FIRST NATIONS POPULATION HEALTH AND WELLNESS AGENDA:

FIRST INTERIM UPDATE, 2024

First Nations Health Authority
Health through wellness

BRITISH COLUMBIA
Office of the Provincial Health Officer

First Nations Population Health and Wellness Agenda:
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Message from the First Nations Health Authority's Chief Medical Officer and BC's Provincial Health Officer and Deputy Provincial Health Officer, Indigenous Health

> "Everything around us—we have to take care of it. Every rock, every pebble, every tree. Be grateful for everything. Every breath that you take. You have to honour that. And the water that nourishes you and cleanses you."
>
> – Kaxte' (Yvonne Marie) Tumangday, Sts'ailes First Nation

The First Nations Population Health and Wellness Agenda (PHWA) baseline report in 2021 represented the beginning of a significant shift in the way the health and wellness of First Nations people is reported on the territories now collectively known as British Columbia. This shift includes moving away from population health reporting that is colonial and deficit-based toward a focus on the strengths and connections that truly support and nurture health and wellness for First Nations people and communities. The PHWA is a series of reports created through a partnership between the First Nations Health Authority's Office of the Chief Medical Officer (OCMO) and the BC Office of the Provincial Health Officer (OPHO). The PHWA report series will monitor and report on the health and wellness of First Nations people in BC over a decade using 22 health and wellness indicators. This is the first interim update in the PHWA report series, which will include additional interim update reports, followed by a final report scheduled for 2030.

First Nations Peoples are experts on their own health and wellness. Sustaining health and wellness requires the ability to foster and maintain deep connections to culture, language, and land; to be autonomous and self-determining in all aspects of life; and to have supportive systems that promote First Nations Peoples' ways of knowing and being. Many First Nations people in BC remain strong despite myriad challenges, including ongoing settler-colonial oppression, systemic Indigenous-specific racism, white supremacy, attempted genocide, intergenerational trauma—and, more recently, overwhelming grief and loss due to COVID-19, the toxic drug crisis, and the climate crisis. To be good partners in the health and wellness journeys of First Nations people, both the OCMO and the OPHO are committed to creating and adapting systems and environments that uphold the rights of First Nations Peoples and enhancing opportunities for sustainable self-determination.

Many First Nations people and communities are flourishing and experiencing a cultural resurgence in which intergenerational knowledge is being honoured and integrated. Recent developments such as the BC *Declaration on the Rights of Indigenous Peoples Act* (DRIPA) and the DRIPA Action Plan are important steps that the Province of BC has taken to affirm and uphold the inherent rights of First Nations people in BC. There is still much work to do, and we are committed to "paddling together" with First Nations Peoples to achieve the vision of healthy, vibrant, self-determining First Nations children, families, and communities.

We raise our hands to the many First Nations communities and individuals who generously shared their time, their stories, and their guidance to make this report stronger. We honour the Elders, Knowledge Keepers, and ancestors, as well as the children, youth, and future generations who connect us and inspire us to do better every day. We honour the lands and waters that have sustained them, and that continue to sustain us all.

To all First Nations people in BC: this report is for you.

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The Office of the Chief Medical Officer's and Office of the Provincial Health Officer's Commitment to Anti-racist Approaches, Indigenous Rights and Self-determination, and Truth and Reconciliation

The First Nations Health Authority's Office of the Chief Medical Officer (OCMO) and the BC Office of the Provincial Health Officer (OPHO) are committed to upholding anti-racist approaches, Indigenous rights and self-determination, and truth and reconciliation with Indigenous Peoples (First Nations, Inuit, and Métis). This commitment includes foregrounding the inherent rights and title of BC First Nations, as well as their deep connections to the land and water in the territories now known as British Columbia. It also includes upholding the rights of all Indigenous Peoples in BC to self-determination, health, and wellness.

The First Nations Population Health and Wellness Agenda (PHWA) is an important part of this ongoing work and commitment. As a co-governed partnership between the OCMO and OPHO, the PHWA supports the right to self-determination. It also supports the right to *wholistic* health and wellness by monitoring and assessing First Nations population health and wellness with an emphasis on First Nations teachings and ways of knowing. The PHWA and the OCMO-OPHO partnership embraces the spirit of truth, reconciliation, and relationship-building with the goal of fostering optimal health, wellness, and self-determination for all First Nations people, communities, and Nations in BC.

Foundational Obligations to Indigenous Peoples

Section 35 of the *Constitution Act, 1982* recognizes and affirms the existing Aboriginal and treaty rights of three distinct Indigenous Peoples in Canada: First Nations, Inuit, and Métis. This and other provincial, federal, and international laws, agreements, treaties, and court rulings set out the obligations of colonial governments and systems to uphold the inherent rights of Indigenous Peoples. The *United Nations Declaration on the Rights of Indigenous Peoples* (2007)[1] creates a framework for action, and Indigenous Peoples have provided additional detailed instructions, including through the documents and initiatives listed below:

- *Truth and Reconciliation Commission of Canada Final Report* (94 calls to action, 2015): https://nctr.ca/records/reports/#trc-reports
- *10 Draft Principles that Guide the Province of British Columbia's Relationship with Indigenous Peoples* (2018): https://news.gov.bc.ca/files/6118_Reconciliation_Ten_Principles_Final_Draft.pdf
- *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls* (231 calls for justice for Indigenous women, girls, and 2SLGBTQQIA+ people, 2019): https://www.mmiwg-ffada.ca/final-report/
- *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care* (24 recommendations, 2020): https://engage.gov.bc.ca/addressingracism/
- BC *Declaration on the Rights of Indigenous Peoples Act* (DRIPA, 2019) and DRIPA Action Plan (89 actions, 2022–2027): https://declaration.gov.bc.ca/
- Canada's *United Nations Declaration on the Rights of Indigenous Peoples Act* (2021) and Action Plan (181 priorities, 2023–2028): https://www.justice.gc.ca/eng/declaration/ap-pa/index.html

Individually and as a whole, these foundational obligations define a clear path forward for all people in BC and Canada to co-create a more just and equitable society—one that promotes truth and reconciliation and that honours and respects the rights of Indigenous Peoples. It is our collective responsibility to uphold these foundational obligations in every aspect of our lives and work.

Acknowledgements

We acknowledge, with respect, the inherent rights and title of the First Nations whose ancestral territories cover every inch of the province now known as British Columbia, including their unextinguished rights to land, self-determination, health, and wellness. Laws and governance systems rooted in the land have upheld the sovereignty of these diverse Nations for thousands of years. The rights and responsibilities of First Nations Peoples to their ancestral territories have, for the most part, never been ceded or surrendered, and are upheld in provincial, national, and international law. These rights are reflected in historical and modern treaties, Section 35 of the Canadian Constitution, court rulings, the *United Nations Declaration on the Rights of Indigenous Peoples*,[1] and the Truth and Reconciliation Commission of Canada's Calls to Action[2] (for more information, see the text box entitled *Foundational Obligations to Indigenous Peoples*).

We are indebted to the Nations on whose unceded ancestral territories the development of this report took place, including the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh Úxwumixw (Squamish), and səlilwətaɬ (Tsleil-Waututh) in Vancouver, BC, and the Esquimalt and Songhees Nations (lək̓ʷəŋən or Lekwungen) and WSÁNEĆ (Saanich) Peoples in Victoria, BC.

We recognize that many Indigenous Peoples from elsewhere in what is now known as Canada also call the lands and waters of this province home, and that they too have Indigenous rights to self-determination, health, and wellness.

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[1] United Nations Department of Economic and Social Affairs. United Nations Declaration on the Rights of Indigenous Peoples [Internet]. Munsee-Delaware Nation, Lenape Nation (Lenapehoking), and (US) Treaty of Easton Territories [New York, NY]: United Nations; 2007 [adopted 2007 Sep 13; cited 2022 Oct 27]. Available from: https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html.

[2] Truth and Reconciliation Commission of Canada. Truth and Reconciliation Commission of Canada: calls to action. Anishinaabe, Ininew, Anisininew, Dene, Dakota, Métis Nation, and Treaty 1 Territories [Winnipeg, MB]: Truth and Reconciliation Commission of Canada; 2015. Available from: https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Calls_to_Action_English2.pdf.

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CONTENT WARNING

The content in this report may trigger unpleasant feelings and memories of negative experiences.

If you need emotional support, please call the
24-Hour KUU-US Crisis Line:
1-800-588-8717 (toll-free)

First Nations and other Indigenous people may find the content in this report distressing and see it reflecting their own experiences of harm and cultural unsafety. The content may also lead to unpleasant feelings for non-Indigenous readers who are asked to witness and think differently about experiences of systemic racism that are often hidden from view. This information is intended to acknowledge the inequities that exist in health and social systems and help to address them.

EXECUTIVE SUMMARY

The First Nations Population Health and Wellness Agenda (PHWA) is a partnership initiative and reporting series of the First Nations Health Authority's (FNHA) Office of the Chief Medical Officer (OCMO) and the BC Office of the Provincial Health Officer (OPHO). Through this work, the partners monitor, report on, and honour the health and wellness journeys of BC First Nations (those Nations whose ancestral territories collectively form what is now known as the province of British Columbia) and all First Nations people in BC (all First Nations people in the province, including those whose ancestral territories are outside of BC). The PHWA baseline report was published in June 2021. It outlined 22 indicators with targets within three main spheres of health and wellness that will be monitored over 10 years: Healthy, Self-determining Nations and Communities; Supportive Systems; and Healthy, Vibrant Children and Families. It also offers seven key actions to nourish First Nations roots of wellness and uphold the FNHA's vision of healthy, self-determining, and vibrant BC First Nations children, families, and communities.

This first interim PHWA report provides updates on 14 of the 22 indicators (those for which new data or qualitative updates are available). The PHWA partners are committed to presenting data in ways that are wellness-based, decolonized, and grounded in First Nations Peoples' teachings, perspectives, and values; that explicitly acknowledge the experiences, resistance, and resilience of First Nations Peoples in the face of persistent and ongoing settler colonialism, Indigenous-specific racism, and discrimination; and that honour First Nations self-determination, data governance, and truth and reconciliation.

The findings in this report demonstrate some improvement since the baseline report was published; however, overall progress has been limited. PHWA reporting intentionally focuses on optimal health and wellness for First Nations Peoples and communities as its own goal. For transparency, PHWA reports also provide data on other BC residents to underscore that health disparities and inequities persist and must be addressed. Even for indicators that have shown improvement since the baseline report was published, substantial gaps remain between the health and wellness outcomes of First Nations people in BC and those of other BC residents; in some cases, the gaps have widened.

Chapter 1 of this report describes some of the ongoing acts of settler colonialism and Indigenous-specific racism that continue to impact First Nations people. These manifest in the inequitable health and wellness outcomes explored in this report, including the disproportionate and devastating impacts of the ongoing and unrelenting toxic drug crisis public health emergency and the COVID-19 pandemic.

Healthy, Self-determining Nations and Communities

Chapter 2 of this report identifies three critical, culturally relevant indicators of First Nations population health and wellness: Self-determination, Connection to Land, and Cultural Wellness. This report provides updates on Self-determination and Connection to Land.

- **SELF-DETERMINATION**
  The OCMO's and OPHO's work to co-develop a self-determination indicator with BC First Nations is intended to highlight the inherent rights of First Nations to control their health and wellness journeys and outcomes. Work since the baseline report was published has included a preliminary review of varying approaches to measuring self-determination among distinct Nations. Future work will include engagement with individual Nations to identify best and wise practices for measuring self-determination.

- **CONNECTION TO LAND**
  The partners have been collecting qualitative data to support reporting on the Connection to Land indicator in a way that highlights its importance to First Nations culture, ceremony, language, and identity. This report provides updates on the We Walk Together project, which explores ways to measure connection to land, water, and territory. We Walk Together project participants represent 23 distinct Nations across three FNHA health regions: Vancouver Coastal, Fraser Salish, and Northern. Three key themes guide the continuing work on this indicator: ancestral knowledge, land and water wellness, and accountability. These themes are explored further in Chapter 2 and show that improving the health and wellness of the land and its inhabitants requires respectful and reciprocal commitments from the FNHA, the OPHO, health system partners, industries, and First Nations communities.

Supportive Systems

Chapter 3 of this report explores some of the ways that settler-colonial systems and policies perpetuate harms and inequities. Advancing inherent First Nations rights and restoring balance requires replacing harmful settler-colonial systems and policies with supportive systems and policies that honour and uplift First Nations' ways of knowing and being. Chapter 3 also reports on four of the six indicators within the sphere of supportive systems presented in the PHWA baseline report: Education, Avoidable Hospitalizations, Cultural Safety and Humility in Receiving Health Services, and First Nations Health Care Providers. Of these, only the Education indicator has shown significant improvement since the baseline report was published.

- **EDUCATION**
  Graduation rates for Indigenous (First Nations, Inuit, and Métis) students in BC have improved since the baseline report was published, with 74.2 per cent of Indigenous graduates in 2019/20 having completed high school within eight years of starting Grade 8 (up from the baseline of 69.9 per cent in 2016/17).

- **AVOIDABLE HOSPITALIZATIONS**
  The rate of avoidable hospitalizations has not improved substantially since the baseline report was published: 72.6 per 10,000 Status First Nations people in BC were admitted to hospital in 2021/22 with diseases or conditions that can usually be well managed at home or in communities, compared to the baseline of 73.3 per 10,000 in 2017/18.

- **CULTURAL SAFETY AND HUMILITY IN RECEIVING HEALTH SERVICES**
  Although new quantitative data were not available for Cultural Safety and Humility in Receiving Health Services, qualitative data show some recent developments in this area, including the creation and launch of a Cultural Safety and Humility Standard for the BC health care system and a BC First Nations Case Study Reflection.

- **FIRST NATIONS HEALTH CARE PROVIDERS**
  The proportion of registered First Nations physicians in BC has not shown meaningful change since the baseline report was published: in 2023, only 0.39 per cent self-identified as First Nations, compared to the baseline of 0.32 per cent in 2019. This interim report includes new measures for the proportion of nurses and midwives in BC who self-identify as First Nations. While there are no earlier years of data to establish a trend, the proportions are notably low: in 2023, only 1.54 per cent of nurses and 1.72 per cent of midwives registered with the BC College of Nurses and Midwives self-identified as First Nations.

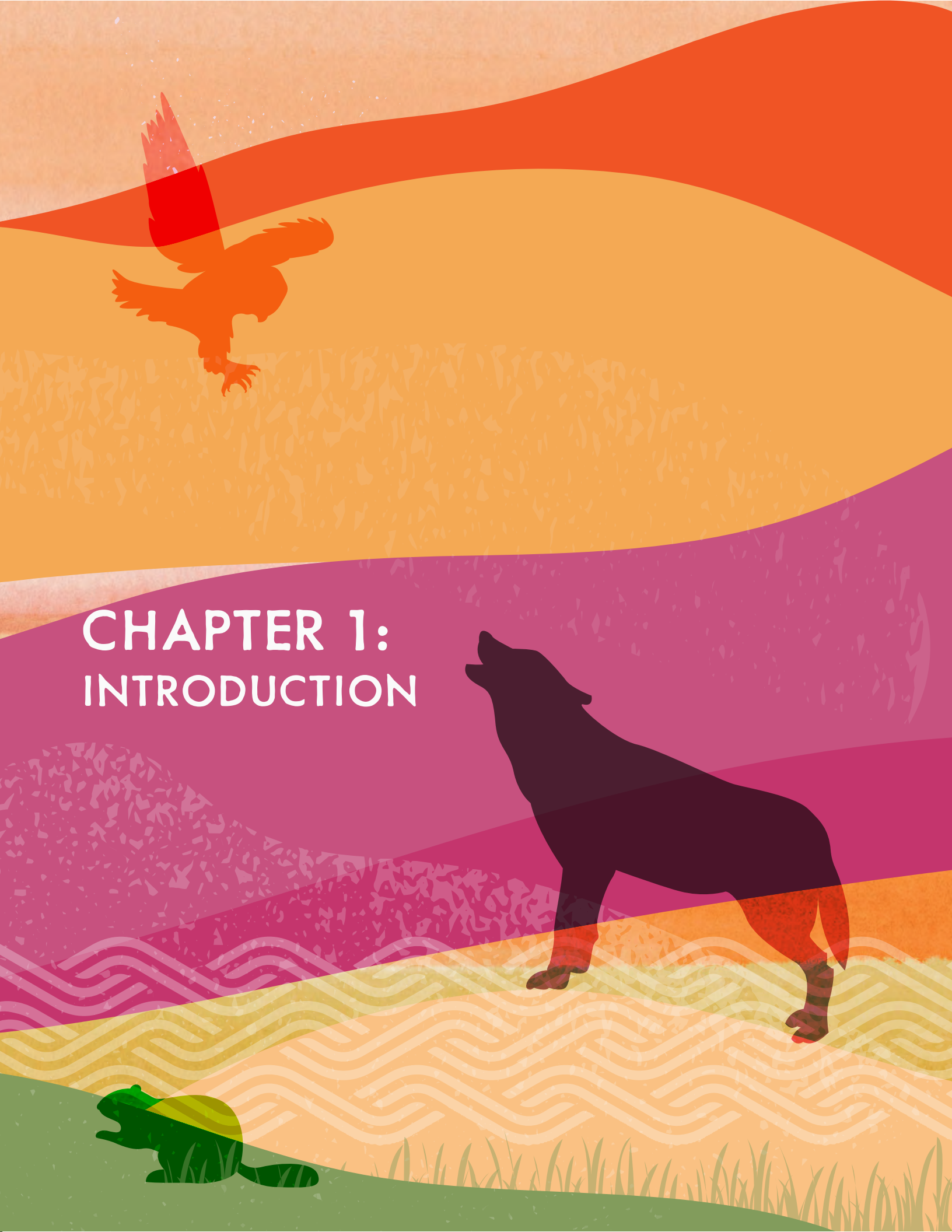
Healthy, Vibrant Children and Families

Chapter 4 of this report reflects the understanding that healthy, vibrant children and families are at the core of strong, healthy, self-determining First Nations communities. Of the 13 PHWA indicators in this sphere, updates are provided on eight of them: Healthy Birth Weights, Infant Mortality, Children's Oral Health, Youth/Young Adult Death by Suicide, Diabetes Incidence, Serious Injuries, Life Expectancy at Birth, and Mortality Rate. Three of these indicators have worsened substantially since the baseline report was released: Diabetes Incidence, Life Expectancy at Birth, and Mortality Rate. A fourth indicator, Healthy Birth Weights, worsened slightly. Infant Mortality was the only indicator in this chapter to show improvement.

- **HEALTHY BIRTH WEIGHTS**
  Healthy birth weights reflect positively on the health of both infant and birth parent. In 2019, 72.1 per cent of singleton Status First Nations babies in BC were born at a healthy birth weight for their gestational age and sex. This was down slightly from the baseline of 73.8 per cent in 2017.
- **INFANT MORTALITY**
  In 2015–19, the rate of Status First Nations infant deaths in BC was 4.6 per 1,000 live births, which represented a slight (though not statistically significant) decrease from the baseline rate of 5.3 deaths per 1,000 live births in 2013–17.
- **CHILDREN'S ORAL HEALTH**
  Updated quantitative data for this indicator have been excluded due to data quality issues (see Chapter 4 for further information). Alternative ways to monitor and report on this indicator in the future are being investigated.
- **YOUTH/YOUNG ADULT DEATH BY SUICIDE**
  Among Status First Nations youth/young adults (age 15–24) in BC, the rate of death by suicide was 2.8 per 10,000 population in 2017–21, down slightly from the baseline rate of 3.1 per 10,000 in 2013–17. There was substantial variation by sex in both the rate and direction of the trend between 2013–17 and 2017–21. In 2017–21, the rate per 10,000 population was 3.8 per 10,000 for males and 1.7 per 10,000 for females.

- **DIABETES INCIDENCE**
  Diabetes incidence among Status First Nations people in BC increased from the baseline of 8.0 per 1,000 population in 2017/18 to 8.5 per 1,000 in 2020/21.
- **SERIOUS INJURIES**
  Among Status First Nations people in BC, the rate of serious injuries requiring hospitalization was 31.1 per 1,000 population in 2021/22. This was virtually unchanged from the baseline of 31.4 per 1,000 in 2017/18.
- **LIVING LONG LIVES (LIFE EXPECTANCY AT BIRTH)**
  Life expectancy at birth for Status First Nations people in BC decreased from the baseline of 73.3 years in 2017 to 67.2 years in 2021. The toxic drug crisis and COVID-19 are key factors that have affected life expectancy.
- **MORTALITY RATE**
  Following relatively minor fluctuations, the mortality rate among Status First Nations people in BC increased from the baseline of 117.3 per 10,000 in 2017 to 156.0 per 10,000 in 2021. As with life expectancy, the toxic drug crisis and COVID-19 have both had a substantial impact on mortality rates.

Chapter 5 summarizes the data on the indicators presented in this report. It also provides progress updates on several of the actions identified in the baseline report to nourish First Nations roots of wellness. The PHWA series will continue to report on the health and wellness journeys of First Nations people in BC, using increasingly decolonized data and approaches wherever possible. The next report will be the midterm update, projected for release in 2026/27. It is expected to present updated data on most of the 22 PHWA indicators, including those not presented in this first interim update.



CHAPTER 1:
INTRODUCTION

The First Nations Population Health and Wellness Agenda (PHWA) is a partnership initiative between the First Nations Health Authority's (FNHA) Office of the Chief Medical Officer (OCMO) and the BC Office of the Provincial Health Officer (OPHO) to monitor and report on the health and wellness of **BC First Nations**[a] (those **First Nations** whose ancestral territories collectively form what is now known as the province of British Columbia) and all **First Nations people in BC** (all **First Nations people** in the province, including those whose ancestral territories are outside of BC).

The PHWA is part of ongoing work to uphold the inherent rights and title of BC First Nations and the rights of all First Nations people in BC. The PHWA baseline report was published in June 2021. It outlined 22 indicators and targets to be tracked over a 10-year period and presented seven calls to action to move toward the FNHA's vision of healthy, self-determining, and vibrant BC First Nations children, families, and communities. The ultimate goal is to see improvements in each of the indicators through the ongoing work of the FNHA, the OPHO, and health system partners. This report is the first interim update. It provides an overview of progress to date on 14 of the 22 PHWA indicators (see Appendix A for details). This chapter summarizes the guiding principles in the development of the PHWA, and contextualizes the PHWA within recent and ongoing events in BC.

Background and Introduction

First Nations Peoples across BC and Canada have distinct ways of knowing and being based on their unique cultures, languages, protocols, and practices. Despite the intrusions of **settler colonialism**, some Nations have succeeded in maintaining their own effective systems of justice, education, health, and governance, embedded in the lands and waters of their territories that promote a healthy way of life for their people and communities. The inherent rights and title of First Nations, including rights to land, governance, resources, and culture, were deliberately disrupted by European occupiers intent on accumulating wealth and power. Racist and discriminatory laws and policies implemented by settler-colonial governments, including the ***Indian Act***, led to the creation of genocidal institutions such as Indian residential schools and Indian hospitals. These, along with other settler-colonial policies and practices such as the ongoing and continuous apprehension of **Indigenous** children known as the **Sixties Scoop** and the **Millennium Scoop**, were and are intended to undermine and eradicate First Nations Peoples and make way for settler dominion.[1,2,3] This is part of a long history of racist and discriminatory child welfare policies being used as weapons of settler-colonial oppression and attempted assimilation. Settler-colonial laws and institutions banned cultural practices, forcibly separated children from their families and communities, and attempted to extinguish language, culture, and familial systems that are foundational to First Nations ways of being.[4] Patriarchal, **cis-heteronormative**, anti-Indigenous laws and policies were designed to degrade and destroy effective First Nations systems and replace them with discriminatory, oppressive, and harmful settler-colonial systems.[4,5,6] Yet, ongoing settler-colonial, racist, and anti-Indigenous systems have failed to extinguish First Nations cultures and traditions. While settler-colonial systems and policies continue to cause significant health and social inequities for First Nations, many First Nations people and communities have actively protected and/or reclaimed their teachings and cultural knowledge and are passing them on to future generations.[7]

PHWA reporting recognizes and acknowledges the work that BC First Nations leaders have undertaken since time immemorial to uphold the inherent right of **self-determination**. Since the cultural disruptions brought by settler colonialism, one of the largest self-determining decisions made by BC First Nations was the vote in 2011 to adopt the *Consensus Paper 2011: British Columbia First Nations Perspectives on a New Health Governance Arrangement*, which described a First Nations vision of a new

[a] Terms bolded in the body of this report are defined in the glossary (Appendix C).

health governance arrangement.[8] Through this Resolution, BC First Nations endorsed the *British Columbia Tripartite Framework Agreement on First Nation Health Governance*—a legal agreement to transfer the operations of Health Canada's First Nations and Inuit Health Branch – BC Region to a First Nations-led health authority, and to enter into a new health partnership with the federal and provincial governments.[8] The Agreement was signed on October 13, 2011.[8] In May 2012, BC First Nations voted on the adoption of *Consensus Paper 2012: Navigating the Currents of Change – Transitioning to a New First Nations Health Governance Structure*.[8] The FNHA was created by BC First Nations for First Nations to advance the **wholistic** BC First Nations Perspective on Health and Wellness by empowering and partnering with First Nations individuals, families, and communities to enact self-determination.[9] The FNHA's authority comes from the inherent right of BC First Nations to self-determination, as reaffirmed in Article 23 of the *United Nations Declaration on the Rights of Indigenous Peoples*.[10]

First Nations people have the right to experience cultural safety in all supports and services, including access to culturally safe health care. Transforming mainstream health and social services to ensure they are anti-racist and culturally safe and provide the highest quality care for First Nations people in BC is essential. This includes resetting relationships between First Nations people in BC and the entire health system in ways that are inclusive and **distinctions-based**, and honour the inherent rights, perspectives, and worldviews of First Nations Peoples. Settlers and settler-colonial governments and institutions such as the OPHO have an integral role to play in this transformation as supporters, facilitators, allies, and partners in the heavy work of decolonization and true reconciliation. This includes foundational obligations to engage in further truth-telling and collaborative health and wellness reporting (see the text box *A Few Key Foundational Obligations to Indigenous Peoples in the Areas of Truth-telling and Decolonization*). As part of this work, many health care and social service providers are taking the time to learn about and recognize the impacts of settler colonialism, including Indigenous-specific racism, and how it has created a system that both impedes access to quality health and social services and generates harmful experiences for Indigenous Peoples (First Nations, Inuit, and Métis).[11] First Nations Peoples are exercising their right to self-determination to reclaim and reassert their knowledge, ways of life, ceremonies, and cultural wellness practices to ensure the health and wellness of current and future generations.

HIGHLIGHT:
A Few Key Foundational Obligations to Indigenous Peoples in the Areas of Truth-telling and Decolonization

- ***United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP, 2007) Article 2.** Indigenous peoples and individuals are free and equal to all other peoples and individuals and have the right to be free from any kind of discrimination, in the exercise of their rights, in particular that based on their Indigenous origin or identity.[10]
- **UNDRIP (2007) Article 8.1.** Indigenous peoples and individuals have the right not to be subjected to forced assimilation or destruction of their culture.[10]
- **Truth and Reconciliation Commission of Canada (TRC, 2015) Call to Action 18.** We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.[12]
- **TRC (2015) Call to Action 19.** We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.[12]
- **National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG 2SLGBTQQIA+,[b] 2019) Call for Justice 15.2.** Decolonize by learning the true history of Canada and Indigenous history in your local area. Learn about and celebrate Indigenous Peoples' history, cultures, pride, and diversity, acknowledging the land you live on and its importance to local Indigenous communities, both historically and today.[13]
- **MMIWG 2SLGBTQQIA+ (2019) Call for Justice 15.3.** Develop knowledge and read the [MMIWG 2SLGBTQQIA+] *Final Report*. Listen to the truths shared, and acknowledge the burden of these human and Indigenous rights violations, and how they impact Indigenous women, girls, and 2SLGBTQQIA people today.[13]
- **MMIWG 2SLGBTQQIA+ (2019) Call for Justice 15.4.** Using what you have learned and some of the resources suggested, become a strong ally. Being a strong ally involves more than just tolerance; it means actively working to break down barriers and to support others in every relationship and encounter in which you participate.[13]

[b] The MMIWG Calls for Justice focus on Indigenous women, girls, and 2SLGBTQQIA+ people. To honour this, the acronym 2SLGBTQQIA+ is included wherever MMIWG is discussed in this report. Please see Appendix C for more information on who the acronym 2SLGBTQQIA+ includes.

Approach and Guiding Principles

In developing and reporting on the PHWA, the OCMO and OPHO have worked to form a new partnership that represents truth, reconciliation, and **reciprocal accountability**. The two offices work collaboratively to decolonize reporting initiatives and break down barriers that impede First Nations people's health and wellness, while promoting reconciliation between First Nations people and communities and **other residents** of BC. Together, the OCMO and OPHO are paddling on a wellness journey alongside other health system partners with the shared goal of improving the health and wellness of First Nations people in BC.

One strength of this partnership is that it incorporates First Nations knowledges and teachings into the way the work is carried out. Another strength is that these knowledges and teachings are reflected in the outcomes of the work. Some of the teachings incorporated into the PHWA include the following:

1. **Establishing and incorporating partnership principles for the relationship between the OCMO and OPHO into the work** – The partnership between the OCMO and OPHO is built on respect and reciprocal accountability. The aim of the partnership is to work in collaboration to focus on the strengths, wellness, and resilience of First Nations individuals, families, and communities. This includes taking a life-course approach to represent the lived experiences of First Nations people of all ages.
2. **Reflecting the BC First Nations Perspective on Health and Wellness** – The PHWA reflects the layers of the BC First Nations Perspective on Health and Wellness (FNPHW) (Figure 1.1). The FNPHW represents a wholistic, interconnected, and balanced model of health and wellness, in which all dimensions of health—mental, physical, emotional, and spiritual—are important for well-being. The FNPHW has five main layers:
    - the centre circle represents the individual and their responsibility for taking care of their health and well-being;
    - the second circle represents the importance of nourishing and maintaining a balance of mental, emotional, spiritual, and physical health for well-being;
    - the third circle reflects the values that uphold wellness—respect, wisdom, responsibility, and relationships;
    - the fourth circle represents who we surround ourselves with and where we come from—land, community, family, Nation; and
    - the outer circle represents the social, environmental, economic, and cultural determinants that affect health and wellness.

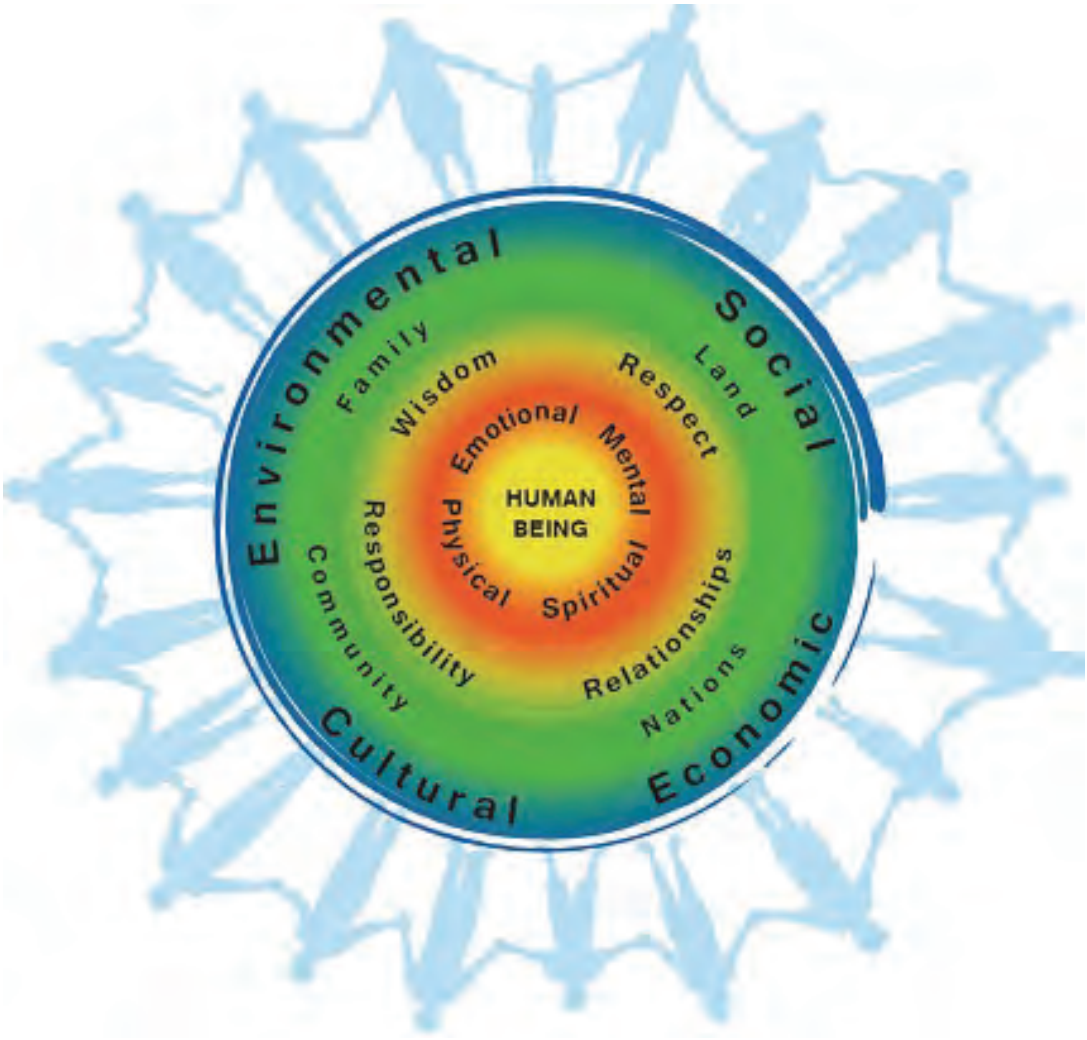
This model depicts the FNHA's vision of healthy, self-determining, vibrant BC First Nations children, families, and communities. Achieving this vision is not and has not been an easy journey due to the ongoing impacts of settler colonialism and its disruptions of First Nations Peoples' ways of being and knowing. Wellness is intergenerational—the wellness of a population is shaped by that of its ancestors, which in turn shapes the wellness of future generations. Settler colonialism continues to create inequitable barriers to First Nations Peoples' health and wellness due to systemic racism, stereotyping, and discrimination, which results in substantial harms, and even death.[14] These barriers include unjust systems, racist policies, a lack of recognition of inherent First Nations rights and title, and disruption of the significant relationships between First Nations Peoples and the land. The FNPHW honours the complexities of First Nations teachings and the current socio-cultural and institutional contexts that impact the health and wellness of individuals. It reflects the understanding that people have the right to guide their own unique health and wellness journeys, which are connected to the settings in which they live and the relationships they hold with their families, communities, and Nations, and the land.

3. **Taking a strengths- and wellness-based approach** – The PHWA advances measuring what makes people well, unlike many mainstream health reports that take deficit-based approaches that focus on illness and emphasize what is "wrong." By focusing on deficits, they subtly reinforce assumptions and stereotypes and perpetuate cycles of Indigenous-specific racism and health inequity.[15,16] The PHWA represents a transformation in health and wellness reporting, moving beyond deficit-based settler-colonial indicators to include strengths-based, culturally relevant indicators that are co-created with communities. Strengths-based approaches emphasize wellness and seek to build on individual and community strengths such as resilience, relationships, and cultural connectedness. Focusing on strengths to improve health outcomes also better aligns with Indigenous ways of knowing and being. The PHWA also acknowledges the roots of wellness to illuminate the structural and systemic barriers that may undermine an individual's wellness journey.

4. **Truth-telling to honour the health and wellness journeys of First Nations people** – Truth-telling is a fundamental part of reconciliation that must come first if transformational change is to occur. Since settler-colonial contact, First Nations Peoples' truths have been challenged, ignored, and dismissed. Progress requires opening our hearts to hear difficult truths and value the stories and experiences of First Nations people. Systemic, structural, institutional, and interpersonal Indigenous-specific racism continues to show up through legislation, policies, and institutions that have been established and organized to exclude and undermine First Nations people; this gravely impacts their health and wellness. It is critical to emphasize that *Indigeneity itself is not a risk factor*, although traditional research and reporting analyses often interpret "gaps" between Indigenous and non-Indigenous people's health and wellness without grounding the data in the truths of how these gaps are created. This report aims to evolve the health system's understanding of First Nations health and wellness, and highlight the strengths and progress underway. It also acknowledges the work still required to address the significant gaps between the health of First Nations people and **other residents** of BC. This includes recognizing truths that have often been excluded from "evidence-based" research and reporting. These truths are essential to contextualize the data in terms of historical and ongoing settler-colonial oppression in order to determine where systemic change is needed to support further progress toward health equity.

5. **Incorporating a two-eyed seeing approach** – **Two-eyed seeing** is an approach that weaves together First Nations Knowledge and ways of knowing with Western knowledge.[17] A two-eyed seeing approach provides invaluable wisdom from First Nations ancestors and **Elders** that is key to understanding the health and wellness of First Nations Peoples. The PHWA privileges the truths and voices of First Nations people throughout this report, highlighting lived experiences that reflect diverse perspectives, including those of different ages, genders, Nations, regions, and language groups. While charts in this report present aggregated numbers that show overall rates and trends, the OCMO and OPHO recognize and respect that these numbers represent unique First Nations individuals who are members of families, communities, and Nations.

Figure 1.1: BC First Nations Perspective on Health and Wellness



"Colonization [settler colonialism] in Canada has occurred through the systematic efforts of governments vis-à-vis policies and practices of assimilation and dispossession. The impacts of colonial efforts maintain the dispossession of Indigenous peoples from land, language, community, culture, identity, and other socio-cultural resources necessary to promote wellbeing."

- Ansloos & Dent, 2021[7(p29-30)]

DEVELOPMENT OF THE POPULATION HEALTH AND WELLNESS AGENDA: VISUALIZING THE AGENDA

Figure 1.2 depicts the key concepts of the PHWA, weaving together First Nations territories, lands, and water within a complex and vibrant ecosystem that includes plants and medicines. The vision of healthy and vibrant BC First Nations children, families, and communities requires self-determination, culture, language, and connection to land as its foundation. The roots of wellness are social, cultural, economic, and environmental systems that First Nations people interact with daily. These systems must be well nourished and free from inequities, racism, and discrimination to foster an environment where First Nations children, youth, adults, seniors, and Elders are able to own and reclaim their health and wellness journeys.

The people at the centre of this image represent the spiritual, mental, emotional, and physical aspects of health and wellness, which are all interconnected. The image also includes the overarching values and principles of wisdom, respect, responsibility, and relationships, which support and uphold wellness and the work being done to sustain it.

This visualization of the PHWA is reflected in the connections across and between the PHWA indicators and their themes.

Figure 1.2: Vision of Healthy, Self-determining, and Vibrant BC First Nations Children, Families, and Communities

BC's Changing Landscapes

The purpose of this report and future PHWA reports is to continue monitoring and sharing health and wellness data about First Nations people and communities in BC through a regular reporting cycle. The PHWA baseline report included targets for each indicator—goals against which to measure improvements in the health and wellness of First Nations people in BC over a 10-year period. However, the landscape of First Nations Peoples' health and wellness in BC is constantly evolving and has undergone substantial changes since the PHWA baseline report was released in 2021. First Nations people in BC have had to navigate the complex intersections of numerous public health crises, during which Indigenous-specific racism in the health care system worsened experiences of the toxic drug crisis[c] and the COVID-19 pandemic for many people. Due to systemic Indigenous-specific racism, settler colonialism, and white supremacy,[18,19] these public health crises have had disproportionate impacts on the health and wellness of First Nations people and have caused trauma to individuals, families, and communities. These events have undermined First Nations people's health and wellness; disrupted connections to family, community, and culture; and precipitated substantial loss of life.[18,20]

THE TOXIC DRUG CRISIS

In 2016, BC's Provincial Health Officer declared a public health emergency in response to an alarming rise in both non-fatal and fatal toxic drug poisoning events[d] linked to the use of poisoned, unregulated drugs[e] in the province.[21] First Nations communities are disproportionately impacted due to the ongoing effects of intergenerational trauma and disconnection from family and community caused by racist settler-colonial policies and practices. Stigma surrounding drug use also negatively impacts wellness by separating

[c] What has been called the "opioid crisis" is now more often referred to as the "toxic drug crisis" or "toxic drug poisoning crisis." This wording emphasizes that the unregulated drug supply is highly unpredictable and potentially lethal.

[d] Most toxic drug poisoning events are non-fatal and represent instances where paramedics have been called.

[e] Also referred to as illegal drugs, illicit drugs, street drugs, or prohibited drugs, "unregulated drugs" are drugs that are prohibited under Canada's laws for all but very limited uses. When these drugs are manufactured and sold illegally, without the benefit of quality controls or regulation, the result is an unpredictable and often toxic supply of drugs.

people from spiritual, cultural, and social support networks.[22,23] In 2020, this public health crisis and response efforts were compounded by the COVID-19 pandemic, as evidenced by the fact that toxic drug events, illnesses, and deaths among people who used drugs increased dramatically at this time.[24] This surge has been linked to factors such as pandemic-related border closures interrupting unregulated drug supply chains; an increasingly toxic (higher potency and/or highly adulterated) drug supply;[25,26] increased social isolation, anxiety, and mental distress leading to increased drug use; reduced access to supervised consumption sites and other social and harm-reduction services;[24] and increased likelihood of people using drugs on their own due to physical-distancing guidelines.

In 2023, the rate of death from the use of unregulated drugs was more than six times higher for **Status First Nations people** than for other residents of BC.[27] The difference in rates among females was even more alarming: in 2023, Status First Nations females died from the use of unregulated drugs at 11.7 times the rate of other female residents of BC.[f,27] There were 3,446 toxic drug poisoning events among First Nations people in BC in 2023, up from 3,068 in 2022.[27] Preliminary data suggest there were a total of 2,511 toxic drug deaths in BC in 2023.[28] Although First Nations people represent less than 4 per cent of the BC population, they accounted for 448 (17.8 per cent) of these deaths.[27] These numbers again reflect the disproportionate impacts of the toxic drug crisis on First Nations people and communities.[29] In September 2022, the FNHA upgraded its emergency response to Level 2 response protocols to better support communities during this public health emergency. This response level enables onboarding teams with special skill sets, mobilization and reassignment of resources, and/or working with partners to ensure communities can access culturally safe supports and services.

For many First Nations people, being or becoming and staying connected to family, culture, and community is a vital part of addressing the toxic drug crisis.[30] The FNHA is responding to the crisis with accessible, timely, culturally safe, and trauma-informed health services, and is using harm-reduction approaches that emphasize cultural teachings and connections to community and the land.[31,32,33] Regional health authorities also have obligations to ensure that the services they provide are culturally safe and

[f] Indigenous people who are not recognized as having First Nations status under the *Indian Act* are not represented in these data. In addition, data reported by sex (female/male) may reflect biological sex assigned at birth. Therefore, Two-Spirit, transgender, non-binary, intersex, and gender-diverse people may be misidentified in the data.

accessible for First Nations people. In 2017, the federal government enacted the *Good Samaritan Drug Overdose Act*, which provides people who are present at a toxic drug poisoning event with legal protection from charges against simple drug possession to encourage them to call for help.[34] In 2021, BC introduced a policy to expand access to legally regulated safer supply to reduce toxic drug events and deaths.[35] Another aspect of the response to the toxic drug crisis has been the work of the BC Ministry of Mental Health and Addictions, the BC Provincial Health Officer, and Health Canada to temporarily decriminalize the possession of small amounts of certain illegal drugs.[30,36,37] A temporary decriminalization exemption came into effect in BC on January 31, 2023. More recent changes have recriminalized drug use in public, while maintaining decriminalization in private spaces.[38]

The FNHA's role in this work has included engaging with and supporting BC First Nations communities in implementing decriminalization in a way that upholds and honours First Nations self-determination and meets the priorities of their communities. This includes reducing stigma and other barriers that prevent people from accessing supports and services; for example, by attempting to shift public perception of substance use from a criminal matter to a health concern. The FNHA encourages using a harm-reduction approach, viewing substance use and addiction from a public health perspective, and promoting the compassion and acceptance required for people to stay safe while working to address addiction issues.[39] The FNHA has created a Framework for Action—a system-wide response to the toxic drug crisis—with four main goals: (1) preventing people who experience drug poisoning from dying; (2) keeping people safer when using drugs; (3) creating a more accessible range of treatment options; and (4) supporting people on their healing journeys.[40] In BC, 10 treatment and outpatient centres funded through the FNHA provide services to First Nations people, including specialized services for men, women, youth, and families.[9,41,42] For more information, see https://www.fnha.ca/what-we-do/mental-wellness-and-substance-use/treatment-centres.

[9] Although these treatment centres may focus on healing for First Nations people, several also provide services to people who are non-First Nations and/or non-Indigenous.

COVID-19

In March 2020, COVID-19 was declared both a global pandemic[43] and a BC public health emergency.[44] Although symptoms vary, COVID-19 can cause serious acute and long-term illness, hospitalization, and death.[45] Initially, public health efforts to reduce the spread of COVID-19 in BC included travel restrictions and self-isolation guidelines, wearing masks, physical distancing, and restrictions on gathering sizes.[46,47,48] In the early stages of the pandemic, First Nations people living **in community** (i.e., "at home" or "on reserve")[h] reported much lower COVID-19 infection and fatality rates and higher recovery rates than other Canadians.[49,50] Although this may have been due in part to many First Nations communities being rural and remote, which may have helped reduce transmission, it has also been credited to the many self-determined, community-driven, First Nations-led public health responses to the pandemic (e.g., communities imposing travel restrictions in and out of community).[51]

Despite this early success in limiting its spread, subsequent waves of COVID-19 created a surge in cases among First Nations. In BC, rates of COVID-19 among First Nations people living in community eventually surpassed rates among non-Indigenous people.[11,52] As of January 3, 2023, there were a total of 21,249 confirmed COVID-19 cases, 2,556 hospitalizations, and 825 critical care admissions among Status/Status-eligible First Nations people living in BC. From the beginning of the pandemic to April 1, 2022, there were also 258 COVID-19-related deaths reported among First Nations people living in BC. Between April 2, 2022, and January 3, 2023, another 54 First Nations people died from any cause within 30 days of testing positive for COVID-19 (these included both COVID-19-related and non-COVID-19-related deaths).[i,53]

[h] Use of the terms "on reserve" and "off reserve" to describe a First Nations person's place of residence is an outcome of settler colonialism and the illegal removal of First Nations Peoples from their traditional territories. The terms "in community" and "away from home" are therefore used in this report instead.

[i] For more information on COVID-19 and COVID-19 vaccination among First Nations people in BC, please see: https://www.fnha.ca/what-we-do/communicable-disease-control/coronavirus/community-leaders.

Pre-existing inequities rooted in settler colonialism and Indigenous-specific racism contributed to elevated rates of COVID-19 among First Nations people.[47] The pandemic highlighted these stark inequities and often made them worse, in some cases leading to increases in unemployment, poverty, and food insecurity.[54,55] At the same time, COVID-19 restrictions impeded access to quality, culturally safe health and social services.[11,46,47,48,56,57] For example, travel restrictions highlighted the lack of health care services in or near more rural and remote communities. Following public health guidelines, some people were no longer able to travel the distances required to get to the nearest health care facility. For many, access to health care and social services was further compromised by reduced service hours, the interruption of in-person services, and high levels of mistrust of the health care system. This mistrust is based on legitimate concerns such as the ongoing Indigenous-specific racism and discrimination in the health care system, lack of cultural safety in health services, previous negative experiences with untrustworthy health care providers, intergenerational trauma, and the legacy of Indian hospitals. COVID-19 restrictions also reduced individuals' ability to gather with family and community, and limited participation in cultural events and ceremonies that are foundational to the wholistic health and wellness of First Nations people and communities. For some, inadequate and often overcrowded housing made self-isolation and physical distancing difficult or impossible.[47,48,56] Many First Nations people were trying to keep their families and communities safe while navigating divided opinions within their families about public health measures, including vaccinations and isolation. These stressors had severe impacts on the health and wellness of First Nations people, including Elders, who were prevented from passing on ancestral knowledge within their communities.[58,59] Women and girls, children and youth, and **2SLGBTQQIA+** people were also disproportionately impacted by COVID-19 response measures, as well as by associated increases in discrimination and violence, and reduced access to social support and services.[j,60,61,62]

[j] For more information on societal and cultural impacts, please see the FNHA's Statement on the Societal Consequences of BC's COVID-19 Response: https://www.fnha.ca/Documents/FNHA-COVID-19-Statement.pdf.

Working closely with the OPHO and regional health authorities, the FNHA continues to support BC First Nations as they respond to and recover from the health impacts of COVID-19. Vaccination has been a major line of defense against COVID-19 and continues to provide protection against severe outcomes. After extensive advocacy efforts by Indigenous leadership to provincial and federal governments, all Indigenous people age 18+ and individuals living in rural and remote Indigenous communities in BC were given priority in the delivery of COVID-19 vaccines and booster shots.[53,63] Still, settler-colonial health systems have long histories of Indigenous-specific racism and not being trustworthy for First Nations people, resulting in heightened levels of **vaccine hesitancy** among some First Nations people. The FNHA worked alongside First Nations and other Indigenous health system leaders—including BC's Deputy Provincial Health Officer, Indigenous Health—to transform this hesitancy into *vaccine confidence* and to support First Nations self-determination by providing First Nations communities with credible information and inviting them to monthly webinars to ask questions about vaccinations and public health measures. Only by holding themselves accountable and demonstrating increased trustworthiness can regional health authorities and other health system partners address vaccine hesitancy among First Nations people in BC. Table 1.1 summarizes vaccination coverage rates among Status/Status-eligible First Nations people in BC.

Table 1.1. COVID-19 Vaccination Coverage Rates Among Status/Status-eligible First Nations People in BC, as of January 3, 2023

	DOSE 1	DOSE 2	DOSE 3	DOSE 4
Age 5 - 11	36.6%	23.3%	-	-
Age 12+	83.5%	78.8%	42.2%	18.0%

Note: These data are from the First Nations Health Authority's Coronavirus disease (COVID-19) community situation report dated June 27, 2023.[53]

There is clear evidence that the COVID-19 vaccine has been effective at reducing negative health outcomes associated with the virus. Analyses run in September 2022 show that the COVID-19 vaccine resulted in lower rates of COVID-19-related hospitalizations and deaths between January 1, 2022, and September 17, 2022. For example:

- The age-standardized rate of hospitalization among unvaccinated First Nations people in BC (age 18+) was nine times higher than the rate among First Nations people who had received at least three doses of the COVID-19 vaccine.[53]
- The age-standardized rate of critical admission (i.e., under serious medical duress) to hospital among unvaccinated First Nations people in BC was 14 times higher than the rate among First Nations people who had received at least three doses of the COVID-19 vaccine.[53]
- The age-standardized mortality rate due to COVID-19 (with COVID-19 as the underlying cause of death) among unvaccinated First Nations people in BC was 10 times higher than the rate among First Nations individuals who had received at least three doses of the COVID-19 vaccine.[53]

Despite the inequities and challenges posed by the pandemic, First Nations communities also reported positive impacts. These included having time to reconnect with the land and nature, using technology creatively to maintain social and cultural connections,[64,65] and being able to focus on learning and sharing traditional teachings, Indigenous languages,[66] and land-based harvesting and subsistence practices.[67,68,69] These approaches to health and wellness are rooted in cultural strengths and values such as resilience, spirituality, and taking care of one another.

INDIAN RESIDENTIAL SCHOOLS—MISSING CHILDREN AND UNMARKED GRAVES

On May 27, 2021, Tk'emlúps te Secwépemc shared the news of an act of genocide connected to the former Kamloops Indian Residential School. The use of ground-penetrating radar detected the remains of 215 children who had been students of the school, buried in unmarked graves. The children's disappearances had been spoken of, but never documented by school administrators. The 215 came to be known as "Le Estcwéy̓"[70] or "Le Estcwicwéy̓"[71] (The Missing), and the confirmation of their unmarked graves began the renewed movement of First Nations across the country using ground-penetrating radar to search the sites of other former residential schools.[70] These efforts, combined with previous reports and investigations, led to the identification of ever-increasing numbers of unmarked graves. As of May 2023, the National Centre for Truth and Reconciliation reported that it had documented the deaths of 4,135 First Nations, Inuit, and Métis children in residential schools across the country.[72] In reality, the number of Indigenous children lost through Canada's residential school system is known to be much higher.[73,74] Although First Nations and other Indigenous Peoples have always known that many children did not return home from residential schools, the detection of unmarked graves at former residential school sites has provided more proof of the harms and horrors of settler colonialism and the genocide enacted through the Indian residential school system.[75] It has also re-traumatized many Indigenous individuals, families, communities, and Nations in BC, Canada, and around the world, and prompted more calls for truth before reconciliation, accountability, and renewed resistance to the ongoing forces of settler colonialism.

Moving Forward

Advancing inherent First Nations Peoples' rights and restoring balance requires that non-First Nations people and institutions dedicate focused attention to arresting and dismantling settler-colonial systems and policies that perpetuate harms and inequities. Redressing this legacy of harm and working toward true reconciliation also requires recognizing hard truths and replacing damaging settler-colonial systems and policies with supportive systems and policies that honour and uplift First Nations ways of knowing. Supportive systems and policies will also promote sustainable connections to culture, ceremonies, spirituality, and the land, and the ability to transmit ancestral knowledge seamlessly to communities and youth.

First Nations Peoples have resisted and challenged oppressive settler-colonial systems since settler-colonial contact and have repeatedly called for accountability for the atrocities and harms inflicted. Settler-colonial governments have failed to respond appropriately and have lacked coherent approaches. On the one hand, federal and provincial governments have invested in social and economic programs, including specialized health services for First Nations people; on the other hand, they have persisted in their attempts to undermine the inherent rights of First Nations, including through lengthy, costly court battles.[76,77,78,79,80] In BC, the *Declaration on the Rights of Indigenous Peoples Act* (DRIPA) is a new lever, and one that both First Nations and the provincial government can use to engage in coherent, coordinated responses that uphold the rights of First Nations people in BC. Indeed, DRIPA has facilitated a new partnership, based on reciprocal accountability and mutual respect that acknowledges and celebrates the diverse histories, traditions, and teachings of First Nations Peoples. With First Nations leadership, such a partnership could support First Nations people and communities in

BC not only to maintain their health and wellness but also to thrive. Only then can the vision of healthy, self-determining, and vibrant BC First Nations children, families, and communities be achieved.

To reflect the changing landscapes of First Nations people's health and wellness in recent years, including substantial harms associated with the toxic drug crisis and COVID-19, this interim update report has been adapted from the original vision in three key ways. First, the timeline for reporting was delayed to accommodate the diversion of OCMO and OPHO resources to respond to the dual public health emergencies (the toxic drug crisis and the COVID-19 pandemic) and other significant health-impacting events in BC. Second, the scope of this report has been expanded to provide data about the consequences of the toxic drug crisis and COVID-19 pandemic for the health and wellness of First Nations people in BC. The negative impacts of these public health crises on some of the PHWA indicators (including mortality rates and life expectancy)[81,82,83,84,85] are discussed later in this report. Third, because the repercussions of the dual public health crises have been so substantial, the 10-year targets identified in the baseline report no longer reflect the goals of the PHWA; therefore, these targets are not included in this interim update. The targets are being reviewed by the PHWA partners, and a revised set of targets may be included in future reports in this series.

These events and emergencies and their disproportionate effects on the health and wellness of BC First Nations and First Nations people in BC have again highlighted the importance of upholding inherent Indigenous rights, advancing truth and reconciliation between First Nations and other BC residents, and improving relationships and coordination between the provincial and federal governments and BC First Nations. This includes the need for better emergency preparedness and response to improve both immediate and longer-term outcomes for First Nations people and communities during future public health emergencies.

Terminology

The terms "First Nations," "First Nations people," and "First Nations Peoples" are all used in this report, but they are not used interchangeably. The differences are sometimes subtle, but they are intentional. "First Nations" as a noun is used to refer to multiple Nations at the level of political and governing bodies ("First Nation" refers to a single Nation at this level). "First Nations" is also used as a descriptor, as in "First Nations woman," "First Nations Elder," or "First Nations languages." "First Nations people" refers to individuals, while "First Nations Peoples" is an all-encompassing term that includes individuals, families, communities, organizations, Nations, and other collective bodies.

As noted earlier in this chapter, in this report, the term "BC First Nations" refers to those Nations whose ancestral territories collectively form what is now known as the province of British Columbia. "First Nations people in BC" refers to all First Nations people in the province, including those whose ancestral territories are outside of BC. This distinction is important because only BC First Nations have Aboriginal title (rights to land and territory) and treaty rights in BC. However, all First Nations people (as well as Inuit and Métis) in BC have rights to health, wellness, and self-determination.

"Status Indian" is a legal term for a First Nations person in Canada who is subject to the provisions of the *Indian Act*. The *Indian Act* is an explicitly racist, sexist, paternalistic, and genocidal piece of legislation that impedes self-determination and gives the federal government undue control over the lives and identities of First Nations people.[86,87,88] Although the term "Status Indian" is still used in many datasets, including administrative datasets at the BC Ministry of Health, it is problematic and can be harmful to First Nations communities; therefore, this report uses the term "Status First Nations" in place of "Status Indian" when reporting on datasets that use this term. "Status First Nations" is a term that encompasses both people with legal status and those who are eligible for status but do not currently have legal status (also referred to as "Status-eligible").

"Indigenous" is a collective term for the Peoples who originally occupied the land now known as Canada. This includes Status and non-Status First Nations, Inuit, and Métis. First Nations, Inuit, and Métis are distinct Indigenous Peoples, and this report takes a distinctions-based approach wherever possible, focusing specifically on the health and wellness of First Nations people, families, and communities. However, some datasets report on Indigenous health and wellness more broadly and do not distinguish between First Nations, Inuit, and Métis data. The term "Indigenous" is also used in discussions that apply to broader groups and understandings of First Nations, Inuit, and Métis Peoples in BC and Canada.

Many charts in this report include data on "other residents" of BC. In addition to non-Indigenous people, the "other residents" category includes non-Status First Nations people and others who may identify as Indigenous, including Inuit and Métis people.

For more definitions, please refer to the glossary (Appendix C).

Data and Reference Notes

Appendix A provides a brief overview of the methodologies, sources, and limitations of the data presented in this report. Information on specific indicators is included in the chart notes for each figure and the report text that accompanies it. PHWA data come from live data sources that change over time, which can result in retroactively updated data. Although these retroactive changes make the data more accurate, they have also led to changes in the baseline values for many PHWA indicators; thus, these numbers may vary slightly from the numbers that appear in the PHWA baseline report. In addition, data presented by sex (female/male) in this report may reflect biological sex assigned at birth; therefore, Two-Spirit, transgender, non-binary, intersex, and gender-diverse people may be misidentified in the data.

Each indicator in this report is marked with one of the three symbols shown here. The symbols show whether changes in the indicators since the baseline report was published represent improvement in (green "up" arrow) or worsening of (red "down" arrow) the associated measure (health outcome or health determinant). The "no/minimal change" symbol (yellow "≈") indicates that there has not been a substantial change. Note that the direction of the arrow is *not* meant to represent the direction of the data trend for any given measure, since an increase in some measures (e.g., graduation rates) represents an improvement, whereas an increase in others (e.g., diabetes incidence) represents a worsening trend.

In this report, Indigenous territories of publication have been added to the references. Although the FNHA and OPHO have tried to ensure that the names provided for territories and Nations are accurate, there may be differences in how communities or Nations choose to identify their lands and territories. The FNHA and OPHO apologize in advance for any oversights, and we ask Nations to contact the OCMO at CMO.office@fnha.ca to report any errors or omissions.

Conclusion

This chapter has provided historical and current context on the health and wellness journeys of First Nations people in BC, the development of the PHWA, and some of the recent events impacting First Nations people in BC. The following chapters (2–4) provide updates on those PHWA indicators for which updated data are available.

PHWA reporting is intended to support the FNHA vision of *Healthy, Self-determining, and Vibrant BC First Nations Children, Families, and Communities*. Chapter 2 focuses on *Healthy, Self-determining Nations and Communities*; Chapter 3 focuses on *Supportive Systems* that uphold the overall FNHA vision; and Chapter 4 focuses on *Healthy, Vibrant Children and Families*. These concepts are presented separately to organize the information in this report, but the PHWA partners recognize that, in reality, these concepts are wholistic, interconnected, and inseparable.

Chapter 5 summarizes the progress made since the PHWA baseline report was published on the indicators presented in this report, and provides a brief overview of developments on the calls to action offered in the baseline report.

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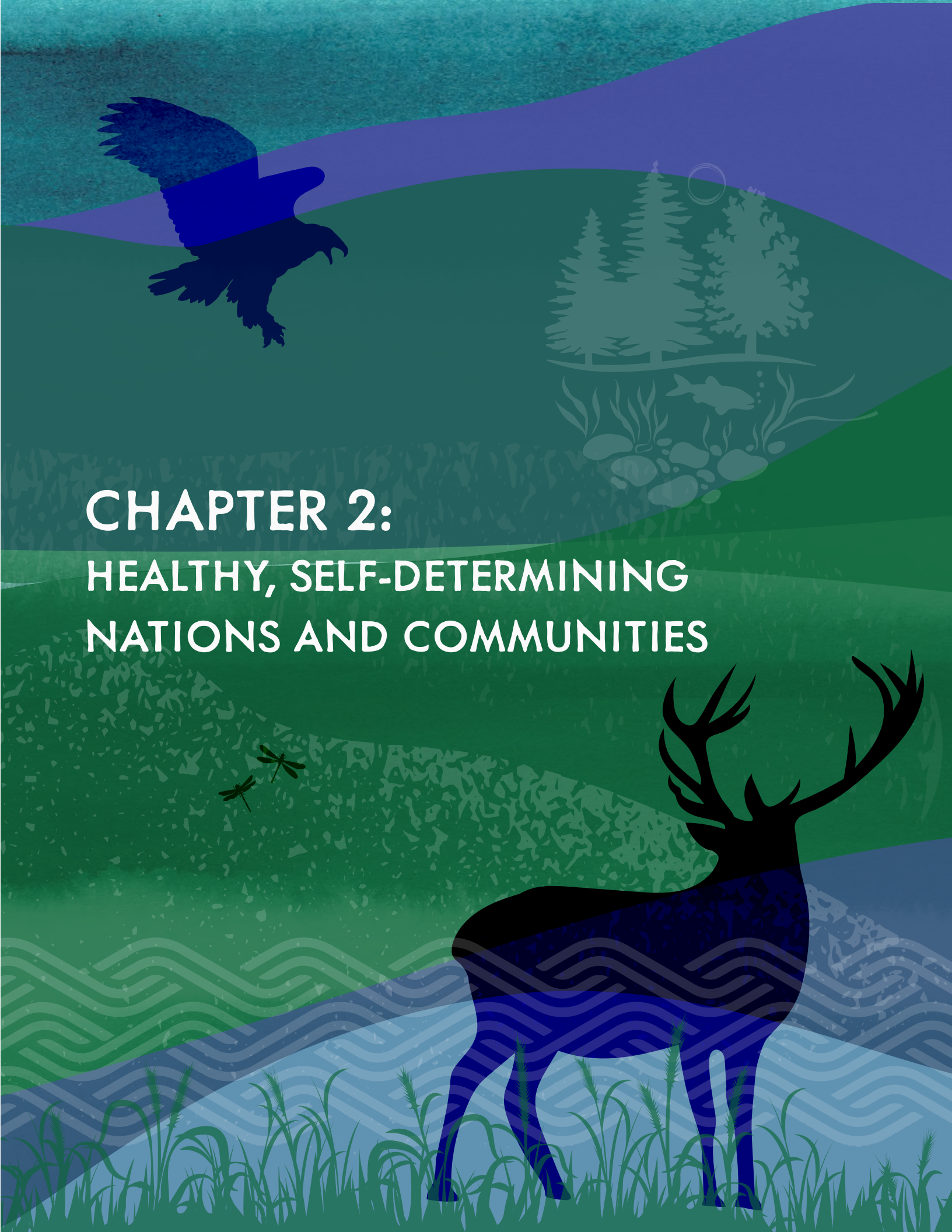

CHAPTER 2:
HEALTHY, SELF-DETERMINING NATIONS AND COMMUNITIES

The deeply interconnected concepts of self-determination, connection to land, connection to each other, and cultural wellness form the roots of identity, health, and wellness for First Nations people and communities.[1,2,3] For First Nations Peoples, wellness is intergenerational, and their connections to one another, to culture, and to land have been fortified by their ancestors. Many First Nations are reclaiming their connections, languages, lands, cultures, traditions, and ceremonies to support the wellness of current and future generations. The continual nourishment of the roots of health and wellness has supported many First Nations people to survive, heal, and remain resilient in the face of the attempted genocide[4,5] and systemic cultural and environmental devastation caused by settler colonialism, Indigenous-specific racism, and white supremacy.

The First Nations Population Health and Wellness Agenda (PHWA) baseline report identified three critical, culturally relevant indicators of First Nations population health and wellness within the sphere of healthy, self-determining Nations and communities: self-determination, connection to land, and cultural wellness. While these concepts may be expressed differently among Nations, they are foundational and vital to improving health and wellness outcomes for First Nations people in BC. No new data are available to provide an update on the cultural wellness indicator in this report. This chapter presents updates on work to develop meaningful ways to measure self-determination and connection to land.

Photo credit: CIRA.ca

Self-determination

Indicator	Self-determination		
Measure	Measure under development		
Baseline	N/A	First Interim Update	Qualitative updates included

Note: Improvements highlighted below represent progress on the important work of establishing and implementing ways to measure this indicator.

BC First Nations have fought since settler-colonial contact to assert their inherent right of self-determination. This right is now enshrined in provincial, federal, and international law. Section 35(1) of the *Constitution Act, 1982* states that "the existing Aboriginal and treaty rights of the Aboriginal peoples of Canada are hereby recognized and affirmed."[6(p.56)] Self-determination is also reaffirmed as an inherent right in Article 3 of the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP), which states 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."[7]

While interpretations of *self-determination* vary, it may be broadly defined as "the ability or power to make decisions for [one]self, especially the power of a nation to decide how it will be governed."[8] Self-determination is linked with other Indigenous rights such as data sovereignty,[9] food sovereignty,[10] and autonomy of economic and political institutions.[11] It is also associated with societal wellness and economic prosperity.[12] Self-determination includes the right to self-governance and decision-making power, particularly in relation to decisions that directly impact First Nations Peoples' health and wellness. This includes

ownership and control of data, including their own health data and research findings. For individuals and communities, it also includes the authority to make decisions related to their own health care and education, and the ability to practice one's culture and traditions. Self-determination has always been fundamental to First Nations Peoples; it is not a response to settler colonialism but *a way of being* that typically includes "a set of interlocking and reciprocal responsibilities to one's community, family, clans/societies (an aspect of some but not all [First Nations cultures]), homelands, and the natural world."[13(p.118)]

Most of BC is unceded land, meaning it was never legally ceded or signed over to the Crown or to Canada. Many BC First Nations that have signed historic treaties (e.g., Douglas Treaties, Treaty 8) maintain that the Treaty obligations of the Crown have not been upheld.[14,15] This has been confirmed in legal decisions such as *Yahey v British Columbia*.[16] As one aspect of self-determination, self-government (including through negotiated self-government agreements, but sometimes prompted by legal actions) provides a path away from the controls of the *Indian Act*.[17,18] One example of this is the landmark 2014 Supreme Court decision in the case of *Tsilhqot'in Nation v British Columbia*.[19] This unanimous ruling recognized that the Tsilhqot'in Nation continues to hold Aboriginal title over 1,700 square kilometres of land, and removed the Province of British Columbia's power to authorize logging in Tsilhqot'in territory without the consent of the Tsilhqot'in Nation.[19] This decision represents the first time in Canadian history that the Supreme Court "issued a specific declaration that Aboriginal title continues to exist today."[19(p.65)] This decision applies to "all parts of Canada where Aboriginal title has not clearly been extinguished."[19(p.80)] In April 2024, the Council of the Haida Nation and the Province of BC announced the signing of a historic, first-of-its-kind negotiated agreement—the *Gaayhllxid • Gíihlagalgang "Rising Tide" Haida Title Lands Agreement*—recognizing the Haida Nation's Aboriginal title in Haida Gwaii.[20]

Individual and collective self-determination are two dynamic processes that nurture and influence each other.[21] In other words, an individual's ability to be self-determining contributes to the collective self-determination of their family, community, and Nation. For many First Nations, true self-determination is limited by the *Indian Act*. For example, under that legislation, although members of a First Nation may vote for their preferred Chief and Councillors, the Chief and Council governance was a foreign process imposed

by settler-colonial understandings of governance.[22] Some Nations also maintain more customary governance systems, such as hereditary chieftainships where the title of Chief is passed down through familial lineages.[23] Sustainable self-determination is an ongoing process that both affirms ways of life that have continued to exist and restores ways of life that were almost stolen but are being reclaimed, despite the persistence of settler colonialism.[13] Self-determination includes the responsibility, freedom, and support to pass on traditions and teachings to future generations. Culture is both grounded in self-determination and a manifestation of the ability to be self-determining.

While many First Nations communities share the common goal of advancing self-determination, the ways in which they define and express this may differ. BC First Nations people who live "**away from home**" (i.e., off reserve and/or outside their ancestral territory) may exercise their self-determination differently from a BC First Nations person who lives in community.[k] For example, First Nations people have called for increased political representation in urban centres, identified the need to maintain First Nations rights and connections to culture in urban environments, and emphasized the importance of distinctions related to geography and place of residence (e.g., rural and remote communities, large cities, smaller urban centres).[24,25,26] However, the creation of such programs and services should always reflect the governance, protocols, and priorities of the territories they are on, in alignment with the principle of reciprocal accountability. The First Nations Health Authority's (FNHA) *Urban and Away-from-Home Health and Wellness Framework* is used to guide strategies and action plans to support the urban and away-from-home population, and is informed by community engagement that is responsive to their circumstances.[27]

[k] While First Nations people may choose to live away from home for a variety of reasons (e.g., educational, occupational, economic), the term "off reserve" may suggest to some that First Nations people have intentionally separated themselves from their territories, cultures, and traditions as well. The term "away from home" is therefore preferred.

Some First Nations have undertaken work that illustrates the multi-dimensional aspects of self-determination and how the unique priorities of individual communities can shape which attributes of self-determination are measured. Defining which indicators are most meaningful in terms of a community's own specific concepts of self-determination is itself an act of self-determination. For example, several First Nations communities have developed their own health and wellness indicators. By engaging directly with their communities, Nations are exercising their self-determination and ensuring that indicators are embedded in culture and capture the full breadth of health and wellness.[28] For example, the Nisga'a Nation in northwest BC developed a framework and survey with both quantitative and qualitative measures to assess their government's performance and the influence of modern treaty agreements on community well-being.[29] In a research paper that describes this work, the authors discuss the importance of ensuring that the survey was grounded in Nisga'a values, as opposed to applying existing well-being indicators developed by the federal government.[29] In administering its own survey, the Nation exercised its right to govern the design, access to, and use of its own data.

While First Nations have always known the importance of self-determination, there is a growing body of literature that demonstrates its impact on people's daily lives: specifically, how an increase in one's self-determination—characterized by a resurgence in culture, language, political power, and individual will—leads to better health and wellness outcomes.[3,13,30] The FNHA and Office of the Provincial Health Officer (OPHO) are working to co-develop a self-determination indicator with BC First Nations that will emphasize the critical role of self-determination for the health and wellness of First Nations Peoples in population health reporting. The next steps in advancing the self-determination indicator within the PHWA project include conducting a new literature review to consider best and **wise practices** for developing a measure for the indicator, followed by engagement with Nations individually to determine what aspects of self-determination would be most meaningful to measure.

Connection to Land

Indicator	Connection to land		
Measure	Measure under development		
Baseline	N/A	First Interim Update	Results of the We Walk Together project (2017–2023)

Note: Improvements highlighted below represent progress on the important work of establishing and implementing ways to measure this indicator.

Connection to land is a foundational determinant of health and wellness for First Nations Peoples[31] and provides the basis for culture, ceremony, language, and identity. Settler colonialism was achieved through the theft of First Nations lands and is sustained through ongoing occupation and exploitation. Settler-colonial governments used land theft as a means of assimilation and dominance, and as a tool of genocide and destruction of culture. Many BC First Nations communities have painstakingly resisted these thefts and occupations, including through numerous legal cases, to assert their unextinguished territorial rights.[32,33,34,35] This ongoing resistance is intended to reclaim connection to and stewardship of the land, and thereby support the restoration of cultural identity for First Nations Peoples. The land provides connection; traditional medicines; sustenance through hunting and gathering; links to First Nations ancestors, histories, and knowledge; and spiritual healing through land-based ceremonies.[36] As stewards of the land since time immemorial, First Nations have an inherent right and sacred responsibility to protect and sustain the land for future generations as their ancestors did.[37] This includes ceremony (e.g., praying for the land or for the fish to return; giving thanks during hunting and gathering) and promoting climate health (see text box). Connection to land and nature is an important aspect of health and wellness for urban and away-from-home First Nations people,[38,39] as well as for those living in their home communities. Connection to land, water, and territory has not been previously measured as an indicator in BC or included in population health reporting more broadly.

CLIMATE HEALTH AND CONNECTION TO LAND

"We, the first peoples of the lands, assert our inherent Title, Rights, and jurisdiction to lead the response to the climate crisis. We exercise our knowledge, laws, and processes in our self-determined ways to care for the Earth and ensure health and stability for generations to come."

- Vision of the *BC First Nations Climate Strategy and Action Plan* (2022)[40(p.10)]

In 2017, the FNHA's Office of the Chief Medical Officer and the OPHO initiated the We Walk Together project to explore the development of a culturally relevant, BC First Nations-led health indicator that measures connection to land, water, and territory. The project included regional gatherings with Elders, **Knowledge Keepers**, and youth on Stó:lō, Líl̓wat, and Lake Babine territories. The project explored the following questions:

- **What do Indigenous Knowledges tell us about connection to land and water as a determinant of health and wellness?**
- **How do BC First Nations describe connection to land, water, and territory? How do communities view this connection in relation to their health and wellness?**
- **How do we gather, uplift, and feature the knowledge and perspectives of First Nations Knowledge Keepers and community members to inform population health at a provincial scale?**

Three overarching themes were identified through the regional gatherings and were validated with participants to ensure they accurately represented their voices, stories, and knowledge.

THEME 1: ANCESTRAL KNOWLEDGE

Participants defined *ancestral knowledge* as knowledge passed down from ancestors. Land is the continual thread linking ancestral relationships. Ancestral knowledge is rooted in relationships to land and territory. Elders and Knowledge Keepers emphasized the importance of privileging Indigenous Knowledges and passing on knowledge to youth and future generations; however, the transmission of ancestral knowledge has often been disrupted by settler colonialism. Land-based healing allows First Nations to reclaim the ancestral knowledge that is theirs to pass down to future generations.

> **"Ancestral knowledge is blood knowledge. We know it in our bones, our DNA, as well as being passed down to us...there's a knowing when it comes to ceremony, there's a knowing when it comes to land and territory, animals, weather. I just know..."**
>
> – Wii Mediik (Marie Oldfield), Kitasoo/Xai'xais (Klemtu) Nation

THEME 2: LAND AND WATER WELLNESS

In defining land and water wellness, participants shared that "the wellness of the land and water is our wellness." Many First Nations people have a deep, spiritual connection with lands and waters that influences their health and wellness. Participants are grateful for the land and water for keeping them wholistically well by providing gifts such as creeks for bathing, cedar for traditional medicines and ceremonies, and traditional foods for sustenance. Understandably, First Nations Peoples worry about the impacts of pollution, industrial activities, and climate change on the environment and their wellness.

> **"I have spent time up at the mountain by the creek praying and meditating because that is something I have learnt from our culture is one of the ways to take care of my mental health."**
>
> – C'tičtəna'at (Mavis Pierre), Katzie First Nation

THEME 3: ACCOUNTABILITY

Participants described accountability as the FNHA, the OPHO, and other institutions acting to address the concerns shared by BC First Nations people and communities about their inherent rights and title, and relationships to land and territory. Participants want reconciliation but are aware that the path to it is not straightforward. They said that in order to move forward and improve the health and wellness of the land and people, a respectful and meaningful joint commitment by health system partners, industries, and First Nations communities is needed. The hope is to create change in ways that uphold the rights of First Nations Peoples to maintain connections with their lands and waters.

> **"One of the biggest things is when we are going to walk together, it is walking together, and it is accepting [each other]... We have healers, we have Knowledge Keepers, we have Medicine Walkers; it's accepting that and bringing it in and using it all, rather than it being, 'How do we incorporate this into the Western society...'"**
>
> - Sandra Fossella, xʷməθkʷəy̓əm (Musqueam) Nation

The findings from the We Walk Together project, as represented by these three overarching themes, reinforce the complex and integral connection First Nations Peoples have with their lands, waters, and territories. The project is just the beginning of exploring these deep relationships. More work is underway to engage with Nations across BC and apply these findings to the development of land-based indicators that are relevant at all levels: individual, Nation, and province.

For more information, please see the We Walk Together final report and videos at https://www.fnha.ca/what-we-do/chief-medical-office.

Conclusion

This chapter has defined and explored self-determination and provided examples of how connection to land and self-determination have been operationalized by BC First Nations. Self-determination is essential to reclaiming First Nations' connection to land, and together these two aspects restore well-being and create a strong foundation for healthy and vibrant First Nations individuals, families, communities, and Nations. The three themes outlined within the Connection to Land indicator—ancestral knowledge, land and water wellness, and accountability—identify areas of focus for First Nations, as well as for non-Indigenous settlers. For settlers, these themes highlight the importance of working to eradicate policies and practices that uphold colonialism, white supremacy, and Indigenous-specific racism, and that undermine First Nations self-determination and connection to land. Upholding the inherent rights of First Nations people and communities through anti-racist policies and actions will advance health and wellness. Future PHWA reports will highlight progress made with Nations on how best to develop and measure the complex indicators of self-determination and connection to land. Future reports will also provide updates on the Cultural Wellness indicator, when updated data are available.

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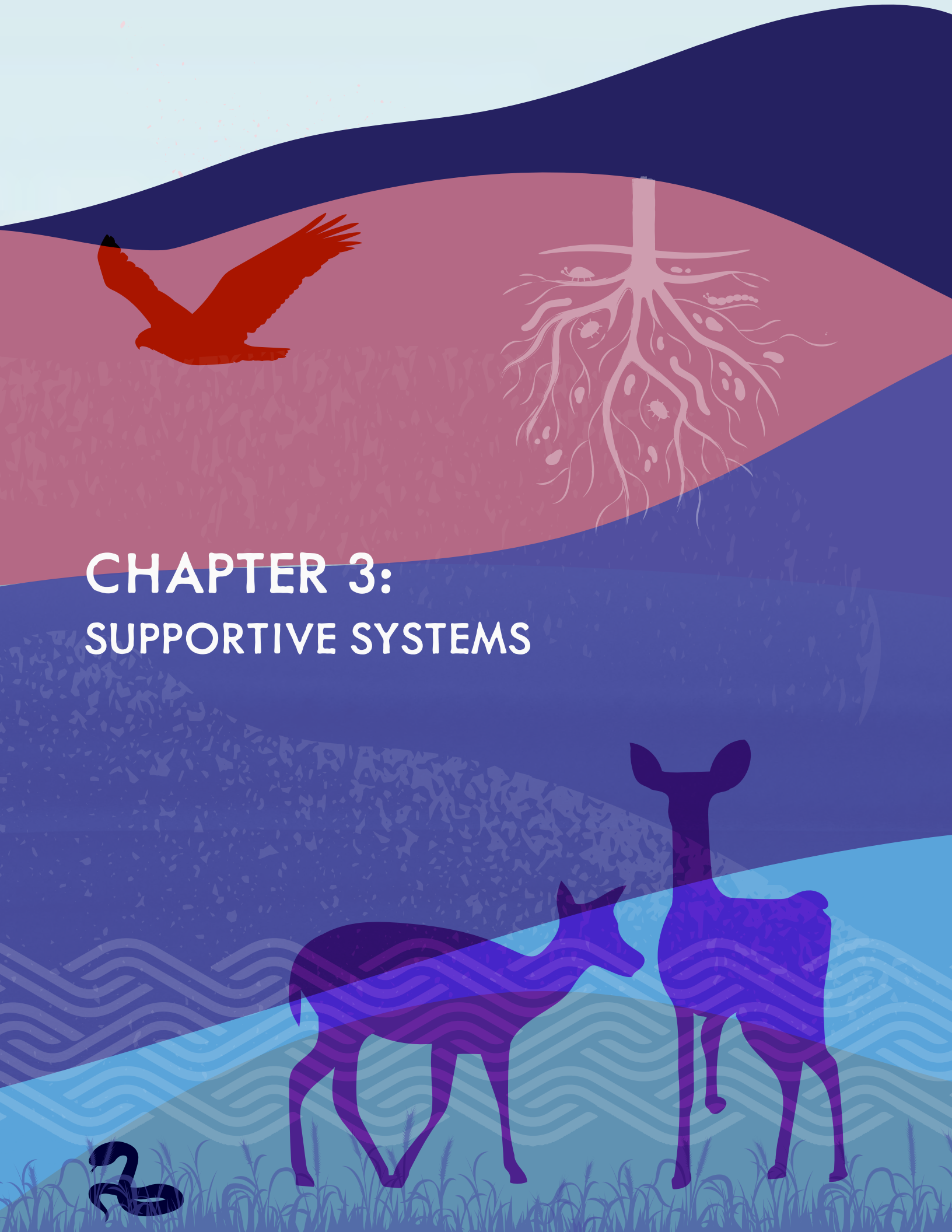


CHAPTER 3:
SUPPORTIVE SYSTEMS

This chapter discusses the social and structural determinants of health and wellness for First Nations people in BC. The ongoing legacy of racist settler-colonial policies that intentionally uphold white supremacy continues to erode many pre-existing, sustainable First Nations systems, including systems of health, education, housing, and food sovereignty, among others. This legacy results in poor health outcomes for many First Nations people. Supportive and equitable systems that are free of discrimination and Indigenous-specific racism, and that uphold First Nations rights, are essential to advance the health and wellness of First Nations people in BC.

The "supportive systems" domain of the First Nations Population Health and Wellness Agenda (PHWA) baseline report includes indicators and measures related to food (in)security, housing, education, and the health care system (avoidable hospitalizations, cultural safety and humility, and First Nations health care providers). Because updated data are not currently available for the food (in)security and housing measures presented in the baseline report, this chapter focuses on indicators related to effective and culturally safe systems of education and health care.

Education

Indicator	Education	Change	Improving
Measure	The proportion of students who complete high school within eight years of starting Grade 8		
Baseline	69.9% (2016/17)	First Interim Update	74.2% (2019/20)

Many First Nations approaches to learning view education as a life-long, real-world process that includes academic training as well as experiential and cultural teachings from communities, Elders, and Knowledge Keepers.[1] Education provided by Elders, Knowledge Keepers, and family members about Nation-specific harvesting techniques, ceremonies, landmarks, songs, and language, and other Nation-based teachings, are invaluable determinants of health and wellness for First Nations Peoples.[2,3] Cultural wellness, self-determination, and connection to land support these aspects of education by reflecting cultural continuity and the passing down of ancestral knowledge (see Chapter 2 for further discussion).[4]

Education in the mainstream settler-colonial system is also a determinant of health and wellness for First Nations people in BC, in part because it is interconnected with other determinants such as poverty, food security, housing, and employment.[5,6] Mainstream education systems are also a reminder of the devastating settler-colonial genocide and assimilation attempts inflicted upon First Nations children, families, and communities through the Indian Residential School System and *Indian Act*.[7] The BC school system reflects a Eurocentric approach to education based on settler-colonial values; for example, learning takes place in a classroom, and students are assessed using a proficiency scale or grades.

As discussed earlier in this report, settler-colonial governments and institutions have foundational obligations to honour and advance Aboriginal and treaty rights in the lands and territories now known as British Columbia and Canada. These obligations include (but are not limited to) actions to uphold the inherent rights of First Nations students, create safe and culturally safe learning environments, and promote true reconciliation through educational system improvements (for examples of these obligations, see text box: *A Few Key Foundational Obligations to Indigenous Peoples in the Education System*).[8,9,10]

HIGHLIGHT:
A Few Key Foundational Obligations to Indigenous Peoples in the Education System

- ***United Nations Declaration on the Rights of Indigenous Peoples* (2007) Article 15.1**. Indigenous peoples have the right to the dignity and diversity of their cultures, traditions, histories and aspirations which shall be appropriately reflected in education and public information.[11]
- **Truth and Reconciliation Commission of Canada (TRC, 2015) Call to Action 8.** We call upon the federal government to eliminate the discrepancy in federal education funding for First Nations children being educated on reserves and those First Nations children being educated off reserves.[8]
- **TRC (2015) Call to Action 64.** We call upon all levels of government that provide public funds to denominational schools to require such schools to provide an education on comparative religious studies, which must include a segment on Aboriginal spiritual beliefs and practices developed in collaboration with Aboriginal Elders.[8]
- **Assembly of First Nations National Youth Council *Calls to Action on Life Promotion in First Nations Communities* (2016) Call to Action 10.** All Canadian children learn about Canada's colonial roots and First Nations' pre-contact history to advance the restoration of respectful and equitable relationships between First Nations and the people of Canada.[12]
- **National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG 2SLGBTQQIA+, 2019) Call for Justice 11.1**. We call upon all elementary, secondary, and post-secondary institutions and education authorities to educate and provide awareness to the public about missing and murdered Indigenous women, girls, and 2SLGBTQQIA+ people, and about the issues and root causes of violence they experience. All curriculum development and programming should be done in partnership with Indigenous Peoples, especially Indigenous women, girls, and 2SLGBTQQIA+ people. Such education and awareness must include historical and current truths about the genocide against Indigenous Peoples through state laws, policies, and colonial practices. It should include, but not be limited to, teaching Indigenous history, law, and practices from Indigenous perspectives and the use of *Their Voices Will Guide Us* with children and youth.[9]
- **MMIWG 2SLGBTQQIA+ (2019) Call for Justice 14.9**. We call upon Correctional Service Canada, in order to support reintegration, to increase opportunities for meaningful vocational training, secondary school graduation, and postsecondary education.[9]
- **BC *Declaration on the Rights of Indigenous Peoples Act* (DRIPA) Action Plan (2022) Action 3.3**. Conduct an external review of Indigenous-specific racism and discrimination in the provincial public education system, and create a strategy, including resources and supports, to address findings.[10]
- **BC DRIPA Action Plan (2022) Action 4.2**. Develop and implement an effective recruitment and retention strategy to increase the number of Indigenous teachers in the K–12 public education system.[l,10]

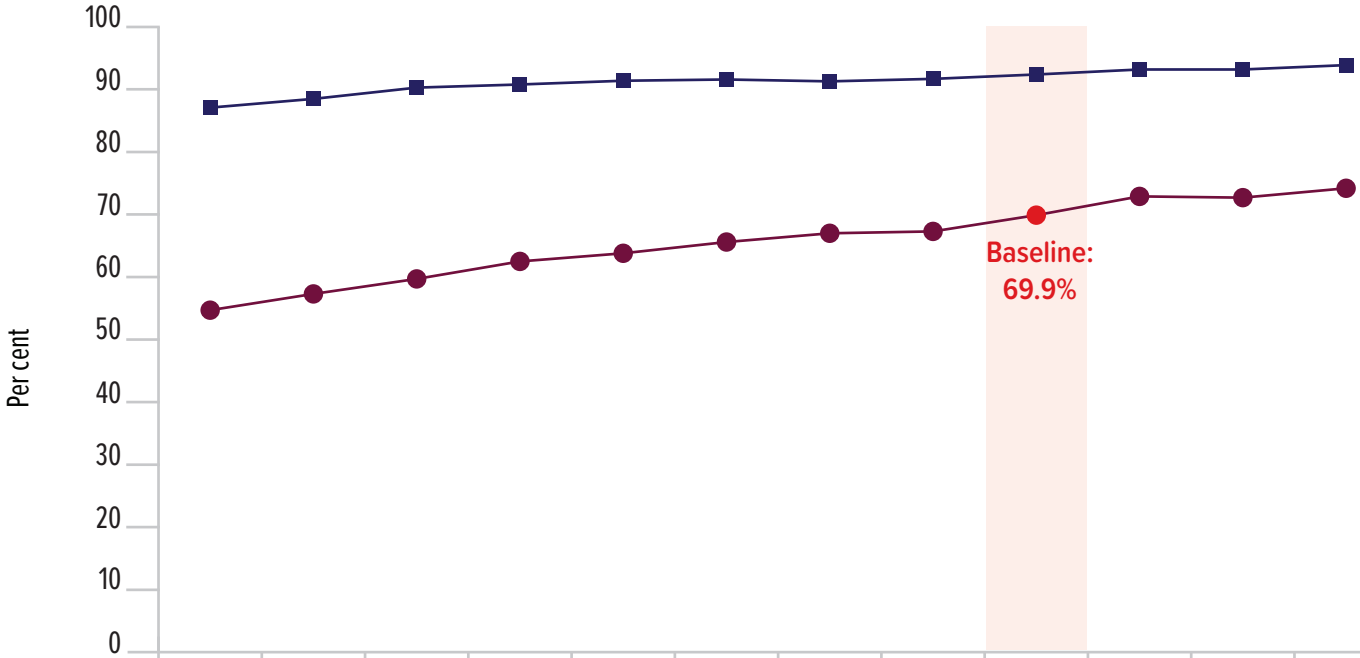
[l] "K–12" refers to the public grade school system from Kindergarten through Grade 12.

> "Like the thunderbird of old I shall rise again out of the sea; I shall grab the instruments of the white man's success — his education, his skills, and with these new tools I shall build my race into the proudest segment of your society."
>
> - Chief Dan George, səlilwətaɬ (Tsleil-Waututh) Nation, Lament for Confederation, July 1, 1967

The PHWA measures education by the percentage of self-identified Indigenous students who achieve a certificate of graduation or adult diploma within eight years of beginning Grade 8. This indicator includes public, private, and First Nations schools located away from home (off reserve) but does not include on-reserve schools; thus, many First Nations students in BC are not represented in the data. The measure itself does not provide a comprehensive representation of wholistic education, nor does it reflect First Nations ways of learning or knowing.[1] It also fails to evaluate the success of the mainstream education system in supporting First Nations learners. In the future, the PHWA will explore opportunities to enhance a two-eyed seeing approach to measuring education that better reflects both mainstream and First Nations education systems and approaches.

FIGURE 3.1

Percentage of Students Who Completed High School Within Eight Years of Starting Grade 8, Indigenous and Non-Indigenous Students, BC, 2008/09 to 2019/20



	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Indigenous - Per cent	54.7	57.3	59.8	62.5	63.8	65.6	67.0	67.3	69.9	72.9	72.7	74.2
Non-Indigenous - Per cent	87.1	88.5	90.3	90.8	91.4	91.6	91.3	91.7	92.4	93.2	93.2	93.9
Indigenous - Count	2,940	3,177	3,225	3,363	3,472	3,578	3,629	3,583	3,688	3,764	3,772	3,845

School Year

Notes: The "eight-year completion rate" is the proportion of students who graduate, with a British Columbia Certificate of Graduation or British Columbia Adult Graduation Diploma, within eight years from the first-time they enrol in grade 8, adjusted for migration in and out of British Columbia. The calculation includes both public and independent schools combined, but not on-reserve First Nations schools. "Indigenous" includes people who self-identify as having "Indigenous Ancestry" on a voluntary basis during school enrollment. This includes First Nations students (both Status and non-Status, living on and off reserve), Métis students, and Inuit students. Please see Appendix A for more information.

Source: Governance & Analytics Division, BC Ministry of Education and Child Care. Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, August 2023.

From 2016/17 to 2019/20, the percentage of Indigenous students who completed high school within eight years of enrolling in Grade 8 increased (from 69.9 per cent to 74.2 per cent) (Figure 3.1). This increase was statistically significant. Additional analyses by the BC Ministry of Education and Child Care, which supplied the data in Figure 3.1, revealed that through 2019/20, the eight-year completion rate for Indigenous females remained several percentage points higher than the rate for Indigenous males.[13] This was consistent with the trend shown in the baseline report. In comparison, the completion rate for non-Indigenous students in 2019/20 was 93.9 per cent.

The BC education system is working toward incorporating Indigenous history and teachings into the curriculum in accordance with Article 15 of UNDRIP.[m,11] Beginning with the 2023/24 school year, all students working to complete their BC Certificate of Graduation (high school diploma) must successfully complete four credits in Indigenous-focused course work.[14] This applies to students in public, independent, First Nations, and international ("offshore") schools using BC curriculum.

[m] Article 15, UNDRIP: Indigenous peoples have the right to the dignity and diversity of their cultures, traditions, histories and aspirations, which shall be appropriately reflected in education and public information.

Avoidable Hospitalizations

Indicator	**Avoidable Hospitalizations**	**Change**	**≈ No/Minimal change**
Measure	**Rate of avoidable hospitalizations per 10,000 population**		
Baseline	**73.3 per 10,000 population (2017/18)**[n]	**First Interim Update**	**72.6 per 10,000 population (2021/22)**

The rate of "avoidable hospitalizations" is often used as a marker of access to effective primary health care for a given population. This indicator measures admissions to hospital related to chronic diseases or conditions that can usually be well managed at home or in communities and should not typically require hospitalization. It does not include admissions related to self-harm, mental health, or interpersonal violence. High rates of avoidable hospitalizations may indicate that primary health care services are unsafe, ineffective, and/or inaccessible.[15,16]

The report *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care* indicated that Indigenous people experience inequitable access to primary preventative care services, which results in a disproportionate and avoidable reliance on emergency services and, in some cases, associated travel.[17] Having perpetuated centuries of discrimination against and trauma among First Nations Peoples, the Western medical system continues to demonstrate a lack of cultural safety, equitable treatment, and trustworthiness. Many First Nations people are forced to make the difficult decision to delay seeking medical care due to the risk of experiencing racism and/or unsafe care.[18] For the BC health care system to manage chronic conditions and improve the health outcomes of First Nations people, it must demonstrate trustworthiness by delivering primary care services that are accessible, effective, equitable, anti-racist, culturally safe, and complementary to First Nations traditions and traditional medicines.[19,20] Such approaches have been associated with lower rates of hospitalization and reduced use of emergency services.[19] The legal imperative for health care and related services to abide by Jordan's Principle (see text box) can reduce avoidable hospitalizations among children.

[n] The rate of avoidable hospitalizations in the PHWA baseline report was based on a 3–5 per cent overestimation of the BC population; this methodological issue has been corrected in this report. For more information, please see Appendix A.

A review of the health care experiences of Indigenous Peoples in BC found "a BC health care system with widespread systemic racism against Indigenous people. This stereotyping, discrimination and prejudice results in a range of negative impacts, harm, and even death. Indigenous women are particularly impacted."

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care[17(p.2)]

JORDAN'S PRINCIPLE

Jordan's Principle honours the short life of Jordan River Anderson, a young boy from Norway House Cree Nation in Manitoba. Jordan was born in 1999 with multiple disabilities and remained in a hospital in Winnipeg, far from his home community, from the time of his birth. When he was 2 years old, doctors were prepared to release him from the hospital, but the provincial and federal governments could not agree on who was responsible for financing the home care he required. Jordan died at the age of 5, having lived his entire life in the hospital because the federal and provincial governments failed to resolve their dispute.

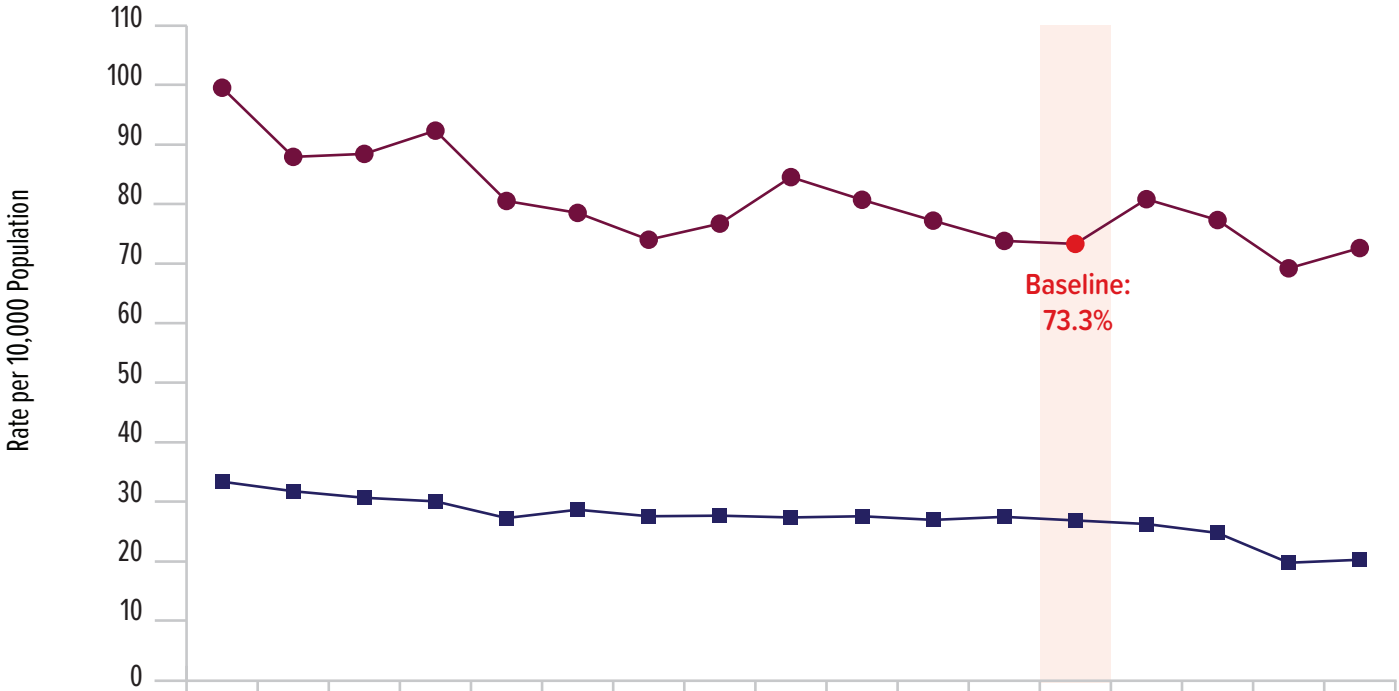
Jordan's Principle is a child-first principle to ensure First Nations children get the services they need when they need them.[21] The government of Canada is legally responsible for implementing Jordan's Principle, making sure that children get the care they need first, with any financial responsibilities worked out after the fact.

Indigenous activists worked for years to have Jordan's Principle enshrined in law to ensure that such jurisdictional issues would not impede care for other children. In 2016, the Canadian Human Rights Tribunal found that the government of Canada discriminated against First Nations children in its provision of services. The following year, the Canadian Human Rights Tribunal ordered the government to take an approach that considers the needs of each child, including in terms of substantive equality, culturally appropriate services, and acting in the child's best interests. Jordan's Principle ensures that First Nations children living in Canada have access to the social, health, and educational products, services, and supports they need to thrive. In relation to education, Jordan's Principle can be used to access school supplies, tutoring services, teaching assistants, specialized school transportation, psycho-education assessments, and assistive technologies and electronics.

For more information, please visit
https://fncaringsociety.com/jordans-principle and www.canada.ca/jordans-principle.

FIGURE 3.2

Age-standardized Rate of Avoidable Hospitalizations, Age 74 and Younger, Status First Nations and Other Residents, BC, 2005/06 to 2021/22



	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Status First Nations - Rate	99.5	87.9	88.4	92.3	80.5	78.5	74.0	76.7	84.5	80.7	77.2	73.8	73.3	80.8	77.3	69.2	72.6
Other Residents - Rate	33.4	31.8	30.7	30.1	27.3	28.7	27.6	27.7	27.4	27.6	26.9	27.5	26.9	26.3	24.8	19.8	20.3
Status First Nations - Events	906	846	864	944	834	851	856	900	1,003	982	962	966	995	1,098	1,087	1,008	1,050

Fiscal Year

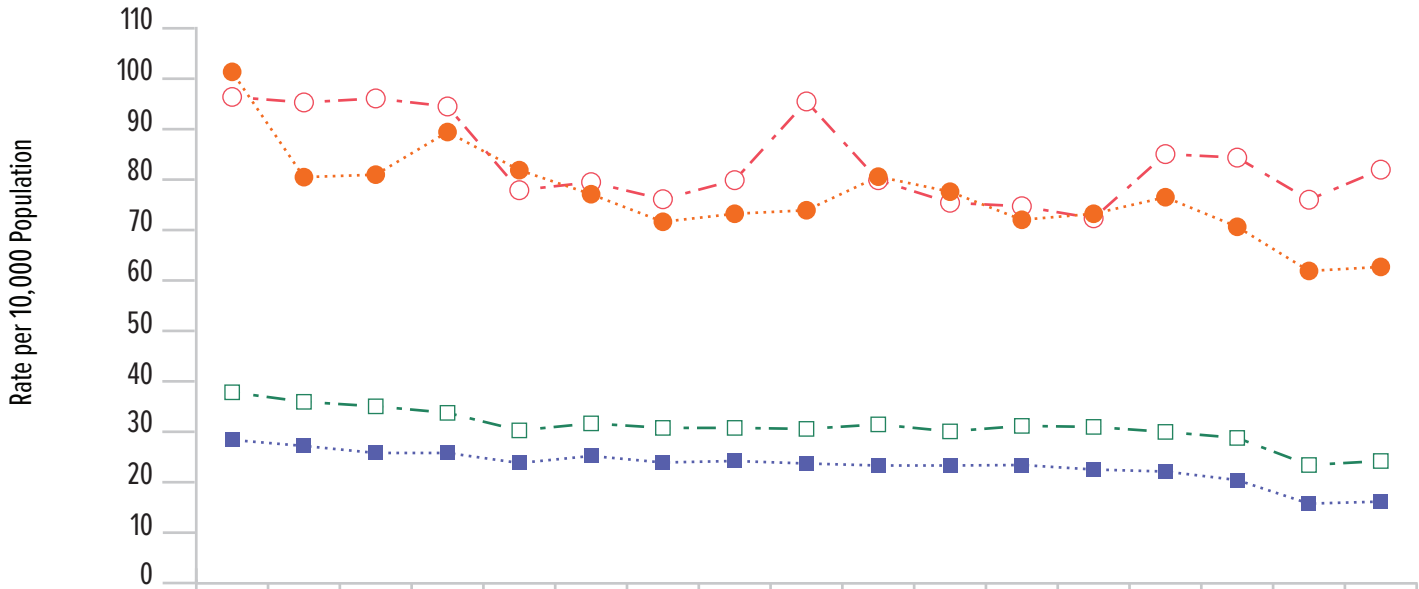
Notes: "Avoidable hospitalizations" are hospitalizations for long-term health conditions that can often be managed with timely and effective treatment in the community, without hospitalization. An event is one hospitalization. A patient may have multiple events during the reporting period. Standardized to the Canada 2011 population. Please see Appendix A for more information.

Sources: BC Ministry of Health, Discharge Abstract Database, Client Roster (Snapshot 2022), and First Nations Client File (Release 2020). Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, August 2023.

The rate of avoidable hospitalizations for Status First Nations people in BC fluctuated substantially between the 2017/18 (baseline) and 2021/22 fiscal years (Figure 3.2). After the rate reached a high of 80.8 per 10,000 population in 2018/19, it declined to 69.2 per 10,000 population in 2020/21. This may have been due to an overall decrease in hospital and other health care service use during the first year of the COVID-19 pandemic.[22] There was a subsequent increase in avoidable hospitalizations between 2020/21 and 2021/22 (to 72.6 per 10,000 population).

FIGURE 3.3

Age-standardized Rate of Avoidable Hospitalizations, Age 74 and Younger, Status First Nations and Other Residents, by Sex, BC, 2005/06 to 2021/22



	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Status First Nations Females - Rate	102.0	81.0	81.5	90.0	82.4	77.6	72.1	73.7	74.4	81.1	78.1	72.5	73.7	77.0	71.1	62.3	63.1
Status First Nations Males - Rate	97.0	95.9	96.7	95.1	78.4	80.0	76.6	80.4	96.1	80.4	75.9	75.2	72.8	85.6	84.9	76.5	82.5
Other Residents Females - Rate	28.6	27.4	26.0	26.0	24.0	25.4	24.1	24.4	23.9	23.5	23.5	23.6	22.7	22.3	20.6	15.9	16.3
Other Residents Males - Rate	38.1	36.2	35.3	34.0	30.5	31.9	31.0	31.0	30.8	31.7	30.3	31.4	31.2	30.2	29.0	23.6	24.4
Status First Nations Females - Events	474	407	419	461	435	446	434	445	462	508	489	484	509	547	517	463	467
Status First Nations Males - Events	432	439	445	483	399	405	422	455	541	474	473	482	486	551	570	545	583

Fiscal Year

Notes: "Avoidable hospitalizations" are hospitalizations for long-term health conditions that can often be managed with timely and effective treatment in the community, without hospitalization. An event is one hospitalization. A patient may have multiple events during the reporting period. Standardized to the Canada 2011 population. Data reported by sex (female/male) may reflect biological sex assigned at birth; therefore, Two-Spirit, transgender, non-binary, intersex, and gender-diverse people may be misidentified in the data. Please see Appendix A for more information.

Sources: BC Ministry of Health, Discharge Abstract Database, Client Roster (Snapshot 2022), and First Nations Client File (Release 2020). Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2023.

Between 2017/18 and 2021/22, there was an overall increase in the rate of avoidable hospitalizations for Status First Nations males (from 72.8 to 82.5 per 10,000 population), whereas the rate for Status First Nations females decreased (from 73.7 to 63.1 per 10,000 population) (Figure 3.3). The rate of avoidable hospitalizations among other resident males and females declined during this period. Rates for all populations decreased from 2018/19 to 2020/21, consistent with overall reduced hospital use during the first year of the COVID-19 pandemic. There were subsequent increases in avoidable hospitalizations for all population groups between 2020/21 and 2021/22, but the increase for Status First Nations males (from 76.5 to 82.5 per 10,000 population) was higher than that for Status First Nations females (from 62.3 to 63.1 per 10,000 population), resulting in an increase in disparity by sex.

Cultural Safety and Humility in Receiving Health Services

Indicator	Cultural Safety and Humility in the health care system	**Change**	N/A
Measure	Percentage of First Nations people who report that their care provider was respectful of their culture and traditions		
Baseline	Acute care – 68.8 per cent (2016/17) Emergency Department – 69.5 per cent (2018)	**First Interim Update**	Updated quantitative data not available; qualitative updates included

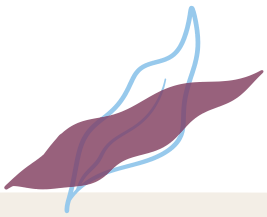
The qualitative updates provided below demonstrate ongoing work to embed cultural safety and humility in the BC health care system.

Creating cultural safety and humility in the health care system ensures that First Nations people can access safe, anti-racist, timely, and high-quality health care that upholds and affirms their rights to and perspectives on health and wellness. This aligns with UNDRIP Article 24.1, which states (in part) that "Indigenous individuals...have the right to access, without any discrimination, to all social and health services."[11] To demonstrate cultural safety, care providers must work proactively to reduce power imbalances in health care encounters and within the health care system. This involves having a deep understanding of and acknowledging "the truth that Indigenous-specific racism is perpetuated through white supremacist policies and practices that remain hardwired into our systems and processes, and that impede the health and wellness of Indigenous Peoples."[23] To promote cultural safety, care providers need to be aware of the negative health impacts caused by historical injustices and genocidal acts (e.g., Indian hospitals, residential schools, the Sixties Scoop and Millennium Scoop), as well as the impacts of ongoing settler colonialism and white settler-colonial privilege. This understanding is necessary to create environments that are free of racism, discrimination, and judgement.[24]

Cultural humility is a life-long process of self-reflection that requires health care providers to recognize systemic and personal biases, and to honour the perspectives and wishes of their patients.[24] By demonstrating trustworthiness and safety, health care providers enable patients to share their cultural beliefs, feel respected, and be heard.[25] This is critical in ensuring First Nations patients are provided the opportunity and space to exercise their right to self-determination and be the main decision-makers in their health and wellness journeys.[24]

Photo credit: disabled and here

Although the quantitative data for this indicator have not been updated since the baseline report was released, recent publications have made it clear that a large number of First Nations people continue to experience substandard and/or culturally unsafe care in BC, and that these experiences are underreported.[17,26] Reasons for underreporting vary: First Nations patients may find health system complaint processes complex, inaccessible, and/or unlikely to result in satisfactory outcomes. As a result, First Nations patients who have experienced inadequate care may choose not to report it because they have no reason to believe that the health system and regulatory bodies will adequately respond to their concerns. They may also be reluctant to report due to the potential for retribution or other repercussions (especially if they have access to only one or a small number of health care providers in or near their community), or because the reporting mechanisms themselves are culturally unsafe.[27] Efforts to improve cultural safety in health care complaint processes in BC are underway (see text box: *Obtaining Feedback from Individuals Receiving Care*).[27,28] In 2022, Health Quality BC published *Sharing Concerns: Principles to Guide the Development of an Indigenous Patient Feedback Process*, which provides nine core principles to improve feedback and complaint processes for Indigenous patients in BC.[29] These include ensuring that processes are grounded in Indigenous rights, cultural values, and traditional protocols; are Indigenous patient- and family-centered; are responsive, accountable, supportive, and trauma-informed; and remove unnecessary barriers to patient engagement.[29] For more information, see https://healthqualitybc.ca/wp-content/uploads/HQBC_IndigenousFeedback_v5.pdf.



OBTAINING FEEDBACK FROM INDIVIDUALS RECEIVING CARE

In 2019, the Cultural Safety Attribute Working Group, co-chaired by the First Nations Health Authority and BC Ministry of Health, made the following recommendations for ensuring cultural safety when obtaining feedback from individuals who are receiving care.

At a minimum, Primary Care Networks (PCNs) should discuss the collection of feedback with Indigenous partners and use community-driven approaches where possible. Health authority Indigenous or Aboriginal Health teams can help ensure alignment to a conscientious, culturally safe approach. PCNs would benefit from using the following options, which are not mutually exclusive:

a. **Simple digital mechanisms such as text message or online surveys.** This could help ensure confidentiality and anonymity, but may also be a barrier due to varying levels of technological literacy and access.

b. **Semi-structured interviews, talking circles, or focus groups.** These methods permit oral feedback and the potential to obtain richer data on individual experiences and areas for improvement; however, information should be collected through a neutral third party that is not associated with health care practitioners or staff.

c. **Community-based participatory approaches, such as community planning or advisory committees and Elder Advisory roles.**

d. **Nominations and recognition of the practice of cultural humility and culturally safe work for PCN practitioners and staff, or sites.** Identifying practitioners and/or clinics that embody cultural safety and cultural humility could enable others to seek care via these practitioners and providers.[27(p.23-24)]

   Such recognition could also provide an example of cultural safety and humility and allyship for the broader health care system, and encourage others to take up their own cultural safety and humility work.

Reports such as *Remembering Keegan: A BC First Nations Case Study Reflection*[26] (see text box: *Remembering Keegan Combes*) and *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care*[17] clearly demonstrate the ongoing lack of cultural safety and humility in the BC health care system. Racism was found to be widespread. During consultations for the *In Plain Sight* report, Indigenous people and health care workers shared their experiences of navigating the health care system in BC. The report's findings confirmed that First Nations people in BC are very likely to have had intergenerational and/or individual experiences within the BC health care system that were culturally unsafe, racist, and profoundly harmful.[17] For some First Nations people, the racism and lack of cultural safety they experienced led to premature death.[17,26] *In Plain Sight* also found that there has been no systemic effort in BC to protect and incorporate the right to use Indigenous traditional medicines and practices, and that health care providers were typically not open to hearing about traditional medicines.[17]

In December 2022, the BC Ministry of Health released a progress report on the recommendations from *In Plain Sight*. While some progress has been made, there is still much to do to ensure that the BC health care system is accessible and safe for all Indigenous Peoples.[30] Like these reports, initiatives such as Jordan's Principle and Joyce's Principle (both discussed in this chapter) provide important policy direction and guidance from First Nations people and communities. Such direction and guidance is critical to transforming the health care system and ensuring that First Nations children and patients of all ages receive timely, accessible, appropriate, compassionate, and culturally safe health care.

REMEMBERING KEEGAN COMBES

Sunrise: February 21, 1986 - Sunset: September 16, 2015

Keegan Combes was a 29-year-old man of Skwah First Nation who died in a BC hospital in 2015 following a delayed diagnosis and treatment after an accidental poisoning. Unfortunately, Keegan's experience was not an isolated incident. Indigenous-specific racism has become rampant in BC's health care system and has proven time and time again to be a matter of life or death. Telling Keegan's story is important as a way to bear witness, document culturally unsafe encounters within the health care system, and contribute to changing the system to prevent similar harms and deaths in the future.

Remembering Keegan: A BC First Nations Case Study Reflection[26] is the first case study of its kind shared by BC First Nations. The Fraser Salish Region of the First Nations Health Governance Structure publicly released the Case Study Reflection and gifted it in ceremony to the BC health care system on what would have been Keegan's 36th birthday, Monday, February 21, 2022. *Remembering Keegan* is an ongoing gift from Keegan to BC health system leaders. Everyone who works in health care is strongly encouraged to read the Case Study Reflection and its learnings and recommendations so they can take initiative and participate in the system-wide education and action required to make the recommended changes. Keegan is a transformer stone for the region: he brought together Stó:lō and Coast Salish leaders to start to transform the health system from a sickness model to a wellness model of care. Keegan's legacy has been to help shape the cultural safety and humility transformation that is currently underway in BC's health system.

You can read more about Keegan at https://www.fnha.ca/what-we-do/chief-medical-office/remembering-keegan.

In 2018, the First Nations Health Authority (FNHA) and Health Standards Organization entered into a partnership to develop the BC Cultural Safety and Humility (BC CSH) Standard, which was released in June 2022. Although there is much more work to be done, the BC CSH Standard is in alignment with Recommendation 8 from the *In Plain Sight* report:

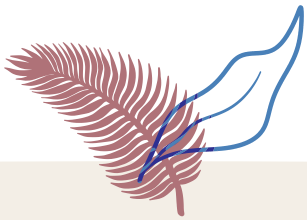
> "That all health policy-makers, health authorities, health regulatory bodies, health organizations, health facilities, patient care quality review boards and health education programs in BC adopt *an accreditation standard* [emphasis added] for achieving Indigenous cultural safety through cultural humility and eliminating Indigenous-specific racism that has been developed in collaboration and cooperation with Indigenous peoples."[17(p.191)]

The purpose of the BC CSH Standard is to "identify, measure, and achieve culturally safe systems and services that better respond to the health and wellness priorities of First Nations, Inuit, and Métis Peoples and communities, regardless of where they are located."[28] The BC CSH Standard is a tool to address Indigenous-specific racism and build culturally safe environments in health and social service systems across BC.[28] This is an important step in addressing health inequities and improving the quality, accessibility, and safety of services received by First Nations people. The intention of the BC CSH Standard is to hardwire cultural safety and humility within the BC health and social service systems and to demonstrate trustworthiness to First Nations Peoples, thereby increasing the accessibility and quality of services, and ultimately improving health and wellness outcomes for First Nations people in BC.

First Nations Health Care Providers

Indicator	Registered First Nations health care providers	Change	≈ No/Minimal change
Measure	Percentage of physicians, midwives, and nurses in BC registered with their respective colleges who self-identify as First Nations		
Baseline	Percentage of physicians in BC who self-identify as First Nations – 0.32 per cent (2019)	First Interim Update	0.39 per cent (2023)
	Percentage of midwives in BC who self-identify as First Nations – data not available in 2019		1.72 per cent (2023)
	Percentage of nurses in BC who self-identify as First Nations – data not available in 2019		1.54 per cent (2023)

First Nations health care providers play a pivotal role in making the health care system safer for First Nations people. The FNHA and OPHO are committed to breaking down barriers that impede the health and wellness of First Nations people; this includes advocating for services, policies, and programs that reflect the vibrant, diverse, and unique First Nations people and communities across BC and Canada.[31] Multiple foundational obligations have directed health care systems to recruit more Indigenous health care providers (see text box: *A Few Key Foundational Obligations to Indigenous Peoples with Respect to Indigenous Health Care Providers*). Only when health system partners and educational institutions are held accountable and challenged to critically examine and improve their practices and policies can the goals of equity, diversity, inclusion, and appropriate levels of representation in the health care workforce be reached. Health system partners and educational institutions in BC must, at minimum, strive to recruit, train, and graduate First Nations and other Indigenous health care providers at a rate that reflects the population that it serves. Upholding obligations to increase both the absolute numbers and proportions of First Nations health care providers will advance self-determination and true reconciliation efforts.



HIGHLIGHT:
A Few Key Foundational Obligations to Indigenous Peoples with Respect to Indigenous Health Care Providers

- Truth and Reconciliation Commission of Canada (TRC, 2015) Call to Action 23. We call upon all levels of government to:
  - i. Increase the number of Aboriginal professionals working in the health-care field.
  - ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
  - iii. Provide cultural competency training for all health-care professionals.[8]
- **National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG 2SLGBTQQIA+, 2019) Call for Justice 7.7.** We call upon all governments, educational institutions, and health and wellness professional bodies to encourage, support, and equitably fund Indigenous people to train and work in the area of health and wellness.[9]
- **MMIWG 2SLGBTQQIA+ (2019) Call for Justice 7.8**. We call upon all governments and health service providers to create effective and well-funded opportunities, and to provide socio-economic incentives, to encourage Indigenous people to work within the health and wellness field and within their communities. This includes taking positive action to recruit, hire, train, and retain long-term staff and local Indigenous community members for health and wellness services offered in all Indigenous communities.[9]
- ***In Plain Sight* (2020) Recommendation 14.** That the BC government, Provincial Health Services Authority, the five regional health authorities, BC colleges and universities with health programs, health regulators, and all health service organizations, providers and facilities recruit Indigenous individuals to senior positions to oversee and promote needed system change.[17]
- ***In Plain Sight* (2020) Recommendation 18**. That the BC government require all university and college degree and diploma programs for health professionals in BC to implement mandatory strategies and targets to identify, recruit and encourage Indigenous enrolment and graduation, including increasing the safety of the learning environment for Indigenous students.[17]

Calls to action are necessary to counteract the intentional exclusion of First Nations people from higher education as a deliberate part of settler-colonial policies. For nearly a century (1876–1961), Status First Nations individuals who attended post-secondary education lost their Status under the *Indian Act*.[32,33] Alongside widespread Indigenous-specific racism in educational and health care settings, this policy has effectively kept First Nations people out of many health care professions.

In addition to the harms done to First Nations people who were discouraged and prevented from becoming health care providers, patients also suffer under these policies. As discussed throughout this chapter, patients face ongoing harms due to racist and unsafe health care settings within a system that does not reflect or include them (see text box: *Joyce's Principle*). First Nations care providers may carry important ancestral and cultural knowledges that enable the provision of culturally safe care, while promoting the creation of safe spaces for First Nations patients to share their experiences and be seen and heard. Increasing the proportion of First Nations health care providers may also improve First Nations people's access to safe health care,[24,34] facilitate meaningful relationships between First Nations patients and health care providers who share similar lived experiences and understandings, and promote the weaving of First Nations Knowledges into the mainstream health care system in a two-eyed seeing approach. Providing greater access to services and culturally safer care will ultimately result in improved health and wellness for First Nations Peoples.

JOYCE'S PRINCIPLE

On September 28, 2020, Joyce Echaquan, a First Nations woman from Atikamekw Nation, died in a Quebec hospital after being denied appropriate and compassionate care due to racial discrimination. The subsequent investigation stated that "[t]he racism and prejudice that Mrs. Echaquan faced was certainly a contributing factor to her death." [35(p.20)]

Joyce Echaquan's inhumane treatment and death was another call to action for the health care system to address systemic Indigenous-specific racism and make health care safe and accessible for all Indigenous Peoples. The Council of the Atikamekw of Manawan and the Atikamekw Nation Council/Conseil de la Nation Atikamekw created "Joyce's Principle" with the following intention:

- Joyce's Principle aims to guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional, and spiritual health.
- Joyce's Principle requires the recognition and respect of Indigenous people's traditional and living knowledge in all aspects of health.[36(p.10)]

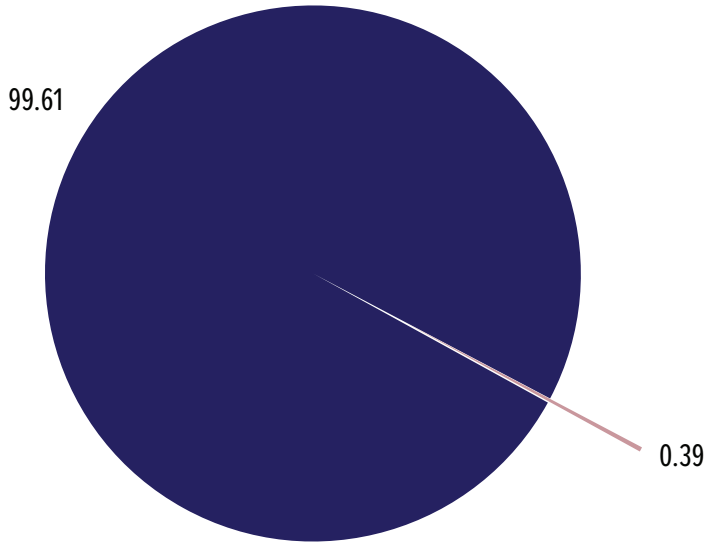
The federal government has since committed to the co-development of distinctions-based health legislation informed by Joyce's Principle.[37]

For more information, please visit https://principedejoyce.com/sn_uploads/principe/Joyce_s_Principle_brief__Eng.pdf.

By actively working to dismantle entrenched and discriminatory practices, policies, and attitudes, health system partners and educational institutions in BC can successfully recruit and support more First Nations people who are or who wish to be health care providers. This, along with concerted efforts to train, graduate, support, employ, and retain First Nations health care providers, is a positive step toward building a health care workforce and a health care system that reflects and better represents the First Nations population in BC. This important work will lead to improved health and wellness for First Nations people and communities.

FIGURE 3.4

Percentage of Physicians Registered with the College of Physicians and Surgeons of BC Who Self-identified as First Nations, BC, 2023



	2023
First Nations Physicians - Per cent	0.39
First Nations Physicians - Count	59
All Other Physicians - Per cent	99.61
All Other Physicians - Count	15,187

Notes: Physicians had the opportunity to self-identify as First Nations during registration of licensing for independent practice. The denominator is represented by a total of 15,246 physicians registered with the College of Physicians and Surgeons of BC (all ethnicities). There were a total of 150 Indigenous physicians, of whom 59 identified as First Nations. Please see Appendix A for more information.

Source: The College of Physicians and Surgeons of BC. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, March 2024.

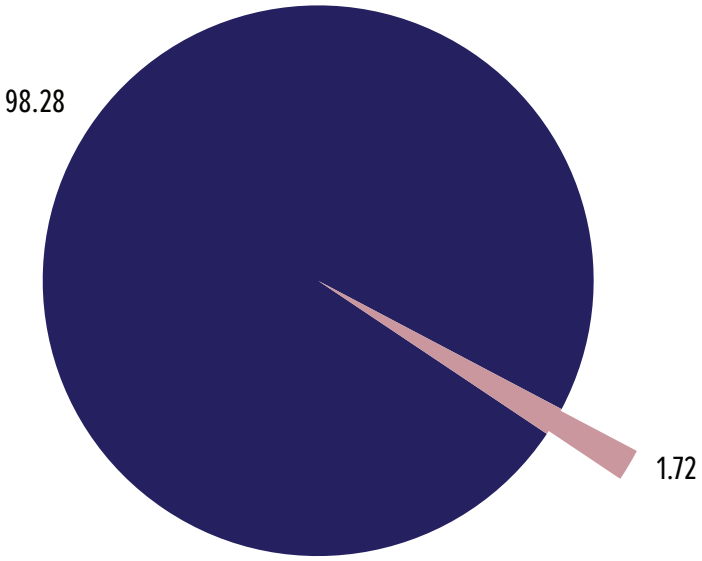
In 2023, First Nations physicians made up only 0.39 per cent of all physicians registered with the College of Physicians and Surgeons of BC (Figure 3.4). This represents a very small increase from the baseline of 0.32 per cent in 2019, and is not a statistically significant change. This equated to only 16 additional First Nations physicians over a four-year period, which may (at least in part) reflect increased self-identification or other factors rather than simply a greater number of physicians. It is also possible that some First Nations physicians may choose not to self-identify with the regulatory college.

In 2026, a new medical school will open at Simon Fraser University (SFU), in partnership with the FNHA and Fraser Health Authority, with the vision of embedding Indigenous knowledge systems into medical training to ensure graduates are equipped to meet the prevention and primary care concerns of BC's First Nations and other Indigenous communities. This includes collaborating with the FNHA, as well as First Nations and other Indigenous partners and communities, to ensure curricula incorporate anti-racism, cultural safety and humility, traditional approaches to health and wellness, and social determinants of health.[38] The opening of a new medical school offers potential to promote First Nations people's health and wellness, engage in meaningful recruitment of and support for First Nations medical students, and prioritize the hiring of First Nations and other Indigenous leaders and physicians familiar with the histories and medicines of local Nations and territories. SFU is considering how to create pathways specifically for Indigenous medical students and opportunities for them to learn from Elders and Knowledge Keepers.[39] The FNHA, the OPHO, and other First Nations and health system partners will be monitoring whether and how these ideas are implemented. Such approaches have the potential to increase cultural safety in the BC health system and a greater number of First Nations physicians in BC, though much more work is required at a systemic level to pave the way for transformative change.

After the publication of the PHWA baseline report, the FNHA and BC College of Nurses and Midwives (BCCNM) entered into a partnership that allows for the collection and sharing of data on the numbers and proportions of First Nations nurses and midwives in BC. These data are presented for the first time in this report. Building on this advancement, plans are underway for all regulatory colleges in BC to collect data on First Nations, Inuit, and Métis health care providers. The overarching goal is to prompt an increased focus on the recruitment and retention of First Nations and other Indigenous health care practitioners across the BC health care system.

FIGURE 3.5

Percentage of Midwives Registered with the BC College of Nurses and Midwives Who Self-identified as First Nations, BC, 2023



	2023
First Nations Midwives - Per cent	1.72
First Nations Midwives - Count	10
All Other Midwives - Per cent	98.28
All Other Midwives - Count	572

Notes: Midwives had the opportunity to self-identify as First Nations during registration of licensing. The denominator is represented by a total of 582 midwives registered with the BC College of Nurses and Midwives (all ethnicities). There were a total of 20 Indigenous midwives, of whom 10 identified as First Nations. Please see Appendix A for more information.

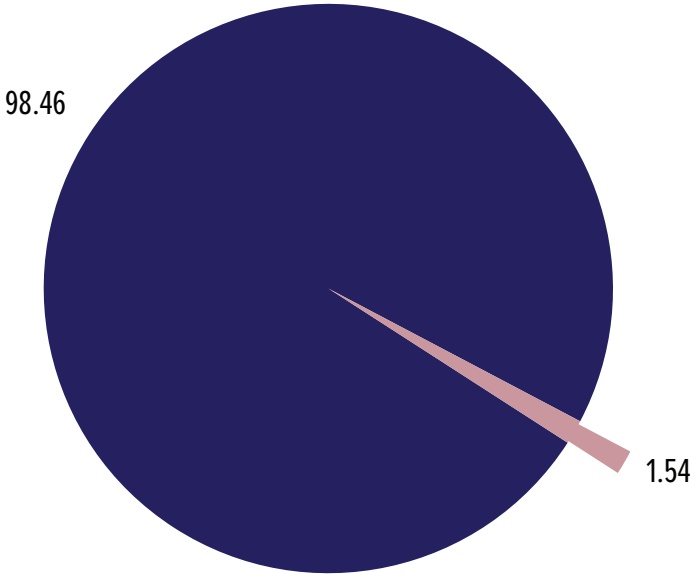
Source: The BC College of Nurses and Midwives. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, March 2024.

In 2023, there were 10 First Nations midwives in BC, which represented 1.72 per cent of all midwives registered with the BCCNM (Figure 3.5). Prior to settler-colonial contact, First Nations midwives had an important role in the physical and ceremonial aspects of pregnancy, childbirth, and the postpartum period.[40,41] Racist, patriarchal, settler-colonial policies that privilege the Western biomedical approach to pregnancy banned First Nations, Inuit, and Métis midwives,[42,43] which stripped communities of sovereignty over birthing and perinatal customs and the ability to practice and pass down ancestral midwifery knowledge.

Pregnancy, birth, and the postpartum period can be especially vulnerable, scary, and stressful times for many First Nations families due to the historical and ongoing traumas of settler colonialism, including those associated with Indian hospitals, forced birth evacuations, forced sterilization, child apprehensions, and racist experiences while receiving care. Increasing the number of registered First Nations midwives practicing in BC will support First Nations women, families, and communities in giving birth closer to home and in a culturally and physically safe environment where their languages and ceremonies are respected.[42] First Nations women, families, and communities are continuing to reclaim ancestral knowledge about pregnancy and birth, and Indigenous midwifery is on the rise.[43] First Nations women are powerful life-givers and matriarchs. Improving midwifery and other supports will contribute to reclaiming pregnancy, birth, and the postpartum period as times when First Nations women and other life-givers feel particularly empowered and connected to community, culture, and the land.[44]

FIGURE 3.6

Percentage of Nurses Registered with the BC College of Nurses and Midwives Who Self-identified as First Nations, BC, 2023



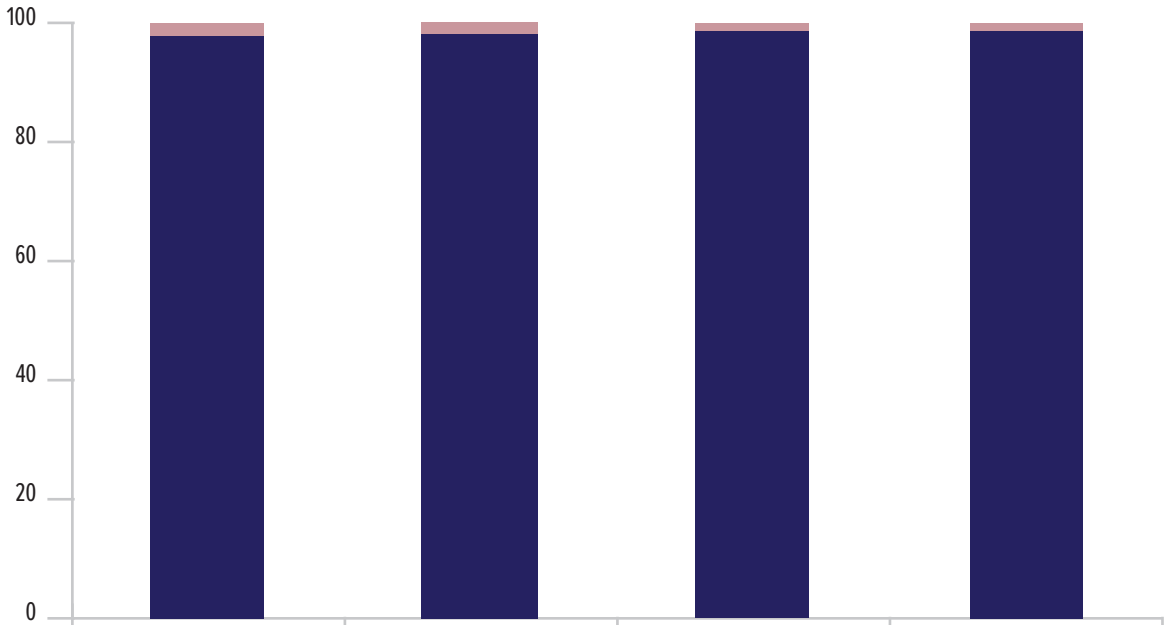
	2023
First Nations Nurses - Per cent	1.54
First Nations Nurses - Count	1,112
All Other Nurses - Per cent	98.46
All Other Nurses - Count	71,001

Notes: Nurses had the opportunity to self-identify as First Nations during registration of licensing. The denominator is represented by a total of 72,113 nurses registered with the BC College of Nurses and Midwives (all ethnicities). There were a total of 2,351 nurses who identified as Indigenous, of whom 1,112 identified as First Nations. Please see Appendix A for more information.

Source: The BC College of Nurses and Midwives. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, March 2024.

In 2023, First Nations nurses represented only 1.54 per cent of all nurses registered with the BCCNM (Figure 3.6). Although this proportion is higher than the proportion of registered First Nations physicians in BC, it is still only a fraction of the proportion of the BC population that is First Nations.[o]

FIGURE 3.7
Percentage of Nurses Registered with the BC College of Nurses and Midwives Who Self-identified as First Nations, by Nursing Type, BC, 2023



	Licensed Practical Nurses	Nurse Practitioners	Registered Psychiatric Nurses	Registered Nurses
First Nations	2.15	1.88	1.47	1.34
Other	97.85	98.12	98.53	98.66

Notes: Nurses had the opportunity to self-identify as First Nations during registration of licensing. There were a total of 72,113 nurses registered with the BC College of Nurses and Midwives (all ethnicities). There were a total of 2,351 nurses who identified as Indigenous, of whom 1,112 identified as First Nations. Please see Appendix A for more information.

Source: The BC College of Nurses and Midwives. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, March 2024.

Figure 3.7 shows the percentage of First Nations nurses registered with the BCCNM in 2023, by nursing type. While there is some variation, the range is quite small: First Nations Registered Nurses (RNs) represent the smallest percentage (1.34 per cent), whereas First Nations Licensed Practical Nurses represent the largest percentage (2.15 per cent). In September 2023, the BCCNM announced a new "certified practice for opioid use disorder (CP-OUD)" designation for RNs and Registered Psychiatric Nurses (RPNs).[p] The BCCNM reported that 110 RNs and RPNs in BC had the CP-OUD designation in 2023, and that fewer than 10 of them self-identified as Indigenous.

[o] According to 2021 census figures, First Nations people account for approximately 4 per cent of the BC population.

[p] For more information, please visit https://www.bccnm.ca/BCCNM/Announcements/Pages/Announcement.aspx?AnnouncementID=466.

On April 10, 2022, BC celebrated the inaugural BC Indigenous Nurses Day. It recognizes Indigenous nurses as champions in decolonizing health care systems and providing culturally safe, trauma-informed, and inclusive care for Indigenous communities in BC.[45] Indigenous nurses play an essential role in advocating for the blending of both traditional and Western practices to improve the health and wellness of Indigenous patients.[46] Because this knowledge and expertise is so vital, it is essential to continue work to increase the numbers and proportions of First Nations and other Indigenous nurses in BC.

Additional efforts are clearly needed to prioritize the recruitment, support for, and retention of First Nations health care providers in BC. First Nations health care providers have the potential to make a positive and powerful difference in the health and wellness of the people and communities they serve. Making improvements across all segments of this indicator is a vital part of substantially improving the health and wellness of First Nations people in BC.

Conclusion

This chapter has reviewed some of the ways that deeply embedded ideologies of white supremacy and racism have undermined supportive systems and impacted structural and social determinants of health and wellness for First Nations people in BC. Although First Nations high school graduation rates are increasing, incorporating First Nations ways of knowing into mainstream education systems in a better way remains a priority. Widespread racism deters First Nations people from seeking medical care, and creates both inequitable access to health care services and inequitable health outcomes. This continues to cause disproportionate numbers of avoidable hospitalizations among First Nations people. Increasing the First Nations health care workforce is a related priority that aims to improve the accessibility and cultural safety of health care services for First Nations people. The inclusion of data from the CPSBC, and the more recent addition of data from the BCCNM to PHWA reporting, informs this overall picture while challenging other health regulators to improve and prioritize the recruitment and retention of First Nations, Inuit, and Métis practitioners in their fields. Future reports will also provide updates on the Food Insecurity and Housing indicators, when updated data are available. In making strides toward true reconciliation, a continued shared focus on eradicating Indigenous-specific racism and white supremacy from the systems and structures that affect health outcomes for First Nations people in BC is paramount.

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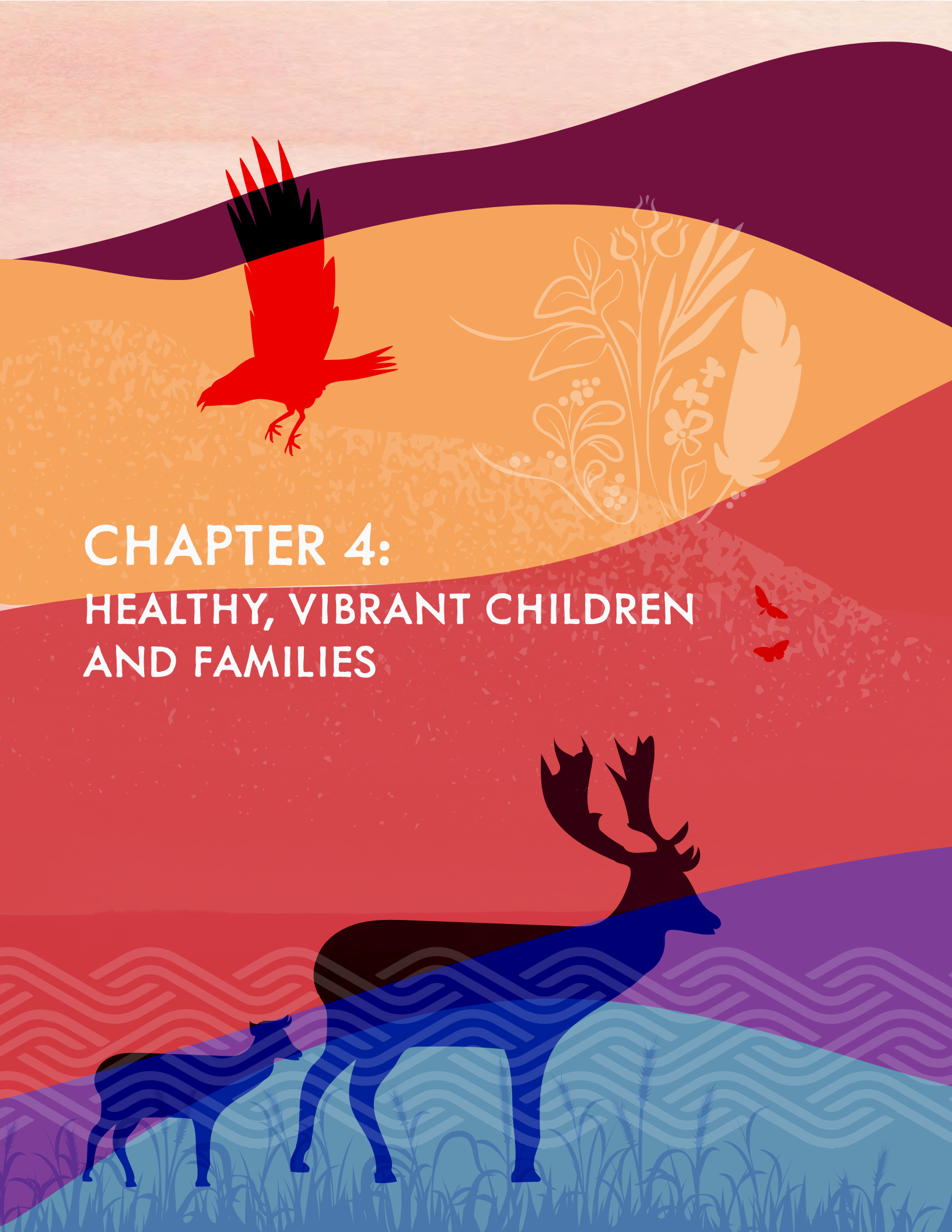


CHAPTER 4:
HEALTHY, VIBRANT CHILDREN AND FAMILIES

The First Nations Population Health and Wellness Agenda (PHWA) seeks to uphold the First Nations Health Authority's (FNHA) vision of healthy, self-determining, and vibrant BC First Nations children, families, and communities, which was set by BC First Nations themselves. Healthy beginnings are grounded in well-nourished roots of wellness and supportive systems that honour and uphold First Nations Peoples' truths and values, and increase First Nations self-determination. This includes self-determination over health and wellness journeys, which involve being connected to land and culture. Roots of wellness are nourished when systemic barriers are removed and equity in social determinants of health has been achieved. Supportive systems include culturally safe education and access to quality health care. This chapter presents updates on eight health and wellness indicators that support healthy, vibrant children and families.

Although several of the indicators in this chapter are inherently deficit-based, data are presented in a strengths-based way wherever possible. Strengths-based approaches "seek to move away from deficit-based understandings of individual and social problems and instead identify, study, and promote individual, social, and cultural capabilities for adaptation, resilience, growth, and well-being."[1(p.4)] Strengths-based interpretations can also promote awareness of health disparities between First Nations and other resident populations. Providing insights into the acute and root causes of these disparities highlights areas where targeted work is required, and facilitates progress toward improved First Nations individual, family, and community health and wellness.

Healthy Birth Weights

Indicator	Infants born at a healthy weight	Change	↓ Worsening
Measure	Percentage of singleton babies born at a healthy birth weight for their gestational age and sex		
Baseline	73.8% (2017)	First Interim Update	72.1% (2019)

Childbirth is a sacred event in many First Nations communities. Each Nation has distinct teachings, knowledge, and ceremonies that support the physical, mental, emotional, and spiritual health of the mother or birth parent,[q] baby, and other family members during pregnancy, birth, and infancy.[2] Settler colonialism disrupted these wholistic teachings and traditional birthing methods, and shifted the focus away from wellness to primarily biomedical aspects of childbirth. This intentional shift was due to settlers' willful ignorance and devaluation of the diverse cultures, histories, knowledges, and ways of knowing that have guided the health and wellness of First Nations Peoples since time immemorial.[3] This shift has resulted in Indigenous-specific racism in the health care system,[3] which has created incidents of trauma, untrustworthy health care providers, and a lack of culturally safe health care services. It has also resulted in severely compromised access to quality care and services for First Nations people who are pregnant, child-bearing, and parenting.

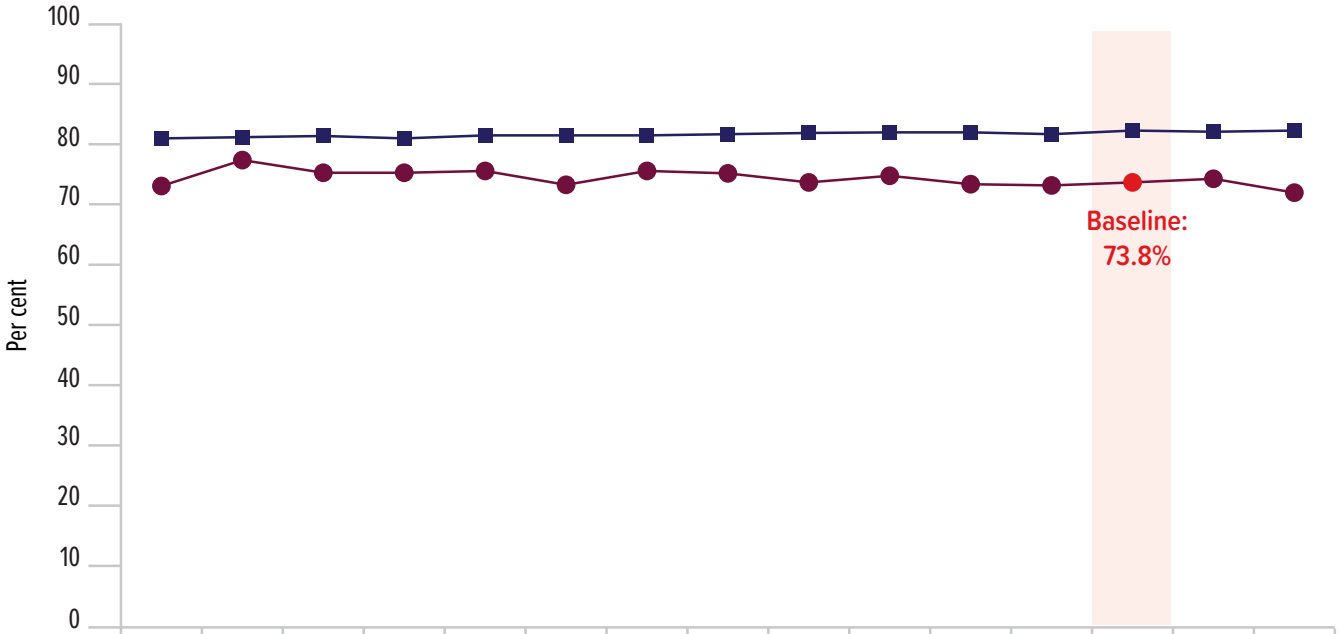
[q] While the words "mother" and "woman" are sometimes used in this chapter, the PHWA partners recognize that discussions of perinatal health and wellness may apply to cisgender females as well as to transgender men, non-binary people, and those who identify as Two-Spirit and/or "Indigiqueer."

Health care providers have a responsibility and a duty to reset their relationships with First Nations Peoples and patients, to be trustworthy, and to create safe spaces that promote culturally safe interactions with First Nations people while supporting their self-determination and autonomy.[3] Many First Nations communities are reclaiming traditional birthing practices to protect and advocate for the health of women, child-bearers, children, and future generations. Healthy First Nations infants reflect the presence of culturally safe, respectful, and supportive systems throughout pregnancy and childbirth, including health care, housing, and education.[4]

Healthy birth weight is an important indicator of health and wellness for the infant, the mother or birth parent, and the community at large. In this report, "Healthy Birth Weight" refers to live singleton babies with birth weights between the 10th and 90th percentiles for their gestational age and sex, based on a Canadian reference population.[5] Both low and high birth weights (i.e., those outside the "healthy birth weight" range) are linked to adverse outcomes.[2,6] Factors such as pre-existing and maternal/gestational diabetes in the birth parent are associated with higher birth weight babies.[2,6]

FIGURE 4.1

Percentage of Singleton Live Births at Healthy Birth Weight for Gestational Age and Sex, Status First Nations and Other Residents, BC, 2005 to 2019



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Status First Nations - Per cent	73.2	77.5	75.4	75.4	75.7	73.4	75.7	75.3	73.8	74.9	73.5	73.3	73.8	74.4	72.1
Other Residents - Per cent	81.1	81.3	81.5	81.1	81.6	81.6	81.6	81.8	82.0	82.1	82.1	81.8	82.4	82.2	82.4
Status First Nations - Count	1,937	2,037	2,062	2,060	2,009	1,928	1,871	1,857	1,725	1,708	1,612	1,603	1,467	1,475	1,280

Year

Notes: "Healthy birth weight" means the birth weight of a singleton live birth was between the 10th and 90th percentiles for the infant's gestational age and sex. Please see Appendix A for more information.

Sources: BC Vital Statistics Agency, data as of January 2023, BC Ministry of Health, Client Roster (Snapshot 2022) and First Nations Client File (Release 2020). Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, August 2023.

The percentage of Status First Nations babies born at a healthy birth weight in BC has not changed substantially in recent years, though it increased slightly from 73.8 per cent in 2017 to 74.4 per cent in 2018 before decreasing to 72.1 per cent in 2019 (Figure 4.1). Similar to what was reported in the PHWA baseline report for 2017, Status First Nations babies born in 2019 were more likely to be large (23.3 per cent) than small (4.2 per cent) for their gestational age and sex.[r,7] The gap between the percentage of Status First Nations babies and other resident babies born at a healthy birth weight widened slightly (by 1.7 percentage points) between 2017 and 2019.

[r] Percentages do not add up to 100 because the data include only those babies whose sex assigned at birth was either female or male.

Infant Mortality

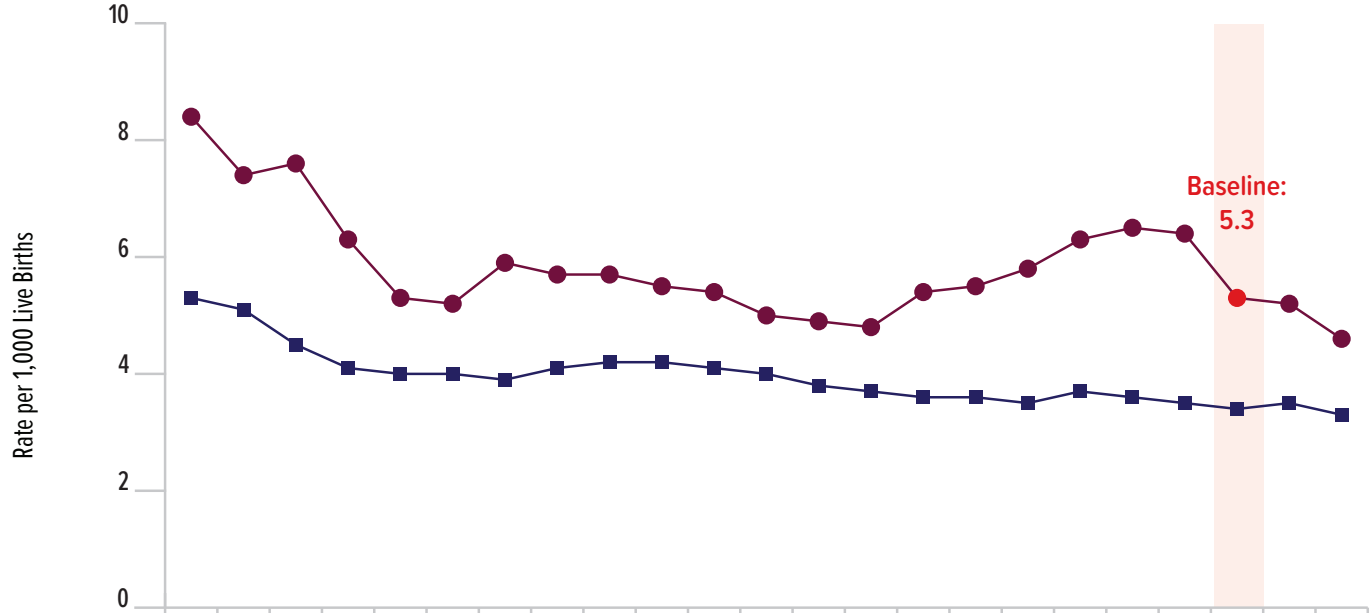
Indicator	Infant mortality rate	Change	Improving
Measure	Rate of infants who die within 365 days of birth (5-year aggregate)		
Baseline	5.3 per 1,000 live births (2013–17)	First Interim Update	4.6 per 1,000 live births (2015–19)

For First Nations Peoples, infants are sacred gifts from the Spirit World.[6] Many First Nations recognize infants as embodying innate wisdom and spiritual strength due to their close ties to the Spirit World; however, their bodies are still connected to the earth and need protection and care.[2,8] When a First Nations infant dies, each Nation has unique cultural practices and protocols to help guide the child to the Spirit World, and to allow the family and community to grieve and heal.[2]

Many infant deaths are preventable. Infant mortality is associated with factors such as poverty, food insecurity, unemployment, inadequate housing, lower levels of parental education and income, and lack of access to health care,[9] including quality prenatal care.[10,11] Factors such as ongoing colonialism and Indigenous-specific racism and discrimination have led to systemic barriers in access to quality, culturally safe maternal and prenatal care for First Nations and other Indigenous people.[2,12] Actions to reduce the risk of infant mortality due to underlying medical conditions and illnesses, as well as sudden infant death, include screening for treatable conditions at birth, immunizing people who are pregnant against vaccine-preventable diseases,[13] and providing culturally safe education and resources to promote safer sleep practices.[14,15,16] However, elevated rates of infant mortality among First Nations Peoples in Canada are recognized as "a direct result of [settler-]colonial policies and practices" that have led to substantial socio-economic and health inequities.[9] As with other indicators in this report, reducing infant mortality rates among First Nations Peoples requires focused work to eliminate systemic Indigenous-specific racism in health care and among health care providers, reset relationships with First Nations Peoples to build trust and stronger health care system engagement, and address inequities in the social determinants of health and their underlying causes.

FIGURE 4.2

Infant Mortality Rate, Status First Nations and Other Residents, BC, 1993-97 to 2015-19



	1993-97	1994-98	1995-99	1996-00	1997-01	1998-02	1999-03	2000-04	2001-05	2002-06	2003-07	2004-08	2005-09	2006-10	2007-11	2008-12	2009-13	2010-14	2011-15	2012-16	2013-17	2014-18	2015-19
Status First Nations - Rate	8.4	7.4	7.6	6.3	5.3	5.2	5.9	5.7	5.7	5.5	5.4	5.0	4.9	4.8	5.4	5.5	5.8	6.3	6.5	6.4	5.3	5.2	4.6
Other Residents - Rate	5.3	5.1	4.5	4.1	4.0	4.0	3.9	4.1	4.2	4.2	4.1	4.0	3.8	3.7	3.6	3.6	3.5	3.7	3.6	3.5	3.4	3.5	3.3
Status First Nations - Deaths	124	107	107	87	71	69	77	74	75	74	74	69	68	66	73	74	75	79	79	76	61	57	48

Years

Notes: "Infant mortality rate" is the number of infants who die in the first year of life, expressed as a rate per 1,000 live births. The infant mortality rate is assigned to the year of the child's birth. Rates for Other Residents infants might be overestimated due to Status First Nations identification issues in the data. Please see Appendix A for more information.

Sources: BC Vital Statistics Agency, data as of January 2023; BC Ministry of Health, Client Roster (Snapshot 2022) and First Nations Client File (Release 2020). Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, August 2023.

There has been a high degree of variability in infant mortality rates among Status First Nations people in BC over the past 30 years, but rates have declined in recent years (Figure 4.2). From the baseline of 5.3 infant deaths per 1,000 live births in 2013–17, the rate continued to trend downward, reaching 4.6 deaths per 1,000 live births in 2015–19. Although the gap between Status First Nations and other residents in terms of infant mortality rates has varied over time, it narrowed from a difference of 1.9 per 1,000 live births in 2013–17 to 1.3 per 1,000 live births in 2015–19. While this downward trend is a positive sign, it is important to remember that each infant death represents a profound loss for parents, families, and communities.

Children's Oral Health

Indicator	Children with healthy teeth	**Change**	N/A
Measure	Percentage of Indigenous kindergarten children who are cavity-free		
Baseline	**45.7%** (2015/16)	**First Interim Update**	Data excluded due to insufficient data quality

Several issues have emerged with respect to the quality of the data originally selected for this indicator. The main concern is that the data source lacks a consistent, appropriate, respectful, and distinctions-based approach to determining Indigenous identity. A more robust data source or sources will be chosen to measure progress on this indicator in future PHWA reports.

Oral health is an important component of health and wellness. Children's oral health is influenced by maternal/birth parent oral health, the knowledge and oral health practices of caregivers, and other social determinants of health.[17] First Nations people are often denied access to dental health services due to factors such as gaps in dental services coverage, geographical location (e.g., rural and remote communities), and past and ongoing settler-colonial violence and discrimination, including in the form of traumatic and untrustworthy dental practices.[3,4] The long-standing and ongoing history of unnecessary and painful dental procedures perpetrated upon First Nations and other Indigenous patients has included forced extractions of healthy teeth and dental work done without freezing. This has resulted in intergenerational trauma and a lasting aversion to going to the dentist for many First Nations people.[18,19]

Poor oral health in childhood can lead to tooth decay, infections, crowded and/or crooked adult teeth, speech issues, gum disease, pain, and difficulty eating or sleeping.[20,21] Pain can interfere with concentration and learning, and gum disease may contribute to health conditions such as heart disease and diabetes.[20] Poor oral and dental health can also lead to low self-esteem,[21] which has broader implications for overall well-being, mental health, and quality of life.

Coverage of oral health services for First Nations people in BC is managed by the FNHA. This coverage includes routine services such as regular cleanings, X-rays, root canals, and extractions, but limited coverage is provided for orthodontic treatment.[22] First Nations children who are not eligible for coverage may suffer years of chronic pain, debilitation, and associated health and wellness problems. The FNHA is committed to continuing to improve oral health education, services, access, and outcomes for First Nations people in BC. This commitment is reflected in programs such as the Children's Oral Health Initiative, which focuses on preventing tooth decay among children up to age 7 and their caregivers, as well as people who are pregnant, in First Nations communities.[23]

Tooth decay (also known as "dental caries" or "cavities") can be prevented, but it is still the most common childhood chronic condition.[21] In the PHWA baseline report, the "Children's Oral Health" indicator relied on data from the BC Dental Survey of Kindergarten Children program.[21] It provides data on "children with healthy teeth," defined as those who are cavity-free (i.e., with no visible decay or broken enamel), based on visual inspection of the children's teeth by dental professionals in schools and public health settings across BC. However, since the PHWA baseline report was released, more has been learned about this data source and methodology. The schools and health authorities do not use a consistent method of determining Indigenous identity, and the data reflect only visual inspection; therefore, they do not reflect Indigenous students' self-identification and the quality and consistency of the data are questionable. For these reasons, those data have been excluded from this report. Future PHWA reports will explore alternative ways to monitor dental care and/or oral health in BC.

Youth/Young Adult Suicide

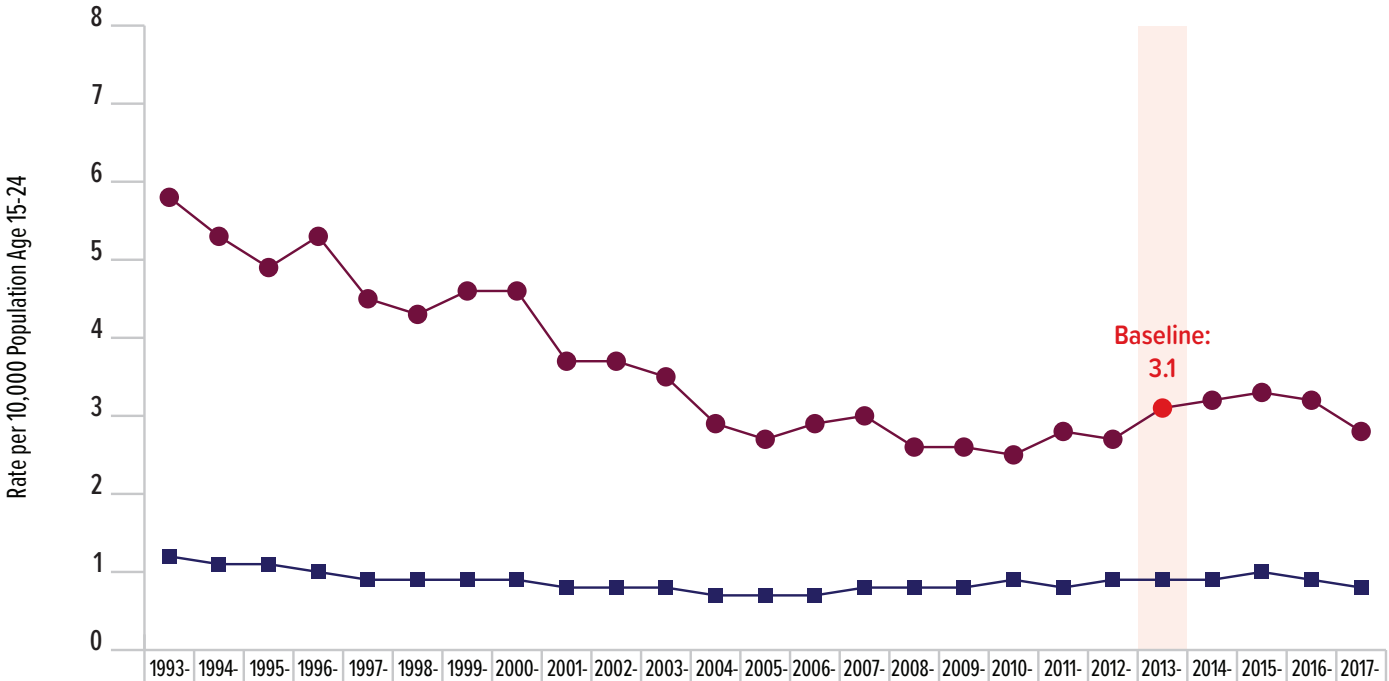
Indicator	Youth/Young adult death by suicide	Change	≈ No/Minimal change
Measure	Suicide mortality rate of youth/young adults age 15–24 (5-year aggregate)		
Baseline	3.1 per 10,000 population (2013–17)	First Interim Update	2.8 per 10,000 population (2017–21)

The available evidence, while limited, suggests that suicide among First Nations Peoples was rare before they came into contact with Europeans.[24] The series of cultural disruptions, dislocations, and other traumatic events introduced with European contact, settlement, and colonialism has led to a wide range of negative societal impacts, including increased rates of suicide.[24,25]

Suicide deaths in First Nations communities reflect the underlying impacts of ongoing settler colonialism and settler-colonial harms, including racism and discrimination, socio-economic exclusion, intergenerational and experiential trauma, forced relocations, collective suffering, and other injustices.[4] Colonial trauma, **lateral violence**, and other direct impacts of settler colonialism may also contribute to cultural disconnection, loneliness, and feelings of hopelessness among First Nations youth. Resources and supports for youth in crisis are insufficient, inaccessible, and difficult to navigate.[26] Stigma and shame related to mental health issues, suicidal thoughts, and seeking help can also isolate youth and prevent them from reaching out for support.[27,28] Together, these factors can have substantial negative impacts on mental health and wellness. This in turn may be linked to substance use and may affect judgement, increasing the likelihood of impulsive behaviour and suicidal thoughts or actions.[29] Suicide among First Nations youth has a devastating and lasting impact on families and communities. **Lateral kindness**, social and cultural connection, cultural continuity, self-determination, and control of ancestral lands, education, and health services have all been found to be protective factors linked to reduced youth suicide rates.[30]

FIGURE 4.3

Youth Suicide Rate, Age 15-24, Status First Nations and Other Residents, BC, 1993-97 to 2017-21



	1993-97	1994-98	1995-99	1996-00	1997-01	1998-02	1999-03	2000-04	2001-05	2002-06	2003-07	2004-08	2005-09	2006-10	2007-11	2008-12	2009-13	2010-14	2011-15	2012-16	2013-17	2014-18	2015-19	2016-20	2017-21
Status First Nations - Rate	5.8	5.3	4.9	5.3	4.5	4.3	4.6	4.6	3.7	3.7	3.5	2.9	2.7	2.9	3.0	2.6	2.6	2.5	2.8	2.7	3.1	3.2	3.3	3.2	2.8
Other Residents - Rate	1.2	1.1	1.1	1.0	0.9	0.9	0.9	0.9	0.8	0.8	0.8	0.7	0.7	0.7	0.8	0.8	0.8	0.9	0.8	0.9	0.9	0.9	1.0	0.9	0.8
Status First Nations - Deaths	65	59	55	60	51	50	55	57	47	49	47	41	39	43	45	40	39	38	42	41	46	47	48	45	39

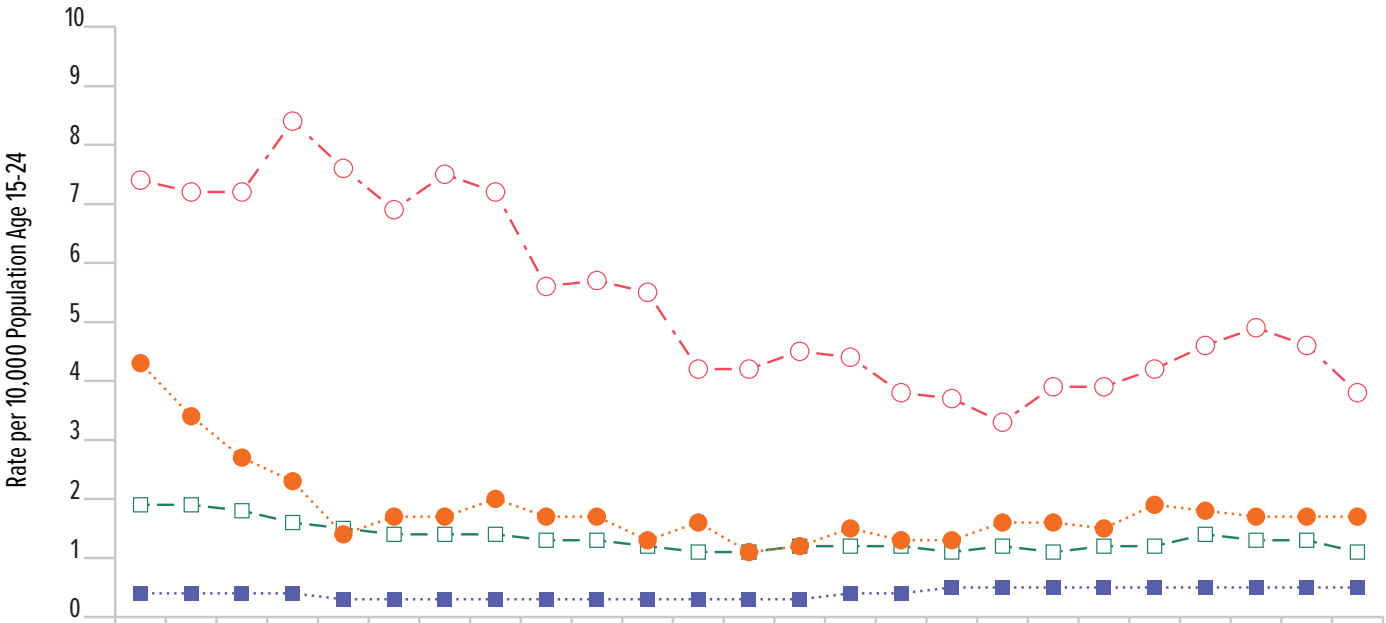
Years

Notes: There is up to a two-year delay in the reporting of deaths by suicide in BC; suicide deaths may therefore be underrepresented in the 2020 and 2021 data because deaths from these years may still be under investigation. Please see Appendix A for more information.

Sources: BC Vital Statistics Agency, data as of January 2023; BC Ministry of Health, Client Roster (Snapshot 2022) and First Nations Client File (Release 2020). Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, August 2023.

FIGURE 4.4

Youth Suicide Rate, Age 15-24, Status First Nations and Other Residents, by Sex, BC, 1993-97 to 2017-21



	1993-97	1994-98	1995-99	1996-00	1997-01	1998-02	1999-03	2000-04	2001-05	2002-06	2003-07	2004-08	2005-09	2006-10	2007-11	2008-12	2009-13	2010-14	2011-15	2012-16	2013-17	2014-18	2015-19	2016-20	2017-21
Status First Nations Females - Rate	4.3	3.4	2.7	2.3	1.4	1.7	1.7	2.0	1.7	1.7	1.3	1.6	1.1	1.2	1.5	1.3	1.3	1.6	1.6	1.5	1.9	1.8	1.7	1.7	1.7
Status First Nations Males - Rate	7.4	7.2	7.2	8.4	7.6	6.9	7.5	7.2	5.6	5.7	5.5	4.2	4.2	4.5	4.4	3.8	3.7	3.3	3.9	3.9	4.2	4.6	4.9	4.6	3.8
Other Residents Females - Rate	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Other Residents Males - Rate	1.9	1.9	1.8	1.6	1.5	1.4	1.4	1.4	1.3	1.3	1.2	1.1	1.1	1.2	1.2	1.2	1.1	1.2	1.1	1.2	1.2	1.4	1.3	1.3	1.1
Status First Nations Females - Deaths	24	19	15	13	≤10	≤10	≤10	12	11	11	≤10	11	≤10	≤10	11	≤10	≤10	12	12	11	14	13	12	12	12
Status First Nations Males - Deaths	41	40	40	47	43	40	45	45	36	38	38	30	31	34	34	30	29	26	30	30	32	34	36	33	27

Years

Notes: Data reported by sex (female/male) may reflect biological sex assigned at birth; therefore, Two-Spirit, transgender, non-binary, intersex, and gender-diverse people may be misidentified in the data. Small numbers (≤10) have been suppressed. There is up to a two-year delay in the reporting of deaths by suicide in BC; suicide deaths may therefore be underrepresented in the 2020 and 2021 data because deaths from these years may still be under investigation. Please see Appendix A for more information.

Sources: BC Vital Statistics Agency, data as of January 2023; BC Ministry of Health, Client Roster (Snapshot 2022) and First Nations Client File (Release 2020). Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2023.

The suicide rate among Status First Nations youth/young adults age 15–24 in BC has been variable since 1993–97, but there was an overall downward trend until 2010–14 (Figure 4.3). While there were increases between 2011–15 and 2015–19, they were likely due, at least in part, to a change in how suicide deaths have been reported since September 2014.[s] This change in reporting would be similarly reflected in the increased suicide rates for males and females since 2011–15 (Figure 4.4). Despite this reporting change, the overall suicide rate for Status First Nations youth has declined since 2015–19, from 3.3 per 10,000 population in 2015–19 to 2.8 per 10,000 population in 2017–21 (Figure 4.3). The rate has also decreased for males, from 4.9 per 10,000 population in 2015–19 to 3.8 per 10,000 population in 2017–21 (Figure 4.4). The corresponding rate for Status First Nations females is much lower, and has remained unchanged at 1.7 per 10,000 population since 2015–19.

In 2017–21, the rate of youth/young adult suicide remained more than three times higher for Status First Nations (2.8 per 10,000 population age 15–24) than for other residents (0.8 per 10,000 population age 15–24) (Figure 4.3). This is the case among both females and males (Figure 4.4).

Each data point in these charts represents the tragic death of a young person, the gifts they had to share and their futures unrealized. Each life lost is deeply felt throughout their entire community and in surrounding communities.[2] First Nations youth are shifting the conversation about suicide prevention and are increasingly paving the way for wholistic and cultural life-promotion efforts that build on strength, resilience, meaning, and purpose.[31,32,33,34]

[s] For details on this reporting change, please see www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/suicide.pdf (p.10).

Diabetes

Indicator	Diabetes incidence	Change	↓ Worsening
Measure	Age-standardized diabetes incidence		
Baseline	8.0 per 1,000 population (2017/18)	First Interim Update	8.5 per 1,000 population (2020/21)

Healthy eating and exercise have physical, mental, emotional, and spiritual benefits for First Nations Peoples.[2] Food is a unifier that brings together First Nations families and communities for social and cultural gatherings, where intergenerational relationships foster connection and the sharing of ancestral knowledge.[35] Prior to settler-colonial contact, First Nations Peoples in BC lived highly active lifestyles and ate healthy traditional diets. As a result, chronic conditions such as diabetes were virtually nonexistent among First Nations communities.[36]

Diabetes is a condition where the body is unable to produce enough insulin and/or to effectively use insulin, a hormone that regulates blood sugar. Diabetes is among the most common chronic diseases in Canada.[37] There are three main types of diabetes: Type 1, Type 2, and maternal or gestational diabetes. Type 1 diabetes (about 9 per cent of diabetes cases in Canada) most often begins in childhood and is typically managed with daily insulin injections.[37] Type 2 diabetes (the most common, representing about 90 per cent of cases) is sometimes called "adult-onset diabetes" because it frequently occurs in adulthood. Type 2 diabetes may be linked to factors such as genetic predisposition, obesity, unhealthy

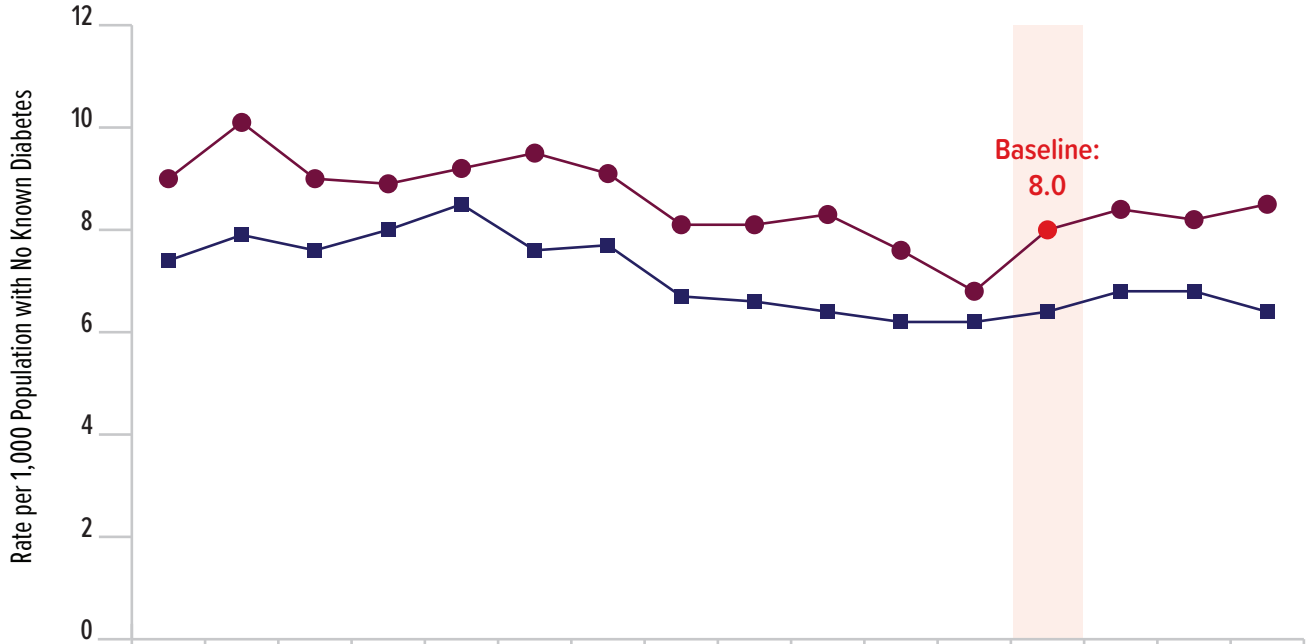
eating, tobacco use, income, and social and physical environments.[37] The third main type is maternal or gestational diabetes (representing fewer than 1 per cent of cases). This type of diabetes is first diagnosed during pregnancy. Although gestational or maternal diabetes tends to go away after delivery, it is associated with a high likelihood of the pregnant individual and/or their baby developing Type 2 diabetes later in life.[37] Diabetes incidence data in this report (Figure 4.5) include Type 1 and Type 2 diabetes, as well as other specified or unspecified diabetes types, and exclude gestational diabetes.

The intergenerational effects of the Canadian government's assimilationist policies and systems, including the Indian Residential School System, have contributed to high rates of diabetes among First Nations Peoples. Research has linked the hunger/starvation and malnourishment of First Nations children who were forced to attend residential schools with high rates of obesity, diabetes, and other chronic conditions—not only for those individuals, but also for their descendants.[38,39]

Many First Nations people in BC continue to live active, healthy lifestyles, which may include maintaining connections to traditional and/or wild foods. However, dispossession from their homelands and confinement to reserves has limited their ability to connect with the land and water, and often disrupted access to traditional foods. This has pushed many First Nations people into poverty and more sedentary lifestyles, and toward less nutritious diets.[40] This dietary shift typically includes increased amounts of simple sugars and saturated fats, as these are often key ingredients in more readily available, affordable, and highly processed market foods.[41] This has created a disproportionate impact on the rate of diabetes among First Nations Peoples.[42,43]

FIGURE 4.5

Age-standardized Diabetes Incidence Rate, Age 1+, Status First Nations and Other Residents, BC, 2005/06 to 2020/21



	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Status First Nations - Rate	9.0	10.1	9.0	8.9	9.2	9.5	9.1	8.1	8.1	8.3	7.6	6.8	8.0	8.4	8.2	8.5
Other Residents - Rate	7.4	7.9	7.6	8.0	8.5	7.6	7.7	6.7	6.6	6.4	6.2	6.2	6.4	6.8	6.8	6.4
Status First Nations - Incident Cases	641	741	715	708	765	814	786	755	762	808	774	733	844	912	918	1,021

Fiscal Year

Notes: Standardized to the Canada 2011 population. Please see Appendix A for more information.

Sources: BC Ministry of Health, Chronic Disease Registries (Version 2022/23), Client Roster (Snapshot 2022), and First Nations Client File (Release 2020). Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, May 2024.

The age-standardized diabetes incidence rate for Status First Nations people age 1 year and up in BC increased from the baseline of 8.0 per 1,000 population in 2017/18 to 8.5 per 1,000 in 2020/21 (Figure 4.5). While the rate among other residents also increased during this time frame, from 6.4 per 1,000 population in 2017/18 to 6.8 per 1,000 population in 2018/19 and 2019/20, it returned to 6.4 per 1,000 population in 2020/21.

First Nations Peoples are reclaiming traditional knowledge and practices of healthy eating and living to support wholistic health, and to both prevent and manage diabetes.[44,45] The FNHA,[46] mobile diabetes telemedicine clinics, and programs such as the Aboriginal Diabetes Initiative and Diabetes and My Nation have provided diabetes prevention, education, support, and care to First Nations communities across BC.[47] In addition to promoting overall health and wellness, preventing and effectively managing diabetes is important to prevent many irreversible complications associated with the disease. These can include negative effects on the eyes (retinopathy, which may cause blindness), heart, kidneys, brain, and nervous system.[48] Traditional medicines can support and empower people with diabetes "by connecting [them] with the lessons of previous generations and traditional beliefs and practices."[49(p.53)]

Serious Injuries

Indicator	Serious injuries	Change	≈ No/Minimal change
Measure	Rate of serious injuries requiring hospitalization		
Baseline	31.4 per 1,000 population (2017/18)[t]	First Interim Update	31.1 per 1,000 population (2021/22)

Social determinants of health and wellness such as poverty, poor housing, greater likelihood of working in high-risk industries, and other forms of ongoing settler-colonial oppression can be linked to heightened rates of serious injuries requiring hospitalization among First Nations Peoples.[50,51] This includes both unintentional injuries (e.g., falls, motor vehicle crashes) and intentional injuries (e.g., interpersonal violence, self-harm). Two linked studies found substantial differences in injury rates among different Indigenous communities: rates were generally higher in rural/remote and more northern environments, and were generally lower in communities with higher levels of education.[50,51]

In 2020, the BC Representative for Children and Youth reported that, among First Nations children and youth who received "reviewable services,"[u] there were higher rates of injury among those in foster homes and those who identified as female. The most common injuries reported among First Nations children and youth who received reviewable services were related to sexualized violence.[52] These types of violent injuries again demonstrate the harms of racist, white supremacist, misogynist, and **heteropatriarchal** settler-colonial belief systems that dehumanize First Nations women and girls.[53]

Serious injuries can have a large impact on the health and wellness of individuals as well as their families, caregivers, and communities. Preventing and reducing serious injuries is a priority for First Nations communities in BC because it allows people to live more active, healthier lives.[44] The rate of hospitalization due to serious injury is used in BC to monitor the rate of serious injuries. This rate includes overdose-related hospitalizations[v,54] but does not include people who died as a result of their injuries.

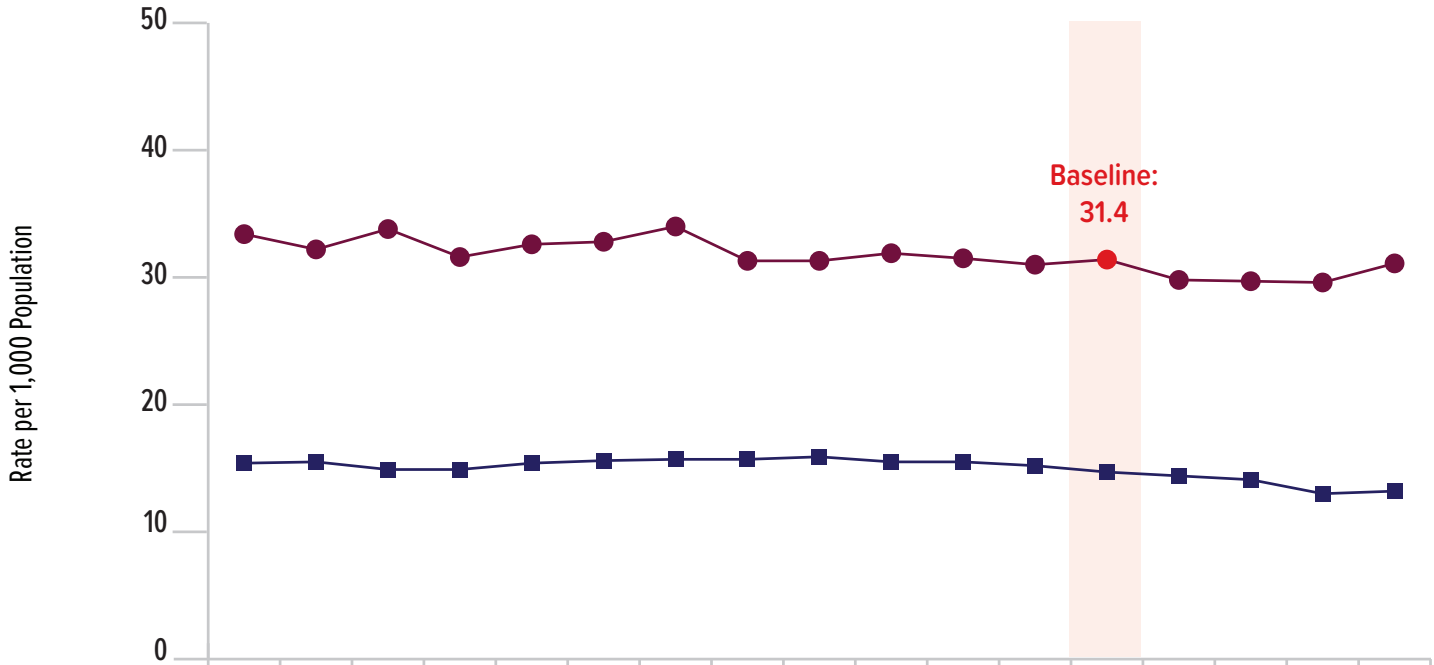
[t] The rate of serious injuries was reported incorrectly in the PHWA baseline report. The numbers in this table represent updated and corrected data.

[u] "Reviewable services" include child protection, services for children and youth with special needs, mental health and addiction services, family support services, and other services provided under the *Child, Family and Community Service Act* and the *Youth Justice Act*.

[v] The proportion of hospitalizations in BC related to unregulated drug toxicity is unknown.

FIGURE 4.6

Age-standardized Rate of Serious Injuries Requiring Hospitalization, Age 15+, Status First Nations and Other Residents, BC, 2005/06 to 2021/22



	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Status First Nations - Rate	33.4	32.2	33.8	31.6	32.6	32.8	34.0	31.3	31.3	31.9	31.5	31.0	31.4	29.8	29.7	29.6	31.1
Other Residents - Rate	15.4	15.5	14.9	14.9	15.4	15.6	15.7	15.7	15.9	15.5	15.5	15.2	14.7	14.4	14.1	13.0	13.2
Status First Nations - Events	2,960	2,987	3,157	3,010	3,136	3,202	3,362	3,154	3,234	3,327	3,382	3,427	3,541	3,411	3,497	3,600	3,879

Fiscal Year

Notes: "Serious injuries requiring hospitalization" are defined as injuries requiring overnight stay, excluding day surgeries. Patients who died of their injury are not included. An event is one hospitalization. A patient may have multiple events during the reporting period. Standardized to the Canada 2011 population. Please see Appendix A for more information.

Sources: BC Ministry of Health, Discharge Abstract Database, Client Roster (Snapshot 2022), and First Nations Client File (Release 2020). Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, August 2023.

The age-standardized rate of serious injuries requiring hospitalization among Status First Nations people age 15 and up in BC has remained relatively constant since the 2017/18 rate of 31.4 per 1,000 population (Figure 4.6). The rate dipped just below 30.0 per 1,000 population from 2018/19 through 2020/21, then increased to 31.1 per 1,000 population in 2021/22. The rate for other residents was substantially lower, and declined from 14.7 per 1,000 population in 2017/18 to 13.2 per 1,000 population in 2021/22.

FNHA's Injury Prevention and Control program supports First Nations communities by monitoring injury trends, promoting best practices, identifying priorities for knowledge development, and contributing to the development of tools to assist First Nations in creating community environments that prevent injuries.[55]

Living Long Lives (Life Expectancy at Birth)

Indicator	Life expectancy	Change	Worsening
Measure	Life expectancy at birth		
Baseline	73.3 years (2017)	First Interim Update	67.2 years (2021)

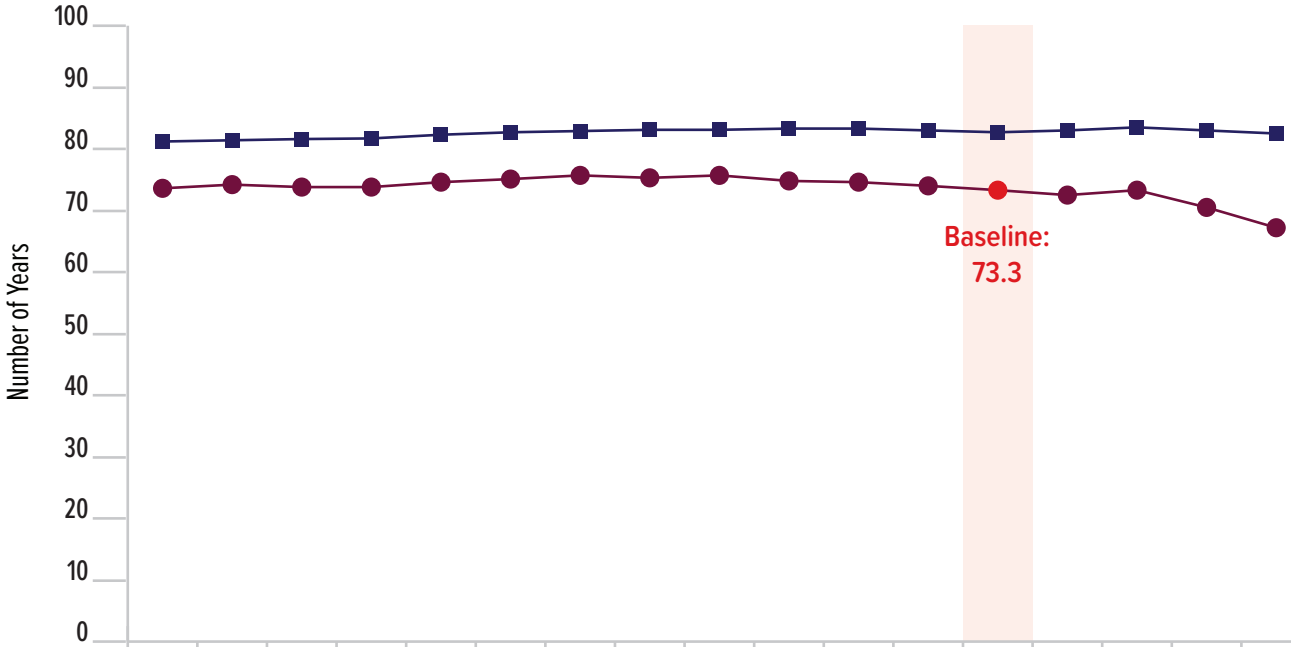
Life expectancy at birth is the number of years a person is expected to live at the time they are born. For many First Nations people, maintaining strong connections to culture, language, traditions, and community is important for living long and fulfilling lives.[56,57] Although this is a core indicator of population health, life expectancy does not indicate quality of life or the number of years one spends in good health. Canada, like other countries around the world, has experienced overall increases in life expectancy at birth in the past 100 years.[58] Between the mid-1990s and 2012, life expectancy at birth in Canada increased by approximately 0.2 years every year.[59] However, life expectancy at birth for First Nations and other Indigenous Peoples has remained consistently lower than that for non-Indigenous people due to profound health inequities.[60]

After 2012, increases in life expectancy at birth in Canada slowed. Subsequently, life expectancy began to decline, largely due to deaths related to the toxic drug crisis, which disproportionately occur among younger people.[59] Beginning in 2020, an increasingly toxic drug supply coupled with the COVID-19 pandemic also impacted life expectancy.[61,62] (For more information about these two public health crises, see Chapter 1 of this report.)

Additional analyses conducted for this report suggest that deaths related to unregulated drug toxicity and COVID-19 are the two leading causes of reduced life expectancy for Status First Nations as well as other resident populations. Deaths related to unregulated drug toxicity tend to occur among younger people, while deaths related to COVID-19 more often occur among older adults. First Nations people are disproportionately represented in both public health emergencies,[63,64] and are experiencing a greater decrease in life expectancy than other residents.

FIGURE 4.7

Life Expectancy at Birth, Status First Nations and Other Residents, BC, 2005 to 2021



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Status First Nations	73.6	74.2	73.8	73.8	74.6	75.1	75.7	75.3	75.7	74.8	74.6	74.0	73.3	72.5	73.3	70.5	67.2
Other Residents	81.2	81.4	81.6	81.7	82.3	82.7	82.9	83.1	83.1	83.3	83.3	83.0	82.7	83.0	83.5	83.0	82.5

Year

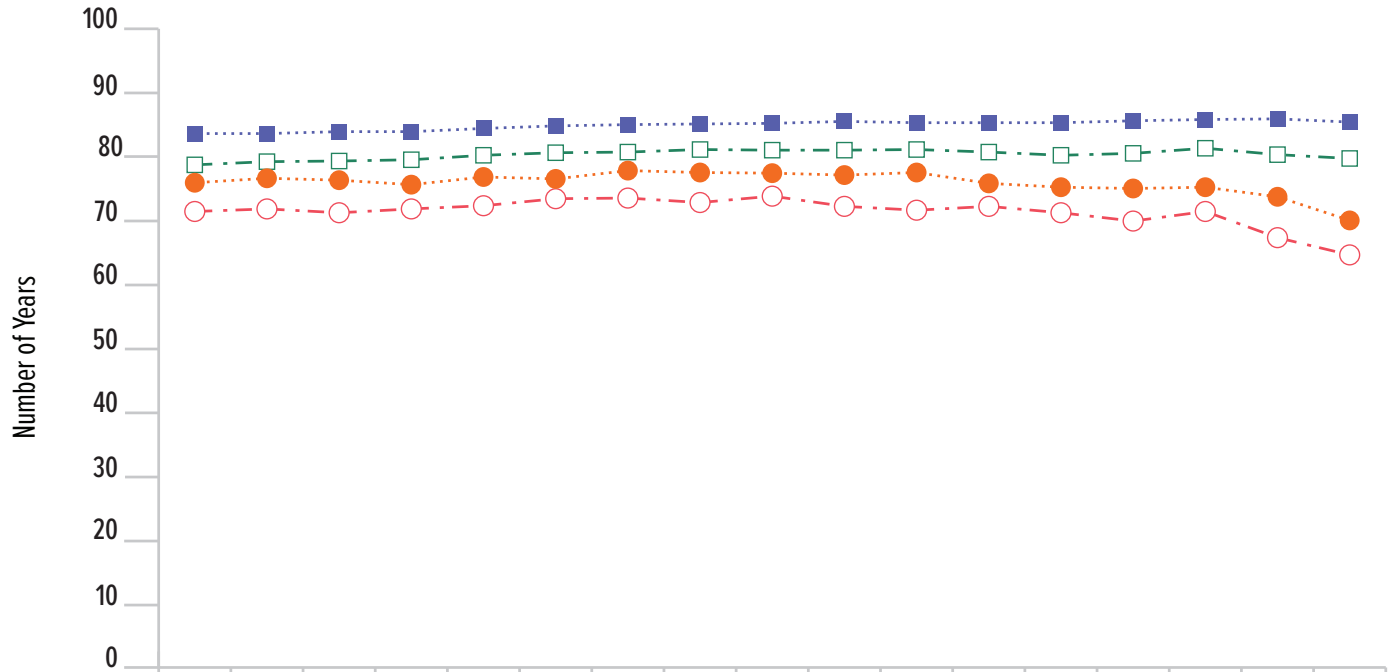
Notes: "Life expectancy" is the expected number of years of life remaining at a given age; in this case, at birth. At the time of this reporting, births from 2020 and 2021 had not yet been added to the First Nations Client File; therefore, this analysis assumes the 2020 and 2021 mortality rate for Status First Nations infants under 1 year of age is the same as the 2019 mortality rate for this age group. Please see Appendix A for more information.

Sources: BC Vital Statistics Agency, data as of January 2023; BC Ministry of Health, Client Roster (Snapshot 2022) and First Nations Client File (Release 2020). Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, August 2023.

Life expectancy at birth for Status First Nations people in BC decreased from the baseline of 73.3 years in 2017 to 67.2 years in 2021 (Figure 4.7). Between 2019 and 2021, life expectancy at birth decreased substantially for Status First Nations people (by 6.1 years). While the decrease for other residents of BC between 2019 and 2021 was also substantial (1.0 year), it is small by comparison. The gap in life expectancy at birth between Status First Nations and other residents grew by 5.1 years during this two-year period.

FIGURE 4.8

Life Expectancy at Birth, Status First Nations and Other Residents, by Sex, BC, 2005 to 2021



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Status First Nations - Females	75.9	76.6	76.3	75.6	76.8	76.5	77.8	77.5	77.4	77.1	77.5	75.8	75.2	75.0	75.2	73.7	70.0
Status First Nations - Males	71.4	71.8	71.2	71.8	72.3	73.4	73.5	72.8	73.8	72.2	71.6	72.2	71.2	69.9	71.4	67.3	64.6
Other Residents - Females	83.6	83.6	83.9	83.9	84.4	84.8	85.0	85.1	85.2	85.5	85.3	85.3	85.3	85.6	85.8	85.9	85.4
Other Residents - Males	78.7	79.2	79.3	79.5	80.2	80.6	80.7	81.1	81.0	81.1	81.2	80.7	80.2	80.5	81.3	80.3	79.7

Year

Notes: "Life expectancy" is the expected number of years of life remaining at a given age; in this case, at birth. At the time of this reporting, births from 2020 and 2021 had not yet been added to the First Nations Client File; therefore, this analysis assumes the 2020 and 2021 mortality rate for Status First Nations infants under 1 year of age is the same as the 2019 mortality rate for this age group. Data reported by sex (female/male) may reflect biological sex assigned at birth; therefore, Two-Spirit, transgender, non-binary, intersex, and gender-diverse people may be misidentified in the data. Please see Appendix A for more information.

Sources: BC Vital Statistics Agency, data as of January 2023; BC Ministry of Health, Client Roster (Snapshot 2022) and First Nations Client File (Release 2020). Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, February 2023.

Life expectancy at birth, by sex, for Status First Nations people decreased from 2019 to 2021; the decline was larger for males (6.8 years) than females (5.2 years) (Figure 4.8). From 2005 to 2021, life expectancy at birth was substantially lower for both Status First Nations males and females than for other resident males and females. The gaps between Status First Nations males and other resident males, and between Status First Nations females and other resident females, widened considerably between 2019 and 2021 (by 5.2 years and 4.8 years, respectively) (Figure 4.8).

Additional analyses revealed that, for both Status First Nations and other resident populations, the COVID-19 pandemic had a greater impact on the life expectancy of males than of females.[65] However, when comparing the gap in life expectancy between Status First Nations and other residents, the pandemic had a greater impact on Status First Nations females than on other resident females, while the toxic drug crisis had a greater impact on First Nations males than on other resident males.[65] (Still, toxic drug deaths disproportionately affect First Nations females compared to First Nations males.[66]) These findings underscore the importance of taking an intersectional approach to data analysis[67] —in this case, using both a First Nations lens and a sex-and-gender lens—to inform the development of policies and actions to increase life expectancy. This will ensure that a focus is placed on addressing inequities in life expectancy for both Status First Nations females and males.

Mortality Rate

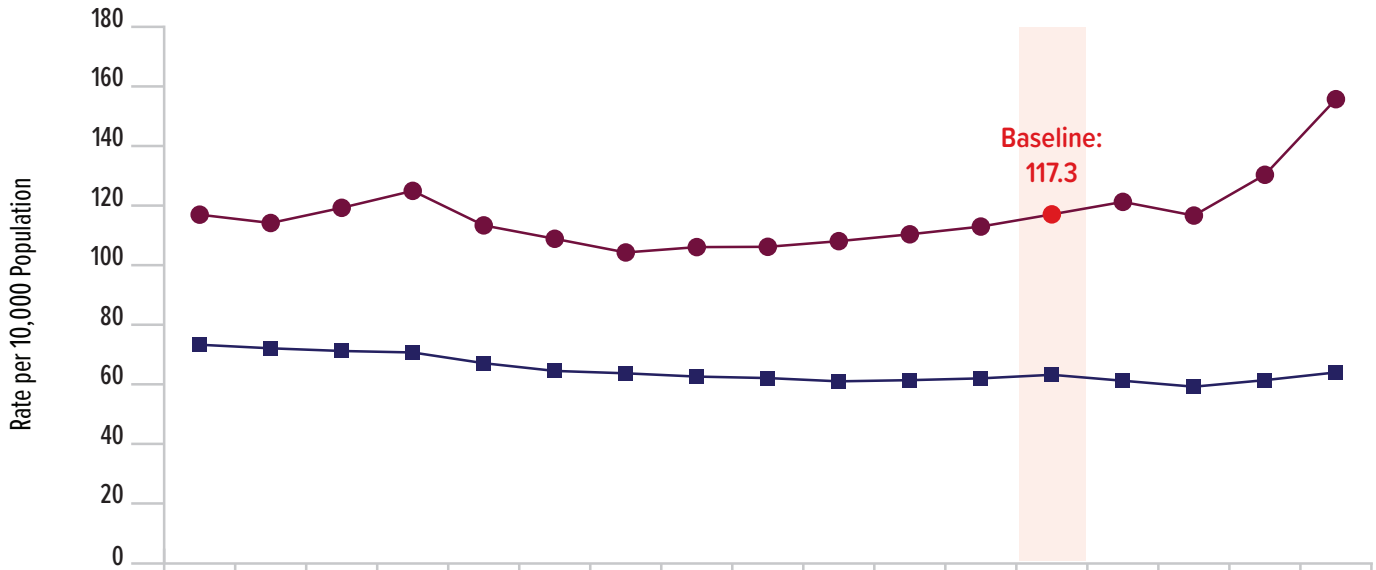
Indicator	Deaths due to all causes	Change	↓ Worsening
Measure	All-cause age-standardized mortality rate		
Baseline	117.3 per 10,000 population (2017)	First Interim Update	156.0 per 10,000 population (2021)

Many First Nations Peoples view end-of-life as a sacred time marked by important responsibilities, ceremonies, and protocols that are unique to each Nation.[68,69] Dying and death mark the stage in which a person returns home[4] or to the Spirit World, and this stage is an inherent part of life.[2] Still, every death is a loss to the family and community, and is deeply grieved. Self-determination and access to resources can support First Nations people to live full and healthy lives until their time comes to take the next step in their life journey.[4]

Figure 4.9 shows mortality (deaths) due to all causes. As is the case for life expectancy, this measure does not indicate the quality of the end-of-life passage for the individual, the family, or the community.[4]

FIGURE 4.9

Age-standardized All-cause Mortality Rate, Status First Nations and Other Residents, BC, 2005 to 2021



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Status First Nations - Rate	117.2	114.4	119.5	125.2	113.6	109.1	104.5	106.3	106.4	108.3	110.6	113.2	117.3	121.5	116.9	130.6	156.0
Other Residents - Rate	73.5	72.3	71.4	70.9	67.3	64.7	63.9	62.8	62.3	61.2	61.6	62.2	63.4	61.4	59.4	61.6	64.2
Status First Nations - Deaths	734	728	746	775	758	762	761	810	801	909	952	1,022	1,125	1,214	1,181	1,468	1,843
Other Residents - Deaths	29,378	29,830	30,379	31,131	30,494	30,400	31,029	31,557	32,261	32,719	34,101	35,453	37,180	37,064	37,205	39,695	42,568

Year

Notes: Standardized to the Canada 2011 population. At the time of this reporting, births from 2020 and 2021 had not yet been added to the First Nations Client File; therefore, this analysis assumes the 2020 and 2021 mortality rate for Status First Nations infants under 1 year of age is the same as the 2019 mortality rate for this age group. Please see Appendix A for more information.

Sources: BC Vital Statistics Agency, data as of January 2023; BC Ministry of Health, Client Roster (Snapshot 2022) and First Nations Client File (Release 2020). Prepared by Population Health Surveillance and Epidemiology, BC Office of the Provincial Health Officer, BC Ministry of Health, August 2023.

The age-standardized all-cause mortality rate for Status First Nations people trended slowly upward from 2011 to 2018 (Figure 4.9). This upward trend halted briefly between 2018 and 2019, then increased at a much steeper trajectory between 2019 and 2021. In BC, unregulated drug toxicity deaths increased considerably in 2020 and 2021;[70] in addition, these were the first two years of the COVID-19 pandemic. The 2021 rate of 156.0 deaths per 10,000 population was 25 per cent higher than the highest pre-pandemic rate charted (125.2 per 10,000 population in 2008). As Figure 4.9 shows, between 2005 and 2021, the mortality rate for Status First Nations people was consistently much higher than for other residents. Although the mortality rate for other residents also increased from 2019 to 2021, it was a much smaller increase; as a result, the gap between Status First Nations and other resident populations has widened considerably.

Conclusion

This chapter has examined progress on eight of the 13 indicators set out in the PHWA baseline report to support healthy, self-determining, and vibrant BC First Nations children, families, and communities. As the data in this chapter have demonstrated, most indicators have undergone minimal change or are worsening. The two public health emergencies of the ongoing toxic drug crisis and the COVID-19 pandemic have had a significant effect and have clearly inhibited improvements in indicators such as life expectancy and mortality rate. Diabetes incidence has increased. A number of indicators discussed in this chapter have not changed substantially since the baseline report was released, which highlights areas where further focused work may still yield improvements: Healthy Birth Weights, Youth/Young Adult Suicide, and Serious Injuries. Infant Mortality Rate decreased slightly, representing improvement on this indicator since the baseline report. Future reports will also provide updates on indicators not presented here (Healthy Childhood Weights, Mental and Emotional Well-being, Physical Activity, Smoking Commercial Tobacco, and Deaths Due to Alcohol), when updated data are available. Systems-level change that addresses the roots of health inequities will drive further improvements in the health and wellness of current and future generations of First Nations children, families, and communities.

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CHAPTER 5:
PADDLING TOGETHER

This chapter summarizes the report, discusses the results, and explores progress on some of the actions to nourish First Nations roots of health and wellness that were identified in the Population Health and Wellness Agenda (PHWA) baseline report. The dashboards below summarize information on the indicators addressed in this interim update and how they have been trending since the baseline report was released. The PHWA partners will continue to provide updates and assess progress through several additional PHWA reports in the coming years. We raise our hands to the health system partners and colleagues who have worked with us (and have committed to continue working with us) to provide First Nations data so that we can deliver this report in accordance with First Nations governance and data protocols and uphold the role of the "**Watchmon**" in the Office of the Chief Medical Officer at the First Nations Health Authority.[1]

Summary of Findings

As described in Chapter 1, each indicator is marked with one of the three symbols shown here. The symbols show whether changes since the baseline report was released represent an improvement or worsening of the measure for each indicator, or whether there has been no or minimal change. The direction of the arrows may not match the direction of the trend for a given measure, as an increase in some measures (e.g., graduation rates) represents an improvement, while an increase in others (e.g., diabetes incidence) represents a worsening trend. Note that these symbols apply to First Nations and Indigenous data only, and are not included for data on other residents.

	BASELINE	FIRST INTERIM UPDATE	CHANGE
HEALTHY, SELF-DETERMINING NATIONS AND COMMUNITIES: Land, Family, Community, Nations			
SELF-DETERMINATION Measure under development	N/A	Qualitative updates included	N/A
CONNECTION TO LAND Measure under development	N/A	Results of the We Walk Together project (2017–2023)	N/A

In the area of *Healthy, Self-determining Nations and Communities*, Chapter 2 provides updated information on two of the three indicators presented in the baseline report: Self-determination and Connection to Land. The PHWA working group is in the process of creating measures for both indicators; in the meantime, this report describes how these indicators are being developed.

	BASELINE	FIRST INTERIM UPDATE	CHANGE
SUPPORTIVE SYSTEMS: Environment, Society, Culture, Economy, and Health Systems			
EDUCATION Proportion of students who complete high school within eight years of starting Grade 8	**INDIGENOUS: 69.9%** (2016/17)	**INDIGENOUS: 74.2%** (2019/20)	↑ Improving
	NON-INDIGENOUS: 92.4% (2016/17)	NON-INDIGENOUS: 93.9% (2019/20)	
AVOIDABLE HOSPITALIZATIONS Rate of avoidable hospitalizations per 10,000 population	**FIRST NATIONS: 73.3 PER 10,000** (2017/18)	**FIRST NATIONS: 72.6 PER 10,000** (2021/22)	≈ No/Minimal change
	OTHER RESIDENTS: 26.9 per 10,000 (2017/18)	OTHER RESIDENTS: 20.3 per 10,000 (2021/22)	
CULTURAL SAFETY AND HUMILITY IN RECEIVING HEALTH SERVICES Percentage of First Nations people who report that their care provider was respectful of their culture and traditions	**ACUTE CARE:** 68.8% (2016/17) **EMERGENCY DEPARTMENT:** 69.5% (2018)	Updated quantitative data not available; qualitative updates included	N/A
FIRST NATIONS HEALTH CARE PROVIDERS Percentage of physicians in BC who self-identify as First Nations	0.32% (2019)	0.39% (2023)	≈ No/Minimal change
Percentage of midwives in BC who self-identify as First Nations	N/A	1.72% (2023)	N/A
Percentage of nurses in BC who self-identify as First Nations	N/A	1.54% (2023)	N/A

In the area of *Supportive Systems*, Chapter 3 provides updated information on four of the six indicators presented in the baseline report: Education, Avoidable Hospitalizations, Cultural Safety and Humility, and First Nations Health Care Providers. Only one indicator (Education) showed improvement. Two others (Avoidable Hospitalizations and First Nations Health Care Providers [physicians]) showed minimal change. Updated quantitative data were not available for the Cultural Safety and Humility indicator, but important developments in this area are discussed in the text. This is the first time that data from the BC College of Nurses and Midwives have been included in PHWA reporting, so there are no baseline data for comparison. The PHWA partners look forward to establishing partnerships and collaborating with additional regulatory colleges to include more data on First Nations health care providers in future PHWA reports.

	BASELINE	FIRST INTERIM UPDATE	CHANGE
HEALTHY, VIBRANT CHILDREN AND FAMILIES — Physical, Mental, Spiritual, and Emotional Wellness			
HEALTHY BIRTH WEIGHTS Percentage of singleton babies born at a healthy birth weight for their gestational age and sex	**FIRST NATIONS: 73.8%** (2017)	**FIRST NATIONS: 72.1%** (2019)	↓ Worsening
	OTHER RESIDENTS: 82.4% (2017)	OTHER RESIDENTS: 82.4% (2019)	
INFANT MORTALITY Rate of infants who die within 365 days of birth, per 1,000 live births (5-year aggregate)	**FIRST NATIONS: 5.3 PER 1,000** (2013-17)	**FIRST NATIONS: 4.6 PER 1,000** (2015-19)	↑ Improving
	OTHER RESIDENTS: 3.4 per 1,000 (2013-17)	OTHER RESIDENTS: 3.3 per 1,000 (2015-19)	
CHILDREN'S ORAL HEALTH Percentage of Indigenous kindergarten children who are cavity-free	45.7% (2015/16)	Data excluded due to insufficient data quality	N/A

	BASELINE	FIRST INTERIM UPDATE	CHANGE
HEALTHY, VIBRANT CHILDREN AND FAMILIES — Physical, Mental, Spiritual, and Emotional Wellness			
YOUTH/YOUNG ADULT SUICIDE Suicide mortality rate of youth/young adults age 15–24 (5-year aggregate)	**FIRST NATIONS: 3.1 PER 10,000** (2013-17)	**FIRST NATIONS: 2.8 PER 10,000** (2017-21)	≈ No/Minimal change
	OTHER RESIDENTS: 0.9 per 10,000 (2013-17)	OTHER RESIDENTS: 0.8 per 10,000 (2017-21)	
DIABETES Age-standardized diabetes incidence	**FIRST NATIONS: 8.0 PER 1,000** (2017/18)	**FIRST NATIONS: 8.5 PER 1,000** (2020/21)	↓ Worsening
	OTHER RESIDENTS: 6.4 per 1,000 (2017/18)	OTHER RESIDENTS: 6.4 per 1,000 (2020/21)	
SERIOUS INJURIES Rate of serious injuries requiring hospitalization	**FIRST NATIONS: 31.4 PER 1,000** (2017/18)	**FIRST NATIONS: 31.1 PER 1,000** (2021/22)	≈ No/Minimal change
	OTHER RESIDENTS: 14.7 per 1,000 (2017/18)	OTHER RESIDENTS: 13.2 per 1,000 (2021/22)	
LIVING LONG LIVES Life expectancy at birth	**FIRST NATIONS: 73.3 YEARS** (2017)	**FIRST NATIONS: 67.2 YEARS** (2021)	↓ Worsening
	OTHER RESIDENTS: 82.7 years (2017)	OTHER RESIDENTS: 82.5 years (2021)	
MORTALITY RATE All-cause age-standardized mortality rate	**FIRST NATIONS: 117.3 PER 10,000** (2017)	**FIRST NATIONS: 156.0 PER 10,000** (2021)	↓ Worsening
	OTHER RESIDENTS: 63.4 per 10,000 (2017)	OTHER RESIDENTS: 64.2 per 10,000 (2021)	

In the area of *Healthy, Vibrant Children and Families* (Chapter 4), eight of the 13 indicators presented in the baseline report were updated in this report. Four showed worsening trends (Healthy Birth Weights, Diabetes Incidence, Living Long Lives, and Mortality Rate), and two demonstrated no/minimal change since the baseline report was released. Infant Mortality Rate has decreased slightly since the baseline report, representing an improvement for this indicator. Data for the Children's Oral Health indicator were excluded from this report due to data quality issues, as discussed in Chapter 4. More robust data sources are being sought to measure this important indicator in future PHWA reports.

Overall, as this report shows, progress on the PHWA indicators has been limited. There has been no meaningful change in Avoidable Hospitalizations, First Nations Health Care Providers (physicians), Youth/Young Adult Suicide, or Serious Injuries. Education (graduation rates) has improved, as has Infant Mortality Rate. The Healthy Birth Weights indicator has worsened slightly. The three indicators that show concerning, significantly worsening changes are Diabetes Incidence, Living Long Lives (life expectancy at birth), and Mortality Rate (deaths due to all causes). As explored in this report, the unprecedented and ongoing unregulated toxic drug crisis and COVID-19 public health emergencies have had negative impacts on many of the indicators, but especially on life expectancy and mortality rate. The toxic drug crisis was declared a public health emergency in BC in April 2016; after eight years of response, it shows no signs of abating, and continues to worsen.[2,3] For the many intersecting reasons laid out in this report (e.g., ongoing settler colonialism, intergenerational trauma, systemic Indigenous-specific racism, lack of access to culturally safe mental health and substance use services), the toxic drug crisis continues to have disproportionate and far-reaching impacts on First Nations people and communities. The COVID-19 pandemic further amplified existing inequities for First Nations people by impeding access to health care and limiting participation in activities linked to health and wellness, such as gathering with friends, family, and community, and the ability to hold cultural events and ceremony. The combined impact of the unregulated toxic drug crisis and the COVID-19 pandemic continues to disproportionately affect First Nations roots of wellness and the associated indicators measured in this report.

Actions to Nourish First Nations Roots of Wellness

In addition to presenting data on the health and wellness of First Nations people in BC, the PHWA baseline report called on systems partners and institutions to work with First Nations organizations and collectives to nourish First Nations roots of wellness by advancing the seven areas listed below. The PHWA partners have updated the wording of six of these actions since the baseline report was released to reflect the evolution of the PHWA goals and objectives:

1. Affirm, uphold, support, and advance First Nations rights and self-determination.
2. Advance First Nations data governance and uphold principles of OCAP® (First Nations' ownership, control, access to, and possession of data).[4]
3. Catalyze intersectoral actions to build supportive, anti-racist, trauma-informed, culturally safe systems, with particular attention given to connection to land.
4. Advance the roots of health and wellness for the next generations, including priority populations such as First Nations babies, children, and youth.
5. Embed First Nations wellness approaches in policies, programs, and services.
6. Commit to cultural safety and humility and eradicating Indigenous-specific racism across all systems.
7. Increase access, good relations, and attachment to anti-racist, trauma-informed, and culturally safe primary health care.

For more information on the actions to nourish First Nations roots of wellness, please refer to pages 140–142 in the PHWA baseline report (https://www.fnha.ca/Documents/FNHA-PHO-First-Nations-Population-Health-and-Wellness-Agenda.pdf). The remainder of this chapter provides an overview of key developments in four of these seven areas since the release of the PHWA baseline report in 2021.

1. Affirm, uphold, support, and advance First Nations rights and self-determination.

- In December 2017, the government of Canada passed Bill S-3, *An Act to amend the Indian Act in response to the Superior Court of Quebec decision in Descheneaux c. Canada (Procureur général)*.[5] Bill S-3 was created to address sex-based discrimination in the *Indian Act* by extending Status eligibility to the descendants of Indigenous women who were denied Status due to the 1985 amendments to the *Indian Act*. In 2019, Bill S-3 was amended to remove the 1951 cut-off date, thus ensuring that all descendants of women who lost Status or who were removed from band lists due to their marriage to a non-Status man are entitled to registration.[6] Although these amendments were introduced prior to the publication of the PHWA baseline report, the implementation of Bill S-3 expands eligibility for First Nations Status; therefore, the total Status First Nations population in Canada will continue to increase. As a result, the number of First Nations people in the First Nations Client File (FNCF) cohort in BC will also increase, and they will be included in indicators that use the FNCF as the data source in future PHWA reports.[w]

[w] Please see Appendix A for information on the First Nations Client File.

- In November 2019, the government of British Columbia passed the *Declaration on the Rights of Indigenous Peoples Act* (DRIPA), which established the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP) as BC's framework for reconciliation, as called for by the Truth and Reconciliation Commission of Canada. Since that time, the BC government has published annual reports that highlight BC's progress on implementing DRIPA, which has included amending new and existing laws (e.g., the *Adoption Act*, the *Human Rights Code*) to align with UNDRIP.[7] In March 2022, the BC government launched the first DRIPA Action Plan (2022–2027), which outlines 89 actions to be undertaken in consultation and cooperation with Indigenous Peoples. For more information, please visit http://declaration.gov.bc.ca.[8]
- In July 2022, Cowichan Tribes, Lil'wat Nation, ʔaq'am, and Sq'éwqel (Seabird Island) signed landmark education jurisdiction agreements with Canada that recognize their law-making authority over their Kindergarten–Grade 12 (K–12) education systems.[9] This includes graduation requirements, course approvals, and teacher and school certification. At the same time, the First Nations Education Authority was established to assist Nations in developing their capacity to provide education in their communities.[9]
- In June 2023, the government of Canada launched its 2023–2028 UNDRIP Action Plan, fulfilling a commitment made with the passing of the federal *United Nations Declaration on the Rights of Indigenous Peoples Act* in June 2021.[10]
- On June 22, 2023, the Parliament of Canada passed Bill C-51: *An Act to give effect to the self-government treaty recognizing the Whitecap Dakota Nation / Wapaha Ska Dakota Oyate and to make consequential amendments to other Acts*.[11] This is an important milestone for ongoing Nation-to-Nation work.
- On November 3, 2023, the governments of Canada and British Columbia and the First Nations Leadership Council signed a tripartite agreement to protect and conserve biodiversity, habitats, and species at risk in BC. This is a historic, first-of-its-kind agreement that is rooted in First Nations Peoples' inherent rights and self-determination as the rightful stewards of their lands and waters.[12]
- On April 14, 2024, the Council of the Haida Nation and the Province of BC signed the *Gaayhllxid • Gíihlagalgang "Rising Tide" Haida Title Lands Agreement*, which recognizes the Haida Nation's Aboriginal title in Haida Gwaii.[13] Along with supporting legislation adopted into law on May 16, 2024, this agreement means land on Haida Gwaii previously considered provincial Crown land will now be known as Haida Aboriginal title lands, and governance of these lands will gradually return to the Haida Nation.[14]

4. **Advance the roots of health and wellness for the next generations, including priority populations such as First Nations babies, children, and youth.**

- In 2019, the Standing Senate Committee on Human Rights undertook a study on the extent and scope of forced and coerced sterilization of persons in Canada. In July 2022, the Committee published its second report, *The Scars That We Carry*, which calls on the federal government to compensate and apologize to all people who were subjected to forced or coerced sterilization.[15]
- In 2021, the First Nations Health Authority (FNHA), Perinatal Services BC, and Senator Yvonne Boyer co-created a shared decision-making and informed consent for contraception form that has been shared nationally and internationally. This form was created to ensure that consent to a contraception method is informed and has been given freely.[16]
- In July 2022, the BC government announced the We Are Indigenous: Big Worries/ Fears Parent/Caregiver Support Program. This program shares culturally grounded wellness practices and strategies through a free virtual parent and caregiver coaching program for Indigenous families with children aged 3–12. It was developed with guidance from the Indigenous advisory group Caring in All Directions and the Canadian Mental Health Association, BC Division.[17,18]
- In December 2022, the Nuu-Chah-Nulth Tribal Council announced a long-term study on improving health and wellness for Indigenous children, in partnership with other Indigenous leaders and university-based health researchers, funded by a $16 million grant from the Canadian Institutes of Health Research. The study, guided by Elders and other Knowledge Keepers, will explore the root causes of health disparities experienced by Indigenous Peoples, including in the areas of mental health and cardiovascular disease, through Indigenous ways of knowing. It will also work to create supportive environments for early development, starting before conception, and to restore traditional family systems.[19]

- In March 2023, the FNHA and Perinatal Services BC created a provincial roundtable working group focused on reclaiming birthing. In 2024, the FNHA began conducting research with First Nations life-givers and birth workers in BC. The findings were shared at a June 2024 Leadership Forum on Birthing Sovereignty. The full report, "Answering the Call: Calls to Action from First Nations Community Members to Improve the Rural and Remote Birthing Journey," will be released in Fall 2024.[34]
- In April 2023, the Senate completed a second reading of Bill S-250, An Act to amend the Criminal Code (*sterilization procedures*). This Bill proposes to add a new indictable offence to the assault provisions of the Criminal Code that is designed to prevent the forced or coerced sterilization of persons in Canada. This offence is focused on specific safeguards to ensure medical providers obtain informed consent before performing a medical act that may cause sterility.[20]
- In July 2023, the Canadian Human Rights Tribunal issued a letter-decision with reasons approving a $23-billion settlement, negotiated by the Assembly of First Nations, for the revised First Nations Child and Family Services, Jordan's Principle, and Trout Class Settlement Agreement. The letter-decision includes a commitment from the federal Minister of Indigenous Services to request an apology from the Prime Minister to First Nations children, youth, and families who were harmed due to the underfunding of Child and Family Services.[21]

6. **Commit to cultural safety and humility and eradicating Indigenous-specific racism across all systems.**

and

7. **Increase access, good relations, and attachment to anti-racist, trauma-informed, and culturally safe primary health care.**

- In April 2021, the government of Canada announced it would dedicate $126.7 million over three years to address Indigenous-specific racism in Canadian health care systems.[22] Though this is a positive step, it remains to be seen whether this will lead to improved health and wellness outcomes for Indigenous Peoples in BC and across Canada. To date, this funding is supporting organizations and projects such as the National Collaborating Centre for Indigenous Health, the Health Arts Research Centre at the University of Northern BC, the Indigenous Physicians Association of Canada, and the National Consortium for Indigenous Medical Education.
- On May 11, 2021, BC's four largest health regulators, the BC College of Nurses and Midwives, the College of Pharmacists of BC, the College of Dental Surgeons of BC, and the College of Physicians and Surgeons of BC, issued *Racism in Health Care: An Apology to Indigenous People and a Pledge to Be Anti-Racist*. Through this work, they are apologizing for the harms from Indigenous-specific racism perpetrated by their organizations and their members, and are committing to work toward an anti-racist, culturally safe health care system.[23] Additional regulators have since issued apologies and made the same commitments.[24,25]

- On February 21, 2022, the Fraser Salish Region of the First Nations Health Governance Structure publicly released in ceremony *Remembering Keegan: A BC First Nations Case Study Reflection*.[26] As detailed in Chapter 3, *Remembering Keegan* tells the tragic story of Keegan Combes of Skwah First Nation, who died in hospital in 2015 following a delayed diagnosis and treatment after an accidental poisoning.[26] This Case Study Reflection—the first of its kind shared by a BC First Nation—is an ongoing gift from the Skwah Nation to the BC health care system. *Remembering Keegan* encourages BC health system leaders to enact system-wide change and improve the quality of care for First Nations and other Indigenous Peoples by reflecting on and implementing the recommendations in this report.[26]
- On February 25, 2022, the BC College of Nurses and Midwives and the College of Physicians and Surgeons of BC released a new practice standard that all registrants are required to follow: "Indigenous cultural safety, cultural humility, and anti-racism."[27,28] In June 2023, both colleges surveyed their registrants to determine their awareness of the standard and how it has been applied in practice.
- In March 2022, the First Nations Education Steering Committee and BC Ministry of Education announced that secondary-school students in BC will now be required to complete Indigenous-focused coursework before they graduate. This new graduation requirement is expected to begin in the 2023/2024 school year and will ensure K–12 students in BC have opportunities to learn about Indigenous perspectives, histories, and cultures.[29,30]
- On June 14, 2022, the FNHA and Health Standards Organization (HSO) published the BC Cultural Safety and Humility Standard (BC CSH Standard, https://healthstandards.org/standard/cultural-safety-and-humility-standard/). This standard is the first of its kind in Canada and will be used to address Indigenous-specific racism and increase cultural safety in BC's health and social service systems.[31]
- In late 2022, the HSO and FNHA received funding from Health Canada for a project in partnership with the Canadian Indigenous Nurses Association. The project, "Advancing Cultural Safety and Humility Through Standards and Accreditation," involves preparing and testing the BC CSH Standard for use as an accreditation standard for health and social services organizations in BC. Implementation resources for accredited organizations are being developed to support the unique considerations of this type of standard.
- The FNHA is in the process of assessing its own alignment with the BC CSH Standard and completed a self-assessment in 2023. Future work will involve further aligning the organization with the standard based on self-assessment findings.
- On April 19, 2023, the BC College of Nurses and Midwives released its *Commitment to Action: 2023–24—Redressing Harm to Indigenous Peoples in the Health Care System* plan. This plan was created to address and dismantle the systemic Indigenous-specific racism evident in the BC health care system.[32]

Conclusion

The lands and territories now known as British Columbia have been home to more than 200 distinct First Nations since time immemorial. Historical and contemporary settler-colonial policies and practices have violently encroached on the inherent rights and title of BC First Nations, resulting in the loss of cultural continuity, including in areas such as ceremony, language, and traditional medicines. These impacts, and the loss of First Nations' jurisdiction over their traditional territories, have adversely affected the health outcomes of First Nations Peoples and communities in BC and across Canada. Settlers have a responsibility to unlearn and undo both individual and systemic Indigenous-specific racism and white supremacy. Such a transformation becomes possible only through an active and ongoing process of humility, learning, and unlearning.[33] Acknowledging and understanding these truths are the first steps toward unlearning racism and white supremacy; these steps are essential for meaningful reconciliation with First Nations Peoples.

This PHWA: First Interim Update report provides updates on 14 of the 22 health and wellness indicators and four of the seven actions to nourish First Nations roots of wellness identified in the PHWA baseline report. Among the quantitative data presented, only the Education indicator has shown significant improvement since the baseline report was released. While this advancement is promising, it is also important to note that during this time, Diabetes Incidence, Living Long Lives (life expectancy at birth), and Mortality Rates all worsened considerably among First Nations people in BC.

First Nations health and wellness is dynamic, and finding ways to measure it effectively requires a commitment to continued exploration, including ongoing work to review and assess data sources, indicators, and targets. Since the release of the PHWA baseline report, perspectives and the world have shifted and evolved. Because research and reporting is an iterative, learning process, the PHWA partners have made changes to reflect this, as seen in the report. This humble and open approach will ensure that PHWA reporting continues to support the goal of improved health and wellness for First Nations people and communities in BC.

Systemic change requires that truths be shared and acknowledged, and that First Nations people be self-determined decision-makers in their own health and wellness journeys. Part of this work involves resetting relationships between First Nations people, settler-colonial governments, providers of mainstream health services, and other residents of BC in ways that uphold and affirm First Nations Peoples' rights and perspectives on health and wellness. Resetting these relationships also requires recognizing that Indigenous-specific racism has denied First Nations people safe and equitable access to health and social services that are free of discrimination for generations. First Nations people have experienced countless harms, including death, within mainstream health care and social service systems. To create systems that are safe, settlers must act as allies, and must also be accountable and take responsibility for embedding cultural safety and anti-racism within their own spheres of influence. This will create the necessary space for systemic social change and health equity.

Ongoing guidance and leadership from BC First Nations will continue to build a new reality that honours, respects, and advances the health and wellness of First Nations people, families, and communities in BC. This transformative progress will occur only when the roots of First Nations health and wellness are nourished. Achieving and sustaining optimal health and wellness is a life-long journey, and, as First Nations teachings tell us, paddling together, with one heart and one mind, is the only way to get there.

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APPENDIX A:
DATA SOURCES AND METHODOLOGIES

HIGHLIGHT:
A Few Key Foundational Obligations to Indigenous Peoples Related to Data Collection and Data Sovereignty

- **National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG 2SLGBTQQIA+, 2019) Call for Justice 5.24**. We call upon the federal government to amend data collection and intake-screening processes to gather distinctions-based and intersectional data about Indigenous women, girls, and 2SLGBTQQIA people.[1]

- **MMIWG 2SLGBTQQIA+ (2019) Call for Justice 9.5v.** Create a national strategy, through the Canadian Association of Chiefs of Police, to ensure consistency in reporting mechanisms for reporting missing Indigenous women, girls, and 2SLGBTQQIA people. This could be developed in conjunction with implementation of a national database.[1]

- ***In Plain Sight* (2020) Recommendation 2 (excerpt)**. Enact legislation to mandate the collection, use and disclosure of disaggregated demographic data for social change, with Indigenous institutions and governments in support of self-determination and sovereignty as recommended in the Office of the Human Rights Commissioner report, *Disaggregated demographic data collection in British Columbia: The grandmother perspective*.[2,3]

- **BC *Declaration on the Rights of Indigenous Peoples Act* Action Plan (2022) Action 3.14**. Advance the collection and use of disaggregated demographic data, guided by a distinctions-based approach to Indigenous data sovereignty and self-determination, including supporting the establishment of a First Nations-governed and mandated regional data governance centre in alignment with the First Nations Data Governance Strategy.[4]

Data analyses and reporting in this Population Health and Wellness Agenda (PHWA) First Interim Update honours First Nations data governance principles and protocols.[5,6] While many indicators in the PHWA reporting series rely on quantitative (numerical) data from settler-colonial government sources, the PHWA partners strive to contextualize these data and include decolonized, culturally safe quantitative data sources wherever possible.[7,8] For example, the PHWA baseline report included data from the First Nations Regional Longitudinal Health Survey (also known as the Regional Health Survey [RHS]). Although updated RHS data were not available for this report, they will be included in future PHWA reports. Qualitative data (e.g., participatory research, quotations, photographs) are also included because these types of data are equally important in understanding the health and wellness journeys of First Nations people in BC, and they balance, ground, and contextualize the quantitative data.

This PHWA First Interim Update reports on a selection of indicators (14 of 22) presented in the 2021 PHWA baseline report, using the same quantitative data sources and the same or similar methodologies, unless otherwise specified. For more information on the sources and general limitations of PHWA data, please refer to Appendix B in the PHWA baseline report: www.fnha.ca/Documents/FNHA-PHO-First-Nations-Population-Health-and-Wellness-Agenda.pdf.

Data Sources, Limitations, and Notes

QUALITATIVE DATA

> **"The most important qualities of our culture are our language and our stories. In oral traditions such as ours, telling stories is how we pass on the history and the teachings of our ancestors. Without these stories, we would have to rely on other people for guidance and information about our past. Teachings in the form of stories are an integral part of our identity as a people and as a nation. If we lose these stories, we will do a disservice to our ancestors—those who gave us the responsibility to keep our culture alive."**
>
> – from *Our Tellings: Interior Salish Stories of the Nlha7kápmx People*[9(p.201)]

Storytelling is a traditional method used by First Nations Peoples to communicate knowledge about culture, beliefs, values, and ways of life. It serves to connect generations and has the power to teach, pass down truths, and help people heal from intergenerational trauma.[10]

As discussed in Chapter 2, work is underway to develop meaningful ways to measure the indicators of Self-determination and Connection to Land. Some Nations use both qualitative and quantitative measures to assess the state of self-determination and connection to land in their communities. For the PHWA, the First Nations Health Authority (FNHA) and the Office of the Provincial Health Officer (OPHO) are working together to develop measures that are useful and of value to First Nations communities through the We Walk Together project. This participatory research project is intended to inform the development of the Connection to Land indicator. We Walk Together is using qualitative data from communities to create a culturally relevant, BC First Nations-led health indicator that measures connection to land, water, and territory. This project has collected truths from Elders, Knowledge Keepers, and youth on Stó:lō, Lil'wat, and Lake Babine territories.

QUANTITATIVE DATA

This section briefly describes each quantitative data source used to produce the figures in Chapters 3 and 4 of this report, and lists the indicator(s) based on each data source. Data limitations or notes associated with specific sources and indicators are also highlighted.

College of Physicians and Surgeons of BC and BC College of Nurses and Midwives

As of February 2019, through a partnership with the FNHA, the College of Physicians and Surgeons of BC (CPSBC) added an option for members to self-identify during the annual registration/license renewal process. This has made it possible to report on the number and proportion of registered physicians in BC who self-identify as First Nations. This report includes data from 2019 and 2023 (see Chapter 3 for analyses and discussion).

The 2019 CPSBC data indicated there were 13,263 registered physicians in BC (all ethnicities), of whom 43 (0.32 per cent) self-identified as First Nations. The 2023 CPSBC data indicated there were 15,246 registered physicians in BC (all ethnicities), of whom 59 (0.39 per cent) identified as First Nations.

The FNHA has worked with the BC College of Nurses and Midwives (BCCNM) to add a First Nations self-identification option for its members. Although these data were not available for the PHWA baseline report, they are now available and have been added to the PHWA reporting series, beginning with this report for 2023 registration. Data are also disaggregated by registrant group (registered nurses, licensed practical nurses, registered psychiatric nurses, nurse practitioners, and registered midwives). The 2023 BCCNM nursing data indicated that a total of 72,113 nurses (all ethnicities) were registered with the college, which included 1,112 who self-identified as First Nations (1.54 per cent). The data for 2023 also indicated that a total of 582 midwives (all ethnicities) were registered with the college, including 10 who self-identified as First Nations (1.72 per cent).

INDICATOR: Registered First Nations Health Care Providers

- **Eight-year Graduation Rate,** BC Ministry of Education and Child Care. Data on graduation rates measure the proportion of students who graduate from high school in BC within eight years of the first time they enrolled in Grade 8. This includes students who earned a BC Certificate of Graduation or a BC Adult Graduation Diploma from a public, private, or off-reserve First Nations school in BC; however, it does not include on-reserve schools. Indigenous identity is based on self-identification as First Nations, Inuit, or Métis at the time of school enrolment.

INDICATOR: Education

- **First Nations Client File (FNCF).** The FNCF is a cohort of registered Status First Nations people (including their unregistered children who may be eligible for Status) who have lived in BC at any point since 1992. The FNCF is one of the best sources of health-related data on Status/Status-eligible First Nations people in BC. However, because the FNCF excludes non-Status/Status-ineligible First Nations people, it presents only a partial picture of the health and wellness of First Nations people in BC. Please see Appendix B in the PHWA baseline report for a discussion of identification issues in the FNCF, particularly for the youngest age groups.

  In this report, FNCF data are linked to the BC Ministry of Health's Chronic Disease Registries, Discharge Abstract Database, and Vital Statistics Agency datasets to report on each of the indicators listed below. At the time of these linkages, births in 2020 and 2021 had not yet been added to the FNCF. This primarily impacts indicators focused on infant health; therefore, data on Healthy Birth Weights and Infant Mortality Rate are presented only through 2019 in this report, whereas more recent data on other FNCF indicators are presented.

INDICATORS:

- **Avoidable Hospitalizations** (Discharge Abstract Database) – The rate of "avoidable hospitalizations," expressed as a rate per 10,000 population, can be used to assess the safety, effectiveness, and/or accessibility of primary health care services. This indicator measures admissions to hospital related to diseases or conditions that can usually be well managed at home or in communities and should not typically require hospitalization. It does not include admissions related to self-harm, mental health, or interpersonal violence. The rate of avoidable hospitalizations in the PHWA baseline report was based on a 3–5 per cent overestimation of the BC population; this methodological issue has been corrected in this report.

- **Diabetes Incidence** (Chronic Disease Registries) – Diabetes incidence rates are estimated using health administrative datasets that include physician visits (two or more visits in one year), hospitalizations (one or more visit in one year), and prescriptions (two or more prescriptions in one year) for diabetes. Prescriptions considered in the case algorithm for diabetes include insulin, metformin, and other anti-hyperglycemic medications used for diabetes management. To prevent off-label use of diabetes medications from being used to identify cases, all prescriptions except insulin must be prescribed within one year of a practitioner visit with a diabetes diagnostic code to be considered in the algorithm. The denominator for the diabetes incidence rate is "population with no known diabetes" (sometimes called "population-at-risk"; i.e., people who have not previously been diagnosed with or treated for diabetes).

- **Healthy Birth Weights** (BC Vital Statistics Agency) – In this report, "healthy birth weights" refer to live singleton babies with birth weights between the 10th and 90th percentiles for their sex and gestational age. The definition of the 10th and 90th percentiles used here is based on a national reference birth cohort of infants born in Canada (except Ontario) between 1994 and 1996 and at gestational ages between 22 and 43 weeks.

- **Infant Mortality Rate** (BC Vital Statistics Agency) – "Infant mortality rate" is the number of infants who die in the first year of life, expressed as a rate per 1,000 live births. The infant mortality rate is assigned to the year of the child's birth. The confidence interval for this measure is very large; therefore, the data should be interpreted with caution.

- **Living Long Lives (Life Expectancy)** (BC Vital Statistics Agency) – "Life expectancy" is the expected number of years of life remaining at a given age; in this case, at birth. At the time this report was prepared, births from 2020 and 2021 had not yet been added to the FNCF; therefore, this analysis assumed the 2020 and 2021 mortality rate for Status First Nations infants under one year of age was the same as the 2019 mortality rate for this age group.

- **Mortality Rate** (BC Vital Statistics Agency) – At the time this report was prepared, births from 2020 and 2021 had not yet been added to the FNCF; therefore, this analysis assumed the 2020 and 2021 mortality rate for Status First Nations infants under one year of age was the same as the 2019 mortality rate for this age group.

- **Serious Injuries** (Discharge Abstract Database) – "Serious injuries requiring hospitalization" are defined as injuries requiring overnight stay, excluding day surgeries. An event is one hospitalization. A patient may have multiple events during the reporting period. Data on serious injuries requiring hospitalization exclude patients who died during their hospitalization for that serious injury.

- **Youth/Young Adult Suicide** (BC Vital Statistics Agency) – There is up to a two-year delay in the reporting of deaths by suicide in BC; therefore, suicide deaths may be underrepresented in the 2020 and 2021 data because those deaths may still have been under investigation at the time of reporting.

IDENTITY AND GEOGRAPHY

These limitations and notes may have implications for the representativeness and comparability of the data.

First Nations, Indigenous, and "Other Resident" Identity

- Indicators that identify Status First Nations people via the FNCF cannot be directly compared to indicators that use other methods of determining First Nations or Indigenous identity (e.g., self-identification).

- "Other Residents" is a data category that includes non-Indigenous people in BC, as well as non-Status First Nations people and others who may identify as Indigenous, including Inuit and Métis people.

- Bill S-3, An Act to amend the *Indian Act* in response to the *Superior Court of Quebec decision in Descheneaux c. Canada (Procureur général),*[11] expands eligibility for First Nations Status. Therefore, the size of the Status First Nations population in Canada (and thus, the size of the population represented by the FNCF in BC) is expected to increase by the time the next PHWA report is written.

Sex and Gender Limitations

Due to current data limitations, analyses do not reflect a full spectrum of gender identification. In this report, data reported by sex (female/male) may reflect biological sex assigned at birth. Therefore, Two-Spirit, transgender, non-binary, intersex, and gender-diverse people may be misidentified in the data. The PHWA partners are committed to working toward meaningful, systemic change that will make more inclusive data collection and reporting possible.

Geographic Data Limitations

Also due to data limitations, regional analyses are based on regional health authority boundaries, which do not align with First Nations communities or territories. Currently, data analyses by First Nations community are not possible.

CHANGES SINCE THE PHWA BASELINE REPORT

Changes to PHWA Baseline Values

The PHWA data come from live data sources that change over time, which can result in retroactive updates to the data. Retroactive updates may be made in the FNCF due to legal changes in Status eligibility (such as those resulting from Bill S-3), corrected or updated information about a person's First Nations or Indigenous identity, and changes to other demographic information such as BC residency. Although these retroactive changes make the data more accurate, many of the values reported in this interim update—including the baseline values for many PHWA indicators—vary slightly from the numbers that appear in the baseline report. This applies to all measures based on FNCF linkages to health administrative datasets (Chronic Disease Registries, Discharge Abstract Database, and Vital Statistics Agency), and to the eight-year graduation rate based on data from the BC Ministry of Education and Child Care. Therefore, values for these indicators in this report are not comparable to those in the baseline report.

Fiscal Year Format

Since the baseline report was released, the way fiscal year is reported (i.e., April 1, YYYY, through March 31, YYYY) changed for the indicators of Avoidable Hospitalizations and Serious Injuries. In this report, fiscal years are shown in the format "YYYY/YY" (e.g., 2017/18), whereas the same fiscal year in the baseline report was labelled "2017" (the year accounting for most of that fiscal period).

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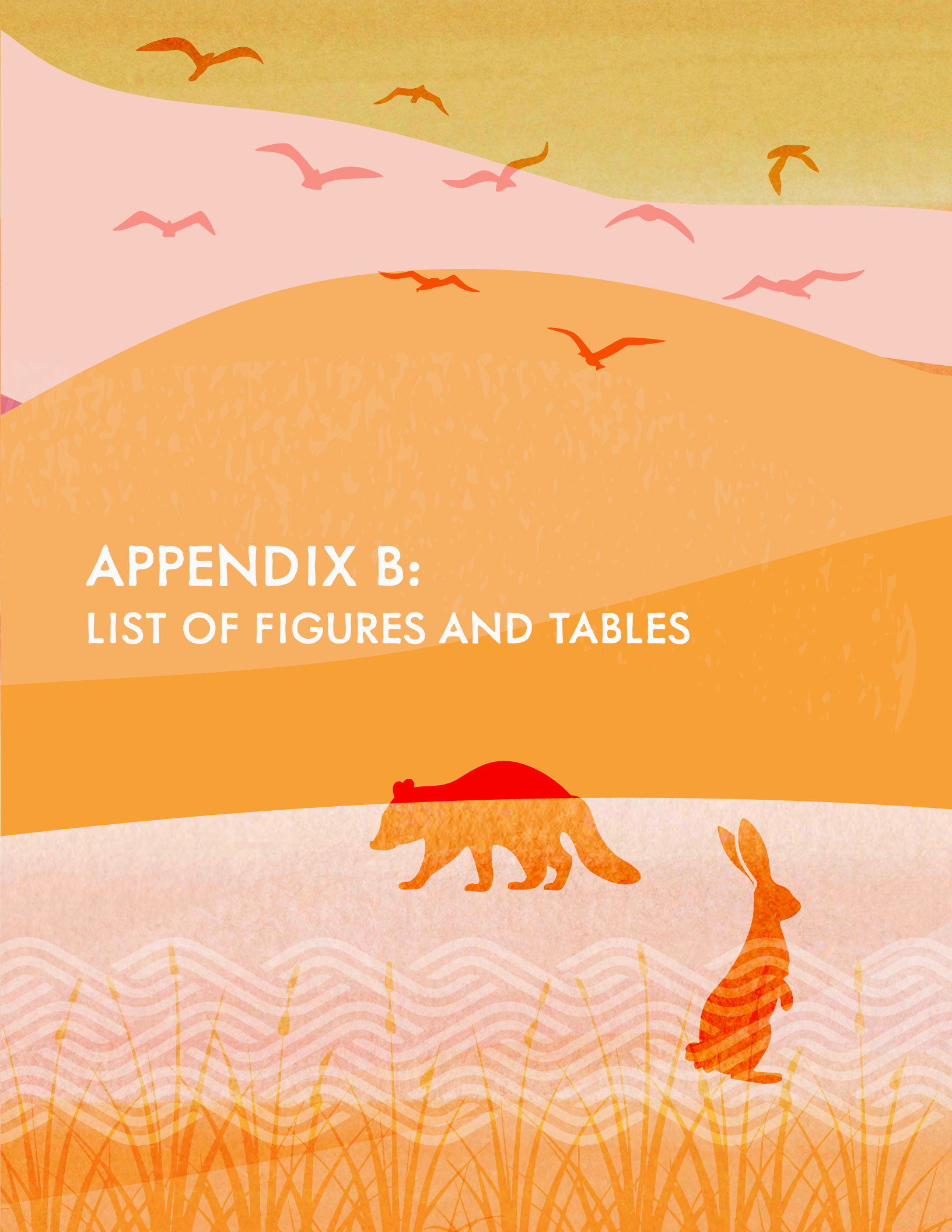
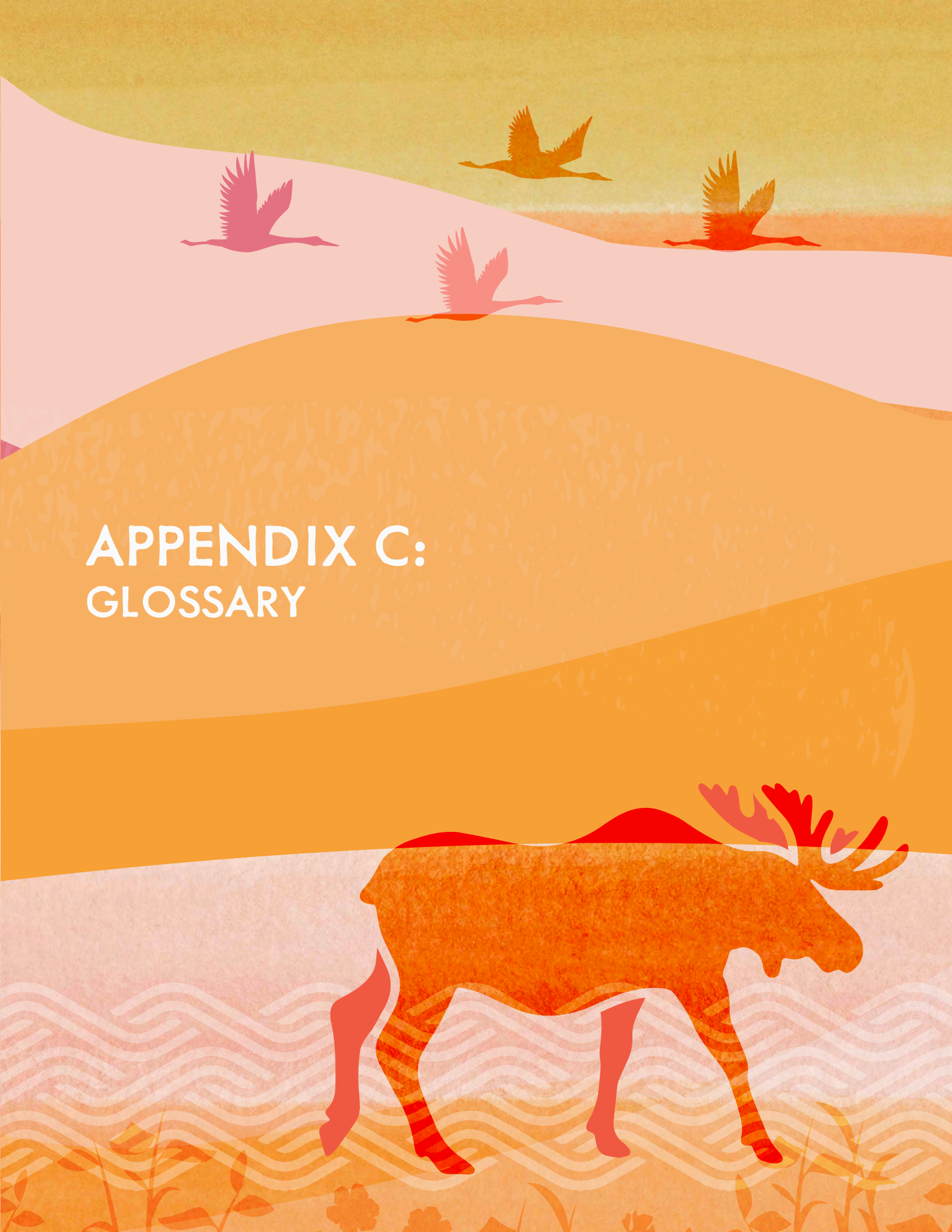


APPENDIX B:
LIST OF FIGURES AND TABLES

CHAPTER 1: INTRODUCTION

CHAPTER 3: SUPPORTIVE SYSTEMS



APPENDIX C:
GLOSSARY

2SLGBTQQIA+	refers collectively to people who identify as Two-Spirit, lesbian, gay, bisexual, transgender, queer/"Indigiqueer," questioning, intersex, and/or asexual, as well as people whose non-binary/non-conforming gender or sexual expression or identity is not reflected in this acronym.
Away from home	refers generally to a First Nations person or people living away from their reserve community and/or ancestral (home) territory, often in an urban area. Used in this report instead of "off reserve." However, BC First Nations people can also be living off reserve but consider themselves "at home" because they are still living on their unceded, ancestral, and traditional territories as a BC First Nations person. For a more nuanced understanding, please visit https://www.fnha.ca/WellnessSite/WellnessDocuments/FNHA-Urban-and-Away-From-Home-Health-and-Wellness-Framework.pdf. (see also *in community*)
BC First Nations	refers to those First Nations whose ancestral territories collectively form what is now known as the province of British Columbia. (see also *First Nations people in BC*)
Cis-heteronormative, cis-heteronormativity	is the widespread and often unquestioned assumption that cisgender and heterosexual people are the norm. This privileges these groups while marginalizing and doing harm to 2SLGBTQQIA+ people.[1,2] (see also *2SLGBTQQIA+*)
Distinctions-based	means recognizing the distinct histories, cultures, and contexts of First Nations, Inuit, and Métis, and treating them as distinct Peoples. A distinctions-based approach avoids generalizing about Indigenous Peoples as a broad category. Ideally, a distinctions-based approach also acknowledges the great diversity among and between First Nations Peoples.
Elders	are highly respected within First Nations communities for their deep historical, cultural, and spiritual knowledge and ancestral wisdom. They provide guidance, advice, and teachings to community members and honour traditional ways of knowing and being. "Elder" is a sacred title that one earns from their community. Elders possess wisdom gained through time and life experience, but the honour is not defined by age.[3(p.92)] The role of an Elder may differ from community to community.[4] (see also *Knowledge Keepers*)

First Nations	as a noun is used to refer to multiple Nations at the level of political and governing bodies ("First Nation" refers to a single Nation at this level). "First Nations" is also used as a descriptor, as in "First Nations woman," "First Nations Elder," or "First Nations languages."
First Nations people	refers to First Nations individuals. (see also *First Nations Peoples*)
First Nations people in BC	refers to all First Nations people in the province, including those whose ancestral territories are outside of BC. (see also *BC First Nations*)
First Nations Peoples	is an all-encompassing term that includes First Nations individuals, families, communities, organizations, Nations, and other collective bodies. (see also *First Nations, First Nations people*)
Heteropatriarchal	describes the widespread system of belief that elevates and privileges heterosexual males, while marginalizing and doing harm to women, girls, and 2SLGBTQQIA+ people.[1,5,6] (see also *cis-heteronormative, 2SLGBTQQIA+*)
In community	(or "at home") refers generally to a First Nations person or people living on a First Nations reserve within their ancestral (home) territory. Used in this report instead of "on reserve." However, there are also First Nations communities located in off-reserve urban and rural settings. For a more nuanced understanding, please visit https://www.fnha.ca/WellnessSite/WellnessDocuments/FNHA-Urban-and-Away-From-Home-Health-and-Wellness-Framework.pdf. (see also *away from home*)
Indian Act	is an explicitly racist, sexist, paternalistic, and genocidal piece of legislation in Canada that impedes self-determination and gives the federal government undue control over the lives and identities of First Nations Peoples.[7,8,9]
Indigenous	is a collective term for the Peoples who originally occupied the land now known as Canada. This includes Status and non-Status First Nations, Inuit, and Métis Peoples.

Knowledge Keepers	are people recognized in their communities and Nations for their extensive cultural, historical, and spiritual knowledge, which has been passed down through generations. They preserve and share this knowledge, which serves as the basis for teaching traditions, customs, spiritual practices and beliefs, and laws. Knowledge Keepers carry themselves according to traditional teachings, and may also be recognized and respected as Elders.[4,10] (see also *Elder*)
Lateral kindness	is an approach to address lateral violence based on Indigenous values, which promote social harmony and healthy relationships. (see also *lateral violence*)
Lateral violence	is a learned behaviour resulting from oppression in which those who have been oppressed feel powerless and may develop social skills and practices that contribute to an unhealthy environment or community. (see also *lateral kindness)*
Millennium Scoop	(see *Sixties Scoop* for definitions of both terms)
Other residents	is a data category used in this report to compare data for Status First Nations people with data for anyone in BC who is not a Status First Nations person. In addition to non-Indigenous people, the "other residents" category includes non-Status First Nations people and others who may identify as Indigenous, including Inuit and Métis people. (see also *Indigenous, Status First Nations*)
Reciprocal accountability	is when all members of a community are accountable for their decisions and actions and for their contributions to the community's wellness as a whole. Traditional First Nations social systems were founded on the concept of reciprocal accountability. These ancestral teachings provide the foundation for this definition.[11]
Self-determination	may be broadly defined as "the ability or power to make decisions for [one]self, especially the power of a Nation to decide how it will be governed."[12]

Settler colonialism	may be defined as "a system of power [rooted in white supremacy] that seeks to eliminate Indigenous Peoples and establish settlers' rights to Indigenous lands."[13(p.229)] It is distinguished from other forms of colonialism by its "replacement of Indigenous populations with an invasive settler society that, over time, develops a distinctive identity and [asserts its own] sovereignty."[14]
Sixties Scoop	refers to a time, beginning prior to and lasting for decades beyond the 1960s, when many First Nations babies and children were "scooped" by the "child welfare" system, removed from their families and communities, and raised in non-First Nations households (the same was done to many Inuit and Métis children and families). This is part of a long history of racist and discriminatory child welfare policies being used as weapons of settler-colonial oppression and attempted assimilation.[15,16,17] This has continued into the 21st century and became known as the "Millennium Scoop."[16]
Status First Nations	is used in this report in place of the problematic legal term "Status Indian." The term "Status First Nations" encompasses people with legal status as well as people who are eligible for but do not currently have legal status under the *Indian Act* (also referred to as "Status-eligible"). (see also *Indian Act, Status Indian*)
Status Indian	is a legal term for a First Nations person in Canada who is subject to the provisions of the *Indian Act*. Although the term "Status Indian" is still used in many datasets, it is problematic and potentially harmful. Therefore, this report uses the term "Status First Nations" in place of "Status Indian." (see also *Indian Act*, *Status First Nations*)
Two-eyed seeing	is an approach that weaves together First Nations Knowledge and ways of knowing with Western knowledge. This approach was first presented by Marilyn Iwama, Mi'kmaq Elders Murdena Marshall and Albert Marshall of Eskasoni Nation, and Dr. Cheryl Bartlett.[18] A two-eyed seeing approach provides invaluable wisdom from First Nations ancestors and Elders that is key to understanding the health and wellness of First Nations Peoples. While the concept of two-eyed seeing is intended to embrace both Western and diverse Indigenous perspectives, the Office of the Provincial Health Officer sometimes uses the term "multiple-eyed seeing" as well to emphasize that there are many distinct First Nations and Indigenous perspectives on any given subject.

Vaccine hesitancy	is defined by the World Health Organization as "a delay in acceptance or refusal of vaccines despite availability of vaccination services."[19]
Watchmon	describes someone who watches over, protects, and guides their community by standing guard and warning community members of impending danger. This is a traditional role in many BC First Nations cultures. In honour of these teachings, the First Nations Health Authority's Chief Medical Officer fills the important role of Watchmon by monitoring, reporting on, and providing two-eyed seeing leadership to improve the health and wellness of First Nations people across the province. For more information, please visit https://www.fnha.ca/Documents/FNHA-CMO-Watchmon-Role.pdf. (see also *two-eyed seeing*)
Wholistic	describes a way of seeing and understanding the world as whole and balanced, interconnected, and circular. This spelling is deliberate as it implies "whole," as recommended by Mi'kmaq Elder Murdena Marshall. Wholistic health includes supporting the whole person; i.e., the physical, mental, emotional and spiritual aspects of their well-being.[20]
Wise practices	are approaches that are strengths-based, community-driven, and rooted in Indigenous wisdom, teachings, worldviews, and ways of creating knowledge. Wise practices promote sustainable and equitable outcomes.[21]

For additional definitions, please refer to the glossary in the First Nations Population Health and Wellness Agenda baseline report:

https://www.fnha.ca/Documents/FNHA-PHO-First-Nations-Population-Health-and-Wellness-Agenda.pdf
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