First Nations Health Authority
Health through wellness

A JOURNEY TOWARDS ACCESSIBILITY

PERSPECTIVES FROM FIRST NATIONS IN BRITISH COLUMBIA

TECHNICAL RESEARCH REPORT

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DIALOG

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EXECUTIVE SUMMARY

Background

First Nations people with disabilities face serious barriers to accessibility. Community engagement done by the Assembly of First Nations found that a lack of accessible homes, programs and services forces many to leave their communities. The 2015-2017 Regional Health Survey, a national health survey conducted by First Nations for First Nations living on reserve, found that 21 per cent of adults reported needing support at home due to a mental or physical health condition. Currently, the degree to which existing accessibility standards and guidelines are contributing to improved accessibility in First Nations communities in BC is not known, and from a cultural perspective, and there are gaps in the scope of existing standards and opportunities to enhance approaches from a cultural perspective. This project aims to identify ways to help address these gaps and improve accessibility standards through community engagement with First Nations in BC. First Nations voices are needed to make standards culturally safe and relevant to First Nations people and communities.

The First Nations Health Authority (FNHA) provides health programs and services throughout the province of British Columbia to all First Nations communities. This includes constructing and maintaining health and wellness facilities to support the delivery of community programs and services. Building safe, accessible and culturally appropriate space is a priority for FNHA.

The FNHA partnered with the Rick Hansen Foundation and DIALOG (an architecture, engineering and planning firm) to develop and conduct the Perspectives on Accessibility from First Nations in BC project. Funded by Accessibility Standards Canada (ASC), the project gathered stories and translated knowledge about what is essential to First Nations in BC from an accessibility perspective.

Purpose of the project

This project offers insight into the ways in which accessibility plans, principles, regulatory standards and guidelines can be enhanced to support the FNHA, as well as federal agencies, in delivering services to First Nations people living in BC. To prioritize First Nations needs, perspectives and protection, this project adopted culturally safe and humble approaches to provide a First Nations-led, community-driven methodology and analysis. This report summarizes the project findings with the aim of supporting the ASC's goal to develop and refine accessibility legislation and regulatory frameworks. With its overall objective of establishing avenues for sharing wholistic and diverse First Nation perspectives on accessibility, this project represents a major step for the FNHA and First Nations people and communities in BC towards envisioning the development of inclusive and meaningful First Nations-led legislation and standards in practice.

Current legislation and gaps in understanding

A rapid review was conducted to identify progress and issues related to accessibility legislation and research in British Columbia and Canada. Over the past two decades, the federal government has made significant strides in advancing accessibility through international and national initiatives, notably adopting the UN Convention on the Rights of Persons with Disabilities and passing the *Accessible Canada Act* (ACA), which sets out to eliminate barriers in federally regulated sectors by 2040. British Columbia has responded with its own legislation, including the *Accessible British Columbia Act* and complementary regulations to promote accessibility across the province. Despite these advancements, substantial gaps remain, particularly for Indigenous Peoples. The ACA included a five-year exemption for First Nations to allow for proper consultation, highlighting a history of exclusion from legislative development. Reports consistently show systemic barriers in Indigenous communities, including inadequate infrastructure, underfunding, limited resources and jurisdictional conflicts. High-profile cases, such as that of Jordan River Anderson, underscore the real-world consequences of these gaps.

Furthermore, research on accessibility from Indigenous perspectives is limited. Existing studies often apply western frameworks and focus heavily on health care. Emerging Indigenous scholarship calls for culturally grounded approaches and highlights the need for inclusive, community-driven policy-making. There is a critical knowledge gap regarding how First Nations in British Columbia specifically relate to and experience accessibility, reinforcing the urgency of meaningful engagement and further research.

Method and analysis

This project used a community-based participatory research approach, with the FNHA reaching out to First Nations communities in BC, First Nations people with lived and living experience of disability, partners, accessibility-related organizations and scholars from across Canada to form a Research Advisory Committee (RAC). Using a relational approach to recruit participants, the RAC connected the research team with individuals interested in participating in the study. Participants joining the project represented a diverse set of identities, including lived or living experiences of disability, Indigeneity, gender, age and geographical location. Other participants included individuals with professional experience working with First Nations people with disabilities and included service providers, early childhood educators, support workers and FNHA staff. All participants had to be a resident of BC when they enrolled in the study.

A total of 89 participants consented to join the project. Between June and December 2023, participants engaged in an individual interview or a focus group session held virtually or in person. During these engagements, participants were asked three research questions:

1) **What does accessibility mean to you?**
2) **What are the barriers to accessibility?**
3) **How do we improve accessibility?**

Participants were encouraged to share stories, experiences and insights about their perspectives on accessibility.

All engagement sessions were audio-recorded for in-person sessions and audio and video-recorded for virtual sessions. All audio files were transcribed manually verbatim. Using these transcriptions, the project team employed a two-phase qualitative analysis. The findings from the analysis were then reviewed by the RAC and shared with the participants for their feedback, ensuring that the results of this study offered an accurate and comprehensive understanding of First Nations perspectives on accessibility, their experiences with disability and recommendations for improvement.

Results

The core message from this research is that accessibility is for everyone. This means that accessibility is to be approached, created and sustained wholistically. Accessibility is understood to be an essential part of health and wellness and is always available both for individuals and their broader communities regardless of their particular identities (e.g., Indigeneity, gender, age, etc.), experience with disability or life circumstances. Participants spoke about the value of a wholistic approach as a way to balance the *mental, emotional, spiritual* and *physical* facets of a healthy, well and balanced life.

Within this approach, five core areas were identified: respect using a strengths-based viewpoint; wisdom through connection to language, traditions, culture and medicine; valuing relationships with family, Elders, community, land and care providers; establishing a sense of safety through empathy and compassion; and encouraging visibility through representation, which fosters a sense of belonging in communities and supports inclusion. Participants also highlighted the critical factor of understanding how diverse identities and life circumstances intersect in unique and impactful ways, thereby shaping how individuals experience everyday life. Participants emphasized the need to examine how power, privilege and trauma intersect with accessibility so that challenges to accessibility can be more comprehensively addressed.

In discussing the accessibility challenges and difficulties participants have encountered, two key themes emerged: systemic barriers, including social and cultural barriers, and environmental barriers, particularly geographical challenges, inadequate designs and poor construction of the built environment within their communities. Both barriers posed significant challenges to First Nations people and their communities. Systemic anti-Indigenous racism, stigma and discrimination based on physical and/or mental ability were often the catalysts for negative and unpleasant social interactions, leading participants to distance themselves from the public sphere and, in extreme cases, avoid seeking essential health care services. Many of the environmental barriers were congruent with the ASC priority areas (employment, the built environment, information and communication technologies, communication other than information and communication technologies, procurement, programs and services, and transportation), although these barriers were especially problematic for those residing in rural and remote areas of the province. Specifically, participants highlighted the lack of attention to accessibility and disability needs in physical infrastructure. Limited access to and availability of transportation, as well as the absence of alternative options such as taxi services and public transit greatly hindered movement to and from essential destinations, including health care services, public facilities and other establishments within and beyond their communities. Deficiencies in road networks further exacerbated these issues, particularly during emergencies, resulting in delays or a lack of ambulance services. Such limitations were especially pronounced for rural and remote communities; however, inadequate options for transportation remain problematic even in urban settings.

To improve accessibility, participants asserted that cultural barriers, anti-Indigenous racism, and discrimination need to be overcome. Participants suggested mandating training in cultural competency, safety and humility for health care staff and the general public. They expressed that there was a need for improved accountability measures so they could feel safe in public and in care settings. Participants suggested that having more Indigenous health care providers could mitigate systemic anti-Indigenous racism and discrimination and that this would also help increase representation and leadership of First Nations people in health care and other decision-making positions. Overall, participants emphasized the need to promote cultural competency, safety and humility training and establish a system of accountability to address unjust treatment.

Participants strongly recommended that programs and services should include cultural and traditional knowledge, including incorporating ceremonies, traditional events and traditional medicines into care practices. Cultural revitalization initiatives and educational opportunities were mentioned as ways to support First Nations people to reconnect with their cultural roots, which have been long disrupted and displaced by colonial and western ways of knowing. Additionally, participants urged meaningful community engagement wherein those with lived or living experiences of disability and accessibility issues would be consulted about the design and planning of spaces. Throughout discussions with participants, there was significant emphasis on the motto “Nothing about us without us.”

To reduce environmental barriers, participants advocated for culturally inclusive designs and bringing services closer to home to improve accessibility and ensure that individuals can remain in their communities. Expanding telehealth was also identified as a way to improve accessibility and access to care. Participants also urged improvements to pre-existing barriers such as poor road networks and the lack of information and telecommunications infrastructure, which are increasingly important given the digitalization of communication and health care delivery.

Discussion

The current research project sought to understand First Nations perspectives on accessibility by exploring their diverse stories and experiences across rural, urban and remote communities in BC. These narratives revealed a wide range of accessibility challenges specific to First Nations people and their communities, many of which were rooted in the legacy of colonialism and ongoing practices that continue to overlook First Nations needs. A multidisciplinary project team successfully guided the project in a meaningful, First Nations-informed, culturally appropriate way, which resulted in gathering perspectives and insights on accessibility and disability challenges from field experts, service providers, Elders, Knowledge Keepers, community members and those with lived or living experience with disabilities. Most importantly, this approach resulted in raising awareness of tangible solutions for overcoming barriers and addressing challenges to accessibility from a diverse set of perspectives.

The most significant finding from this project is that accessibility extends beyond physical and environmental factors, which are often the sole focus of current legislation. Both the ACA and the *Accessible British Columbia Act* reflect a clear commitment to achieving accessibility for all—a vision echoed by First Nations. However, the findings highlighted in this study suggest that addressing systemic and cultural barriers is just as critical for improving accessibility for First Nations people as addressing environmental barriers. Many examples of systemic and cultural barriers, including discrimination, systemic racism and negative personal experiences while seeking or receiving services, underscored that these challenges are neither new nor adequately addressed. Similarly to the findings outlined in the *In Plain Sight* report, many of the barriers that participants spoke to in this project were attributed to the legacy and ongoing impacts of colonialism and colonial practices. These experiences reiterate the urgent need to address systemic and cultural barriers, such as anti-Indigenous racism, that continue to persist and create barriers to accessibility.

Areas for improvement

Various organizations and levels of government have already committed to developing cultural safety and addressing systemic racism. For instance, the Health Standards Organization has pledged to address systemic racism by following the guidance of the Truth and Reconciliation Committee's (TRC) Calls to Action. Both federal and provincial governments have adopted the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). BC's *Declaration on the Rights of Indigenous Peoples Act (DRIPA)* further signifies a commitment to ensuring legislation implements actionable measures toward addressing systemic and cultural barriers. Yet accessibility legislation does not adequately acknowledge and address these barriers, which means that disparities and inequities for First Nations health and well-being will continue to exist.

The project team identified six main areas for improvement to move forward in a good way:

1. **Build relationships through meaningful community engagement and collaboration to promote inclusivity, accessibility and equitable health outcomes.** Meaningful consultation with First Nations must prioritize respect for their sovereignty, ensuring that decisions related to wellness, health and quality of life reflect Indigenous rights and values. This includes addressing barriers that prevent First Nations people from participating in an equitable manner. Meaningful collaboration must be grounded in mutual respect among all parties involved, along with a shared goal of working towards collective well-being. Relationship-building serves as the foundation from which such collaboration can emerge.

2. **Mandate cultural safety and humility training, including education on First Nations traditional teachings and worldviews.** As expressed by the participants, improved cultural safety and humility and awareness of Indigenous worldviews, ceremonies, values, and practices would improve relationships and interactions at both personal and community levels between First Nations people and the non-Indigenous population, including health care providers. To make Canada more accessible, particularly for First Nations, it is imperative that governments remain committed to the TRC's Calls to Action, UNDRIP, and that they mandate cultural safety and humility training. This commitment is crucial for putting forth the necessary awareness of the continued inequalities that First Nations people continue to experience.

3. **Support First Nations-led solutions through community-led examples.** Examples of community-led and First Nations-informed services illustrate wise practices that incorporate culturally informed and culturally safe ways of bridging western health care systems and First Nations ways of approaching health and wellness. These services are often effective, compassionate and responsive. They highlight how First Nations-led solutions can be supported across BC, by integrating them with mainstream services, enriching care experiences through strength-based, person-centred, and individualized approaches within communities.

4. **Engage in advocacy by promoting First Nations leadership and representation.** Ensuring First Nations representation, including champions and leaders with lived and/or living experience of disability, in decision-making spaces is essential not only for appropriately addressing the needs of First Nations but also for strengthening self-determination and advocacy efforts. This representation can help uphold First Nations inherent rights to health and wellness, free from discrimination and stigma, for both individuals and communities. As outlined in the TRC's Calls to Action, UNDRIP and DRIPA, greater First Nations participation in the discussion and decision-making process is imperative to ensure that critical priorities are identified and addressed from First Nations perspectives. By actively supporting this inclusion, governments and organizations can fulfil their commitments under these legislative frameworks, which affirm that Indigenous Peoples have the right to determine and develop their priorities and strategies for development.

5. **Improve essential infrastructure.** Urgent attention is needed to upgrade transportation and road networks within and outside of communities, especially those on reserve lands, including basic structures like paved roads and sidewalks, as well as infrastructure for internet connectivity and information and communication technology. Access to essential infrastructure should not be viewed as a privilege but as a fundamental right. If BC and Canada have pledged to uphold the TRC's Calls to Action, UNDRIP and DRIPA, then addressing the infrastructure gap must remain a top priority to ensure meaningful progress.

6. **"We are no longer recommending, it is our demand to be prioritized" – reconciliation through accountability and responsibility.** In the ongoing work of reconciliation, governments and key stakeholders must engage in mutual and reciprocal actions that catalyze systemic shifts away from the systems rooted in colonialism that continue to affect First Nations people and communities. Governments and key stakeholders have already committed to legislation and frameworks such as UNDRIP, DRIPA and the TRC Calls to Action. By endorsing these commitments, governments have not only acknowledged but pledged to recognize and respect Indigenous cultures, beliefs, values and traditional teachings in their entirety. However, given the persistence of systemic discrimination within existing systems, robust countermeasures and meaningful accountability mechanisms are needed to ensure adherence to these commitments. Enforcing compliance and holding those who fail to uphold these commitments accountable is a fundamental responsibility of governments and all involved stakeholders.

Recommendations

Following these areas for improvement, the findings support and suggest implementing the following actionable recommendations:

1

Align policy and regulatory frameworks to address systemic barriers: First Nations leaders recommended implementing cultural infrastructure (i.e., increased human resources capacity) and fully integrating Indigenous cultural ways of knowing and healing. Formal and legal accountability measures must be implemented to eliminate discriminatory practices. Frameworks should be analyzed and revised to address accessibility barriers specific to First Nations. These revisions should involve collaboration with First Nations representatives and be supported by education, cultural competency training and awareness campaigns to share knowledge and promote learning.

2

Address existing environmental barriers: Focused attention is needed to address existing environmental barriers, including more financial support, to achieve substantive equality and improve the quality of life for First Nations people, especially those in rural and remote communities. Regionalization also supports flexible funding and closer-to-home services, breaking down barriers in localized, community-driven, Nation-based ways. Likewise, developing a full continuum of services and supports that uphold wholistic approaches to accessibility will also help address existing barriers.

3

Promote cultural safety and humility by mandating training and education: While governments and organizations have made commitments to promote cultural safety and humility, it is no longer enough to *recommend* cultural safety and humility training. Governments and organizations must mandate training to promote culturally safe care for First Nations people. Initiatives such as book clubs, movie viewings and sharing circles that promote staff engagement with stories and experiences from the perspectives of people living with disabilities were suggested to allow for discussions around rights, leadership, advocacy, champions and power.

4

Shift from a medical model of disability to a social model of accessibility: Shifting perspectives on accessibility from a disability-focused to a person-centric perspective was one of the key messages brought forward from this study. This change can be initiated by examining how current amenities, signage, tools and resources focus on disability purposes and adapting them to be more inclusive. Promoting inclusive language also helps to foster community and connection.

Conclusion

This research aimed to deepen the understanding of First Nations perspectives on accessibility and disability by amplifying the stories, insights and expertise of those with lived and living experiences. Guided by principles of cultural safety and humility, the project was developed in partnership with experts, local organizations and community members, ensuring that these priorities remained central throughout the study. While the FNHA primarily focuses on health care services and programs, this study underscores that accessibility extends beyond the health care sector and must be considered across multiple sectors and communities.

The project concludes with an urgent note, emphasizing the lack of policy and legislative provisions to address systemic barriers to accessibility. As demonstrated in the findings, systemic and cultural barriers remain among the most pressing challenges for First Nations people. Feedback from participants during the virtual knowledge-sharing event and in the online survey strongly demands follow-up actions to share and address the findings and recommendations from this research. In alignment with the recommendations from study participants, the research team and project partners advocate for increased collaboration and partnerships with First Nations communities, prompt action to address existing challenges, and sustained efforts toward reconciliation through cultural safety and humility education. While the multi-level governance and jurisdictional complexities overseeing First Nations communities further complicate accessibility efforts and can make it difficult to implement effective solutions, it remains critical to push for substantive changes to improve the quality of life for First Nations people.

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LIST OF ABBREVIATIONS

ABCA – Accessible British Columbia Act
ACA – Accessible Canada Act
ASC – Accessibility Standards Canada
BC – British Columbia
BCANDS – British Columbia Aboriginal Network on Disability Society
CBPR – Community-based Participatory Research
DRIPA – Declaration on the Rights of Indigenous Peoples Act
FNPOHW – First Nations Perspectives on Health and Wellness
FNHA – First Nations Health Authority
RAC – Research Advisory Committee
SDOH – Social Determinants of Health
TRC – Truth and Reconciliation Committee
UNDRIP – United Nations Declaration on the Rights of Indigenous Peoples

ACKNOWLEDGEMENTS

This report has been designed and written for First Nations communities to document and share their experiences, stories and thoughts on accessibility issues in BC. All quotes used in this report came directly from people who participated in the research project.

This project was made possible by funding support from Accessibility Standards Canada. We gratefully appreciate the agency's support and contribution in helping us conduct this important research that addresses accessibility needs and challenges for First Nations people in BC. We also extend our gratitude to the First Nations Health Authority for their overall support throughout this project.

We sincerely thank all those involved in the research project and the making of this report. We especially thank our participants who wholeheartedly shared their stories with us during this journey to learn about how accessibility impacts First Nations people and communities. We are grateful for the friendships and relationships we have built along the way. We hope this report sheds light on the accessibility issues in First Nations and brings a greater focus to address these issues going forward.

We gratefully send our appreciation and gratitude to the members of the project's Research Advisory Committee for their expertise, commitment and devotion to addressing accessibility and disability issues among First Nations communities. Their humility and invaluable insights were instrumental in guiding us throughout the project, and we are deeply thankful for their support. We would like to offer a special thank you to Patrick Aleck (Xwaluputhut), a Resilience Keeper from Stz'uminus First Nation and Penelakut Island, as well as a motivational speaker, drummer and advocate with living experience of cerebral palsy. Patrick's invaluable contributions to this project have been deeply impactful. His unwavering dedication and passion for advocating for First Nations and individuals with disabilities resonated profoundly throughout his involvement, enriching the connections he made with participants. We are truly grateful for his insights, commitment and support in making this project meaningful.

We acknowledge that this work was carried out on the traditional, ancestral and unceded territories of numerous First Nations. We honour and respect the diverse cultures, histories and contributions of these Nations. We are grateful for the opportunity to work on these lands and are committed to supporting the well-being and self-determination of First Nations communities throughout the province.

RESEARCH ADVISORY COMMITTEE

We are sincerely grateful to the following members of this panel for sharing their expertise, bringing the support of their respective organizations and participating in a collaborative discussion. Their contributions have generated actionable recommendations that we are confident will contribute to improving accessibility for First Nations in BC.

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ABOUT THIS PROJECT

First Nations people with disabilities face serious barriers to accessibility. Community engagement done by the Assembly of First Nations found that a lack of accessible homes, programs and services forces many to leave their communities.[1] The 2015-2017 Regional Health Survey, a national health survey conducted by First Nations for First Nations living on reserve, found that 21 per cent of adults reported needing support at home due to a mental or physical health condition.[2] Currently, the degree to which existing accessibility standards and guidelines are contributing to improved accessibility in First Nations communities in BC is not known, and there are gaps in the scope of existing standards and opportunities to enhance approaches from a cultural perspective. This project aims to help address these gaps by improving accessibility standards through community engagement with First Nations in BC, as First Nations voices are needed to make standards culturally safe and relevant to First Nations communities.

The First Nations Health Authority (FNHA) is a health and wellness partner to over 200 First Nations communities across BC. Being the first organization of its kind in Canada, the FNHA began a new era of First Nations health governance in BC by taking responsibility for the programs and services that were formerly delivered by Health Canada.[3] Since 2013, the FNHA has addressed service gaps through partnerships, close collaboration, health system innovation, reform and redesign of health programs and services for First Nations individuals, families, communities and Nations. The FNHA is also a champion of culturally safe practices throughout the broader health care system. By taking a leadership role, the FNHA actively works with health partners to embed cultural safety and humility into health service delivery and improve health outcomes for First Nations people. The FNHA's community-based services largely focus on health promotion and disease prevention. Part of the FNHA's mandate is to, over time, modify and redesign health programs and services through a collaborative and transparent process with First Nations in BC to better meet their health and wellness needs.[4] This project offers a unique opportunity to explore the concepts of accessibility alongside the lived and living experience of First Nations people with disabilities in BC and will serve to inform future modifications or redesigns of health programs and services provided by the FNHA.

Along with partners at the Rick Hansen Foundation and DIALOG (an architecture, engineering and planning firm), the FNHA was granted funding by Accessibility Standards Canada (ASC) to gather stories and translate knowledge about what is important to First Nations in BC from an accessibility perspective. This project was designed to seek input from First Nations individuals, families and communities to explore the concepts of accessibility alongside the lived and living experience of First Nations people with disabilities. This included exploring the concept of accessibility within public and private settings, from community facilities and housing to wayfinding signage. It also examined broader accessibility planning topics, such as the equitable inclusion of people with a diversity of abilities in areas such as employment, transportation and other spheres of community life.

This project offers insight into the ways in which accessibility plans, principles, regulatory standards and guidelines can be enhanced to support the FNHA and federal agencies in the delivery of services to First Nations living in BC. This work provides an opportunity to engage in research that amplifies *and* integrates First Nations perspectives, with the aim of removing barriers that hinder full participation in community life. This project strives to contribute to more equitable systems that are responsive to community needs—which will, in turn, benefit all First Nations in BC.

Background

Accessibility is the idea that people should be able to use something without being excluded because of a disability. At its core, accessibility refers to the ease with which individuals can reach, enter and use facilities and services.[5,6] This includes the physical and spatial distribution of resources, the organizational structure of institutions and businesses, the affordability of services, and the cultural acceptability of providers and practices.[6,7,8,9,10,11,12,13] Accessibility encompasses various dimensions, including geographic, organizational, financial and sociocultural factors, which can either facilitate or hinder the use of facilities and services.[5,6]

In the context of health care, accessibility is often conceptualized as a crucial determinant of health care utilization, with direct implications for equity in health systems.[5,6] Geographical accessibility to health care services, for instance, reflects the spatial distribution of health care facilities and the ease with which residents can reach them, which can vary significantly within and across regions.[9] Other barriers to health care accessibility include language barriers,[14,15] cultural participation,[8] anti-Indigenous discrimination,[11,16] systemic barriers for Indigenous children and families,[17,18] educational barriers[19,20] and Indigenous identity and gender discrimination.[11,13,21,22] Many of these barriers intersect in compounding ways, adding complexity to an already complex and multidimensional health care system.

Accessibility has been an urgent area of focus for Indigenous communities, especially for Indigenous people with disabilities and chronic health conditions. According to the 2017 Aboriginal Peoples Survey (APS) and as shown in Table 1, 32.3 per cent of First Nations people living off reserve, 30.0 per cent of Métis and 18.6 per cent of Inuit respondents aged 15 years and older reported having a disability that limited them in their daily activities. The survey also found that disability rates were higher for women than for men across the three Indigenous groups. Among all Indigenous groups, mild disabilities were most commonly reported, with pain-related disabilities being the most prevalent.

Table 1: Percentage of Indigenous people with disability[23]

	First Nations living off reserve	Métis	Inuit
Aged 15+ years	**32.3%**	**30.0%**	**18.6%**
Women aged 15+ years	**44.1%**	**43.4%**	**38.0%**
Men aged 15+ years	**39.8%**	**36.4%**	**35.7%**

Phase 3 of the First Nations Regional Health Survey in 2018 provided a more detailed look at the prevalence of chronic conditions among the Indigenous population. Of those surveyed, 59.8% of First Nations adults (aged 18 and older), 33.2% of First Nations youth (aged 12-17) and 28.5% of First Nations children (aged 0-11) reported having one or more chronic health conditions. In the survey, the participants were asked to self-identify diagnosed chronic conditions from a list of 34 conditions; Table 2 shows the top 10 reported chronic conditions by First Nations adults.

Table 2: Top 10 reported chronic conditions in First Nations populations [24]

Allergies	21.5%
Arthritis	18.3%
High blood pressure	17.2%
Diabetes	15.9%
Chronic back pain	12.4%
High cholesterol	10.2%
Asthma	9.6%
Anxiety disorder	8.9%
Stomach and intestinal problems	8.0%
Mood disorder	7.8%

Barriers to accessibility through poorly built environments and/or a lack of appropriate services and supports have been shown to have a direct relationship with both disability and chronic conditions.[24,25] Research has also shown that individuals who experience disability and/or have additional health problems and challenges are often restricted from access to resources that might mitigate problems.[25] For instance, living in conditions of poverty has been linked to increased illness and disability, which in turn is linked to diminished opportunities for gainful employment, thereby exacerbating circumstances of poverty.[24,25] Other barriers include a lack of safe housing (e.g., mould and mildew problems) and overcrowding, as well as a lack of access to safe drinking water, the internet and transportation due to poor infrastructure.[24(p35)] These barriers often define the lived experience of people with disabilities and/or chronic conditions—demonstrating how accessibility is deeply interconnected with disability and chronic conditions.

This interconnection can be explained by the social determinants of health (SDOH), which have been extensively studied to conceptualize the root of health disparities and inequities among Indigenous populations.[26] While social determinants can influence a broad spectrum of health, they can also act as catalysts for subsequent determinants—as seen in the prior example of living in conditions of poverty.[25] The SDOH illustrate how health is shaped not only by medical factors but also by structural and systemic influences. There are varying levels of SDOH; for instance, immediate SDOH encompass determinants linked to inequities such as "health-related behaviours, physical environments, and socioeconomic status." System-level factors of SDOH can include the "health care system, community, environmental stewardship, and cultural continuity," and distal SDOH includes "colonialism, fascism, and self-determination."[26] Unfortunately, Indigenous people who experience adverse impacts of SDOH "not only carry an additional burden of health problems but they are often restricted from access to resources that might ameliorate problems."[25] Therefore, accessibility cannot be examined separately from any one of these issues and, instead, must focus on the removal of physical, systemic and social barriers.[25] It must also be understood that disability is not solely a medical condition but also a socially constructed experience shaped by barriers.[27,28] This understanding aligns with the social model of disability, which highlights how inaccessible environments and discriminatory attitudes marginalize individuals, emphasizing the need for systemic change rather than individual adaptation.[27] In other words, addressing accessibility is critical for fostering inclusion and equity for people with disabilities.

Barriers to accessibility are also deeply rooted in the legacy of colonialism, which disrupted Indigenous governance, economies and social systems. Colonial policies, such as forced displacement, the reserve system and residential schools, undermined community cohesion, eroded cultural practices and created cycles of intergenerational trauma. These systems often severed ties to land and resources, which are central to Indigenous peoples' health, identity and economic independence, leading to ongoing health and socio-economic disparities.[29,30] Furthermore, systemic racism and exclusionary policies entrenched inequalities in areas such as education, health care and housing, perpetuating poor outcomes in health, income and overall well-being.[31] Health care, in particular, has been shaped by systemic barriers rooted in colonialism.[29] For instance, the pathologization of Indigenous identities, which often reflects a view of biological and cultural inferiority, has enabled the continued violence against Indigenous bodies in health care settings.[29] The ongoing impacts of colonialism have meant that First Nations people living with disabilities in on-reserve communities and urban settings experience considerable structural and attitudinal barriers that perpetuate poorer health outcomes.[29,32,33] These barriers oftentimes impede social and economic inclusion in ways that are, in contrast, distinct from non-Indigenous individuals.[10,34]

Objectives

1. **Identify gaps and opportunities for improvement in select areas of current accessibility standards from the perspectives of First Nations in BC, considering a range of disabilities.**
2. **Establish a multidisciplinary project team—made up of First Nation Elders/Knowledge Keepers in BC; artists, architects or designers; and community members who identify as a person with a disability—to apply a relational approach and form collaborative partnerships that serve as a foundation for informing and guiding accessibility research activities.**
3. **Share findings of research, information and recommended practices on accessibility barriers and standards to advance accessibility for a range of disabilities through the perspectives of First Nations in BC, supporting federal agencies and the FNHA in its work.**

Scope

To address the above objectives, this project provided opportunities for First Nations people in BC to share their living and lived experiences with respect to accessibility, the challenges they face accessing facilities and services, and their perspectives on how to improve accessibility in their community. The following three research questions facilitated the knowledge gathering:

1) **What does accessibility mean to you?**
2) **What are the barriers to accessibility?**
3) **How do we improve accessibility?**

Research design

This project follows a community-based participatory research (CBPR) approach, which has been well adopted and supported by Indigenous communities. CBPR can be integrated with Indigenous research methodologies, such as storytelling and relationality, and its principles uphold the inherent rights and values of Indigenous Peoples. CBPR is "an orientation to research that advances the development of culturally centred research designs and public health interventions, as well as the integration of Indigenous research methods."[35,36] Grounded in this approach, the project provides insights into the current landscape of accessibility for First Nations people and their communities, gathering their perspectives, experiences and stories as strong evidence to enhance understanding of their perspectives on accessibility, accessibility challenges and the barriers they face, and their recommendations for improving accessibility within their communities.

Additionally, the CBPR approach complements the FNHA's 7 Directives, specifically Directive #1 (which fosters community-driven, Nation-based principles), Directive #2 (which aims to increase First Nations influence in health programs and service philosophy), Directive #3, (which commits to protecting, incorporating and promoting First Nations knowledge and traditions) and Directive #4 (which supports meaningful collaboration and partnership with First Nations people and communities). To further enhance community-based participation, this project applied a partnership approach rooted in relationality and grounded in First Nations traditional teachings and ways of knowing, as described in Objective 2. The Research Advisory Committee (RAC) was also formed to help guide research activities while maintaining the focus on emphasizing First Nations perspectives on accessibility. The details of the partnership approach and the RAC are elaborated below.

Partnership approach

Establishing collaborative partnerships with key informants, including individuals with lived or living experience, is beneficial in helping researchers better understand the phenomena of interest. These informants may have expertise that can help researchers frame their preliminary understanding, identify the most relevant questions or appropriate approaches to the phenomenon of interest, and provide qualitative, in-depth detail about a phenomenon of interest.[37] Furthermore, the partnership framework approach developed by the FNHA and the Rural Coordination Centre of BC underscores the importance of forming partnerships with key stakeholders who are socially accountable for improving Indigenous health and advancing health equity.[38] Partnership approaches also align with Indigenous-centred research methodologies, such as relationality, which are based on relationship-building and reflect the purposeful intent of raising up Indigenous voices and people with lived experience.[35,39]

In alignment with this approach, the second objective of this project was dedicated to establishing a multidisciplinary RAC made up of members that included including BC First Nations Elders/Knowledge Keepers; artists, architects and designers; and community members who identify as a person with a disability, to inform and guide accessibility research activities. First Nations members brought in Indigenous insight and knowledge to guide the project activities, lead community engagement and provide support based on their cultural knowledge and traditional teachings regarding accessibility.

Twenty committee members were recruited over the course of the project. The RAC met quarterly or as needed throughout the project to provide guidance, advice and recommendations; review progress; and help address related issues. Their involvement in the project is detailed throughout this report.

To welcome expert opinions from those involved in creating an accessible environment, this project was partnered with the Rick Hansen Foundation and the architecture firm DIALOG to gain expertise in addressing accessibility issues. Representatives of the Rick Hansen Foundation and DIALOG have been involved in the study design, data analysis and recommendation development and provided their expertise and input on project approaches and activities. This included scoping the impacts of accessibility considerations for this project and its outcomes.

Rick Hansen Foundation

The Rick Hansen Foundation is actively working on developing guiding principles and an accessibility framework to inform recommendations for ASC standards, with a focus on universal design. Additionally, the foundation contributes to advancing ASC technical standards and provides training opportunities to become Rick Hansen Foundation certified while offering support and mentorship to trainees.

DIALOG

DIALOG is an architecture firm focused on embedding the DIALOG Community Wellbeing Framework through research approaches and streams. The firm works in collaboration with Indigenous and First Nations architects and designers and develops questions for accessibility considerations. They value community input and support a portfolio of engagement.

CURRENT LEGISLATION

There has been considerable effort in the last two decades to improve what is known about accessibility both internationally and within Canada. The *United Nations Convention on the Rights of Persons with Disabilities* was adopted in 2006 with the aim to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity.[40,41,42] The convention concerns itself with the difficult conditions faced by people with disabilities who are subject to multiple aggravated forms of discrimination on the basis of race, ethnicity, sex, gender, language, religion, political or other opinion, national, ethnic, Indigenous or social origin, property, birth, age or other status. In response to the convention, the Government of Canada implemented the *Accessible Canada Act* (ACA) in 2019, which aimed to make Canada barrier-free by January 1st, 2040.[43] This involves identifying, removing and preventing barriers in federal jurisdiction in the following priority areas: employment, the built environment, information and communication technologies, communication other than information and communication technologies, procurement, programs and services, and transportation. During the development of the ACA, the Government of Canada decided that First Nations band councils would be exempt from the ACA until 2026, pending further engagements with communities.[40,41]

To assist in implementing the ACA, the Government of Canada developed the Federal Data and Measurement Strategy for Accessibility 2022-2027.[44] The strategy covers an initial five-year period and explains what the Government of Canada will do to improve what is known about accessibility, especially with regard to information on current barriers to accessibility, how best to remove those barriers and how to prevent them in the future. In addition, the *Employment Equity Act* has also been implemented, with its purpose aimed at achieving equality in the workplace so that no person shall be denied employment opportunities or benefits for reasons unrelated to ability.[45] The act also serves to "correct the conditions of disadvantage in employment experienced by women, Aboriginal peoples, persons with disabilities and members of visible minorities by giving effect to the principle that employment equity means more than treating persons in the same way but also requires special measures and accommodation of differences."[45]

Provincial legislation has also been put into effect in response to the ACA. For instance, the Government of British Columbia enacted the *Accessible British Columbia Act* (ABCA) in 2021.[46] This act outlines accessibility requirements for the BC provincial government and organizations prescribed under the act.[47] It states specific requirements of the minister for recognition and accountability for accessibility, including the establishment of a Provincial Accessibility Committee. Organizations under the act are required to develop accessibility plans and feedback mechanisms. Health authorities, including the FNHA, are prescribed effective September 1, 2024, or earlier. The British Columbia Accessibility Directorate focuses on improving accessibility for people with disabilities by working across government and with business communities.[48] The *BC Building Code* (BCBC, 2018) is a provincial regulation that governs how new construction, building alterations, repairs and demolitions are completed.[49] The code establishes minimum requirements for safety, health, accessibility, fire and structural protection of buildings and energy and water efficiency. It applies throughout the province except for some federal lands and the City of Vancouver. The *Building Accessibility Handbook* (2020) provides further information on requirements under the BCBC regarding accessibility. It also offers recommendations on how to implement many of the code's requirements.[50] Finally, AccessibleBC: B.C.'s Accessibility Plan for 2022/23 to 2024/25 presented actions to date and priorities for 2022 to 2025.[41,42,49,51] This plan demonstrates that the provincial government is working towards a truly inclusive and accessible BC. The plan affirms the government's commitment to supporting the full and equal participation of people with disabilities in their communities.

Legislative issues

The federal ACA was developed in 2019 with an exemption for Indigenous Peoples across Canada for the first five years to allow sufficient time for consultation and co-operation with Indigenous Peoples. Historically, consultation and co-operation with Indigenous Peoples have been ignored or outright dismissed in the development and implementation of legislation and policy.[13,14,52,53,54,55] For instance, the First Nations National Building Officers Association[54] examined existing literature regarding barriers for Indigenous peoples with disabilities and found that persons with disabilities faced several accessibility challenges in Indigenous communities. There was also a lack of community involvement when designing spaces and developing standards. These barriers and lack of community consultation resulted in poorly developed built environments (e.g., limited or poor ramp access, inaccessible interior design), limited employment opportunities, an inability to meet accessibility standards set by the ACA, and limited knowledge, capacity, and resources for First Nations Chief and Council to effectively care for persons with disabilities in the community. Several other studies, such as Gerlach et al,[18] Antony et al[7] and Simpson,[56] also demonstrate the need for Indigenous inclusion in decision-making and the development of social programs.

While the exemption of First Nations in the ACA until proper consultation has been conducted is a move in the right direction, several reports leading up to the enactment of ACA (and provincial legislation in response to the ACA) have already pointed out significant gaps in addressing accessibility issues for First Nations communities. For instance, the British Columbia Aboriginal Network on Disability Society[57] compiled a report summarizing government/stakeholder and community perspectives and recommendations for federal accessibility legislation, programs, services and opportunities. The report indicates a number of issues, including underfunding, lack of information sharing and co-ordination within and between federal and provincial governments, and inaccessible housing. Barriers identified included limited non-insured health benefits, lack of proper community infrastructure and limited access to programs specific to disability. Overall, the report found the need for including First Nations and First Nations people with disabilities when developing and implementing disability-related policies and programs. Another report in 2018 by BCANDS[58] found similar issues and expressed the need for community-level education and training to address biases against Indigenous people and persons living with disabilities. What these reports demonstrate is the need for significant effort and funding to resolve the barriers that have already been identified.

Other issues that arise in the current legislation are jurisdictional barriers, particularly in relation to the split between federal, provincial and Indigenous government jurisdictions, which has resulted in an uneven patchwork of policies related to disabilities and overall care for Indigenous people.[59] For example, Jordan River Anderson, a young boy from Norway House Cree Nation in Manitoba, was denied timely care because different levels of government fund different services for First Nations children, which led to disputes between levels of government about who should pay for which services.[60] As a result, Jordan passed away in the hospital because governments could not agree on who should pay for his home-based care. Following the tragic event, Jordan's Principle was established in 2016 to stipulate the legal obligations that First Nations children can access products, services and supports they need when needed, with payments being worked out later.[61] While this legal rule is an excellent start, unfortunately, Jordan's Principle suffers from extensive backlogs—as of December 2024 in BC, approximately 2000 requests have not been answered—while the Government of Canada has continued to delay consultation with the Assembly of First Nations to address the problems.[62] Experts have also long criticized Jordan's Principle, stating that the law and its current interpretation are narrow, ambiguous and not transparent. Others suggest that Jordan's Principle does not go far enough, stating that a similar program be implemented for Indigenous adults.[17,58] As with the aforementioned legislation and studies focused on Indigenous accessibility, meaningful consultation *and* effective implementation are imperative in addressing accessibility issues faced by Indigenous people.

Gaps in understanding

Before the enactment of the ACA, accessibility studies relating to Indigenous people and communities have been few and far between, with even fewer studies focusing specifically on how First Nations understand accessibility. When accessibility literature did discuss Indigenous people or Indigenous communities, much of it related to health care settings and health systems more generally. Vives and Sinha[63] found that health systems were discriminatory towards Indigenous families and children. Other researchers, including Gerlach et al,[18] Loyola-Sanchez et al,[32] Puszka et al,[34] Simpson[56] and Umaefulam et al [64] explored the need for incorporating accessibility into models of care. Shochet et al[65] and Antony et al[7] examined how more culturally appropriate care needed to be implemented in the health system, especially for Indigenous patients. Researchers like Phillips-Beck et al,[66] Moore,[20] Croxall et al[8] and Hillier and Al-Shamma[16] centred their focus on the ongoing impacts of colonialism and barriers Indigenous people face in accessing health care.

Of the studies that offered insight into First Nations perspectives, the focus was more on Indigenous understandings of disability, which was viewed from a Western science perspective and demonstrated limitations, as Yellow Old Woman-Healy and Running Rabbit[67] pointed out. On the other hand, First Nations teachings, such as the spirit of a person found in Blackfoot culture, enable the strength and the resiliency of the person to shine through. Gerlach[68] offered some insight into the relevance of the concepts of “disability” and “rehabilitation” in the context of settler colonialism in Canada. Ineese-Nash[69] described that Indigenous ways of knowing disability were rooted in seeing people—especially children—as gifts. A few other scholars even provided intimate accounts of Indigenous women and elderly persons' lived experiences with disability.[8,11,16,22,70] While these accounts offer context-specific insights, further comprehensive knowledge gathering is needed to better understand how First Nations understand accessibility and the barriers to accessibility given the unique and distinct worldviews and experiences among First Nations people and communities. Crucially, there remains a gap in published literature about what is important to First Nations people in British Columbia within the context of accessibility. This project gathers information to inform a timely and pertinent conversation about how First Nations people in BC relate to existing accessibility principles, policy areas and standards in practice, as identified in the ACA.[43]

METHOD AND ANALYSIS

This study employed ethnographic qualitative methods, including in-depth, open-ended, semi-structured interviews and focus groups to gather First Nations perspectives on accessibility. The project began in 2021, and a total of 89 participants joined the project and shared their stories and experiences. The project used a community-based approach and embedded Indigenous methodologies—such as storytelling and relationality—throughout the project.[71,72,73] Moreover, inductive and narrative approaches to the analysis helped ensure that First Nations perspectives on accessibility were appropriately collated and analyzed to highlight key messages aimed to provide recommendations for improving accessibility. Justifications for selecting these approaches are explained in the "Analysis" section below.

Research guidance

This project followed a community-based participatory design model, guided by the RAC, to ensure research activities respected Indigenous ways of knowing and followed cultural safety and humility protocols.[74] In addition, this project was also informed by the First Nations Perspective on Health and Wellness (FNPOHW), which is a visual model that serves as a starting point for discussion by First Nations communities on what they conceptualize as a vision of wellness for themselves (Figure 1).[75] The current visual model and description were put into circulation after feedback and ideas were gathered from First Nations in BC at the Gathering Wisdom V in May 2012.

Currently, the FNPOHW is the only framework that offers insight into the perspectives of First Nations in BC on health and wellness. As such, the research team believed it was imperative that this project be informed by this framework. The visual model was used both throughout the interview process and during data analysis. During the interview process, participants were shown the diagram to help prompt discussions around accessibility. How the model was used during data analysis is discussed further in the report.

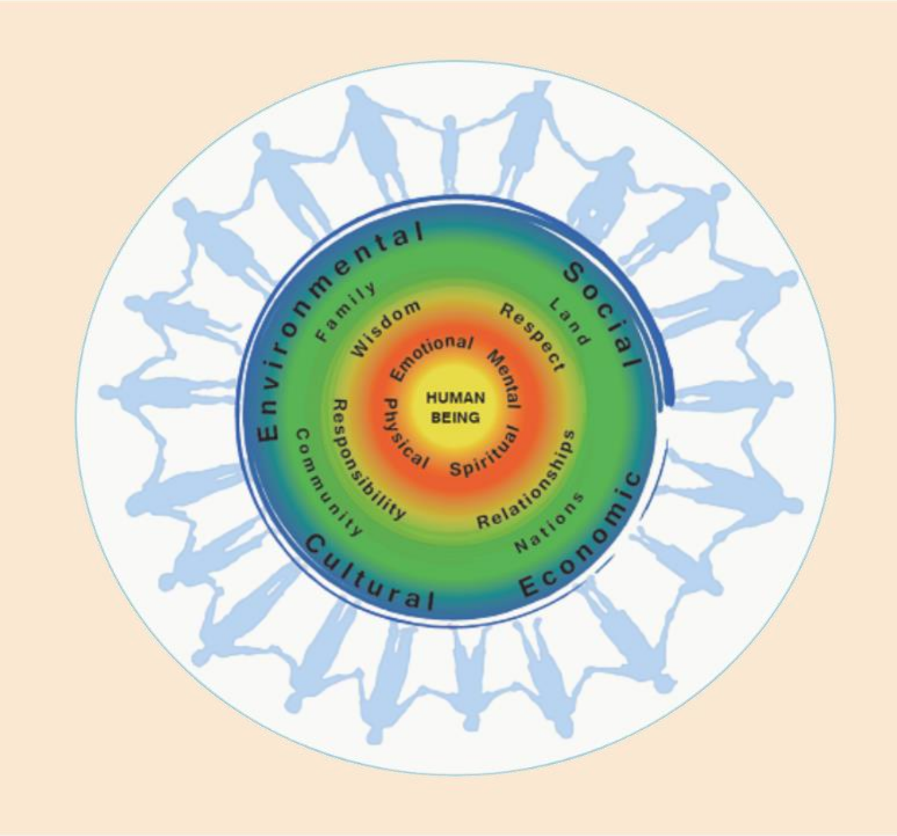


Figure 1. First Nations Perspective on Health and Wellness Visual Model

Participant recruitment

The FNHA operates across five health regions—Vancouver Coastal, Vancouver Island, Northern, Interior and Fraser Salish—working alongside and for First Nations communities to help address unique region-specific priorities defined by the communities. Recognizing these regional-specific challenges and distinct realities of living in urban, rural and remote communities, the priorities for recruiting participants were to seek representation from across the regions of BC and from people living in each of these types of communities.

Leaning on the Indigenous methodology of relationality, which centres on our relations to and with others, the recruitment of participants began with individuals known by and in relation to members of the RAC.[73] These connections included people from RAC members' own communities and personal circles who were interested in participating in this study. Participants were then encouraged to share the opportunity with their friends, family and community members and invite them to participate. Recruitment was also supported by FNHA regional teams, who advised on the appropriate communities and approaches to reach out based on their availability and experience. Wilson and Breen (2019) noted that our relations—to others, to the land, to our ancestors, to culture and ideas—are what make us who we are while also situating us within the larger social context in which we exist. By recruiting participants based on their relations with RAC members, FNHA or their First Nations communities, as well as their relationship to and with accessibility issues, this research is grounded in a relational understanding of reality.[36] In other words, the research team acknowledges that where and how we are connected to and with the ideas of this research project are co-emergent with our relations to and with RAC members, FNHA regional teams, the participants and their experiences, their communities and lands, and all the extended relations that we each bring into this research but are not visibly involved in the project.[36] In this way, the research team acknowledges the active relational process in which knowledge is learned and co-created together.

To minimize sample biases and improve the representation of project participants, participation was encouraged from First Nations community members and professionals with experience working with and for First Nations people with disabilities in BC; these included service providers (e.g., nurses, early childhood educators, support workers) and non-service providers (e.g., FNHA staff, professors, cultural facilitators). The project further encouraged participation from individuals from the above groups who also identified with any of the following:

- **Diverse identities**
- **Lived and living experiences of disability**
- **Gender**
- **Age**
- **Geographical locations (as per health regions)**
- **Community types (urban, rural, remote)**

Of the 107 individuals recruited, **89 were formally enrolled** and participated in the study.

Participant eligibility

Only residents of BC at the time of the interview were eligible to participate in the project, aligning with the FNHA mandate to support and improve the health and well-being of First Nations in BC. This includes incorporating and promoting First Nations knowledge, beliefs, values, practices and models of health and healing into First Nations health programs, policies and research, and recognizing that these may be reflected differently in different regions of British Columbia.[4]

Knowledge gathering

Between June and December 2023, participants engaged in an individual interview or a focus group session, either virtually or in person, wherever possible. The project team was also given opportunities to tour facilities in communities to observe accessibility features (or their lack thereof). Sites were chosen based on recommendations from study participants as well as the availability of the project team and the facility for a tour. In all, there were 11 focus groups, ranging from two to 11 people in attendance, and 24 individual interviews were conducted. There were four site tours, wherein four of the 11 focus group sessions took place.

An interview guide, which was co-developed by the RAC and the project team, helped facilitate in-depth, open-ended, semi-structured discussions with participants. The interview guide included the First Nations Perspectives on Health and Wellness (FNPOHW) diagram and participants were given the option to reflect on how the graphic related to their understanding and experience of accessibility (see Appendix B for Interview Guide). Both interviews and focus groups typically lasted one hour, but were held for as long as participants expressed a desire to continue the conversation.

Focus groups were formed with First Nations participants from regional communities, regional service providers working with First Nations people facing accessibility and disability challenges, and regional teams from the FNHA to offer perspectives from a health authority standpoint. All focus group sessions started with a round of introductions, an opening song performed by an Indigenous Elder or Knowledge Keeper from their community, and a reading of the consent form (see Appendix A for the community member consent form and Appendix B for FNHA staff consent form). Participants were either asked to sign the consent form for in-person sessions or verbally consent for virtual sessions, and were reminded that consent could be withdrawn at any time. An honorarium was provided to all participants (excluding FNHA employees) for their time and dedication to the project.

All interviews and focus group sessions were recorded in English, with permission from participants. For in-person sessions, the interviewer also took notes in real time to ensure the project team understood the perspectives shared during the session. The participants were asked to review and validate the notes as the conversation continued. After the session, audio files were sent to a third-party transcription service for full verbatim transcription; each transcription was further reviewed for its completeness by reviewing any parts flagged as “inaudible” by the transcription service. For inaudible parts of the transcripts, the researcher would go back to the audio file to attempt to catch more words or phrases and edit the transcripts if possible. Transcription files were then de-identified manually by the researchers by removing personal identifiers, such as personal names, age, gender and community names where they were from. De-identified transcription files were used for qualitative analysis.

Analysis

All data used for the analysis was from the interviews, focus group sessions and site tours. The project team employed a two-phase qualitative analysis, beginning with an inductive approach for the first phase and transitioning to a narrative approach for the second. As mentioned above, inductive and narrative approaches were selected for analysis due to their close alignment with Indigenous methodologies. Both of these methods are well-developed in western qualitative studies; however, the inductive method, for example, has been identified as compatible in research with Indigenous communities.[35] Narrative analysis, on the other hand, has been adopted as an analysis method that "relies on Indigenous ways of using stories for thinking."[76] Some critics, however, have raised concerns about its suitability for Indigenous research, as it "focuses on the researcher's interpretation of another's story, not the storyteller's interpretation."[35] To address this potential limitation and minimize the risk of misinterpreting perspectives, the findings from the analysis were reviewed by the RAC throughout the process and shared with the participants for feedback, ensuring that the results of this study offered in-depth insights into First Nations perspectives on accessibility, their experiences with disability, and recommendations for improvement. The analysis was conducted using NVivo version 14 and MS Excel.

In the first phase, researchers reviewed each transcript and began coding by identifying *what* participants discussed, capturing these as thematic inductive codes. Coding was performed by two research analysts, who each reviewed one transcript at a time. To ensure consistency, the analysts cross-reviewed each other's work, particularly when ambiguities arose regarding how specific quotes should be coded. A list of code definitions was also developed to maintain uniformity throughout the process. By the end of this phase, 145 unique inductive codes were identified. These codes were organized into progressively larger theme topics, resulting in three groupings corresponding to each research question. See Figure 2 for an example of an inductive coding process.

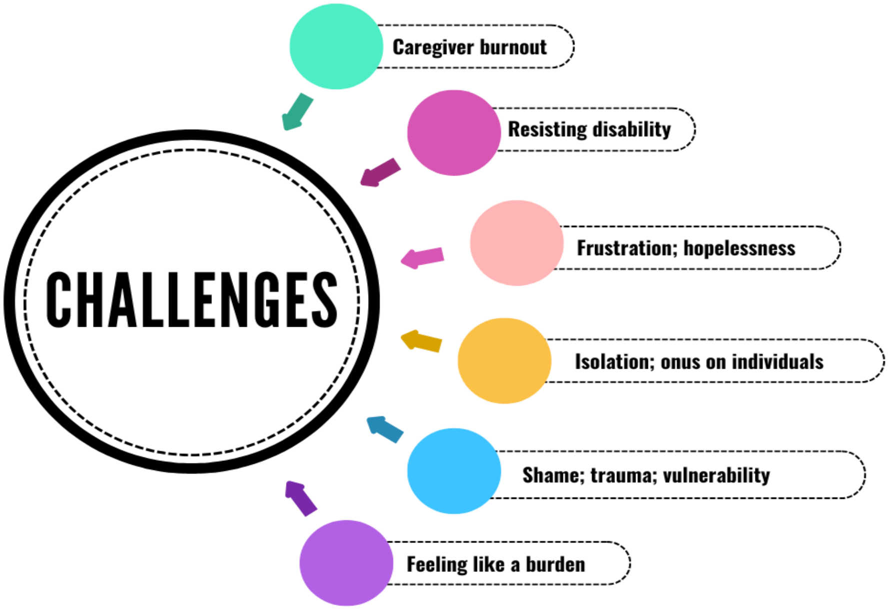


Figure 2. Example of inductive coding (question 1)

Following the inductive analysis in the first phase, the researchers consulted with the RAC to review codes identified from the analysis. Based on these findings, the RAC suggested a more narrative-driven approach, emphasizing perspectives and storytelling from the engagements. A narrative approach was thus adopted as the researchers proceeded with the second phase of the analysis, highlighting high-level key messages from participants and using direct quotes to define thematic codes and theme topics.

As this project relied on the FNPOHW during the interview process, the researchers recognized that many of the larger themes that came from thematic coding aligned with the FNPOHW framework, especially the second, third, fourth and fifth circles of the visual model. Therefore, the researchers chose to organize the high-level key messages from the thematic coding in line with the FNPOHW framework. Definitions for each of the FNPOHW circles were reviewed based on the descriptions provided by FNHA[75] to ensure codes were categorized correctly. This both helped validate this project's findings and validated the FNPOHW framework. While the majority of themes did align with FNPOHW, the tool itself was used only as a starting point; many participants both elaborated and expanded the FNPOHW framework, ultimately providing nuanced insights into First Nations perspectives as they relate specifically to accessibility.

To help inform recommendations and wise practices, thematic topics were also aligned with ASC priority areas, which will be discussed further in this report. The ASC priority areas are employment, the built environment, information and communication technologies, communication other than information and communication technologies, procurement, programs and services, and transportation.

Knowledge validation

To ensure community engagement and involvement in the research activities throughout the project, participants were asked to provide feedback, especially to validate the following:

- If the findings clearly and appropriately articulated their perspectives, stories, and reflections.
- Whether the findings represented their challenges with accessibility.
- Whether the stories and perspectives they shared can be used further for publications about the project.

In addition, participants were given opportunities to provide feedback on the research findings and draft project reports through town hall-style sessions, emails or over the phone. The research findings and the draft community-facing report were also shared with general audiences at events such as biannual FNHA Regional Caucuses in BC. To validate data and gather feedback on the results, research findings were shared with participants during a virtual knowledge-sharing circle and an online survey.[39] The feedback received was reflected and incorporated into this technical report.

RESULTS

The results section of this report is organized around the three research questions: what accessibility means, what barriers to accessibility exist, and how accessibility can be improved. The results offer insights into First Nations perspectives on accessibility and highlight the barriers and opportunities for improvement. The discussion section of this report provides further insight into the specific gaps and opportunities for improvement in select areas of current accessibility standards from a First Nations perspective, along with wise practices that emerged from participants. To begin, a review of participant demographics offers a glance at who participated in this study.

Participant demographics

A total of 89 participants consented to and joined the project, with their demographics summarized in Table 3. Of these, 30 individuals (33.7%) who identified as First Nations or Indigenous (including some who identified as Métis or as members of Indigenous communities from outside of BC) reported having lived and/or living experiences of disability.

Table 3. Participant demographics

Participant demographics	
The total number of participants	**89**
Seniors (aged 65+)	15 (16.9%)
Adults (aged 30-64)	69 (77.5%)
Youth (aged 29 and younger)	5 (5.6%)
Individuals identified as women	85 (95.5%)
Individuals identified as men	4 (4.5%)
Members of LGBTQ2+	8 (9.0%)

Identified as First Nations or Indigenous (Métis or from communities outside of BC) living with lived and living experience of disability	30 (33.7%)
Individuals with professional experience working with and for First Nations people with disabilities (incl. service providers and non-service providers)	48 (53.9%)
Service providers with lived experience of disability	11 (12.4%)

Of the participants, 48 (53.9%) were individuals with professional experience working with and for First Nations people with disabilities. This group included service providers such as nurses, early childhood educators and support workers, as well as non-service providers such as FNHA central staff, professors and cultural facilitators. Additionally, 11 participants (12.4%) were service providers who also had lived experiences of disability.

Regarding regional representation, 27 participants (30.3%) were residents of the Interior Region, 22 (24.7%) were from Vancouver Coastal Region, 15 (16.9%) were from the Vancouver Island Region, 13 (14.6%) were from the Northern Region and three (3.4%) were from the Fraser Salish Region. The regional locations of nine participants (10.1%) were not identified.

Accessibility is for everyone

> ***"So, it's, yeah, I think when you start thinking about accessibility, you realize that if you make something accessible for someone with things like ramps, that makes it accessible for everyone."***

When asked what accessibility means to them, participants expressed one key message: *accessibility is for everyone*. This means that accessibility is to be approached, created and sustained wholistically—where accessibility is an essential part of health and wellness and is always available for both a person individually and the larger community they are within. Accessibility, therefore, should not be something considered only by individuals living with a disability. For participants, this means shifting the perspective from a select few (i.e., only for those with disabilities) to the broader community, where accessibility is considered important for all (e.g., able-bodied people, providers, Elders, community members, family, friends, etc.). To enable this shift in perspective, participants highlighted the need for a wholistic and intersectional approach, which is discussed in more detail below. Direct quotes from participants are included to highlight First Nations perspectives and amplify their voices, providing a nuanced understanding of accessibility from a First Nations point of view.

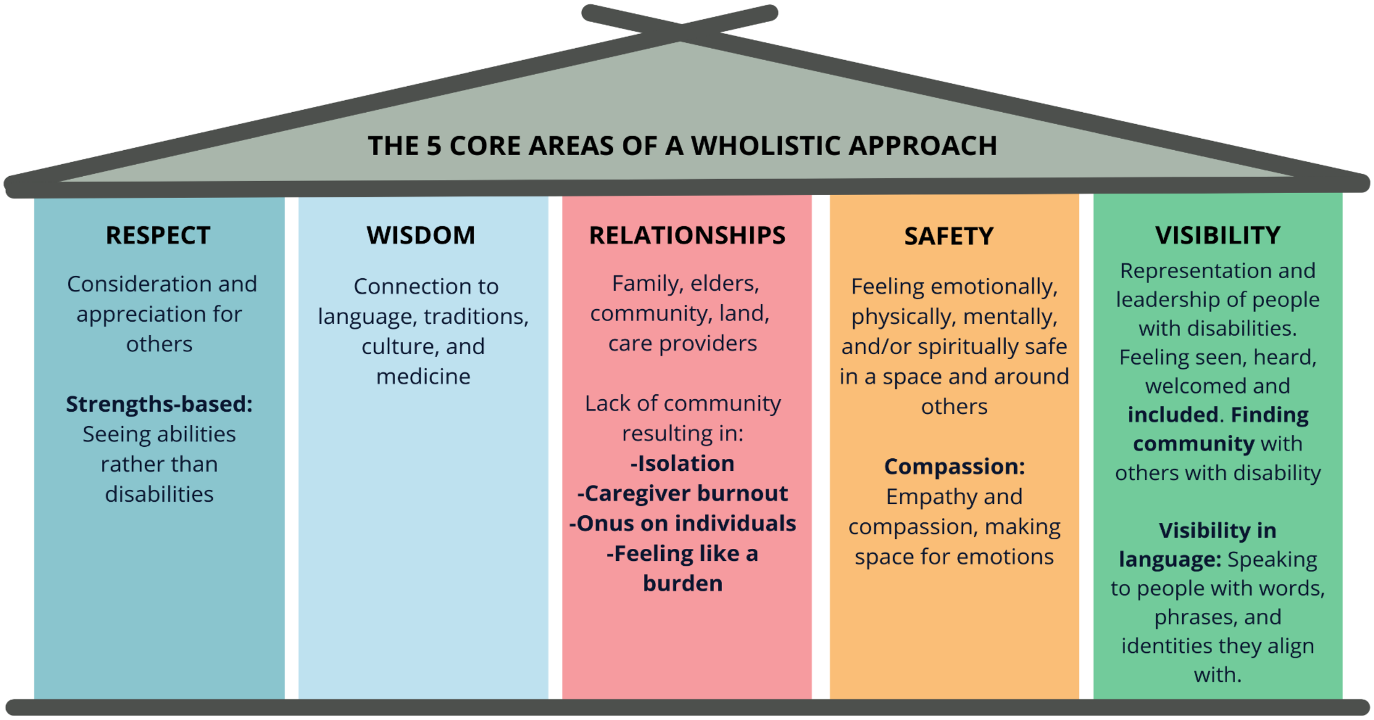
A wholistic approach

A wholistic approach, as expressed by participants, focuses on maintaining a balance between the *mental, emotional, spiritual* and *physical* facets of a healthy, well and balanced life. These elements of a balanced life align with the second circle of the FNPOHW diagram, which illustrates the importance of balancing and nurturing each of these elements together to create a wholistic level of well-being. One participant described the wholistic view and its depiction in a circle similar to the medicine wheel:

> ***"The medicine wheel, the way the medicine wheel works is you have to feed every quadrant of that circle, the mental, the spiritual, the emotional and the physical. And just think of that, that medicine wheel as rolling around on the ground. That's your wellness, just rolling around. But can you imagine if you weren't feeding your spiritual, so now you got a big bump there and, 'Oh well I'm not doing enough for my emotional, there's another big bump there.' It's not balanced, and as you're rolling along all of a sudden it would get all bumpy. And then that, that hole is in that medicine wheel the bigger chances of toppling over."***

Together with the mental, emotional, spiritual and physical elements of a balanced life spoken of by participants, the research team identified five core areas that supported and upheld a wholistic approach to accessibility—respect, wisdom, relationships, safety and visibility (see Figure 3 for the summary). Three of the five areas (respect, wisdom and relationships) align with the third circle of the FNPOHW diagram. Safety and visibility are additional elements that participants described as important to supporting and upholding a wholistic approach to accessibility.

Figure 3. Core areas of a wholistic approach



THE 5 CORE AREAS OF A WHOLISTIC APPROACH

RESPECT

Consideration and appreciation for others

Strengths-based: Seeing abilities rather than disabilities

WISDOM

Connection to language, traditions, culture, and medicine

RELATIONSHIPS

Family, elders, community, land, care providers

Lack of community resulting in:

-Isolation
-Caregiver burnout
-Onus on individuals
-Feeling like a burden

SAFETY

Feeling emotionally, physically, mentally, and/or spiritually safe in a space and around others

Compassion: Empathy and compassion, making space for emotions

VISIBILITY

Representation and leadership of people with disabilities. Feeling seen, heard, welcomed and **included**. **Finding community** with others with disability

Visibility in language: Speaking to people with words, phrases, and identities they align with.

Core area 1: Respect

Respect is an element in the third circle of the FNPOHW, defined as consideration and appreciation for others. According to the FNPOHW, respect also embodies a higher standard of care, consideration, appreciation and honour, which is fundamental to the health and well-being of First Nations people. In keeping with the FNPOHW definition of respect, participants described respect as honouring their traditions, cultures and selves, as well as being inherently intergenerational. Respect encompasses an understanding of where one comes from and is passed on through communities and families. Rooted in this understanding, First Nations people place a high value on consideration and appreciation for others. Accessibility, therefore, must align with this teaching by incorporating respect through thoughtful consideration and appreciation, particularly for those with accessibility needs. One participant explained:

> ***“No matter what they're there for, no matter how they look, or dress, or behave or, so it's that too, it's how you're treated when you're there. And whether you're listened to and whether your concerns are respected, and that's accessibility for me.”***

Moreover, respect, as described by participants, emphasized a **strengths-based** view of physical abilities rather than focusing on deficits or *dis*-abilities. Strength-based approaches challenge the medical model of disability, which emphasizes deficits, as opposed to the social model, which looks at **how environments are disabling rather than how individuals are disabled**. Indigenous participants tended to view people living with disabilities as people first, with diverse abilities, and as gifts to communities. An interviewee expanded on this understanding, explaining:

> ***“I think [it] is really important for people with disabilities in particular, is being treated like you're whole. Right? And not, like, you are, like, forever less than or you are just like a whole person. And I don’t have a lot to expand on that, but I think it just, it stands alone. You’re whole."***

Another participant further elaborated, providing context on the role of systems in perpetuating the notion of *dis*ability:

> ***“I think that that’s a really important thing that we talk about. So, like, really when we're using a definition of disability, I think it’s speaking to the fact that the current situation does not support individuals to thrive. Right? So it’s not a deficit. … we're not looking at a deficit in the individual. It’s that there are barriers in their system blocking their full participation. Whether that’s in employment, whether that’s in access to health care. … it’s a systemic issue that creates the disability. It’s not like a health condition that necessarily creates the disability.”***

A different participant further critiqued the deficit-based approach of the medical model:

> ***“don’t like the deficits that are used freely – mental health, mental health team, mental health clinician – I’d like to see more cultural and spiritual titles, cultural workers, traditional wellness, put a positive spin on our wording, put a positive spin on our teachings. Like provide a holistic approach to wellness as opposed to just a medical model of getting somebody better, because that medical model doesn’t work, and it only***

> ***addresses the physical and it doesn’t address the emotional or the spiritual and the cultural. And it’s very, very limiting to our people who are going through serious medical conditions.”***

Another participant shared a similar sentiment:

> ***“We look too much at the disabilities rather than the abilities. So when we’re looking at accessibility, I don’t like there being limits or anything. I think we need to look at the ability that the person – the abilities of the child, the abilities of the family. And what the family sees as those abilities as well.”***

From the strength-based approach, accessibility can also be defined as the “removal of barriers,” as explained by one participant:

> ***“We need to look at accessibility as a removal of barriers. So when we talk about having a disability, it’s not that there’s something inherently wrong with them as an individual. Because most people will develop a disability over the course of their lives. And that’s something that we often forget about. Like, as we age people become ill, they sustain injuries. So was I born with chronic pain disability? No. That came through my life. So. And my life experience …So we're talking about removal of barriers, we're talking about, like, removal of stigma around getting the accommodations that are required.”***

Core area 2: Wisdom

Participants discussed **wisdom** in the context of First Nations peoples’ connections to the land, distinct cultures and traditions, emphasizing how this fosters a sense of self and identity. Wisdom is also a key element in the third circle of the FNPOHW and is understood to be passed on by First Nations ancestors from generation to generation. One participant expressed:

> ***“We need to relearn our ways. And understand that as First Nations people we are gifted; we are gifted beyond many other people, many other folks. So we, for myself, we have we can feel, we can see, we can sense, we can be in a different dimension through our cultures and our practices. So we need to have those in with us through all aspects. That’s why we carry the medicine wheel, that’s why we work through the medicine wheel.***

> ***Because of everything I've learned about my culture, I walk in the world with my head held high, with my voice loud, and my chest out while I hold my drum and I sing. I feel powerful because of what I have learned. Everybody should have that ability to feel what I feel, to have their culture back, to have their support and their family."***

Building on wisdom and **traditional teachings**, another participant provided insights on the importance of relationality in accessibility, stating that:

> ***"Indigenous traditions are aligned with accessibility, in the sense that we don't leave our family and community to suffer while others thrive. Bringing this perspective into a health care setting opens doors for disabled Indigenous people to participate in alignment with their community practices."***

Highlighting the importance of following traditional teachings in maintaining health and addressing accessibility, two participants shared how they return to these valuable teachings:

> ***"I always go back to, you know, granny's teachings. 'We did things in a simple way,' she said to me. 'We were never complicated.' And that has always rang true for me."***

> ***"We have to find different ways of … looking after our kids and just our whole families, I guess. Finding different ways, like you say, go back to sweats and have community sweats and bringing the people in, bringing their traditions back. Like how we used to do. I used to hear our Elders talk about that lots and how our communities used to work together and that's how things brought us together was our traditions and our cultures."***

Language was also a significant topic of discussion. Language is a component of wisdom in the FNPOHW diagram (third circle) and is understood as an essential component of Indigenous peoples' culture. Language plays a vital role in communication and the intergenerational sharing of knowledge. In the context of accessibility and disability, the way language is used and communicated can be interpreted differently depending on an individual's disability, accessibility needs and First Nations identity. Participants emphasized the importance of using language and words that are considerate of individuals' backgrounds, experiences, and the identities they align with. One interviewee explained:

> ***"I think language is key. Having people be familiar with Indigenous people is key as well. But I think language is key, and fighting those assumptions, the assumptions that just come out, or people make off-hand comments. 'What are you doing… where are you coming from?' I think that's one of the big issues there."***

Additionally, the words chosen can have an emotional impact on First Nations people, particularly given their history of trauma and distrust in colonial systems. One participant stated:

> ***"Three words come to mind, and that is trust, relational and trauma-informed. … When you look at words like school or clinical or hospital, and being trauma-informed you recognize that those do connect to things like tuberculosis hospitals or Indian hospitals. Or getting into residential schools or day schools, where there's an intergenerational distrust of the system. And being able to work from a relational standpoint where it's about healing rather than prescribing something."***

Core area 3: Relationships

Relationships emerged as a key component of the wholistic understanding of accessibility and was a central focus in participants' conversations across several areas of analysis. Relationships, as defined by the third circle in the FNPOHW, are not solely about individual connections but also about building accessible spaces where meaningful connections can be fostered between the community, Elders, family and caregivers, land and nature, and service providers. Furthermore, inclusive accessibility promotes socialization and connection, which in turn fosters relationship-building—a foundational element in the wholistic view of health and well-being. Participants agreed with the FNPOHW definition, expounding that accessibility is inherently rooted in relationships. As one participant explained:

> ***"When we're talking about accessibility and disability, it has to be built on the relationship. And it needs to be – yes, structured in a way that's modelling that. And by relationship I mean holistically. It doesn't have to be person to person. The land, the spirit world. Its relationship to me is about all the rest."***

One service provider spoke to how individuals seeking services can be better supported through relationship-building:

> ***“Because we built these relationships with the youth and family. They felt comfortable enough to talk about different things, the problems and barriers they were running against and we said well, you know, we have different programs we can connect you with.”***

Adding further insights, another service provider shared the importance of providing support to all individuals accessing services:

> ***“Accessibility, really, for me was having the resources available to eat, and for it to be easy access. So, in a manner that was reachable, and supported, I just feel like it should be a smooth process. And I guess, like part of that process would be that whether adult, teen, whoever it is that's accessing the services, that they don't have to walk that road alone. So, I think that's a huge piece. That if we are, and we are willing and able, but to be part of that, that it doesn't have to be just put on the individual or the parent to navigate the system, and to navigate what their needs are. And that's why we are here, and we are those, we are a bit of those lightworkers.”***

Participants also noted that relationship-building needs to start immediately to foster trust, especially with providers who will be in the community for many years. As one participant expressed:

> ***“I think the key is to recognize that [accessibility is] going to be a relationship-building process. But also aiming for some sort of long-term stability with regards to people in community so that when they’re building that relationship from the get go… they’re in the community for multiple years.”***

Relationships go beyond the patient-provider dynamic. For First Nations, relationships are the foundation of community. Participants agreed—reiterating how relationships in a community setting can be paramount for supporting emotional well-being, especially for individuals with disabilities, as explained by one participant:

> ***“It’s a lifesaver. And I really need this to get out, to socialize, to be with people. And it’s important for me to have accessibility to be able to do that. Rather than staying in my house all the time and not doing anything and becoming a hermit. That’s very dangerous stuff, right? To your mental health***

> ***that's why my mental health is OK, because I have someone who reached out and helped me to get this wheelchair or this scooter. I'd never be able to do anything. It's hard enough just to get dressed in the morning. Try to have to go to the store, get milk or something, right? Yes, I wouldn't be able to do this sort of thing. I can, but it would take me a long time."***

As one interviewee pointed out, having a strong sense of community also fosters a feeling of mutual care and protection toward its members, ensuring that everyone is cared for:

> ***"I want all of us to get our needs met. So as a community, we all stand up and stand together. Not just individually like that sour grape."***

Participants also reflected on the **absence of community** and its negative impact on accessibility. Those with disabilities, in particular, expressed feeling like a burden when they needed assistance. They described the emotional weight of responsibility and frustration that comes from having to independently seek out the care and support they require. Similarly, caregivers shared experiences of burnout stemming from the overwhelming effort to provide support, especially for individuals navigating significant accessibility and disability challenges. Here are the participants' voices on the lack of community and its effects on accessibility:

One participant described how feelings of loneliness and disconnection can lead to **isolation**:

> ***"Getting into kind of the emotional perspective. I think where accessibility doesn't exist, it can be quite emotionally taxing on individuals, people barely, if they do want to participate, they can't, or they feel like they can't. So, I think there's that factor that comes into play. And I think it can create this sense of isolation from the community as a whole."***

Caregivers often experienced burnout, particularly when those they cared for felt helpless and lost, unable to navigate the current care system to access the support they needed—or when no services were available at all. In such cases, caregivers frequently described bearing a disproportionate amount of responsibility to support individuals with disabilities and/or accessibility needs. Below is a personal account from a participant:

> ***"Yes, all the things we take for granted my son can't do. And I – if I get exhausted from work, or from all the medical stuff, and I need a break, I have guilt for wanting to take care of myself. I'm like, 'I'm too tired to cook.' Yes, it's really tiring. So that's all I wanted to say."***

On the other side of caregivers' experiences are the perspectives of individuals requiring additional support. When individuals with accessibility and disability needs must heavily rely on those around them, they often describe feeling like a burden and perceiving themselves as helpless within the community. Below is a personal account from another participant:

> ***"Because unfortunately doctors are taught a lot, you know, like I said, disabled people aren't considered people that can do stuff, right. They're considered more like a burden. People hear the word disability and they're like, 'Oh, you can't work. You can't do anything,' you know, so people look at us as burdens, right, and I don't like that. And I'm very blessed to have the friends that I have; they've never looked at me like a burden."***

When accessibility is not adequately addressed, individuals are left to bear the responsibility for managing their own health and other needs. Individuals with accessibility and disability challenges often experience an amplified sense of burden—which is compounded among First Nations individuals. A participant explained that:

> ***"I was talking about barriers to access to services for First Nations people within the health care system, education system and those sorts of things. I find that with a lot of our families, there's a lot of need for advocacy, especially when it comes to health care and education. Especially, whether there's disabilities or emergency services, there's a lot of need for advocacy for First Nations people because when we go to the hospital, we're not treated the same as a … non-First Nations people. How do I word this? It's like I feel like we're … marginalized in those systems and to add disabilities is just another barrier on top of our identity barriers."***

Another participant echoed this sentiment:

> ***"I feel there's so much onus on those with disabilities, instead of on the people who are supposed to be working and supporting them, and ensuring they're doing their end to be the educated and aware."***

Core area 4: Safety

The topic of **safety** emerged as an element of a wholistic approach in participants' discussions, particularly when sharing personal experiences. Feeling emotionally, physically, mentally, and/or spiritually safe—both in a space and around others—was identified as a critical aspect of accessibility. Although 'safety' is not explicitly included in the FNPOHW, participants expressed that it is deeply connected to the emotional, mental, physical, and spiritual elements found in the FNPOHW's Second Circle. Many participants emphasized the challenge of finding spaces where they feel safe. One participant explained this, highlighting the difficulty this presents for individuals living in rural or remote communities with limited service options:

> ***"From an emotional and mental perspective, we might look at basic personal safety and security. So feeling comfortable with the programs or individuals that you're having to speak with to get here. In a lot of our remote communities there's only one option, and if that person doesn't align, or you don't feel comfortable or safe or have trust in them, or if you don't feel heard by them, you're really limited in your options, in where to go next."***

Another participant elaborated on the importance of safety in accessibility, explaining how some institutional settings can be particularly retraumatizing for Indigenous people:

> ***"From a mental perspective, always going back to the safety piece, and understanding that even from a cultural perspective or an indigenous lens that facilities can be quite triggering, depending on how they look. Obviously from our traumas inflicted from residential schools to indigenous hospitals. So I think accessibility from a mental perspective, you know, we should be mindful of those triggering facilities or spaces for people, so they feel safe when they come in."***

Participants described several ways in which safety can be achieved. For instance, a participant highlighted how building relationships grounded in trust can contribute to emotional safety:

> ***"I think it's so important to have, like, relationship is the number one thing. And if we have people with – you know, that we need accessibility for, we***

> ***need them to feel safe emotional. Number one. We need them to feel safe in that.***
>
> ***And I always say to parents that when a child comes to a childcare centre, they're gifting us their most sacred gift they have in the world, and we need to ensure that they feel safe. That emotional safety. And I know that we need to address that in many different ways with different families, but it's that guiding thing of building release and making sure people feel safe."***

Compassion and **empathy** also emerged as critical elements for creating emotionally safe spaces, emphasizing their importance in how individuals should be treated within care settings. One participant from a focus group explained how accessibility is compassionate:

> ***"For me accessibility is compassionate. Compassionate and a human – the human side of us…Really looking at those individuals as human beings. And they're your brother, they're your sister, they're your auntie, they're your uncle. They're whoever they might be, they're somebody's person, right? Yes. So for me that's kind of how I wrap up accessibility. It's not just about the access, but it's also about the elements the kind of come behind that. About the individuals, like us, providing that space for accessibility."***

When accessibility is addressed with compassion, there is validation. One participant stated:

> ***"Accessibility validates the emotions of disabled people, particularly those that are troubled by the state of the colonial system."***

Another participant highlighted the fundamental role of exercising compassion and respect in care settings:

> ***"I think the big one for me is being, just being very respectful and treating someone, and treating people like you want to be treated.***
>
> ***Yes, 100%. Treating people – I think that's, for me, that's the biggest one. That's my biggest takeaway from my, from my job is treating people how I want to be, how I want to be treated. Treating people with respect and dignity, regardless of their background, regardless of where they live, regardless of who they are, but treating them how I would like to be treated."***

A participant elaborated on a wholistic view of accessibility, where compassion is central to supportive care:

> ***"Creating that space where people are treated with compassion and … emotional support [is] available. It's not just physical, it's creating that mental emotional support for those that are seeking help, because it takes a lot for them to step into that space of taking care."***

Core area 5: Visibility

The last core area that participants identified to support and uphold a wholistic approach to accessibility is **visibility.** Visibility refers to the **representation** and **leadership** of persons with disabilities, which is crucial because it fosters a sense of being seen, acknowledged and heard by others. It enables individuals with disabilities to connect with others, forming a community and a space of belonging. Moreover, visibility raises awareness and promotes education about disability, paving the way for greater inclusivity. One participant shared the following insights about the relationship between visibility and accessibility:

> ***"I think that goes hand in hand, visibility before accessibility almost. So, yes and making things easier for people and even people that are getting older.***
>
> ***People who have a hard time with accessibility and not feeling like a burden. And making it easier to go into spaces for people who have physical barriers. Even my mom, a former soccer player, I go up faster on stairs than she does because she's got some knee problems. So, it's … important to – I never really thought about it until we started this project because you just learn how to push through. I guess that's that mental part, that mental perspective. But why do we need to always push through? And we don't need to."***

Representation of disability and accessibility needs in First Nations communities is essential for spreading awareness. One interviewee shared:

> ***"Fundamentally and foundationally, one of the things that has really driven me to a point of knowing that talking about disability amongst Indigenous Peoples needs to be amplified. And it needs to be amplified from a perspective that's not only capturing our experiences and our day-to-day interactions with the world, but what's not being shared? So what part of our knowledge systems has not been brought forward into the fold of our current understanding about what accessibility means, and about what a barrier is, and about what the premise of relationships must entail as we try to create a more accessible community and place of belonging."***

Another participant further added:

> ***"You really need dedicated resources to really be champions in this space and start to highlight the incredible power of resilience and strength that people who have different abilities have."***

Participants made clear that visibility fosters **inclusion** by helping individuals with disabilities feel welcomed into a space or program and that they belong. One interviewee explained:

> ***"What does accessibility mean to me? I think it's the freedom to be included without barriers in place. And that can mean mental, physical, all states that could put a person in a position to not have that freedom of access, whether that's a building, another person or a service rendered."***

Further, collaborating with individuals with disabilities and accessibility needs in the decision-making process can enhance the creation of inclusive spaces and programs by improving their overall inclusivity. As a participant from a focus group shared:

> ***"We should be developing partnerships, where it makes sense to like amplify some of the work that we can do together rather than build our own kind of thing that doesn't make sense. It's more like how do we, how do we start to identify our people, our champions in this work? And how do we ensure that the research is, is serving questions that our people actually have and want to work towards solving and stuff like that."***

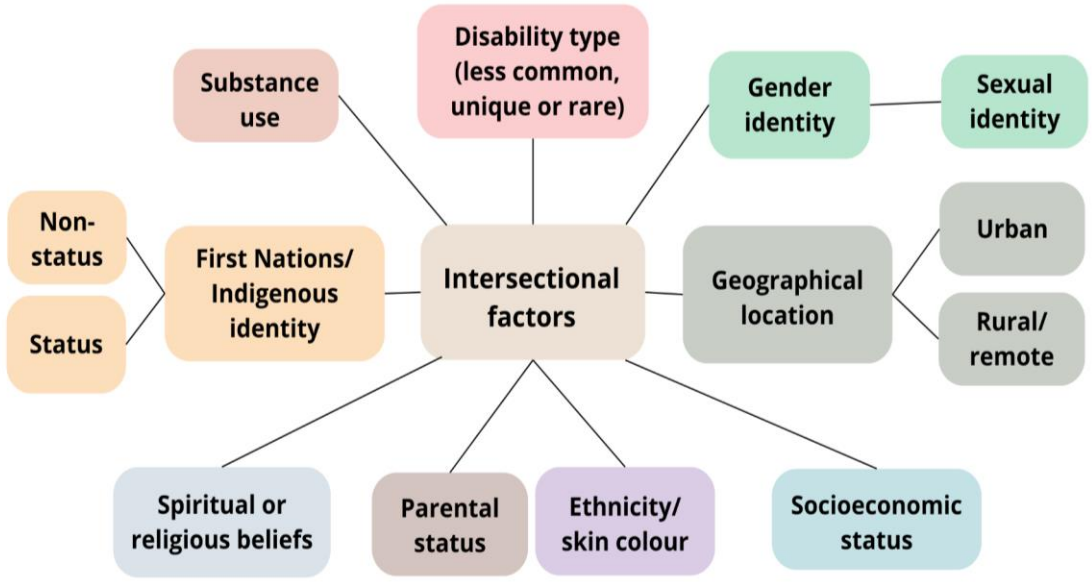
Adding to the importance of **leadership** among individuals with disabilities, one participant expressed:

> ***"Accessibility is way more than just buttons just allowing people access into spaces. It's actually giving them leadership roles in those spaces. And talking First Nations, nothing about us without us and then we do that, you know, people do that to other people."***

An intersectional approach

Intersectionality was raised as an important topic in understanding accessibility. In order to approach accessibility wholistically for First Nations people and communities, having an in-depth understanding of diverse First Nations perspectives is key. Intersectionality adds further dimensions of understanding to how accessibility can be achieved wholistically by exploring how unique and complex identities and circumstances contribute to how individuals experience their everyday lives. Overall, an intersectional approach means everyone is seen, heard, welcomed and included—regardless of their specific identities, abilities and life circumstances. Participants discussed how intersectionality shaped the ways accessibility and disability influenced individuals' lives, leading to unique experiences, distinct barriers and opportunities for improving accessibility. Intersectionality also impacted individuals' ability to enjoy independence and exercise their rights. Identity factors, such as being First Nations or a member of the 2SLGBTQQIA+ community, further contributed to diverse accessibility and disability needs (Figure 4).

Figure 4. Intersectional factors



As one participant from a focus group explained:

> ***"When I think of the ... considerations on creating welcoming spaces, for those with diverse abilities. I feel that can be answered in, like, and also a mental, physical and spiritual. Like, once again to those questions, you can answer that what a safe space – a welcoming space looks like. ... And even, like, the answers for those emotional, mental, physical, spiritual are going to be different for First Nations people, ... to be different for women, it would***

> ***be different for men, non-binary, two-spirit, different for youth, different for Elders. And so really the considerations for creating welcoming spaces is just listening to the diverse voices, and people feeling represented within those spaces."***

They went on to say:

> ***"The discrimination that you face, like, not just being, you know, Indigenous and also having a certain disability, you know, just all of those combined, it makes it really hard for people to go and access services and have access to safe services. And then actually feel comfortable disclosing that, because they don't want to further the stigma they're already experiencing with the discrimination they're already experiencing, right?"***

In sharing a personal account, a participant stated that:

> ***"So for myself, I can only speak to my own experience as someone who battles chronic illness, but I also have friends who struggle with similar things. And even if they are cisgendered white, if they're female – or depending on the intersection, like I think about the times that I've gone into a doctor with my partner present, and I get way different treatment. So if I have a white male with me, I'm listened to in a different way than if I go in by myself."***

Emphasizing intersectionality for First Nations when addressing accessibility underscored that accessibility extends beyond physical ability or disability. The intersection of **power** and **privilege** adds further dimensions to accessibility and disability experiences, shaping how they affect individuals' lives. In sharing a personal account, one interviewee pointed out that:

> ***"I would say one is the fact that we don't talk about intersectionality enough. My dad has these challenges because he's First Nations and he's disabled. And that's an automatic intersectionality that he has to navigate and it's had a huge impact on his life. And now that he is older, because he's in his 70s now, he now has an additional barrier in the fact that he's not young and strong, as strong as he used to be. So, he has a third additional challenge that is difficult. I would say another one that my dad faces, so this is a fourth intersectionality I think that probably is nuanced in the disability world. Is my dad's physical disabilities are unique. So, even in the picture that you show, a wheelchair, my dad's ... my dad's disability is not common. So, the***

> ***accommodations for him are not included in any of the accessibility considerations for the 'normal' world, for lack of a better word."***

One participant discussed their personal experience with accessibility through an intersectional lens:

> ***"I think accessibility is, there's so many aspects to it, but I think feeling welcome is really important, safety. And I'm not sure of the right word for this, but kind of suitability. Services are only accessible if they're suitable for your needs. And I think because of some of my identities and health issues and neurodivergence, etc., I know what services that, or they don't quite fit, because they're designed on a heteronormative, cis-normative, to, they're all normative services."***

In summary, from the participants' perspective, accessibility is for everyone, regardless of ability, identity or life circumstances. This means shifting the focus of accessibility from individuals with living or lived experience of disabilities to *all* individuals (e.g., able-bodied people, providers, Elders, community members, family, friends, etc.). The participants emphasized the need for institutions to take a wholistic and intersectional approach when considering accessibility, with a focus on five core areas—respect, wisdom, relationships, safety and visibility—and taking into account all aspects of a person's life (e.g., the mental, emotional, physical and spiritual) to secure a balanced and fulfilling life. Participants also highlighted the necessity of considering a person's identity and the ways in which power, privilege and trauma can impact how accessibility is achieved. This is particularly important when addressing accessibility in space planning and design, as further discussed in the next section.

Barriers to accessibility

In Question 2, participants shared the accessibility challenges and difficulties they have encountered in and outside their communities. From the conversations, two main themes emerged: systemic barriers, including political and social barriers, and environmental barriers, such as geographical factors and the built environment.

Systemic barriers

Systemic barriers were dominant in causing and creating barriers to accessibility for First Nations people and communities. Participants identified many types of systemic barriers that disrupted First Nations culture and traditional ways of being and living, impacted participants deeply at personal and interpersonal levels, and influenced their experiences in society, including in public spaces and in care settings.

***Colonization* continues to create complex and cascading harms stemming from historical and ongoing system-level policies and practices** that infringe not only on accessibility and disability but also on the overall health and wellness of First Nations communities. One participant described how accessibility is addressed differently between Eurocentric/western views and decolonial First Nations perspectives. They explained how the Canadian health care system is a colonial system with clear hierarchies of power, and how this structure excludes the voices of equity-deserving groups, with significant impacts on accessibility for Indigenous people with disabilities:

> ***"So we look at like access and then ability. And it's like access from a Eurocentric or western or North American lens, and the lens of privilege, is gatekeeping, in my experience. Who has access in that hierarchy? Doctors are at the top of that food chain and everybody else kind of falls in line from what I've seen. And so that gatekeeping really means that the patient or the person who has the disability is at the bottom of that rung. Whereas accessibility from more of a decolonial or First Nations lens, from what I've experienced sitting in a sweat lodge or in circle, is that we each have a voice at that table. And I don't find that in spaces, whether it be politically, at school, through the health care system. None of those spaces are built to have everyone's voice matter. Each of those colonial spaces, to me, has been one gatekeeping experience after the other."***

***Systemic anti-Indigenous racism, stigma and discrimination*,** which are rooted in the legacy of colonialism, have continued to marginalize and segregate Indigenous people from the rest of society. Participants described experiencing racism and discrimination based on their identity as First Nations, people with disabilities and/or health conditions, members of 2SLGBTQQIA+ communities, people with mental health challenges and substance use, and their socioeconomic status, age, and involvement with the criminal justice system. These factors were described as catalysts for negative and unpleasant social interactions, leading participants to distance themselves from society and, in extreme cases, to avoid seeking essential health care services. A participant stated:

> ***"Yeah, accessibility is so many different things. And it's also whether that experience affects your wanting to go back next time. And yeah. And whether you're treated well, I'm thinking of all the people who have told me,***

> ***Indigenous people who have told me that, when they go to the hospital, they're treated like an alcoholic or drug addict. No matter what they're there for, no matter how they look, or dress, or behave or, so it's that too, it's how you're treated when you're there. And whether you're listened to and whether your concerns are respected, and that's accessibility for me. And whether you can afford to, of course, if you're not that rich, that can afford to access services, the services you need."***

Additionally, the impact of colonialism continues to perpetuate through First Nations communities as ***intergenerational trauma***. Many participants spoke about the trauma of residential schools that continued to impact their health and well-being and that of their families across generations. Intergenerational trauma leads to mental and physical health challenges, relational difficulties, feelings of ***shame*** resulting from systemic racism, and ***mistrust*** in the institutional and medical system, further manifesting as a barrier to accessibility.[77,78,79] One participant described:

> ***"Oh, a big part of our trauma is my parents are residential school survivors. I have three older sisters that are day school survivors. So there was a lot of – I don't know how to say it without – it sounded like it's their fault because they went through bad stuff, but it affected us and how they treated us in a negative way."***

Another participant elaborated further, explaining how the province's health care system did not consider health wholistically and treated patients through a biomedical lens—neglecting to integrate culturally safe and trauma-informed care:

> ***"I think the biggest frustration for me is that – kind of circling back to like what I said about accessibility – I think one of the biggest things that I see as a barrier is the gatekeeping and that there's not space in a hospital or health care setting for the emotional and spiritual. They might touch on the mental, but it's more from that biological perspective of what pills could I give you. Not what programs might actually help shift the trauma that's happening in the body, … Because being someone who's been impacted by trauma, and those adverse childhood experiences – which many First Nation folks have had due to impacts of colonization and residential school and the intergenerational trauma – that trauma is a huge piece that the medical system just kind of sweeps under the rug and is like, oh yes, people have experienced trauma. Next? Stiff upper lip, let's move along.***

> ***And it's like, no, but that trauma piece actually is one of the big pieces of that pie that I talked about that is impacting all of those other things, including physical health. And without accessibility to treatment for that trauma piece, folks don't have as much chance to get better. If I had an option to go to – there are some, very few, but some treatment centres for addictions trauma, but there's not a lot for folks that genuinely – like a wellness model for folks to go get trauma care in the medical system."***

One interviewee explained another harm stemming from colonial policies:

> ***"There are a lot of students I ran into who, this was a big barrier to participation, maybe, their parents maybe been involved in the Sixties Scoop, or got residential school, or maybe they've been adopted out. And so, they wanted to reconnect. But they also were nervous that they, if they went to some sort of community event that they went out themselves as not being familiar with the culture. And so, there is that divide that actually can exist and, again people being hard on themselves as you say that."***

From a social perspective, many participants felt that ***the lack of consideration for cultural safety and attention to trauma caused by colonialism*** was a significant barrier to accessibility because of the ongoing overt and covert racism and discrimination they faced in public spaces and care settings. Many noted that the lack of available, culturally safe services in their communities presented a major barrier to well-being. For some, it was especially difficult when their cultural teachings and beliefs conflicted with western models of care around disability, leaving them at a crossroads between accepting care and refusing it. For example, one participant during the knowledge-sharing circle noted that the tension between western understandings of disability (i.e., as something that needs to be "fixed") and First Nations understanding of disability (i.e., as a gift) pressures First Nations people to view themselves as broken or not whole, leaving them feel ostracized and alienated in society. This highlights not only that First Nations perspectives and meaning of accessibility are conceptually different from the western view of accessibility, but also how this difference creates a significant barrier for First Nations, and how a lack of consideration for cultural safety can cause further harm.

Another participant expressed that an ongoing systemic challenge is the lack of respect for Indigenous cultures, laws and governance structures across institutions in the province. They called for greater awareness among service providers around cultural safety, sensitivity and appropriateness:

> ***"I think the recurrent barriers for people is … lack of culturally safe services, lack of culturally safe practices, and lack of services that are designed and implemented and facilitated by Indigenous people. We have all these Indigenous allies, and whatever, who speak for us and about us as if it were their right in terms of education and support and programming and delivering a service. Some of these people aren't culturally sensitive or culturally appropriate in delivering our services because there's lack of cultural respect and knowledge and teachings of Nations that they're working in. And I think that's a huge barrier for people whether they be doctors or nurses, therapists, professionals in the world, the lack of cultural sensitivity, the lack of respect, the lack of acknowledgement of our own societies, and our own governance, our own traditional structure of our Nations and our communities that aren't respected or honoured or acknowledged, that's a huge barrier. A huge barrier is lack of respect for our traditional teachings and our culture when we're in these vulnerable positions in the hospital, or in jail, or in the prisons or in the hospital. Any institution that we have in this province, I believe is a detriment to our people. Honestly. Especially the prisons. Especially the prisons."***

Environmental barriers

Participants identified environmental barriers as significant challenges, particularly ***geographical barriers and inadequate designs and poor constructions of the built environment*** within their communities. Geographical barriers were especially pronounced for those residing in rural and remote areas of the province. However, similar concerns were also voiced by participants from urban communities, who highlighted physical barriers stemming from a lack of attention to accessibility and disability needs. These challenges included limited access to and availability of transportation, as well as the absence of alternative options such as taxi services and public transit. For example, Greyhound terminated its operations in northern BC in 2018, with a full closure of service to Western Canada in 2021.[80,81] Although BC Bus North and a few other private bus companies have offered some reprieve to the loss of Greyhound service, these options are infrequent and overly expensive.[82] To compound the issue, BC Transit, the provincial corporation responsible for co-ordinating and delivering public transport, is routinely underfunded and has provided few viable options for intercity connections across the province.[82] These transportation barriers hindered movement to and from essential destinations, including health care services, public facilities and other establishments within and beyond their communities. It also creates major safety concerns as seen with the Highway of Tears, which refers to a section of Highway 16 between Prince Rupert and Prince George, BC, where inadequate transportation has forced locals to resort to hitchhiking as a form of transportation.[83] Deficiencies in road networks further exacerbate these issues, particularly during emergency situations, resulting in delays or a lack of ambulance services. One participant explained the impact of having no public transportation in their rural community:

> ***"We don't have a lot of public transportation. There's one bus that kind of provides a circuit of public transportation within the main city, but for those of us that live outside of the city in the more rural areas, there's no public transportation. So that leaves people like my parents or even our son, who doesn't drive, you know, with no option to be able to access services that they might need. Like the grocery stores, mail, the doctor, dentist. You know, some of the, what I would consider essential services."***

Another participant shared the numerous negative impacts of inaccessible design on their ability to get around in their everyday life:

> ***"So back home, my band office wasn't accessible. So I'd never been to my band office for my first, whatever, 15, 20 years because it wasn't accessible. And then, then they finally moved and built a new building. And then I was able to get into our band office back home. And the same thing with schools. I mean, as I mentioned that none of them were accessible and so they had to make a lot of those adaptations.***
>
> ***I had to adjust my parking to make sure that I could get my chair out, because it's just a gap. So if I was even just a couple inches off, and there was just a little three inch, four inch gap, which you're like, 'Oh, that's pretty good parking.' But for me, I pull my wheelchair up to the car as close as possible. And so if it's there then my front wheels fall into that little gap. And so that's where that makes it that much more difficult. And so that's where that makes it a bit easier. So for me, I still could do it, even though I'd be transferring and it was on the ramp. I can do that, but other people might not."***

One interviewee discussed the infrastructure challenges present on their reserve lands, which create a number of safety concerns for their community:

> ***"The physical perspective of accessibility is probably the easiest one to see and identify. And it can be the easiest one to address as well. We have ... but***

> ***we're not really set up to address a lot of physical challenges in our communities from the home to the office anywhere. Our homes are all built with the budget in mind, they're not well-designed for those with physical disabilities. Our lands are usually unpaved. There's no sidewalks. There's no connection between the community house to house. The offices are not accessible because for the same reasons, they've been built on a budget. So, we have people with physical disabilities that can't even come in and see our nurse because of that. We have people that can't go outside because they can't get around. The majority of Elders have to leave their homes, leave their communities and leave their families when it comes to the point where they can't navigate themselves out to the car anymore even with assistance. And the ambulances can't come in to – and can't get to the door, can't get through the community to get to the house. It's isolating. As people become more physically challenged in our community, they become more isolated."***

Further, with the increasing frequency of more severe weather due to ***climate change***, a participant explained that:

> ***"I mean the thing that screams out from what we've heard is transportation. The need to be able to access it, but also one of the things that came up is where there's been aggressive weather events, the transportation that is there isn't always sufficient. Roads are closed for wildfires, flooding. They're being routed, so it needs a wider solution."***

The design and architecture of the built environment also need to ***include trauma-informed understanding*** for individuals suffering from intergenerational trauma. One participant expressed how certain designs (like those reminiscent of residential schools or Indian hospitals) can be triggering:

> ***"I'm remembering the Elders, that you have to be mindful what trauma has been with this person. And even the building itself can cause trauma without realizing, even though you're in a place of care and medicine and healing."***

The systemic and environmental barriers to accessibility led to poorer health outcomes, intergenerational trauma, shame and institutional mistrust, among other challenges. Lack of cultural safety when accessing different services further added to traumatic stress, shame and feelings of mistrust. Environmental barriers, including geographical barriers and issues with the built environment, created complex access challenges and posed significant safety risks. Participants noted that a lack of transportation and the absence of a trauma-informed understanding of accessibility are significant barriers to accessibility and, thus, safety and well-being.

Visions for improved accessibility for future generations

In question 3, participants were asked about their perspectives on improving accessibility for themselves and their communities. **Cultural themes** emerged as the most frequently raised topic, with participants unanimously emphasizing the need for a stronger focus on culture to address the accessibility and disability challenges faced by First Nations people. Participants expressed that greater cultural understanding and acceptance among institutions (i.e., medical systems, policing, justice systems) and non-Indigenous service providers was essential to achieving wholistic health and wellness. **Environmental themes** were also prominently discussed as means of improving accessibility within communities by bringing services closer to home, reflecting participants' concerns about broader geographical, physical and structural barriers.

Overcoming cultural barriers

Participants emphasized that ***cultural competency, safety and humility training for health care staff and the general public*** is a key priority for improving accessibility, as they asserted that such training is essential to tackle the ongoing impact of anti-Indigenous racism on First Nations people and communities. A participant noted that this training was especially crucial for service providers, who often lack cultural competency:

> ***"I would like to see more support with training, [like] train the trainers, teach the teachers, [so that there is] Indigenous […] cultural competency. Even just the way you talk to people, the way you look at them in the eye and stuff, that's, that's a way that we grew up. My teachings, we didn't look people in the eye when we talked to them. So that's a cultural thing. And yet some, some people tried to force eye-looking on you, and that's really uncomfortable when – these kinds of things. Yes, so train the trainers, teach the teachers, re-educate the doctors. I think all doctors, all counsellors, all social workers in the western world should be re-educated [in] cultural competency, and it should be on their list before we even show up to their doctors."***

One interviewee stated that **bringing Indigenous perspectives about relational accountability** into health care would be a powerful way to improve approaches to care.

Relational accountability refers to the responsibility, care and reciprocity one has towards the relationships they have, which includes friends, family, ancestors, community, traditions and land.[36]

> ***"Accessibility from a spiritual perspective allows Indigenous folks the ability to have a culturally safe and informed space. It also allows us a connection to our ancestors and traditions. Indigenous traditions are aligned with accessibility in the sense that we don't leave our family and community to suffer while others thrive. Bringing this perspective into a health care setting opens doors for disabled Indigenous people to participate in alignment with their community practices."***

In addition, participants discussed ***the need for increased social accountability*** and the establishment of a system to address discrimination and unjust treatment to help foster feelings of safety, protection and formal recourse for First Nations people in the public and care settings.[38] A participant explained that:

> ***"Yeah, the system is wrong, not you. You should feel comfortable saying to your health care provider, or long-term care unit, 'Actually, I do need to have these cultural or spiritual supports in my environment, and that's part of my wholistic wellness,' and that's OK. So yes, it's removing barriers, but it's also say, you know, if there is this larger accessible Canada piece, do we need to be putting in legislation that's not just removing barriers, but having a recourse or an empowerment route to say, 'Hey, if something goes wrong, you can do XYZ.' You can hold people to accountability."***

The importance of Indigenous service providers was also frequently mentioned by the participants. Participants felt that having more representation and leadership of First Nations and Indigenous people in health care positions and decision-making tables might address the current gap in cultural understanding in care settings and promote culturally informed care in the system. A participant stated that:

> ***"It's almost like, you need to have Indigenous people across the counter that you're talking to, because they get it, we get it"***

Another participant echoed this and suggested that bringing in Indigenous doulas could help support the wholistic well-being of parents and their infants:

> ***“That’s another thing I do is advocate. And it’s so necessary for our women. They need strong advocates. Totally. I said to AIDP – you know what that is in town, Aboriginal Infant Development Program – I told their head honchos right from the get-go, I said, ‘Every AIDP program in this province should have a doula.’ We should have women protecting our women right from the get-go, right from prenatal to postpartum. And being with our women all that time, and looking after them, and holding them up like they should be held up, because we’re in a perfect position to do it. We’re taking those kids into our programs from zero right up until six, why can’t we do it prenatally, and postnatally, postpartum, and have those beautiful babies brought into our program to continue those services to protect those women and those children?***
>
> ***And having doulas attached – Indigenous birth workers and doulas attached to all our women would create so much more safety and accessibility and care on a continuum for our people using all parts of that medicine wheel; the emotional, the physical, the spiritual, the cultural. So yeah, I could go on and on about doula work too. It’s huge. That’s not even the spiritual, that’s just the safety, the cultural – lack of cultural safety our women experience when they’re going through these life events are very, very real.”***

To further address cultural barriers, participants talked about ***promoting programs that enhance cultural and traditional knowledge***, including initiatives and educational programs that ***reconnect First Nations people with their cultural roots***. Examples such as incorporating ***culturally inclusive design, including the inclusion of spaces dedicated to First Nations culture and traditional ceremonies and events,*** were highlighted as vital for fostering connectedness and a sense of safety. Adding cultural elements like artwork and traditional medicines was also described as a way to ground these spaces in their traditional territories. Furthermore, participants stressed the importance of raising awareness of triggering environments due to intergenerational trauma. A participant highlighted that:

> ***“Learning about the powwows, right now currently doing ribbon skirts and ribbon shirts, all self-taught. I just I felt I wanted to connect with my culture and spirituality, and I'm slowly getting there. But having access to Indigenous culture and relearning to be an asset in the government, should have Indigenous people who wanting to find their culture, and relearn and there should be programs like that.”***

Another participant elaborated on this point, discussing how education can reduce stigma:

> ***"I think a lot more needs to be [done] on the education part of it, of what society is dealing with and what does it mean, the definitions, and how we can work together. Because then it becomes a community effort and in some sense, in a good way, it becomes a norm. It becomes normalized to the point where it's not stigmatized. Does that make sense?"***

Breaking down environmental barriers

While concerns about environmental barriers, such as transportation challenges, were raised, many participants asserted the importance of improving their immediate environment—their communities—by ***promoting culturally inclusive designs*** to services and care ***and bringing services closer to home*** to improve accessibility. Additionally, participants highlighted ***the need for improvements to infrastructure for information and communication technology***, such as stable internet connectivity and cellular phone networks, particularly given the increased prevalence of the digitalization of communications and health care delivery in communities. Furthermore, participants urged ***community engagement***, especially regarding accessibility and disability challenges, to consult with persons with lived or living experiences about designing and planning accessible spaces. The motto, "Nothing about us without us," was also emphasized throughout these discussions. One focus group participant noted that:

> ***"It's frustrating when people just automatically make decisions for you without checking in with you. A person with disabilities like myself, I find that frustrating when people try to be my voice. And they're not. So, it is frustrating. And it's not fair."***

One participant shared an analogy as an example stating that:

> ***"I think that that's a big thing is not being consulted, right? That's like inviting people – all your friends – over for dinner and not knowing what to cook because, well, what if somebody's allergic, so then what? Do you end up cooking every single meal because you don't know what somebody needs? It's like, no, how about you ask them what they need, they will tell you, and then you can figure out what to cook."***

Bringing services closer to home was frequently brought to the foreground by those with mobility issues, as was living in an area with limited transportation availability and/or living in rural and remote communities. The ***expansion of telehealth*** was mentioned as a way to improve accessibility and linkage to care, although the absence of (or poor quality) infrastructure for information and communication technology was debilitating for some communities. This was especially true when many services, including primary care services, moved online during the COVID-19 pandemic, and online platforms and social media became vital for socializing, sharing and accessing information, and staying connected. A focus group participant pointed out some of these challenges:

> ***"Current barriers is physical access to some of the really remote communities. Roads, air services, transport, patient transport and the communications for the telehealth system needs improvement. We just upgraded to Starlink in most of them. We'll see how this fares, but I think it's a real positive step forward."***

One interviewee elaborated on the utility of telehealth services:

> ***"I think the one benefit of COVID, we've learned to do this, Teams, Zoom, telephone counselling. So I think COVID did do a few good things, and that was one of them. Because we had to do that for quite a while during that peak of the pandemic."***

In discussing the expansion of telehealth, a participant from one focus group expressed that public spaces in communities should also be expanded so that all could have reliable internet access:

> ***"I'm wondering if, also with the virtual services, it's infrastructure to support connectivity, but also that community hubs. So you know, the local library has connectivity, or the local whatever that might be. Because you know, it may not be that everyone has the capacity to have that in their home, but they could access support somewhere, somewhere central."***

In conclusion, participants identified a number of ways in which accessibility can be improved. For example, participants described the need to promote greater cultural understanding and acceptance of First Nations perspectives, traditions and worldviews. This was particularly relevant in institutional settings (i.e., medical systems, policing, justice systems). Participants described cultural competency and training as essential to achieving wholistic health and wellness. Cultural revitalization by way of promoting programs that reconnect First Nations people with their cultural roots was also identified as a way forward in breaking down accessibility barriers. Examples included incorporating culturally inclusive spaces for traditional ceremonies and events and promoting cultural elements such as artwork and traditional medicines. To address environmental barriers, participants suggested improving culturally inclusive designs of services and care and bringing services closer to home. Improving infrastructure for information and communication technology may help diversify the range of health and wellness services to communities by enhancing telehealth accessibility. Increased community engagement was identified as a way to ensure physical environments reflect First Nations' concerns and needs when planning and designing spaces, programs and services.

DISCUSSION

The current research project sought to gain an understanding of the perspectives of First Nations in BC on accessibility through the stories and knowledge of First Nations people with lived experience and expertise in accessibility and disability. These narratives revealed a wide range of accessibility challenges specific to First Nations people and their communities. These included health disparities and inequity stemming from systemic and environmental barriers, which are rooted in the legacy of colonialism and ongoing practices that continue to overlook First Nations needs and well-being.

The multidisciplinary project team successfully guided the project in a meaningful, First Nations-informed, culturally appropriate way. Specifically, the research team used culturally safe and humble approaches to provide a First Nations-led, community-driven analysis from relevant data. The team gathered perspectives and insights on accessibility and disability challenges from field experts, service providers, Elders, Knowledge Keepers, community members, and those with lived or living experience with disabilities. Most importantly, this approach resulted in identifying and raising awareness of tangible solutions for overcoming barriers and challenges from a diverse set of perspectives.

The project's overall objective was to establish avenues for sharing wholistic and diverse Indigenous perspectives on accessibility. Findings from this research will support the ASC’s development and refinement of accessibility and regulatory frameworks, as well as the ongoing work of the ASC’s technical committee that focuses on accessibility in Indigenous communities. This project represents a major step for the FNHA and First Nations in BC towards envisioning the increased implementation of inclusive and meaningful legislation and standards in practice.

As discussed in the section below, the research findings highlight a number of wise practices that have successfully been implemented to provide First Nations-led services and care, and that demonstrate culturally appropriate approaches to overcoming accessibility challenges. Additionally, the research findings offer insights into areas for improvement by examining the gaps in current approaches to accessibility while identifying actionable steps for addressing current barriers and challenges faced by First Nations individuals and communities.

What is accessibility?

Overwhelmingly, what has been gleaned from the current research project is that from a First Nations perspective, accessibility is for everyone, regardless of ability, identity or life circumstances. First Nations people recognize that accessibility must consider *all* elements of a person's well-being rather than limiting the focus to the physical environment. According to the First Nations perspectives on the SDOH, every level of a person's life is connected; therefore, all work towards health and wellness must be grounded in a wholistic approach, which includes connection to the land, environment, language, culture and tradition.[84] This approach also aligns with the FNPOHW visual that was shown to participants. Participants agreed that a wholistic approach is necessary when addressing accessibility. They further expanded on this approach by articulating how a person's mental, emotional, physical and spiritual well-being must be taken into account. Through thematic analysis, participants spoke to five core areas that they described as essential for creating and supporting a wholistic approach: respect, wisdom, relationships, safety and visibility.

Respect emphasizes a strengths-based view of physical abilities rather than focusing on deficits or *dis*-abilities. This view looks at how environments are disabling rather than how individuals are disabled. ***Wisdom*** is concerned with how First Nations are connected to the land, their distinct cultures and traditions and how these connections foster a sense of self and identity. Wisdom is also deeply connected with language and is vital in the intergenerational sharing of knowledge. ***Relationships*** are another core area that supports and upholds a wholistic approach. From a First Nations perspective, relationships are fundamental to understanding accessibility; specifically, it is only through relations that community is nurtured and meaningful support and accessible spaces can be created. An absence of community and relationships leads to isolation and feelings of guilt or feeling like a burden. ***Safety***, which was not explicitly tied to the FNPOHW, emerged as a core area of upholding and supporting a wholistic approach. Participants described ***safety*** as a key element in relationship-building. Compassion and empathy were described as vital approaches to creating safety within spaces and within relationships. Lastly, ***visibility*** was identified as a core component of a wholistic approach to accessibility. Participants expressed that representation and leadership of First Nations people with disabilities was crucial for fostering a sense of being seen, acknowledged and heard by others. Participants expressed that First Nations leadership in decision-making would improve accessibility by ensuring First Nations perspectives are appropriately embedded into the design, planning, and delivery of programs, spaces and services.

A wholistic approach to accessibility differs from western approaches, which, according to participants, typically focus on the built environment and systemic infrastructure, such as those outlined as ASC priority areas (e.g., architecture, transportation, IT and communication technology). This approach centralizes its focus on individuals who already have accessibility challenges—for instance, those living with disabilities.[67,69,85] Participants described how a western approach places undue burden on individuals, especially with regard to finding appropriate support and care services. Participants also expressed that such an approach created segregation between those living with disabilities and those considered able-bodied, which further entrenches barriers to accessibility and contributes to worsening overall health and well-being.

Participants identified significant differences between western and Indigenous understandings of disability. Several participants expressed that the very concept of disability is a western and colonial construct because, in many First Nations languages and teachings, there are no words equivalent to disability.[67,69,85] Moreover, participants described how western understandings of disability often perceive disability negatively and as something that requires "fixing".[67] Unlike western perspectives of disability, First Nations perspectives regard disabilities as a valuable gift and disabilities are often celebrated by the communities. Because First Nations people acknowledged accessibility to be for everyone, not just those with accessibility challenges, the responsibility for care and consideration towards accessibility shifted from the individual to the community. That is to say, for First Nations people, accessibility is rooted in communities and mutual support. Communities come together and offer support instead of letting individuals seek support on their own. This aligns with what Shawn Wilson and Andrea Breen[36] describe as "relational accountability," which happens when there is a recognition of reality as relationships force us to act differently — "We [...] become bound by our relations of responsibility, care, and reciprocity. We have to act in accordance with our values." For participants, accessibility and disability needs must be addressed by and for communities, which includes welcoming individuals with all physical abilities and capabilities. In a positive and supportive environment, individuals feel included and cared for instead of holding negative feelings toward their accessibility and disability challenges. Reiterating the need for a strengths-based and individual-centred approach, participants highlighted the important way in which supportive communities can help to elevate individuals' abilities rather than *dis*abilities.

Environmental barriers and ASC priority areas

Many environmental barriers identified throughout this project were congruent with the ASC priority areas. For instance, transportation and road networks in rural and remote areas of

BC significantly impacted the ability to travel within and beyond communities. Those with mobility issues or without access to transportation faced substantial difficulties navigating due to poor design and the lack of consideration for people with accessibility and disability challenges. Participants expressed that these environmental barriers could be attributed to inadequate support and involvement from the government. For instance, transportation and road networks in rural and remote areas of BC fall under the mandate of the Ministry of Transportation and Transit, and First Nations reserves are overseen by the Government of Canada.[86,87] Many participants highlighted how few infrastructural improvements (e.g., sidewalks, signage, road networks, etc.) have been made to their communities over the years—a longstanding problem for First Nations communities across Canada.[88,89,90,91] It should be noted that accessibility was often used synonymously with improving community living because *community* is paramount to First Nations peoples. For First Nations, community was not only a place to call home but was also a place where healing can happen.

Concerns were also heard regarding health care services and other public programs, where accessing services and programs often required significant effort, particularly from individuals already facing accessibility and disability challenges. Participants frequently mentioned the need to advocate for themselves when seeking help and navigating the current health care system. Yet many were uncertain about how to proceed or whom to connect with. Limited access to resources, such as information on health care providers, available services, and service providers within their communities, further compounded these challenges, particularly for those without a computer or internet at home or those facing mobility issues when seeking assistance outside of their homes. Many described feeling isolated from the health care system, stating that provisions for support were not designed with accessibility challenges and disabilities in mind, and that these were particularly exacerbated by existing First Nations-specific barriers identified in the findings.

Participants suggested that access to health care could be improved by expanding telehealth. Many health services became available online during the COVID-19 pandemic and ongoing improvements to information and communication technology and infrastructure are becoming increasingly necessary as health care systems evolve with the use of technologies.

More than environmental barriers exist

It is important to highlight, as the section on current legislation demonstrated, that various levels of governments and organizations are working to address barriers to accessibility. Both the ACA and ABCA signal a strong commitment to advancing accessibility. Participants were clear that environmental barriers do exist and create significant challenges in their daily lives. However, as important as addressing the built environment is, so too is addressing the systemic and cultural barriers experienced by First Nations people.

Participants shared many examples of systemic barriers and cultural barriers, including discrimination and systemic racism, negative personal experiences while seeking or receiving services, and stories about how these barriers impacted their lives. Unfortunately, participants' personal experiences and stories of facing systemic barriers are not new. In fact, many participants' experiences echoed those of participants in the 2020 *In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in B.C.* report, which specifically examined anti-Indigenous racism in BC's health care system.[92] As was found in the *In Plain Sight* report, many of the barriers faced by participants in this current study are attributed to colonialism, demonstrating a clear need to address systemic racism across sectors beyond just health care settings.[92] For instance, due to the impact of the *Indian Act*, residential schools, the Sixties Scoop and Indian hospitals, many of the participants had already developed a deep mistrust and aversion toward institutions. This institutional mistrust and aversion are reaffirmed when participants experience emotional and mental distress when they experience discrimination and anti-Indigenous racism in care settings.[73,77,78,79,84]

Likewise, participants expressed a feeling of cultural and spiritual deprivation because of the historical outlawing of cultural practices under the *Indian Act*.[93,94,95,96,97] Many spoke about avoiding health care and social services to distance themselves from negative and unpleasant experiences they or their loved ones had previously had.

Many First Nations individuals, especially those living in rural and remote communities, continue to face persistent challenges in accessing even general medical care. Participants shared that they were often left with very few, if any, options for suitable service providers or programs that met their needs. They highlighted how health disparity, stemming from a lack of medical access and the limited availability of health care professionals and specialists, was often linked to adverse health outcomes, such as prolonged hospitalization and compounded medical issues requiring additional medical care. Furthermore, participants recounted their experiences and witnessing friends and family members suffer unnecessarily while in medical care, which often left them feeling their Indigeneity influenced the quality and attentiveness of the care they received. They expressed that these negative care service experiences often became the catalyst for avoiding services, further contributing to increased unmet needs and worsening health outcomes. Limited availability of support was also identified as a significant risk for First Nations people who rely on services for their health and livelihood—leaving them vulnerable to ongoing accessibility challenges. These challenges were often tied to issues such as provider availability and lack of funding to sustain programs in communities.

These personal experiences of inadequate and inaccessible medical care and specialized care, along with anti-Indigenous racism and discrimination towards Indigenous people, align with findings from the *In Plain Sight* report. BC is experiencing widespread shortages of medical professionals, resulting in a decline in the quality of care and health outcomes as a province.[98] However, the report also highlights that many First Nations people lack access to family doctors and other primary care services, and are often left relying on the emergency room as their only option for addressing health concerns.[92,99] These severe deficiencies in access to and availability of care, combined with rampant discrimination in BC's health care system, continue to widen health disparities and worsen health outcomes for First Nations people.[92,99,100]

Expanding on participants' comments regarding the types of available services, it became clear that different identities and life circumstances can create additional barriers for First Nations people. For instance, participants called attention to the importance of creating safe spaces where everyone can feel seen and heard regardless of their physical abilities and social identities (e.g., being a First Nations individual, a member of the 2SLGBTQQIA+ community, being young or old). Unfortunately, participants often experienced unsafe spaces, for example, in health care settings, due to a lack of understanding of their particular life circumstances or needs and because of anti-Indigenous racism. Some participants also explained that inequities and unequal opportunities exist across intersecting identities in the current system. For instance, a participant who recently underwent cancer treatment shared that wigs were only available for certain genders, but not for all. Participants described feeling burdened, ashamed and embarrassed about their disability or life challenges in these situations. They emphasized that a one-size-fits-all model of care is less appropriate for First Nations people, and that models of care should instead meet individuals where they are at, with respect, understanding and compassion. Additionally, participants called for greater visibility and representation of accessibility and disability as a way of providing opportunities for community building and fostering learning. Such opportunities, they suggested, could enable individuals with disabilities to take on leadership roles and participate in decision-making processes, ultimately promoting overall inclusion (see the section "First Nations Leadership and Representation" for further discussion).

As an example of creating inclusive spaces and communities for First Nations people with disabilities, the Indigenous Disability Canada/British Columbia Aboriginal Network on Disability Society (IDC/BCANDS) plays a leading role in successfully addressing the diverse disability needs of Indigenous people and delivering specialized disability programs, as one of the few organizations of its kind in Canada.[101] The organization's web site provides accessible resources and information specific to Indigenous disability programs and services. IDC/BCANDS also hosts the annual Indigenous Disability and Wellness Gathering, bringing together community members, professionals, scholars, organizations and government representatives from across Canada to "collaborate in addressing and dismantling the unique barriers Indigenous people with disabilities face." The organization's determination to advocate for inclusivity and its responsiveness to the needs of Indigenous people with disabilities has been internationally recognized, earning it Special Consultative Status with the United Nations Economic and Social Council.[101]

To address systemic barriers, participants suggested alternative care models such as trauma-informed care, culturally informed care and wraparound care. These models all emphasize the importance of individualized, person-centred care, with tailored plans that consider individuals' backgrounds and challenges, and that this care is provided with empathy and is supported by a compassionate understanding of cultural and historical factors. Participants also highlighted the significance of attending to the intersecting identities of First Nations people. Additionally, these models must also value the importance of building supportive relationships between individuals, service providers and the broader public. It is these elements together that make such models of care truly wholistic.

Moving forward in a good way

> ***"I think it's really, really fundamental that people understand that Indigenous health does not just encapsulate our isolated individual spaces of where we are healthy, whether that be physically, mentally, you know, it's about our spiritual health. It's about our health with lands, with culture, with our families, with our communities."***

In alignment with the ASC priority areas, environmental barriers are a top concern for most legislation and regulations when addressing accessibility barriers. However, the findings of this study demonstrate there is a clear need for addressing systemic and cultural barriers in addition to environmental barriers. Participants identified that these barriers could be addressed through cultural safety training, promoting cultural revitalization through designated and inclusive spaces for traditional ceremonies and events, and bringing Indigenous perspectives about relational accountability into the existing system, including health care. Various organizations and levels of government have already committed to developing cultural safety and addressing systemic racism.[102] For instance, the Health Standards Organization has made commitments to address systemic racism by following the guidance of the TRC.[103] Both federal and provincial governments have adopted UNDRIP, signifying a commitment to ensuring legislation is consistent with its principles.[41,104,105] This includes a commitment to meaningful consultation and co-operation with Indigenous Peoples (see Article 19 of UNDRIP[105]). Although these commitments have been made, legislation, regulations and frameworks continue to ignore the systemic barriers that First Nations people experience. The research team therefore urges that all amendments and new legislation implement actionable measures to address these barriers, especially with regard to accessibility. Failing to acknowledge or address these systemic and cultural barriers, will perpetuate the disparities and inequities for First Nations health and well-being.

The following section offers insight into six areas for improvement. These areas of improvement propose tangible solutions for addressing both the built environment and systemic and cultural barriers that often prevent First Nations people from achieving full participation in the broader community.

Building relationships through community engagement and collaboration

It is essential to foster partnerships with First Nations communities and organizations to promote inclusivity, accessibility and equitable health outcomes. Meaningful consultation with First Nations must prioritize respect for their sovereignty, ensuring that decisions related to wellness, health and quality of life reflect Indigenous rights and values. This includes addressing the health disparities experienced by Indigenous people, including those with disabilities, by removing barriers to care and ensuring culturally appropriate services. Upholding UNDRIP and DRIPA commitments, especially Articles 18 and 19 with regard to Indigenous Peoples having the right to participate in decision-making and consulting and co-operating in good faith with Indigenous Peoples, is crucial to ensure that First Nations have a leading role in decision-making processes that directly impact their well-being.[105] To begin building relationships, participants emphasized the importance of *going the extra mile* for those who seek support. Moreover, participants expressed the need for concerted efforts towards establishing trust and connection between providers and the people they work with. First Nations people often use cultural practices such as traditional ceremonies or healing or spiritual circles to foster trust, which forms the basis for strong relationships. Meaningful collaboration must be grounded in mutual respect among all parties involved, along with a shared goal of working toward collective well-being. Relationship-building serves as the foundation from which such collaboration can emerge.

Mandating cultural safety and humility training, including education on First Nations traditional teachings and worldviews

As expressed by the participants, improved cultural safety and humility and awareness of Indigenous worldviews, ceremonies, values and practices would improve relationships and interactions at personal and community levels between First Nations people and the non-Indigenous population, including health care providers. In adopting UNDRIP, governments and organizations are committing to supporting the right of Indigenous peoples to their traditional medicines and ceremonies. This includes taking the necessary steps to help the full realization of this right, as well as committing to full acceptance and appreciation of Indigenous traditions, cultural teachings, values and beliefs (see article 24 of UDRIP[105]). Governments and organizations are also committing to Action 23 of the Truth and Reconciliation Committee Calls to Action, which urges governments to provide cultural competency training for all health care professionals.[106] Therefore, to make Canada more accessible, particularly for First Nations, it is imperative that governments mandate cultural safety and humility training. This will bring about the necessary awareness of the continued inequalities experienced by First Nations people. Training and further education will also promote relationship-building, which leads to better health outcomes and safer care practices for all.

Supporting First Nations-led solutions through community-led examples

Several examples of good work within communities were shared throughout this research. Friendship centres across the province were described as demonstrating wise practices by incorporating culturally informed and culturally safe ways to bridge western health care systems and First Nations ways of approaching health and wellness. Ensuring cultural safety is essential in remaining mindful of First Nations-specific challenges and addressing their root causes, such as the impact of colonialism and subsequent intergenerational trauma. Participants described trauma-informed care as being successful in mitigating potential triggers and reducing re-traumatization for First Nations people.

First Nations-informed and -led services spoken of by participants were consistently regarded as highly attentive to the needs of people and communities. Participants expressed that these programs and services demonstrated an openness to developing innovative and responsive solutions. They also explained that these services are continuously evaluated and adapted to align with community-specific needs. Language programs, programs for school-aged children and support programs for families with children with special needs were described as exceedingly successful in promoting a commitment to accessibility and a compassionate approach to improving community wellness. Most importantly, these services were described as having successfully integrated First Nations-led approaches with mainstream services, enriching experiences for First Nations people through a strength-based, person-centred and individualized approach.

Community-led organizations, such as friendship centres and culturally and trauma-informed programs embedded within mainstream systems, not only offer important examples of how accessibility can be advanced by integrating First Nations culture and traditional teachings in culturally safe and appropriate ways, but also serve as self-determined avenues for communities to advocate for themselves and promote First Nations representation. These efforts should be given more attention as they play a vital role in improving accessibility for the benefit of people within First Nations communities.

Engaging in advocacy by promoting First Nations leadership and representation

The above examples highlight the importance of raising awareness and advancing campaigns focused on accessibility for First Nations people, especially for those with lived and/or living experiences of disability. The lack of First Nations representation in policy development and senior positions in health care remains a significant gap. This is evident from the current provincial and federal accessibility frameworks, which were developed without First Nations consultation, leading to a framework that falls short in addressing systemic barriers, identified in this project as one of the major barriers to accessibility for First Nations. A recent report highlights that self-identified Indigenous doctors make up less than 0.39% of all doctors in BC, underscoring the need for more representation within the health care system.[106] Health institutions must make a concerted effort to train and hire more Indigenous staff at all levels of leadership to support equity and improve patient care. Not only would increased hiring and training of Indigenous staff answer Action 23 of the TRC Calls to Action, but doing so would ensure governments and organizations are meeting their commitment to Article 21 of UNDRIP, which emphasizes that Indigenous people have the right to determine and develop priorities and strategies for exercising their right to development.[105]

Additionally, it is imperative to have greater representation of First Nations people in discussion and decision-making processes, to emphasize critical priorities from a First Nations perspective, particularly from those with lived and/or living experiences of disability. The principle "*Nothing About Us Without Us*" is particularly relevant in this context, which calls for "the full participation and equalization of opportunities for, by and with persons with disabilities."[107] Promoting collaborations among Indigenous organizations enhances representation and creates a stronger, unified community voice to advocate for First Nations peoples. The presence of First Nations champions, representations, and leaders in these spaces not only ensures that their needs are addressed appropriately but also strengthens self-determination and advocacy efforts that uphold their inherent rights in achieving health and wellness, without discrimination and stigma, for their people and communities.

In efforts to improve accessibility, participants emphasized that many families and individuals are heavily reliant on government- and organization-supported programs and assistance. Due to this dependence, they are particularly vulnerable to changes in the availability and accessibility of these supports. When compounded by the already limited resources and services in many First Nations communities, even small disruptions can drastically affect accessibility. For instance, financial cuts and lack of service providers can pose serious risks to health, safety and overall well-being.

Advocacy is therefore essential in upholding First Nations people's rights to health and wellness. For those most dependent on these programs, advocacy is not just important—it is critical to their survival and the fulfillment of their most basic needs and livelihood.

Improving essential infrastructure

Urgent attention is needed to upgrade transportation and road networks within and outside of communities, especially those on reserve lands, including basic structures like paved roads and sidewalks, as well as infrastructure for internet connectivity and information and communication technology. Addressing these longstanding issues is critical to improving the quality of life for First Nations and requires increased momentum for action. A report published by the Assembly of First Nations states that an estimated $349.2 billion is required to address the infrastructure gap that exists in many First Nations communities, with an additional $75 billion for Inuit communities, highlighting the ever-growing cost of improving infrastructure while underscoring the consequence of "failed fiduciary duties and unfair distribution of Canada's wealth as a country".[88,108,109]

In an era of increased digitalization, there is significant potential to enhance connectivity, improve communication and expand access to information. Health care innovations like those seen in the wake of the COVID-19 pandemic, with the rapid expansion of telehealth services, are one of the latest examples of how technology can improve the quality of health for First Nations people.[110] Participants expressed how they benefited from remote and virtual medical appointments and consultations when public health measures, such as social distancing and travel bans, limited their access to services they needed. However, further effort remains to ensure communication connectivity throughout the province. The 2022/23 evaluation report on the Real-Time Virtual Support that launched in April 2020, found that 81 per cent of rural communities had been reached. However, the report did not specify why the remaining 19 per cent of communities lacked access. Additionally, the BC First Nations Community Internet Connectivity report indicated that approximately 20 per cent of First Nations households on reserve still lack access to high-speed internet.[110,111] Improving essential infrastructure not only ensures the quality of life and health outcomes for First Nations people but also advances equity and helps eliminate SDOH-caused disparities between Indigenous and non-Indigenous people. Access to essential infrastructure should not be viewed as a privilege but as a fundamental right. If BC and Canada have pledged to uphold UNDRIP, and the TRC's Call to Action, then addressing the infrastructure gap must remain a top priority to ensure meaningful progress on this front.[112]

"We are no longer recommending, it is our demand to be prioritized" - Reconciliation through accountability and responsibility

The call to uphold the commitments made under UNDRIP, DRIPA and the TRC's Calls to Action, was firm and univocal among participants. They expressed a strong sense of urgency, calling on governments and key stakeholders to follow through and take decisive, meaningful action as outlined in these frameworks. By endorsing these commitments, governments have not only acknowledged but pledged to recognize and respect Indigenous cultures, beliefs, values and traditional teachings in their entirety. The recommendations outlined in this report are grounded in both logical and substantive rationale that reflect the depth of commitments embedded in these frameworks. This also extends to how accessibility is understood and addressed within BC. As highlighted in the findings, accessibility must be inclusive, for ***everyone,*** and approached wholistically, supported by an intersectional lens that cultivates empathy and compassion. Current accessibility legislation must reflect these principles and be implemented accordingly.

Actions such as fostering relationships with First Nations communities, mandating cultural safety and humility education and training, promoting First Nations leadership and representation, and improving essential infrastructures are necessary responses to accessibility and disability challenges. They also directly address the cumulative impacts of colonial practices and policies, compounded by generations of systemic neglect. These actions should have already been implemented and upheld as part of prior commitments. In the ongoing work of reconciliation, governments and key stakeholders must engage in mutual and reciprocal actions that catalyze systemic shifts away from systems rooted in colonialism that continue to affect First Nations people and communities.

Given the persistence of systemic racism and discrimination, participants emphasized the need for robust countermeasures and meaningful accountability mechanisms to ensure adherence to commitments and legislation. They asserted that enforcing compliance and holding those who fail to uphold these commitments accountable is a fundamental responsibility of governments and all involved stakeholders.

The conversation, and the movement to advance this systemic shift, must continue.

Recommendations

> ***“And again, I think part of it too, more long-term planning is making sure that you are creating spaces that are inherently designed to be welcoming. Because you can always retrofit your things, and that’s always a possibility. But I think if you can pre-plan it, it can be so much better.”***

“**čačim hihak kʷaa**” or “***Everything in order***”

This phrase, shared by a participant from one of the Nations from the Nuu-Chah-Nulth Tribal Council, is an example of cultural and traditional teachings that highlight a First Nations perspective on addressing accessibility. While this phrase is a traditional greeting, the participant explained that it carries an underlying meaning, which teaches the importance of anticipating the needs of people of all abilities before they enter spaces or seek services. Having everything in order means people do not have to ask for accommodations because the considerations for those with diverse needs should already be in place.

> ***“čačim hihak kʷaa standard “hello” literal “is everything in order” as it was interpreted to me by my language holders. … It’s a greeting that we have. It’s a common greeting in my language. And I love how our language translates literally, like, it doesn't make sense in English, but I see it and hear it, and what it literally translates to, is everything in order? So when an organization has everything in order, and has done all the work on accessibility, on doing what you're doing right now, assessing what are those barriers. When an organization does and puts everything in order, that hits me, like, in an emotional place. Like, I know they're cognizant of any disabilities, any – across the board, they've done their work. They’ve put their house in order.”***

When considering implementing the following recommendations, the research team urges governments and organizations alike to consider what it means to have “everything in order” in relation to accessibility. Asking this question helps set the stage for meaningful and concerted efforts toward taking accessibility seriously in relation to First Nations people and their communities. With this in mind, the following recommendations are being offered as tangible actions for addressing and improving accessibility for First Nations people.

1

Align policy and regulatory frameworks to address systemic barriers.

The current accessibility standards and frameworks fall short in addressing systemic barriers, particularly those affecting cultural safety and perpetuating social barriers such as racism and discrimination against First Nations people and communities. First Nations leaders from the Gathering Wisdom XII meeting in 2023 suggested implementing cultural infrastructure, which they describe as increased human resources capacity (including fairly compensated and sustainably funded traditional healers and other cultural staff) and fully integrating Indigenous cultural ways of knowing and healing.[84] Likewise, implementing formal and legal accountability measures to eliminate discriminatory practices is essential. Further analysis and revisions of the frameworks should be conducted to address accessibility barriers specific to First Nations. These revisions should involve collaboration with First Nations representatives and be supported by education, cultural competency training and awareness campaigns to share knowledge and promote learning.

2

Address existing environmental barriers

Despite being included in the ASC priority areas, environmental barriers are long-standing issues often overlooked by all levels of government. Focused attention is necessary to address these barriers, including more financial support, as part of efforts toward substantive equality and to improve the quality of life for First Nations people, especially those in rural and remote communities. For example, supporting regionalization will enable self-determination among communities, thereby giving them decision-making power. Regionalization also supports flexible funding and closer-to-home services, which break down barriers in localized and community-driven, Nation-based ways.[84] Likewise, developing a full continuum of services and supports that uphold wholistic approaches to accessibility will also help address existing barriers. Community health centres, schools, daycares, employment agencies, courts, policing, housing and children and family agencies all play an important role and have a responsibility to provide services that promote health and well-being.[84] Suggestions from the Gathering Wisdom XII meeting in 2023 included greater investments in equipment and technology that supports connectivity and innovations in health care. Indigenous ways of knowing and healing must also be fully integrated with this equipment and technologies.[84]

3

Promote cultural safety and humility by mandating training and education.

While governments and organizations have made commitments to promote cultural safety and humility, it is no longer enough to *recommend* cultural safety and humility training. Governments and organizations must mandate training to effectively promote culturally safe care for First Nations people. Mandating such training will answer the long, unfulfilled call to action by the Truth and Reconciliation Commission.[103] Without acknowledging cultural barriers, that First Nations people continue to face, including the history and legacy of colonialism, barriers to accessibility will continue to create challenges for First Nations people and their communities. Cultural barriers significantly impact First Nations people's access to healthy living and other opportunities. Cultivating empathy and compassion through an understanding of colonization, intergenerational trauma, and perspectives rooted in Indigenous culture and traditional worldviews can foster better relationships between First Nations and the non-Indigenous population.

Some participants suggested that organizations like the FNHA can take steps such as implementing book clubs, movie viewings, and sharing circles that promote staff engagement with stories and experiences from the perspectives of people living with disabilities, which allows for discussions around rights, leadership, advocacy, champions and power. These exercises can promote meaningful integration of learning into the daily work of professionals serving and supporting people living with disabilities, which reminds us to come at the work with a strengths-based perspective rather than a colonial, deficit-based and paternalistic perspective.

4

Shift from a medical model of disability to a social model of accessibility.

Individualized care, one of the key messages brought forward from this study, requires a shift from a disability-focused perspective to a person-centric perspective. From a First Nations point of view, accessibility must be for everyone and not just for individuals living with disability. This change can be initiated by examining how current amenities, signage, tools and resources focus on disability purposes and adapting them to be more inclusive. For instance, one participant explained that accessibility buttons to open doors should not be labelled as disability buttons. Attention to these details will ensure accessibility improvements are meant for everyone, not only for those living with a disability. Likewise, inclusive language can also help to shift the perspective from a medical model to a social model of accessibility. Leaning into First Nations understanding of disability, where disability is seen as a gift, can open up opportunities for providers and public servants to help families and communities. An example is shifting the perspective from seeing illness or disability as "bad" and instead viewing it as an opportunity to help others. Language is also an important tool for communicating First Nations traditions and healing practices. Promoting inclusive language helps to foster community and connection.

The FNHA's actions towards accessibility

As a health organization, the FNHA has been mandated to develop an accessibility plan under the ACA and the ABCA. The findings and recommendations from this project have been referred to and used to inform the development of an organizational-wide accessibility plan and then a provincial-wide Indigenous-led accessibility plan for BC.[113,114] The FNHA Accessibility Plan includes actions to enhance and improve accessibility for FNHA employees as a first step towards meeting the requirements of ABCA. Actions taken so far include a mandate letter from the FNHA CEO, developing an accessibility committee, hiring an accessibility lead, developing an accessibility feedback tool, and initiating the Metro Vancouver Office Project, which is a new working space for FNHA employees. The building will meet the requirements of the Rick Hansen Foundation Accessibility Certified Gold standard, which is a national rating system that measures and certifies the level of meaningful access to buildings and sites. Further, the FNHA has been developing a closer relationship with the provincial government's Accessibility Directorate, aiming to strengthen efforts and promote the narrative of improving accessibility for First Nations people.

The project was designed with cultural importance, accessibility and sustainability in mind. The organization recognizes the urgency of the matter surrounding accessibility for First Nations people. Future actions include increased promotion and advocacy, starting with FNHA staff, raising awareness of the Ability Matters program, strengthening organizational commitment to foster a culture of accessibility, recruiting and retaining a diverse, talented workforce that is welcoming and accommodating to people of all abilities, and improving accessibility of information and communication to staff at all levels.[113] Dissemination of research findings, identified areas of improvement, and actionable recommendations are also planned to create learning opportunities and encourage ongoing dialogue aimed at improving accessibility for First Nations people and communities. Community-facing reports, educational and informational videos, and additional publication materials are being developed to engage communities and key stakeholders responsible for shaping accessibility in BC, with the aim of creating tools that draw greater attention to the complex accessibility challenges faced by First Nations communities and the systemic barriers that persist.

CONCLUSION

This research aimed to deepen the understanding of First Nations perspectives on accessibility and disability by amplifying the stories, insights and expertise of those with lived and living experiences. These perspectives were gathered through interviews, focus groups, a knowledge-sharing circle and a survey. Guided by cultural safety and humility, identified as a priority area in this study, the project was conducted in partnership with experts, local organizations and community members.

While the FNHA is largely focused on health care services and programs, this study has demonstrated that accessibility must be considered across sectors and communities. As First Nations have emphasized in this project, accessibility is for everyone, regardless of ability, identity and life circumstances. This means that addressing accessibility from a First Nations perspective must consider all elements of a person and their community's well-being.

This study revealed many barriers that impact First Nations people and their communities, some of which align with the ASC priority areas (e.g., environmental barriers). However, the lack of provisions to address systemic barriers within current policy and legislative frameworks for accessibility was identified as a significant issue. Systemic and cultural barriers were found to be one of the key challenges for First Nations people. The findings and discussion of this study strongly recommend revising existing ASC priority areas to ensure systemic barriers are appropriately addressed. This could mean adding additional priority areas such as health and well-being, which would not only promote a wholistic approach to accessibility but would encourage strategies and solutions that tackle systemic barriers.

Participants reiterated the importance of overcoming systemic and cultural barriers through cultural competency, safety and humility training and fostering First Nations culture and traditional knowledge through programming and inclusive design to advance accessibility. The participants highlighted a number of ways to overcome environmental barriers, such as building inclusive spaces, bringing services closer to home, building and improving infrastructure, especially telecommunications infrastructure (which would help expand telehealth services) and engaging with community members in space design and planning.

The project concludes with an urgent call to address the lack of policy and legislative provisions targeting systemic barriers to accessibility. Feedback from participants from the virtual knowledge-sharing circle and online survey emphasized the demand for follow-up actions including sharing and addressing the findings and recommendations from this research. Upholding the recommendations of participants, the research team and partners strongly advocate for increased collaboration with First Nations communities, timely actions to address ongoing challenges, and meaningful progress toward reconciliation through cultural safety and humility education. Both BC and Canada have already committed to the principles outlined in the UNDRIP, DRIPA and the TRC's Calls to Action. Participants expressed a unanimous and pressing demand for governments and key stakeholders to fulfil these commitments and take decisive, sustained action. Accordingly, current accessibility legislation must be aligned with these frameworks and implemented in practice. While multi-level governance and jurisdictional complexity continue to compound accessibility challenges for First Nations communities, these barriers cannot justify inaction. It remains imperative to advocate for substantive, systemic changes that will improve accessibility and quality of life for First Nations people.

Despite the barriers that exist, this study identified several wise practices where First Nations-informed and led services have successfully improved accessibility and quality of care for communities. Drawing from these examples, this study concludes that it is possible to create culturally safe environments and services within the current care system, although further efforts are necessary to expand and deliver these services and programs to more communities.

Limitations

Although efforts were made to be inclusive and representative of First Nations people and communities in BC throughout this study, some health regions remained underrepresented, as did representation from First Nations people experiencing additional hardships such as homelessness and unemployment. The lack of representation, particularly from those experiencing homelessness or unemployment, has limited an important discussion around poverty and financial well-being. As discussed in the background section of this report, experiences of poverty or other hardships impact other elements of one's life (e.g., SDOH). Future research into the intersections of the SDOH and accessibility would provide a more comprehensive analysis of the ways these social determinants and systemic barriers are linked and impact First Nations communities.

This project did not undertake a comprehensive analysis of how current accessibility policies and regulatory frameworks (outside of the ASC priority areas) align with and impact First Nations communities. Therefore, future directions should involve deeper investigation into how First Nations-led and informed services and programs can be integrated into existing systems, and a thorough policy analysis should be completed to better understand the true impact of these frameworks and to inform improved policies for First Nations people and communities. Although data gathering included a tour of facilities across the province to learn strategies for overcoming accessibility challenges, it was beyond the scope of this project to conduct an in-depth analysis of these services and programs.

Lastly, this study did not include all sectors of working accessibility and disability. Reaching out to professionals and service providers outside of health care would add further dimensions to understanding the accessibility challenges faced by First Nations people.

APPENDIX A: PARTICIPANT (COMMUNITY MEMBERS) CONSENT FORM

First Nations in BC's Perspectives on Accessibility

Consent Form for Participants

On behalf of the First Nations Health Authority (FNHA), we are inviting you to participate in a study called, *A Journey Towards Accessibility, Perspectives from First Nations in BC.*

What is this research about?

This study will explore the perspectives of British Columbia (BC) First Nations on accessibility and disability. We want to explore what accessibility means. We hope this research will help organizations to do better with First Nations people in BC living with disabilities.

Why were you invited?

We invited you to take part in this research because of your knowledge and experience with accessibility and disability. We believe that your perspective will be important to address accessibility and disability issues for First Nations people in the future.

Who is funding this study?

This study is being funded by the Government of Canada through the Advancing Accessibility Standards Research Program.

Who is leading this study?

Courtney Defriend is the lead of this study, also known as the Principal Investigator. She is Director of the Research and Knowledge Exchange team at the FNHA. Greg

Shea is also leading this project as Vice President of Health Infrastructure at the FNHA.

What will happen if you decide to participate and what are the potential risks?

If you decide to participate, you will give your **verbal consent**. The study will take between 1-2 hours. During this time, we will ask what is important to you about accessibility. The interview will be audio recorded with your permission.

We will be talking about accessibility and disability, which may be upsetting or difficult to talk about for some people. **Please know that it's up to you whether you want to join us**, **and you may choose to leave at any time. If you choose to leave, we will delete your audio recording and not include any of the information you've shared today in our final report. You will still receive your payment if you choose to leave before finishing.**

Potential Benefits

We hope this work will be shared with law makers and organizations to create better programs and services for First Nations people and families in BC living with disabilities.

Questions

The research question of "*What does accessibility mean to you?"* will be followed by other questions, such as:

1. What are the mental aspects of accessibility?
2. What are the emotional aspects of accessibility?
3. What are the physical aspects of accessibility?
4. What are the spiritual aspects of accessibility?

5. What are the current barriers for First Nations people in accessing services?
6. What are the stigmas associated with access to health services?
7. What are some considerations for creating welcoming spaces for those with diverse abilities?

We will also be asking you questions about your identity, such as where you come from, your gender, your age, and so on. We are collecting this information so that we can make sure this research includes a diverse group of people. You can decide how much or how little you would like to share with us about your identity. The information we collect about your identity will not be used to identify you in our final reports if you wish to be kept anonymous.

Cultural Wellness Supports

You will be provided with a resource sheet to connect you with mental, emotional, physical, and spiritual supports.

Legal Rights

By agreeing to participate in this study, you do not waive any of your legal rights.

Payment

You will receive $250 through either a mailed cheque or preloaded Visa gift card.

How will your data be protected and stored?

The recording of the interview will only be listened to by members of the project team. We will type out the recording word for word. This will not have any names or other information that could identify you. After the transcript of the interview is completed, the audio recording will be destroyed. The electronic document of the interview will be put onto a secure spot located on FNHA's computer system. Only research study staff that have permission will be able to access the document, which will contain no personal identifying information. All answers will be kept de-identified and confidential unless you choose to share your name. However, you may want to have your name attached quotes from the interview or the information you give.

We will strive to ensure a strong commitment to the principles of Ownership, Control, Access, and Possession (OCAP®) throughout our process. If a mistake or oversight is made, we will address and correct it to uphold your safety, privacy, and security. First Nations have collective ownership of their data and information and will ensure security of the data at all phases of the research.

Questions or Concerns

If you have any questions about what we are asking of you, or any concerns about the interview itself, please contact Kate Checknita at Kate.Checknita@fnha.ca or by phone at 604-813-4481, or Courtney Defriend at Courtney.Defriend@fnha.ca or by phone at 250-802-1278.

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, you may contact FNHA Ethics at ethics@fnha.ca and the appropriate FNHA staff person will respond in a timely manner.

CONSENT CHECK LIST

Read aloud and record the following information

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read (or been read) and received a copy of this consent form?	Yes	No
Have you been offered a copy of the interview guide and had time to review it if you chose to?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No

Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to withdraw from the study at any time, without having to give a reason?	Yes	No
Has confidentiality been explained to you?	Yes	No
Do you understand who will have access to your responses?	Yes	No
Do you have any questions?	Yes	No
Do you agree to be in the study?	Yes	No
Do you wish to be identified by your name, community/Nation, and/or region with quotes in our final report?	Yes	No

Preference for identification:

Participant name	
Email	
Phone number	
Research team member signature	
Date	

APPENDIX B: PARTICIPANT (FNHA STAFF) CONSENT FORM

First Nations in BC's Perspectives on Accessibility

Consent Form for Participants

On behalf of the First Nations Health Authority (FNHA), we are inviting you to participate in a study called, *A Journey Towards Accessibility, Perspectives from First Nations in BC.*

What is this research about?

This study will explore the perspectives of British Columbia (BC) First Nations on accessibility and disability. We want to explore what accessibility means. We hope this research will help organizations to do better with First Nations people in BC living with disabilities.

Why were you invited?

We invited you to take part in this research because of your knowledge and experience with accessibility and disability. We believe that your perspective will be important to address accessibility and disability issues for First Nations people in the future.

Who is funding this study?

This study is being funded by the Government of Canada through the Advancing Accessibility Standards Research Program.

Who is leading this study?

Courtney Defriend is the lead of this study, also known as the Principal Investigator. She is Director of the Research and Knowledge Exchange team at the FNHA. Greg

Shea is also leading this project as Vice President of Community Capital Projects at the FNHA.

What will happen if you decide to participate and what are the potential risks?

If you decide to participate, you will give your **verbal consent**. The study will take between 1-2 hours. During this time, we will ask what is important to you about accessibility. The interview will be audio recorded with your permission.

We will be talking about accessibility and disability, which may be upsetting or difficult to talk about for some people. **Please know that it's up to you whether you want to join us**, **and you may choose to leave at any time. If you choose to leave, we will delete your audio recording and not include any of the information you've shared today in our final report. You will still receive your payment if you choose to leave before finishing.**

Potential Benefits

We hope this work will be shared with law makers and organizations to create better programs and services for First Nations people and families in BC living with disabilities.

Questions

The research question of "*What does accessibility mean to you?"* will be followed by other questions, such as:

1. What are the mental aspects of accessibility?
2. What are the emotional aspects of accessibility?
3. What are the physical aspects of accessibility?
4. What are the spiritual aspects of accessibility?

Cultural Wellness Supports

You will be provided with a resource sheet to connect you with mental, emotional, physical, and spiritual supports.

Legal Rights

By agreeing to participate in this study, you do not waive any of your legal rights.

How will your data be protected and stored?

The recording of the interview will only be listened to by members of the project team. We will type out the recording word for word. This will not have any names or other information that could identify you. After the transcript of the interview is completed, the audio recording will be destroyed. The electronic document of the interview will be put onto a secure spot located on FNHA's computer system. Only research study staff that have permission will be able to access the document, which will contain no personal identifying information. All answers will be kept de-identified and confidential unless you choose to share your name. However, you may want to have your name attached quotes from the interview or the information you give.

We will ensure a strong commitment to the principles of Ownership, Control, Access, and Possession (OCAP®) throughout our process. First Nations have collective ownership of their data and information and will ensure security of the data at all phases of the research.

Questions or Concerns

If you have any questions about what we are asking of you, or any concerns about the interview itself, please contact Kate Checknita at Kate.Checknita@fnha.ca or by phone at 604-813-4481, or Courtney Defriend at Courtney.Defriend@fnha.ca or by phone at 250-802-1278.

If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, you may contact FNHA Ethics at ethics@fnha.ca and the appropriate FNHA staff person will respond in a timely manner.

CONSENT CHECK LIST

Read aloud and record the following information

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read (or been read) and received a copy of this consent form?	Yes	No
Have you been offered a copy of the interview guide and had time to review it if you chose to?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to withdraw from the study at any time, without having to give a reason?	Yes	No
Has confidentiality been explained to you?	Yes	No
Do you understand who will have access to your responses?	Yes	No
Do you have any questions?	Yes	No
Do you agree to be in the study?	Yes	No

Participant name	
Email	
Phone number	
Research team member signature	
Date	

APPENDIX C: INTERVIEW TOPIC GUIDE

First Nations in BC's Perspectives on Accessibility

Semi-Structured Interview Guide

[Introduce self and team. Territory acknowledgement. Opening prayer if someone wants to do it.]

First, I am going to ask you a little bit about yourself for background. Then I will ask about health, wellness, accessibility and disability.

Demographic Questions

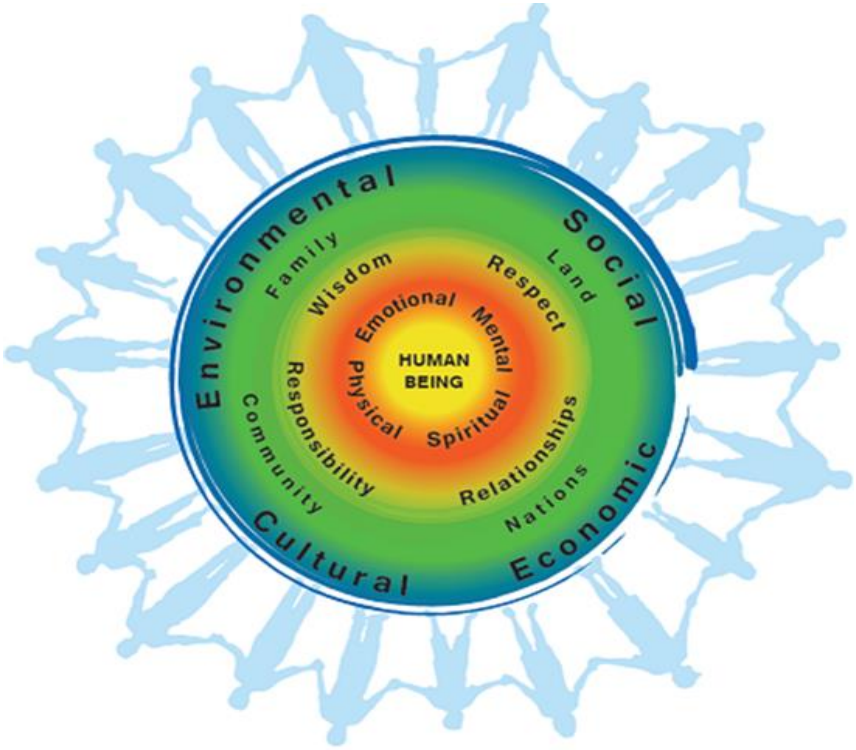
1. Please introduce yourself how you would like to identify culturally, personally, or in any other way you choose including age, gender, or any other part of your identity.

First Nations Perspective on Health and Wellness

[Show participant the FNPOHW diagram on the next page]

This is the First Nations Perspective on Health and Wellness, and is our guiding framework for this project. This graphic was made by First Nations in BC, First Nations Healers, and Elders, Each of these rings represents a layer of a First Nations perspective on health and wellness. It is meant to create a shared understanding of wholistic wellness. This image is just a starting point: it can be changed or customized for each person who looks at it.

Accessibility means different things to different people. One way to define accessibility is that everyone has equal access to services, facilities, and communities. The FNPOHW may be able to help us understand what accessibility and disability are from a First Nations perspective. I will give you a few moments to look at the FNPOHW. After you get a chance to look at it, we can discuss what about this diagram stands out to you. [Pause for as long as the participant needs to review]



These are a few questions that we can use to guide our conversation. You can answer as many questions as you want, in whatever order you want. You do not have to answer all of these questions. If you want to talk about something that is not included in these questions, we can do that as well. [Interviewer will show these questions to the participant on a piece of paper, and/or read these questions out loud.]

*Our guiding research question is: "**What does accessibility mean to you?"***

For focus groups, we will do two rounds of each person talking about whichever question(s) they would like to discuss.

What does accessibility mean to you?
What does accessibility mean from an emotional perspective?
What does accessibility mean from a mental perspective?
What does accessibility mean from a **physical** perspective?
What does accessibility mean from a **spiritual** perspective?
What are the **current barriers** for First Nations people in accessing services?
What are the **stigmas** associated with access to health services?
What are some **considerations for creating welcoming spaces** for those with diverse abilities?

Appendix:

Detailed description of the FNPOHW: This is for people who would like to know more about the graphic or have questions about what each part of the diagram means.

The centre circle is the core of wellness, where people take responsibility for their own health and wellness. The second ring is the aspects of wellness, and include emotional, mental, physical, and spiritual health. The third ring is the values of wellness, and include respect, wisdom, responsibility, and relationships. The fourth ring is the relationships of wellness, and include relationships to land, community, family, and Nations. The fifth ring is the determinants of wellness, and include the social, cultural, economic, and environmental factors that impact health and wellbeing. The people holding hands represent the children, families, Elders and community members being of "one heart, one mind", grounded in relationships and togetherness.

Visual description of FNPOHW: We will visually describe the FNPOHW for participants who are blind, have low vision, or are colour blind.

The FNPOHW is a circle that has 6 rings that fit inside of each other. The centre of the circle is yellow, and has the words "Human Beings" written inside it. Around the yellow centre is the second ring which is orange, and has the words "Emotional, Mental, Physical, and Spiritual" that wrap around the ring. Around the orange ring is the third ring which is yellow, and has the words "Wisdom, Respect, Responsibility and Relationships" that wrap around the ring. Around the yellow ring is the fourth ring which is green, and has the words "Family, Land, Community and Nations" that wrap around the ring. Around the green ring is the fifth ring which is blue, and has the words "Environmental, Social, Economic, and Cultural" that wrap around the ring. The outer layer of the circle are blue silhouettes of children and adults holding hands.

APPENDIX D: RESEARCH RESULTS FEEDBACK SURVEY

Below is the research results feedback survey that was forwarded to participants following the knowledge-sharing circle, to gather their feedback and insights on the research project, the research findings and the recommendations that were synthesized based on perspectives from the participants received through interviews and focus groups.

FNHA Accessibility Research Results Feedback Survey

Thank you for your participation in the FNHA Accessibility Research Project. We recently held a knowledge-sharing circle to present our findings and gather feedback, and we understand that some of you were unable to attend. To ensure everyone has a chance to provide input, we've created this brief 10-question survey. In order to answer the questions, **please first read our community report**, which outlines the research results. Your feedback will help us refine the final report and ensure it reflects the community's needs and experiences.

Thank you for your time and contribution!

Required

1. After reading the research findings, do you feel we’ve accurately captured what accessibility means to you?
   A) Yes, you’ve summarized it well.
   B) Yes, but you’re missing something.
   C) No, I don’t feel like that is what accessibility is.
   D) I’m not sure.

2. Please provide any additional details or explanations for your answer to question 1.

3. Have you personally experienced some of the cultural, systemic or environmental barriers to accessibility that we’ve mentioned in the report?
   A) Yes, those are the only barriers that I have experienced.
   B) Yes, but there are other barriers that I experienced frequently that you have missed.
   C) No, I have not experienced those barriers but I know someone who has.
   D) No, I don't believe those are barriers.

4. Please provide any additional details or explanations for your answer to question 3.

5. Do you feel we’ve accurately captured the areas that should be improved for accessibility?
    A) Yes, you’ve summarized it well.
    B) Yes, but you’re missing something.
    C) No, I don’t feel like these are the right areas for improvement.
    D) I’m not sure.

6. Please provide any additional details or explanations for your answer to question 5.

7. Do you agree with the recommendations for improving accessibility we have suggested in the report?
    A) Yes, I agree with those recommendations.
    B) Yes, but I have additional recommendations to add.
    C) I don't agree with these recommendations.

8. Please provide any additional details or explanations for your answer to question 7.

9. How likely are you to discuss or share the results that we found and the report with your peers, family, friends, and community?
    A) Very likely
    B) Likely
    C) Not sure
    D) Not very likely

10. Do you have any additional feedback or important thoughts you'd like to share about the community report or the research findings?

11. Please provide your name and email below to receive an honorarium for completing the survey.

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