population

12. Travel

12.1. Address travel issues for remote sites/communities

12.2. Address travel issues for patients with mobility challenges, including establishing a space to rest while waiting for the community bus

13. Policy

13.1. Revise and develop policies from a First Nations perspective

14. Chronic disease prevention, education and management

14.1. Enhance supports which incorporate the physical, mental, emotional and spiritual components of health in the prevention and management of chronic conditions (diabetes, arthritis, asthma, heart/circulation and disabilities) eg. Community gardens

15. Database

15.1. Support communities to obtain a database (eg. Mustimuhw)

16. Communications

16.1. Develop a communication plan that speaks to:
  16.1.1. Band Administration and health
  16.1.2. Interior Health Authority services and structures
  16.1.3. FNHA services and structures
  16.1.4. First Nations Health Benefits services, process and appeal of services

17. Infrastructure

17.1. Improve infrastructure in communities, including for for water and internet

18. Health Authority Boundaries

18.1. Address the issues of communities that are at the boundaries of Regional Health Authorities

Secwepemc

1. Sexqeltqín - Adams Lake
2. St'uxwtéws - Bonaparte
3. Tsq'éscen - Canim Lake
4. Esk'étemc – Alkali Lake
5. Llenllenéy'ten – High Bar
6. Qw7ewt – Little Shuswap Lake
7. Sk'atsin - Neskonlith
8. Stswécem'c/Xgét'tem' -Canoe/Dog Creek
9. Kenpésq't - Shuswap
10. Simpcw - North Thompson
11. Skítsesten - Skeetchestn
12. Splats'in - Spallumcheen
13. Tk'emlúps - Kamloops
14. Ts'kw'aylaxw - Pavilion
15. Stil'qw/Pelltíq't – Whispering Pines/Clinton
16. T'éxel'c – Williams Lake
17. Xats'úll – Soda Creek

The Secwepemc, more commonly known as the Shuswap, are comprised of 17 Bands located over approximately 18% of the total area of British Columbia. Their lands, Secwepemcúl'ecw, are geographically located in the South Central Interior of the Province. The Secwepemc, in terms of land base and population, are one of the largest Indigenous people in BC. Their lands cover over 180,000 km^2. The traditional Secwepemc were a semi-nomadic people, living during the winter in warm semi-underground "pit-houses" and during the summer in mat lodges made of reeds. The traditional Secwepemc economy was based on fishing, hunting and trading. Secwepemc diet consisted of fish, meat, berries and roots. Many Secwepemc people still depend on these subsistence food gathering activities to meet their basic needs while also participating in the broader economy.

The Secwepemc Health Caucus has identified the following priorities:

1. **Relationship with Interior Health Authority**
    - Letter of Understanding and Workplan implementation
    - Effective discharge planning process developed and implemented
    - Secwepemc on board of Interior Health Authority
    - Interior Health Authority financial allocations for 17 communities
    - Health services same for on- and off- reserve members

2. **Mental Wellness and Substance Use**
    - Nation based community driven mental wellness and substance use plan
    - Re-establish family values
    - Re-store traditional justice activities
    - Research and implement healing plan/strategies
    - Nation-based treatment programs
    - Youth suicide plan
    - Drug abuse plan
    - Assessment of long-term cost of addressing FASD effects

3. **Long Term Care – Elder Care**
    - Elders homes in Kamloops and Williams Lake
    - Host Elders Forum

- Appoint Elder/Youth seats to Secwepemc Health Caucus Table
- Assessment of existing programs and services for Elders
- Elders coordinator for social functions

4. **First Nations Health Benefits/Non-Insured Health Benefits**
    - Nation FNHB/NIHB coordinator
    - Develop partnerships with FNHA Health Benefits staff
    - Address FNHB/NIHB issues (FNHDA)

5. **Transition to a new Health Authority**
    - Funding arrangements and processes
    - Capital projects
    - Communications and technology
    - Capacity
    - Ensuring adequate resourcing for services taken over

Additional priorities - To start implementation for April 1st, 2014 – March 31st, 2015 Fiscal Year

6. Social Determinants of Health – Hold 2nd Forum
7. Traditional Medicine & Healers – Hold 2nd Forum
8. Wellness and Lifestyle
9. Nutrition and food security
10. Brain Injury
11. Linkages with physicians
12. Relationships with other health care providers
13. Crisis response planning
14. Metis and Urban Aboriginal health jurisdiction
15. Research and data governance

Northern St'át'imc

The St’át’imc Traditional Territory is 20,500 square kilometres and is home to 11 St’át’imc communities. The six Northern St’át’imc communities are: Tsal’alh (Seton Lake), which is considered remote, and the rural communities of Xwisten (Bridge River), Ts’kw’aylaxw (Pavilion), Xaxli’p (Fountain), T’it’q’et (Lillooet), and Sekw’el’was (Cayoose Creek). Approximately half of our community members live on reserve and half live off reserve, either in Lillooet or in surrounding neighbourhoods and communities, towns, cities, and other First Nations communities.

The St'át'imc are the original inhabitants of the territory which extends north to Churn Creek and to South French Bar; northwest to the headwaters of Bridge River; north and east toward Hat Creek Valley; east to the Big Slide; south to the island on Harrison Lake and west of the Fraser River to the headwaters of Lillooet River, Ryan River and Black Tusk. The St'át'imc way of life is inseparably connected to the land. Our people use different locations throughout our territory of rivers, mountains and lakes, planning our trips with the best times to hunt and fish, harvest food and gather medicines. The lessons of living on the land are a large part of the inheritance passed on from St'át'imc Elders to our children. As holders of one of the richest fisheries along the Fraser River, the St'át'imc defend and control a rich resource that feeds our people throughout the winter and serves as a valued staple for trade with our neighboring nations. The St'át'imc can think of no other better place to live.

The current health priorities of the Northern St’át’imc are:

1. Complete Community Health Plans in all six Northern St’át’imc communities.
2. Carry out an Urban Health Strategy in the Northern St’át’imc Territory.
3. Develop a Northern St’át’imc Health Plan which will contribute towards the Interior Regional Health and Wellness Plan.
4. Strategize on improvements to the First Nations Health Benefits Program.

Syilx

1. Lower Similkameen Indian Band
2. Okanagan Indian Band
3. Osoyoos Indian Band
4. Penticton Indian Band
5. Upper Nicola Band
6. Upper Similkameen Indian Band
7. Westbank First Nation

The Okanagan Nation Alliance (ONA) is a tribal council and was formed in 1981. It is representative of the seven member Bands (noted above) including the Colville Confederated Tribes of Northern Washington State. The ONA's mandate is to advance, assert, support and preserve Syilx title and rights. The ONA is charged with providing members with a forum to discuss and develop positions on areas of common concern. ONA's responsibilities include serving the Syilx people as a collective, by addressing common issues and opportunities of the Nation and supporting a shared vision that promotes asset and capacity building for long term sustainable self-sufficiency.

The Syilx Nation represent their citizenry regardless of residency and supports the pursuit of its rights to retain responsibility for the health, safety, survival, dignity and well-being of Syilx children and families, consistent with the UN Convention on the rights of the child and the UN Declaration on the rights of Indigenous Peoples.

Listed below are priorities from the 2010 Syilx Nation Health Plan and emerging priorities that have been identified through more recent community engagement sessions:

1. Addressing current health priorities

1.1. Explore the potential for more effective and efficient use of existing resources among ONA communities
1.2. Develop Nationwide initiatives to address addictions and mental wellness
1.3. Develop a Regional Wellness Program to address chronic disease management
1.4. Build and sustain relationships with regional, provincial and federal partners
1.5. Address issues underlying HIV/AIDS
1.6. Offer violence, abuse and suicide prevention programs to all seven Bands

2. Developing Frameworks

2.1. Work on a reciprocal Accountability Framework with Interior Health to define relationships, communication protocols, operations, and reporting
2.2. Continue to develop a Health Governance Framework
2.3. Develop early childhood development initiatives and strategies

3. Strengthening Partnerships/Linkages

3.1. Letter of Understanding implementation
3.2. Ensure Okanagan Nation representation at all Interior Health policy and program development activities affecting Okanagan Nation populations
3.3. Enhance systems and linkages with partners in Housing, Education, Economic Development, Child and Family Services that address Social Determinants of Health

4. Identifying Future Nation Health Priorities for Action

4.1. Review recommendations from ONA "Pathways to Health and Healing Report" and move forward on identified priorities

4.2. Develop, implement and assess an action plan to address Nation health priorities

5. Strengthening the role of ONA in supporting the health of the Syilx Peoples

5.1. Ensure the ONA health office has sustainable and appropriate resources

5.2. Ensure ONA and member bands are positioned to secure future program funding

Emerging Priorities:

- Develop a mental health strategy
- Increase access to nurse practitioner services
- Develop a communication and community engagement strategy
- Strengthen research partnerships with UBCO (eg. chronic disease, cultural competency)
- Prepare for accreditation
- Increase and improve programs and services for Elders
- Develop regional wellness programs for youth. These programs could encompass nutrition, mental health, self-esteem, healthy activities and supports for parents and guardians
- Create improvements in the First Nations Health Benefits Program
- Increase the equity of services received on and off reserve
- Develop a regional wellness program to address dental health for children in all communities
- Obtain the services of a mental health clinician to be shared among the communities, similar to the Nurse Practitioner
- Develop the health system to be consistent with the Community-Driven, Nation-Based directive and is based on a strong cultural framework

Tsilhqot’in

1. ?Esdilagh (receives services from both Interior Health and Northern Health)
2. Tl’esqox
3. Tl'etinqox Government
4. Tsi Del Del
5. Yunesit'in Government
6. Xeni Gwet'in First Nation Government

Chilcotin, meaning "people of the river," also refers to the Chilcotin Plateau region in British Columbia. The Chilcotin (Tsilhqot'in) First Nation are a DENE-(Athapaskan) speaking people numbering nearly 3200 who live between the Fraser River and the Coast Mountains in west-central BC. The Chilcotin traditional culture was similar to that of other Northern Athapaskan. Through much of the year, families moved about independently hunting, fishing and gathering roots and berries. In late summer most families gathered along the rivers to fish the salmon runs. In midwinter they moved to sheltered locations, usually near lakes suitable for ice fishing, where they lived in shed-roofed houses or pit houses.

The current health priorities of the Tsilhqot’in are:

1. Mental health and addictions
2. Elder care
3. Patient travel
4. Youth services
5. Promote traditional diet, medicines and Healers
6. Implementation of the Tsilhqot’in Wellness Plan:
   - 6.1. Unify the Tsilhqot’in people by gathering and sharing ideas and resources
   - 6.2. Balance and strengthen the spiritual, language and cultural traditions of the Tsilhqot’in people. Deni gatŝin gwayajelh tīg
   - 6.3. Integrate traditional and contemporary health services in the community wellness centres
   - 6.4. Promote holistic wellness practices
7. Letter of Understanding implementation

Next Steps

The next steps for the iRHWP will be the development of a detailed implementation work plan and framework for reporting and evaluation. Implementation of the iRHWP will be a collaborative process by the First Nations Health Authority, Nation health technicians and Leads, and Interior Health Authority. To support implementation, the iRHWP will be linked with human and financial resources from the First Nations Health Authority and Interior Health Authority. Reporting and evaluation are essential components for accountability and establishing a clear, transparent framework will enable tracking of progress in achieving the goals that have been set, identification of lessons learned and celebration of successes.

Conclusion

This first *interim* Regional Health and Wellness Plan lays a strong foundation consisting of the principles, values, structures and processes that will support the 7 Nations, the First Nations Health Authority and Interior Health Authority in the work moving forward in their new partnership. Recognizing that additional planning will be conducted at the Nation level to develop Nation Health and Wellness Plans, the iRHWP is a living document that will be revisited and revised to reflect new information and priorities identified by the Nations.

The 7 Nations, the First Nations Health Authority and Interior Health Authority have a vision to create improvements in the health and well-being of First Nations in the Interior Region by transforming healthcare for the better. The 7 Nations are driven by the common values of their cultures and their holistic perspectives of health and wellness. They look to their traditions to enhance health practices and they look to their current and future health leaders for guidance. This is an historic opportunity to achieve transformative change in First Nations health and wellness, and all of the partners involved are committed to make the most of this opportunity. Through their combined strengths and assets, the 7 Nations, the First Nations Health Authority and Interior Health Authority will strive to make this vision a reality.

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23. Okanagan/Syilx Nation Health Plan (2010)
24. Secwepemc Health Caucus Strategic Plan Up-Date June 19 (2013)
25. St'át'imc Nation Health Priorities: 3rd annual Elder's gathering, March 13-14, 2013 (2013)
26. Summary of Health Priorities by Nation for the Dãkelh Dené, October 4, 2013 (2013)
27. Tsilhqot'in Wellness Plan (2012)

Appendix A: Interior Regional Profile

Regional Profile of First Nations Communities in Interior Region

November 2013

DRAFT

Table of Contents

1. Demographics

Population Data Sources

Census: The mandatory long-form Census (2006) contained a field in which Aboriginal peoples could choose to self-identify as First Nations (status or non-status), Metis or Inuit[1]. However, some First Nations reserve communities did not participate in enumeration. The mandatory long-form Census was cancelled and replaced in the 2011 Census with the non-mandatory National Household Survey (NHS)[2]. Since participation in NHS is voluntary, Aboriginal data from the NHS are less representative than those from the long-form Census. Note that only on-reserve population data are available from the 2011 Census.

AANDC Indian Registry: The AANDC's Indian Registry is the definitive registry for all individuals registered under the Indian Act (Status First Nations). The AANDC population for BC captures all First Nations registered to BC bands and is not a BC Resident population. It excludes BC residents who are members of non-BC Bands. Two major limitations of the Indian Registry as a population data source are late reporting of life events (e.g. births and deaths) and the fact that residency code (e.g. on- and off-reserve) is not consistently updated after initial registration.

1.1 Geography

The territorial land base of the Interior Region, as defined by BC Regional Health Authority boundaries is 237,692 km squared, 25.7% of the total provincial land base. For the purposes of this profile, the administrative geographic boundaries of the Interior Health Authority (IHA) are used but there are First Nations communities within these geographic boundaries that are included in other health regions for First Nations health planning purposes (see section 1.3).

1.2 Population

Table 1 provides estimates of the First Nations population living in Interior Region using different data sources, including the 2011 Aboriginal Affairs and Northern Development Canada (AANDC)'s Indian Registry, the 2006 Census and the 2011 Census (see Sidebar for more information on these data sources). According to AANDC 2011 data, the First Nations population in Interior Region is close to 30,000, representing 22.3% of the First Nations population in BC.

Table 1 Interior Region Status First Nation Population Estimates, 2006 and 2011

Data Source/Year	On-Reserve	Off-Reserve	Total
AANDC 2011	15165	14772	30030
Census 2006	11205	11605	22810
NHS 2011	11570	13205	24780

Sources: Aboriginal Affairs and Northern Development Canada (AANDC), Census 2006, Statistics Canada, National Household Survey (replaces long form Census), Statistics Canada

[1] Statistics Canada. 2006 Census: Aboriginal Peoples in Canada in 2006: Inuit, Métis and First Nations. Available: http://www12.statcan.gc.ca/census-recensement/2006/as-sa/97-558/note-eng.cfm. Accessed: Apr 24, 2013.
[2] Statistics Canada. 2011 Census questionnaire. Available: http://www12.statcan.ca/census-recensement/2011/ref/gazette-eng.cfm. Accessed: Apr 25, 2013.

1.3 First Nations Communities

The following table illustrates the population estimates and distance to service centre for the 54 communities in the Interior Region.

Table 2 Population Estimates for Interior Region First Nation Communities, by Nation and Distance to Service Centres

		Distance to Service Centre[7]	AANDC Band Affiliation 2011 total	AANDC Band Affiliation 2011 on-reserve	AANDC Band Affiliation 2011 off-reserve	2011 Census on-reserve
Dãkelh Dene:						
1	Lhoosk'uz Dene Government[3]	n/a	209	51	158	44
2	Lhtako Dene Nation[3]	n/a	161	74	87	73
3	Ulkatcho[4]	No year round access	998	700	298	349
Ktunaxa:						
4	?Akisq'nuk First Nation	<50 km	268	154	114	114
5	Lower Kootenay	<50 km	214	108	106	113
6	St. Mary's	<50 km	364	215	149	109
7	Tobacco Plains	<50 km	193	95	98	57
Nlaka'pamux[5]:						
8	Ashcroft	<50 km	255	79	176	97
9	Coldwater	<50 km	795	404	391	385
10	Cook's Ferry	<50 km	310	79	231	64
11	Kanaka Bar	n/a	215	78	137	68
12	Lower Nicola	<50 km	1115	549	566	672
13	Lytton	<50 km	1892	938	954	686
14	Nicomen	<50 km	133	70	63	64
15	Nooaitch	<50 km	206	118	88	127
16	Oregon Jack Creek	<50 km	63	20	43	15
17	Shackan	< 50km	121	83	38	55
18	Siska	<50 km	308	104	204	131
19	Skuppah	<50 km	106	67	39	46

[3] ?Esdilagh First Nation, Lhoosk'uz Dene and Lhtako Dene Nation are included in the Northern Region but have signed a unity declaration with Interior Region Nations. They are included in both Northern and Interior Regional profiles.

[4] Ulkatcho has signed a unity declaration with interior Region Nations. They are included in both Vancouver Coastal and Interior Regional profiles

[5] Boothroyd, Boston Bar First Nation and Spuzzum all belong to Nlaka'pamux Nation which has communities in both Fraser and Interior Regions. These First Nations are included in the Fraser Regional Profile.

Secwepemc:						
20	Adams Lake	<50 km	742	421	321	356
21	Bonaparte	<50 km	852	236	616	221
22	Canim Lake	<50 km	585	441	144	229
23	Esketemc	50-350 km	835	466	369	403
24	High Bar	n/a	93	n/a	n/a	5
25	Little Shuswap Lake	<50 km	326	235	91	379
26	Neskonlith	<50 km	621	326	295	327
27	Stswecem'c Xgat'tem First Nation	n/a	712	317	395	207
28	Shuswap	<50 km	249	115	134	293
29	Simpcw First Nation	<50 km	664	249	415	267
30	Skeetchestn	<50 km	509	246	263	253
31	Splatsin	<50 km	813	391	422	435
32	T'kemlups	<50 km	1158	641	517	2577
33	Ts'kw'aylaxw First Nation[6]	<50 km	543	275	268	119
34	Whispering Pines/Clinton	<50 km	148	61	87	60
35	Williams Lake	<50 km	688	264	424	227
36	Xatsull	<50 km	395	183	212	144
Syilx:						
37	Lower Similkameen	<50 km	466	285	181	243
38	Okanagan Indian Band	<50 km	1862	912	950	5193
39	Osoyoos	<50 km	490	372	118	628
40	Penticton	<50 km	992	609	383	1667
41	Upper Nicola	<50 km	891	426	465	302
42	Upper Similkameen	<50 km	77	63	14	76
43	Westbank First Nation	<50 km	732	422	310	7068
St'át'imc:						
44	Bridge River (Xwisten)	<50 km	432	218	214	236
45	Cayoose Creek (Sekw'el'was)	<50 km	194	86	108	84
46	Tsalahh	<50 km	643	348	295	264
47	T'it'q'et	<50 km	394	198	196	264
48	Ts'kw'aylaxw First	<50 km	543	275	268	119

[6] Included in both Secwepemc and St'át'imc.

	Nation					
49	Xaxlip First Nation	<50 km	981	392	589	
Tsilhqot'in:						
50	?Esdilagh	<50 km	180	54	126	52
51	Tl'esqox	<50 km	312	166	146	118
52	Tl'etinqox-t'in Government	50-350 km	1503	604	899	475
53	Tsi Del Del	50-350 km	639	347	292	200
54	Yunesit'in Government	50-350 km	424	277	147	201
55	Xeni Gwet'in First Nation Government	50-350 km	416	258	158	176

Sources: Aboriginal Affairs and Northern Development Canada (AANDC) and Census, Statistics Canada

Figure 1 Percent of Interior Region First Nation communities by community size (number, %), 2011 AANDC

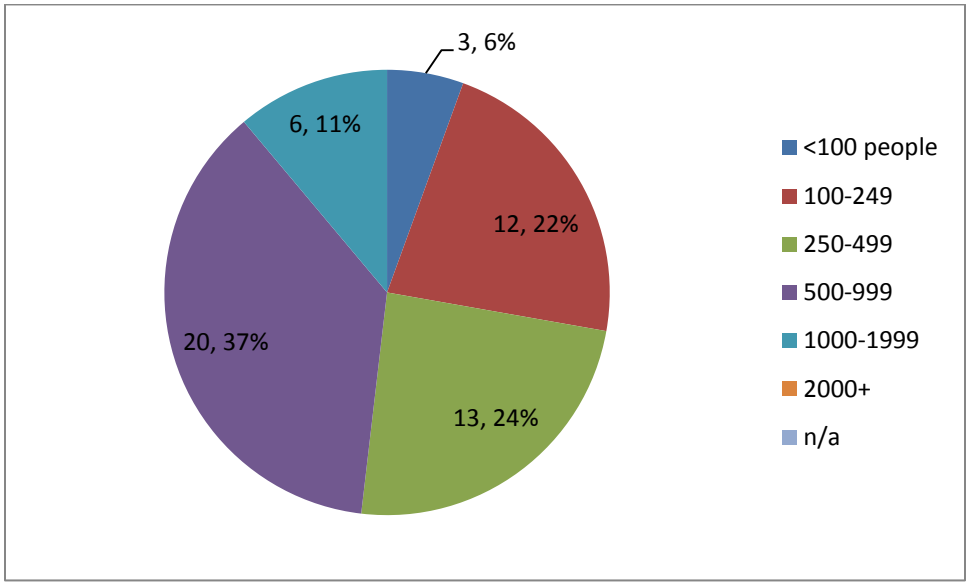


Figure 2 Percent of Interior Region First Nation Communities by Distance to a Service Centre[7] (number, %), 2011 AANDC

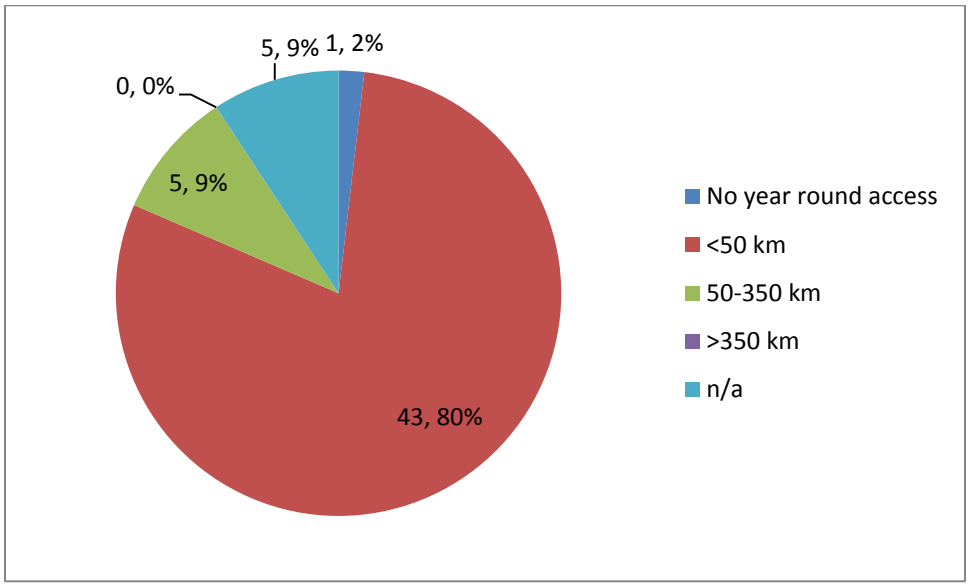


Figure 2 above indicates that within Interior Region, a large proportion of communities are within 50 km of a service centre.

[7] Service centre is defined as the nearest community to which a First Nation can refer to gain access to government services, banks and suppliers. The nearest service centre would have the following services available: (a) Suppliers, material and equipment (i.e., for construction, office operation, etc.) (b) A pool of skilled and semi-skilled labour, and (c) At least one financial institution (i.e., bank, trust company, credit union, etc.) In addition, the following services would typically be available: (d) Provincial services (such as health services, community and social services, environmental services, etc.), and (e) Federal services (such as Canada Post, Service Canada, etc.)

1.4 Community Engagement Hubs

Community Engagement Hubs (CeH's) are groups of First Nations communities who agree to plan, collaborate, and communicate to meet their nation's health priorities.

Table 3 Community Engagement Hubs in Interior Region

Sub-region (Nation)	**Number of Communities**	**Hubs supporting the sub-region 2013-2014 (*Contribution Holder*)**
Tsilhqot'in	6	• Tsilhqot'in Health Hub (Tsilhqot'in National Government)
Northern St'at'imc	5	• Northern St'at'imc Hub (Lillooet Tribal Council)
Nlaka'pamux		• Fraser Canyon Hub (Fraser Canyon Tribal Administration) • Merritt area Hub (First Nations Health Authority Direct Contract) • Lytton Area Hub (Lytton FN)
Syilx	7	• Okanagan Nation Hub (Okanagan Nation Alliance)
Secwepemc	17	• Health Director's Hub (Q'wemtsin Health Society)
Ktunaxa	4	• Ktunaxa Nation Hub (Ktunaxa Tribal Council Society)
Southern Dakelh Dené	3	• Southern Dakelh Dené Hub (Carrier Chilcotin Tribal Council)
	54	**Number of Communities not formally involved in the Hub process: 0**

**Dakehl Dene hub is based out of Interior Region and includes 3 communities, 2 of which are in the Northern Region Communities (Lhoosku'z Dene Government, Lhtako Dene Nation)

Figure 3 Interior Community Engagement Investment 2013/2014

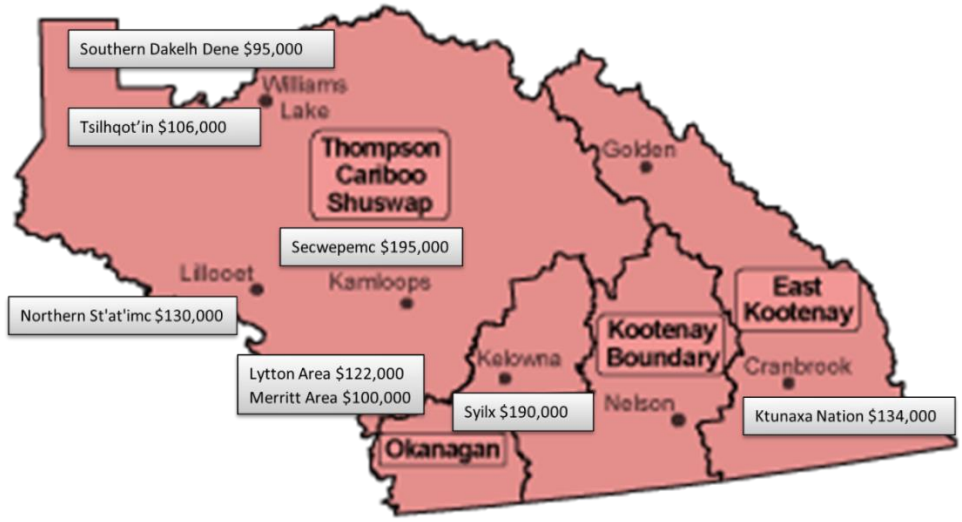
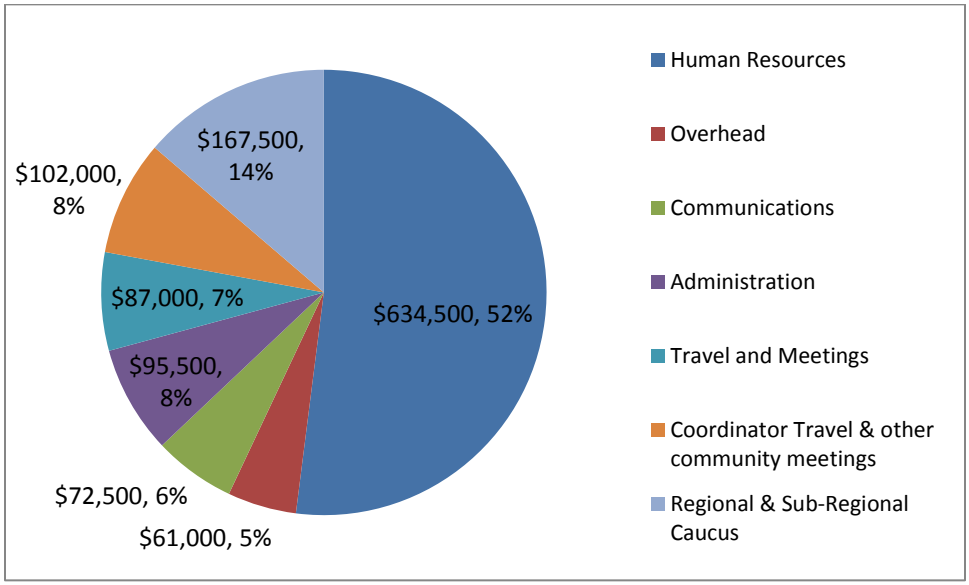


Figure 4 Interior Region Hub Budget ($ dollar amount, %), 2012-2013



There are 10.5 FTEs in the Interior Health Authority Hub with a total budget of $1,220,000.

1.5 Tribal Councils

Tribal Councils are defined as institutions established as "a grouping of bands with common interests who voluntarily join together to provide advisory and/or program services to member bands".[8]

Table 4 Tribal Councils in Interior Region

Tribal Councils
1. Northern Secwepemc Tribal Council
2. Carrier-Chilcotin Tribal Council
3. Ktunaxa Nation Council
4. Lillooet Tribal Council
5. Nicola Tribal Association
6. Nlaka'pamux Nation Tribal Council
7. Okanagan Nation Alliance
8. Shuswap Nation Tribal Council
9. Tsilhqotin National Government

1.6 Umbrella Health Organizations

Umbrella health organizations can be defined as an organization that coordinates the activities of a number of member organisations and hence promotes a common purpose. The organizations in the following table receive funding from the First Nations and Inuit Health BC Region.

Table 5 Umbrella Health Organizations in IHA

Umbrella Health Organizations	Communities Covered In the Umbrella Health Organization
1. Heskw'en'scutxe Health Services Society	Siska Cook's Ferry Band
2. Q'wemtsin Health Society	Skeetchestn Tk'emlups Whispering Pines
3. Fraser Thompson Indian Services Society	Spuzzum Boston Bar Boothroyd Oregon Jack Creek
4. Three Corners Health Services Society	Soda Creek Canoe Creek Williams Lake
5. Skeesht Health Services Society	Lytton
6. Scw'exmx Community Health Services Society	Coldwater Shackan Nooaitch

[8] As defined by Aboriginal Affairs and Northern Development Canada's website: http://www.aadnc-aandc.gc.ca/eng/1100100013812/1100100013813 accessed on: June 27, 2013

2. Health Status Information

The graphs included in this section pull in data from a number of sources outlined in the "Health Status Data Sources" panel below.

Statistics reported in this section are based on currently available data. These statistics are largely "illness-based" and do not reflect the envisioned Wellness approach to health reporting.

Health Status Data Sources

First Nations Client File (FNCF)[9]: The First Nations Client File is the product of a record linkage between an extract of the Aboriginal Affairs and Northern Development Canada Indian Registry and the BC Ministry of Health Client Registry and subsequent probabilistic matching. The Personal Health Number contained in the FNCF enables linking to other administrative databases. The First Nations Client file is a cohort of BC Resident First Nations people registered under the Indian Act, and their unregistered descendants for whom entitlement-to-register can be determined, linkable on their BC Ministry of Health PHN number. In the 2012 FNCF, approximately 5% of the total FNCF cohort has had their Status inferred. The First Nations Client File is updated on an annual basis using a fresh extract from the BC Client Registry and the AANDC Indian Registry. The data presented in this section are derived from databases held by the British Columbia Vital Statistics Agency linked to the First Nations Client File.

Vital Statistics Agency Database: The Vital Statistics Agency Database registers all births, marriages, deaths, and changes of name that occur in British Columbia.

Medical Services Plan Group 21: The MSP Registration & Premium Billing Group 21 includes individuals who have registered to have their MSP premium funded by the federal government. Eligible recipients are Status First Nations, Inuit recognized by Inuit Land Claim organizations and infants less than one year of age whose parent is an eligible recipient. MSP Group 21 does not include Status First Nations who have not requested their premiums to be paid by the federal government (eg. those who are working and have their MSP premiums covered by their employers).

Blue Matrix: The Blue Matrix is a collection of chronic disease and health service utilization registries held by the BC Ministry of Health. This data source includes physician services, hospital inpatient and day surgeries, PharmaCare, Residential Care, Home and Community Care Services.

Non-insured Health Benefits (NIHB): Data are presented for NIHB pharmacy utilization for status First Nations using pharmacies in British Columbia. The NIHB Program covers claims for pharmacy benefits not covered by private, public or provincial health care plans. The NIHB Program covers prescription drugs listed on the NIHB Drug Benefit List and approved over-the-counter medications.

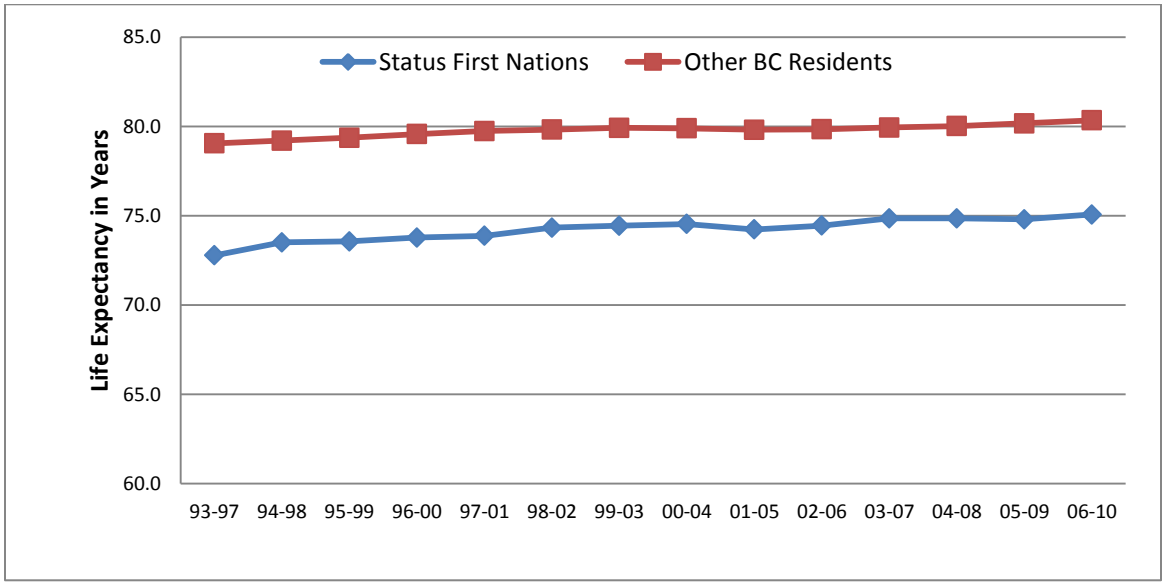
Provincial Health Officer (PHO) Annual Report 2007[10]: BC Resident Status Indian population in the 2007 PHO report was estimated using Health Canada's Status Verification File (SVF) with the Ministry of Health's Client Roster to count persons living in BC. The SVF is an extract of data from the AANDC Indian Registry.

[9] BC Ministry of Health. Presentation to the Tripartite Data and Information Planning Committee. August 2012.
[10] British Columbia Provincial Health Officer. Pathways to Health and Healing – 2nd Report on the Health and Well-being of Aboriginal People in British Columbia. Provincial Health Officer's Annual Report 2007. Victoria, BC: Ministry of Healthy Living and Sport.

2.1 Life Expectancy

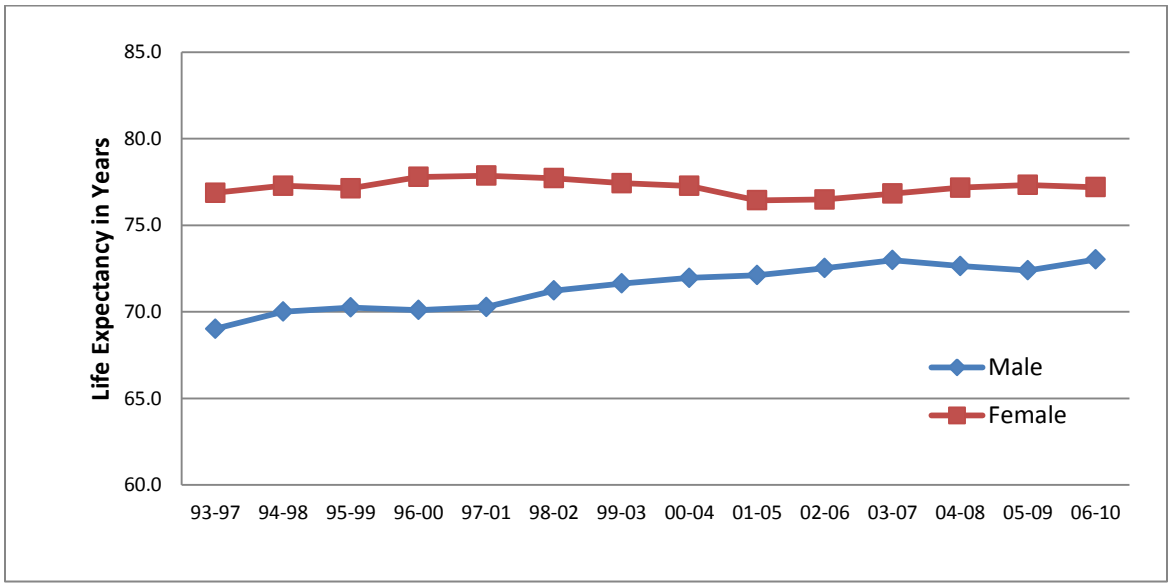
Life expectancy is the expected (in the statistical sense) number of years of life remaining at a given age. The following graphs show life expectancy at birth for Status First Nations in Interior Region, as compared to other residents and then life expectancy at birth comparing males and females among Status First Nations in the region.

Figure 5 Life Expectancy in years, Status First Nations and Other BC residents 1993-2010, Interior Region



Source: BC Vital Statistics Agency, data as of April 17, 2012 (First Nations individuals identified through linkage to the First Nations Client File – see description in the Health Status Data Sources panel)

Figure 6 Life Expectancy in years, Status First Nations by Gender 1993-2010, Interior Region

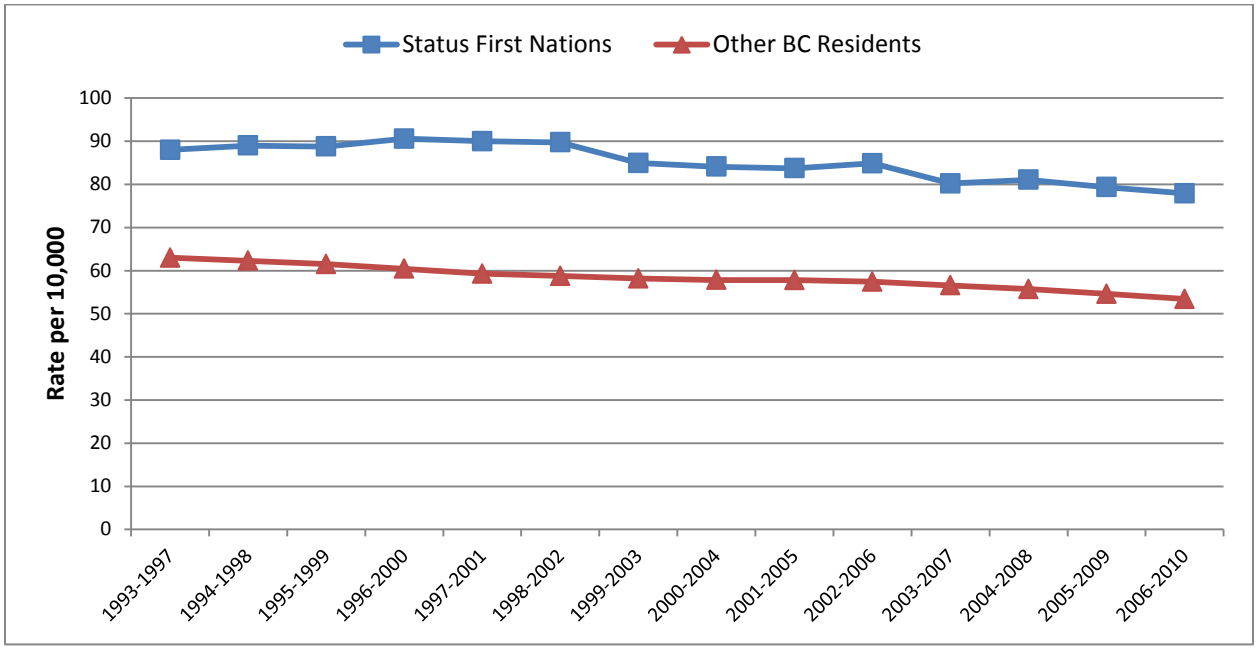


Source: BC Vital Statistics Agency, data as of April 17, 2012 (First Nations individuals identified through linkage to the First Nations Client File – see description in the Health Status Data Sources panel)

2.2 All-cause Mortality

Age-standardized mortality rate (ASMR) measures the number of deaths due to all causes, expressed as a rate per 10,000 people. This measure allows for comparison in death rates between Status First Nations and other BC residents by adjusting for differences in population age distribution.

Figure 7 All-cause mortality (age-standardized), Status First Nations and Other Residents, 1993/97-2006/10, Interior Region

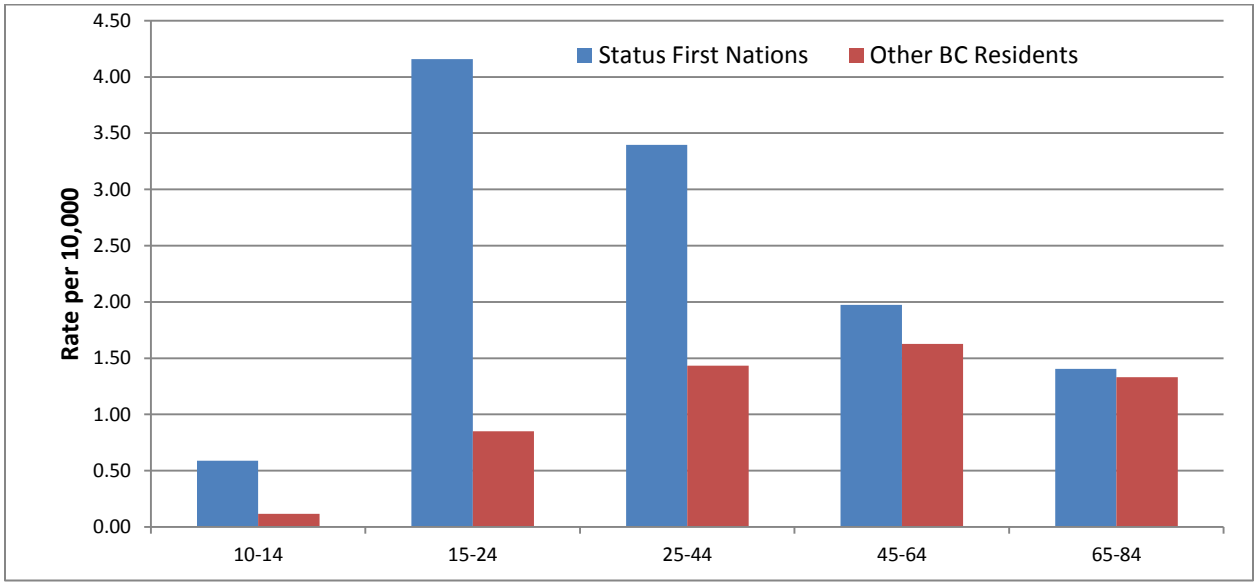


Source: BC Vital Statistics Agency, data as of April 17, 2012 (First Nations individuals identified through linkage to the First Nations Client File – see description in the Health Status Data Sources panel)

2.3 Suicide

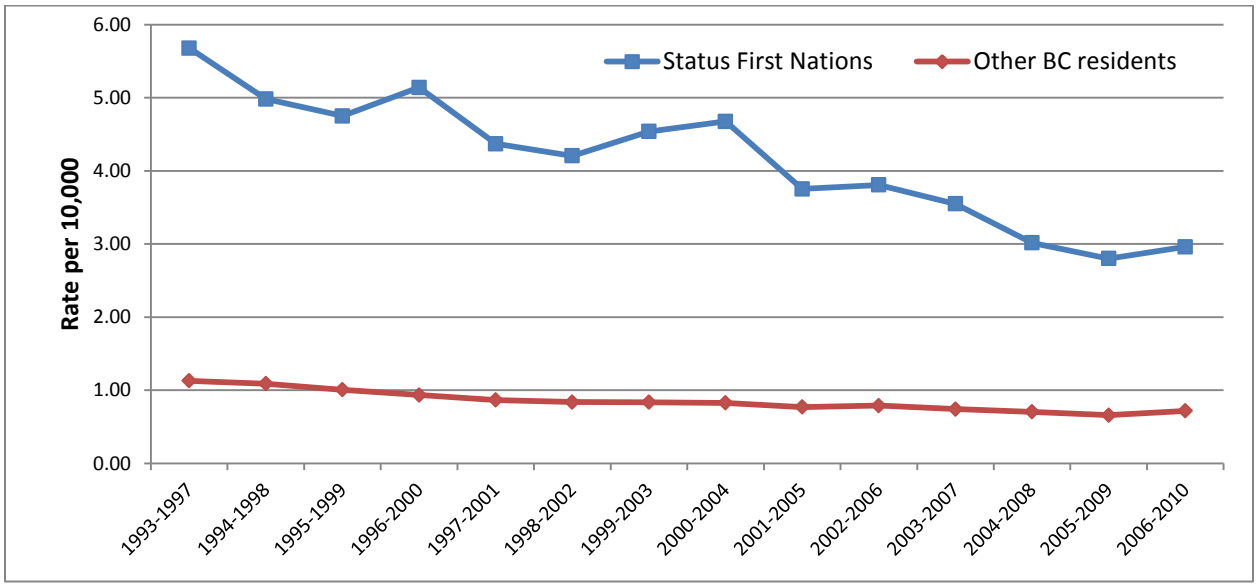
Between the years 1993-1997 to 2006-2010, the suicide mortality rate has decreased for Status First Nations resident in BC. However it is still relatively high compared to other residents of BC and remains an important concern for all communities.

Figure 8 Suicide Mortality Rate, by Age Group, Status First Nations and Other BC residents, Average for 1993-2010 combined



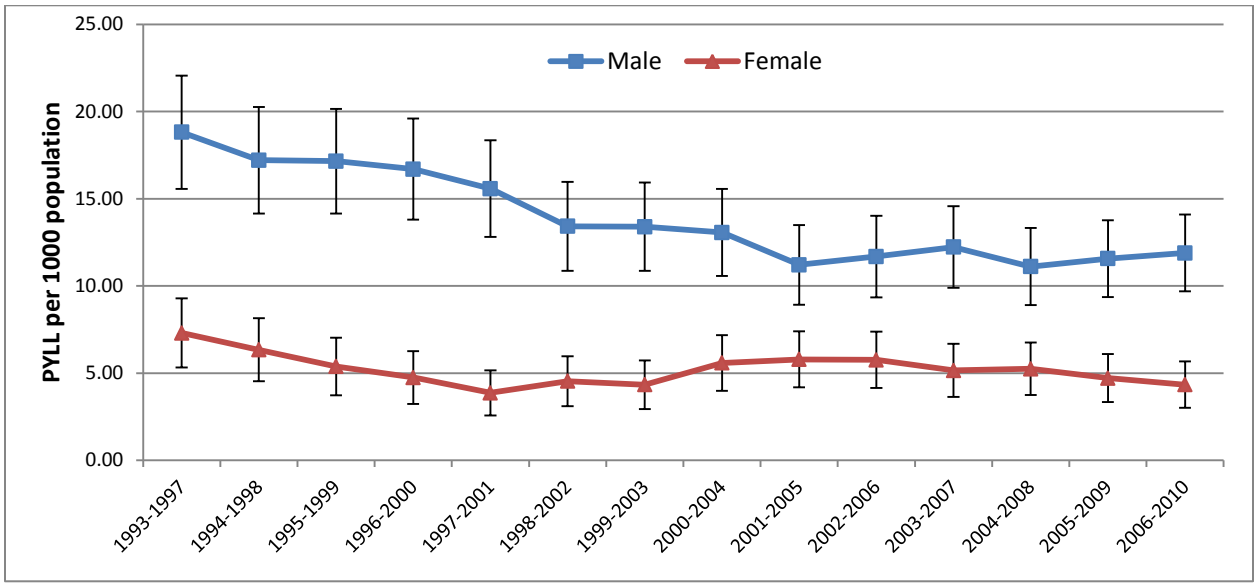
Source: BC Vital Statistics Agency, data as of April 17, 2012 (First Nations individuals identified through linkage to the First Nations Client File – see description in the Health Status Data Sources panel)

Figure 9 Suicide Mortality Rate, Youth Aged 15-24, Status First Nations and Other BC residents, 5-year aggregate 1993/97-2006/10



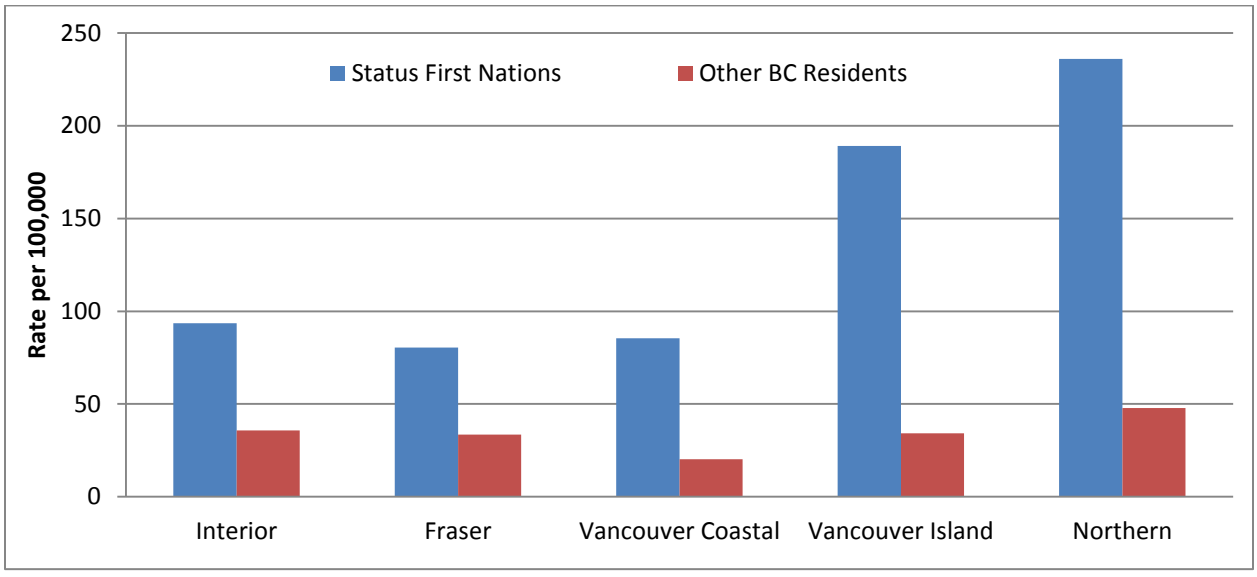
Source: BC Vital Statistics Agency, data as of April 17, 2012 (First Nations individuals identified through linkage to the First Nations Client File – see description in the Health Status Data Sources panel)

Figure 10 Potential Years of Life Lost (PYLL) due to Suicide (with 95% Confidence Intervals)[11], Status First Nations in BC, by Gender, 1993/97-2006/10



Source: BC Vital Statistics Agency, data as of April 17, 2012 (First Nations individuals identified through linkage to the First Nations Client File – see description in the Health Status Data Sources panel)

Figure 11 Hospitalization rate for Suicide/Attempted Suicide, Status First Nations and Other Residents, by BC Regional Health Authority, 2006



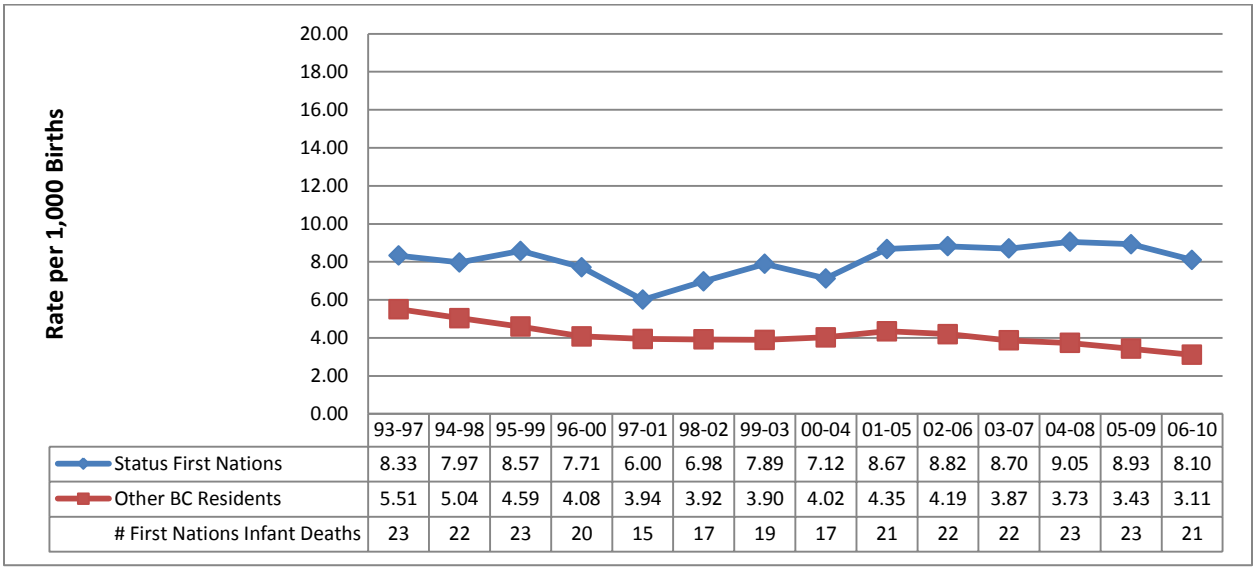
Source: Provincial Health Officer's Annual Report 2007. Victoria, BC

2.4 Infant Mortality

[11] A confidence interval is a statistical technique that measures the range of values estimated in the sample of a population. A 95 per cent confidence interval means that 19 times out of 20, the true values lies between the horizontal bars shown as (I) on the charts. Because of the fluctuations in the small numbers of events, the use of confidence intervals helps to determine whether changes from year to year are more likely to be due to chance alone or are reflecting a real change.

Infant mortality rates for Status First Nations living in Interior Region have improved between the years 1993-1997 to 2006-2010, however it still higher than the rate for all other residents.

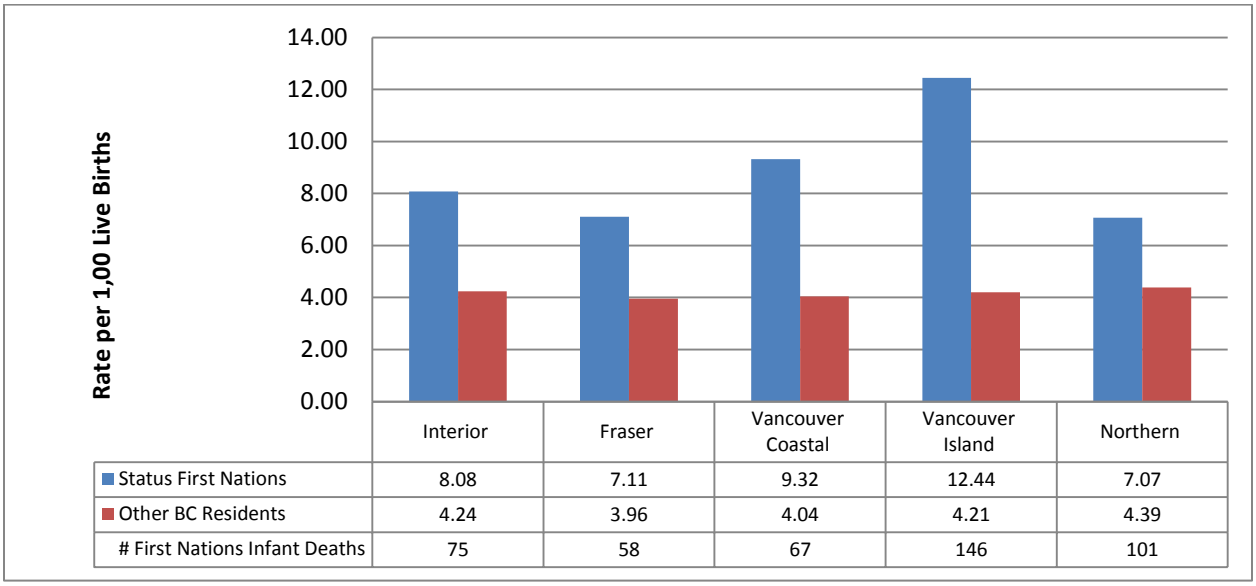
Figure 12 Infant Mortality Rate (per 1,000 births), Status First Nations and Other Residents, Interior Region, BC, 1993/97-2006/10



	93-97	94-98	95-99	96-00	97-01	98-02	99-03	00-04	01-05	02-06	03-07	04-08	05-09	06-10
Status First Nations	8.33	7.97	8.57	7.71	6.00	6.98	7.89	7.12	8.67	8.82	8.70	9.05	8.93	8.10
Other BC Residents	5.51	5.04	4.59	4.08	3.94	3.92	3.90	4.02	4.35	4.19	3.87	3.73	3.43	3.11
# First Nations Infant Deaths	23	22	23	20	15	17	19	17	21	22	22	23	23	21

Source: BC Vital Statistics Agency, data as of April 17, 2012 (First Nations individuals identified through linkage to the First Nations Client File – see description in the Health Status Data Sources panel)

Figure 13 Infant Mortality Rate (per 1,000 births), Status First Nations and Other Residents, by BC Regional Health Authority, 1993/97-2006/10



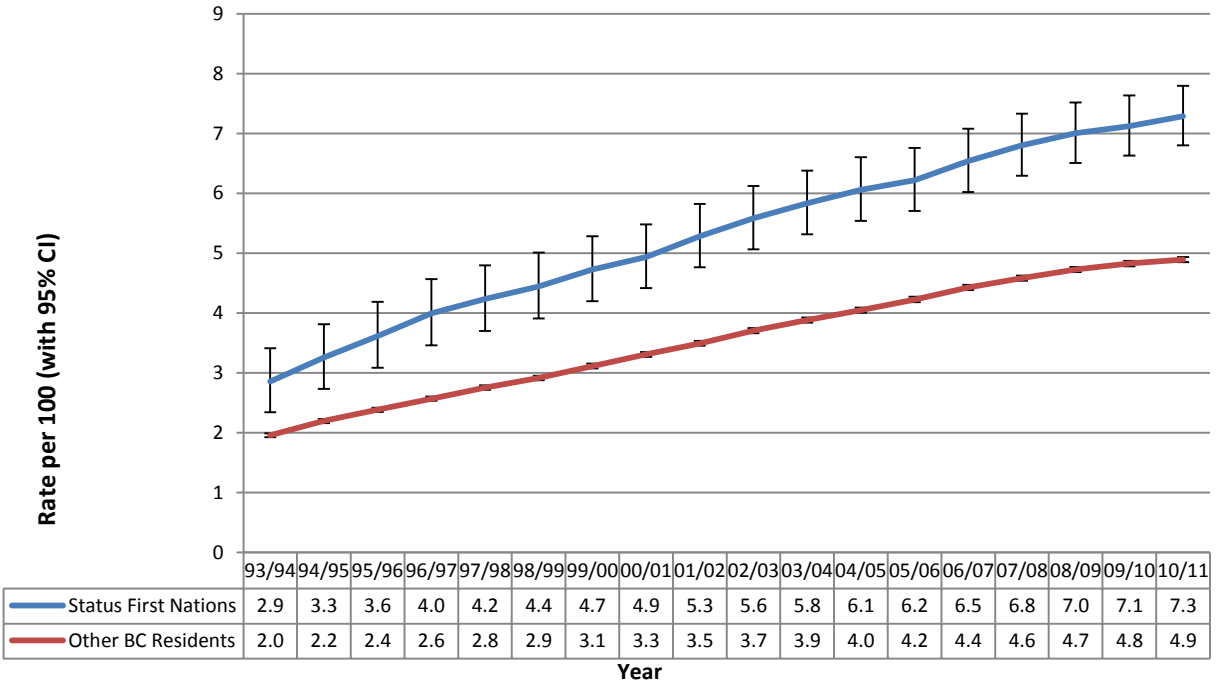
	Interior	Fraser	Vancouver Coastal	Vancouver Island	Northern
Status First Nations	8.08	7.11	9.32	12.44	7.07
Other BC Residents	4.24	3.96	4.04	4.21	4.39
# First Nations Infant Deaths	75	58	67	146	101

Source: BC Vital Statistics Agency, data as of April 17, 2012 (First Nations individuals identified through linkage to the First Nations Client File – see description in the Health Status Data Sources panel)

2.5 Diabetes

For the diabetes statistics displayed in this section, a case may be defined as an individual with a physician diagnosis of diabetes or be identified through record of diabetes drug utilization. It is evident from the figures that diabetes is a growing concern for Status First Nations as well as other residents of BC.

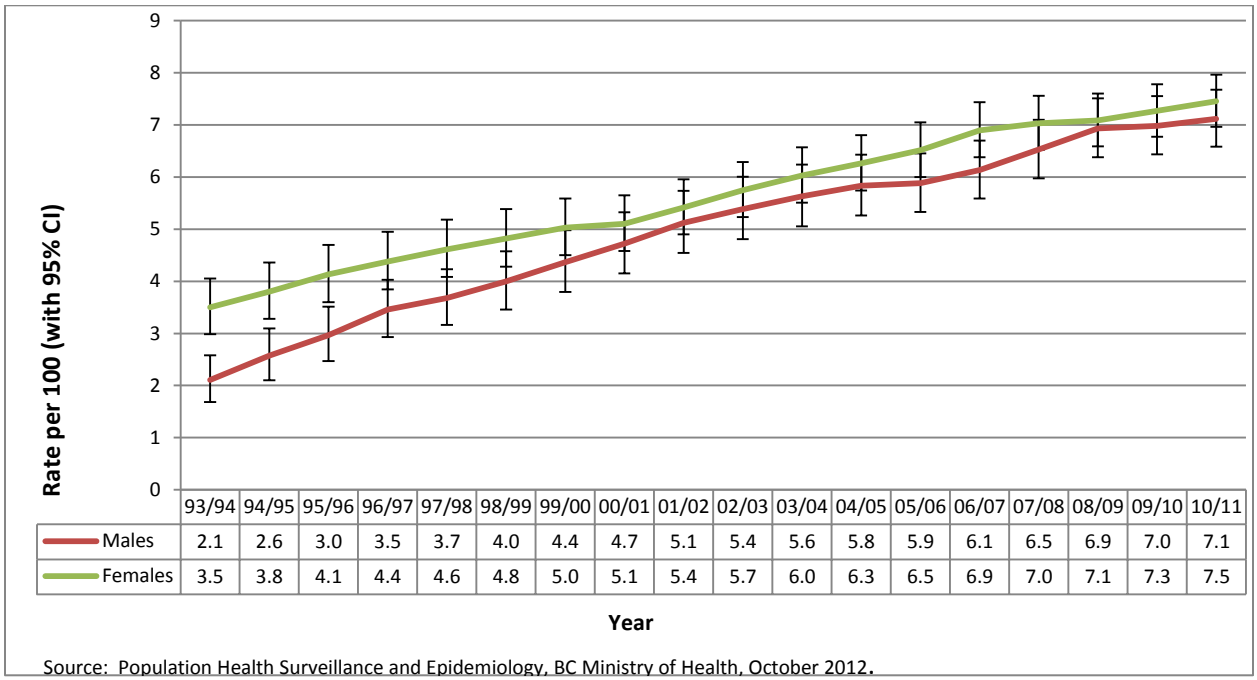
Figure 14 Age-standardized Diabetes Prevalence, Status First Nations and Other Residents, Interior Region, BC 1993-2011



	93/94	94/95	95/96	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11
Status First Nations	2.9	3.3	3.6	4.0	4.2	4.4	4.7	4.9	5.3	5.6	5.8	6.1	6.2	6.5	6.8	7.0	7.1	7.3
Other BC Residents	2.0	2.2	2.4	2.6	2.8	2.9	3.1	3.3	3.5	3.7	3.9	4.0	4.2	4.4	4.6	4.7	4.8	4.9

Source: Population Health Surveillance and Epidemiology, BC Ministry of Health, October 2012.

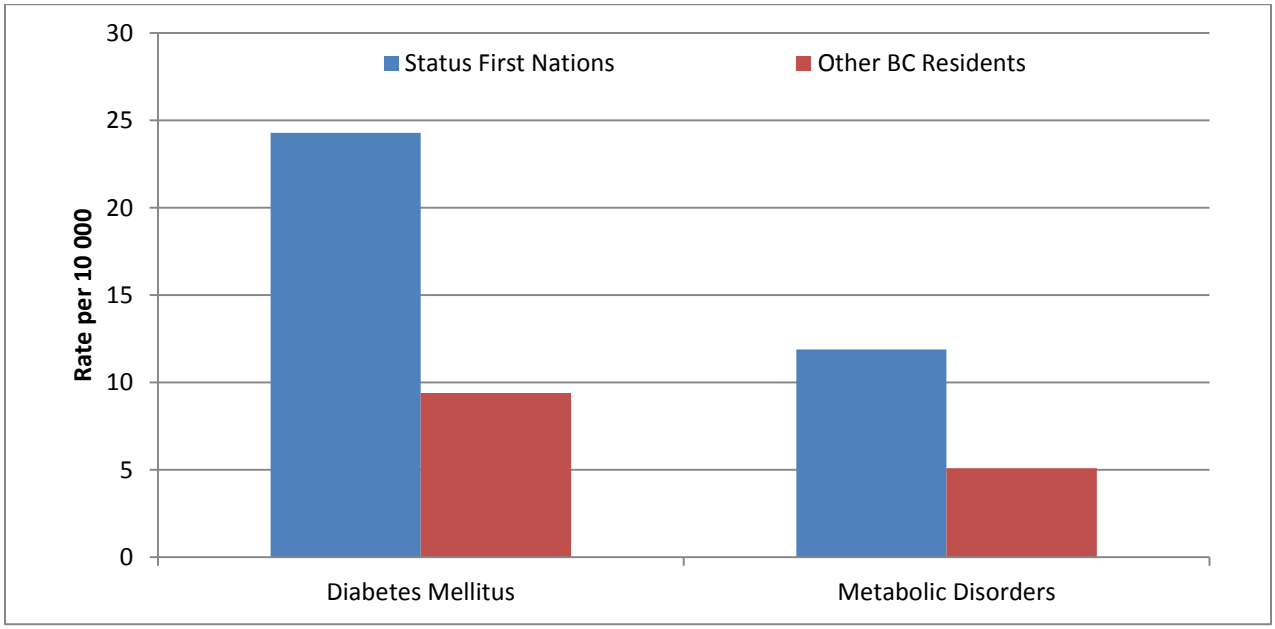
Figure 15 Age-standardized Diabetes Prevalence, Status First Nations by Gender, Interior Region, BC 1993-2011



	93/94	94/95	95/96	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11
Males	2.1	2.6	3.0	3.5	3.7	4.0	4.4	4.7	5.1	5.4	5.6	5.8	5.9	6.1	6.5	6.9	7.0	7.1
Females	3.5	3.8	4.1	4.4	4.6	4.8	5.0	5.1	5.4	5.7	6.0	6.3	6.5	6.9	7.0	7.1	7.3	7.5

Source: Population Health Surveillance and Epidemiology, BC Ministry of Health, October 2012.

Figure 16 Hospitalization for Endocrine, Nutritional and Metabolic Disorder, First Nations and Other Residents, BC, 2004-2007

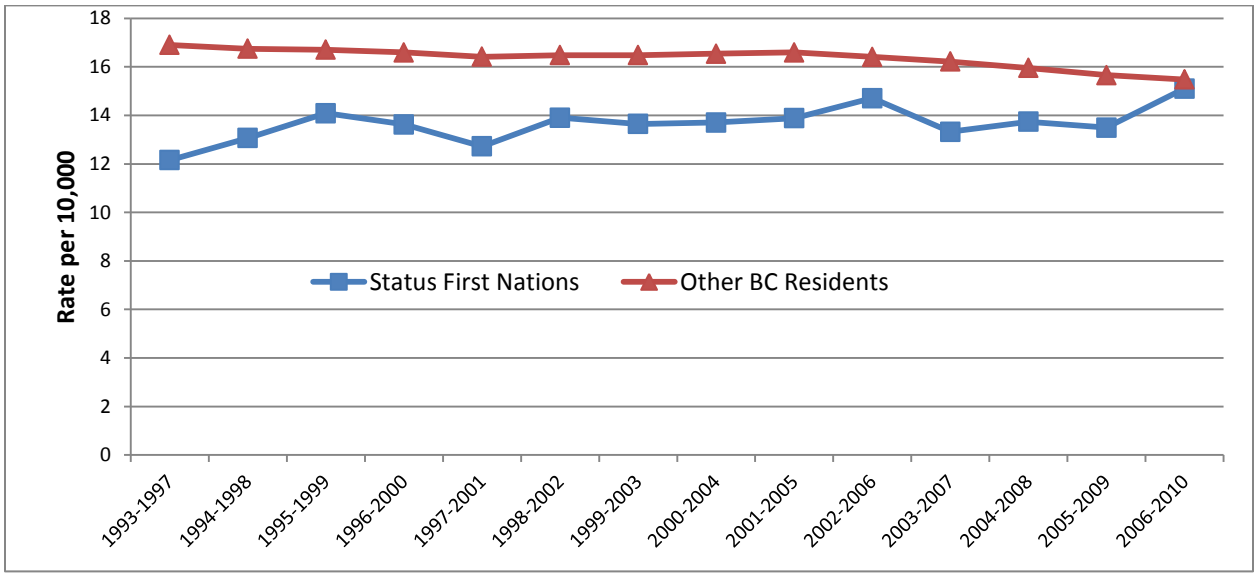


Source: Pathways to Health and Healing – 2nd Report on the Health and Well-being of Aboriginal People in British Columbia. Provincial Health Officer's Annual Report 2007. Victoria, BC: Ministry of Healthy Living and Sport

The figure above indicates that Status First Nations people resident in BC have a higher rate of hospitalization due to diabetes and metabolic disorders than other BC residents.

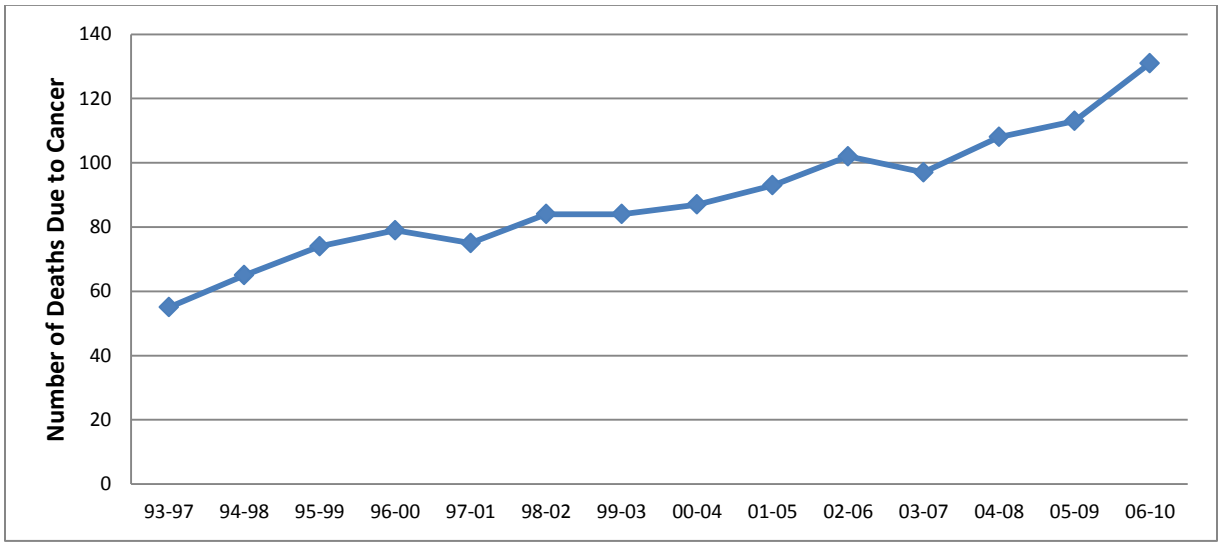
2.6 Cancer

Figure 17 Cancer Mortality (age-standardized), Status First Nations and Other Residents, Interior Region, BC 1993/97-2006/10



Source: BC Vital Statistics Agency, data as of April 17, 2012 (First Nations individuals identified through linkage to the First Nations Client File – see description in the Health Status Data Sources panel)

Figure 18 Number of Deaths due to Cancer, Status First Nations, Interior Region, BC, 1993/97-2006/10



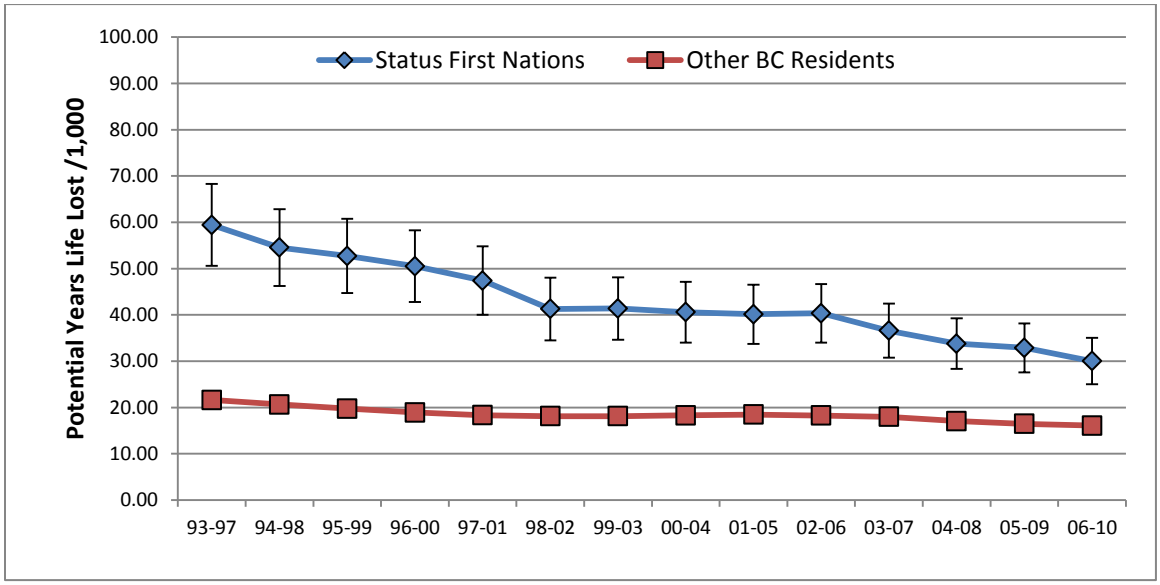
Source: BC Vital Statistics Agency, data as of April 17, 2012 (First Nations individuals identified through linkage to the First Nations Client File – see description in the Health Status Data Sources panel)

The age-standardized mortality rate due to cancer for Status First Nations people resident in Interior Region has decreased between 1993-1997 to 2006-2010. However the absolute numbers of deaths due to cancer has increased during this same time period.

2.7 Injury

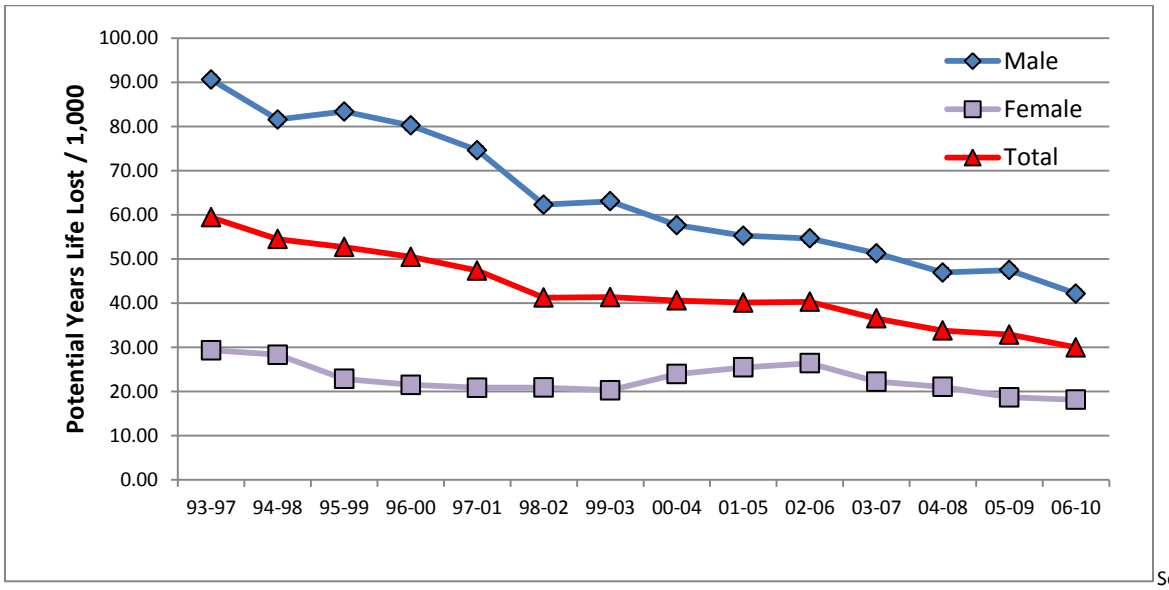
Potential Years **L**ife **L**ost (PYLL) was used as a unit of measurement in presenting death by external causes. This measure integrates information on both the mortality event and the years of life lost, from the referent age of 75. For a more detailed description of PYLL see Appendix 6.1. An external cause of death, defined by the WHO's ICD-10 codes[12], is a death due to accidents, violence, poisoning, other adverse events, including environmental events.

Figure 19 Potential Years of Life Lost (PYLL), External Causes, Status First Nations and Other Residents, Interior Region, BC, 1993/97-2006/10



[11] World Health Organization website: http://www.who.int/classifications/icd/en/ retrieved November 23, 2012

Figure 20 Potential Years of Life Lost (PYLL), External Causes, Status First Nations by Gender, Interior Region, BC, 1993/97-2006/10



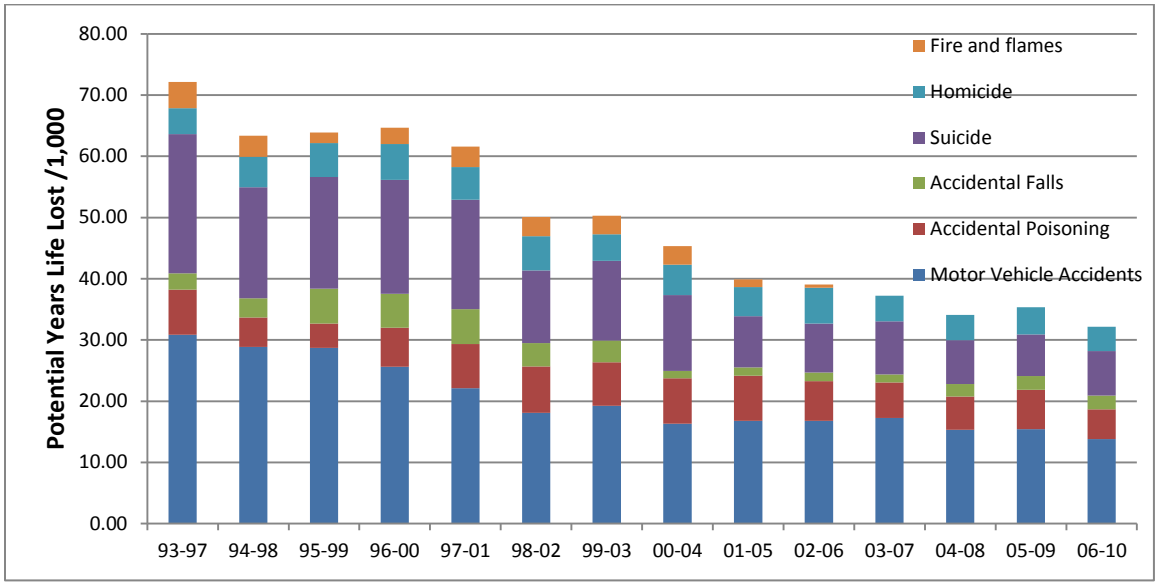
Source: BC Vital Statistics Agency, data as of April 17, 2012 (First Nations individuals identified through linkage to the First Nations Client File – see description in the Health Status Data Sources panel)

Accidental poisonings defined by the WHO's ICD9 codes[13], include the following:

- Analgesics antipyretics and antirheumatics
- barbiturates
- sedatives and hypnotics
- tranquilizers
- other psychotropic agents
- other drugs acting on central and autonomic nervous system
- antibiotics
- other anti-infectives
- other drugs
- alcohol not elsewhere classified
- cleansing and polishing agents disinfectants paints and varnishes
- petroleum products other solvents and their vapors not elsewhere classified
- agricultural and horticultural chemical and pharmaceutical preparations other than plant foods and fertilizers
- corrosives and caustics not elsewhere classified
- foodstuffs and poisonous plants
- other and unspecified solid and liquid substances
- gas distributed by pipeline
- other utility gas and other carbon monoxide
- other gases and vapors

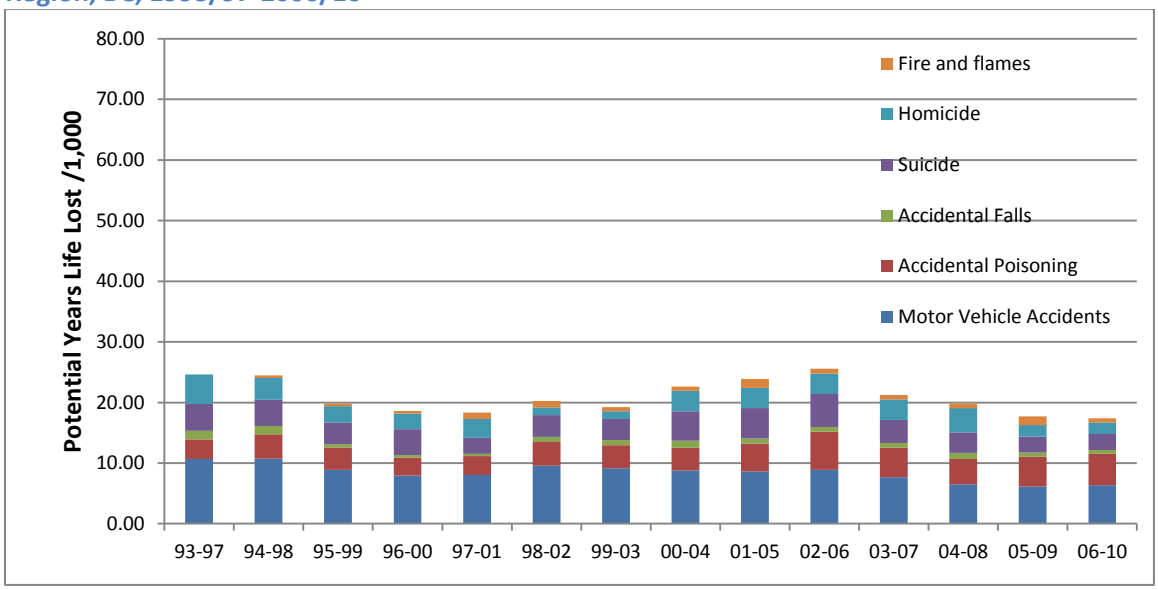
[13] World Health Organization website:http://www.icd9data.com/2012/Volume1/E000-E999/E860-E869/default.htm accessed on June 20, 2013

Figure 21 Potential Years of Life Lost, by External Cause, Status First Nations - Male, Interior Region, BC, 1993/97-2006/10



Source: BC Vital Statistics Agency, data as of April 17, 2012 (First Nations individuals identified through linkage to the First Nations Client File – see description in the Health Status Data Sources panel)

Figure 22 Potential Years of Life Lost (PYLL), by External Cause, Status First Nations - Female, Interior Region, BC, 1993/97-2006/10



Source: BC Vital Statistics Agency, data as of April 17, 2012 (First Nations individuals identified through linkage to the First Nations Client File – see description in the Health Status Data Sources panel)

As you can see in Figure 20, the proportion of PYLL/1,000 due to suicide and motor vehicle accidents has decreased over time for Status First Nation males in Interior Region.

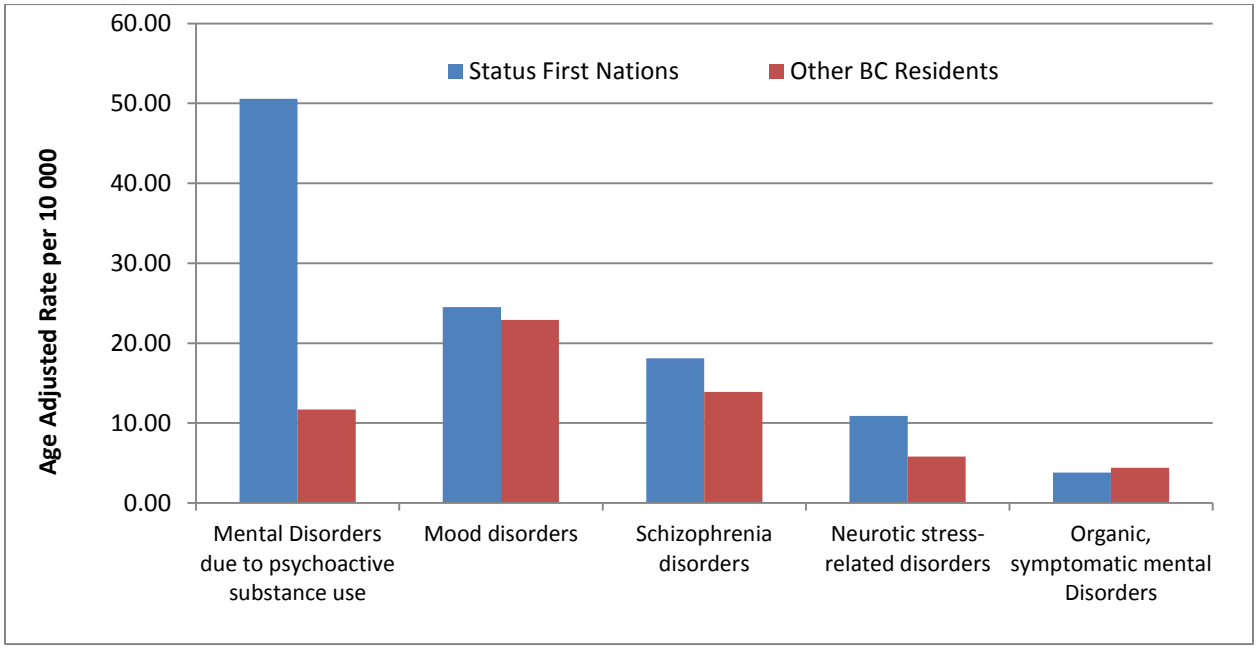
2.8 Mental Health and Wellness

Figure 22, below, illustrates the rates of hospitalizations for Mental and Behavioural Disorders for Status First Nations people compared to other residents in BC for the years 2004 to 2007 combined. The category "Mental disorders due to psychoactive substance use" are defined by the WHO's ICD 10[14] as those mental disorders due to the use of:

- alcohol
- opioids
- cannabinoids
- sedative hypnotics
- cocaine
- other stimulants, including caffeine
- hallucinogens
- tobacco
- volatile solvents
- multiple drug use and use of other psychoactive substances

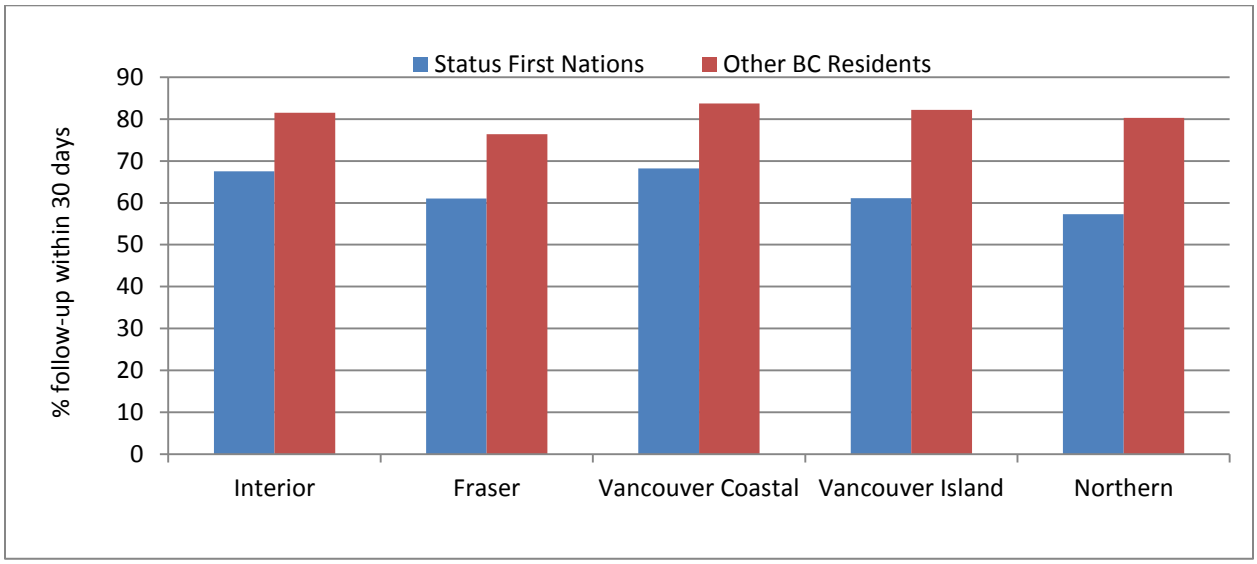
"Mood disorders" include various types of depression, bipolar, and mania.

Figure 23 Rate of hospitalizations for Mental and Behavioural Disorder, Status First Nations and Other Residents, BC, 2004-2007 Combined



[14] World Health Organization website: http://www.who.int/substance_abuse/terminology/ICD10ResearchDiagnosis.pdf accessed on June 20, 2013

Figure 24 Percentage of Mental Health Hospital Admissions with Community Follow-up within 30 days after Discharge, Status First Nations and Other Residents, by BC Regional Health Authority, 2006



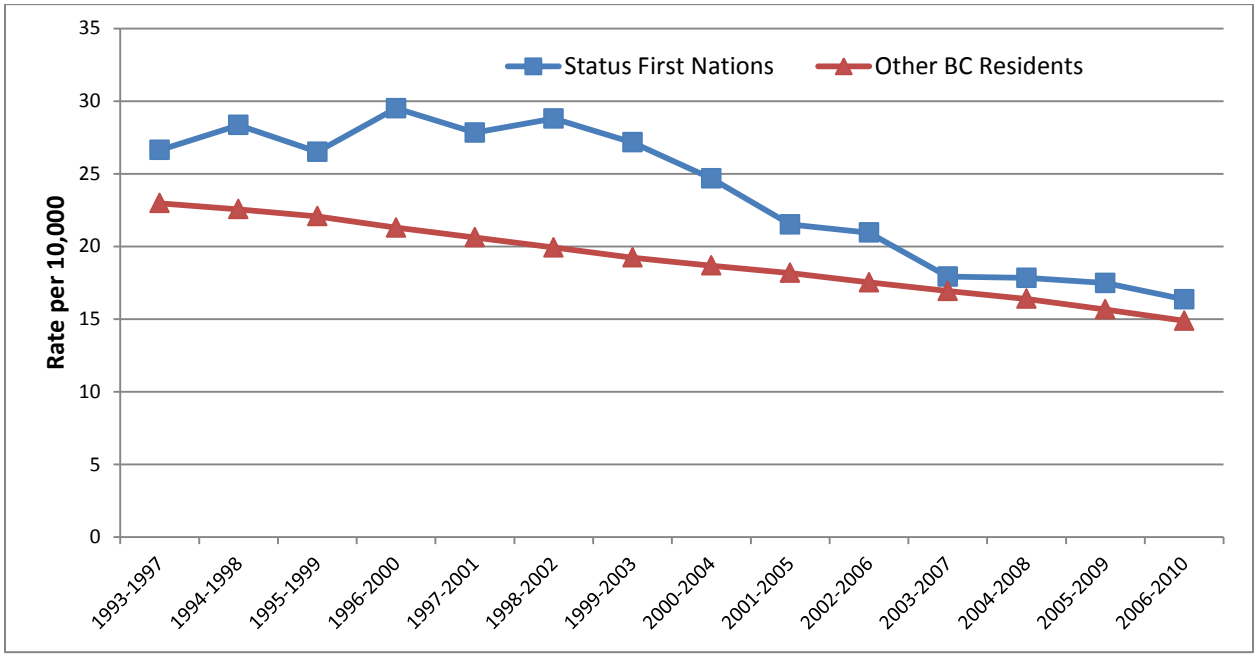
Source: Pathways to Health and Healing – 2nd Report on the Health and Well-being of Aboriginal People in British Columbia. Provincial Health Officer's Annual Report 2007. Victoria, BC: Ministry of Healthy Living and Sport

From the data summarized in Figure 23, above, it is evident that a lower proportion of First Nations people who had been admitted to hospital due to mental health reasons received community follow-up within 30 days after discharge than other residents for all Regional Health Authorities.

2.9 Circulatory System Disease

Mortality due to circulatory system disease captures deaths attributed to stroke and/or heart disease.

Figure 25 Age-standardized mortality due to Circulatory System Disease, Status First Nations and Other Residents, Interior Region, BC, 1993/97-2006/10



Source: BC Vital Statistics Agency, data as of April 17, 2012 (First Nations individuals identified through linkage to the First Nations Client File – see description in the Health Status Data Sources panel)

2.10 NIHB Pharmacy Utilization

The Non-Insured Health Benefits Program is Health Canada's national, medically necessary health benefit program that provides coverage for benefit claims for a specified range of drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention mental health counselling and medical transportation for eligible First Nations people and Inuit.

An eligible recipient is someone who is entitled to receive benefits such as vision care, prescription drugs or other benefits or services from the NIHB Program.
An eligible recipient must be identified as a resident of Canada and one of the following:

- A registered Indian according to the *Indian Act*;
- An Inuk recognized by one of the Inuit Land Claim organizations; or
- An infant less than one year of age, whose parent is an eligible recipient.[15]

Table 6 Remoteness and percentage of clients who filled out prescriptions in BC First Nations Communities (2011)

Remoteness and % of clients who filled out prescriptions in BC First Nations Communities (2011)			
Proximity to Service Center [7]	**# Communities**	**% of eligible clients who filled out prescriptions using NIHB**	**95% Confidence Interval**
< 50 km to service center	75	63.1%	63.5 – 69.6
Between 50 and 350 km to service center	73	63.5%	60.2 – 69.1
> 350 km from nearest service center	11	64.7%	61.9 – 65.2
No year round access to service center	28	66.6%	61.1 – 65.1

The above table illustrates that proximity to a service centre had no effect on the % of eligible clients who filled out prescriptions using NIHB. All clients were approximately equally likely to fill out a prescription regardless of their proximity to a service centre.

[15] As defined by Health Canada on: http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/index-eng.php accessed on June 27, 2013

Table 7 NIHB Pharmacy Utilization by Region, 2011

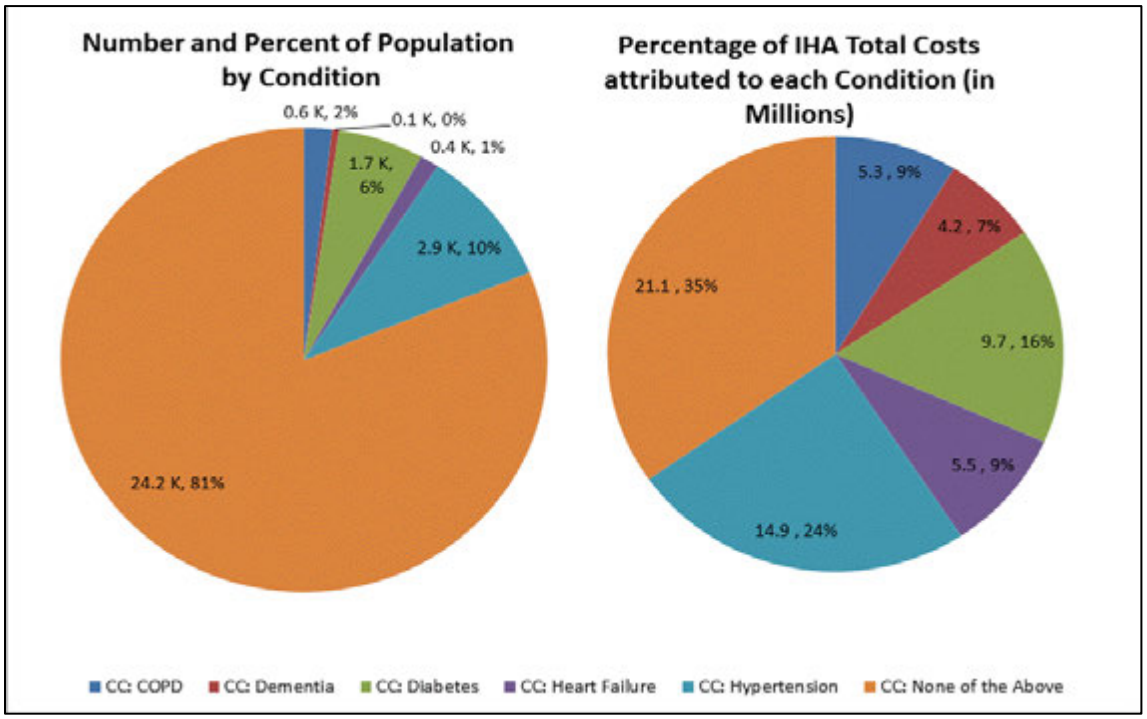
NIHB Pharmacy Utilization by Region					
	NHA	**IHA**	**FHA**	**VCHA**	**VIHA**
Number of clients eligible for NIHB (2011)	47 173	29 487	8 946	15 959	30 888
% of population who filled a prescription with NIHB (2011)	62.5	62.3	58.9	69.1	66.1
Average Cost / Claimant in 2011 ($)	622	660	748	736	674
Average Cost / Claimant in 2000 ($)	322	330	435	428	384
Amount Paid in 2011	19 087 006	12 356 184	4 337 775	8 188 050	13 695 873

Source: Non-insured Health Benefits Pharmacy Data Cube

Table 7 illustrates that for that for Interior Region, there was in increase in the average cost per claimant between the years 2000 and 2011 from $330 to $660. This may be due to factors such as an increase in professional fees charges by pharmacists and the addition of new medications being covered under the NIHB plan.

2.11 Healthcare Utilization

Figure 26 Number and Percentage of Status First Nations Population by Chronic Condition and Percentage of Interior Region Total Costs attributed by Chronic Condition (number, %)



Source: MSP Group 21 denominator file linked to the Ministry of Health's Blue Matrix, (see the Health Status Data Sources panel)

3. Budget Information

First Nations Inuit Health- BC Region Program Funding data

This report includes regional summaries on the status of First Nations and Inuit Health's (FNIH) Health Transfer Program, which began in 1989. In 2005, FNIH introduced new Health Funding Arrangements entitled the Contribution Funding Framework (CFF) to the Health Transfer Program. According to FNIH, the new CFF is designed to be more responsive to communities and have increased flexibilities across sectors, as well as allowing the possibility of greater community-control.[16] Under the new CFF, a recipient can enter into a longer term contribution agreement (up to ten years in the flexible transfer funding model) compared to the old maximum of five years associated with previous model Transfer agreements. Significantly, a recipient does not need to go through each of the four models in the new CFF to apply for the highest level of self-control. Rather, following a capacity assessment done collaboratively between the recipient and FNIH, a recipient can apply for the most appropriate model based on their capacity and abilities.

The previous funding arrangements consisted of three defined funding agreement models (**General, Integrated,** and **Transfer).** Associated with these funding models were additional elements, such as community size that determined whether a community may reach the final phase.
In 2007, updated funding models were introduced (**Set, Transitional, Flexible,** and **Flexible Transfer**). One or more of these funding models could be accommodated in a single funding agreement, with flexible transfer allowing for the most community-control.

In 2011, new funding models were introduced (**Set, Flexible** and **Block**) in an effort to harmonize federal government funding mechanisms. These funding models are similar to the funding models introduced in 2007, with the exception of the Block funding model, which combines the characteristics of the previous Flexible and Flexible Transfer funding models[17]. The funding models vary in the amount of participation of FNIHB in program management and administration; flexibility in reallocating funds within and between programs; the ability to carry forward unspent funds from fiscal year to fiscal year and to use a surplus; as well as reporting and evaluation requirements.

At the time of publication, updated funding arrangement and program funding data from FNIH BC Region were not available so the 2008/2009 funding amounts and funding arrangement details published in the previous version of this Profile report are repeated.

[16] First Nations and Inuit Health, BC Region (2007). Contribution Funding Framework and Health Planning Process, May 2007. Retrieved May 6, 2009 from http://74.125.155.132/search?q=cache:dmiEXtBgTEUJ:www.bcfnhs.org/downloads/admin/national/Natl_Funding_Changes_2008.ppt+FNIHB+Health+funding+arrangements&cd=6&hl=en&ct=clnk .

[17] For more information on types of FNIHB contribution agreements, please see: http://www.hc-sc.gc.ca/fniah-spnia/finance/agree-accord/index-eng.php#type. Accessed: September 26, 2011.

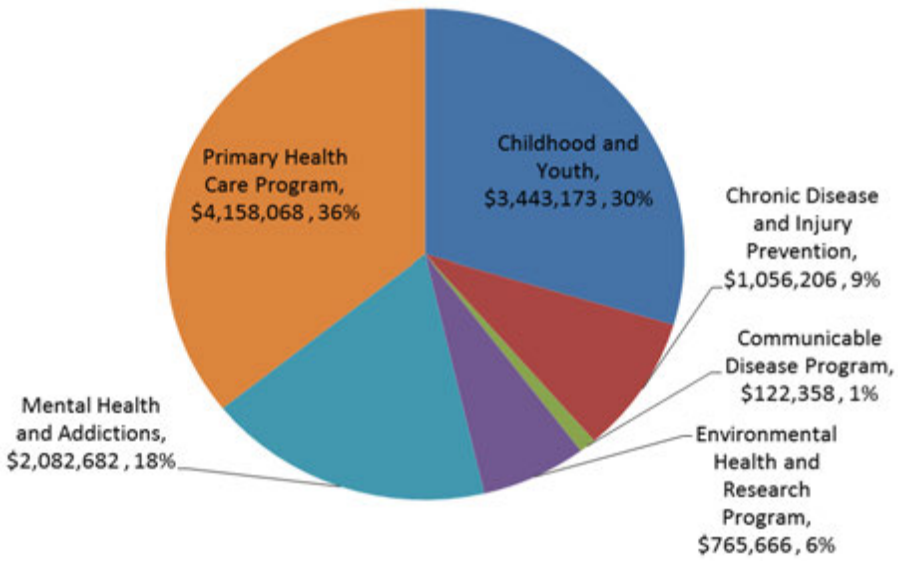
Table 8 Funding Arrangements between First Nations communities in the Interior Health Region with FNIHB (as of January 29, 2013)

Type of Funding Arrangement	Number	%
Total number of Bands with a Block Flexible Transfer Agreement	11	20.00%
Total number of Bands with a Flexible Transfer Agreement	36	65.45%
Total number of Bands who receive Set Funding	7	12.73%
Total number of Bands with no funding agreement	1	1.82%
TOTAL	55	100%

Table 9 Interior Health Region Summary of FNIHB Clusters funded by Contribution Agreements, 2012/13[18]

FNIHB Cluster	**Funding amount**
Childhood and Youth	$3,443,173
Chronic Disease and Injury Prevention	$1,056,206
Communicable Disease Program	$122,358
Environmental Health and Research Program	$765,666
Mental Health and Addictions	$2,082,682
Primary Health Care Program	$4,158,068
Total	$11,628,153

Figure 27 Interior Health Region Summary of FNIHB Clusters funded by Contribution Agreements, 2012/13



[18] For a description of programs in each cluster, please see Appendix.

4. Aboriginal Health & Wellness Strategy: 2010-2014[19]

The IHA Aboriginal Health & Wellness Strategy presents five key strategies that define their 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

[19] IHA. Aboriginal Health and Wellness Strategy (2010-2014). Available: http://www.interiorhealth.ca/YourHealth/AboriginalHealth/Documents/AboriginalHealthStrategy2010-14.pdf. Accessed: Apr 24, 2013

5. Appendix

5.1 Definition of Potential Years of Life Lost[20]:

Potential years of life lost (PYLL) is the number of years of life "lost" when a person dies "prematurely" from any cause – before age 75. A person dying at age 25, for example, has lost 50 years of life. Potential years of life lost are calculated by taking the median age in each age group, subtracting from 75, and multiplying by the number of deaths in that age group disaggregated by sex and cause of death. These data are presented as a standardized rate per 100,000 population. (However, in this report, the data are presented as a rate per 1,000 population.)

Causes of death are classified according to the International Classification of Disease (ICD–9) from 1979 to 1999. The year 2000 and subsequent years available are classified according to the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD–10).

[20] Statistics Canada website: http://www.statcan.gc.ca/pub/82-221-x/2011002/def/def1-eng.htm#de1pyo retrieved November 23, 2012

5.2 First Nations Health Authority Health Services

<table>
<tr><th>Health Promotion & Prevention</th><th>Health Protection</th><th>Dental</th><th>Health Surveillance</th></tr>
<tr>
<td rowspan="3">Children and Youth
Maternal Child Health
Canada Prenatal Nutrition Program
Fetal Alcohol Spectrum Disorder
Aboriginal Head Start
Mental Health and Addictions
Indian Residential Schools
National Native Alcohol & Drug Abuse Program
National Aboriginal Youth Suicide Prevention Strategy
Chronic Disease and Injury Prevention
Aboriginal Diabetes Initiative
Nutrition
Injury Prevention</td>
<td>Communicable Disease Control Unit
TB Control
Pandemic/Emergency Planning
HIV/AIDS
STI/BBI
Immunization
Consultation for Environmental Public Health</td>
<td>Children's Oral Health Initiative
Therapy and Treatment
Prevention and Promotion</td>
<td>Epidemiology
Health Reporting
e-Health Solutions
Regional Pharmacist
Consultation for Nursing, Non-Insured Health Benefits and Tripartite First Nations Health Plan</td>
</tr>
<tr><th>Environmental Public Health Services</th><th>Non-Insured Health Benefits</th><th>Health Transfer & Benefits</th></tr>
<tr>
<td>Drinking Water
Waste Water
Waste Management
Food Safety
Facilities Health Inspection
Emergency Response
Housing
Zoonotic Diseases
Communicable Disease Control
Environmental Contaminant</td>
<td>Pharmacy
Dental Care
Vision Care
Medical Supplies & Equipment
Short-term Crisis Intervention
Medical Transportation
Administration of Provincial Care Card</td>
<td>Manage Post Transfer
Manage Transfer Development
Community Development and Capacity Building
Quality Improvement and Accreditation
Contracts & Contributions</td>
</tr>
<tr><th>Nursing Services</th><th>Policy and Strategic Planning</th><th>Capital</th></tr>
<tr>
<td>Transfer Nursing
Recruitment and Retention
Nursing Education
Nursing Practice and Research
Northern Operations
Home and Community Care</td>
<td>Planning with FNHA in year of transition
Health Services Integration Fund
Supporting Transition Engagement and change management</td>
<td>Health Facility Development
Health Facility Replacement
Health Facility operations and maintenance
Best Practices for construction/tender process
Residences - use and management</td>
</tr>
</table>

Appendix B: First Nations Health Transfer History and Context

The *Transformative Change Accord* (2005) was the starting point of a shared journey of BC First Nations and the federal and provincial governments to improve the quality of life of First Nations people. In health, incremental progress has been made since then through a series of health plans and agreements, including the *Transformative Change Accord: First Nations Health Plan* (2006)*;* the *First Nations Health Plan Memorandum of Understanding* (2006)*;* the *Tripartite First Nations Health Plan* (2007)*;* the *BC Tripartite Framework Agreement on First Nations Health Governance* (2011)*;* and the *Health Partnership Accord* (2012). These are illustrated in figure 1, and key agreements are summarized below.

Figure 1. Health Plans and Agreements

The *Transformative Change Accord: First Nations Health Plan* (TCA: FNHP; 2006) was signed by the First Nations Leadership Council[1] and the Province of BC. The 10-year plan includes 29 action items in four areas: Governance, Relationships and Accountability; Health Promotion/Disease and Injury Prevention; Health Services and Performance Tracking.

Subsequently, a tripartite process was established to develop a *Tripartite First Nations Health Plan* (TFNHP, 2007) to build on the commitments in the TCA: FNHP. The *BC Tripartite Framework Agreement on First Nation Health Governance* (the "Framework Agreement") provided for the creation of a new health governance structure and the transfer the federal programs and operations to First Nations control. This new health governance structure includes the First Nations Health Council (FNHC), First Nations Health Authority (FNHA), First Nations Health Directors Association (FNHDA) and the Tripartite

[1] First Nations Leadership Council – Collective body of First Nations organizations in BC (BC Assembly of First Nations, First Nations Summit, and Union of BC Indian Chiefs) who came together to push for improvements to policies and programs and a new relationship with BC, and later with Canada.

Committee on First Nations Health (TCFNH) (see figure 2). It holds responsibility for health planning and administration as well as health design, delivery and accountability to better support the health care and service delivery needs of BC First Nations.

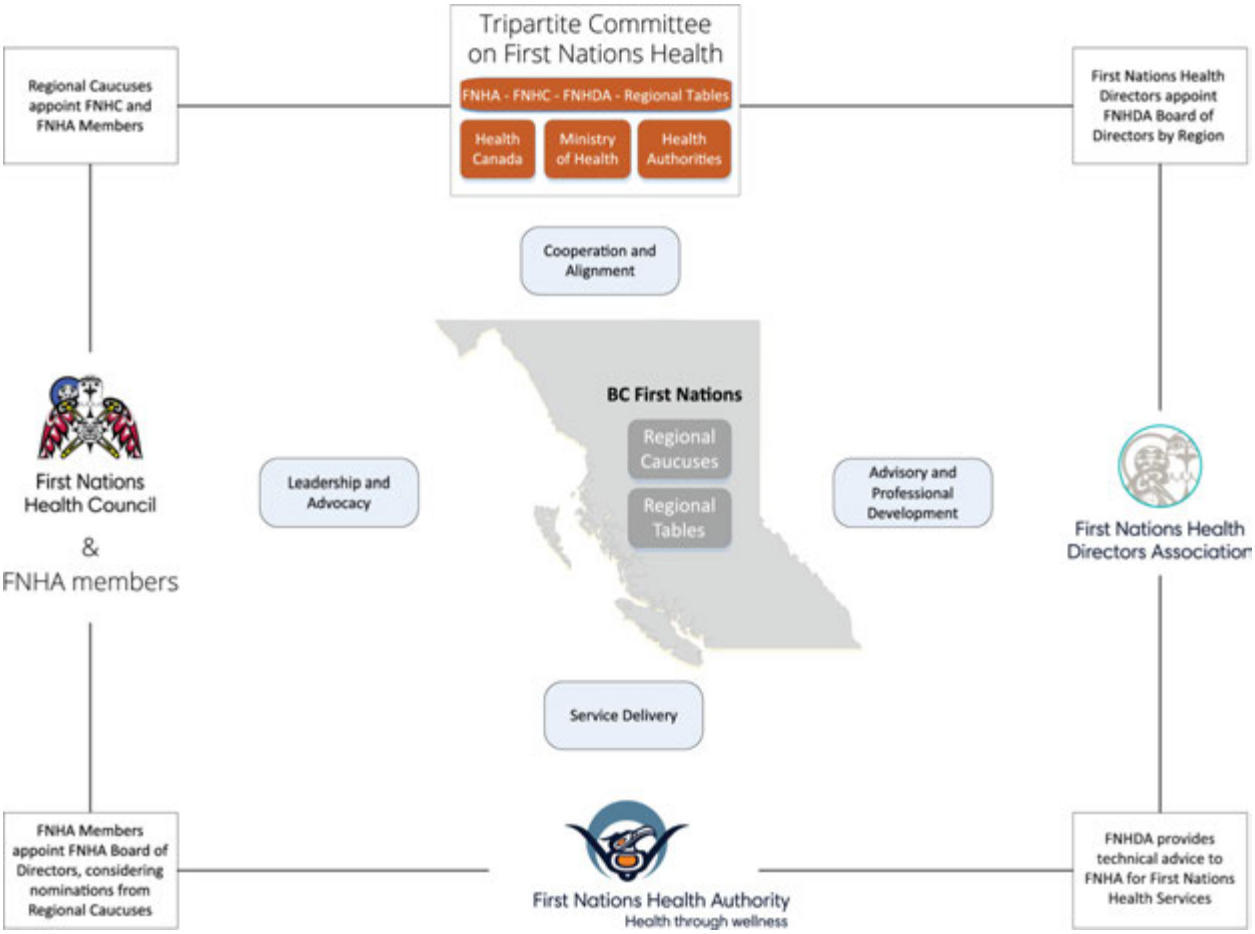


Figure 2. Overview of the First Nations Health Governance Structure

The *Health Partnership Accord* describes the parties' common vision for the tripartite partnership, including the scope of possibilities for health innovation enabled by a committed, resourced and supportive relationship. It sets context for the tripartite efforts in implementing the Framework Agreement and the other tripartite commitments regarding First Nations health.

As part of this new health governance structure, BC First Nations have, through engagement and consensus-building processes, collectively established a new First Nations health governance structure and standards. The structure and standards build from the ground-up and include a strong regional emphasis, recognizing the value of making decisions at the appropriate levels (e.g., community decisions made in communities, regional decisions made in the region).

A key part of this new structure are regional caucuses in each of the health regions. The Interior Region Caucus is represented by 54 communities and seven Nations: Dakelh Dené, Ktunaxa, Secwepemc, Syilx, St'at'imc, Tsilhqot'in and Nlaka'pamux.

The Interior Region Nation Executive[2] and the Interior Health Authority signed the *Interior Partnership Accord* on November 14, 2012 with the overall goal to improve the health and wellness outcomes for First Nations people in the Interior by establishing a coordinated and integrated First Nations health and wellness system. A Partnership Accord Leadership Table has been developed to oversee the implementation of the Partnership Accord.

At *Gathering Wisdom for a Shared Journey V* (2012), BC First Nations Chiefs and leaders provided direction to establish Regional Offices (now referred to as regional teams and supports) in order to support the implementation of these agreements and improve health programs and service delivery and health outcomes for First Nations in the regions. To date, the FNHA has supported the development and implementation of extensive community engagement in each region to facilitate dialogue and participation through the regional structures and Community Engagement Hubs. Activities have taken place to build regional teams and supports, including the hiring of Regional Directors in each Region in 2013. The iRHWP will further support the planning, collaboration and implementation of the evolving regional work, including regional health and wellness priorities and regional envelopes

[2] Acts as an executive body to the Interior Region First Nations Community Health Caucus and carries out the directions of the Caucus.

Appendix C: Interior Nations Declaration of Unity

INDIGENOUS NATIONS OF THE INTERIOR

Declaration of Unity

FEBRUARY 24, 2010

Whereas, Indigenous Nations of the Interior of British Columbia endorse the UN Declaration on the Rights of **Indigenous People which affirms that Indigenous peoples** have the right to the lands, territories and resources which they have traditionally owned, occupied or otherwise used or acquired; and that

Indigenous peoples have the right to maintain and strengthen their distinct political, legal, economic, social and cultural institutions, while retaining their right to participate fully, if they so choose, in the political, economic, social and cultural life of the State; and further that

Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development; and ...in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local **affairs...; and**

Whereas, the title and rights of First Nations of British Columbia have been intact since time immemorial and remain intact, despite numerous attempts by other governments to disregard or otherwise extinguish these rights; and

Whereas, historically, Indigenous Nations of the Interior acknowledged each others' autonomy, collectively stating in a letter to Sir Wilfred Laurier in 1910 that ... they found the people of each tribe supreme in their own territory, and having tribal boundaries known and recognized by all and **more recently reaffirmed this spirit and intent in the All** Our Relations accord of 2007; and

Whereas, the Nations of the Interior of British Columbia: **Dákelh Dené, Ktunaxa, Nlaka'pamux, Syilx, Secwepemc St'át'imc and Tsilhqot'in of the Interior wish to reaffirm** and build upon these historic agreements; and

Whereas, the Nations of the Interior continue to recognize the sovereignty of each Nation and their inherent rights for their citizenry, which includes the right to plan for and **respond to their specific social, cultural, economic and** environmental realities with support and investment, not interference, from outside sources; and

Whereas, the Indigenous Nations of the Interior of British Columbia, as Indigenous Nations, each assert their authority to govern over both their lands (territorial jurisdiction) and their peoples (personal jurisdiction) and to relate Nation-to-Nation with the government of Canada and government-to-government with the government British Columbia; and

Whereas, the Nations have stated their desire to establish and maintain a desired level of capacity in the areas of health research, health career development, health service delivery (including traditional practices), information management and governance (health planning, administration, policy/ program design and implementation and...), in order to achieve their individual and collective Nation visions.

THEREFORE, the Nations of the Interior hereby declare that we will respectfully work together, collaborating for the betterment of the health, safety, survival, dignity and well-being of all of our peoples; and further

THAT we will be guided by the following principles while working together:

- Health and Wellness Outcomes and Indicators will be defined by each Nation
- Partnerships will be defined by each Nation
- Agreements will be negotiated and ratified by the Nations
- No Nation will be left behind; needs are addressed collectively
- The federal fiduciary obligation must be strengthened, not eroded
- Services will be provided to all of our people regardless of residency/status
- Adequate funding will be provided for our corporate structure(s)
- Socio-economic indices will be incorporated into planning and projections – plan for 7 generations
- Negotiations will be interest based - not position based (Nations define)
- Community hubs will be linked to the health governance process
- Documents will be kept simple and understandable
- The Interior Leadership caucus will meet regularly
- Liability will be minimized; the Nations will inherit no liability from other entities
- Celebration will be included in all activities
- The speed at which development occurs will be determined by the Nations
- The authority to govern rests with each Nation, as does the responsibility for decision-making

Chief Geronimo Squinas – Dákelh Dené

Owen Phillips – Ktunaxa

Chief Shana Gottfriedson – Secwepemc

Chief Ko'waintco Michel – Nlaka'pamux

Chief Arthur Adolph – St'át'imc

Chief Jonathan Kruger – Syilx

Chief Bernie Elkins – Tsilhqot'in

FIRST NATIONS HEALTH COUNCIL
Interior Region

Interior Health

PARTNERSHIP ACCORD

FIRST NATIONS HEALTH COUNCIL:

INTERIOR REGION NATION EXECUTIVE

(INTERIOR NATIONS)

and

INTERIOR HEALTH AUTHORITY

(INTERIOR HEALTH)

Whereas, the First Nations of the Interior of British Columbia, as Indigenous People, (Interior Nations) endorse the UN Declaration on the Rights of Indigenous People which affirms, amongst other things, that *...Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development;* and *...in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs;* and

Whereas, the title and rights of First Nations of British Columbia have been intact since time immemorial and remain intact, despite numerous attempts by other governments to disregard or otherwise extinguish these rights; and

Whereas, the Nations of the Interior continue to recognize the sovereignty of each Nation and their right to assert their authority to govern over both their lands (territorial jurisdiction) and their peoples (personal jurisdiction) and to relate Nation-to-Nation with the Government of Canada and Government-to-Government with the Government of British Columbia; and

Whereas, the First Nations of British Columbia, the Province of British Columbia and the Canadian Government, ratified the Tripartite Framework Agreement on First Nation Health Governance, which empowers B.C. First Nations to take-over the administration of Health Canada programs and services and identifies additional provincial resources, to be administered by a First Nations Health Authority; and

Whereas, the Nations have stated their desire to establish and maintain a desired level of *capacity* in the areas of health research, health career development, health service delivery (including traditional practices), information management and *governance* (health planning, administration, policy/program design and implementation...), in order to achieve their individual and collective Nation visions; and

Whereas, the province is organized into five geographic regions for purposes of health-care service delivery, and Interior Health is the provincial Authority whose operating region includes the territories of seven Indigenous Nations: **Dãkelh Dené, Ktunaxa, Secwepemc, Syilx, St'át'imc, Tsilhqot'in and Nlaka'pamux;** and

Whereas, Interior Health, is the party with whom the Interior First Nations primarily relate with respect to delivery of health services to their citizens; and

Whereas, the Interior First Nations have and will remain committed to working together as unified Nations in establishing Nation-based Health and Wellness plans, with a number of the Interior Nations' territories extending across more than one Provincial Health Authority boundary; and

Whereas, First Nations, on a regional/tribal basis, are now forming structures and processes through which to carry out the engagement, research, planning and development work required to shape the final form the First Nations Health Authority will take; and

Whereas, the Government of British Columbia created the Interior Health Authority through the Health Authorities Act, for the purpose of delivering health services and planning.

Whereas, Interior Health is governed by a Board of Directors, and each Director is appointed by the Minister of Health. The Board strives to have a diverse and balanced set of skills and geographic representation, bringing differing perspectives of community, culture and geography to the Board. The governing principle for the Board of Directors is that each Director's duty of care is to the organization as a whole. Interior Health delivers its health services through a President and Chief Executive Officer and the staff of Interior Health, according to the Vision, Mission and Values for Interior Health, and within the broad directions of the Ministry of Health. (See Appendix eleven for Interior Health Strategy Map.)

Whereas, Interior Health, pursuant to its Vision, Mission and Values has established a Strategic Plan which enunciates four Goals. Goal #1 is to Improve Health and Wellness. Under this goal, item 1.2 is, "Meet the needs of First Nations and Aboriginal communities by collaboration with them to plan and deliver culturally sensitive health care services."

Whereas, Interior Health, pursuant to the Goal Statement 1.2 noted above, has developed an Aboriginal Health and Wellness Strategy 2010-2014 which is based on 5 key strategies:

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.

Whereas, Interior Health supports the concept that the First Nations that are party to this Accord may represent other organized groups of Aboriginal people, provided there are written formal agreements to that effect.

Whereas, the Indigenous Nations of the Interior and Interior Health (herein after referred to as the Parties) have stated their commitment to work together to avoid the creation of separate and parallel First Nation and non-First Nation health systems, and to develop a more integrated health and wellness system with stronger linkages to the provincial health-care system, including the creation of new approaches to achieving the desired health and wellness outcomes of each Nation; and

Whereas, the Interior Nations have declared their desire to be fully involved in decision-making regarding the health of their people, and in defining how health services and programs are planned, designed, managed and delivered and have entered into, or will enter into relationships directly with Interior Health; and

Whereas, the Framework Agreement on First Nations Health Governance and a resolution at the Gathering Wisdom IV directed First Nations leaders to enter into partnerships with provincial health regions in order to establish collaborative working relationships to carry out planning and to implement health actions aligned with the Transformative Change Accord: First Nations Health Plan and the Tripartite First Nations Health Plan, as well as providing guidance to the development of reporting systems and measures of performance; and

Whereas, the Parties agree that a coordinated approach to governance undertakings, in relation to diverse topics, can best be addressed in the context of an Accord that establishes an Action Plan for the purpose of achieving substantial progress on matters of shared priority.

****

Therefore, the Parties do hereby agree as follows:

Definitions, titles of organizations and agreements which appear in this Accord are listed in Appendix One, and form part of this Accord.

Purpose:

The Parties are committed to improving the health and wellness outcomes for First Nations people of the Interior Region. The purpose of this Partnership Accord is to clarify the roles and relationships of each of the Parties, jointly and severally, as they work together to fulfill this commitment.

Further, it is intended to be a general statement of purpose but does not create a legally binding obligation on the Parties nor is it enforceable against either of the Parties in any court of law or otherwise.

This Accord builds on the following documents:

Transformative Change Accord: First Nations Health Plan (TCA: FNHP) (November 2006);

- Identifies priorities and actions to improve the health and well-being of First Nations in BC. First Nations and the Province identified actions required in four key areas: Governance, relationships and accountability; Health promotion and disease and injury prevention; Health services; and, Performance tracking. Signed by the Province of BC and the BC First Nations Leadership Council.

Tripartite First Nations Health Plan (TFNHP) (June 2007);

- The Federal Government joined with the Province and First Nations Leadership Council to build on the TCA: FNHP by releasing the TFNHP. Central is a commitment to create a new governance structure that will enhance BC First Nations' control of health services, and will promote better integration and coordination of services to ensure improved access to quality health care by all BC First Nations.

British Columbia First Nations Perspectives on a New Health Governance Arrangement: Consensus Paper (May 2011);

- Clearly articulates the collective direction and feedback given by First Nations to the First Nations Health Council in their work to establish a new health governance arrangement that is Community-Driven and Nation-Based.

British Columbia Tripartite Framework Agreement on First Nation Health Governance (October 2011);

- Establishes commitments to transfer the operations of First Nations and Inuit Health Branch-BC Region to a First Nations Health Authority, and to provide a greater role for First Nations in the broader health system in Canada and BC with respect to First Nations health needs.

Navigating the Currents of Change: Transitioning to a New First Nations Health Governance Structure – Consensus Paper (May 2012)

- Captures First Nations feedback and broadly reflects how change will be managed through the transition process of taking control over First Nations Inuit Health Branch – Pacific Region into First Nations Health Authority control.

Parties:

Interior Region Nation Executive

Due to the large size of the Interior Region and the high number of First Nation Communities who reside within the Interior Region, the First Nations Community Health Caucus (54 First Nation Communities) have agreed to work under a model that is 'Community-Driven and Nation-Based'. This principle means that services will be developed and delivered as close to home as possible and that the Nations each have responsibility for developing and implementing health and wellness strategies and relating directly to Interior Health in implementing these strategies. Each of the 7 Nations will negotiate a Letter of Understanding, or other agreement, independently with Interior Health. Issues or interests that are common to the Nations will be addressed in a collaborative manner. Nations who are accessing health services from other Health Authorities may develop additional agreements.

As per the First Nations Health Council Interior Region Governance Entities Terms of Reference, the leadership of the respective Nation will ensure that their Nation has a comprehensive health and wellness plan in place, building on Community Health Plans and where possible, proposing areas where aggregation of services into a Regional Health Plan, might occur. The Nations' member communities will approve their Nation Health Plan. The Interior Nations will jointly establish a Regional Health and Wellness Plan, at the Interior Region Nation Executive Table, for adoption by the Interior Region First Nations Community Health Caucus.

This Interior Region Nation Executive Table acts as an executive body to the Interior Region First Nations Community Health Caucus and carries out directions in between Caucus sessions. They also ensure that the First Nations Health Council is being accountable (implementing the work plan as approved), and responsive to regional issues. They interface with the region's First Nations Health Directors and with the Interior Health Board and Senior Executive, leading the negotiation and implementation of Regional Agreements with Interior Health.

The Executive functions as the 'Regional Table' for purposes of First Nations Health Council activities. Executive Membership consists of 1 member from each of the following Nations: Dākelh Dené, Ktunaxa, Secwepemc, Syilx, St'át'imc, Tsilhqot'in, Nlaka'pamux, selected in accordance with Nation-approved processes and appointed through resolution, signed by authorized Nation representatives (Tribal Council Motion or Resolution). (See appendix eight for detailed Terms of Reference to describe these relationships)

The 7 Nation Representatives, coordinated as the Regional Table, are signatories to this Accord and are jointly, a Party to this Accord.

Interior Health

Interior Health is one of 5 regional health authorities, established under provincial legislation. Interior Health is led by a government-appointed Board of Directors and is accountable to the Ministry of Health through the Interior Health Board. The Interior Health Board sets the mission, vision, values and strategic plan for Interior Health within the broad directions set for the health care system by the Government of British Columbia through the Ministry of Health. The President and CEO is responsible for leading Interior Health's operations in accordance with the direction set by the Interior Health Board and ensuring the implementation of directives issued, from time to time, by the BC Ministry of Health. (See appendix three for a map of Interior Health, showing the First Nations of the Interior)

The Interior Health Board Chair and the President and CEO are the signatories to this accord, representing Interior Health as a Party.

Principles:

The Nations of the Interior have signed a Unity Declaration which states they will be guided by a set of principles. Interior Health recognizes and respects these principles as stated by the First Nations, guiding the Nations involvement in the Partnership Accord. Interior Health also notes that pursuit of some of these Principles are beyond the scope of Interior Health as a health service organization, such as funding First Nation corporate structures or strengthening federal fiduciary responsibility, and that these are the subject of agreements between the First Nations, the federal government and the Government of British Columbia.

The principles of the Unity Declaration are:

- Health and Wellness Outcomes, and Indicators will be defined by each Nation
- Partnerships will be defined by each Nation
- Agreements will be negotiated and ratified by the Nations
- No Nation will be left behind; needs are addressed collectively
- The federal fiduciary obligation must be strengthened, not eroded

- Services will be provided to all of our people regardless of residency/status
- Adequate funding will be provided for our corporate structure(s)
- Socio-economic indices will be incorporated into planning and projections – plan for 7 Generations
- Negotiations will be interest based - not position based (Nations define)
- Community engagement will be linked to the health governance process
- Documents will be kept simple and understandable
- The Interior Region Community Health Caucus and Interior Nation Executive will meet regularly
- Liability will be minimized; the Nations will inherit no liability from other entities
- Celebration will be included in all activities
- The speed at which development occurs will be determined by the Nations
- The authority to govern rests with each Nation, as does the responsibility for decision-making

The Interior Region will work together in ways which promote our values of Collaboration, Trust, Inclusion, Celebration and Innovation.

Objectives:

To establish a coordinated and integrated First Nations health and wellness system in the Interior that:

1) will contribute to the achievement of Interior Nations' wellness goals, by continually improving quality, accessibility, delivery, effectiveness, efficiency, and cultural appropriateness of health care programs and services for First Nations in the Interior;
2) reflects the cultures and perspectives of Interior First Nations, incorporates First Nations' models of wellness, builds First Nations health human resource capacity, and respects that the Nations have and will continue to work together;
3) affords equitable recognition in strategies to address First Nations who have limited capacity, including small and isolated communities;
4) embraces knowledge sharing and facilitates discussions in respect of addressing broader determinants of health; and
5) is based on respecting and addressing the lands, history, health, safety, food security, dignity and well-being of all Interior First Nations people.

Action Plan:

With a goal of improving the health outcomes for First Nations People, the Parties will form a Health and Wellness Committee, comprised of Senior Management from Interior Health (appointed by the Vice President responsible for Aboriginal health) and First Nations of the Interior Region

(appointed by the Interior Region Nation Executive). The Committee will be co-chaired by the senior representatives of Interior Health and the Interior Region Nation Executive. The Board Chair and President and CEO of Interior Health and the 7 Nation Executive members will monitor the work of the Committee and receive reports from them annually.

Terms of Reference for the Committee will be established by the Parties. The work of the committee will also be reported to the Interior Region First Nations Community Health Caucus. The Committee will carry out specific actions including, but not limited to, the following:

1) develop a consistent and harmonized Planning and Evaluation Framework;
2) develop a Regional Health and Wellness Plan that builds upon Community/Nation Health Plans and Interior Health Plans including setting standards, targets, outcomes and measurements;
3) review of the existing standards and processes;
4) continually improve on processes;
5) localize cultural competency training throughout the Interior Health Region;
6) develop service delivery systems to better reflect the needs of First Nation people in the Interior Region;
7) develop a comprehensive health human resources strategy;
8) establish common indicators, targets, milestones, benchmarks;
9) engage in dialogue, identify linkages and establish networks with other Aboriginal and non-Aboriginal stakeholders;
10) discuss program and service delivery changes and manage impact;
11) identify those matters including policy issues that will address gaps and eliminate overlaps; and
12) establish, at the program level, communications with the First Nations Health Authority and at the governance level, with the First Nations Health Council.

The Parties will:

a) support each other in a positive and constructive manner intended to facilitate improved health and wellness outcomes for First Nations people residing in the Interior Region;
b) collaborate to identify health needs of First Nations people residing in the Interior;
c) establish mechanisms to address issues of those Nations whose territories encompass more than one Regional Health Authority;
d) respectfully educate one another about each other's governance structures, service delivery processes, fiscal restraints, opportunities, budgetary process and other matters;
e) develop partnerships with other Ministries, municipal governments and non-profit organizations to work together in order to address the social determinants of health;
f) hold each other accountable in the spirit of reciprocal accountability for the commitments in this Accord;

g) maintain clear roles and responsibilities and performance expectations balanced by capacity of each party;
h) provide timely reporting;
i) meet annually to receive reports and review this Accord;
j) participate in scheduled meetings to conduct the work of this Accord;
k) communicate in a timely and effective way, potential risks or impediments to achieving the objectives of this Accord, or those outlined in the Interior First Nations Health and Wellness Plan.

Success Indicators:

a) Improved health outcomes for First Nations people of the Interior Region;
b) Interior Region Nation Executive Table nominates to the Provincial Government, a candidate for consideration to the Interior Health Board;
c) Regular and appropriate communication between Interior Health Senior Staff and First Nation Health Directors;
d) Investment strategies are based on Health and Wellness Plans;
e) Increased number of First Nations health professionals and staff working in the Interior;
f) Increased awareness of Interior Nation specific culture, traditions, geography and history amongst Interior Health Staff;
g) Community Engagement Hub meetings are attended and supported by Interior Health staff;
h) Rural and Remote health strategy developed in partnership with Interior First Nation Communities;
i) Letters of Understanding in place between Interior Health and each of the 7 Interior Nations;
j) Regional First Nations Health and Wellness Plan (inclusive of First Nations and Interior Health Plans) adopted and implemented;

Term and Review:

This Partnership Accord will be in effect for a term of five (5) years from the date of signing and will be reviewed by the Parties annually. After five years, the Partnership Accord will automatically be renewed for an additional 5 years with the opportunity by the Parties to review and rejuvenate the Accord.

Amendments:

Any amendments to this Accord will be approved by the Interior Caucus and the Interior Health Board of Directors prior to being adopted by the Parties.

Interior Partnership Accord signed on the 14 **, day of** November **2012**

Signatories for the Interior Region First Nations:

Kukpi7 Wayne Christian
Secwepemc

Mic Werstuik
Syilx

Kevin Skinner
Dãkelh Dené

Chief Bernie Elkins
Tsilhqot'in

Chief Arthur Adolph
St'át'imc

Chief Ko'waintco Michel
Nlaka'pamux

Gwen Phillips
Ktunaxa

Signatories for the Interior Health Authority:

Norman Embree, Board Chair

Dr. Robert Halpenny, President and CEO

Witness Signatories for the First Nations Health Authority:

Joe Gallagher, CEO
First Nations Health Authority

Lydia Hwitsum, Board Chair
First Nations Health Authority

APPENDIX ONE: DEFINITIONS

Definitions:

Aboriginal

"Aboriginal people" is a collective name for the original peoples of North America and their descendants. The Canadian Constitution (the Constitution Act, 1982) recognizes three groups of Aboriginal peoples — Indians, Métis and Inuit. These are three separate peoples with unique heritages, languages, cultural practices and spiritual beliefs.

Community Engagement Hubs:

Community Engagement Hubs are a network of First Nations who want to work collectively to the benefit of the positive health of their collective members. The purpose of Community Engagement Hubs is to develop communication, collaboration, and planning opportunities for member communities to work together in health services and program areas to make improvements. The formation of Community Hubs encourages natural collaborations based on tribal and/or geographical factors and helps to facilitate coordination work between communities.

Community Health Plan

A description by a First Nation, Indian Band or Health Organization of its health needs, priorities, and strategies, informed by its vision and its inventory of assets, opportunities, risks, programs, and health outcomes. Provides a roadmap forward for community health improvement and guides collaboration with potential local health partners.

Consensus Paper: BC First Nations Perspectives on a new Health Governance Arrangement

The Consensus Paper: British Columbia First Nations Perspectives on a new Health Governance Arrangement was adopted by resolution by BC First Nations on May 26, 2011. The Consensus Paper sets out a historic level of agreement amongst First Nations in BC about their health and well-being and a series of next steps for the First Nations Health Council to undertake.

First Nations

"First Nations peoples" refers to the Indian peoples in Canada, both Status and non-Status. The term is rarely used as a synonym for "Aboriginal peoples" because it usually doesn't include Inuit or Métis people.

First Nations Health Authority (FNHA):

A non-profit Society, representative of and accountable to BC First Nations, with a mandate to promote and advance health and health service issues on behalf of First Nations in BC, including by: assuming administrative responsibility for the functions, programs, and services transferred from First Nations & Inuit Health Branch-BC Region and delivering other health services to First Nations; supporting the implementation of the Transformative Change Accord: First Nations Health Plan (2006), the First Nations Health Plan MOU (2006) the Tripartite First Nations Health Plan (2007), and the British Columbia Tripartite Framework Agreement on First Nation Health Governance (2011); collaborating with governments and other health authorities and service agencies to coordinate and support the provision of health services to First Nations in BC; and, carrying out research, policy, planning and other activities related to health and the

determinants of health. The Society is guided by its members (also the members of the First Nations Health Council) who receive guidance and direction from First Nations at Gathering Wisdom for a Shared Journey forums.

First Nations Health Council (FNHC):

An unincorporated association, representative of and accountable to BC First Nations, with a mandate to: support and assist BC First Nations in achieving their health priorities and objectives; provide advocacy on health issues and health services for First Nations people in BC; provide a BC First Nations leadership perspective to research, policy and program planning processes related to First Nations health and determinants of health in BC; and, provide continued leadership for the implementation of the Transformative Change Accord: First Nations Health Plan (2006), the First Nations Health Plan MOU (2006) the Tripartite First Nations Health Plan (2007), and the British Columbia Tripartite Framework Agreement on First Nation Health Governance (2011). The First Nations Health Council receives guidance and direction from First Nations at Gathering Wisdom for a Shared Journey forums.

Interior Region First Nations Community Health Caucus:

The Interior Region First Nations Community Health Caucus table provides a forum for the 54 First Nations of the Interior Region to engage with each other for purposes of networking and planning, as related to the implementation of the Gathering Wisdom IV Resolution and Consensus Paper and the Tripartite Framework Agreement on First Nation Health Governance. Each of the five regions of the province has a First Nations Health Council Caucus that engages communities locally and offers a direct avenue to bring regional issues to the provincial First Nations Health Council table.

Interior Region Nation Executive Table:

The Interior Region Nation Executive Table is comprised of one representative from each of the 7 Nations of the Interior Region, and acts as an Executive body to the Interior Region Caucus, carrying out directions in between Caucus sessions and functioning as the Interior Regional Table for purposes of networking with Interior Health. The Executive Table offers a more equitable decision-making capacity for Interior First Nations and gives regional direction to the First Nations Health Council Caucus.

First Nations Health Directors

Managers working in First Nation communities, Health Directors have for many years managed and overseen a range of services and programs for their communities – based in diverse health facilities, with programs largely funded by Health Canada – First Nations and Inuit Health (FNIH). Health Directors are responsible for delivering front-line health services for First Nations community members, planning, coordinating and managing services (as well as other services of other health providers). First Nations Health Directors design and implement a comprehensive capacity development for the management and delivery of community-based services and support BC First Nations and their mandated health organizations in training, program development and knowledge transfer.

Gathering Wisdom

The Gathering Wisdom for a Shared Journey forums are the largest assembly of BC First Nations leadership in the province. The event brings together Chiefs, Elders, front-line health workers, community members, and provincial and federal partners to move forward on health systems transformation for BC First Nations. It's a

celebration of culture, tradition and the vision of healthy, self-determining and vibrant BC First Nations children, families and communities.

Nation Health Plan

A description by a group of individual First Nations or Indian Bands that share a common history, language, and identity of their collective health needs, priorities, and strategies, informed by their shared vision and cultural identity, their health outcomes, opportunities, and risks, and their members' Community Health Plans. Provides a roadmap forward for Nation health improvement, and guides collaboration with potential Nation-level health partners.

Regional Health and Wellness Plan

A description by communities and Nations within the Interior Region of their collective needs, priorities, and strategies, informed by their shared historical experience and relationships, their health outcomes, opportunities and risks, their various Nation Health Plans and Interior Health Plans. Provides a roadmap forward for regional health improvement, guides collaboration with potential regional-level health partners, and provides strategic guidance to provincial-level health service delivery and representation entities.

Transformative Change Accord First Nations Health Plan

The Transformative Change Accord: First Nations Health Plan (TCA: FNHP) was released on November 27, 2006 by the First Nations Leadership Council and the Province of BC. This ten-year Plan includes twenty-nine action items in the following four areas: Governance, Relationships and Accountability; Health Promotion/Disease and Injury Prevention; Health Services; and Performance Tracking. Under the Transformative Change Accord: First Nations Health Plan, the Province, including Regional Health Authorities, has the responsibility for providing all aspects of health services to all residents of British Columbia including Non-status Aboriginal people, Métis, and Status Indians living on and off reserve.

Tripartite Framework Agreement on First Nations Health Governance

The British Columbia Tripartite First Nations Health – Basis for a Framework Agreement on Health Governance (2010), was initialed by tripartite partners on July 26, 2010. The Basis Agreement outlined a staged approach for reaching a new administrative arrangement between First Nations, BC and Canada, where work currently undertaken by First Nations and Inuit Health-BC Region, will instead be undertaken by a new First Nations Health Authority.

Tripartite First Nations Health Plan

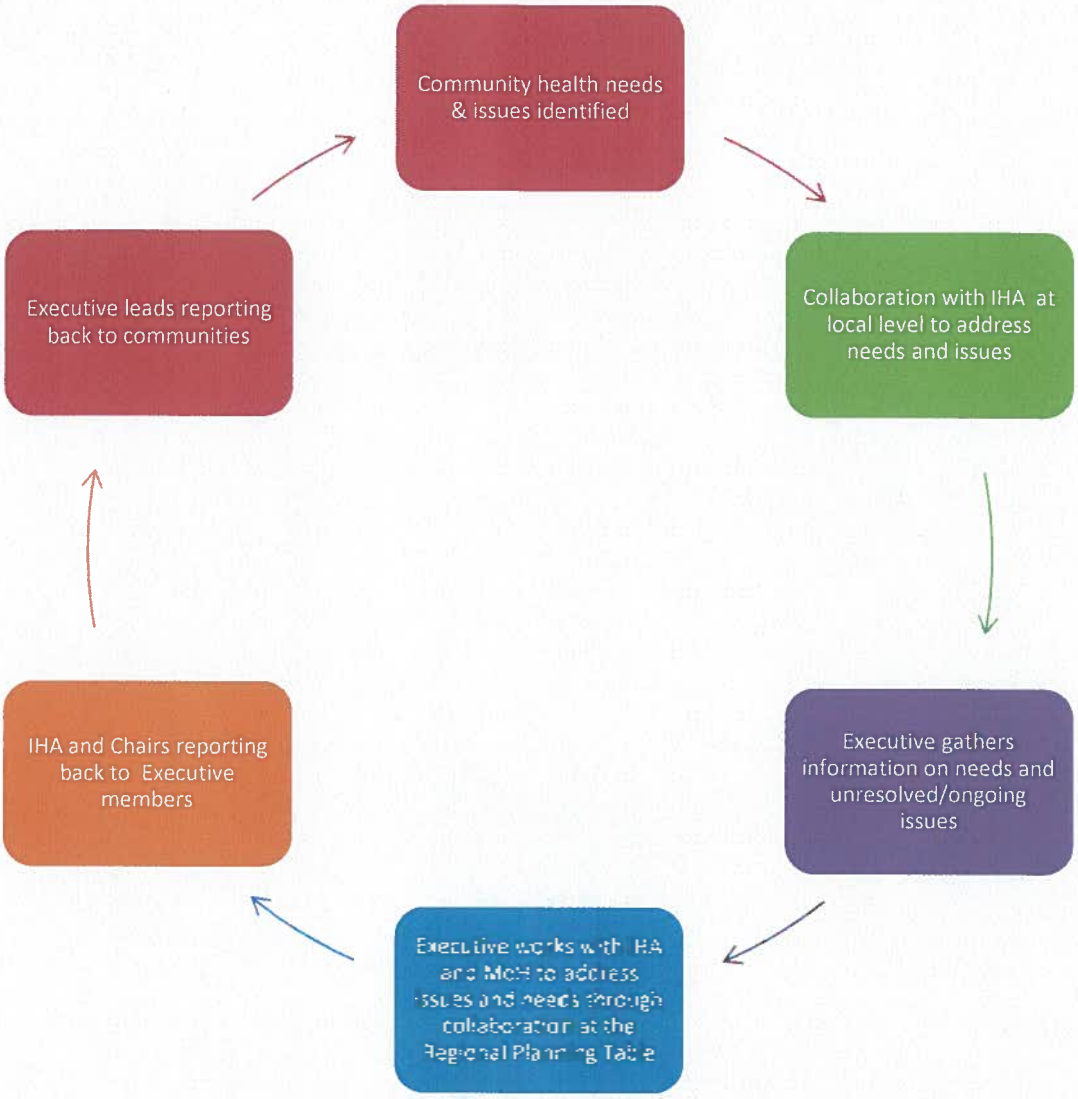
The Tripartite First Nations Health Plan (TFNHP) was signed on June 11, 2007, by the political executive of the Union of BC Indian Chiefs, First Nations Summit, and BC Assembly of First Nations, the Province of BC and Health Canada. The Plan builds on the TCA: FNHP and includes a number of new actions to be addressed by the partners in addition to the original 29 actions in the TCA: FNHP; new actions include the development of a new health governance model for First Nations.

UN Declaration on Rights of Indigenous People

The United Nations Declaration on the Rights of Indigenous Peoples was adopted by the United Nations General Assembly during its 61st session at UN Headquarters in New York City on 13 September 2007. The Declaration sets out the individual and collective rights of Indigenous peoples, as well as their rights to culture, identity, language, employment, health, education and other issues. It prohibits discrimination against

Indigenous peoples, and it promotes their full and effective participation in all matters that concern them and their right to remain distinct and to pursue their own visions of economic and social development. The goal of the Declaration is to encourage countries to work alongside Indigenous peoples to solve global issues, like development, multicultural democracy and decentralization.

APPENDIX TWO: INFORMATION AND REPORTING FLOW



APPENDIX THREE: INTERIOR HEALTH MAP OF NATIONS

APPENDIX FOUR: INTERIOR NATIONS AND MEMBER COMMUNITIES

Dãkelh Dene:	Lhoosk'uz Dene Government**, Lhtako Dene Nation** and Ulkatcho Indian Band
Ktunaxa:	Akisq'nuk First Nation, Lower Kootenay Indian Band, St. Mary's Indian Band, Tobacco Plains Indian Band
Secwepemc:	Adams Lake Indian Band, Bonaparte Indian Band, Canim Lake Indian Band, Esketemc First Nation, High Bar Band, Little Shuswap Lake Indian Band, Neskonlith Indian Band, Stswecem'c Xgat'tem, Shuswap Indian Band, Simpcw First Nation, Skeetchestn Indian Band, Splatsin First Nation, T'kemlups Indian Band, Ts'kw'aylaxw First Nation, Whispering Pines/Clinton First Nations, Williams Lake Indian Band, and Xatsull First Nation
Syilx:	Lower Similkameen Indian Band, Okanagan Indian Band, Osoyoos Indian Band, Penticton Indian Band, Upper Nicola Band, Upper Similkameen Indian Band, and Westbank First Nation
St'át'imc:	Xwisten, Sekw'el'was, Tsalahh, T'it'q'et, Xaxli'p, and (Ts'kw'aylaxw First Nation)
Tsilhqot'in:	?Esdilagh,** Tl'esqox, Tl'etinqox-t'in Government, Tsi Del Del, Yunesit'in Government, and Xeni Gwet'in First Nation Government
Nlaka'pamux:	Ashcroft Indian Band, Boothroyd Indian Band*, Boston Bar First Nation*, Coldwater Indian Band, Cooks Ferry, Kanaka Bar Indian Band, Lower Nicola Indian Band, Lytton First Nation, Nicomen Indian Band, Nooaitch, Oregon Jack Creek, Shackan, Siska, and Skuppah Indian Band, Spuzzum First Nation*

*Part of Fraser Region
**Part of Northern Region

APPENDIX FIVE: INDIGENOUS NATIONS OF THE INTERIOR: UNITY DECLARATION

INDIGENOUS NATIONS OF THE INTERIOR

Declaration of Unity

FEBRUARY 24, 2010

Whereas: Indigenous Nations of the Interior of British Columbia endorse the UN Declaration on the Rights of **Indigenous Peoples which affirms that Indigenous peoples** have the right to the lands, territories and resources which they have traditionally owned, occupied or otherwise used or acquired; and that

Indigenous peoples have the right to maintain and strengthen their distinct political, legal, economic, social and cultural institutions, while retaining their right to participate fully if they so choose, in the political, economic, social and cultural life of the State; and further that

Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development; and ... in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs...; and

Whereas, the title and rights of First Nations of British Columbia have been intact since time immemorial and remain intact, despite numerous attempts by other governments to disregard or otherwise extinguish these rights; and

Whereas, historically, Indigenous Nations of the Interior acknowledged each others' autonomy, collectively stating in a letter to Sir Wilfred Laurier in 1910 that "...they found the people of each tribe supreme in their own territory, and having tribal boundaries known and recognized by all and **more recently reaffirmed this spirit and intent in the All** Our Relations accord of 2007; and

Whereas, the Nations of the Interior of British Columbia: **Ktunaxa, Nlaka'pamux, Secwepemc, Syilx, Stl'atl'imx and Tsilhqot'in of the Interior wish to reaffirm** and build upon these historic agreements; and

Whereas, the Nations of the Interior continue to recognize the sovereignty of each Nation and their inherent rights for their citizenry, which includes the right to plan for and **respond to their specific social, cultural, economic and** environmental realities with support and investment, not interference, from outside sources; and

Whereas, the Indigenous Nations of the Interior of British Columbia, as Indigenous Nations, each assert their authority to govern over both their lands (territorial jurisdiction) and their peoples (personal jurisdiction) and to enter Nation-to-Nation with the government of Canada and government-to-government with the government of British Columbia; and

Whereas, the Nations have stated their desire to establish and maintain a desired level of capacity in the areas of health research, health career development, health service delivery (including traditional practices), information management and governance (health planning, administration, policy/program design and implementation and...), in order to achieve their individual and collective Nation visions.

THEREFORE, the Nations of the Interior hereby declare that we will respectfully work together, collaborating for the betterment of the health, safety, survival, dignity and well-being of all of our peoples, and further

THAT we will be guided by the following principles while working together:

- Health and Wellness Outcomes and Indicators will be defined by each Nation
- Partnerships will be defined by each Nation
- Agreements will be negotiated and ratified by the Nations
- No Nation will be left behind; needs are addressed collectively
- The federal fiduciary obligation must be strengthened, not eroded
- Services will be provided to all of our people regardless of residency/status
- Adequate funding will be provided for our governance structure(s)
- Socio-economic indices will be incorporated into planning and projections – plan for 7 generations
- Negotiations will be "nation based" – not position based (Nations define)
- Community input will be linked to the health governance process
- Documents will be kept simple and understandable
- The Interior Leadership Forum will meet regularly
- Liability will be minimized; the Nations will obtain no liability from other entities
- Collaboration will be included in all activities
- The speed at which development occurs will be determined by the Nations
- The authority to govern rests with each Nation, as does the responsibility for decision-making

Chief Geronimo Squinas – Ktunaxa

Gwen Phillips – Ktunaxa

Chief Shane Gottfriedson – Secwepemc

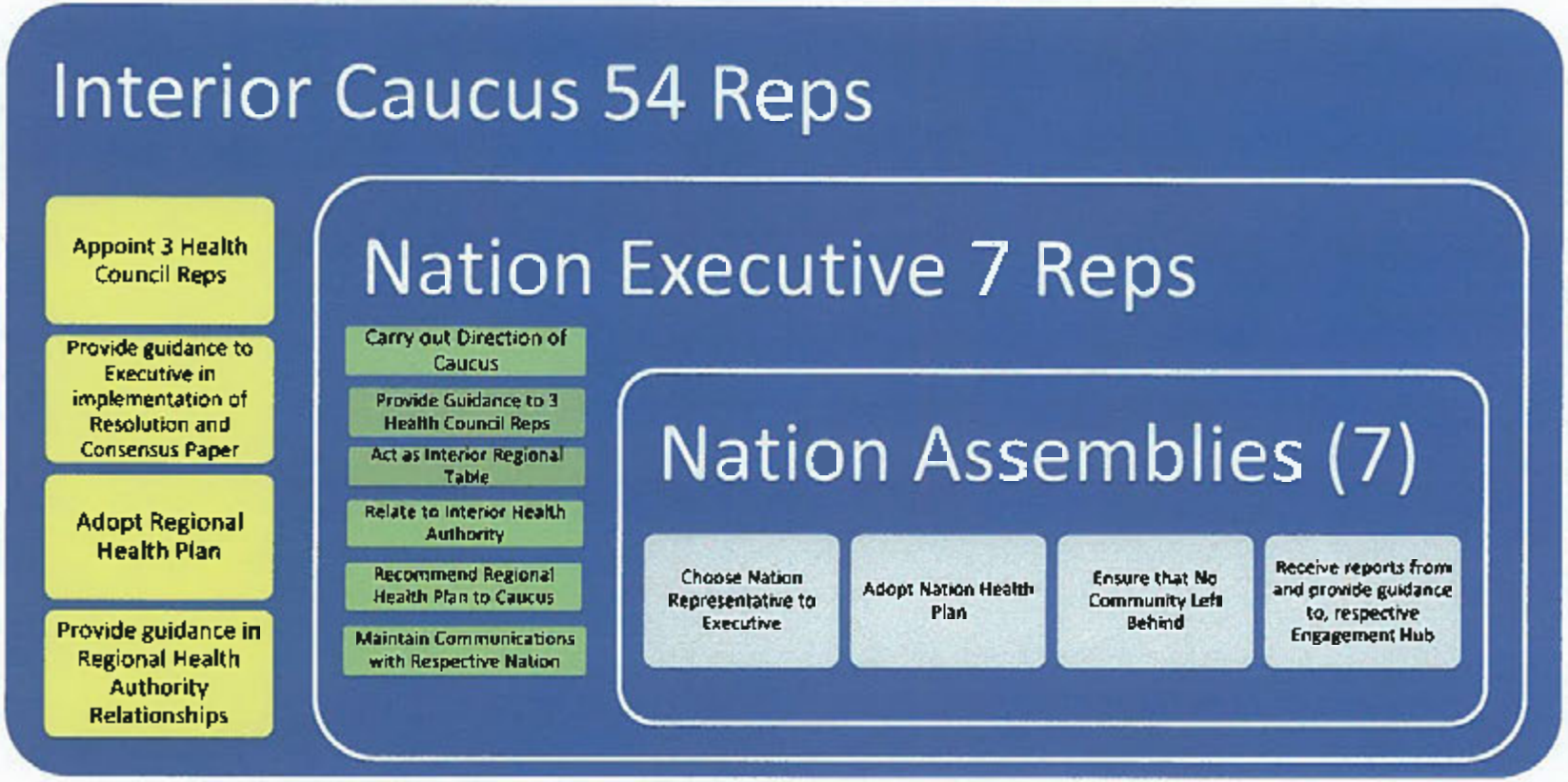
Chief Ke'waintec Michel – Nlaka'pamux

Chief Arthur Adolph – St'at'imx

Chief Jonathan Kruger – Syilx

Chief Bernie Elkins – Tsilhqot'in

APPENDIX SIX: INTERIOR GOVERNANCE ENTITIES FUNCTIONAL RELATIONSHIP DIAGRAM



Interior First Nation Community Councils participate in Nation Assemblies and send a representative to the Community Caucus meetings.

APPENDIX SEVEN: INTERIOR FNHC GOVERNANCE ENTITIES TERMS OF REFERENCE

First Nations Health Council
Interior Governance Entities

Terms of Reference

Approved December 16, 2011

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1. Preamble:

A. The First Nations of British Columbia, the Province of British Columbia and the Canadian Government, ratified the Tripartite Framework Agreement on First Nation Health Governance, which will empower B.C. First Nations to take-over the administration of Health Canada programs and services and identifies additional provincial resources, to be administered by a First Nations Health Authority.

B. Under this yet to be defined First Nations Health Authority, BC First Nations Governments will be fully involved in decision-making regarding the health of their people, and in defining how health services and programs are planned, designed, managed and delivered. They have agreed that First Nations should avoid the creation of separate and parallel First Nation and non-First Nation health systems, and develop a more integrated health and wellness system with stronger linkages to the provincial health-care system and the creation of new approaches to achieving the desired health and wellness outcomes of each Nation.

C. The Framework Agreement briefly describes the roles of the entities formed as a result of the Agreement, including a Tripartite Committee on First Nations Health, a First Nations Health Authority, a First Nations Health Council and the First Nations Health Directors Association (FNHDA).

D. The Tripartite Committee on Health is made up of federal, provincial and Health Council representatives, and their role is to engage in discussion on the progress and implementation of the Agreement and other health arrangements including the *Transformative Change Accord: First Nations Health Plan* (2006), the *First Nations Health Plan MOU* (2006), the *Tripartite First Nations Health Plan* (2007) and the Health Partnership Accord.

E. The First Nations Health Authority and Health Council roles are described in more detail later in this document.

F. The First Nation Health Directors Association represents health directors and managers working in First Nation Communities to:

   i. support education, knowledge transfer, professional development and best practices for health directors and managers of First Nation Health Providers; and

   ii. act as an advisory body to the provincial First Nation Health Council and the First Nations Health Authority, on research, policy, program planning and design related to administration and operation of health services in First Nation communities.

G. The First Nations Health Directors Association, as a provincial body, relates to the First Nation Health Council and Society at that level. Individual Health Directors work with their respective First Nations through the Hub and Caucus tables, at the Regional level, to provide expert advice in program and policy review and redesign.

H. The First Nations of B.C. are now modeling a provincial First Nations Health Authority to implement the Tripartite Framework Agreement; defining its structure and functions, in relation to the structures and functions of their own local health governance authorities. They envision a province-wide, coordinated First Nations wellness system that:

   i. is based on respecting and meeting the rights of First Nations people;

   ii. will result in improved quality, accessibility, delivery, effectiveness, efficiency, and cultural appropriateness of health care programs, and services for First Nations;

   iii. reflects the cultures and perspectives of BC First Nations, incorporates First Nations' models of wellness, and respects that the Nations have and will continue to work together

   iv. embraces knowledge and facilitates discussions in respect of determinants of health in order to contribute to the design of First Nation health programs and services;

   v. Provides First Nations in all regions of British Columbia with access to quality health services that are at a minimum, comparable to those available to other Canadians living in similar geographic locations.

   vi. First Nations, on a regional/tribal basis, are now forming structures and processes through which to carry out the engagement, research, planning and development work required, to define the authority of the Authority, and to shape the final form it will take. This Terms of Reference is the instrument that describes the roles of the parties that are working together to advance the formation of the First Nations Health Authority, specifically the Interior First Nations government officials and their technical support.

2. Interior Region Values:

The Interior Region will work together in ways which promote our values of Collaboration, Trust, Inclusion, Celebration and Innovation.

3. Purpose:

A. The purpose of these Terms of Reference is to describe the roles and responsibilities of the governance entities and advisory/planning bodies involved in the First Nations Health Council Governance processes of the Interior Region. These entities include:
   i. Interior Region First Nations Community Health Caucus (**54 Communities - *Caucus***)
   ii. Interior Nation Health Assemblies (**7 Nations - *Assemblies***)
   iii. Interior Region Nation Executive Table (***Executive – Regional Table***)

B. The document will also describe the relationship of these governance entities to the First Nations Health Council Society Members and Directors and the Community Engagement Hubs and Health Directors of the Interior Region.

C. A list of the First Nation Communities belonging to each Nation of the Interior Region is attached as an Appendix "A" to this document.

D. Engagement and Approvals Pathways will be clearly defined, to ensure that the pathway model will enable the FNHC to gather First Nations input and guidance for key decisions of the First Nations health governance structure. This engagement and approvals pathway could be included in the governing documents of the First Nations Health Council, First Nations Health Directors Association, and a future First Nations Health Authority, so that First Nations have clarity and certainty about the process for decision-making, and know that their voice and direction will be heard on key decisions such as program redesign.

E. **Reciprocal Accountability:**
   The members of the Interior Region First Nations Community Health Caucus, the Interior Nation Health Assemblies, and Interior Region Nation Executive Table are to report to their First Nations and Nations on the First Nations Health Authority (FNHA) and regional progress, share information, and develop common positions and perspectives.

4. Parties, Roles and Relationships of FIRST NATIONS HEALTH GOVERNANCE STRUCTURE:

A. First Nations Health Society

The First Nations Health Society has two divisions carrying out different functions within it; the *Society Members* (who sit as the Health Council) carrying out the Governance function on behalf of B.C. First Nations and the *Society Directors* (Health Society acting as the Interim First Nations Health Authority), carrying out the Management function without political interference.

i. **First Nations Health Council (First Nation Health Society) *Members*** (*Council/Society Members*):
The First Nations Health Council is comprised of 15 members, with 3 members appointed by the First Nations resident in each of the 5 geographic Health Authority regions of the province; the Interior Region is one of these 5 Regions and the 54 First Nation Communities of the Interior Region, through the Caucus, appoint their 3 representatives to the Health Council from amongst the 7 Nation representatives who form the Interior Region Nation Executive (Community-driven – Nation-based).

For purposes of these Terms of Reference, the First Nations Health Society *Members* will be called the Health Council as the collective or Health Council Members in reference to individuals.

The First Nations Health Councils' primary role is to implement the Gathering Wisdom IV Resolution and Consensus Paper; to finalize the sub-agreements in preparation for the transfer of Health Canada Resources (human, facilities...) to the new First Nations Health Authority and, as guided by the First Nations of the province, to establish the final structures through which to administer First Nation-designed programs and services as the new First Nations Health Authority.

In carrying out this work, the Health Council representatives, as Society *Members*, also have a responsibility to ensure that the Society (which operates as the *Interim* FN Health Authority) is responsive, transparent and accountable to First Nations of the province. As Health Council Members, the individuals represent the collective of all BC First Nations, not the individual Nations appointing them.

As per the Constitution and By-laws of the Society, the Health Council Members appoint the Directors to the Society Board, and provide high level governance oversight of the FN Health Society operations; as Members, they don't get involved in the day-to-day operations of the Society. These roles are described in the Terms of Reference for the FNHC. The Health Council Members cannot serve on the Board of Directors for the Society. The Constitution and By-laws provide the basic terms of reference for the Society Members and Directors. The Health Council Provincial and Regional Staff will ensure that all First Nation Communities receive frequent, accessible reports on the progress of the Council and Society; transparency and accountability are key governance principles.

ii. **First Nations Health Society (Interim First Nation Health Authority) *Directors*** (*Society Directors*):
The Society acts as the health management and administration body ensuring that there is no 'political' interference in carrying out the directions given collectively to the Health Council by the First Nations of the province, at Gathering Wisdom Forums.

The Board provides direction to the Society CEO in leading the business arm of the Society, managing resources and working with the technicians from First Nations communities in delivery of Health Actions. All First Nations Communities receive Annual Reports and newsletters from the Society Directors and First Nations Health Society Staff, reporting on their work.

The First Nations Health Society *Board of Directors* are selected for their expertise in health related fields as required for the Incorporated Society, as a legal entity, to carry out the day-to-day business related to administration of health programs. As the operational arm, the Society (The Interim First Nations Health Authority) is the body responsible for entering into contracts and other arrangements on behalf of the First Nations Health Council.

Background on the Society Directors, strategic plans and financial statements of the Society can be found on the Health Society Page of the Health Council Website at:

www.fnhc.ca/index.php/about/councilmembers/health_society/

B. Interior Region First Nations Community Health Caucus (*54 Communities Caucus*):

The province is broken down into 5 geographic regions for purposes of health-care service delivery. The Health Council Regions coincide with these Provincial Health Authority Regions. The Interior Region First Nations Community Health Caucus table provides a forum for the 54 First Nations of the Interior Region to engage with each other for purposes of networking and planning, as related to the implementation of the Gathering Wisdom IV Resolution and Consensus Paper and the Tripartite Framework Agreement on First Nation Health Governance.

i. **Caucus Mission**

We will assure the development of a comprehensive and inclusive Health Governance Framework that leads to the establishment of a people first, community driven and nation based BC First Nation Health Authority(s).

ii. **Caucus Membership**

The 54 First Nation Communities of the Interior Region as listed in Appendix "A" each have a voting seat as members of the Interior Region Community Health Caucus table.

iii. **Meetings and Voting**

Caucus meetings are the forum through which to provide guidance to the Health Council, in defining the structure and authority (functions) of a BC First Nations Health Authority; implementing the Gathering Wisdom IV Resolution and Consensus Paper.

a. Full caucus meetings will be held a minimum of 2 times per year.
b. For a Caucus meeting to be a valid meeting, a minimum of 35 Voting Members, must be present.
c. The Caucus representatives will attempt to achieve consensus on all matters requiring a decision.
d. If voting occurs, a resolution will pass with 50% plus 1 of those Communities present, voting in favor of the resolution.
e. Each of the First Nations belonging to the Interior Caucus will have 1 vote at meetings.
f. If a First Nations Chief or Council Members are unable to attend and would like to have representation at a Caucus Meeting, they must send a proxy letter with a designated representative that has the authority to make decisions at the Caucus Meeting on behalf of their First Nations. A Proxy Holder may represent more than one First Nations.
g. Funding will be provided to cover the travel costs for one voting representative from each of the Interior First Nation communities and one health director, or other technical support person from each of the First Nation communities, as approved by the First Nation.
h. Meeting dates and agenda will be set by the Nation Executive (described below) and notices provided at least one month in advance of meetings dates.

iv. **Purpose of Caucus Meetings**:

a. To engage with each other as First Nations and to reach out to First Nations of the Interior to ensure that all Communities achieve the same level of participation in meetings and achieve the same level of readiness, through consultation and planning.
b. To provide a forum for receiving reports from Health Council Regional Staff and for providing them with guidance in the development of the First Nations Health Authority.
c. To provide direction to the Health Council Representatives on the implementation of the Gathering Wisdom IV Resolution and Consensus Paper.
d. To provide guidance and leadership in the development of relationships and the implementation of arrangements between the First Nations of the Region and the Interior Health Authority.
e. To provide guidance and leadership in the redesign of First Nations community and regional health programs and services and the establishment of regional priorities.
f. To develop standards to ensure that resources are used in the most efficient and effective way possible, in achieving objectives.
g. To select the Interior Region's 3 Representatives to the First Nations Health Council, from amongst the Nation Executive Members.
h. To share good practices and progress towards achieving health and wellness outcomes.
i. To promote the Interior Unity Declaration.
j. To establish and sustain effective communication with all Interior First Nations.
k. This work will be carried out in accordance with the Gathering Wisdom IV Resolution and Consensus Paper.
l. When appropriate, the Caucus will appoint a Resolutions Committee.

C. Interior Nation Health Assemblies (*7 NationS Assemblies*):

The 54 First Nation Communities of the Interior have agreed to work under a model that is 'Community-driven and Nation-based'. This principle means that services will be developed and delivered as close to home as possible and that the Nations will have responsibility for governance.

The Nations of the Interior have signed a Unity Declaration that includes the following principles:

- Health and Wellness Outcomes and Indicators will be defined by each Nation
- Partnerships will be defined by each Nation
- Agreements will be negotiated and ratified by the Nations
- No Nation will be left behind; needs are addressed collectively
- The federal fiduciary obligation must be strengthened, not eroded
- Services will be provided to all of our people regardless of residency/status
- Adequate funding will be provided for our corporate structure(s)
- Socio-economic indices will be incorporated into planning and projections – plan for 7 Generations
- Negotiations will be interest based - not position based (Nations define)
- Community hubs will be linked to the health governance process
- Documents will be kept simple and understandable
- The Interior Leadership caucus will meet regularly
- Liability will be minimized; the Nations will inherit no liability from other entities
- Celebration will be included in all activities
- The speed at which development occurs will be determined by the Nations
- The authority to govern rests with each Nation, as does the responsibility for decision-making

The 7 Interior Region Nations will each host a Nation Health Assembly to ensure that their member Communities, (as per Appendix "A"), are engaged in the Health Council planning processes (making sure that no-one is left behind).

The leadership of the respective Nation will ensure that their Nation has a Comprehensive Health and Wellness Plan in place, building on community health plans and where possible, proposing areas where aggregation of services into a Regional Health Plan, might occur. The Nations' member Communities in Assembly will approve their Nation Health Plan

The Nation's communities in Assembly will choose their representative to the Interior Region Executive Table, in accordance with their own processes.

The Health Council will be provided with a Nation resolution signed by their member Communities, indicating who their representative is, as soon as possible, after the appointment is made.

i. **Meetings and Voting:**
   a. Nation Health Assemblies are the forums through which each of the 7 Interior Nations' member Communities (see Appendix "A") meet to share information and formulate health-related strategies. The Nations in Assembly are also responsible for making decisions regarding the assertion of their rights, the establishment of Nation health standards and outcomes and for the approval of the Nation health plan.
   b. Nation Assemblies will be held a minimum of 2 times per year.
   c. Each of the First Nations Communities belonging to the Nation will have 1 vote at Assemblies.
   d. The Nations' will determine their own voting procedures.
   e. The Assembly participants will attempt to achieve consensus on all matters requiring a decision.
   f. Funding will be provided to cover the travel costs for one voting representative from each of the First Nation communities. Other meeting costs related to hosting the Assembly will be covered by the Nation (facility, stationary, equipment).
   g. Funding for technician participation is provided through the Community Engagement Hub budgets.
   h. Meeting dates and agenda will be set by the Nation, in consideration of dates set for Caucus meetings and notices provided at least one month in advance of meetings dates.

ii. **Purpose of Nation Assembly Meetings**:
   a. To provide a forum for receiving reports, approving plans and providing direction to the work of the Nation Community Engagement Hub.
   b. To select the Nation's representative to the Interior Executive Table.
   c. To share good practices and progress towards achieving health and wellness outcomes.
   d. To confirm Nation interests in relation to Interior Health Authority (IHA) relationships and, where desired, negotiate Nation-level Agreements with the IHA.
   e. To identify any health-related issues or concerns that their member Communities may have and to, when unable to address issues within the Nation, bring the issue forward through their representative to the Nation Executive Table, for resolution, or advancement to the Health Council.

D. Interior Region Nation Executive Table (*Executive*):

Due to the large size of the Interior Region and the high number of First Nation Communities resident within the Region, a Nation Executive Table has been established by the 7 Nations of the Interior Region; this table will function as the 'Regional Table' for purposes of Health Council activities.

This table acts as an Executive body to the Interior Region First Nation Community Health Caucus and carries out directions in between Caucus sessions. They also ensure that the Health Council is being accountable (implementing the work plan as approved), and responsive to Regional issues. They interface with the Region's

Health Directors and with the Interior Health Authority (IHA) Board and Senior Executive, leading the negotiation and implementation of Regional Agreements with the IHA.

Executive Membership consists of 1 member from each of the following Nations, selected in accordance with Nation-approved processes and appointed through resolution, signed by authorized Nation representatives (Tribal Council Motion or Resolution).

Dãkelh Dene, Ktunaxa, Secwepemc, Syilx, St'át'imc, Tsilhqot'in, Nlaka'pamux

Members are responsible for bringing forward issues of concern to their Nation and for reporting back to their Nations on the activities of the Executive and Health Council within a timeframe agreed upon by their Nation.

In order to ensure that full participation is maintained at the Executive Table, Nations may choose an Alternate representative to the Executive Table to attend meetings when the designated representative is unable to attend, provided the alternate is an official that has been designated with the authority to make decisions at this table, on behalf of the Nation.

When an Alternate is chosen, a resolution or motion will be provided to the Executive Table informing them of the expanded representation and the Alternate will from that point forward, receive all communications that Executive members receive, related to this role.

Members and Alternates are responsible for bringing forward issues of concern to their Nation and for reporting back to their Nations on the activities of the Executive and Health Council.

It is acknowledged that governance and government are different functions, both equally important in the implementation of the Health Agreements. The First Nations Health Council and by extension the Community Caucus table and Executive table, are *governance* (authority/control) tables; the Health Directors and Hubs are part of the First Nations *government* (administration/management).

i. **Meetings and Voting:**
   a. Executive Meetings will be held a minimum of 4 times per year, and may be either in person, or through video or teleconference.
   b. Quorum at Executive meetings will be 5 Members.
   c. The Executive members will attempt to achieve consensus on all matters requiring a decision.
   d. If voting occurs, a resolution will pass with a minimum of 4 of those members present, voting in favor of the resolution.
   e. Each of the Members belonging to the Executive will have 1 vote at meetings.
   f. Funding will be provided to cover the travel costs for one appointed Nation representative from each of the seven Interior Nations.
   g. Technical support to the table will be provided by Health Council Regional Staff; technicians invited to the table by their Nation will have their travel costs paid for by that member Nation, or by the Executive table, if the table has requested their attendance.
   h. Meeting dates and agenda will be set by the Executive Members.
   i. Meeting summaries and a record of decisions will be forwarded to the Interior Region Chiefs following each meeting.

ii. **Purpose of Executive Meetings:**

Interior Region Executive meetings are the forum through which the 7 Interior Nation representatives chosen by the Communities of the Interior Region meet:

a. To receive reports from the Interior Representatives to the Health Council.
b. To provide direction to the Health Council Representatives on the implementation of the Gathering Wisdom IV Resolution and Consensus Paper.
c. To establish a work plan to achieve the Interior Region's objectives, as related to the Gathering Wisdom IV Resolution and Consensus Paper and establishment of First Nations Health Authority, and to identify work to be undertaken at the Community, Hub, Nation Assembly, or Caucus levels.
d. To provide a forum for receiving reports and providing direction to the Health Council Regional Staff.
e. To share good practices and progress towards achieving health and wellness outcomes.
f. To address any health-related issues or concerns that a member Nation may have, and when unable to address the issue within the Region, bring the issue forward through their representatives to the Health Council Table for resolution.

5. Amendments and Review of Terms of Reference:

The terms of reference shall be reviewed at least once a year at a regular meeting of the Interior Region First Nations Community Health Caucus. The terms of reference may be amended through an agreement by a majority of the membership from each sub-group at an Interior Region First Nations Community Health Caucus meeting.

This Terms of Reference will be maintained as a living document. Any regional Caucus Member may submit a formal motion for an amendment of this Terms of Reference. The formal motion for amendment shall be presented to the Interior Region First Nations Community Health Caucus for approval. Such amendments shall enter into force upon the approval of said motion at an Interior Region First Nations Community Health Caucus meeting.

APPENDIX EIGHT: COMMUNITY ENGAGEMENT HUBS (HUBS) AND HEALTH DIRECTORS

Community Engagement Hubs:

Health and wellness technicians working in First Nations Communities are important advisors to the leadership tables, identifying policy barriers and gaps. Work towards Nation-based Community Engagement Hubs, which have been established by the Health Council as the forums through which technicians can identify issues that require discussion/resolution at the Nation Assembly and as relevant, the Executive Table or Health Council related to structure and authority development and health service transformation, as per the Gathering Wisdom IV Resolution and Consensus Paper.

These are non-political advisory bodies. Each Hub will operate under a Terms of Reference established by the member Communities and in-line with FNHC standards/directives. The Nation-based Community Engagement and Planning Hubs should be comprised of Health Directors, Hub Coordinators and other relevant health and wellness technicians and community members, Elders, etc. All First Nation Communities should be represented at a Nation Hub. Hubs will promote the Unity Declaration principles.

Meetings:

a) Hub meetings are the forum through which community and Nation representatives working in health and wellness (Health Directors, CHRs, Nurses, Head Start Coordinators…) come together with other care providers, (such as IHA staff) to plan and develop local and regional strategies through which to establish and manage the most effective health and wellness programs possible for their Communities.
b) Hub Meetings will be held a minimum of 4 times per year.
c) Funding will be provided to cover the meeting travel costs for one appointed Community Representative from each of the Nation's Member Communities. Funding may also be made available to assist others with travel subsidies, as per the approved budget. Additional technicians are invited to the table however their Community/Nation/Organization may be required to cover their costs.
d) Technical support to the table will be provided by Hub Staff.
e) Meeting dates and agenda will be set by the Hub Staff, in consultation with the Members.
f) Purpose of Hub Meetings:
g) To establish a work plan to carry out direction received from Nation Assembly and/or Caucus and ensure that no Community is left behind.
h) To carry out research and formulate recommendations for consideration by leadership, related to health service transformation and policy shifts.
i) To provide a forum for receiving reports and engaging with the Health Council Regional Staff.

j) To share good practices and progress towards achieving health and wellness outcomes.
k) To identify a Nation Health Director, or lead, to interface with the Executive Table as requested.

Health Directors:

The Health Directors or Senior Managers working for the First Nations of the Interior Region should sit as members of their respective Community Engagement Hub and should work collaboratively with the Hub Staff to coordinate Community/Nation plans and activities.

APPENDIX NINE: MILESTONES AND DIRECTIVES

1. Interior Entities Governance Milestones:

May 2012: Regional Caucus and Regional Table Work Plans finalized; Appointments to Health Council and Regional Tables underway (current term of 3 Representatives expires June 2012) as required.

May 2012: Gathering Wisdom V

November 2012: Interior Health Authority Partnership Agreements completed.

December 2012: Implementation of Regional Caucus and Regional Table Work Plans; Establishment or update of Community Health and Wellness Plans completed (as required).

May 2013: Nation and Regional Health Plans Completed and Approved.

2. Consensus Paper Directives:

The First Nations Health Governance Interior Caucus will abide by the directives from the Chiefs in Assembly at Gathering Wisdom for a Shared Journey IV:

Directive #1: Community-Driven, Nation-Based

Directive #2: Increase First Nations Decision-Making and Control

Directive #3: Improve Services (*Consistent with the Principle of Comparability*)

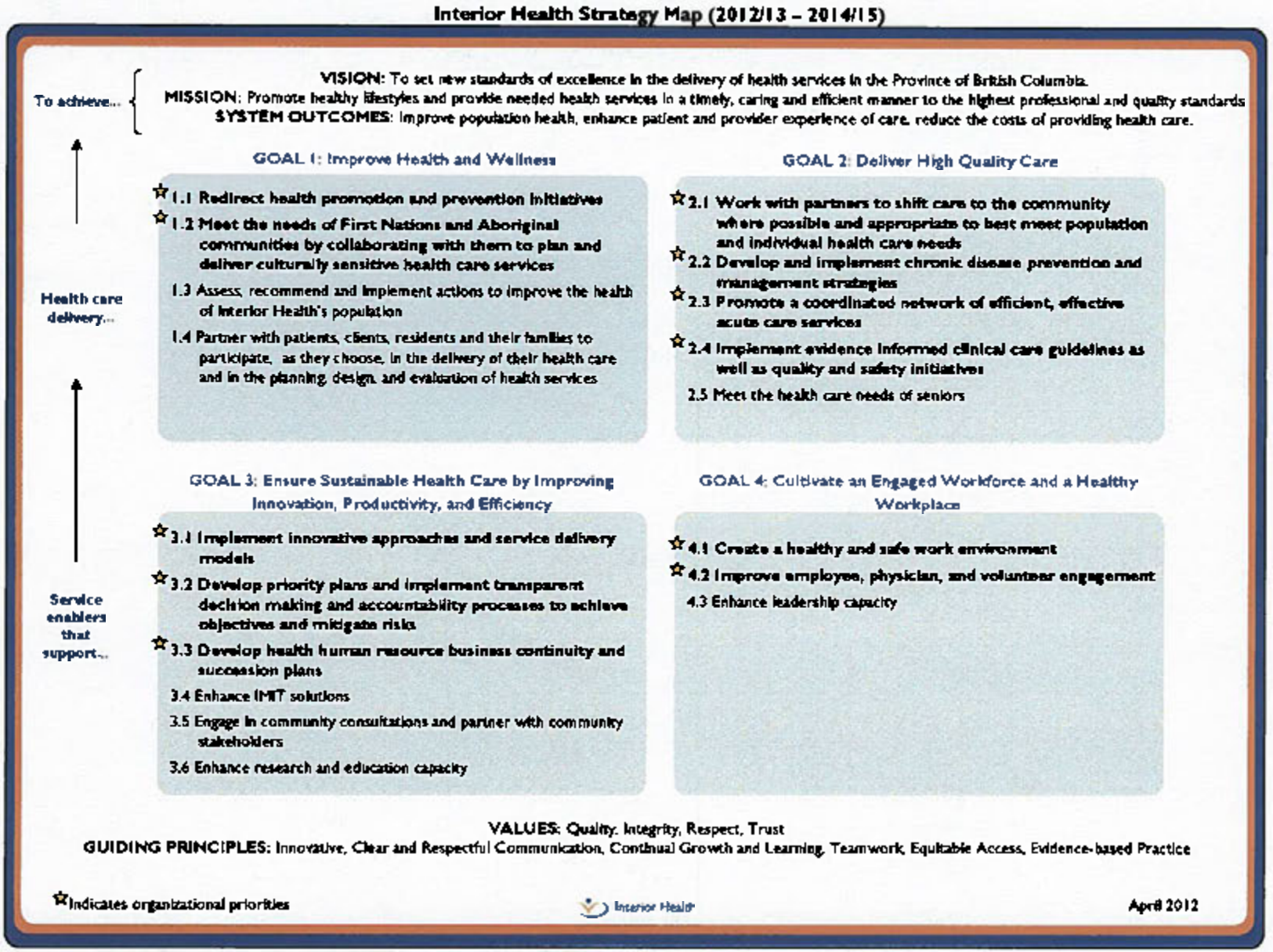
Directive #4: Foster Meaningful Collaboration and Partnership

Directive #5: Develop Human and Economic Capacity

Directive #6: Be Without Prejudice to First Nations Interests (including but not limited to Aboriginal Title and Rights, Treaty Rights, self-government agreements, court proceedings, the fiduciary duty of the Crown, and existing community health funding agreements)

Directive #7: Function at a High Operational Standard

APPENDIX TEN: INTERIOR HEALTH STRATEGY MAP (2012/3-2014/15)



Appendix E: Nation Letters of Understanding

Included in this section are the following Letters of Understanding between Nations and Interior Health Authority:

1. Letter of Understanding between Ktunaxa Nation and Interior Health Authority
2. Letter of Understanding between Nlaka'pamux Nation and Interior Health Authority
3. Letter of Understanding between Okanagan Nation Alliance and Interior Health Authority
4. Letter of Understanding between Secwepemc Health Caucus and Interior Health Authority
5. Letter of Understanding between Northern St'át'imc and Interior Health Authority
6. Letter of Understanding between Tsilhqot'in National Government and Interior Health Authority

LETTER OF UNDERSTANDING

between

Ktunaxa Nation Council

and

Interior Health Authority

(each a "Party" and collectively "the Parties")

1.0 PURPOSE

1.1 The Ktunaxa Nation Council and the Interior Health Authority are working together to increase the influence of the Ktunaxa Nation Council in decisions related to health services that impact its members and other Aboriginal peoples residing within Ktunaxa Traditional Territory.

1.2 The Parties understand that the Ktunaxa Nation is working towards full authority in all affairs related to its citizenry.

1.3 The Parties seek to improve the health outcomes for Aboriginal people by achieving effective shared decision making that will reduce the barriers for Aboriginal people to access better health services.

2.0 PREAMBLE

2.1 The Parties agree to enter into a mutually beneficial relationship that will work toward, in a quantifiable manner, shared responsibility and shared decision making as it impacts the provision of Health Services to Aboriginal people.

2.2 The Parties agree to use a cooperative, collaborative approach to improving the health status of Aboriginal individuals, families and communities through the design, delivery and evaluation of health programs and services for Aboriginal individuals, families and communities.

2.3 Interior Health acknowledges the inherent rights of the Ktunaxa Nation Council for its citizenry regardless of residency and supports the Ktunaxa Nation‟s pursuit of its rights to retain responsibility for the health, safety, survival, dignity and well-being of Ktunaxa children and families consistent with the UN Convention on the Rights of the Child and the UN Declaration on the Rights of Indigenous people.

2.4 The Parties agree and understand that this Letter of Understanding, herein referred to as the „LOU‟, pertains to the Interior Health Authority‟s roles and responsibilities according to the purpose and description under the Health Authorities Act, Section 5 (1) and Section 5 (2), which states that:

"(1) The purposes of a board are as follows:

(a) To develop and implement a regional health plan that includes
(i) the health services provided in the region, or in a part of the region,
(ii) the type, size and location of facilities in the region,
(iii) the programs for the delivery of health services provided in the region,
(iv) the human resource requirements under the regional health plan, and
(v) the making of reports to the minister on the activities of the board in carrying out its purposes.

(b) To develop policies, set priorities, prepare and submit budgets to the minister and allocate resources for the delivery of health services, in the region, under the regional health plan.

(c) To administer and allocate grants made by the government for the provision of health services in the region.

(d) To deliver regional services through its employees or to enter into agreements with the government or other public or private bodies for the delivery of those services by those bodies.

(e) [Repealed 2002-61-4] therefore not applicable.

(f) To develop and implement regional standards for the delivery of health services in the region.

(g) To monitor, evaluate and comply with Provincial and regional standards and ensure delivery of specified services applicable to the region.

(2) In Carrying out its purposes, a board must give due regard to the Provincial standards and specified services."

3.0 GEOGRAPHIC AREA

3.1 The activities referred to in this LOU will be carried within that portion of the Ktunaxa Traditional Territory within British Columbia as shown in Appendix A.

4.0 SERVICE PROVISION

4.1 The Parties agree that:

4.1.1 the planning for and the provision of health services will be inclusive of all Aboriginal people,

4.1.2 the Ktunaxa Nation Council may represent other organized groups of Aboriginal people provided that there are formal written agreements to that effect,

4.1.3 mutual respect, trust, openness, accountability and transparency will be the basis of the understanding and foundation of the relationship established under this LOU,

4.1.4 every effort will be made where possible to harmonize and integrate programs and services including potential expansion to include social determinants of health,

4.1.5 activities will be carried out with a view to sustainability, efficiency, and effectiveness without limiting innovation, equitable access or quality and by building on existing best practices,

4.1.6 a strengths-based approach will be used to measure outcomes,

4.1.7 mutually agreed upon indicators of health will be followed as a baseline for measurement, and

4.1.8 there will be a balance of qualitative and quantitative outcomes.

5.0 IMPLEMENTATION

5.1 Coordination

5.1.1 The Parties will establish a Joint Committee that will be tasked with the following actions, which may include, but are not limited to:

a. development of annual work plans;
b. evaluate outcomes related to annual work plans;
c. overseeing research projects involving Aboriginal people or communities;
d. reviewing all activities of the working groups to ensure that their work builds upon existing processes, explores and incorporates best practices and maximizes the value added to planning processes and service delivery;

e. drafting an Interior Health/Ktunaxa Health Plan;
f. ensuring that the Interior Health/Ktunaxa Health Plan is coordinated with the Health Plans developed by the First Nations Health Council, Provincial and Federal governments and others; and
g. reporting out to the respective Parties on activities of the Joint Committee.

5.2 Activities

5.2.1 To improve the health outcomes for Aboriginal people, the Parties will carry out specific actions including but not limited to the following:

a. improve on processes;
b. review of the existing standards;
c. develop service delivery systems to better reflect the needs of Aboriginal people;
d. develop a Planning Framework;
e. develop a consistent and harmonized planning process;
f. establish common indicators, targets, milestones, benchmarks;
g. develop Health Plans, including setting standards, targets, outcomes and measurements;
h. engage in dialogue, identify linkages and establish networks with other Aboriginal and non-Aboriginal stakeholders;
i. identify those matters including policy issues that will address gaps and eliminate overlaps; and
j. establish at the program level communications with the First Nations and Inuit Health branch of Health Canada.

5.2.2 The Parties will establish working groups to carry out the activities set out in paragraph 5.2.1.

5.3 Resource Requirements

5.3.1 The Parties will identify the human, financial and capital resources required to achieve the goals of the LOU.

5.3.2 The Parties will work cooperatively to secure resources identified under paragraph 5.3.1, both internally and externally.

6.0 COMMUNICATION AND INFORMATION SHARING

6.1 Communication between the Parties will be open, regularized and reciprocal.

6.2 The Parties will work together to coordinate and determine the most effective and efficient means of data exchange, system integration, and information–sharing, to the fullest extent possible.

7.0 EVALUATION OF LOU

7.1 The Parties will review the Letter of Understanding annually.

7.2 Upon successful attainment of agreed upon outcomes or unless otherwise agreed by the Parties, the Parties will assess the potential for heightened forms of agreement leading to gradual increased authority for Ktunaxa Nation Council.

8.0 OTHER AGREEMENTS

8.1 The Parties acknowledge and agree that this Letter of Understanding is between the Parties identified and should not be interpreted to have any influence, bearing or impact on other agreements including, but not limited to:

- 8.1.1 Enabling Agreements;
- 8.1.2 Federal Health Transfer Agreement;
- 8.1.3 Protocols or Agreements between Ktunaxa Nation Council and other Aboriginal or non-Aboriginal entities; and
- 8.1.4 Relationship to Treaty Process Stage IV.

9.0 PROCESSES

9.1 This Letter of Understanding does not extend to the following processes:

- 9.1.1 Interior Health Authority Corporate planning; and
- 9.1.2 Ktunaxa Nation Council National planning.

9.2 The Parties agree to use a consensus-building model.

10.0 TERM

10.1 Duration

- 10.1.1 The term of the LOU will be in perpetuity with review every 3 years from the date of signing.

10.2 Termination

- 10.2.1 The Parties agree that either Party may terminate this agreement by providing sixty (60) days written notice, including the cause for termination.

11.0 AMENDMENT

11.1 The LOU may be amended by the Parties at any time by mutual consent of both Parties in writing.

Dated on the 26th day of July, 2012

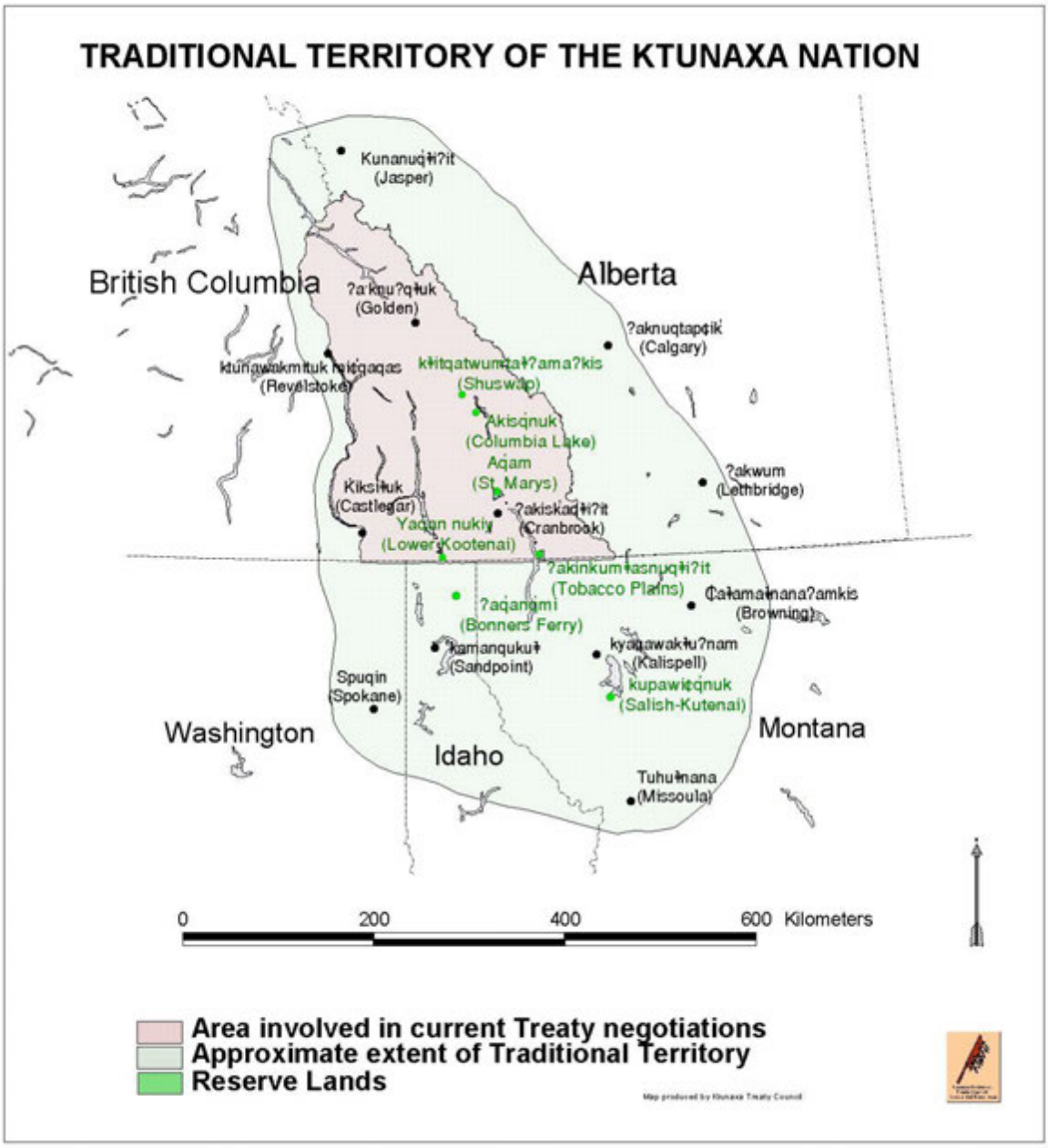
Signed by:

Kathryn Teneese, **Ktunaxa Nation Chair**	**Dr. Robert Halpenny** **President and Chief Executive Officer** **Interior Health**

Witnessed by:

Chief Cheryl Casimer, **St. Mary's Indian Band**	**Norman Embree,** **Board Chair** **Interior Health**

APPENDIX A: Geographic Map



LETTER OF UNDERSTANDING

Between

Nlaka'pamux Nation

Nlaka'pamux Nation

As represented by the Nlaka'pamux Nation Bands

and

Interior Health Authority

FINAL-October 2013

Nlaka'pamux Nation

Interior Health

APPENDIX 1

LETTER OF UNDERSTANDING

Between

Nlaka'pamux Nation

As represented by the Nlaka'pamux Nation Bands

and

Interior Health Authority
(each a "Party" and collectively "the Parties")

1.0 PURPOSE

1.1 The Parties commit to working together through meaningful participation and collaboration, to increase the influence of the Nlaka'pamux communities in decisions related to health services that impact their members and other Aboriginal peoples residing within the Nlaka'pamux Territory.

1.2 The Parties seek to improve the health outcomes for Aboriginal people by achieving effective shared decision making that will reduce the barriers for Aboriginal people to access better health services.

2.0 PREAMBLE

2.1 The Parties agree to enter into a mutually beneficial relationship that will work toward, in a quantifiable and qualitative manner, shared responsibility and shared decision-making as it impacts the provision of health services to Aboriginal people.

2.2 The Parties agree that cultural and spiritual aspects should be respected, where possible, in all areas of health services.

2.3 The Parties agree to use a cooperative, collaborative approach to improving the health status of Aboriginal individuals, families and communities through the design, delivery and evaluation of health programs and services.

2.4 Interior Health Authority acknowledges the inherent rights of the Nlaka'pamux people. Further, Interior Health Authority recognizes that the established Nlaka'pamux Bands represent their citizenry regardless of residency. Furthermore, Interior Health authority supports the Nlaka'pamux pursuit of its rights to retain responsibility for the health, safety, survival, dignity and

APPENDIX 1

well-being of Nlaka'pamux children and families, consistent with the United Nations (UN) Convention on the Rights of the Child and the UN Declaration on the Rights of Indigenous people.

2.5 The Parties agree and understand that the Letter of Understanding pertains to the Interior Health Authority's roles and responsibilities according to the purpose and description under the Health Authorities Act, Section 5(1) and Section 5(2), which states that:

2.5.1 The purposes of a board (IHA) are as follows:

(a) *To develop and implement a regional health plan that includes*

(i) the health services provided in the region, or in a part of the region,

(ii) the type, size and location of facilities in the region,

(iii) the programs for the delivery of health services provided in the region,

(iv) the human resource requirements under the regional health plan, and

(v) the making of reports to the minister on the activities of the board in carrying out its purposes.

(b) To develop policies, set priorities, prepare and submit budgets to the minister and allocate resources for the delivery of health services, in the region, under the regional health plan.

(c) To administer and allocate grants made by the government for the provision of health services in the region.

(d) To deliver regional services through its employees or to enter into agreements with the government or other public or private bodies for the delivery of those services by those bodies.

(e) [Repealed 2002-61-4] therefore not applicable.

(f) To develop and implement regional standards for the delivery of health services in the region.

(g) To monitor, evaluate and comply with Provincial and regional standards and ensure delivery of specified services applicable to the region.

2.5.2 In Carrying out its purposes, a board must give due regard to the Provincial standards and specified services.

3.0 PRINCIPLES

3.1 The Parties acknowledge and respect established and evolving jurisdictional and fiduciary relationships and responsibilities, and will seek to remove impediments to progress by establishing cooperative working relationships.

3.2 The Letter of Understanding is a living document that will transcend changes within the Parties and will represent an integrated approach to the enhancement of relationships and development of services.

3.3 The Parties acknowledge and respect the need for transparency and reciprocal accountability.

APPENDIX 1

4.0 GEOGRAPHIC AREA

4.1 The activities referred to in the Letter of Understanding will be applicable within that portion of the Nlaka'pamux Territory which lies within the Interior Health Authority Service area (see attached IHA Map).

5.0 SERVICE PROVISION

The parties agree that:

5.1 Mutual respect, shared responsibility, shared decision-making, trust, openness, accountability and transparency will be the basis of the understanding and the foundation of the relationship established under this Letter of Understanding.

5.2 The planning for and the provision of health services will be inclusive of all Aboriginal people.

5.3 The Nlaka'pamux Nation may represent other organized groups of Aboriginal people, provided there are formal written agreements to that effect.

5.4 Every effort will be made to harmonize and integrate health programs and services including potential expansion to include social determinants of health.

5.5 Activities will be carried out with a view to maintaining principles of equitability, sustainability, efficiency and effectiveness without limiting innovation, improving access or quality and by building on existing best practices.

5.6 Appropriate qualitative and quantitative methods will be used to measure outcomes, including participatory action oriented and strengths-based approaches (e.g. client focused, holistic or "wrap-around").

5.7 Mutually agreed upon indicators of health will be followed as a baseline for measurement.

5.8 There will be a balance of qualitative and quantitative data collection tools used to measure changes in the health status of Aboriginal people.

6.0 IMPLEMENTATION

6.1 Coordination

6.1.1 The parties will establish a Joint Committee that will be tasked with the following actions, including but not limited to:

a) Developing annual work plans.
b) Evaluating outcomes related to annual work plans.
c) Overseeing research projects involving Aboriginal people or communities.

APPENDIX 1

d) Reviewing all activities of the working groups to ensure that their work builds upon existing processes, explores and incorporates best practises and maximizes the value added to planning processes and service delivery.
e) Drafting an Interior Health/Nlaka'pamux Health Plan.
f) Ensuring that the Interior Health/Nlaka'pamux Health Plan is coordinated with the Health Plans developed by the First Nations Health Authority, Provincial and Federal governments and others.
g) Reporting out to the respective Parties on activities of the Joint Committee.

6.2 Activities

6.2.1 To improve the health outcomes for Aboriginal people, the Parties will carry out specific actions including but not limited to the following:

a) Improve on processes.
b) Review of the existing standards.
c) Develop service delivery systems to better reflect the needs of Aboriginal people.
d) Develop a Planning Framework.
e) Develop a consistent and harmonized planning process.
f) Establish common indicators, targets, milestones, benchmarks.
g) Develop Health Plans, including setting standards, targets, outcomes and measurements.
h) Engage in dialogue, identify linkages and establish networks with other Aboriginal and non-Aboriginal stakeholders.
i) Identify those matters including policy issues that will address gaps and eliminate overlaps.
j) Establish at the program level communications with the First Nations, First Nations Service providers and First Nations Health Authority.

6.2.2 The Parties will establish working groups to carry out the activities set out in paragraph 6.2.1

7.0 RESOURCE REQUIREMENTS

7.1 The parties acknowledge that Interior Health Authority is responsible for the provision of health services to all citizens residing in its service delivery area.

7.2 The parties will identify the human, financial and capital resources required to achieving the goals of the Letter of Understanding.

7.3 The Parties will work cooperatively to secure resources, both internally and externally.

8.0 COMMUNICATION AND INFORMATION SHARING

8.1 Communication between the Parties will be respectful, transparent, regular and reciprocal.

8.2 The Parties will work together to coordinate and determine the most effective and efficient means of data exchange, system integration and information-sharing, to the fullest extent possible.

APPENDIX 1

8.3 The principles of Ownership, Control, Access and Possession (OCAP) will be consistently applied wherever applicable.

9.0 EVALUATION OF LETTER OF UNDERSTANDING

9.1 The Parties will review the Letter of Understanding annually or as otherwise agreed by all Parties.

9.2 The *Joint Committee* will determine and agree upon the process and procedures for the evaluation and implementation of recommendations.

10.0 OTHER AGREEMENTS

10.1 The Parties acknowledge and agree that this Letter of Understanding is between the Parties identified and should not be interpreted as having any influence, bearing or impact on other agreements including, but not limited to:

10.1.1 Enabling Agreements (i.e. contracts).

10.1.2 Federal Health Transfer Agreement including the Tri-partite Agreement.

10.1.3 Protocols or Agreements between Nlaka'pamux communities and other Aboriginal or non-Aboriginal entities.

10.2 The Parties agree and understand that this Letter of Understanding is not prejudicial to the implementation of any inherent right of self-government or any other agreements that may be negotiated with respect to self-government.

11.0 PROCESSES

11.1 This Letter of Understanding does not extend to the following processes:

11.1.1 Interior Health Authority Corporate planning.

11.1.2 Nlaka'pamux Nation planning.

11.1.3 Planning processes conducted by the Nlaka'pamux communities (for example, strategic plans and community plans).

12.0 TERM

12.1 ***Duration:*** The term of the Letter of Understanding will be in effect for five (5) years from the date of signing and will be reviewed by both parties annually.

12.2 ***Extension*****:** The term of the Letter of Understanding may be extended by mutual consent of the Parties.

12.3 ***Termination*****:** If mediation and/or resolution cannot be achieved, the Parties agree that either Party may terminate this agreement by providing sixty (60) days written notice, including the cause for termination.

APPENDIX 1

13.0 AMENDMENT

13.1 The Letter of Understanding may be amended by the Parties at any time by mutual consent of all parties, in writing.

APPENDIX 1
Dated this 06 of NOVEMBER, 2013

For Nlaka`pamux Governments

1. Coldwater Band
2. Lower Nicola Band
3. Nooaitch Band
4. Shackan Band
5. Cooks Ferry Band
6. Oregon Jack Creek Band
7. Ashcroft Band
8. Nicomen Band
9. Lytton Band
10. Siska Band
11. Boston Bar Band *
12. Boothroyd *
13. Kanaka Bar Band
14. Skuppah Band
15. Spuzzum Band *

*In Fraser Health Region at this time

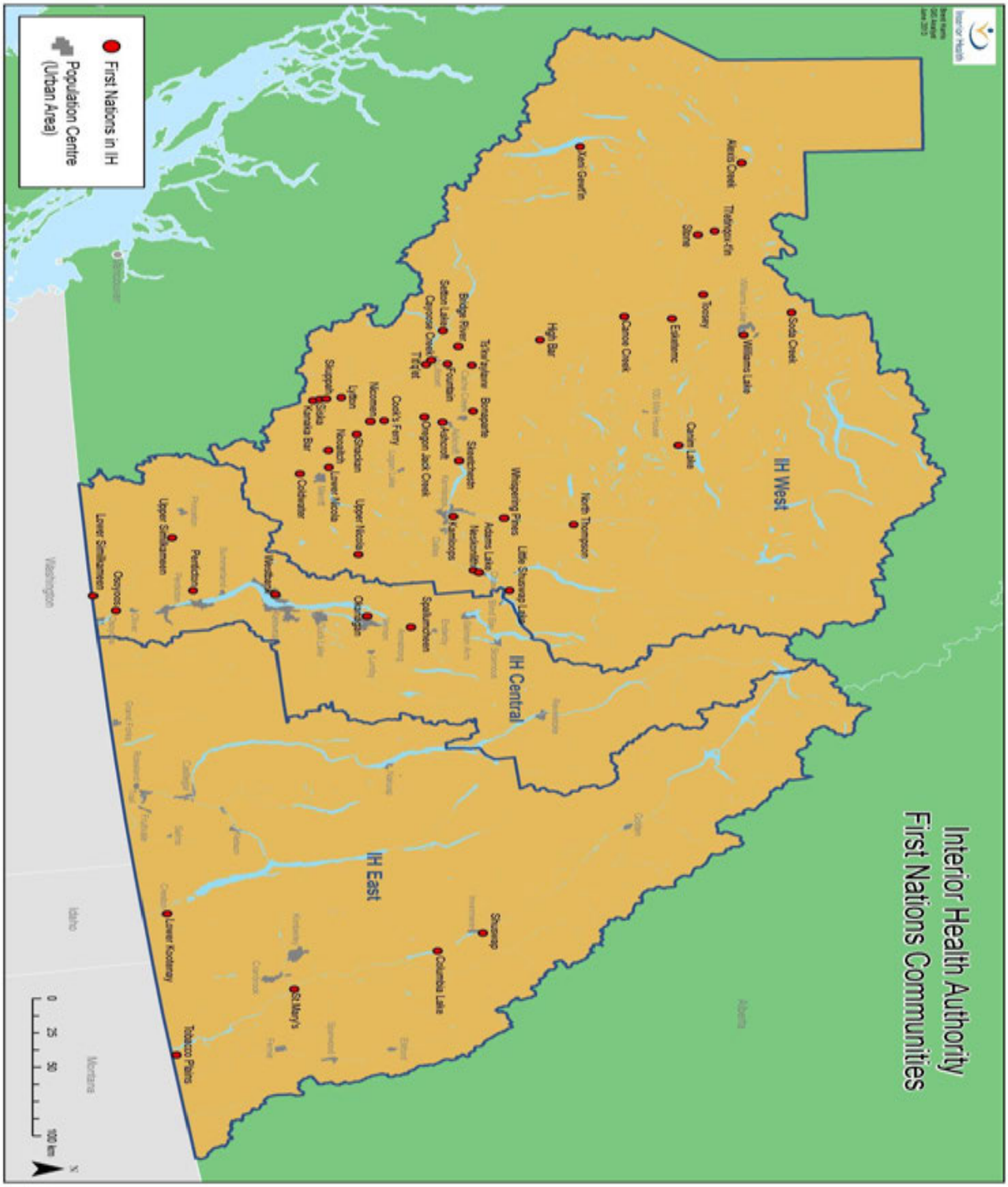
For Interior Health Authority

Dr. Robert Halpenny, President and Chief Executive Officer

Norman Embree, Board Chair, Interior Health Authority

Nlaka’pamux Nation

APPENDIX 1



LETTER OF UNDERSTANDING

between

Okanagan Nation Alliance and the seven member communities:
Upper Nicola Band, Okanagan Indian Band, Westbank First Nation,
Penticton Indian Band, Osoyoos Indian Band, Lower Similkameen Indian Band
and Upper Similkameen Indian Band

and

Interior Health Authority

(each a "Party" and collectively "the Parties")

1.0 PURPOSE

1.1 The Parties wish to define a collaboratively developed engagement process for the planning of Aboriginal services and operations across their respective territories.

1.2 The Parties seek to improve the health outcomes for Aboriginal people by achieving effective shared decision making that will reduce the barriers for Aboriginal people[1] to access better health services.

1.3 The Parties commit to working together through meaningful participation and collaboration, to increase the influence of the Okanagan Nation Alliance and the seven member communities in decisions related to health services that impact their members and other Aboriginal peoples residing within Okanagan Territory.

1.4 The Parties agree that health outcomes should be comparable for all residents of British Columbia.

2.0 PREAMBLE

2.1 The Parties agree to enter into a mutually beneficial relationship that will work toward, in a quantifiable and qualitative manner, shared responsibility and shared decision making as it impacts the provision of Health Services to Aboriginal people.

2.2 The Parties agree to use a cooperative, collaborative approach to improving the health status of Aboriginal individuals, families and communities through the design, delivery and evaluation of culturally safe health programs and services.

2.3 Interior Health Authority acknowledges the inherent rights of the *Syilx* people. Further, Interior Health Authority recognizes that the Okanagan Nation Alliance and the seven

[1] See Glossary for definition.

member communities represent their citizenry regardless of residency and supports the *Syilx* pursuit of its rights to retain responsibility for the health, safety, survival, dignity and well-being of *Syilx* children and families, consistent with the UN Convention on the Rights of the Child and the UN Declaration on the Rights of Indigenous people[2].

2.4 The Parties agree and understand that this Letter of Understanding pertains to the Interior Health Authority's roles and responsibilities according to the purpose and description under the Health Authorities Act, Section 5(1) and Section 5(2), which states that:

"(1) The purposes of a board are as follows:

(a) To develop and implement a regional health plan that includes
(i) the health services provided in the region, or in a part of the region,
(ii) the type, size and location of facilities in the region,
(iii) the programs for the delivery of health services provided in the region,
(iv) the human resource requirements under the regional health plan, and
(v) the making of reports to the minister on the activities of the board in carrying out its purposes.

(b) To develop policies, set priorities, prepare and submit budgets to the minister and allocate resources for the delivery of health services, in the region, under the regional health plan.

(c) To administer and allocate grants made by the government for the provision of health services in the region.

(d) To deliver regional services through its employees or to enter into agreements with the government or other public or private bodies for the delivery of those services by those bodies.

(e) [Repealed 2002-61-4] therefore not applicable.

(f) To develop and implement regional standards for the delivery of health services in the region.

(g) To monitor, evaluate and comply with Provincial and regional standards and ensure delivery of specified services applicable to the region.

(2) In Carrying out its purposes, a board must give due regard to the Provincial standards and specified services."

3.0 PRINCIPLES

The development of this Letter of Understanding was based upon the following principles:

[2] See the ONA Declaration in Appendix 1.

3.1 The Parties acknowledge and respect established and evolving jurisdictional and fiduciary relationships and responsibilities, and will seek to remove impediments to progress by establishing effective working relationships.

3.2 The planning and coordination of Interior Health Authority services for Okanagan Nation Alliance members will be more effective if there is increased participation of the Okanagan Nation Alliance and the seven member communities in the planning of services.

3.3 The Letter of Understanding is a living document that will transcend changes within the Parties and will represent an integrated approach to the enhancement of relationships and development of services.

3.4 The Parties acknowledge and respect the need for transparency and reciprocal accountability.

4.0 GEOGRAPHIC AREA

The activities referred to in this Letter of Understanding will be applicable within that portion of the *Syilx* (Okanagan) Territory which lies within British Columbia as shown in Appendix 2.

5.0 SERVICE PROVISION

The Parties agree that**:**

5.1 Mutual respect, trust, openness, accountability and transparency will be the basis of the understanding and foundation of the relationship established under this Letter of Understanding; the Four Food Chiefs as defined in the Syilx Health Plan[3] are to be utilized as guiding principles.

5.2 The planning for and the provision of health services will be inclusive of all Aboriginal people, and services will be culturally safe.

5.3 The Okanagan Nation Alliance may represent other organized groups of Aboriginal people provided that there are formal written agreements to that effect.

5.4 Every effort will be made where possible to create culturally safe services, and to harmonize and integrate programs and services.

5.5 Activities will be carried out with a view to maintaining principles of sustainability, efficiency and effectiveness without limiting innovation, improved access or quality and by building on existing best practices.

5.6 Appropriate methods will be used to measure outcomes, including a strengths-based approach (e.g. client focused, holistic or “wrap-around”).

5.7 Mutually agreed upon indicators of health will be followed as a baseline for measurement, and there will be a balance of qualitative and quantitative outcomes.

[3] See Appendix 3

6.0 ACTIVITIES

6.1 To improve the health outcomes for Aboriginal people, the Parties will carry out specific actions including but not limited to the following:

- 6.1.1 Review of the existing standards.
- 6.1.2 Development of service delivery systems to better reflect the cultural context of Aboriginal people.
- 6.1.3 Development of a consistent and harmonized planning process.
- 6.1.4 Establishment of common indicators, targets, milestones and benchmarks.
- 6.1.5 Review alignment within health plans, including setting standards, targets, outcomes and measurements.
- 6.1.6 Engagement in dialogue, identification of linkages and establishment of networks with other Aboriginal and non-Aboriginal stakeholders.
- 6.1.7 Identification of those matters including policy issues that will address gaps and eliminate duplication.

6.2 The Parties will establish a Joint Committee and working groups (with specific terms of reference and deliverables) to carry out the activities set out in paragraph 6.1.

7.0 IMPLEMENTATION

As per 6.2 above, the Parties will establish a "Joint Committee" comprising representatives from all Parties that will be tasked with responsibilities which may include, but are not limited to:

7.1 Development of a strategy for building relationships between the Parties, including an engagement strategy and communication and consultation processes.

7.2 Development of protocols between the Parties including the sharing of information on initiatives that are of interest or are shared between the Parties.

7.3 Prioritization of services.

7.4 Laying the foundation for relationship documents (e.g. Letters of Understanding, Memorandum of Understanding, etc.) between the Parties on specific service-related issues.

7.5 Overseeing research projects involving Aboriginal people or communities, applying the principles of Ownership, Control, Access and Possession (OCAP).

7.6 Where appropriate, establishment and implementation of a process for establishing and reviewing the activities of specific working groups to ensure that their work builds upon existing processes, explores and incorporates best practices and maximizes the value added to planning processes and service delivery (including Terms of Reference and deliverables).

7.7 Reviewing the Parties' Health Plans to ensure alignment with each other and with the Tri-Partite First Nations Health Plan.

7.8 Development, agreement and implementation of a Data Sharing Agreement.

7.9 Determination of and agreement upon the process and procedures for the evaluation of this Letter of Understanding and the implementation of subsequent recommendations.

7.10 The Joint Committee representatives will report through their respective organizations.

8.0 RESOURCE REQUIREMENTS

8.1 It is acknowledged that through the Ministry of Health, Interior Health Authority is responsible for the provision of health services to all citizens.

8.2 The Parties will identify the human, financial and capital resources and potential sources of funding required to achieve the goals of the Letter of Understanding.

8.3 The Parties will work cooperatively to secure resources, both internally and externally.

9.0 COMMUNICATION AND INFORMATION SHARING

9.1 Communication between the Parties will be transparent, regular and reciprocal.

9.2 The Parties will work together within the legislative framework, e.g. Freedom of Information and Protection of Privacy Act (FOIPPA) etc., to coordinate and determine the most effective and efficient means of data exchange, system integration and information-sharing to the fullest extent possible.

9.3 The principles of Ownership, Control, Access and Possession (OCAP) will be consistently applied wherever applicable.

10. 0 EVALUATION OF LETTER OF UNDERSTANDING

The Parties will review the Letter of Understanding annually or as otherwise agreed by all Parties. As per paragraph 7.9 above, the Joint Committee will determine and agree the process and procedures for the evaluation and implementation of subsequent recommendations.

11.0 OTHER AGREEMENTS

11.1 The Parties acknowledge and agree that this Letter of Understanding is between the Parties identified and should not be interpreted as having any influence, bearing or impact on other agreements including, but not limited to:

- 11.1.1 Enabling Agreements (i.e. contracts).
- 11.1.2 Federal Health Transfer Agreement including the Tri-Partite Agreement.
- 11.1.3 Protocols or Agreements between Okanagan Nation Alliance and other Aboriginal or non-Aboriginal entities.

11.2 The Parties agree that this Letter of Understanding is not prejudicial to the implementation of any inherent right of self-government or any agreements that may be negotiated with respect to self-government.

12.0 PROCESSES

12.1 This Letter of Understanding does not extend to the following processes:

- 12.1.1 Interior Health Authority Corporate planning.
- 12.1.2 Okanagan Nation Alliance organizational/business planning.

12.1.3 Planning processes conducted by the seven member bands (for example, strategic plans and community plans).

12.2 The Parties agree to use a consensus-building model.

13.0 TERM

13.1 Duration: The term of the Letter of Understanding will be four years from the date of the signing.

13.2 Extension: The term of the Letter of Understanding may be extended by mutual consent of the Parties.

13.3 Resolution of Issues: The Parties will work towards remedy of any issues pertaining to this Letter of Understanding through a mutually agreed-upon process (such as mediation).

13.4 Termination: If mediation and/or resolution cannot be achieved, the Parties agree that either Party may terminate this agreement by providing sixty (60) days written notice, including the cause for termination.

14.0 AMENDMENT

The Letter of Understanding may be amended by the Parties at any time by mutual consent of all Parties, in writing.

Dated this 13th day of June, 2012

Signed by:

Okanagan Nation Alliance

Grand Chief Stewart Phillip,
Okanagan Nation Alliance Chair

Pauline Terbasket,
Okanagan Nation Alliance
Executive Director

Interior Health Authority

Dr. Robert Halpenny,
President and
Chief Executive Officer

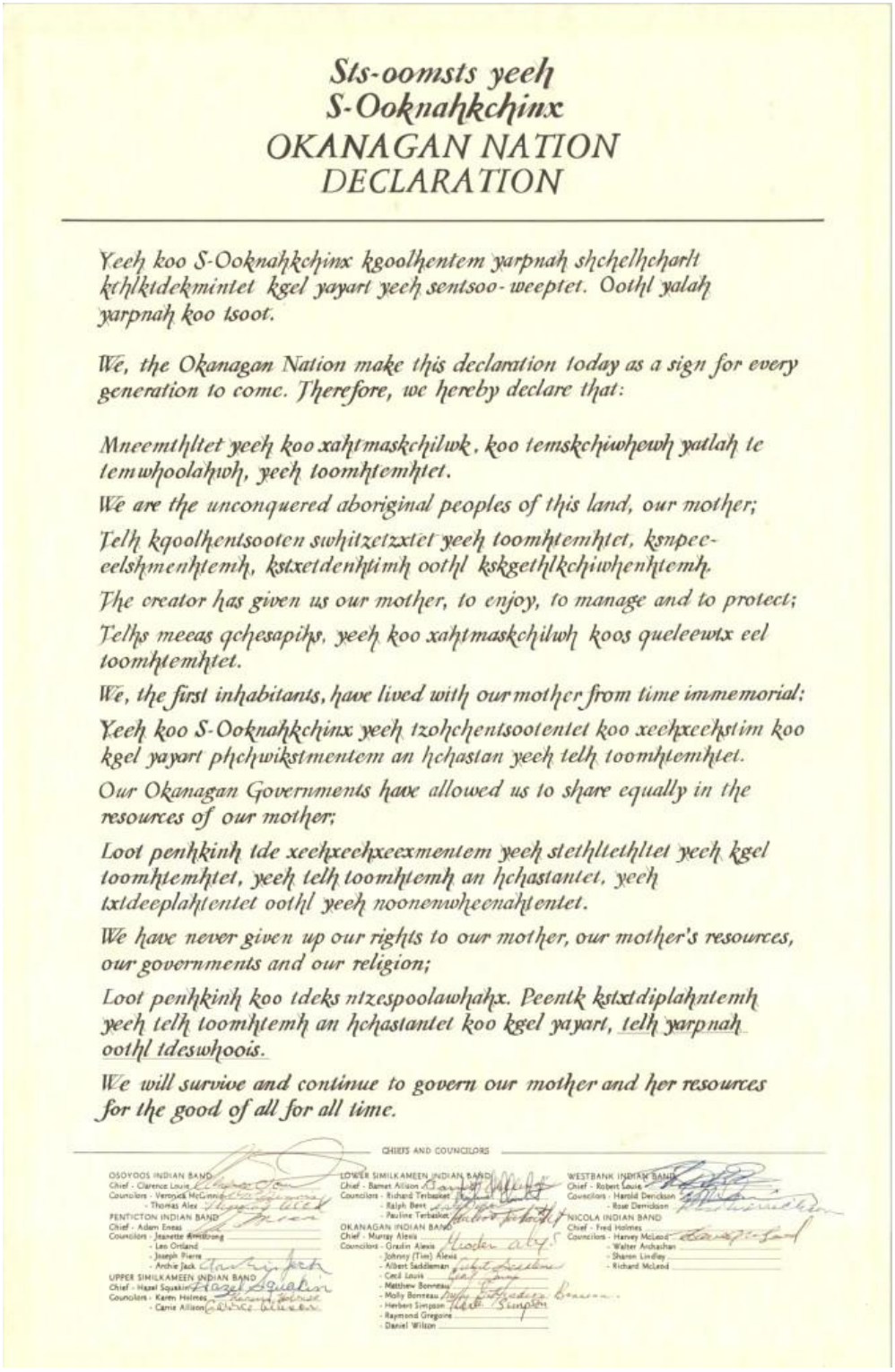
Norman Embree,
Board Chair, Interior Health
Authority

Witnessed by:

Jacki McPherson,
ONA Wellness Committee Member

Appendix 1

The Declaration



Sts-oomsts yeeh
S-Ooknahkchinx
OKANAGAN NATION
DECLARATION

Yeeh koo S-Ooknahkchinx kgoolhentem yarpnah shchelhcharlt kthlktdekmintet kgel yayart yeeh sentsoo-weeptet. Oothl yalah yarpnah koo tsoot.

We, the Okanagan Nation make this declaration today as a sign for every generation to come. Therefore, we hereby declare that:

Mneemthltet yeeh koo xahtmaskchilwk, koo temskchiwhewh yatlah te temwhoolahwh, yeeh toomhtemhtet.

We are the unconquered aboriginal peoples of this land, our mother;

Telh kgoolhentsooten swhitzetzxtet yeeh toomhtemhtet, ksnpee-eelshmenhtemh, kstxetdenhtimh oothl kskgethlkchiwhenhtemh.

The creator has given us our mother, to enjoy, to manage and to protect;

Telhs meeas qchesapihs, yeeh koo xahtmaskchilwh koos queleewtx eel toomhtemhtet.

We, the first inhabitants, have lived with our mother from time immemorial;

Yeeh koo S-Ooknahkchinx yeeh tzohchentsootentet koo xeehxeehstim koo kgel yayart phchwikstmentem an hchastan yeeh telh toomhtemhtet.

Our Okanagan Governments have allowed us to share equally in the resources of our mother;

Loot penhkinh tde xeehxeehxeexmentem yeeh stethltethltet yeeh kgel toomhtemhtet, yeeh telh toomhtemh an hchastantet, yeeh txtdeeplahtentet oothl yeeh noonenwheenahtentet.

We have never given up our rights to our mother, our mother's resources, our governments and our religion;

Loot penhkinh koo tdeks ntzespoolawhahx. Peentk kstxtdiplahntemh yeeh telh toomhtemh an hchastantet koo kgel yayart, telh yarpnah oothl tdeswhoois.

We will survive and continue to govern our mother and her resources for the good of all for all time.

CHIEFS AND COUNCILORS

OSOYOOS INDIAN BAND
Chief - Clarence Louie
Councilors - Veronica McGinnis
- Thomas Alex
PENTICTON INDIAN BAND
Chief - Adam Eneas
Councilors - Jeanette Armstrong
- Lee Ortland
- Joseph Pierre
- Archie Jack
UPPER SIMILKAMEEN INDIAN BAND
Chief - Hazel Squakin
Councilors - Karen Holmes
- Carrie Allison

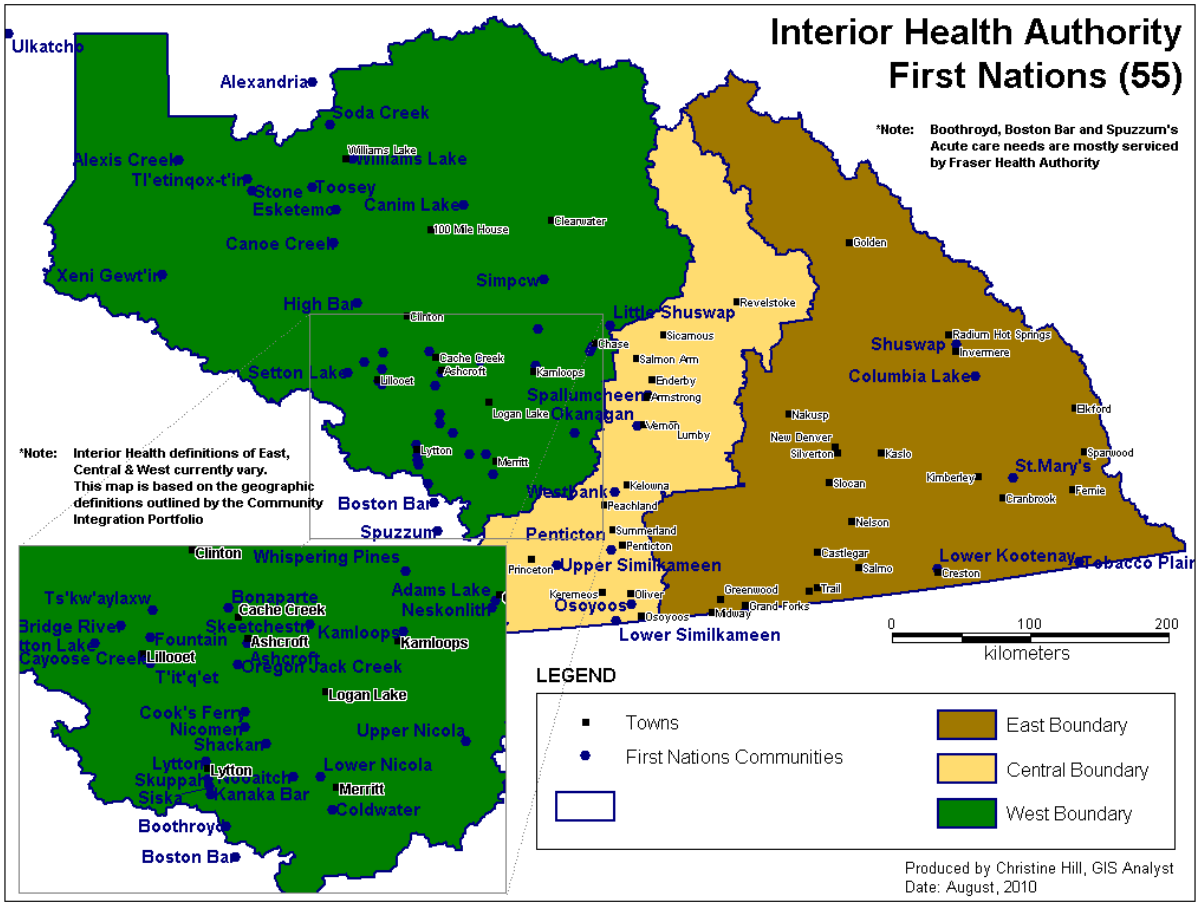
LOWER SIMILKAMEEN INDIAN BAND
Chief - Barnet Allison
Councilors - Richard Terbasket
- Ralph Baez
- Pauline Terbasket
OKANAGAN INDIAN BAND
Chief - Murray Alexis
Councilors - Gradin Alexis
- Johnny (Tim) Alexis
- Albert Saddleman
- Cecil Louis
- Matthew Bonneau
- Molly Bonneau
- Herbert Simpson
- Raymond Gregoire
- Daniel Wilson

WESTBANK INDIAN BAND
Chief - Robert Louie
Councilors - Harold Derickson
- Rose Derrickson
NICOLA INDIAN BAND
Chief - Fred Holmes
Councilors - Harvey McLeod
- Walter Archachan
- Sharon Lindley
- Richard McLeod

Appendix 2

The ONA Territory

The Okanagan Nation territory includes an area that extends over approximately 69,000 km. The northern area of this territory is close to the area of Mica Creek, just north of modern-day Revelstoke, B.C., the eastern boundary lies between Kaslo and Kootenay Lakes. The southern boundary extends to the vicinity of Wilbur, Washington, and the western border extends into the Nicola Valley. The map below is the IHA region, showing our communities.



Appendix 3

Syilx Health Plan 2010

Extract: The Four Food Chiefs

Chief Siya (Saskatoon Berry) – Vision & Innovation Perspective

For ***Syilx*** people, health is multifaceted, holistic and interconnected. The health of the ***Syilx*** people is reflected in the health of the individual, family, community and land. These elements are inseparable and cannot be looked at in isolation. The survival of the Nation as a whole is dependent on the well-being of the individuals, the families, and the community. The reverse is also true. We know that cultural pride, cultural identity and traditional knowledge are important to our individual health and to the health of our families, the community and the land. The long history of colonization has therefore played a major role in the current health of individuals, families and the Nation. This was very evident in the environmental scan.

We have therefore applied our Indigenous "way of knowing" as the framework for this Health Plan.

"**COMMUNITY**" in Nsyilxcən (Okanagan) is a word that has the meaning that we are **'OF ONE SKIN'.** The one skin is not referring so much to the idea that we're biologically related as to the idea that we share something which gives us a covering, a security, a protection – in the same way that our skin, stretched over our blood and bones protects us from dissipating back into our larger selves which is the external world. Your skin holds you together."

Syilx Cultural Framework

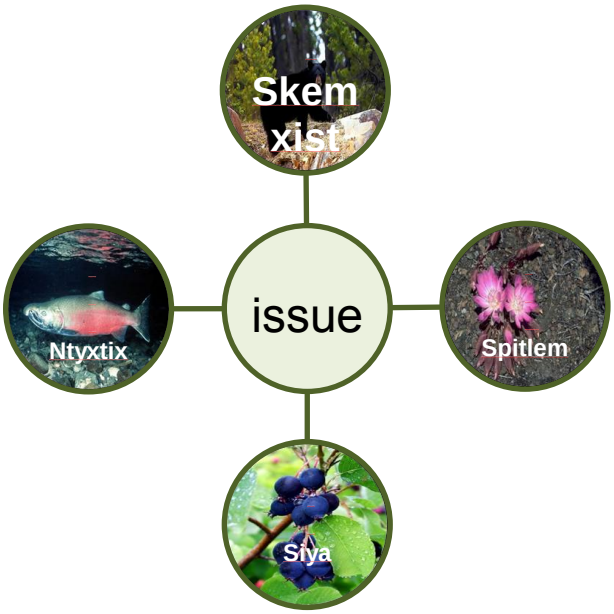
The ***Syilx*** people have passed down their cultural way of knowing from one generation to the next, orally through storytelling. When we tell ***Chaptikwl,*** **"**our stories", we breathe life into the ember that is waiting to come alive again. When we talk about how we are going to reclaim and restore the well-being of our communities, we are breathing life into our words and into our actions and into the people. This is a regenerating experience that creates fluid dynamic movement and begins to address the years of oppression when the colonial governments attempted to silence our stories, literally to strip us of the knowledge of our ancestors.

The ***Syilx*** (Okanagan) cultural framework is built on the foundation of ***Syilx*** cultural ways of knowing and of being and is drawn from a ***Chaptikwl*** called ***"How Food was Given."*** In this story, ***Kul'nchut'n*** *(*creator) visited the ***Tmixw*** (including but not limited to the people, animal plants, air and water). ***Kul'nchut'n*** (creator) sent ***Senklip*** (coyote) to prepare for the future of the ***Stelsqilxw*** (people-to-be). ***Kul'nchut'n*** *t*old the ***Tmixw*** that people were coming. The **four (4) Chiefs**: ***Skemxist*** *(*Black Bear) ***Siya*** (Saskatoon Berry), ***Spitlem*** (Bitter Root), ***Ntyxtix*** (King Salmon) then came together and made a plan for how to feed **Stelsqilxw** (people to be). The story then tells how the differing perspectives of the four chiefs were brought together to inform the discussion, the problem solving, the decision making and the action plan.

The ***Chaptikwl*** illustrates the ***Enowkinwixw*** process, the cultural practice or discipline that describes how to plan, solve problems, make decisions, resolve conflicts and/or develop an action plan. It brings people together to dialogue on specific issues. The practice welcomes, encourages and supports the expression of differing perspectives that, at times, may be in opposition to each other. The practice of ***Enowkinwixw*** embraces the dynamic tension that emerges and uses it to develop a collective understanding or to shape a shared approach to an issue or concern. This process has been described as a "mind meld" (Okanagan Nation Response Team 2007 Booster Training Session).

Enowkinwixw is a consensus based practice developed on the principles of respect, trust and inclusion. The following principles/actions are embedded within the process.

- Consensus
- Establishment of Common Ground
- Protocols for discussion
- Full participation
- Commitment to see the process to its end, regardless of the time involved
- Differing perspectives (***Siya, Spitlem, Skemxist, Ntyxtix***) that have a defined place: Innovators, Traditional, Action, and Relationships
  The process is complete when an action and implementation plan incorporating all views is in place.



Differing Perspectives

"How Food was Given" is a teaching that illustrates how the Okanagan/Syilx community can come together and make decisions about how to take care of future generations, especially in relation to their well being. It lends itself very well to providing a framework for, and an understanding of, the four main components of our health plan.

The Four Food Chiefs are described as having the following attributes
(please note this list is not meant to be exhaustive.)

Siya **(Saskatoon Berry)**	Chief of all things growing above Land	Youth Innovation/Creative	We CAN do it No Barriers Think BIG Creative
Spitlem **(Bitterroot)**	Chief of all Roots	Female Relationships	Interconnectedness Nurturing
Skemxist **(Black Bear)**	Chief of all 4 legged Animals	Elder Tradition	Protocols Culture Contemplation/Thinking
Ntyxtix **(King Salmon)**	Chief of all that is in the Water	Male Action	Get it done Timely Efficient Planning

1 **Chief *Siya*** (Saskatoon Berry) embodies the spirit of creative energy, vision and innovation that can be associated with Youth. In this section of our health plan we provide those components that relate to the Nation's **vision** and the **innovation** associated with the use of the **Syilx Cultural Framework** to assist in the understanding of the health plan.

2 **Chief *Spitlem*** (Bitter Root) describes relationships, and the interconnectedness among **Tmixw** including but not limited to the people, the animals, the plants, the land, the air and the water. This provides the "context" in which individuals, families and communities endeavor to live in harmony with each other, and with their relatives - the animals, the plants and the land. This section of our plan provides a description of the Okanagan Nation Alliance (ONA) including its **structure**, **capacity** and existing **programs**, and profiles of the seven Okanagan member Bands and the Wellness Committee. The need for the health plan and the phases of the health plan are also described.

3 **Chief *Skemxist*** (Black Bear) represents the traditions and cultural practices, the concept of reflection and contemplation on "what is" informed by an understanding of the past and how that is connected to the future. It is this understanding that then shapes development of protocols. In this section of the health plan, the **environmental context**, the **analysis of data**, **research, key findings** and the establishment of **priorities** are the focus.

4 **Chief Ntyxtix** (King Salmon) exemplifies the process of preparing (readiness), determining the objective (aim), and then taking action (act). In this section, the **Findings, Action Plan** and the **Conclusions** are presented.

The concepts of individual, family, community, land (Armstrong, J. 2000-Let us begin with courage) are defined thus:

"*Each **individual** person is singularly gifted, each person actualizes full human potential only as a result of physical, emotional, intellectual and spiritual well-being – those four aspects of existence are always contingent on external things. Each individual is a single facet of a trans-generational organism known as family."*

"*Through this organism flows the powerful lifeblood of cultural transference designed to secure the best probability of well-being for each of the generations. **Family** systems are the foundation of a long-term living network called community*."

"*In its various configurations this network spreads its life force over centuries and across physical space; it uses its collective knowledge to secure the well-being of all by the short- and long-term choices made via its collective process. A **community** is the living process that interacts with the vast and ancient body of intricately connected patterns in perfect unison called the land.*"

*"**Land** sustains all life and must be protected from depletion in order to insure its continued good health and ability to provide sustenance over generations.*"

All of these Syilx concepts and framework are integrated in the Wellbeing of the Syilx.

Appendix 4

Glossary of Terms

Aboriginal People	Aboriginal People include all Indigenous people of Canada. The Constitution recognizes three groups of Aboriginal people: Status and Non-Status First Nations, Métis and Inuit.
ONA Member Bands	Okanagan Indian Band, Westbank First Nation, Penticton Indian Band, Lower Similkameen Indian Band, Upper Similkameen Indian Band, Upper Nicola Indian Band, Osoyoos Indian Band.
Cooperate	To act or work together with another or others for a common purpose.
Collaborate	To work with another party towards a shared goal.
Consultation	A process by which the interested party's input on matters affecting them is sought. Note: IH will consult (confer) with the ONA on issues that pertain to the Nation as a whole. Specific band issues will be the responsibility of IH and the band. Recognizing that there are some changes that IHA has no control over (e.g. at Ministry level), IH determined service changes that impact bands will be required to include consultation process with the band.
Cultural Safety	Cultural safety is the effective care of a person/family from another culture by a health-care provider who has undertaken a process of reflection on their own cultural identity and recognizes the impact of the health-care provider's culture on their practice. Unsafe cultural practice is any action which diminishes, demeans or dis-empowers the cultural identity and well-being of an individual.
Client focused, holistic or "wrap-around"	These terms are used within the respective Parties to reflect similar principles. Terms that are also used include "recipient of service" (not client) thus the appropriate terminology will be used in each context.
Mediation	Mediation is a voluntary settlement negotiation facilitated by a neutral third party who has no decision-making power (as defined by the BC Dispute Resolution Office).

Acronyms

FOIPPA	Freedom of Information and Protection of Privacy Act
IHA	Interior Health Authority
LSIB	Lower Similkameen Indian Band
OCAP	Ownership, Control, Access and Possession
OIB	Osoyoos Indian Band
OKIB	Okanagan Indian Band
ONA	Okanagan Nation Alliance
PIB	Penticton Indian Band
UNB	Upper Nicola Band
USIB	Upper Similkameen Indian Band
WFN	Westbank First Nation

“WORKING IN PARTNERSHIP”

Letter of Understanding

Between

Secwepemc Health Caucus

and

Interior Health Authority
(each a “Party” and collectively “the Parties”)

Table of Contents

1.0 Purpose

1.1. The Parties wish to define a collaboratively developed engagment process for the planning of Aboriginal services, programs and operations across Secwepemc Territory for the improvement of services for Secwepemc people.

1.2. The Parties seek to improve the health outcomes for Secwepemc people by achieving effective shared decision making that will reduce the barriers for Secwepemc people to access better health services.

1.3. The Parties commit to working together through meaningful participation and collaboration, to increase the influence of the Secwepemc Health Caucus in decisions related to health services that impact their members and other Aboriginal peoples residing within Secwepemc Territory.

1.4. The Parties agree that health outcomes held in common with all residents of British Columbia should be at least equal for Secwepemc citizens and health outcomes beyond these, as defined by Secwepemc citizens, pursued with equal vigor and diligence.

2.0 Preamble

2.1 The Parties agree to enter into a mutually beneficial relationship that will work towards, in a quantifiable and qualitative manner, shared responsibility and shared decision making as it impacts the provisions of Health Services to Secwepemc people within Secwepemc Territory.

2.2 As capacity grows, planning and provision of health care by The Parties will extend beyond care for Secwepemc citizens to include other groups in Secwepemc Territory.

2.3 The Parties agree to use a cooperative, collaborative approach to improving the health status of Secwepemc individuals, families and communities through the design, delivery and evaluation of culturally safe health programs and services.

2.4 Interior Health Authority acknowledges the inherent and Aboriginal rights (including but not limited to self-determination and freedom from discrimination) of the Secwepemc People. Further, Interior Health Authority recognizes the Secwepemc Health Caucus "Authority" represents their citizenry regardless of residency and supports the Secwepemc pursuit of its rights to retain responsibility for the health, safety, survival, dignity and well-being of the Secwepemc children and families, consistent with the UN Convention on the Rights of the Child and the UN Declaration on the Rights of Indigenous Peoples.

2.5 This letter of understanding does not abrogate nor derogate from Secwepemc Aboriginal Rights as per Section 35(1) *Constitution Act. 1982*.

2.6 The Parties agree and understand that this Letter of Understanding pertains to the Interior Health Authority's roles and responsibilities according to the purpose and description under the Health Authorities Act which states that:

5 (1) The purposes of a board are as follows:

(a) To develop and implement a regional health plan that includes
  (i) The health services provided in the region, or in a part of the region,
  (ii) The type, size and location of facilities in the region,
  (iii) The programs for the delivery of health services provided in the region.
  (iv) The human resource requirements under the regional health plan and,
  (v) The making of reports to the minister on the activities of the board in carrying out its purposes.

(b) To develop policies, set priorities, prepare and submit budgets to the minister and allocate resources for the delivery of health services, in the region, under the regional health plan.

(c) To administer and allocate grants made by the government for the provisions of health services in the region.

(d) To deliver regional services through its employees or to enter into agreements with the government or other public or private bodies for the delivery of those services by those bodies.

(e) [Repealed 2002-61-4] therefore not applicable

(f) To develop and implement regional standards for the delivery of health services in the region.

(g) To monitor, evaluate and comply with Provincial and regional standards and ensure delivery of specified services applicable to the region.

5 (2) In Carrying out its purposes, a board must give due regard to the Provincial standards and specified services."

3.0 Principles

This Letter of Understanding is based upon the following principles:

3.1 The Secwepemc Health Caucus will be guided by the following principles adopted from the 7 Nations Unity Declaration. [1] (See Appendix B)

3.2 The Parties acknowledge and respect established and evolving jurisdictional and fiduciary relationships and responsibilities, and will seek to remove impediments to progress by establishing effective working relationships.

3.3 The planning, coordination and implementation of Interior Health Authority services for Aboriginal people in Secwepemc Territory will be more effective with increased participation of the Secwepemc Health Caucus in the planning of services.

3.4 The Letter of Understanding is a living document that will respond to changes within the Parties and will represent an integrated approach to the enhancement of the relationship and development of services.

3.5 The Parties acknowledge and respect the need for transparency, reciprocal accountability, and accountability to the communities affected by decisions made by The Parties.

4.0 Service Provisions

The Parties agree that:

4.1 Mutual respect, trust, openness, accountability and transparency will be the basis of the understanding and foundation of the relationship established under this Letter of Understanding.

4.2 Ensuring cultural safety is of paramount importance to the effectiveness of and access to, health services provision. Where *Cultural Safety* is defined by the health services recipient.

4.3 The cultural safety of Secwepemc people will require ongoing education, dialogue and active participation and engagement between parties including:

4.3.1 Collaboration on Indigenous Cultural Competence (ICC) supplementary training and documents, including innovation of techniques and relationship building.

[1] Duplicated from the 7 Nations Unity Declaration

4.3.2 Supporting the interaction of all levels of IH staff with Aboriginal and Secwepemc people at cultural, non-cultural, and IH hosted events.
4.3.3 Collaboration on the evaluation of cultural safety improvement measures and grievance mechanisms for Aboriginal and Secwepemc employees and customers.

4.4 Every effort will be made where possible to create culturally safe services to harmonize and integrate programs and services. Including potential expansion to include social determinants of health.

4.5 Activities will be carried out with a view to maintaining principles of sustainability, efficiency, and effectiveness without limiting innovation, improved access or quality and by building on existing best practices.

4.6 Appropriate methods will be used to measure outcomes, including a strengths based approach (e.g. client focused, holistic or "wrap-around").

4.7 Mutually agreed upon indicators of health and indicators of success will be followed as a baseline for measurement, and there will be a balance of qualitative and quantitative outcomes.

Indicators such as but not limited to:

4.7.1 Improved service accessibility and use of health resources for First Nations and other Aboriginal people in Secwepemc Territory.
4.7.2 Coordinated health service planning and delivery between Secwepemc Health Caucus and the Interior Health Authority.
4.7.3 Stronger linkages are developed (e.g. referrals, service integration) between Secwepemc Health Caucus and the Interior Health Authority.
4.7.4 Partnerships to improve health service for First Nations citizens
4.7.5 First Nations eHealth initiatives in Secwepemc Territory are coordinated with Secwepemc Health Caucus.
4.7.6 Partnerships with other ministries, municipalities and non-profit service providers are established to address the social determinants of health including those specified by Secwepemc people beyond the conventional social determinants.

5.0 Activities

5.1 To improve the health outcomes for Secwepemc people, the Parties will carry out specific actions including but not limited to the following:

5.1.1 Develop service delivery systems which better respect and reflect the cultural and socioeconomic context of Secwepemc and non-Secwepemc Aboriginal people in Secwepemc Territory.
5.1.2 Develop a consistent and harmonized planning process.
5.1.3 Establish common indicators, targets, milestones, benchmarks.
5.1.4 Review alignment within health plans, including setting standards, outcomes and measurements.
5.1.5 Engage in dialogue, identify linkages and establish networks with other Aboriginal and non-Aboriginal stakeholders.
5.1.6 Identify those matters including policy issues that will address gaps and eliminate duplication.
5.1.7 Establish at the program level communication and collaboration with the First Nations Health Authority.

5.2 The Parties will establish a Joint Committee to oversee the activities set out in the work plan See Appendix D.

6.0 Implementation

As per 5.2 above, the Parties will establish a "Joint Committee" comprising representatives from all parties that will be tasked with responsibilities which may include, but are not limited to:

6.1 Development of a strategy for building relationships between the Parties, including an engagement strategy and communication/consultation processes.

6.2 Development of protocols between the Parties including the sharing of information on initiatives that are of interest/shared between the Parties.

6.3 Development of annual work plans and;

6.4 Evaluate outcomes related to annual work plans.

6.5 Prioritization of services.

6.6 Laying the foundation for relationship documents between the Parties on specific service-related issues.

6.7 Where appropriate, establish and implement a process for establishing and reviewing the activities of specific working groups to ensure that their work builds upon existing processes, explores and incorporates best practices and maximizes the value added to planning processes and services delivery (including Terms of Reference and deliverables).

6.8 Reviewing the Parties' Health Plans to ensure alignment with each other, the Tri-Partite First Nations Health Plan, the First Nations Health Authority, the Provincial and Federal Governments and others;

6.9 Determine and agree upon the process and procedures for the evaluation of this Letter of Understanding and the implementation of subsequent recommendation.

6.10 Formation of a Research, Ethics and Data Sub-committee charged with the responsibility to:

- 6.10.1 Develop and implement an evaluation and approval procedure for any and all data collection involving or affecting Secwepemc people in Secwepemc Territory.
- 6.10.2 Oversee and ensure application and compliance with the Secwepemc Health Caucus Research Policy (See Appendix C) on all research projects involving or affecting Secwepemc people and communities.
- 6.10.3 Develop a Data Sharing Agreement to be ratified and implemented by the "Joint Committee."
- 6.10.4 Ensure the highest standards of privacy, protection and confidentiality are applied to all data collected from programs or projects involving or affecting Secwepemc people in Secwepemc Territory.
- 6.10.5 Forward recommendations regarding research and data use as well as relevant amendments to this LOU.

6.11 The Joint Committee representatives will report through their respective organizations and where appropriate to affected Aboriginal citizens and communities.

7.0 Resource Requirements

7.1 It is acknowledged that through the Ministry of Health, Interior Health Authority is responsible for the provision of health services to all citizens.

7.2 The Parties will identify the human, financial and capital resources and potential sources of funding required achieving the goals of the Letter of Understanding.

7.3 The Parties will work cooperatively to secure resources, both internally and externally.

8.0 Communication and Information Sharing

8.1 Communication between the Parties will be transparent, consistent, reciprocal and timely.

8.2 The Parties will work together within the legislative framework e.g. Freedom of Information and Protection of Privacy Act (FOIPPA) etc. To coordinate and determine the most effective and efficient means of data exchange, system integration, and information – sharing to the fullest extent possible.

8.3 The principles of Ownership, Control, Access and Possession (OCAP) will be consistently and judiciously applied wherever applicable.

9.0 Evaluation of Letter of Understanding

9.1 The Parties will review the Letter of Understanding annually.

9.2 The Joint Committee will determine and agree on the process and procedures for the evaluation and implementation of subsequent recommendations.

10.0 Other Agreements

10.1 The Parties acknowledge and agree that this Letter of Understanding is between the Parties identified and should not be interpreted as having any influence, bearing or impact on other agreements including, but not limited to:

10.1.1 Enabling Agreements (i.e. contracts).
10.1.2 Federal Health Transfer Agreement including the Tri-Partite Agreement.
10.1.3 Protocols or Agreements between Secwepemc Health Caucus and other Aboriginal or non-Aboriginal entities.

11.0 Process

11.1 This Letter of Understanding does not extend to the following processes:

11.1.1 Interior Health Authority Corporate planning.
11.1.2 Secwepemc Health Caucus planning.
11.1.3 Planning processes conducted by the 17 Secwepemc Communities (i.e. strategic planning, community plan.)

11.2 The Parties agree to use a consensus – building model.

11.3 Resolution of issues: the Parties will work towards remedy of any issues pertaining to this Letter of Understanding through a mutually agreed process (such as mediation).

12.0 Term

12.1 Duration: The term of the Letter of Understanding will be three (3) years from the date of the signing.

12.2 Extension: The term of the Letter of Understanding may be extended by mutual consent of the Parties.

12.3 Termination: If mediation and/or resolution cannot be achieved, the Parties agree that either Party may terminate this agreement by providing sixty (60) days written notice, including the cause for termination.

13.0 Amendment

The Letter of Understanding may be amended by the Parties at any time by mutual consent of all Parties, in writing.

Dated on the 10th, day of September 2013

Secwepemc Kukpi7's

1.	Kukpi7 Nelson Leon	Adams Lake	_____
2.	Kukpi7 Randy Porter	Bonaparte	_____
3.	Kukpi7 Judy Wilson	Neskonlith	_____
4.	Kukpi7 Paul Sam	Shuswap Indian	_____
5.	Kukpi7 Rita Matthew	Simpcw	_____
6.	Kukpi7 Ron Ignace	Skeetchestn	_____
7.	Kukpi7 Wayne Christian	Splats'in	_____
8.	Kukpi7 Shane Gottfriedson	Tk'emlups	_____
9.	Kukpi7 Mike LeBourdais	Whispering Pines	_____
10.	Kukpi7 Michael Archie	Canim Lake	_____
11.	Kukpi7 David Archie	Canoe Creek	_____
12.	Kukpi7 Bev Sellars	Xats'ull	_____
13.	Kukpi7 Ann Louie	Williams Lake	_____
14.	Kukpi7 Felix Arnouse	Little Shuswap Lake	_____
15.	Kukpi7 Fred Robbins	Esketemc	_____
16.	Kukpi7 Larry Fletcher	High Bar	_____
17.	Kukpi7 Robert Shintah	Ts'kw'aylaxw	_____

Interior Health Authority

1.	Dr. Halpenny	CEO / President IHA	_____
2.	Norman Embree	Board Chair, IHA	_____
3.	Andrew Neuner	Vice President Community Integration, IHA	_____
4.	Colleen LeBourdais	Witnessed by: Health Director – QHS	_____
5.	Brad Anderson	Director Aboriginal Health IHA	_____

Appendix A SHC Membership

The Secwepemc Chiefs will be comprised of the current Chief or their designate from the following First Nations.

Chief:	Sexqeltqín – Adams Lake
Chief:	St'uxwtéws – Bonaparte
Chief:	Tsq'éscen – Canim Lake
Chief:	Stswécem'c/Xgét'tem' – Canoe/Dog Creek
Chief:	Esk'étemc – Alkali Lake
Chief:	Llenllenéy'ten – High Bar
Chief:	Tk'emlúps – Kamloops
Chief:	Qw7ewt – Little Shuswap Lake
Chief:	Sk'atsin – Neskonlith
Chief:	Simpcw – North Thompson
Chief:	Ts'kw'aylaxw – Pavilion
Chief:	Kenpésq't – Shuswap
Chief:	Skítsesten – Skeetchestn
Chief:	Xats'úll – – Soda Creek
Chief:	Splats'in – Spallumcheen
Chief:	T'éxel'c – Williams Lake
Chief:	Stil'qw/Pelltíq't – Whispering Pines/Clinton

The Secwepemc Health Directors Hub will be comprised of the current Health Director and or the First Nation's designate from the following First Nations.

Health Director:	Sexqeltqín – Adams Lake
Health Director:	St'uxwtéws – Bonaparte
Health Director:	Tsq'éscen – Canim Lake
Health Director:	Stswécem'c/Xgét'tem' – Canoe/Dog Creek
	T'éxel'c – Williams Lake
	Xats'úll – – Soda Creek
Health Director:	Esk'étemc– Alkali Lake
Health Director:	Llenllenéy'ten – High Bar
Health Director:	Tk'emlúps – Kamloops
	Skítsesten – Skeetchestn
	Stil'qw/Pelltíq't – Whispering Pines/Clinton
Health Director:	Qw7ewt – Little Shuswap Lake
Health Director:	Sk'atsin – Neskonlith
Health Director:	Simpcw – North Thompson
Health Director:	Ts'kw'aylaxw – Pavilion
Health Director:	Kenpésq't – Shuswap
Health Director:	Splats'in – Spallumcheen

Appendix B SHC Principles

The Secwepemc Health Caucus will be guided by the following principles adopted from the 7 Nations Unity Declarations. [2]

- Health and Wellness Outcomes and Indicators will be defined by each Nation.
- Partnerships will be defined by each Nation.
- Agreements will be negotiated and ratified by the Nations.
- No Nation will be left behind; needs are addressed collectively.
- The federal fiduciary obligations must be strengthened, not eroded.
- Services will be provided to all of our people regardless of residency/status.
- Adequate funding will be provided for our corporate structure(s).
- Socio-economic indices will be incorporated into planning and projections – plan for 7 generations.
- Negotiations will be interest based – not position based (Nations define).
- Community hubs will be linked to the health governance process.
- Documents will be kept simple and understandable.
- The Interior Leadership caucus will meet regularly.
- Liability will be minimized; the Nations will inherit no liability from other entities.
- Celebration will be included in all activities.
- The speed at which development occurs will be determined by the Nations.
- The authority to govern rests with each Nations, as does the responsibility for decision-making.

The Secwepemc Health Caucus will also apply the five main principles found in the Canada Health Act. [3]

- **Public Administration:** All administration of provincial health insurance must be carried out by a public authority on a non-profit basis. They also must be accountable to the province or territory, and their records and accounts are subject to audits.
- **Comprehensiveness:** All necessary health services, including hospitals, physicians and surgical dentists, must be insured.
- **Universality**: All insured residents are entitled to the same level of health care.
- **Portability:** A resident that moves to a different province or territory is still entitled to coverage from their home province during a minimum waiting period. This also applies to residents which leave the country.
- **Accessibility:** All insured persons have reasonable access to health care facilities. In addition, all physicians, hospitals, etc., must be provided reasonable compensation for the services they provide.

[2] (Duplicated from the ***7 Nation Unity Declaration*** signed by: Chief Geronimo Squinas, Chief Ko'waintco Michel, Chief Arthur Adolph, Chief Shane Gottfriedson, Chief Jonathan Kruger, Chief Bernie Charlie and Gwen Phillips)

[3] Canadian Health Care: Canada Health Act http://www.canadian-healthcare.org/page2.html

Appendix C Secwepemc Health Caucus Research Policy

2012

Secwepemc Health Caucus

Drafted by: Hub Coordinator

Reviewed by:
Secwepemc Health Caucus

Adopted:
October 18th, 2012

Reviewed/Updated:
_____, 2013

SECWEPEMC HEALTH CAUCUS

RESEARCH POLICY

Working for Health Excellence for the Secwepemc Nations Members

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Policy

Rationale

Research is the front line of knowledge creation, transmission, translation and storage. It is one of the major factors influencing the way we look at, interpret and interact with the world around us and thus an integral part of our living culture. The process of conducting research can itself perpetuate the colonization of Secwepemc knowledges and ways of knowing by privileging Western research techniques and knowledge over Secwepemc research techniques and knowledge keepers. Researchers must understand the historical relationship Indigenous peoples have had with research and be committed to, and held accountable through, relationships with the people and community they partner with. This research policy is meant to be a vehicle to ensure research is conducted in partnership with Secwepemc communities and individuals with the aim to strengthen the Secwepemc Nation on Secwepemc terms.

The Secwepemc Health Caucus (SHC) recognizes its duty to develop protocols to address the need for an organized, transparent and accountable approach for individuals and/or groups conducting research in Secwepemc Territory related to Health.

These protocols have been developed to aid researchers in ensuring they abide by the protocols of the Secwepemc communities when conducting research in their territory. Where there is any discrepancy between the protocols of an individual Secwepemc community and those in this policy, the community protocols will take precedence.

Application

This Secwepemc Health Caucus Research Policy applies to all individuals and / or groups conducting research within the Secwepemc Nation, who request to consult with members of the Secwepemc Nation and whose research will or could potentially impact Secwepemc Nation members, ancestors, descendants or territories (including but not limited to land, air and water).

Health Information

Health information includes any information relating to the health and wellbeing of individuals and communities (as defined by the individuals and communities) including physical, emotional, mental, spiritual, and intergenerational wellbeing.

Point of Contact and FN Community Participation

Each Secwepemc First Nation will be contacted via the Health Director/Health lead and the Chief and Council. Each FN will follow their internal process to determine if and how their community will participate.

A written confirmation from each community is required before commencement of the project.

A written research agreement will be created collaboratively between the community, group and/or Health lead addressing the principles of ownership, control, access, and possession of the data, as well the participation and protection of the community and individuals from potential outcomes of the research program.

Individual FN members may participate in research as individuals. However, without written agreement from the FN, the FN is not to be identified as a project participant.

Researchers must offer the following information prior to obtaining participation from member FNs:

1. Purpose of the research
2. Requirements of participants
3. Expected timeframe of project
4. Credentials of organization/individual conducting the research
5. How participants will be informed of the risks, if any, associated with the research
6. The proposed agreement for ownership, control, access and possession of the data and research findings
7. How the data will be protected
8. The anticipated outcomes of the research
9. How the participants and community will be protected from potential outcomes
10. How the results of the research will be used

Upon completion of the research program any individuals involved will be provided with a research report which clearly conveys the contribution of participants and outcomes of the program.

Protocol

Following written agreement to participate from individual Secwepemc First Nations, the following protocol will be implemented:

Information to Community

The researcher and Health Director/lead will coordinate an announcement of the project to community/Band members prior to the commencement of the research.

All individuals who may be impacted or potentially impacted will be given a copy of this policy.

Informed Consent and Voluntary Participation

Researchers will clearly and concisely offer information on the research (including aims and anticipated outcomes) and obtain consent of individuals prior to commencement of the research. Researchers will recognize and respect the historical relationship Indigenous people have had with research(ers) and ensure a relationship of reciprocity is fostered. The participation must be free, voluntary and where possible, compensated. Consent must be provided based on being "informed" about the research and research activities. Conditions of the informed consent will be jointly decided by the Health Director/lead and researcher and where appropriate, provisions for oral consent will be made.

All researchers must apply the following when seeking and obtaining "consent":

1. Obtain written and/or oral consent from individuals / community prior to the commencement of research, and on an ongoing basis.
2. The "consent agreement" must be easily understood and thoroughly explained to the participant in a respectful and non-intimidating manner
3. If the participant is an Elder, the Researcher must ensure that the Elder has a member of the community, whom the Elder is familiar, present to ensure that the Elder understands the details and implications of consent
4. The signed consent forms and/or oral consent recording or witness account must be available to the Health Director for review
5. A provision will be made where the participant may withdraw from the research program without penalty
6. A provision will be made where the participant may revoke any and all information provided to the research program including beyond the program's completion

Privacy and Confidentiality

All data must be kept secure at all times following accepted standards for health research. The identity of respondents must be protected at all times and researchers must ensure that all data released ensures the anonymity of the participants.

Ownership, Control, Access and Possession of Data

A written research agreement will be created collaboratively between the community, group and/or Health lead and researcher addressing the following (but not limited to):

1. How the principles of Ownership, Control, Access and Possession will be applied and upheld
2. How the community will benefit from the research program itself with the training of research assistants and other capacity building

1. How the community will benefit from the outcomes of the research including royalties or credit for published materials
2. How the researcher will be held accountable during the research process and for both the intended and unintended consequences and outcomes of the research program
3. How Secwepemc participants and Secwepemc resources in the research process will be protected, including as far as possible protection from any negative impact that might result from the finding of the project being made public. This may include placing a moratorium on the research material for an agreed period of time or on keeping confidential certain material [i]
4. A provision will be made requiring the researcher to provide the community or individuals involved an opportunity to ensure the data provided is interpreted and analyzed appropriately
5. Explicit provisions will be made giving the community or individuals the opportunity to remove or censure their contribution to the research prior to publication[ii]
6. Use of obtained data and research results for secondary or new studies will trigger initiation of the SHC research policy anew.
7. How the physical and digital copies of raw data and products of research will be secured and stored both physically and temporally.

Community specific data and statistics will not be released without the explicit permission of community authorities.[iii]

Release of aggregated data for the Secwepemc Health Caucus members requires the explicit permission of all participating communities.

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[i] 2003 < http://web.uvic.ca/igov/pdf/igov_598/protocol.pdf > Protocols & Principles for Conducting Research in an Indigenous Context. (February 2003) Faculty of Human and Social Development. University of Victoria

[ii] Ibid.

[iii] 2009 < http://www.afn.ca/uploads/files/rp-research_ethics_final.pdf > Assembly of First Nations Environmental Stewardship Unit – Ethics in First Nations Research. (March 2009) "Privacy and Confidentiality" (p.11-12)

Appendix

Ownership, Control, Access and Possession (OCAP) Principles

The Secwepemc Health Caucus adheres to the principles of Ownership, Control, Access and Possession (OCAP) as a tool for the assertion of First Nations rights to self-determination and Nation building within the area of Health.

- **Ownership:** Ownership refers to the relationship of First Nations to their cultural knowledge, data, and information. This principle states that a community or group owns information collectively in the same way that an individual owns his or her personal information.

- **Control:** The principle of control affirms that First Nations, their communities and representative bodies are within their rights in seeking to control over all aspects of research and information management processes that impact them. First Nations control of research can include all stages of a particular research project-from start to finish. The principle extends to the control of resources and review processes, the planning process, management of the information and so on. Control from conception to completion.

- **Access:** First Nations must have access to information and data about themselves and their communities, regardless of where it is currently held. The principle also refers to the right of First Nations communities and organizations to manage and make decisions regarding access to their collective information. This may be achieved, in practice, through standardized, formal protocols.

- **Possession:** While ownership identifies the relationship between a people and their information in principle, possession or stewardship is more concrete. It refers to the physical control of data. Possession is a mechanism by which ownership can be asserted and protected.[i]

- And further declared within our collective position to honour the political relationship proposed in the Memorial Sir Wilfred Laurier, Premier of the Dominion of Canada.

The Secwepemc Health Caucus supports the research protocols and principles as outlined by the Assembly of First Nations (AFN) Ownership, Control, Access and Possession (OCAP) standards[ii], as follows:

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[i] 2009 <http://www.fnigca.ca/node/2 > First Nations Information Governance Center

[ii] Assembly of First Nations – Environmental Stewardship Unit. (March 2009). "Ownership, Control, Access and Possession" (p.21) in Ethics in First Nations Research. Retrieved 04-01-2012 from: http://www.afn.ca/uploads/files/rp-research_ethics_final.pdf

These Principles,

- Apply to all research, data, and information initiatives that involve First Nations Health Issues.
- Helps ensure self-determination over all research concerning First Nations is respected and adhered to;
- Provides a means to decide – what research will be approved; how collected information and data will be used; where information will be stored; and who will be able to access the information.

In agreeing to these principles, the Secwepemc Health Caucus recognises and affirms:

- Secwepemc Title, jurisdiction, and self-determination on Secwepemc territory and guardianship over the preservation, dissemination, and use of traditional knowledge and cultural heritage;

- The crucial importance of the active participation and leadership of Indigenous research partners in all phases of research, including its application and management of all project phases and funds. Thus, all research partners are entitled to be fully informed of and discuss the nature, scope and ultimate integration of their participation, knowledge and narratives in all stages of the thesis work, as well as its potential publication, dissemination, and use;

- That material relating to the Secwepemc people that are collected by the researcher or any of his/her project team is owned by the Secwepemc People and ultimately housed in the Secwepemc Health Caucus archives. This includes oral testimony (transcripts) historical, genealogical, anthropological, traditional use study, resource based data and studies and other relevant material;

- The research will be conducted in an ethical, open and respectful manner;

- That the raw data obtained from interviewees must be reviewed and approved by the interviewees prior to finalizing and/or inclusion in a research document/thesis;

- That the copyright of the final written report will remain with the Secwepemc Health Caucus as the author and the project funder (if outlined accordingly) but it is understood that the Secwepemc retain their respective inherent rights, including all intellectual property rights associated now and in the future, and have ownership of all cultural information obtained from them;

- That the information obtained is not to be used for consultation purposes of any kind but for educational purposes solely;

- That there will be no claims to the intellectual property rights of Secwepemc people (either individual or collective), or a copyright to reproduction of its products.

- Those individuals who share personal knowledge and memories with us beyond the intellectual property rights discussed above, as per consent form, we are securing permission of the interviewee, now and in the future; for us, SHC, to utilize this personal knowledge for purpose of the organization. [i]

[i] Shuswap Nation Tribal Council – Research Protocol Principles (2011).

Template for First Nation Consent to Participate in Research

Research Project Title:

Purpose:

Researcher (Institution, Company):

Date of Request:

Review Process:
Discussion/ meetings to review project (identify participants, discussion, conclusions, actions)

Decision:

BCR required yes/no

[1] 2003 < http://web.uvic.ca/igov/pdf/igov_598/protocol.pdf > Protocols & Principles for Conducting Research in an Indigenous Context. (February 2003) Faculty of Human and Social Development. University of Victoria

[1] Ibid.

[1] 2009 < http://www.afn.ca/uploads/files/rp-research_ethics_final.pdf > Assembly of First Nations Environmental Stewardship Unit – Ethics in First Nations Research. (March 2009) "Privacy and Confidentiality" (p.11-12)

[1] 2009 <http://www.fnigca.ca/node/2 > First Nations Information Governance Center

[1] Assembly of First Nations – Environmental Stewardship Unit. (March 2009). "Ownership, Control, Access and Possession" (p.21) in Ethics in First Nations Research. Retrieved 04-01-2012 from: http://www.afn.ca/uploads/files/rp-research_ethics_final.pdf

[1] Shuswap Nation Tribal Council – Research Protocol Principles (2011).

Appendix D Secwepemc Health Caucus – Interior Health Authority Workplan 2013 – 2014

Letter of Understanding

Between the Parties:

Northern St'át'imc

And

Interior Health

(each a 'Party', collectively 'the Parties')

Table of Contents

Definitions

St'at'imc: The St'at'imc Traditional Territory is 20,500 square kilometres and is home to 11 St'at'imc communities: Xwisten, Sekw'el'was, Tsal'alh, T'it'q'et, Xaxli'p, Ts'kw'aylaxw, Lil'wat, N'Quatqua, Samahquam, Skatin, and Xa'xtsa. The St'át'imc are the original inhabitants of the territory which extends north to Churn Creek and to South French Bar; northwest to the headwaters of Bridge River; north and east toward Hat Creek Valley; east to the Big Slide; south to the island on Harrison Lake and west of the Fraser River to the headwaters of Lillooet River, Ryan River and Black Tusk. The St'át'imc way of life is inseparably connected to the land. Our people use different locations throughout our territory of rivers, mountains and lakes, planning our trips with the best times to hunt and fish, harvest food and gather medicines. The lessons of living on the land are a large part of the inheritance passed on from St'át'imc elders to our children. As holders of one of the richest fisheries along the Fraser River, the St'át'imc defend and control a rich resource that feeds our people throughout the winter, and serves as a valued staple for trade with our neighboring nations.

Northern St'at'imc: the six communities are Tsal'alh (Seton Lake Indian Band) which is considered remote, and the rural communities of Xwisten (Bridge River), Ts'kw'aylaxw (Pavilion), Xaxli'p (Fountain), T'it'q'et (Lillooet), and Sekw'el'was (Cayoose Creek) (Appendix A).

Southern Stl'atl'imx – the five communities are Lil'wat, N'Quatqua, Samahquam, Skatin, and Xa'xtsa.

British Columbia Health Authorities: The province of BC is organized into 5 geographic regions for purposes of health-care service delivery. Interior Health and Vancouver Coastal are the provincial Authorities whose operating regions align within the territory of the St'át'imc. The Government of British Columbia created the Health Authorities through the Health Authorities Act, for the purpose of delivering health services and planning.

Interior Health Authority - The Interior Health Authority (IHA), is the party with whom the Northern St'at'imc primarily relate with respect to delivery of health services to their citizens. Interior Health is governed by a Board of Directors, and delivers its health services through the President and Chief Executive Officer and the staff of Interior Health, according to the Vision, Mission and Values for Interior Health, and within the broad directions of the Ministry of Health. Interior Health, pursuant to its Vision, Mission and Values has established a Strategic Plan which enunciates four Goals. Goal #1 is to Improve Health and Wellness. Under this goal, item 1.2 is, "Meet the needs of First Nations and Aboriginal communities by collaboration with them to plan and deliver culturally sensitive health care services." Interior Health, pursuant to the Goal Statement 1.2 noted above, has developed an Aboriginal Health and Wellness Strategy 2010-2014 which is based on 5 key strategies: 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. Interior Health supports the concept that the First Nations that are party to this Accord may represent other organized groups of Aboriginal people, provided there are written formal agreements to that effect.

Vancouver Coastal Health Authority - Vancouver Coastal Health Authority (VCHA) is the party with whom the Lower Stl'atl'imx primarily relate with respect to delivery of health services to their citizens. The Lower Stl'atl'imx communities have not created a Letter of Understanding with VCHA to date.

1.0 Purpose

1.1. The Parties wish to define a collaboratively developed engagment process for the planning of Aboriginal services, programs and operations across St'at'imc Territory for delivery of health services and improvement of health outcomes for St'at'imc people.

1.2. The Parties seek to improve the health outcomes for St'at'imc people by achieving effective shared decision making that will reduce the barriers for St'at'imc people to access better health services.

1.3. The Parties commit to working together through meaningful participation and collaboration, to increase the influence of the Northern St'at'imc in decisions related to health services that impact their members and other Aboriginal peoples residing within the St'at'imc Territory.

1.4. The Parties agree that health outcomes held in common with all residents of British Columbia should be equal or exceeding for St'at'imc citizens and health outcomes beyond these, as defined by St'at'imc citizens, pursued with equal vigor and diligence.

2.0 Preamble

2.1 The First Nations of British Columbia, the Province of British Columbia and the Canadian Government, ratified the Tripartite Framework Agreement on First Nation Health Governance, which will empower B.C. First Nations to take-over the administration of Health Canada programs and services and identifies additional provincial resources, to be administered by a First Nations Health Authority.

2.2 Under the First Nations Health Authority, BC First Nations Governments will be fully involved in decision-making regarding the health of their people, and in defining how health services and programs are planned, designed, managed and delivered. They have agreed that First Nations should avoid the creation of separate and parallel First Nation and non-First Nation health systems, and develop a more integrated health and wellness system with stronger linkages to the provincial health-care system and the creation of new approaches to achieving the desired health and wellness outcomes of each Nation.

2.3 The First Nations of B.C. are now modeling a provincial First Nations Health Authority to implement the Tripartite Framework; defining its structure and functions, in relation to the structures and functions of their own local health governance authorities. They envision a provincially coordinated wellness system that:

2.3.1 will result in improved quality, accessibility, delivery, effectiveness, efficiency, and cultural appropriateness of health care programs and services for First Nations;

2.3.2 reflects the cultures and perspectives of BC First Nations and incorporates First Nations' models of wellness;

2.3.3 embraces knowledge and facilitates discussions in respect of determinants of health in order to contribute to the design of First Nation health programs and services;

2.3.4 provides First Nations in all regions of British Columbia with access to quality health services that are at a minimum, comparable to those available to other Canadians living in similar geographic locations.

2.4 First Nations on a Regional/Nation basis, are now forming structures and processes through which to carry out engagement, research, planning and development work required, to define the authority of the First Nations Health Authority, and to shape the final form it will take:

- The First Nations Health Council Interior Governance Entities Terms of Reference describe the roles and responsibilities of the parties that are working together to advance the formation of the First Nations Health Authority. The Interior Region Nation Executive Table acts as an executive body to the Interior Region First Nations Community Health Caucus and carries out directions in between Caucus sessions. They also ensure that the First Nations Health Council is being accountable (implementing the work plan as approved), and responsive to regional issues. Executive Membership consists of 1 member from each of the following Nations: Dãkelh Dene, Ktunaxa, Secwepemc, Syilx, St'át'imc (Northern), Tsilhqot'in, Nlaka'pamux, selected in accordance with Nation-approved processes and appointed through resolution.
- The Parties of the Interior Partnership Accord; the Interior Health Authority and the 7 Nations in the Interior are committed to improving the health and wellness outcomes for First Nations people of the Interior Region. The purpose of the Interior Partnership Accord is to clarify the roles and relationships of each of the Parties as they work together to fulfill this commitment. The overall objectives are to establish a coordinated and integrated First Nations health and wellness system in the Interior that: a) will contribute to the achievement of Interior Nations' wellness goals, by continually improving quality, accessibility, delivery, effectiveness, efficiency, and cultural appropriateness of health care programs and services for First Nations in the Interior; b) reflects the cultures and perspectives of Interior First Nations, incorporates First Nations' models of wellness, builds First

Nations health human resource capacity, and respects that the Nations have and will continue to work together; c) affords equitable recognition in strategies to address First Nations who have limited capacity, including small and isolated communities; d) embraces knowledge sharing and facilitates discussions in respect of addressing broader determinants of health; and e) is based on respecting and addressing the lands, history, health, safety, food security, dignity and well-being of all Interior First Nations people (p.7) . One of the success indicators of the Interior Partnership Agreement is Letters of Understanding [will be] developed and implemented between Interior Health and each of the Seven (7) Interior Nations (p.8);

2.5 The Parties agree to enter into a mutually beneficial relationship that will work towards, in a quantifiable and qualitative manner, shared responsibility and shared decision making as it impacts the provisions of Health Services to Aboriginal people within the St'at'imc Territory.

2.6 The Parties agree to use a cooperative, collaborative approach to improving the health status of St'at'imc individuals, families and communities through the design, delivery and evaluation of culturally safe health programs and services.

2.7 Interior Health Authority acknowledges the inherent and Aboriginal rights (including but not limited to self-determination and freedom from discrimination) of the St'at'imc People. Further, Interior Health Authority recognizes the St'at'imc regardless of residency and supports the St'at'imc pursuit of its rights to retain responsibility for the health, safety, survival, dignity and well-being of St'at'imc children and families, consistent with the UN Convention on the Rights of the Child and the UN Declaration on the Rights of Indigenous people.

2.8 This letter of understanding does not abrogate nor derogate from St'at'imc Aboriginal Rights as per Section 35(1) *Constitution Act. 1982*.

2.9 The Parties agree and understand that this Letter of Understanding pertains to the Interior Health Authority's roles and responsibilities according to the purpose and description under the Health Authorities Act which states that:

"5 (1) The purposes of a board are as follows:

(a) To develop and implement a regional health plan that includes

(i) The health services provided in the region, or in a part of the region,

(ii) The type, size and location of facilities in the region,

(iii) The programs for the delivery of health services provided in the region.

(iv) The human resource requirements under the regional health plan; and,

(v) The making of reports to the minister on the activities of the board in carrying out its purposes.

(b) To develop policies, set priorities, prepare and submit budgets to the minister and allocate resources for the delivery of health services, in the region, under the regional health plan.

(c) To administer and allocate grants made by the government for the provisions of health services in the region.

(d) To deliver regional services through its employees or to enter into agreements with the government or other public or private bodies for the delivery of those services by those bodies.

(e) [Repealed 2002-61-4] therefore not applicable

(f) To develop and implement regional standards for the delivery of health services in the region.

(g) To monitor, evaluate and comply with Provincial and regional standards and ensure delivery of specified services applicable to the region.

5 (2) In carrying out its purposes, a board must give due regard to the Provincial standards and specified services."

3.0 Principles

This Letter of Understanding is based upon the following principles:

3.1 The St'at'imc will be guided by the principles adopted from the 2010 Unity Declaration of the 7 Nations. (Appendix B)

3.2 The Parties acknowledge and respect jurisdictional and fiduciary relationships and responsibilities, and will seek to remove jurisdictional impediments and improve progress in integration and flow of health services for St'at'imc People.

3.3 The planning, coordination and implementation of Interior Health Authority services for Aboriginal people in St'at'imc Territory will be more effective with increased participation of the St'at'imc in the planning of services.

3.4 This Letter of Understanding (LOU) is a living document that will respond to changes within the Parties and will represent an integrated approach to the enhancement of the relationship and development of services.

3.5 The Parties acknowledge and respect the need for transparency, reciprocal accountability, and accountability to the communities affected by decisions made by The Parties.

3.6 Mutual respect, trust, openness, accountability and transparency will be the basis of the understanding and foundation of the relationship established under this Letter of Understanding.

3.7 Indigenous cultural competency.

4.0 Geographic Area

The activities referred to in this Letter of Understanding will be applicable within that portion of the St'at'imc Territory as shown in Appendix C.

5.0 Service Provisions, Activities and Outcomes

The Parties agree that:

5.1 Every effort will be made where possible to harmonize and integrate programs and services in the Northern St'at'imc territory.

5.2 Commitments will be made by the Parties to pursue a model of wellness that is client/family/community -centred, health promotion/ disease prevention focused, builds on relationships, integrative service delivery, builds on St'at'imc strengths, integrates St'at'imc traditional values and concepts of healing, is holistic including the social determinants of health, and has high standards in quality of care .

5.3 Activities will be carried out with a view to maintaining principles of sustainability, efficiency, and effectiveness without limiting innovation, improved access or quality and by building on existing best practices.

5.4 The St'at'imc may represent other organized groups of Aboriginal people, and organizations that represent off-reserve Aboriginal Peoples provided there are formal written agreements to that effect.

5.5 As capacity grows, planning and provision of health care may extend beyond care for St'at'imc citizens to include other people, neighbours within the St'at'imc Territory.

5.6 Mutually agreed upon indicators of health and indicators of success will be followed as a baseline for measurement, and there will be a balance of qualitative and quantitative outcomes.

6.0 Implementation

The Parties will establish a "Joint Committee" comprising representatives from all Parties, develop a Terms of Reference that outline responsibilities which may include, but are not limited to:

6.1 Development of a strategy for building relationships between the Parties, including creating communications, engagement and consultation protocols. This will include the roles of the appointed Northern St'at'imc political and technical representatives to the Interior Region Partnership Accord Leadership Table.

6.2 Draft a St'at'imc Model of Wellness in collaboration with IHA that builds from the Northern St'at'imc community health plans.

6.3 Ensure the Parties' Health Plans are in alignment with the Tri-Partite First Nations Health Plan, including the Tripartite First Nations Health Authority Health Actions and other relevant partners.

6.4 Establish and implement a process for establishing and reviewing the activities of specific working groups to ensure that their work builds upon the principles and concepts of this LOU, i.e. the development of annual work plans, prioritization, indicators, targets, milestones, benchmarks, including evaluating their outcomes.
For Example: The formation of a working group or committee that works towards ensuring cultural safety which is of paramount importance to the effectiveness of and access to, health services provision. The cultural safety of St'at'imc people will require ongoing education, dialogue and active participation and engagement between parties including the following outcomes:

- 6.4.1 Collaboration on Indigenous Cultural Competence (ICC) supplementary training and documents, including innovation of techniques and relationship building
- 6.4.2 Supporting the interaction of all levels of IH staff with Aboriginal and St'at'imc people at cultural and non-cultural events.
- 6.4.3 Collaboration on the evaluation of cultural safety improvement measures and grievance mechanisms for Aboriginal and St'at'imc employees and customers.

6.4.4 Develop service delivery systems which better respect and reflect the cultural and socioeconomic context of St'at'imc and Aboriginal people in St'at'imc Territory.

6.5 Formation of a Research, Ethics and Data Sub-Committee with the following outcomes:

6.5.1 Develop and implement an evaluation and approval procedure for any and all data collection involving or affecting all St'at'imc (on or off-reserve).

6.5.2 Oversee and ensure application and compliance with the Lillooet Tribal Council Research Ethics Policy on all research projects involving or affecting St'at'imc people and communities.

6.5.3 Develop a Data Sharing Agreement to be ratified by their respective organizations and implemented by the "Joint Committee."

6.5.4 Ensure the highest standards of privacy, protection and confidentiality are applied to all data collected from programs or projects involving or affecting all St'at'imc.

6.5.5 Forward recommendations regarding research and data use as well as relevant amendments to this LOU.

6.5.6 The principles of St'at'imc Ownership, Control, Access and Possession (OCAP) will be consistently and judiciously applied wherever applicable.

6.6 The Joint Committee representatives will report through their respective organizations and where appropriate to affected Aboriginal citizens and communities.

7.0 Resource Requirements

7.1 It is acknowledged that through the Ministry of Health, Interior Health Authority is responsible for the provision of health services to all citizens residing in its service delivery area.

7.2 The Parties will identify the human, financial and capital resources and potential sources of funding required achieving the goals of the Letter of Understanding.

7.3 The Parties will work cooperatively and seek opportunities to secure resources, both internally and externally.

8.0 Evaluation of Letter of Understanding

8.1 The Parties will review the Letter of Understanding annually,

8.2 The Joint Committee, in collaboration with their respective organizations, will determine and agree on the development of the process and procedures for the evaluation and implementation of subsequent recommendations.

9.0 Other Agreements

9.1 The Parties acknowledge and agree that this Letter of Understanding is between the Parties identified and should not be interpreted as having any influence, bearing or impact on other agreements including, but not limited to:

9.1.1 Enabling Agreements (i.e. contracts)

9.1.2 Federal Health Transfer Agreement including the Tri-Partite Agreement.

9.1.3 Protocols or Agreements between the St'at'imc and other Aboriginal or non-Aboriginal entities.

9.1.4 The Parties agree that this Letter of Understanding is not prejudicial to the implementation of any inherent right of self-government or any agreements that may be negotiated with respect to self-government.

10.0 Process

10.1 This Letter of Understanding does not supersede the following processes:

10.1.1 Interior Health Authority Corporate planning.

10.1.2 St'at'imc Health planning

10.1.3 Community Health Plans conducted by the 11 St'at'imc Communities

10.2 The Parties agree to use a consensus – building model.

10.3 Resolution of issues: the Parties will work towards remedy of any issues pertaining to this Letter of Understanding through a mutually agreed process (such as mediation).

11.0 Term

11.1 Duration: term of the Letter of Understanding will be three (3) years from the date of the signing.

11.2 Extension: The term of the Letter of Understanding may be extended by mutual consent of the Parties.

11.3 Termination: If mediation and/or resolution cannot be achieved, the Parties agree that either Party may terminate this agreement by providing sixty (60) days written notice, including the cause for termination.

12.0 Amendment

The Letter of Understanding may be amended by the Parties at any time by mutual consent of all Parties, in writing.

Signatures

Dated this 21st day of March, 2014

Party Signatories:

St'at'imc Chiefs

1.	Chief Arthur Adolph	Xaxli'p	_____
2.	Chief Kevin Whitney	T'it'q'et	_____
3.	Chief Larry Casper	Tsal'alh	_____
4.	Chief Michelle Edwards	Sekw'el'was	_____
5.	Chief Susan James	Xwisten	_____
6.	Chief Robert Shintah	Ts'kw'aylaxw	_____

Interior Health Authority

1.	Dr. Halpenny	CEO / President IHA	_____
2.	Norman Embree	Board Chair, IHA	_____

Witnessed by: _____

_____

Appendix A: Northern St'at'imc Membership

The Northern St'at'imc Chiefs will be comprised of the current Chief or their designate from the following First Nations.

Chief Arthur Adolph	Xaxli'p (Fountain)
Chief Susan James	Xwisten (Bridge River)
Chief Larry Casper	Tsal'alh (Seton Lake Indian Band)
Chief Michelle Edwards	Sekw'el'was (Cayoose Creek Indian Band)
Chief Kevin Whitney	T'it'q'et (Lillooet)
Chief Robert Shintah	Ts'kw'aylaxw (Pavilion)

The Northern St'at'imc Health Directors/ Leads will be comprised of the current Health Director and or the First Nation's designate from the following First Nations.

Angela Wrede, Health Director	Xaxli'p (Fountain)
Fay Michell, Health Lead	Xwisten (Bridge River)
Angela Alexander, Health Lead	Tsal'alh (Seton Lake Indian Band)
Kelsey Schwindt, Health Lead	Sekw'el'was (Cayoose Creek Indian Band)
Franny Alec, Health Director	T'it'q'et (Lillooet)
Cora Watkinson, Health Lead	Ts'kw'aylaxw (Pavilion)

Appendix B: Interior Unity Declaration

INDIGENOUS NATIONS OF THE INTERIOR

Declaration of Unity

FEBRUARY 24, 2010

Whereas, Indigenous Nations of the Interior of British Columbia endorse the UN Declaration on the Rights of **Indigenous People which affirms that Indigenous peoples** have the right to the lands, territories and resources which they have traditionally owned, occupied or otherwise used or acquired; and that

Indigenous peoples have the right to maintain and strengthen their distinct political, legal, economic, social and cultural institutions, while retaining their right to participate fully, if they so choose, in the political, economic, social and cultural life of the State; and further that

Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development; and ...in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local **affairs...; and**

Whereas, the title and rights of First Nations of British Columbia have been intact since time immemorial and remain intact, despite numerous attempts by other governments to disregard or otherwise extinguish these rights; and

Whereas, historically, Indigenous Nations of the Interior acknowledged each others' autonomy, collectively stating in a letter to Sir Wilfred Laurier in 1910 that ... they found the people of each tribe supreme in their own territory, and having tribal boundaries known and recognized by all and **more recently reaffirmed this spirit and intent in the All** Our Relations accord of 2007; and

Whereas, the Nations of the Interior of British Columbia: **Dákelh Dené, Ktunaxa, Nlaka'pamux, Syilx, Secwepemc St'át'imc** and **Tsilhqot'in** of the Interior wish to reaffirm and build upon these historic agreements; and

Whereas, the Nations of the Interior continue to recognize the sovereignty of each Nation and their inherent rights for their citizenry, which includes the right to plan for and **respond to their specific social, cultural, economic and** environmental realities with support and investment, not interference, from outside sources; and

Whereas, the Indigenous Nations of the Interior of British Columbia, as Indigenous Nations, each assert their authority to govern over both their lands (territorial jurisdiction) and their peoples (personal jurisdiction) and to relate Nation-to-Nation with the government of Canada and government-to-government with the government British Columbia; and

Whereas, the Nations have stated their desire to establish and maintain a desired level of capacity in the areas of health research, health career development, health service delivery (including traditional practices), information management and governance (health planning, administration, policy/ program design and implementation and....), in order to achieve their individual and collective Nation visions.

THEREFORE, the Nations of the Interior hereby declare that we will respectfully work together, collaborating for the betterment of the health, safety, survival, dignity and well-being of all of our peoples; and further

THAT we will be guided by the following principles while working together:

- Health and Wellness Outcomes and Indicators will be defined by each Nation
- Partnerships will be defined by each Nation
- Agreements will be negotiated and ratified by the Nations
- No Nation will be left behind; needs are addressed collectively
- The federal fiduciary obligation must be strengthened, not eroded
- Services will be provided to all of our people regardless of residency/status
- Adequate funding will be provided for our corporate structure(s)
- Socio-economic indices will be incorporated into planning and projections – plan for 7 generations
- Negotiations will be interest based - not position based (Nations define)
- Community hubs will be linked to the health governance process
- Documents will be kept simple and understandable
- The Interior Leadership caucus will meet regularly
- Liability will be minimized; the Nations will inherit no liability from other entities
- Celebration will be included in all activities
- The speed at which development occurs will be determined by the Nations
- The authority to govern rests with each Nation, as does the responsibility for decision-making

Chief Geronimo Squinas – Dákelh Dené

Owen Phillips – Ktunaxa

Chief Shana Gunderson – Secwepemc

Chief Ke'wuuta Michel – Nlaka'pamux

Chief Arthur Adolph – St'át'imc

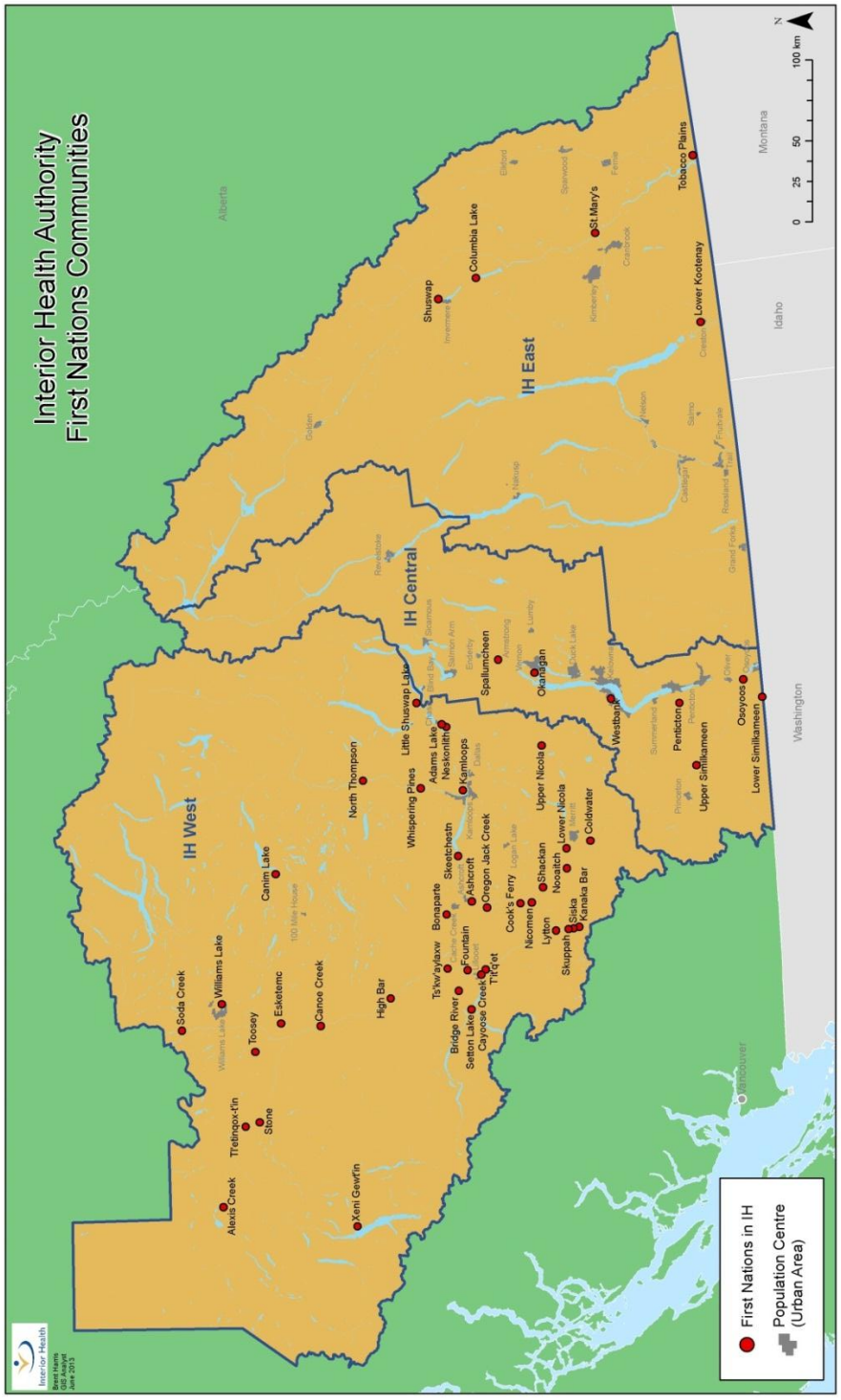
Chief Jonathon Kruger – Syilx

Chief Bernie Elkins – Tsilhqot'in

Appendix C: St’at’imc Territory Map

1. Tsal’alh
2. Xwisten
3. T’it’q’et
4. Sekw'el'was
5. Xaxli’p
6. Ts'kw'aylaxw
7. N’Quatqua
8. Lil’wat
9. Samahquam
10. Skatin
11. Xa’xtsa

Appendix D: Interior Health Authority Map



LETTER OF UNDERSTANDING

Between

Tsilhqot'in National Government and the six member communities of Xeni Gwet'in First Nations Government, Yunesit'in First Nations, Tl'esqox Indian Band, Tsi Deldel First Nations, ?Esdilagh First Nations and Tl'etinqox-tin Government Office.

And

Interior Health Authority

(each a"Party" and collectively "the Parties"

1.0 PURPOSE

1.1 The Parties wish to work together to develop a process that allows the Tsilhqot'in Nation to engage in planning of Aboriginal services and operations that impact the health services of its members.

1.2 The Parties seek to establish effective shared decision-making to reduce the barriers for Tsilhqot'in people and to allow for better access to culturally appropriate health services.

1.3 The Parties agree that health and wellness outcomes should be comparable to those outlined in the Tsilhqot;in Wellness Plan.

2.0 **FOUNDATION**

2.1 The Parties agree to enter into a mutually beneficial relationship that will work toward, In a quantifiable and qualitative manner, shared responsibility and shared decision making as it impacts the provision of Health Services to Aboriginal people.

May, 28, 2013

2.2 The Parties agree to use a cooperative, collaborative approach to improving the health status of the Tsilhqot'in Nation including Aboriginal individuals, families and communities through the design, delivery and evaluation of culturally appropriate health programs and services

2.3 Interior Health Authority acknowledges the inherent rights of the Tsilhqot'in people. Further, Interior Health Authority recognizes that the Tsilhqot'in National Government and the six member communities represent their citizenry regardless of residency and supports the Tsilhqot'in pursuit of its rights to retain responsibility for the health, safety, survival, dignity and well-being of Tsilhqot'in children and families, consistent with the *UN Convention on the Rights of the Child and the UN Declaration on the Rights of IndigenousPeoples.*

2.4 The Parties agree and understand that this Letter of Understanding pertains to the Interior Health Authority's roles and responsibilities according to the purpose and description under *the Health Authorities Act, Section 5(1) and Section 5(2), which states that:*

"(1) The purposes of a board are as follows:

(a) To develop and implement a regional health plan that includes

(i) the health services provided in the region, or in a part of the region,
(ii) the type, size and location of facilities in the region,
(iii) the programs for the delivery of health services provided in the region,
(iv) the human resource requirements under the regional health plan, and
(v) the making of reports to the minister on the activities of the board in carrying out its purposes.

(b) To develop policies, set priorities, prepare and submit budgets to the minister and allocate resources for the delivery of health services, in the region, under the regional health plan.

(c) To administer and allocate grants made by the government for the provision of health services in the region.

(d) To deliver regional services through its employees or to enter into agreements with the government or other public or private bodies for the delivery of those services by those bodies.

(e) [Repealed 2002-61-4] therefore not applicable.

(f) To develop and implement regional standards for the delivery of health services in the region.

(g) To monitor, evaluate and comply with Provincial and regional standards and ensure delivery of specified services applicable to the region.

(2) In Carrying out its purposes, a board must give due regard to the Provincial standards and specified services."

3.0 PRINCIPLES

The development of this Letter of Understanding was based upon the following principles:

3.1 The Parties acknowledge and respect established and evolving jurisdictional and fiduciary relationships and responsibilities and will seek to remove impediments to progress by establishing effective working relationships.

3.2 The planning and coordination of Interior Health Authority services for the Tsilhqot'in Nation members will be more effective if there is increased participation of the Tsilhqot'in National Government and the six member communities.

3.3 The Letter of Understanding is a living document that will transcend changes within the Parties and will represent an integrated approach to the enhancement of relationships and development of services.

3.4 The Parties acknowledge and respect the need for transparency and reciprocal accountability.

4.0 GEOGRAPHIC AREA

The activities referred to in this Letter of Understanding will be carried out within the Tsilhqot'in Territory.

5.0 SERVICE PROVISION

The Parties Agree that:

5.1.1 the planning for and the provision of health services will be inclusive of all Aboriginal people and services will be culturally appropriate.

5.1.2 Mutual respect, trust, openness, accountability and transparency will be the basis of the understand and foundation of the relationship established under this Letter of Understanding

5.1.3 The Tsilhqot'in National Government may represent other organized groups of Aboriginal people provided that there are formal written agreements to that effect.

5.1.4 Every effort will be made between the parties where possible to create culturally appropriate services and to harmonize and integrate programs and services.

5.1.5 Activities will be carried out with the view of maintaining principles of sustainability, efficiency and effectiveness without limiting innovation, improved access or quality and by building on existing best practices.

5.1.6 Appropriate methods will be used to measure outcomes, including a strengths based approach (e.g. client focused, holistic or "wrap-around")

5.1.7 Mutually agreed upon indicators of health will be followed as a baseline for measurement and there will be a balance of qualitative and quantitative outcomes.

6.0 ACTIVITIES

6.1 To Improve the health outcomes for Aboriginal people, the Parties will carry out specific actions including but not limited to the following:

6.1.1 Review of the existing standards

6.1.2 Development of service delivery systems to better reflect the cultural context of Aboriginal people. This may include localized training on cultural competency.

6.1.3 Development of a consistent and harmonized planning process.

6.1.4 Alignment of services with existing health plans to identify service overlaps and gaps.

6.1.5 Establishment of standards, targets, outcomes and measurements as well as common indicators, milestones and benchmarks.

6.1.6 Engagement in dialogue, identification of linkages and establishment of networks with other Aboriginal and non-Aboriginal stakeholders

6.2 The Parties will establish a Joint Committee and working groups (with specific terms of reference and deliverables) to carry out the activities set out in paragraph 6.1.

7.0 IMPLEMENTATION

As per 6.2 above, the Parties will establish a "Joint Committee" comprising representatives from all Parties that will be tasked with responsibilities which may include but are not limited to:

7.1 Development of a Strategy for building relationships between the Parties including an engagement strategy, communication strategy and consultation process.

7.2 Reviewing the Parties Health Plans to ensure alignment with each other and with the Tripartite First Nations Health Plan

7.3 Ensuring that the Nation is consulted prior to any changes to existing and future services to ensure equitable health care .

7.4 Development of Protocols and Strategies for ensuring that First Nations applicants are considered when hiring for position and retaining those positions.

7.5 Development, agreement and implementation for Data Sharing Agreement between Interior Health Staff and Community Health Staff.

7.6 Prioritization of Services

7.7 Development of Culturally Appropriate Practices within Interior Health Services.

7.8 Identification of barriers to access to culturally appropriate health services for Tsilhqot'in members as well as concerns relating to outcomes for Tsilhqot'in members, and mutual development of strategies and procedures to address these barriers and concerns.

7.9 Ensuring that culturally appropriate protocols are developed and followed for complaints.

7.10 Determination of and agreement upon the process and procedures for the evaluation of this Letter of Understanding and the implementation of subsequent recommendations

7.11 Determination of and agreement upon the process and procedures for the implementation of subsequent recommendations

7.12 The Joint Committee representatives will report through their respective organizations.

8.0 RESOURCE REQUIREMENTS

8.1 It is acknowledged that through the Ministry of Health, Interior Health Authority is responsible for the provision of health services to all citizens.

8.2 The Parties will identify the human, financial and capital resources and potential sources of funding required to achieve the goals of the Letter of Understanding including Tsilhqot'in participation in the Joint Committee.

8.3 The Parties will work cooperatively to secure resources, both internally and externally.

9.0 COMMUNICATION AND INFORMATION SHARING

9.1 Communication between the Parties will be transparent, regular and reciprocal. (as per 7.1)

9.2 The Parties will work together within the legislative framework, e.g. *Freedom of Information and Protection of Privacy Act* etc, to coordinate and determine the most effective and efficient means of data exchange, system integration and information sharing to the fullest extent possible.

9.3 The principles of the OCAP (Ownership, Control, Access and Possession) will be consistently applied wherever possible.

10.0 EVALUATION OF LETTER OF UNDERSTANDING

The Parties will review the Letter of Understanding annually or as otherwise agreed by all Parties. As per paragraph 7.10 above, the Joint Committee will determine and agree the process and procedures for the evaluation and implementation of subsequent recommendations.

11.0 OTHER AGREEMENTS

11.1 The Parties acknowledge and agree that this Letter of Understanding is between the Parties identified and should not be interpreted as having any influence, bearing or impact on other agreements including but not limited to:

- 11.1.1 Enabling Agreements (i.e contracts)
- 11.1.2 Federal Health Transfer Agreement including the Tri-Partite Agreement
- 11.1.3 Protocols or Agreements between the Tsilhqot'in National Government and other Aboriginal or non Aboriginal entities.

11.2 The Parties agree that this Letter of Understanding is not prejudicial to the implementation of any inherent right to self government or any agreements that may be negotiated with respect to self government.

12.0 PROCESSES

12.1 This letter of Understanding does not extend to the following processes:

- 12.1.1 Interior Health Authority organizational/business planning
- 12.1.2 Tsilhqot'in National Government organizational/business planning
- 12.1.3 Planning processes conducted by the six member bands (for example strategic plans and community plans)

12.2 The Parties agree to use a consensus-building model.

13.0 TERM

13.1 Duration: The term of the Letter of Understanding will be four years from the date of signing.

13.2 Extension: The term of the Letter of Understanding may be extended by mutual consent of the parties

13.3 Resolution of Issues: The Parties will work towards remedy of any issues pertaining to this Letter of Understanding through a mutually agreed upon process (such as mediation)

13.4 Termination: If mediation and/or resolution cannot be achieved, the Parties agree that either Party may terminate this agreement by providing sixty (60) days written notice including the cause of termination

14.0 AMENDMENT

The Letter of Understanding may be amended by the Parties at any time by mutual consent of all Parties in Writing.

May, 28, 2013

Dated on this ____ day of _____, 2013

Signed by:

Interior Health Authority	Tsilhqot'in National Government
_____ **Dr. Robert Halpenny** **President and CEO**	_____ **Chief Joe Alphonse** **Tl'etinqox-t'in Government Office**
_____ **Norman Embree** **Board Chair, Interior Health Authority**	_____ **Chief Bernie Mack** **Esdilagh First Nations**
	_____ **Chief Roger William** **Xeni Gwet'in First Nations**
	_____ **Chief Russell Myers** **Yunesit'in First Nations**
	_____ **Chief Percy Guichon** **Tsi Deldel First Nations**
	_____ **Chief Francis Laceese** **Toosey First Nations.**

May, 28, 2013

Appendix F: Interior Health Authority Context and Aboriginal Programs and Services

Region

Interior Health (IH) is mandated by the *Health Authorities Act* to plan, deliver, monitor, and report on publicly funded health services for the people that live within its boundaries. Interior Health's Vision, Mission, Values, and Guiding Principles inform how it delivers on its legislated mandate.

Interior Health provides health services to over 744,000 people across a large geographic area covering almost 215-thousand square kilometres and serves larger, urban centres alongside a large number of small, rural and remote communities. Only 11 of the 59 incorporated communities in the health authority have a population of 10,000 or more.[1] Within IH there are 55 First Nations Bands, the majority of which are rurally located.

In 2006, there were 44,900 people who identified with an Aboriginal group living in the Interior Health region, constituting 6.7 per cent of the overall IH population (British Columbia's overall rate is 4.8 per cent).[2] While improvements in overall mortality and increasing life expectancy in the Aboriginal population have been made, significant gaps in health status between Aboriginal and non-Aboriginal populations still exist. For instance, the Aboriginal population in B.C. experiences a disproportionate rate of chronic diseases and injuries compared to other British Columbia residents.[3]

Interior Health has 19,428 staff, 1563 physicians (which includes 954 general practitioners) physicians and 5,312 nurses.[4] There are 2 tertiary level hospitals, 4 service area hospitals, and a network of community hospitals and health centres offering services to the population of the region.

Interior Health Structure

Structurally, Interior Health has both service delivery and support portfolios. Service delivery portfolios include: Community Integrated Health Services, Residential Care, and Acute Services. The Aboriginal Health Program is one program area within the Community Integrated Health Services Portfolio and includes specific programs and services such as the Aboriginal Patient Navigator Program, Aboriginal Tobacco Reduction Coordinator and Aboriginal Addictions Knowledge Exchange Lead.

Service delivery is coordinated through a regional "network of care" that includes hospitals, community health centres, residential and assisted living facilities, supports for housing for people with mental health and substance use problems, primary health clinics, homes, schools, and other community settings.

Aboriginal Communities

The IH region includes a large number of First Nations reserve communities. Figure 1 identifies the 55 First Nations Bands within the Interior Health service region. This includes five Bands that are located

[1] BC Stats. Demographic Analysis Section. Ministry of Citizens' Services and Open Government. Municipal Estimates, 2006 – 2012.

[2] BC Stats. Statistical Profile of Aboriginal Peoples 2006, Interior Health Authority.

[3] British Columbia Provincial Health Officer (2009). Pathways to Health and Healing – 2nd Report on the Health and Well-being of Aboriginal People in British Columbia. Provincial Health Officer's Annual Report 2007. Ministry of Healthy Living and Sport.

[4] Source: MSP Information Resource Manual 2011/12; Interior Health HR Planning extracted from Meditech Payroll data Oct, 2012; LHA definitions and PEOPLE 2013

within the boundaries of other regional health authorities, but who may access services from IH because of local tribal affiliations. Many of these 55 Bands are rurally or remotely located.

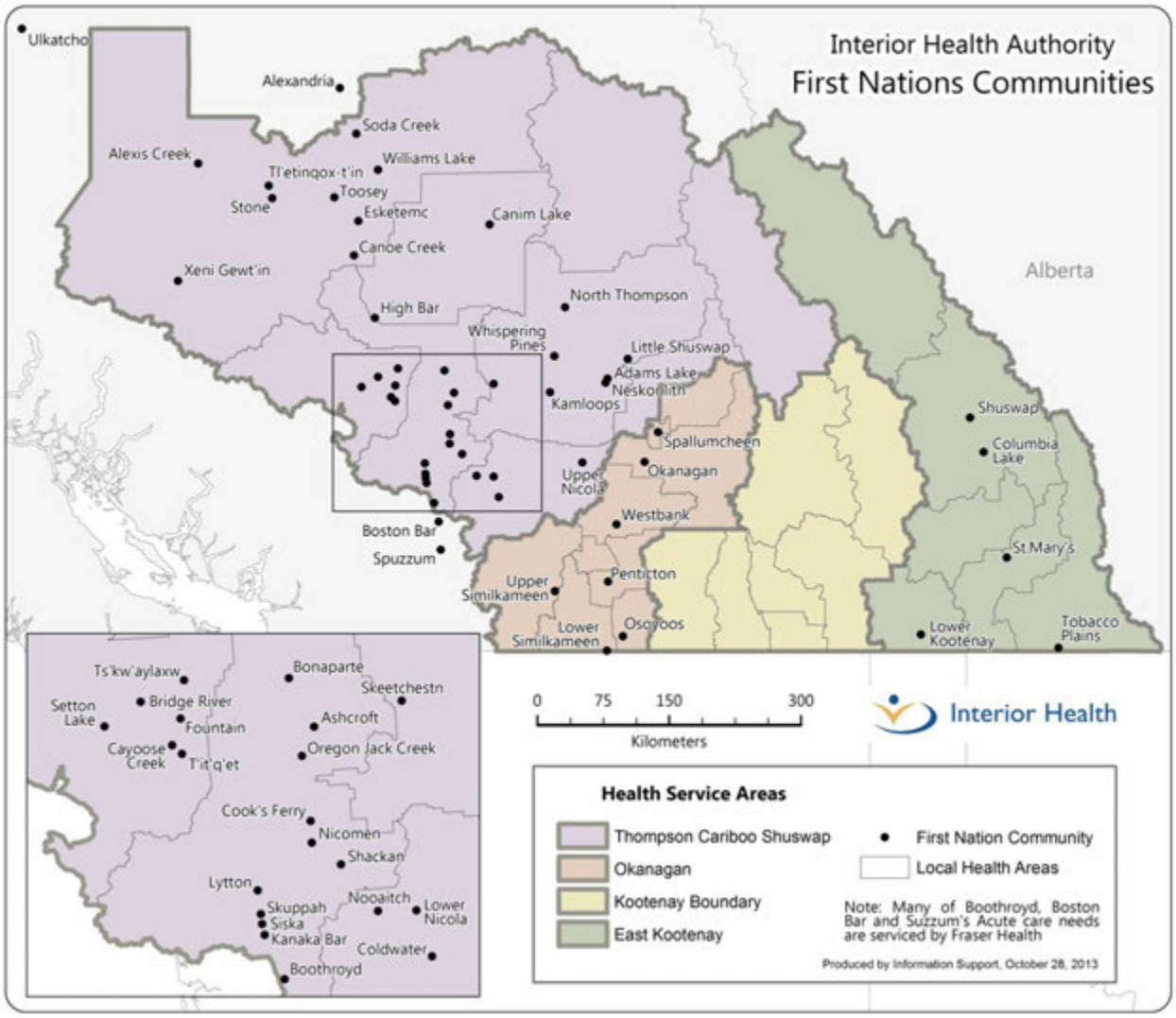


Figure 1: First Nations Communities in IH Region

Interior Health Aboriginal Specific Programs and Services

Our vision is to improve the health status of Aboriginal people within Interior Health by improving access and creating a culturally safe environment and culturally appropriate care for Aboriginal people and acting as a resource for health care service providers. Our mission is to improve access and ensure Aboriginal people receive culturally safe and appropriate service

Aboriginal Patient Navigator Program

Aboriginal Patient Navigators are located in community or acute sites across Interior Health. Aboriginal Patient Navigators support families by providing resources to help connect them to appropriate health care services and provide cultural support. Aboriginal Patient Navigators also work with health care workers to provide resources to assist in providing culturally appropriate care and to connect them with external Aboriginal services. There is no financial cost to clients that access the services.

The Aboriginal Patient Navigator works as part of the Interdisciplinary Care Team, and as required, acts as a resource for both Aboriginal patients and health care providers to ensure care is culturally specific, ethno sensitive and patient centered.

1. For every Aboriginal person who presents and requests APN service at identified referral sites to have timely access to Aboriginal Patient Navigator Services.
2. For Aboriginal Patient Navigators to support culturally safe and appropriate care in health care and community settings through education, advocacy, identification of service gaps and barriers
3. The APN provides referrals, services, and/or resources for patients to meet the unique health needs as identified by the patient, family, and/or interdisciplinary care team.
4. The APN functions as an active member of interdisciplinary healthcare teams.

The target Populations are:

1. Individuals who identify as Aboriginal (Metis, First Nations Status and Non-Status, Inuit).
2. Healthcare Providers

Aboriginal Health and Wellness Strategy

The Aboriginal Health and Wellness Strategy is a primary guiding document for the Aboriginal Health team and Interior Health. Interior Health's Aboriginal Health and Wellness Strategy, 2010-2014, presents a strategic framework that consists of 5 specific strategies, with the goal to improve the health of the Aboriginal peoples we serve. The 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.
The 5 strategies are:

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

Aboriginal Governance Structures

Aboriginal Health and Wellness Advisory Committee (AHWAC) is a committee of the Interior Health's Board of Directors that is composed of representatives from First Nation's communities, Friendship Centers, and the Métis Nation BC, plus members of IH's Board of Directors and Aboriginal Health Program to provide advice to Interior Health on matters pertaining to the improvement of health and health services for Aboriginal people.

The *Partnership Accord* signed in November, 2012, in Kamloops, details the foundations of working relationships with the 7 Nations in the IH region. This agreement ensures that the Nations are partners in health care decisions that impact their communities and peoples. The agreement aligns with IHA Goal #1 "improve health and wellbeing". The Partnership Accord Leadership Table is comprised of Interior Health and First Nations Representatives for the implementation of the Partnership Accord.

Letters of Understanding (LoU) have been signed with several Aboriginal Nations within Interior Health. The purpose of the LoU is to enhance direct relationships between decision makers to improve health outcomes of the respective Aboriginal group. Decision makers may include Aboriginal leadership (such as Health Directors, HUB coordinators, etc.), IHA Aboriginal Health (Practice Lead and/or Director) and IHA representatives (Program and Operations representation).

Other Aboriginal Health Funding Opportunities, Initiatives, and Partnerships

Aboriginal Health Contracts

Aboriginal Health contracts are awarded to qualified not-for-profit Aboriginal organizations. The contracts support grassroots programs that will improve health of Aboriginal people in their communities and within IH. Funds are distributed by a population based funding formula, with the statistics derived from the 2009 Stats Canada data. The proposals are received and evaluated by an internal team that cleared conflict of interest guidelines.

Interior Health awards three different types of contracts to allow for flexibility and innovation of programs that will work with each community's specific needs.

1. AHIP I funding is designated for projects that fall into the Community Health Education and Community Health Collaboration categories.
2. AHIP II is directed towards health promotion and disease prevention programs that run for over 2 years. These programs support community development and health education, health promotion, and or disease prevention activities.
3. Lastly, Direct Service contracts are contracts are currently focused on Mental Health & Substance Use.

Aboriginal Self Identification (ASI) Project

The Aboriginal Self Identification was implemented as a result of the Ministry of Aboriginal Relations and Reconciliation (MARR) which sponsored development of Aboriginal Administrative Data Standard (AADS) in 2007. Following the development of this process, the Ministry of Aboriginal Relations and Reconciliation (MARR) formally recommended the standard to the Government of British Columbia. British Columbia adopted the standard and mandated it to several Ministries including Health. Since 2007 most provincial Ministries have implemented the standard, with Health being the notable exception.

Interior Health's Aboriginal Health & Wellness Advisory Committee (AHWAC) recommended in 2007 that Interior Health adopt the standard and implement Aboriginal Self-Identification. AHWAC approved the Aboriginal Health & Wellness Strategy 2010-2014 which featured Aboriginal Self Identification as one of the key projects to be implemented by the Aboriginal Health Program.

ASI is foundational to:

1. Closing the health status gap between Aboriginal and non-Aboriginal populations via an evidenced based approach.
2. Delivering client-centered, culturally competent, appropriate care to Aboriginal people.
3. Obtaining a base-line understanding of:
    a. Current Aboriginal service utilization by program/service by Aboriginal sub-populations;

b. Variance in needs across Aboriginal populations and compared to non-Aboriginal populations.

4. Enhancing care continuity, service coordination, flow optimization to appropriate services thereby reducing wasted patient days, transitional service gaps and unnecessary and preventable acute care admission and recidivism.
5. Creating the basic conditions to support culturally appropriate, effective and efficient, evidenced-based, research, planning, policy, and program development.
6. Performance monitoring and evaluation of programs or services serving Aboriginal people.
7. Increasing accountability and 'ability' at all levels across all stakeholders.
8. Improving Aboriginal peoples access to services by better understanding barriers to access and then acting to reduce or eliminate these barriers based on evidence.
9. Improving Aboriginal people's attachment to primary care providers by understanding the dimensions and scope of the current gap.
10. Creating novel business and funding models to more effectively allocate scarce financial resources to programs and initiatives that demonstrably target populations with the greatest needs and prevalence of disease and disability in an equitable and sustainable manner.
11. Realizing the potential and promise of IH community integration via:
    a. Appropriately sharing de-identified Aboriginal Health Information to empower Aboriginal Communities, Bands, Tribal Councils, and other Provincial or Federal entities responsible for service delivery and planning to the benefit of Aboriginal people.
    b. Integrated case management, shared care planning, and improved service transitions across diverse and multi-jurisdictional service organizations:
        1. Integrated EMR's and transactional sharing of personal health information;
        2. Discharge notices, referrals, client instructions for home care, etc.
        3. Creating a single virtual ubiquitous client health record and thus:
        4. Eliminating the need for Aboriginal and Non-Aboriginal people having to repeat their stories to every service provider they choose to engage with
        5. Eliminating false provider economies and increasing consumer choice and purchase power.

Diabetes Strategy

The Aboriginal Health program's involvement in the Interior Health Diabetes Strategy ensures Aboriginal participation and representation occurs at all stages of strategy planning and implementation.

The focus of the Diabetes Strategy work included engagement and communication about the three year pilot in select Interior Health communities where Aboriginal participation is promoted and encouraged. This component of the strategy focuses on those living with diabetes, specifically target populations such as Aboriginals. The focus has been on communicating and promoting the strategy to garner interest and participation of local Aboriginal stakeholders in the select communities. Participation is important to ensure that the Aboriginal perspective and experience of living with diabetes is shared with stakeholders in the strategy.

The selected communities represent urban, rural, on-reserve and Métis populations with high rates of current and projected diabetes. In addition, this work included collaboration and information sharing with Health Canada to determine the services and work from federal departments related to diabetes for on-reserve populations.

Thompson Rivers University Dementia Care

The Aboriginal Health program is pleased to support the Thompson Rivers University based research project on culturally safe dementia care for elderly Aboriginal people. The research, funded through the Michael Smith Foundation, is lead by Dr. Wendy Hulko with the intent to translate findings to support healthcare professionals caring for Aboriginal clients with dementia.

Advanced Care Planning

This innovative working group, accountable to the IH End of Life Care Collaborative Committee, was established to provide knowledge and recommendations on the strategic planning for Advanced Care Planning, including identification of cross service linkages.

The Aboriginal Health Program's largest contribution was the development of the Aboriginal specific brochure to accompany the provincially legislated My Voice workbook. This was done to make the workbook more culturally safe for Aboriginal people. The brochure was developed with collaboration of Aboriginal people in the area to ensure the topic of 'end of life' was communicated in a respectful and relevant way for Aboriginal people. The Advance Care Planning brochure is now being accepted provincially to accompany the My Voice workbook. The brochure assists in directing Aboriginal patients on how and where they can express their future traditional health care choices. The work results from participation on the Advance Care Working Group and previewing the "My Voice" workbook. It was noted that this workbook was an opportunity for Aboriginal persons to express traditional and ceremonial rites that are culturally relevant and important to them.

Doula Initiative:

The Aboriginal Health Program recently participated in the Tripartite First Nations Aboriginal Doula Initiative with the goal of "improving maternal health services for Aboriginal women and bringing birthing closer to home and back into the hands of women". This goal was identified within the priorities outlined in the Transformative Change Accord First Nation's Health Plan (Nov 2006) that First Nations, Provincial and Federal governments are working towards.

As a member of the Aboriginal Doula Implementation Working Group, directed by the Tripartite Maternal Child Health Planning Committee, the Aboriginal Health program worked towards addressing the many barriers Aboriginal families within our region face today in accessing culturally appropriate and accessible maternity care.

The BC Aboriginal Doula Initiative was one way we are working towards achieving our goal. The role of the Doula is to build on the more traditional role of aunty, a lay woman recruited from the community who bridges language and cultural barriers and provides the woman, her partner and family with continuous emotional support, physical comfort and assistance in obtaining information before, during, and just after childbirth.

Our region was selected to host Doula training which took place in Kamloops. Twelve Aboriginal women attended the training from a variety of communities across the health authority. As a part of our commitment to this initiative we were also offered demonstration funding to hire a 0.5 FTE Aboriginal

Doula Liaison to help support the Aboriginal women trained within our region to achieve certification as a Doula, in order for them to be able to provide these much needed services in their local communities.

Aboriginal HR Strategy:

The Aboriginal population represents approximately 6.7% of the total population in the southern interior (BC Stats, 2009). Compared to other Health Authorities, Interior Health has the second highest total Aboriginal population in the province (Statistics Canada, 2006). From data collected through the Employee Aboriginal Self-Identification Project, 2.24% (422) of the total Interior Health employee count have identified as Aboriginal as of December 2012. This rate is below a representative workforce target of 6.7% of the total Interior Health Aboriginal population.

The government of British Columbia and the First Nations Health Society are signatories to the "Transformative Change Accord: First Nations Health Plan" [Accord], designed to support the health and wellness of First Nations in British Columbia. Health Canada later signed the "Tripartite First Nations Health Plan" that, in effect, has all parties adopting the Accord. One of the key elements in the Accord is:

"Each regional health authority will increase the number of professional and skilled trades First Nations in health professions. Health authorities will identify emerging employment opportunities, share the information, and link Aboriginal learners with appropriate training institutions."

The expectation is that health authorities in British Columbia will work to meet this commitment. Interior Health's Aboriginal Human Resource Plan will support this on-going commitment.

The Plan was built upon a scan of best practices "Building an Aboriginal Strategy" and stakeholder involvement "Aboriginal HR Strategy: Summary of Focus Groups", to ensure the Plan was relevant and informed by the Aboriginal peoples in Interior Health. Four cornerstones were identified that will form the foundation for ongoing work:

1. Employee Engagement,
2. Workplace Readiness,
3. Recruitment and
4. Education.

Appendix G: Interior Health Authority Aboriginal Strategy 2010-2014

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

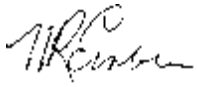
Message from the Board Chair

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

Table of Contents

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.

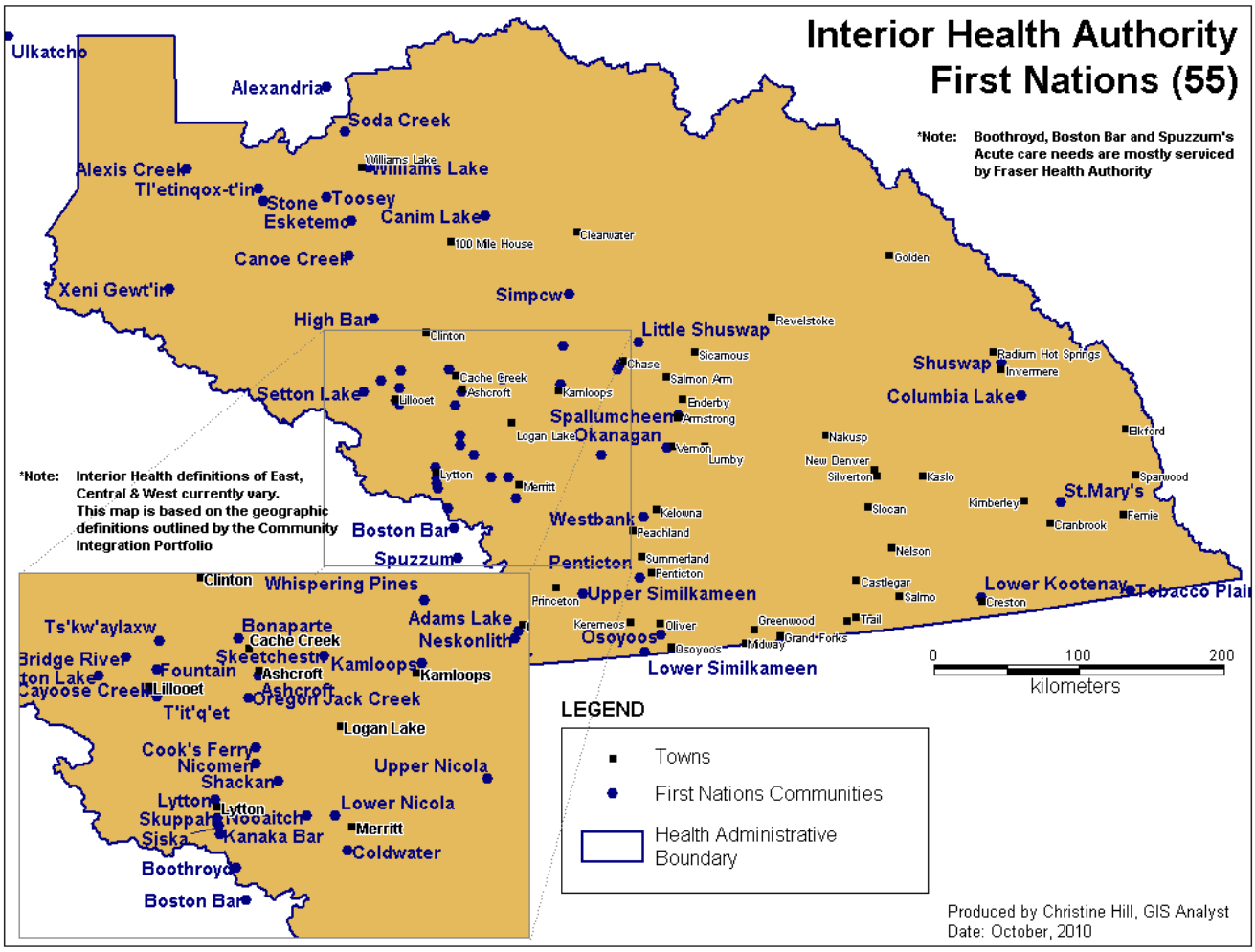
iii. "Métis Nation" means the Aboriginal people descended from the Historic Métis Nation which is now comprised of all Métis Nation citizens and is one of the "aboriginal peoples of Canada" within the meaning of s.35 of the *Constitution Act* 1982.

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.

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

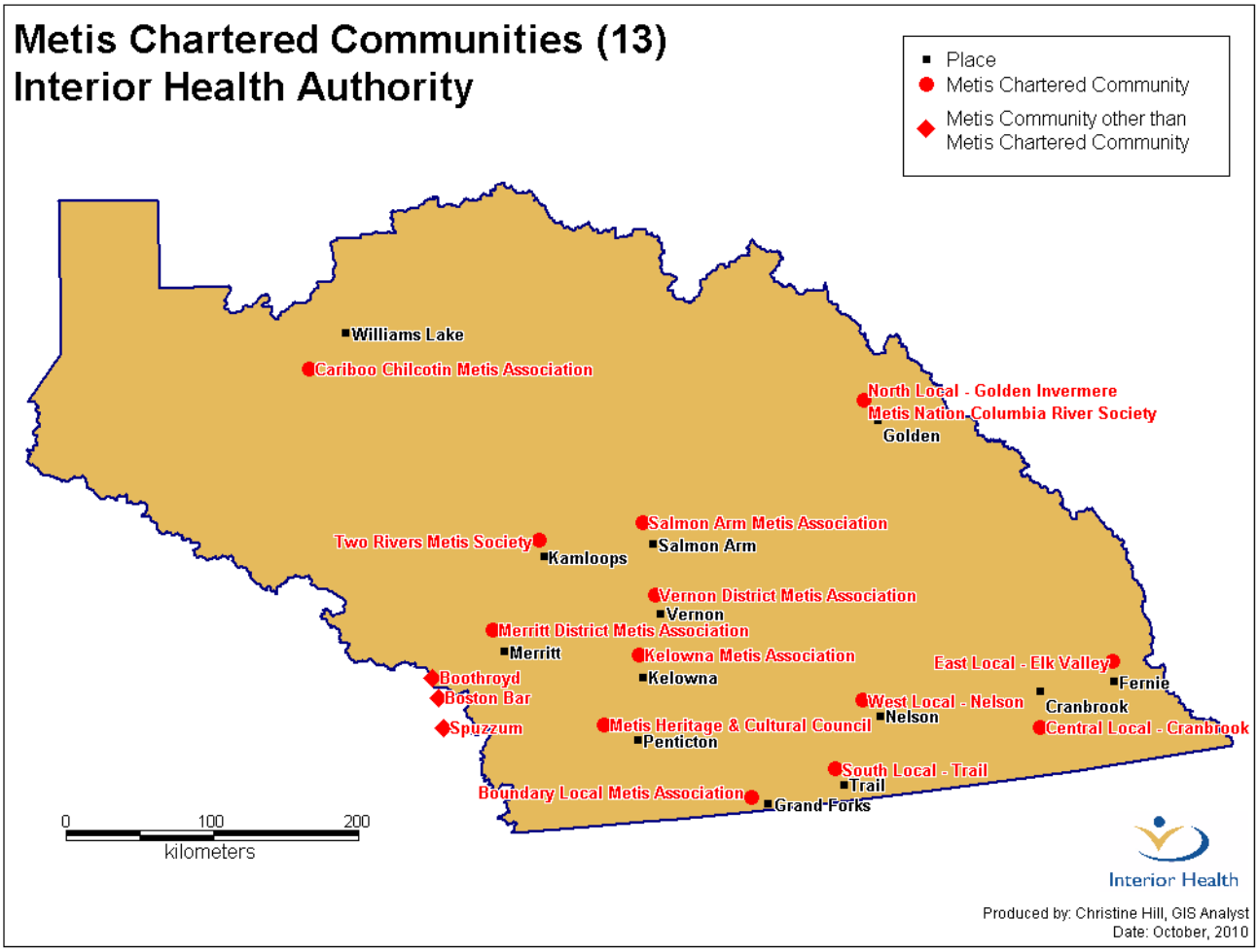
Besides Friendship Centres, Aboriginal people may access numerous other community organizations for off-reserve health and social services.

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

Appendix H: Interior Team Charter

The Interior Team Charter is under development and will take direction from the priorities laid out in this plan. The purpose of the Charter is to establish a Regional Team to support the work of the Interior Region, including the functions of the Regional Office, the implementation of the Interior Partnership Accord, and other regional efforts of the Regional Caucus, Regional Table, FNHC, FNHDA, and FNHA.