

***To the People Who are Able:
A Perspective on First Nation Children
and Disability***

**A Discussion Paper
Prepared for the Assembly of First Nations
Social Development Secretariat**



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The following is an excerpt of the thoughts of a First Nation leader after listening to Standing Committee Hearings on First Nations Disability:

*I guess I could consider myself lucky
For I am able to walk, to talk and to see
But this hearing that you had,
Really did a number on me.*

*I never realized the hardships that you faced,
I was always too busy with other things to do.
And if I was in your situation.
I doubt that I could be as courageous as you.*

*I know you look not for sympathy,
You don't need it for you are strong
But I feel that I should apologize,
For thinking in ways that were wrong.*

*Now when I pray to my Creator,
I'll ask him in a special way.
To help you remove those obstacles
And to guide you through each day.*

*V. Phillips
Akwasasne*

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Introduction

Poor health and poverty among First Nations people causes higher rates of disability, exacerbates existing disability and further diminishes quality of life for First Nations people with a disability (National Aboriginal Network on Disability).

Poor health conditions in First Nation communities are caused by harsh and inferior living environments. Health and social services in many First Nation communities are not locally controlled nor are they adequately resourced or staffed. Culturally appropriate programming is yet another problem First Nation individuals face when attempting to receive services. Medical treatment is inadequate and early detection of a disability is unlikely. Without early detection the point at which treatment can be administered to minimize seriousness is even less unlikely. Without adequate medical treatment services First Nation people are at a higher risk than most Canadians of improper treatment of injuries which inevitably predisposes them to permanent disabilities.

According to a 1994 United Nations Development Program study that measured the quality of life around the world, Canada placed first as one of the best countries in which to live. As described in the 1996 Royal Commission on Aboriginal Peoples (RCAP) report, most Canadians enjoy adequate food, shelter, clean water, public safety, protection from abject poverty, access to medical and social services and good health as a result of these things. In contrast, Aboriginal and First Nation people face inadequate nutrition, substandard housing and sanitation, unemployment and poverty, discrimination and racism, violence, inappropriate or absent services and high rates of physical, social and emotional illness, injury, disability and premature death.

Canada's Census figures indicate that the income of 9 out of every 10 Aboriginal persons living on a reserve with a disability is below the poverty line. Only 2 out of every 10 Aboriginal persons with a disability living on a reserve have some kind of employment

and 5 of every 10 Aboriginal persons with a disability living on a reserve have less than grade 8 formal schooling.

One in every 2 or 3 children in First Nation communities currently stands to develop permanent hearing loss. Because of the predisposition of First Nation children to middle ear disease the likelihood of normal speech and language development is minimized. This is a direct result of poor living conditions in many First Nation communities. Permanent neuromotor disabilities in remote and under-serviced regions are yet another result of lack of adequate medical services.

Life expectancy at birth is seven to eight years less for registered *Indians* than for Canadians generally. The reason for this difference in life expectancy is the high rates of infant mortality among registered First Nation individuals. For infants, the death rate is about twice as high as the national average. There are also high rates of injury and accidental death among Aboriginal children and adolescents. Infectious diseases of all kinds are more common among Aboriginal people than others. Rates of overcrowding, educational failure, unemployment, welfare dependency, conflict with the law and incarceration all point to major imbalances in the social conditions that shape the well being of Aboriginal and First Nation people.

Without healthy, socially developed children and youth we will have no future. They are our future leaders, teachers, administrators, politicians and nation builders. Without them we have no guarantees for anyone beyond today. To survive as a people, a culture and nation we must attend to the health of our children and our people.

Aboriginal children are the fastest growing segment of the Aboriginal population. In 1996, 35% of Aboriginal people were younger than 15 years of age compared to about 21% for Canada. Even more significantly, the fertility rate among the Aboriginal population is about 69% higher than the rate for the general Canadian population and population growth is twice the national rate (1996 Census). Given that, we know Aboriginal children are most likely to grow up in low-income families and communities, and are twice as likely to live with a lone-parent. So the demand for programs and services is high.

Injuries remain the leading cause of death for children and youth after their first birthday and a major cause of hospitalization and disability. Aboriginal children are six times more likely to die by injury, poisoning or violence (ACPH, 1999)

Children with disabilities or identified special needs are even less likely to survive or receive the services they need.

A Historical Overview of General Health Conditions In First Nation communities

Prior to the arrival of the European, First Nation people were healthy. They enjoyed rigorous lifestyles and nutritious diets. This changed as the explorers and settlers, upon their arrival, carried communicable diseases to North America. This devastated First Nation communities. Diseases, such as small pox, measles and influenza began a decline in community health for First Nations. Centuries of colonialism, repression and indifferent health policies have resulted in Aboriginal people having the poorest health status in the Americas (AFN report to RCAP 1993).

Today many diseases are raging at epidemic levels in First Nation communities. Diabetes ranks as the most prevalent chronic disease condition found in First Nation populations. The tuberculosis rate among the registered *Indian* population is nine times the national average. Also, over 30 percent of First Nation population suffers from a disabling condition. Suicide rates among First Nation youth, age 1-19, is six times the national rate. Fetal Alcohol Syndrome is thirty times that of the general population.

These conditions have been caused by negligence on the part of the federal government through its role as federal trustee to First Nations. It has abdicated trust responsibilities by dispersing health care programs and services to various levels of government, without consideration to First Nation governments. These decentralization methods have affected accountability and commitment causing inconsistency in the delivery of health care. The overall impact has resulted in damage to the health and quality of life of First Nation people (AFN submission to RCAP 1993), particularly children. (For the purposes of this paper children will include the age group of 0-18).

The health of a people is determined in large part by their ability to control their health care system. First Nations have no such control. First Nations people, are for the most part, passive recipients of health care and social services. Any action that allows First Nations people to exercise their inherent right to control their health programs and services will result in the improvement of their overall status of health. Full federal recognition of Aboriginal and treaty rights to health services would measurably improve First Nations health. Although in recent years through health transfer initiatives the federal government has permitted First Nations to administer some federal health and social programs, Federal departments still, however, retain authority to design programs, determine resources and set standards regardless of First Nation needs and concerns.

Especially troubling are the overlapping layers of federal, provincial, municipal and institutional health jurisdictions. These overlapping jurisdictions can result in duplication of service and sometimes lead to a lack of proper health care. The Standing Committee on Human Rights and the Status of Disabled Persons, found for example, that health care for the disabled suffers considerably because of jurisdictional wrangling between the Department of Indian and Northern Affairs and Health Canada.

Until the mid-1980's, the Province of Ontario had a policy that explicitly prohibited the extension of provincial health care services to First Nation communities, unless a federal-provincial financial arrangement was in place or existing legislation required it. This meant that First Nations requiring access to provincial services, such as vocational rehabilitation and psychiatric counseling, were forced to go off reserve. Even though this restrictive policy has since been amended, "access to service" continues to mean that First Nation citizens must go to urban centres to receive services.

Disabilities and fetal alcohol syndrome is a shared responsibility between the Department of Indian Affairs and Health Canada. Problems arise in determining what constitutes a "health" service (Health Canada) and a "social service" (DIAND). This complicated jurisdictional confusion can no longer be an excuse to deny First Nations access to the full range of health care services. The health care and social service system must be rebuilt in a way that better benefits First Nations.

First Nation Children and Disability From a Historical Perspective

In order to effectively discuss disability from a First Nations perspective we must first take a look back at how disability has been characterized historically. To do so we will look at three time periods, the 1960's, 1980's and 1990's.

During the 1960's and earlier, First Nation children and adults with disabilities lived in residential institutions where they were cared for as patients. This institutional-medical model of care was based on the assumption that people with disabilities were totally and permanently incapacitated, incapable of doing any work or of serving any useful function in society. There were two consequences of this model of care. One was that children and adults with disabilities were treated as a group. Facilities and services were not designed to meet individual needs; therefore, individuals had no right to make choices about their own lives.

The second consequence was the isolation of children and adults with disabilities from the community. Society in general was unaware of the needs of individuals with disabilities. This emphasized the difference between the population of general society and persons with disabilities. The result was stereotyping and labeling of disabled people. Something that still occurs today.

During the 1980's advancements of rehabilitative medicine and government social service programs occurred as a result of the World Wars. Soldiers who returned home wounded and traumatized provided the initial incentive for these developments. This resulted in improved rehabilitation and social service programs nationwide. Additionally, special schools were established for children and adults with disabilities resulting in a move away from residential institutions so that both homes and schools were more community based.

Although these were positive developments, they were counteracted with the fact that they were still group strategies, rather than one-on-one means for meeting individual needs. Real integration did not occur because individuals with disabilities were still segregated within group homes, sheltered workshops and special school situations.

Finally, in the 1990's the philosophies of the 1960's and 1980's evolved into one of integration and de-medicalization of services. The right of First Nations people with disabilities to live full-integrated lives within their communities and to participate in all aspects of community life prevailed. Furthermore, the movement away from viewing the individual with a disability as "sick" and in need of a complex bureaucracy of services changed to a view of disability as a life problem or social condition that relates to all sectors of society including the family and community.

First Nation people's right to self-determination and the dignity of risk was finally acknowledged. This movement also implied personal choice, user control over on-going support services and equal access to the rights and responsibilities accorded to all First Nations people. This included access to education, employment, recreation, communication and housing. (Source: First Nations Education Council Policy Study on Special Education).

Scope of the Problem of Child Disability Nationally

Over time, peoples of the world tend to experience various stages of health and illness, as they become more urbanized and industrialized. The first stage, according to RCAP, is marked by famine, high rates of infectious disease and death rates – especially among infants and children. The second is marked by declining rates of infectious disease and rapid population growth. The final stage is marked by the rise of chronic and degenerative diseases.

Aboriginal peoples are experiencing today, a transition from the second to the third stage. Birth rates are high and infectious diseases are declining, although not totally controlled. Degenerative conditions, however, such as heart disease, cancer and diabetes are on the rise. Social pathologies – particularly alcohol and drug abuse – are rampant.

Infant mortality rate (IMR) is an important measure of population health. In the case of Aboriginal populations, the ratio of Aboriginal to non-Aboriginal infant deaths is just the same today as it was 100 years ago – twice as high for First Nation people and three times as high for Inuit as for other Canadians. The IMR for Canadians generally is seven per 1,000 live births. The IMR in contrast for Aboriginal people is 14 among registered First Nation people and 20 among Inuit. These ratios also hold true for stillbirths (death of the fetus less than 28 weeks gestation) and prenatal (death of the fetus after 28 weeks gestation) mortality. Both these death rates are double the Canadian average. Among Inuit living in the Northwest Territories they are about two and a half times the Canadian average.

According to RCAP, not only is there the risk of infant mortality, there is also the long term health influence by what happens in the womb and in the first months and years of life. Neonatal and infant health is generally a result of the living conditions and health care choices of pregnant women and new mothers. Abnormal birth weight – low birth weight – is a known risk factor for ill health in childhood and later life. Alcohol consumption during pregnancy is another leading cause of ill health in infancy. Fetal alcohol syndrome and fetal alcohol effect (FAS and FAE) are results of alcohol abuse that many First Nation communities are struggling with.

Low birth weight increases the chance of death in infancy and of lifelong health and social problems (RCAP). Low birth weight babies are likely to have underdeveloped respiratory and other systems and weak immune systems. Long term they are in serious risk of chronic ill health or disability.

In the case of FAS, researchers now recognize that prenatal alcohol exposure may cause subtle deficits in judgement and reasoning in people with apparently normal intelligence. The estimated cost of meeting the needs of someone who is severely affected by FAS over a lifetime is \$1 to \$1.5 million. (RCAP). All of this is just a pre-cursor to the larger disability issue for First Nations.

According to the Aboriginal Peoples Survey (APS) 31 percent of Aboriginal people have some form of disability. This is twice the national average of the general Canadian population. For young adults the rate is almost three times as high. Disabilities affecting mobility and agility are most common, but hearing and visual disabilities affecting a large portion of the Aboriginal population are also prevalent.

According to RCAP this disparity between Aboriginal and non-Aboriginal rates of disability corresponds to the disparity in rates of injury, accident, violence, self-destructive or suicidal behavior and illnesses, such as diabetes, all of which can result in permanent impairments.

It is clear that the living conditions which exist in First Nation communities greatly increase the probability of being disabled at some time in a person’s life; especially that of an Aboriginal child.

**Table 1.1
Persons with Physical Disabilities Total & Aboriginal Populations 1991.**

	Total Population	Total Aboriginal	First Nation On-Reserve	First Nation Off-Reserve	Metis	Inuit
Mobility disability	45	45	47	45	44	36
Hearing Disability	23	35	39	33	34	44
Seeing Disability	9	24	32	21	22	24
Agility	44	35	34	36	38	26
Speaking Disability	10	13	14	13	13	10
Other Disability	37	36	37	37	35	36

Note: Population is those 15 years of age and older

Source: Statistics Canada/RCAP Vol. 3 Chp. 3

Table 1.2
Population of First Nation People with Disabilities by Region

Region	Population *	People with Disabilities**
Yukon	7,199	2,260
Northwest Territories	13,998	4,395
British Columbia	102,075	32,052
Alberta	76,419	23,999
Saskatchewan	94,953	23,815
Manitoba	95,113	29,865
Ontario	138,518	43,495
Quebec	58,640	18,415
NB-PEI	18,857	5,912
NS-NFLD/Labrador	20,834	6,542
TOTAL	626,606	190,748

Note: *Population Source: Indian Register Population by Region INAC December 31, 1997

**Disability Rate of 31.4% for Aboriginal People data source: Statistics Canada

Aboriginal children and adults with disabilities who live on reserve or in rural settings face numerous access problems. These include inaccessible buildings (such as schools, churches, homes, band offices) and inaccessible places of community activity (such as arenas, community centres, meeting halls) and lack of appropriate recreation opportunities. To compound this problem many First Nations children and adults with disabilities are forced to make the difficult choice of staying on-reserve with limited resources or leaving home to seek services in urban centres where family, friends and relatives are far away and the surroundings are unfamiliar.

Infectious diseases, inadequate housing conditions, overcrowding and lack of sanitation facilities are also a major risk factor for the disabled, or those at risk of being disabled. Children are at most risk due to exposure to colds or flu. This weakens the immune system, which is an additional risk. Exposure to second-hand cigarette smoke is yet another risk factor. Most premature hearing loss results from excessive noise or from otitis media (OM). OM is an acute or chronic inflammation of the middle ear – something that children are highly susceptible to. This occurs when an infection of the nose or throat (such as from a cold or flu) blocks the passageway connecting the back of the throat to the middle ear. Children who are otitis-prone will likely have temporary or permanent hearing problems which over their lifetime may interfere with language learning, school success and social development generally (RCAP).

Although Canada has made several attempts to improve accessibility and programming for people with disabilities inequity still plagues the existence of First Nation and Inuit peoples across the country. In a Special Parliamentary Committee on the Disabled and Handicapped report released in the early 1980's, the committee concluded that Aboriginal people live in poverty and suffer from living conditions that greatly increase the probability of being disabled at some point in their lifetime (RCAP 1995). They urged

all governments to develop programs to meet the needs identified for Aboriginal people and to amend the Human Rights Act of Canada to protect all Canadians with disabilities from discrimination, specifically employment, architecture, communication systems, public transportation and public housing. In April 1982 the Canadian Charter of Rights and Freedoms was expanded to include the rights of persons with disabilities. This legislation guaranteed equal benefits and protection under the law and prohibited discrimination based on physical or mental disability (FN and Inuit Regional health Survey Report 1999).

Despite these attempts, overall federal initiatives and programs do not address the major problems experienced in First Nation communities. The Table 1.3 describes the risk factors related to poor housing that create health problems for First Nations children and individuals.

Completing the Circle – the Standing Committee on Human rights and the Status of Disabled Persons (1993) and The Path to Healing (Sinclair 1993) illustrate the continuing history of inequity. Each of these reports, along with the RCAP and numerous others, identify the major determinants to poor health:

1. Jurisdictional problems in health and social service delivery
2. Unemployment
3. Poverty
4. Social –geographic isolation
5. Inadequate living conditions.

Other disability prevention issues such as coordinated service, delivery, accountability and accessible/culturally sensitive health care were also identified by the Council of Canadian with Disabilities as health determinants.

Convention on the Rights of the Child
United Nations High Commissioner for Human Rights
Article 23

States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions, which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate for the child's condition and to the circumstances of the parents or other caring for the child.....To ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development.

Table 1.3
Housing Conditions and Health Problems

Housing Conditions	Health Problems
Crowded Conditions	Infections (e.g. Respiratory, skin and eyes, tuberculosis, meningitis, measles) Injuries Mental Health Homicides and Domestic/Non-Domestic Violence
Inadequate Housing Stock (E.g. house in disrepair)	Injuries
Water Sewage Systems	Gastroenteritis, Skin infections
Indoor Air Quality (e.g. wood stoves, high humidity levels and mold, cigarette smoke)	Respiratory symptoms e.g. Asthma
Cleanliness (Dust)	Respiratory e.g. Asthma
Structure: ➤ Steps and handrails ➤ Cupboard and closets ➤ Washrooms ➤ Exterior doors ➤ Interior doors	Barrier to people with mobility, agility, sensory or physical disability
Safety: ➤ No electricity or appliance resulting in candle, kerosene lamp or camp stove use in the home ➤ Faulty wiring ➤ Faulty installation of wood stoves ➤ No inspection or cleaning of chimneys in houses with wood stoves	Fires

Source: First Nations and Inuit Regional Health Survey

Disability Defined

According to the FN and Inuit Health Survey literature review, *disability* is a measure of difficulty in performing an activity in a manner or within the range considered normal for human beings. This refers to impairments of mobility, sensory and intellectually “deficit” or abnormalities of psychological, physiological or anatomical structure or function. Thus impairment or “health problems” is something that presents difficulty for a person doing activities at home or in a community environment. Disability, therefore, is something that is experienced by the person as a whole.

It should be noted that for the purposes of this paper the above definition has been utilized and that there are various differences in the definition of disability that can effect

eligibility for disability related programs. Some definitions are based on a traditional medical model that looks at the physical or mental issue affecting the individual. Other definitions are based on a social and environmental model that focuses more on identifying the barriers the individual faces. In this case we are most interested in the latter model.

According to national statistics an estimated 57,000 Canadian children under 12 experienced hunger due to lack of food or money in 1994. The majority of hungry children lived with lone parents and a high proportion were Aboriginal.

For example, Table 1.4 illustrates the hospital utilization rates by age of First Nation individuals living in the province of Manitoba. It is clear that there are excessively high rates in all age groups compared to general Manitoba residents. One of the highest rates, however, were in the age category of under 10 years of age.

Table 1.4
Hospital Utilization Rates by Age, Registered Indian and Provincial Populations Manitoba 1990-1991

Age Category	Registered Indians* Days per 1,000 population	Manitoba**
Under 10 years	1,105	338
10-17	622	272
18-34	1,318	600
35-64	1,983	941
65+	7,200	7,022

Notes: * on and off-reserve population
** all Manitoba residents.

High levels of poverty experienced by First Nations children and adults have strongly influenced levels of disabilities and chronic conditions experienced over time. As an impairment advances, the more extensive the use of services required, such as rehabilitative services, helping aids and barrier free and healthy environments.

Some of the specific needs that exist to ensure integration and equal access of First Nation individuals are as follows:

1. *Rehabilitation Services*
2. *Preventative and Assistive Aides*
3. *Transportation*
4. *Housing*
5. *Recreation*
6. *Education and Training*
7. *Employment*
8. *Communications*

Table 1.5
Services Required to Insure Disabilities are Addressed

What is Required	Source
Rehabilitation	<p>Rehabilitation services make it possible for First Nation children and adults to receive services that include occupation, physical, mental, social and nutritional support. These consist of teams, in the ideal sense, composed of physiotherapists, occupational therapists and speech pathologists, physicians, nurses, psychologists, physicians, nurses, social workers, dieticians and other health care providers</p> <p>Eligibility for vocational and rehabilitative services often requires First Nation individuals to leave their communities and establish permanent residence where services are available</p>
Preventative and Assistive Aides	<p>The Medical Services Non-Insured health benefits program (NIHB) provides supplementary health benefits to registered First Nations, Inuit and Innu peoples to meet medical or dental needs that cannot be met by provincial services or other health plans. Under this program assistive devices for children and adults with disabilities or chronic conditions are made available to enhance independence.</p> <p>They may be used for functional activities such as mobility or agility; pain management and prescription drugs; and prevention. Other items include eyeglasses, hearing aids, limb braces, wheel chairs, crutches, or augmentative communication devices.</p>
Transportation	<p>Access to transportation makes it possible for children or adults with disabilities to go to school, acquire jobs and participate fully in First Nation communities. It facilitates independence and integration into every area of life.</p> <p>Access to specialist services and other medically required services is provided for under the NIHB medical transportation program. There is a fixed budget, however, and individuals have to wait until their condition is chronic to be able to access transport. Although funding is one part of the problem of access to transportation, communities that are remote, or are only accessible by plane, have problems with standards which are not always at par in terms of disability requirements e.g. seating, ramps, wheelchair access, etc.</p> <p>Accessible transportation in small communities and rural areas is often limited and a serious concern for children and adults living in these areas.</p>
Housing	<p>Today a range of housing options are available to First Nation children and adults with disabilities. The problem for First Nations is the lack of availability of community support services such as transportation, home support services and access to specialized programs; availability of disability accessible housing; and the willingness of the community to accept children and adults with disabilities and to provide support services and access to specialized programs.</p> <p>Limited housing resources are a significant barrier and ongoing concern which actually contributes to disability and chronic conditions instead of helping. Overcrowding being the most critical hindrance to obtaining housing for disabled children and adults. Costly wheelchair access, ramps and special modifications are not always affordable in First Nation communities where housing is a crisis situation already.</p>

Table 1.5
Services Required to Insure Disabilities are Addressed (Continued)

What is Required	Source
Recreation	Sports and leisure for children and adults with disabilities have evolved from segregated therapeutic programs to a combination of integrated courses and events. Social interaction and physical activity are promoted through pairing volunteers with those who have disabilities. This provides opportunities for friendships and a sense of participation in the community
Education and Training	In the early 1970's children with disabilities were sent to special schools. In the last three decades, however, the trend has increased towards mainstreaming disabled children into regular classes. Research indicates that First Nation children with disabilities continue to be handicapped by a general lack of access to education. Local First Nation schools are now responding to the needs of students with disabilities by improving physical access and by accepting new methods of study. Improved methods of diagnosing special education students and increasing special education delivery is required. Currently special education is not resourced as an integral part of First Nation educational budgets.
Communications	<p>These include telephone, television, radio, the print media, library resources, films, music, and theatre. Children who lack access to some, or all, of these forms lack a significant means of integration with society. TV is particularly important as a means of information and as a part of the right to access. Both closed and open captioning for people with hearing disabilities should be available.</p> <p>Children with visual or reading/learning disabilities require reading services, and access to Braille or audiocassettes. Similarly library resources, telephone and information mechanisms should be accessible to children and adults with disabilities.</p>
Employment	A full range of employment opportunities is essential for the parents of children with disabilities to ensure independence and access to resources. Vocational rehabilitation resources and vocational counseling, assessment, work training, interpreters, attendant care, etc. should be available for children as they age to ensure they have a place in the work force and society. Employment opportunities for people with disabilities in First Nation communities is often limited. First Nations, therefore, must organize their own placement and counseling services and start their businesses.

Source: First Nations Education Council Report on Special Education & the First Nations and Inuit Health Survey

As noted in this table there are several layers of strategies required to address the needs of First Nation children with disability. The bottom line is three major things:

- a.) *Access* (housing, education and work),
- b.) *Resources* (awareness, prevention and research)
- c.) *Support* (support, advocacy and care)

The Specifics:

First Nation Children and Disability

According to the National Aboriginal Network on Disability, First Nation children with a disability face severe problems when living in a First Nation community. Roads are rough and usually unpaved, there are no wheelchair ramps to facilitate access to community or commercial buildings, and there are no transportation services. This is especially true in northern communities where transportation may only consist of all terrain vehicles or snowmobiles.

Northern reserve communities also have few home care programs. Physiotherapist visits are infrequent and there is no equipment in these communities for therapeutic treatments for First Nation children or adults with disabilities. Even more frustrating is the inevitability of overcoming so many obstacles. Many First Nation children and adults end up being institutionalized because their families have no other option. Without adequate housing, home support, assistive devices or therapeutic and rehabilitative services this situation will only worsen over time.

In 1997 15% of children under six, 11% of children aged 6-11 and 9% of children aged 12 years and older had asthma. Bronchitis affected almost one in ten children under 6. Respiratory illness is the single greatest cause of hospitalization for young First Nation's children. HIV/AIDS is a serious health issue among Aboriginal peoples, with Aboriginal people being one of the fastest growing segments of the HIV-positive population (CICH).

According to the 1998 report on disability "In Unison" the Canadian Approach to disability issues by Federal/ Provincial/ Territorial Ministers responsible for social services consists of several approaches that could be taken to address the problem of disability. They are illustrated in Table 1.6 as follows:

Table 1.6
"In Unison" – Canada's New Approach to Disability

Old Concepts	New Approaches
Recipients	Participants
Passive income support	Active measures to promote employment
Dependence	Independence
Government responsibility	Shared responsibility
Label as "unemployable"	Identification of Work skills
Disincentives to leave income support	Incentives to seek employment
Inadequate employment supports	Opportunities to develop skills and experience
Program centered approach	Person centered approach
Insufficient portability of benefits and services that are not portable	Portable benefits and services
Multiple access requirements	Integrated access requirements

First Nations response to “In Unison” was a major concern that for programs and services to meet the needs of First Nation children and adults they must be developed and delivered in an efficient and culturally appropriate manner. Although the new approaches described in the “in Unison” document addressed a global vision for increased participation of the disabled in society the document did not address First Nation realities. Lack of housing, youth supports, meaningful employment opportunities, education and awareness programs for the disabled, the *Indian Act*, lack of willingness of government stakeholders to accept responsibility e.g. federal, provincial, etc. were just a few of the myriad of problems faced by First Nations when they struggle to provide services for individuals with disabilities.

Table 1.7
A Comparative Analysis of First Nation Realities re: “In Unison”

Approach	Barriers in First Nation Communities
Employment readiness and life skills	Where these initiatives were undertaken they were designed to meet the needs of others and First Nation consultation during planning does not always occur
Institutionalization	Although the concept of integration is embraced by Canada generally there is an inequity of service availability for children and adults with disabilities who live in northern and First Nation communities. Institutionalization is forced on disabled individuals coming from these communities because there are just no other options – even worse First Nations children and adults with disabilities are forced to go to institutions that are in the south which further alienate them from their communities and their families
Education	DIAND provides inadequate funding for First Nation schools to provide integrated education programming for children with disabilities in terms of qualified staff, resource people, and teaching assistants
Housing	Housing on reserves is generally poor and inadequate. Many First Nations children and adults are forced to live in old, ill repaired houses with no insulation, running water or sewer systems. Resources are usually lacking as well to build access ramps or other modifications. In urban areas First Nation children and adults face housing problems because of discrimination and high cost
Access to Public Places	Many First Nation communities do not have barrier free design policies for their public places e.g. health centres, nursing stations, recreational centres, band offices, etc. Retrofits are expensive and as a result services are not accessible to all community members especially those with a disability
Accessible Barrier-free transportation	Many communities do not have road systems or if they exist they are poorly maintained. Wheel chair access is very limited resulting in isolation, loneliness and depression for disabled individuals resulting in high rates of suicide and dysfunction.
Income Security and Poverty Issues	Income security rates set by DIAND are lower than provincial rates resulting in inadequate supplementary funding to offset the costs of disability. This results in disputes over jurisdictional responsibility for service delivery making it difficult to obtain necessary technical aids, prosthetics, orthotics, etc.
Lack of Traditional healing and health services	Services are not provided to address the holistic health care needs in First Nations communities. This includes emotional, spiritual, physical and mental healing.
Negative Attitudes and Cultural alienation	First Nation children and adults are faced with far greater negative stereotypes than non-First Nation people are. Culturally appropriate services are difficult to obtain and systemic barriers to service result in First Nation’s individuals enduring culturally inappropriate and insensitive treatment by service providers

Table 1.8
Actions Required to Address Barriers
For First Nation Children and Adults with Disabilities

Approach	Action Required
Employment and life skills	<ul style="list-style-type: none"> ➤ Demonstration projects are required to improve First Nation youth and adult access to the labor market ➤ Equitable access to education and training is also required ➤ Accommodation is required to support FN individuals in the area of employment and training ➤ Evaluation criteria for program delivery should recognize the principles of the Medicine Wheel
Institutionalization	<ul style="list-style-type: none"> ➤ Funding is required to enhance independent and community living options to decrease the rate of institutionalization ➤ Training is required to home care workers, attendants, teaching assistants, who would then be qualified to work with children with special needs
Housing	<ul style="list-style-type: none"> ➤ Funding is required to enable communities to become more aware of the principles of barrier free design ➤ Funding is required to enable FN communities to implement barrier free design
Transportation	<ul style="list-style-type: none"> ➤ Resources are required to assist FN communities in enhancing transportation options ➤ Small aircraft need to be equipped to enhance wheelchair access that can be accommodated in a dignified manner
Income Security	<ul style="list-style-type: none"> ➤ DIAND must raise its income security rates so that they are comparable to or better than provincial rates ➤ A reimbursement system is required for the additional costs of disability ➤ Steps are required to remedy disincentives
Health	<ul style="list-style-type: none"> ➤ Traditional health practices and spirituality must be accommodated to ensure equity of access
Disability related supports	<ul style="list-style-type: none"> ➤ Research is required to assist First Nations communities in developing culturally appropriate rehabilitation services based on FN culture and values
Prevention	<ul style="list-style-type: none"> ➤ The rates of disability among FN children and adults are higher as compared to non-First Nation due to poverty and socio-economic conditions. Education and awareness programs are required to address FAS, diabetes and AIDS/HIV

Source: Our Perspective of Aboriginal People with Disabilities

The biggest problem overall as it is clear to see in Tables 1.6, 1.7 and 1.8 there are no comprehensive strategies that address the specific needs of CHILDREN who are disabled. Although government strategies are well intended and target very important issues for First Nations individuals with disability, children with disabilities are at the very edge of a big bureaucratic abyss. The black hole of nothing in terms of a vision for our disabled First Nations children. Government does not worry about children until they are old enough to enter the work force (note Statistics Canada, DIAND, HRDC or other government agency databases whose figures start at age 15 and go up). How can we quantify the needs of our children when they aren't even counted, especially in terms of disability?

How Could Things Get Any Worse?

According to two CBC reports released on November 20, 2000 Canada, is failing to protect its children from poverty and abuse, despite public pledges to do so. The federal government vowed to eradicate child poverty by the year 2000. Instead child poverty has actually **risen** in the past decade. The ninth annual report on child poverty in Canada says **1.3 million Canadian children live below the poverty line – 400,000 more than a decade ago**. The report is compiled by Campaign 2000. Campaign 2000 is an anti-poverty coalition of 80 national, community and provincial organizations. Families living below the poverty line spend more than 55% of their income on food, shelter and clothing, according to Campaign 2000's definition. This is despite a children's budget, a children's agenda and an economic boom. MORE children are going hungry and MORE families are using food banks, says Campaign 2000.

Table 1.9
Children in Canada Living in Poverty 1989-1998

Year	Number of Poor Children	Percentage
1989	936,000	14.4%
1990	1,107,000	16.9%
1991	1,142,000	18.2%
1992	1,080,000	18.8%
1993	1,247,000	21.3%
1994	931,000	19.5%
1995	1,472,000	21.0%
1996	1,515,000	21.4%
1997	1,441,300	21.4%
1998	1,336,000	19.0%

Source: Campaign 2000 based on figures from the Canadian Council on Social Development and Statistics Canada

Poverty activists say that the parents of poor children are the working poor. They are stuck in low-paying jobs and that keeps them below the poverty line. Activists also say that the cost of bringing every Canadian child out of poverty would be \$12 billion. The investment, they say, would pay benefits in the long term by reducing social problems such as crime.

Table 1.10 illustrates the provincial numbers of children in Canada who are poor. In Ontario there was a 91% increase in child poverty over a nine-year period. This is compared to a national average increase of 27% during the same period.

Table 1.10
Poor children in Canada
Provincial Statistics

Province	Number of Poor Children in 1998	Rate of Child Poverty in 1997
Newfoundland	31,000	25.1%
Quebec	388,000	23.8%
Manitoba	63,800	23.6%
Nova Scotia	40,200	19.1%
New Brunswick	30,500	18.0%
Saskatchewan	48,300	18.7%
Ontario	471,500	17.5%
Alberta	128,800	17.1%
BC	131,000	14.8%
PEI	4,200	12.4%

Source: The Canadian Council on Social Development and Statistics Canada

According to the Campaign 2000 “Child Poverty in Canada” Report Card 2000, inadequate income and child development are key determinants to a healthy population. Researchers unanimously agree that adequate income and a healthy start in life have a long-term impact on the well being of children. Low-income children are more than twice as likely to have low levels of vision, hearing, speech, mobility, dexterity, cognition and emotion. They are also less likely to have an annual visit to the dentist and more likely to be exposed to environmental contaminants.

As described earlier in this paper poverty levels are at crisis proportions in most First Nations communities. If we apply Canadian national statistics to the circumstances in First Nations we know that the problem is even worse than that of Canada.

According to Health Canada, injury is a major cause of death among First Nations young people aged 15-24 at a rate of 86% with 14% being *other* causes. Children in First Nation communities have higher rates of accidental death and injury compared to all Canadian children. Death rates for First Nation infants from injuries are four times the rate of non-First Nation infants and death rates from other causes such as birth defect, low birth weight, respiratory illness are significantly higher for Aboriginal infants and children when compared to the non-Aboriginal population (CICH). This is compounded, as we have described throughout this paper, with children living in socioeconomic environments that make them more vulnerable to health care problems that are: physical, emotional and mental in nature.

Money is required to meet the special needs of First Nation children yet, there is no national policy addressing special education needs for these children. What funding is available from DIAND for special education is grossly inadequate. Incidence rates of

FAS are considerably higher among Aboriginal Canadians and other socially disadvantaged groups. In some regions of the country where most families consist of Aboriginal single mothers, a prevalence of 50% live births is not uncommon.

On December 5, 2000 a government report entitled *Sacred Lives* was released indicating that 90% of child and teen prostitutes in Canada are Aboriginal. The report states that widespread racism; crushing poverty and declining culture are the primary reasons why Native youth end up on the streets. One hundred and fifty Aboriginal youth were interviewed for the report, which was conducted by *Save the Children Canada*. The report concluded that Native youth are targets for prostitution because they're vulnerable and used to exploitation. A series of round table discussions and building a national youth network is recommended by the report to address the problem.

What other Reports have concluded

There are Standing Committee Reports and investigations that have taken place over the years, too few actually, and with limited results, it appears. On the overall disability issue there has been some movement but in terms of a comprehensive strategy that addresses First Nation children and disability, progress seems to be less prevalent. In an effort to summarize what key documents have recommended to address Aboriginal disability the following is a list of the issues and recommendations identified in the research for this paper:

1998 Gathering Strength

Agenda for Action

1. Better beginnings for children – Healthy lives start with healthy beginnings. By continuing the off-reserve Aboriginal Head Start program and extending it to include on-reserve communities, *the government will work with Aboriginal people to address the early childhood development needs of Aboriginal children*. As well, the First Nations and Inuit Child Care Program that was developed in the last mandate will be continued.
2. The government is also committed to working with First Nations to ensure that their children, like other Canadian children, will benefit from the National Child Benefit system when it is introduced nationally. An increased federal child benefit will be provided to low-income families in First Nation communities. *Welfare savings that may accrue from these changes on reserve will be available for re-investment in First Nation communities to help alleviate the depth and consequences of child poverty and to support welfare reform*

1996 Royal Commission on Aboriginal Peoples

Recommendations:

1. The Government of Canada acknowledge a fiduciary responsibility to support Aboriginal nations and their communities in *restoring Aboriginal families to a state of health and wholeness*.
2. Aboriginal governments adopt the principle of including women, youth, Elders, and *persons with disabilities* in governing councils and decision-making bodies the modes of representation and participation of these persons being whatever they find most agreeable.
3. Aboriginal, federal, provincial and territorial governments, in developing policy to support health, acknowledge the common understanding of the determinants of health found in Aboriginal traditions and health sciences and endorse the fundamental importance of
 - a) *holism, that is, attention to whole persons in their total environment;*

- b) *equity, that is, equitable access to the means of achieving health and rough equality of outcomes in health status;*
 - c) *control by Aboriginal people of the lifestyle choices, institutional services and environmental conditions that support health; and*
 - d) diversity, that is accommodation of the cultures and histories of First Nations, Inuit and Metis people that make them distinctive within Canadian society and that distinguish them from one another.
4. Governments recognize that the health of a people is a matter of vital concern to its life, welfare, identity and culture and is therefore, a core area for the exercise of self-government by Aboriginal nations.
5. Government and organizations collaborate in carrying out a comprehensive action plan on *Aboriginal health and social conditions*, consisting of the following components:
- a) development of a system of Aboriginal healing centres and healing lodges under Aboriginal control as the prime units of holistic and culture-based health and wellness services;
 - b) development of Aboriginal human resources compatible with the new system, its values and assumptions;
 - c) full and active support of mainstream health and social service authorities and providers in meeting the health and healing goals of Aboriginal people; and
 - d) *implementation of an Aboriginal community infrastructure development program to address the most immediate health threats in Aboriginal communities, including the provision of clean water, basic sanitation facilities and safe housing.*
6. Federal, provincial and territorial governments collaborate with Aboriginal nations, regional Aboriginal service agencies, community governments and Aboriginal organizations, as appropriate, to adapt legislation, regulations and funding to promote
- a) integrated service delivery that transcends restricted service mandates of separate ministries and departments;
 - b) *collaboration and shared effort between federal, provincial/ territorial and local governments; and*
 - c) the pooling of resources flowing from federal, provincial, territorial or Aboriginal sources.

1996 Federal Task Force on Disability Issues

Recommendations

1. The Standing committee's recommendations reflect key principles that were stated again and again in the Task Force consultations:

- *The situation of Aboriginal Canadians with disabilities is a serious one that requires immediate and comprehensive action on the part of all those whose decisions have a direct or indirect impact on the lives of these Canadians.*
 - *Aboriginal Canadians with disabilities themselves know best what their issues are and how they can best resolved.*
 - *Federal government departments whose mandates directly affect the lives of Aboriginal Canadians with disabilities must acknowledge their responsibility to ensure that the programs and services they provided are flexible, transparent and coordinated.*
2. The Government of Canada should recognize the ways in which it has contributed to the jurisdictional complexities that prevent Aboriginal Canadians with disabilities from gaining access to the support and services they need, and begin to work in collaboration with provincial governments and Aboriginal communities to provide flexible, client centered services and supports to Aboriginal Canadians with disabilities.
 3. *The Government of Canada should assess the appropriateness of using accountability mechanisms to ensure the federal commitments made to address the needs of Aboriginal Canadians with disabilities are captured, assessed and evaluated in a way that ensures continued action.*

1993 Standing Committee on Human Rights and The Status of Disabled Persons Recommendations:

1. Ensure immediate action to co-ordinate federal programs and activities that are directed towards, or are used by, Aboriginal people with disabilities.
2. In consultation with Aboriginal people with disabilities, create a working group composed of senior managers of all responsible departments to establish and to monitor an integrated approach to policy and program formulation and development for Aboriginal people with disabilities. This working group should ensure that individual federal departments and agencies collect and use up-to-date and appropriate data in devising policies and programs for Aboriginal people and disabilities.
3. The federal government should prepare a tripartite/federal / provincial/ territorial / First Nation government action plan that will ensure consultation, cooperation and collaboration on all issues pertaining to Aboriginal people with disabilities. This action plan must contain specific agendas, realistic target dates and evaluation mechanisms. It should deal with existing or proposed transfers of the delivery of services to ensure that these transfers meet the needs of Aboriginal people with disabilities.

4. The Minister of Indian and Northern Affairs, Health Canada and Treasury Board should cooperate with the Minister responsible for the Status of Disabled Persons and set up a working group to determine the support in the community for a Canadian Council on Aboriginal Peoples with Disabilities. This council would advise the government on issues related to Aboriginal people with disabilities and raise awareness within Aboriginal communities and all levels of government on issues related to disability. This Council would also ensure that government departments are obliged to consult Aboriginal people with disabilities about relevant policies and initiatives. (Note: this same recommendation was made in 1981 in the report *Obstacles* A report of the Special Committee on the Disabled and the Handicapped.)

1981 A Report of the Special Committee on the Disabled and the Handicapped Recommendations:

1. Establish a national advisory body on community services for disabled Indian persons – to advise on community services affecting disabled First Nation people, similar in concept and format to the National Commission Inquiry on *Indian Health*.
2. Expand the role of Friendship Centres for Disabled Native people – to include urban based referral programs providing liaison and assistance to migrant Natives who are disabled.
3. Consider transfer of health services to *Indian and Inuit* people who are disabled.
4. Establish data on problems of disabled *Indian and Inuit* people – to undertake community based surveys to supplement program data presently available regarding the extent and nature of problems facing disabled *Indian and Inuit* peoples.
5. Expand health profession opportunities for Native persons – to expand career opportunities and attract Native people to the health professions and in particular to the field of health education and promotion. *First Nation babies die at twice the national rate. Those who survive the ravages of pneumonia, bronchitis and parasitic diseases frequently suffer from malnutrition, unhealthy living conditions and family breakdown. The easiest disability to care for is one that does not occur in the first place. This means PREVENTION. This education can only occur in an environment, which incorporates the language, customs and lifestyles of First Nation people.*
6. Educate public servants on the needs of disabled Native people – an understanding of the history, values, and perceptions of Native groups is needed by all public servants who work with them.

7. Increase support for national Native alcohol abuse programs – to ensure the program involves members of those communities for which the program is intended. *Sixty percent of First Nation “children in care” arrives in that situation as a direct result of alcohol abuse.*
8. Ensure access to rehabilitation services for status *Indians* – DIAND and Health Canada in consultation with Native organizations must develop a suitable mechanism to ensure that disabled First Nations people have access to a full range of rehabilitation services.

Gaps in Information on First Nations Children and Disability – Implications for Policy Reform

It is apparent from the summary of recommendations from other reports on the topic of Aboriginal people and disability that the following issues need to be addressed in order to address the needs of First Nations children with disabilities:

- Lack of accurate statistical data on Aboriginal people and disability
- Lack of child specific and accurate disability data generally
- Inter-jurisdictional overlaps with education, health, social services, childcare, etc. – who is really responsible?
- Lack of understanding of non-Aboriginal people that disability has different cause and effect in First Nation communities and, therefore, requires different interventions and different policy frameworks

There is a need for additional research. Hard data is required to be able to make the necessary decisions. The following is recommended to address the issues identified in this paper:

- More data and analysis is required to enumerate the problem – currently it is “hidden” within education, child and family service data, etc.
- Research is required on pre-natal impacts and predisposition towards disability due to poor pre-natal and post-natal care
- Analysis is required on early identification of disability in children and the need for resources and linkages
- Analysis of what disability means from a First Nation perspective – how is it different from the Non-Aboriginal definition and perspective – this is very important
- Determination of a Vision on First Nation child disability – what will the parameters be?
- What is the role of traditional healing in interventions for children with disabilities?
- What are the cultural implications of providing services to children with disabilities – how is it different from non-Aboriginal?

In conclusion:

A comment on self- government and Health

What is the connection between self-government and health? Poverty as we have described in graphic detail throughout this paper is an important determinant of health over time. Mortality and longevity are deeply linked to social class and income. First Nations people suffer the highest rate in Canada of unemployment, dependency on social assistance and low income. In short, poverty is rampant in First Nation communities. If self-government improves the economic status of Aboriginal people it may be concluded that health status will also improve.

Self-government is linked to land and land claims. The conclusion of these claims for First Nations will provide resources both in terms of land and cash, which will improve the economic status of Aboriginal communities long term. Furthermore, self-government, and job creation will provide the opportunity for wages to expand.

Policy agendas will no longer be set externally, as self-government becomes more of a reality. Traditional values, social and political development will be fostered under self-government, which will lead to capacity building, empowerment and long term partnerships/ linkages. Improved health will be a result as self-esteem and control over conditions in local communities increases. If poverty and overcrowding can be reduced, and infrastructure improved, the incidence of infectious diseases will also be reduced.

Change will be like the components of the Medicine Wheel. If increased role modeling, diminished alcoholism, violence and various dependencies are addressed the causes of ill health will be alleviated. This is a long-term vision that First Nations have had for decades. Even more important is our responsibility to look forward and make wise decisions with our seven generations in mind. What better place to start than with our children.

Next Steps

On December 6, 2000 in a post election speech Prime Minister Jean Chretien told more than 2,000 party faithful that “too many Aboriginal Canadians live in third world conditions. And as a Liberal that he deeply believes the government has responsibility to promote social justice.” As Prime Minister he stated, he is “committed to carry out that responsibility.” Given this commitment we are duty bound to do the following:

- A detailed literature review is required as a follow up to this discussion paper – the data contained herein is only a sampling of what material exists, and what does not exist, on the critical issue of First Nation children and disabilities.
- First Nations leadership must make a clear position statement to government based on the problems identified in this discussion paper and any subsequent literature review on the crisis First Nations children with disabilities are now facing
- A national strategy on First Nations Children and Disability must be developed immediately
- An information campaign is necessary to bring attention to this dire situation. Community education is also required as a preventative measure for the prevention of future disability through improve pre-natal and post-natal care.
- The cost to government for inaction must be correlated to the savings for immediate and long-term intervention re: the cost for maintenance of a disabled person over their lifetime.

Article 42 of the CONVENTION on the RIGHTS of the CHILD

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right to access to such health care services
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
 - a) To diminish infant and child mortality
 - b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care.
 - c) To combat disease and malnutrition, including the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution.
 - d) To ensure appropriate pre-natal and post-natal care for mothers
 - e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and have support in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents.
 - f) To develop preventative health care, guidance for parents and family planning education and services.
3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

POPULATION PROJECTIONS 1991-2015

For First Nation Populations - A Demographic Profile

Canada's registered Indian population is projected to grow by approximately 379,000 persons within the next 25 years, from 511,000 in 1990 to 890,000, plus or minus 44,000 to 66,000 by 2015, depending on the growth scenario considered.

In 1990, the registered Indian population comprised 1.9% of Canada's total population; by 2015 this population would increase to 2.7%

The youth population (aged 0-17) would increase from 204,000 in 1990 to 277,000 in 2015.

The working age population (18-64) would double from 286,000 in 1990 to 666,000 in 2015.

Of the projected 890,000 Indians in 2015, some 484,000 will live on-reserve (54%) and about 406,000 off-reserve (46%), assuming the continuation of the recent slow decline in the on-reserve population (Statistics Canada 1993:1).

Canada's registered Indian population grew substantially during the last decade. The growth rate was almost five times that of the Canadian population. (Statistics Canada 1993:1).

The age distribution illustrates the case of a young demographic structure with a large proportion of children and a small proportion of elderly persons. Young people (age 0-17) make up about 40% of the Indian population while the labor force age group (age 18-64) accounted for 56% and the elderly (age 65+), only 4%.

Population growth projections are essential in the planning and policy development of government and First Nations for the next foreseeable future given the above described trends.

First Nations Child Disability At a Glance Can we Really Afford to do Nothing?

According to the Aboriginal Peoples Survey (APS) 31 percent of Aboriginal people have some form of disability. This is twice the national average of the general Canadian population. For young adults the rate is almost three times as high.

Disabilities affecting mobility and agility are most common, but hearing and visual disabilities affecting a large portion of the Aboriginal population are also prevalent.

The population of First Nation people nationally is 626,606 and out of that there are 190,748 with a disability. *Source: Indian Register Population by Region INAC December 31, 1997*

In 1997 15% of children under six, 11% of children aged 6-11, and 9% of children aged 12 years and older had asthma.

Bronchitis affects almost one in ten children under 6. Respiratory illness is the single greatest cause of hospitalization for young First Nation's children.

HIV/AIDS is a serious health issue among Aboriginal peoples, with Aboriginal people being one of the fastest growing segments of the HIV-positive population (CIHC).

According to Health Canada, injury is a major cause of death among First Nations young people aged 15-24 at a rate of 86% with 14% being *other* causes.

Death rates for First Nation infants from injuries are four times the rate of non-First Nation infants and death rates from other causes such as birth

defect, low birth weight, respiratory illness are significantly higher for Aboriginal infants and children when compared to the non-Aboriginal population (CICH).

Canada's Census figures indicate that the income of 9 out of every 10 Aboriginal persons living on a reserve with a disability is below the poverty line.

Only 2 out of every 10 Aboriginal persons with a disability living on a reserve have some kind of employment and 5 of every 10 Aboriginal persons with a disability living on a reserve have less than grade 8 formal schooling.

One in every 2 or 3 children in First Nation communities currently stands to develop permanent hearing loss.

Life expectancy at birth is seven to eight years less for registered *Indians* than for Canadians generally.

For infants, the death rate is about twice as high as the national average.

Aboriginal children are the fastest growing segment of the Aboriginal population. In 1996, 35% of Aboriginal people were younger than 15 years of age compared to about 21% for Canada.

The fertility rate among the Aboriginal population is about 69% higher than the rate for the general Canadian population and population growth is twice the national rate (1996 Census)

Injuries remain the leading cause of death for children and youth after their first birthday and a major cause of hospitalization and disability.

Aboriginal children are six times more likely to die by injury, poisoning or violence (ACPH, 1999)

Children with disabilities or identified special needs are unlikely to survive or receive the services they need.

Diabetes ranks as the most prevalent chronic disease condition found in First Nation populations.

The tuberculosis rate among the registered First Nation population is nine times the national average.

Suicide rates among First Nation youth, age 1-19, is six times the national rate.

Fetal Alcohol Syndrome is thirty times that of the general population.

Infant mortality rate (IMR) is an important measure of population health. In the case of Aboriginal populations, the ratio of Aboriginal to non-Aboriginal Infant deaths is twice as high for First Nation people and three times as high for the Inuit as for other Canadians.

Abnormal birth weight - low birth weight - is a known risk factor for ill health in childhood and later life.

Alcohol consumption during pregnancy is another leading cause of ill health in infancy.

Fetal alcohol syndrome and fetal alcohol effect (FAS and FAE) are results of alcohol abuse. Prenatal alcohol exposure may cause subtle deficits in judgement and reasoning in people with apparently normal intelligence.

The estimated cost of meeting the needs of someone who is severely affected by FAS over a lifetime is \$1 to \$1.5 million. (RCAP).

The ninth annual report on child poverty in Canada says 1.3 million Canadian children live below the poverty line - 400,000 more than a decade ago.

Families living below the poverty line spend more than 55% of their income on food, shelter and clothing, according to Campaign 2000's definition.

The cost of bringing every Canadian child out of poverty would be \$12 billion. The investment according to activists would pay benefits in the long term by reducing social problems such as crime.

In Ontario there was a 91% increase in child poverty over a nine-year period. This is compared to a national average increase of 27% during the same period.

According to the Campaign 2000 “Child Poverty in Canada”, inadequate income and child development are key determinants to a healthy population.

Adequate income and a healthy start in life have a long-term impact on the well being of children.

Low-income children are more than twice as likely to have low levels of vision, hearing, speech, mobility, dexterity, cognition and emotion. They are also less likely to have an annual visit to the dentist and more likely to be exposed to environmental contaminants.

One hundred and fifty Aboriginal youth were interviewed by *Save the Children Canada* and they concluded that 90% of child and teen prostitutes in Canada are Aboriginal. The report states that widespread racism; crushing poverty and declining culture are the primary reasons why Native youth end up on the streets.

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