



Cancer Care Ontario

Aboriginal Cancer Strategy III

2015–2019

together we will



Ontario
Cancer Care Ontario

The Aboriginal Cancer Strategy III is the result of the three peoples (First Nation, Inuit and Métis and other Aboriginal partners) coming together with Cancer Care Ontario. Together, we will work to address cancer issues, creating unique and diverse solutions for healing and health.

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Unified in our commitment

As we work to improve the performance of our cancer system, Cancer Care Ontario and First Nations, Inuit and Métis communities across our province are firmly unified. Together, we are working to understand how and why cancer is disproportionately affecting Aboriginal Ontarians, and we are committed to addressing the unique needs of the First Nations, Inuit and Métis through the six priorities in this strategy.

Our third Aboriginal Cancer Strategy (ACS) closely aligns with the Ontario Cancer Plan IV, a road map for how Cancer Care Ontario, the Regional Cancer Programs (RCPs), our many partners and the Ministry of Health and Long-Term Care will work together to continue to improve the performance of the cancer system in this province. It also builds on our mutual trust and respect, recognizes traditions and practices, and honours the history, culture and diversity of Aboriginal peoples.

This strategy is designed to help address cancer control issues affecting Aboriginal Ontarians, including barriers to accessing cancer services and improving health equity. It will enable our efforts in relationship-building, research and

“We have learned a great deal about the unique needs of Aboriginal communities directly from community members and these accomplishments demonstrate the progress we are making, but there is much more to be done.”

surveillance, prevention, screening, diagnosis, treatment, survivorship and palliative care, all in a manner that focuses on the unique burdens Aboriginal peoples face.

We have made great strides since the ACS II was launched three years ago, and we look forward to building on those significant achievements.

Since 2012, Cancer Care Ontario has signed six Relationship Protocols with First Nations, Inuit and Métis groups across Ontario. I believe that the strength of these partnerships has ensured a sustained ongoing two-way dialogue, which has been instrumental to the implementation of Regional Aboriginal Cancer Plans that are resulting in improved access and person-centred care.

With 10 of our RCPs, we have hired Regional Aboriginal Cancer Leads, as well as Aboriginal Navigators, who facilitate and coordinate access to cancer services for First Nations, Inuit and Métis people with cancer and their families.

In addition, we are developing new knowledge and information to support greater awareness of cancer through the

development of community cancer profiles. This includes reports on cancer risk factors for First Nations and Métis communities, which will support the development of culturally appropriate programs.

We have learned a great deal about the unique needs of Aboriginal communities directly from community members and these accomplishments demonstrate the progress we are making, but there is much more to be done.

As we move forward in the next phase of the ACS, we remain steadfast in our partnerships and commitment to improving the cancer system to better address the needs of First Nations, Inuit and Métis communities in Ontario, and I am confident that the work outlined in this strategy will help us achieve our goals.



Michael Sherar
President & CEO of CCO

Former Grand Chief Harvey Yesno with President and CEO Michael Sherar at the Nishnawbe Aski Nation and Cancer Care Ontario Relationship Protocol Signing Event, Fort William First Nation, August 2014

Together we will ... continue on this path

Cancer Care Ontario and First Nations, Inuit and Métis peoples across Ontario are on a journey together, a journey to improve the performance of the cancer system with and for Aboriginal peoples in Ontario in a way that honours the Aboriginal Path of Well-being. With this Aboriginal Cancer Strategy (ACS) III, we take our next step towards reaching our goal.

As with any journey, it is important to take a look back, not only to measure how far we have come, but also to ensure that we are on the right course. As we close out our second ACS (2012 to 2015), we can see that significant strides have been made in identifying and working to address the cancer burden within communities across the province. One of the most significant of these has been Cancer Care Ontario's approach and commitment to working with the First Nations, Inuit, Métis and other Aboriginal organizations and to formalize this engagement through Relationship Protocols. To date, five have been signed with Aboriginal organizations and one with an Independent First Nation. These protocols set a new course for the way Cancer Care Ontario will engage and collaborate with the First Nations, Inuit,

Métis and other Aboriginal groups to address increasing cancer incidence and mortality rates among Ontario's Aboriginal populations. Also notable is the development of Aboriginal Cancer Plans in collaboration with 10 Regional Cancer Programs (RCPs) that involve direct engagement between the RCPs and First Nations, Inuit and Métis communities in these regions, a process that is supported and strengthened by the Relationship Protocols.

While much has been accomplished under ACS II, there is still more to be done as we continue to address gaps in Aboriginal cancer care. Cancer Care Ontario worked directly and individually with First Nations, Inuit and Métis leadership, healthcare providers, cancer survivors, Aboriginal health networks and the Joint Ontario Aboriginal Cancer Committee (JOACC) in identifying and validating areas in which to prioritize initiatives through 2019. The consensus is that we need to stay focused on the six strategic priorities outlined in ACS II: building productive relationships, research and surveillance, prevention, screening, palliative and end-of-life care, and education. Beyond "staying the

course," we need to "work on the work"—that is, take advantage of opportunities to improve on what is being done and how it is being done. This will include improving the way Aboriginal cancer care is embedded across Cancer Care Ontario's head office and at all levels of the healthcare system.

I want to thank everyone—Elders, cancer patients and their families, First Nations, Inuit and Métis leadership, healthcare providers and our JOACC representatives—for sharing their insights, expertise and hard work as we developed ACS III. I particularly want to recognize Cancer Care Ontario and the RCPs for their support because all partners worked together to improve cancer services for Aboriginal communities. None of us have been down this path before, and it is wonderful to see how far we have come—and will be able to go—when we navigate the path to achieving health and well-being together.



Alethea Kewayosh

Director, Aboriginal Cancer Control Unit

Aboriginal Cancer Control
Unit Director Alethea
Kewayosh with Partnership
Liaison Officers Richard
Steiner and Caitlin Mills,
Toronto, July 2015



journey

Cancer in Aboriginal communities

A unique burden

Cancer is not an equal opportunity disease. Some populations are at greater risk for developing cancer and suffer poorer outcomes than others. First Nations, Inuit and Métis peoples are among those populations who bear a disproportionately high cancer burden.

People with any Aboriginal origins have been found to have higher age standardized mortality rates than people with no Aboriginal ancestry (Marrett and Chaudhry 2003; Wilkins 2008). Mortality rates have been found to be highest among Registered Indians (those who are registered as Indians under the Indian Act) (Wilkins 2008). Cancer incidence rates for major cancers are increasing more rapidly among First Nations people, and cancer survival is worse in this population compared with other Ontarians.

The rising burden of cancer among Aboriginal peoples has been attributed at least in part to the higher prevalence of several modifiable risk factors, such as smoking, poor diet and obesity.

Focusing risk reduction efforts on individual behaviour is unlikely to have a significant and lasting impact on reducing cancer risk and incidence

community

On the banks of the river in
Fort Severn First Nation,
September 2013

Our vision

To improve the performance of the cancer system with and for First Nations, Inuit and Métis peoples in Ontario in a way that honours the Aboriginal Path of Well-being.

without also putting in place complementary system-level initiatives that target the broader determinants of health through improved public health policy and community programming. Without both, our efforts to reduce the prevalence of modifiable risk factors in First Nations, Inuit and Métis populations will be of limited effectiveness.

These patterns underscore the need for a cancer strategy to address the unique needs of First Nations, Inuit and Métis people.

Ontario's Aboriginal Cancer Strategy envisions a day when First Nations, Inuit and Métis people no longer die prematurely from preventable and treatable cancers. When they no longer suffer due to avoidable under-treatment of cancer. When Aboriginal people with cancer and their families are approached with respect and appreciation for the communities they come from.

Only then will Aboriginal people be able to respond to cancer in their family and community with confidence in their healthcare system, and service providers will be fully equipped to help First Nations, Inuit and Métis people prevent or manage cancer.

As we travel together on the path towards this day, Aboriginal and non-Aboriginal partners must turn productive dialogue into consistent and concerted actions that address Aboriginal cancer care gaps in primary care, specialized care and care coordination.

About us

Cancer Care Ontario is the provincial government's cancer advisor. Working with our many partners, we implement provincial cancer prevention and screening programs; develop and implement quality improvements, standards and accountability for cancer care; and use electronic information and technology to increase accessibility to and advance the safety, quality and efficiency of Ontario's cancer services. Cancer Care Ontario also develops multi-year system plans—including the Ontario Cancer Plan (OCP) IV and the Aboriginal Cancer Strategy (ACS) III—to ensure that the needs of current and future people with cancer will be met.

OCP IV is the road map for the way Cancer Care Ontario, healthcare professionals and organizations, cancer experts and the provincial government will work together to develop and deliver cancer services from 2015 to 2019. The goals of OCP IV focus on quality of life and patient experience, safety, equity, integrated care, sustainability and effectiveness. An important strategic objective of OCP IV is the development and implementation of the third ACS.

The **Aboriginal Cancer Control Unit** (ACCU) addresses the issue that cancer rates among First Nations, Inuit and Métis are increasing disproportionately compared with overall Canadian cancer rates. First Nations, Inuit and Métis have higher mortality rates from preventable cancers,

show higher rates of some modifiable risk factors and tend to present with later-stage cancers at the time of diagnosis. The ACCU works directly with provincial First Nations, Inuit and Métis groups in developing the ACS III and ensuring that programs and strategies are relevant and effective at the community level.

The **Joint Cancer Care Ontario-Aboriginal Cancer Committee** (JOACC) guides and advises Cancer Care Ontario on outreach strategies directed at First Nations, Inuit and Métis peoples to reduce the incidence of cancer among Ontario's Aboriginal populations. JOACC includes representatives from Aboriginal organizations and other partners.

Our continuing journey

The Aboriginal Cancer Strategy (ACS) is a guide for the way Cancer Care Ontario, Aboriginal groups, the Regional Cancer Programs (RCPs), and cancer system partners work together to improve the performance of the cancer system with and for First Nations, Inuit and Métis peoples in Ontario in a way that honours the Aboriginal Path of Well-being. ACS III builds on the progress made since the launch of the ACS II (2012 to 2015), and our efforts will focus on the same six strategic priorities.

Much has been accomplished since the launch of ACS II in June 2012. A large body of work has been initiated, funded and staffed with the aim of realizing the objectives in that strategy, with projects currently at various stages of development and implementation.

Key accomplishments achieved under ACS II include Cancer Care Ontario formalizing partnerships over the past two years through the signing of

Relationship Protocols with Grand Council Treaty #3 (May 2013), the Anishinabek Nation (June 2013), Ontario Federation of Indigenous Friendship Centres (July 2014), Nishnawbe Aski Nation (August 2014), Kitchenuhmaykoosib Inninuwug (Big Trout Lake First Nation, October 2014), and a Memorandum of Understanding with the Métis Nation of Ontario (February 2015). Through the signing of these Relationship Protocols and Memorandum of Understanding, Cancer Care Ontario has effectively entered into relationships to engage and work with

member communities and respective organizations and committees, to improve the cancer system for all community members. Following the signing of these Relationship Protocols and Memorandum of Understanding, the Aboriginal Cancer Control Unit (ACCU) started to build RCP capacity through the development of Regional Aboriginal Cancer Plans across 10 priority regions. The ACCU has also successfully recruited nine Aboriginal Navigators and appointed 10 Regional Aboriginal Cancer Leads. The Aboriginal Navigators facilitated and coordinated

access to cancer services for First Nations, Inuit and Métis people with cancer and their families, addressing cultural and spiritual needs and arranging translation services. Over the past two years, the Regional Aboriginal Cancer Leads provided significant contributions to the regions and Cancer Care Ontario by engaging and collaborating across various primary care settings, and advocating for and addressing the primary care needs of First Nations, Inuit and Métis people in their regions. More specifically, the leads supported discussions regarding indigenous knowledge and the integration of traditional medicine in cancer care, developed innovative pilot projects to increase access to screening in remote communities (e.g., Wequedong Lodge project in the Northwest), developed cancer screening educational materials (e.g., a cancer screening toolkit) and provided an integral equity perspective to the Provincial Primary Care and Cancer Network (PPCCN).

The execution of the ACS II has helped stakeholders in Ontario to jointly develop, fund and implement Aboriginal cancer care policies and programs that improve the performance of the cancer system for Aboriginal peoples in a way that honours the Aboriginal Path of Well-being. In 2013/2014, through deliberations by the ACCU, Cancer Care Ontario successfully amended Health Canada's Non-Insured Health Benefits (NIHB) medical travel policy to cover medical travel for women in First Nation communities to participate in the Ontario Breast Screening Program. Following this success, the ACCU collaborated with partners to develop recommendations to improve Health Canada's NIHB program for healthcare providers and First Nation and Inuit people with cancer. Moving forward,

ACS III STRATEGIC PRIORITIES

1. Building Productive Relationships

Work with Aboriginal groups to formalize relationships based on trust and mutual respect

2. Research and Surveillance

Compile and/or develop data to inform and monitor progress in cancer control

3. Prevention

Focus on smoking cessation efforts and begin to address other modifiable risk factors

4. Screening

Increase participation in cancer screening across the province

5. Palliative and End-of-life Care

Help address the palliative and supportive care needs of Aboriginal people with cancer

6. Education

Increase the knowledge and awareness of cancer through education and awareness initiatives

The Aboriginal Path of Well-being

The steps on this path are:

- Health in balance;
- Wellness, both emotional and spiritual;
- Active choice;
- Holistic approach;
- Understand root causes; and
- Joint and personal responsibility.

the ACCU will work with the Regional Executive Committee of Health Canada's First Nation Inuit Branch to collaboratively address cancer control issues in First Nation communities.

In 2014/2015, Cancer Care Ontario conducted a needs assessment to obtain and report on evidence and input by and with First Nations, Inuit and Métis



Tobacco-Wise Lead Jeff Werner, Regional Aboriginal Cancer Lead Dr. Shannon Wesley and Aboriginal Navigator Jeannie Simon discussing the hazards of commercial tobacco on Wawatay Radio, Thunder Bay, January 2014

and cancer system partners on the impact of current Aboriginal cancer care efforts to guide the ACS III priorities. The needs assessment also aimed to reflect the decision-making needs of community health professionals, RCPs and First Nations, Inuit and Métis groups regarding Aboriginal cancer care priorities. The results told us that we are effectively improving the performance of the cancer system with and for First Nations, Inuit and Métis peoples in Ontario in a way that honours the Aboriginal Path of Well-being.

The key opportunity for continued progress is to stay focused on these efforts, while addressing limitations or imperfections in how they are done. The implications as we look to the future are threefold:

1. It is important to stay the course on our six strategic priorities.

In order to close the gap between current Aboriginal cancer outcomes and our vision, we must continue to improve programs to help First Nations, Inuit and Métis peoples address smoking and other risk factors, increase screening participation and access culturally sensitive, timely treatment and palliative care. We must also promote joint problem-solving, develop more Aboriginal-specific data and target education to support broader uptake of new behaviours that are within an individual's control.

2. There is an opportunity to do more work on the work, i.e., improve how Cancer Care Ontario builds on and implements Aboriginal cancer care projects.

Cancer Care Ontario and all our partners need to examine how and why the system works—or doesn't work. Aboriginal people with cancer and healthcare providers live and work in very

diverse communities, so community-driven programs and services must be flexible enough to accommodate this diversity. Continuous improvement of community-driven approaches will underpin the work of ACS III.

3. We need to find better ways to embed Aboriginal cancer care at all levels of healthcare, including Cancer Care Ontario, RCPs and other health service programs and providers.

ACS III will enable us to embed Aboriginal cancer care in health equity discussions and structures (i.e., provincial-, regional- and hospital-level planning), a process that will begin within Cancer Care Ontario and the RCPs. We will also invest in enlisting more people who have the requisite attitude, skill and experience to lead the work of setting new milestones towards building a community for Aboriginal cancer control.

At the same time, we need to simplify the way individuals, families and communities interact with and move through the healthcare system. This will require renewed support for the role of primary and community care. Regional Aboriginal Cancer Leads and the Aboriginal Tobacco Program are helpful in facilitating frontline knowledge exchange, solution-seeking and experimentation with new approaches. Although Cancer Care Ontario is not funded to fill the Aboriginal primary and public healthcare delivery gap, as a system integrator it can help start to address access to timely care and work with First Nations, Inuit and Métis groups, as well as federal and provincial policy-makers and funders, towards more sustainable solutions.

Building Productive Relationships

The Path:
Health in balance



Paula Doering (black) and Champlain Regional Cancer Program staff with First Nations, Inuit and Métis partners at the opening of the Windôcàge Community Room at the Ottawa Hospital, Ottawa, December 2014

"I didn't have a good understanding of all the barriers to access to care for the First Nations, Inuit and Métis population. Everyone talks about the social determinants of health, but it was really driven home for us when we started to work closely with our Aboriginal partners. I think that our work together and experiences have truly impacted our relationship with our Aboriginal partners so we can move forward in an insightful way."

Paula Doering

Regional Vice-President,
Champlain Regional Cancer Program

Work with First Nations, Inuit and Métis groups to formalize relationships based on trust and mutual respect

Supporting OCP IV goal to ensure health equity for all Ontarians across the cancer system

Achievements from Aboriginal Cancer Strategy (ACS) II

Cancer Care Ontario signed six relationship protocols with First Nations, Inuit and Métis groups.

Ten Regional Aboriginal Cancer Plans were drafted to start building regional capacity in addressing First Nations, Inuit and Métis cancer control in the regions.

Working relationships were established with Health Canada's Ontario Region First Nation Inuit Health Branch to identify opportunities to address cancer control issues.

Ten Regional Aboriginal Cancer Leads were hired to support the Regional Cancer Programs (RCPs) and Cancer Care Ontario to further the mandate of ACS III in primary care.

The Challenge

Bringing patients, healthcare providers and policy-makers together in their own jurisdictions to work on shared agendas will, over time, help build local and regional capacity to tailor cancer care service delivery to individual communities. Building these relationships will also provide direction to provincial system leaders, such as Cancer Care Ontario, on how to improve provincial policy and resource allocation.

Ontario Renal Network

The Ontario Renal Network, a division of CCO, is the provincial government's advisor on chronic kidney disease (CKD), providing leadership and strategic direction to effectively organize and manage the delivery of kidney care services in Ontario in a consistent and coordinated manner. The Ontario Renal Plan (ORP) II provides a comprehensive road map for how the Ontario Renal Network, healthcare professionals, organizations and the provincial government will all work together to improve the lives of people with CKD. One of the goals of ORP II is to improve patients' access to kidney care, which will involve making culturally and geographically appropriate kidney care available to First Nations, Inuit and Métis people. To accomplish this, Cancer Care Ontario's Aboriginal Cancer Control Unit (ACCU) and the Ontario Renal Network are working closely with several First Nation communities to develop models of care and initiatives to support Aboriginal people across Ontario. As part of this collaboration, the Ontario Renal Network respects and works within the established relationships, protocols and approaches developed by the ACCU.

Objectives—by 2019

Create accountability for ACS III between Cancer Care Ontario and the governance bodies of First Nations, Inuit and Métis groups.

Support capacity building of RCPs to lead, successfully engage local First Nations, Inuit and Métis groups and implement cancer control initiatives as guided through Regional Aboriginal Cancer Plans.

Help First Nations, Inuit and Métis people with cancer navigate cancer services in and outside of the hospital in a way that honours the Aboriginal Path of Well-being and ensure that patients have access to high-quality, culturally appropriate care throughout their cancer journey.

Work with First Nations and Inuit leaders and Health Committees to help address programming and service gaps and extend the Non-Insured Health Benefits (NIHB) policy to include cancer control needs.

Build Cancer Care Ontario's capacity for planning appropriate services and guidelines that take into consideration the unique needs of the Aboriginal population.

Strengthen energy for and sustain outcomes of relationship-building by defining and measuring respect and trust.

Tony Jocko

Health Policy Analyst,
Union of Ontario Indians; JOACC Member

“The approach taken by the Aboriginal Cancer Control Unit was both innovative and unprecedented. Starting from the grassroots up was something we had never seen in any mainstream engagement process when developing policies or priorities. Such an approach led to the formulation of collaboration agreements and significant buy-in from our First Nations. The First Nations were made to feel as though they were/are true partners in the process. This has led to solid working relationships between the Aboriginal Cancer Control Unit and First Nations in Ontario.”

Action

- **Establish accountability** for the delivery of ACS III with First Nations, Inuit and Métis partners through protocols and regular reporting.
- **Continue to implement, plan and measure** productive relationships with First Nations, Inuit and Métis and non-Aboriginal partners.
- **Strengthen RCP and Aboriginal community relations** by building on and establishing the engagement processes and structure among Cancer Care Ontario and RCPs with First Nations, Inuit and Métis communities.
- **To support and inform** Regional Aboriginal Cancer Plans through the experiences and insights gained by the Regional Aboriginal Cancer Leads and Aboriginal Navigators to address patient and community needs and opportunities.
- **Identify and collaborate** with key service providers (i.e., Community Care Access Centres [CCACs], Aboriginal Health Access Centres [AHACs] and Local Health Integration Networks [LHINs]) on programming and services for First Nations, Inuit and Métis.
- **Collaborate with** Health Canada's First Nation and Inuit Health Branch (i.e., NIHB) to help address cancer issues and gaps.
- **Further develop** Aboriginal expertise within the regional cancer system and the Provincial Primary Care and Cancer Network (PPCCN) through Regional Aboriginal Cancer Leads.
- **Explore options to include** measures on building productive relationships in the Cancer System Quality Index.
- **Work with partners to promote respect** for, and understanding of, indigenous knowledge and traditional medicine.

Research & Surveillance

The Path:
Understand
root causes



"Good surveillance data and high quality research are essential—without them we don't know where the greatest needs are, we can't make a strong case for new resources, programs and policies and we won't know the impact of our efforts to improve the cancer system for all First Nations, Inuit and Métis people in Ontario."

Dr. Loraine Marrett

Senior Scientist,
Aboriginal Cancer Control Unit

Tom McHugh

Regional Vice-President,
Central East Regional Cancer Program

“What I look forward to is moving from the ‘getting to know you’ phase, to be able to agree on some achievable steps that really make a difference to the health of First Nations, Inuit, and Métis. We will hear clearly articulated needs and we will be able to work with communities to address these needs in ways that work for them. The investment in resources is usually fairly modest, but it is working out what works for communities that takes time.

I also look forward to figuring out how we hear what the needs are for First Nation patients who may be living in Scarborough or Oshawa, away from their communities. Being attuned to those needs will be a big next step. There is a lot of diversity between urban centres. How do we make our services real to them? We need to work to think about what that urban reality is.

We want to provide meaningful services to those we do know, and for those we don’t yet know, figuring out how we use the skills we have to get to know them.”

Compile and/or develop data to inform and monitor progress in cancer control

Supporting OCP IV goal to ensure health equity for all Ontarians across the cancer system

Achievements from ACS II

The update of the Indian Registry System-Ontario Cancer Registry linkage was initiated to develop an understanding of the burden of cancer on status First Nations.

A methodology was developed in collaboration with First Nations to create community cancer profiles.

A First Nations, Inuit and Métis report was completed to inform Cancer Care Ontario of identifiers for data linkage opportunities.

Developed a project partnership agreement and preliminary content for the Métis Nation of Ontario (MNO)-Cancer Care Ontario risk factor and screening report.

The Challenge

Evidence suggests that cancer rates among First Nations, Inuit and Métis people are rising to meet or exceed those of the general population. For example, among Ontario First Nations, this pattern was seen for two of the most common types of cancer (lung and colorectal) using data that are now more than 15 years out of date. Furthermore, the prognosis for First Nations people with cancer was found to be generally worse than for other Ontarians.



Looking out onto the lake in Pikangikum First Nation, May 2013

Objectives—by 2019

Identify, access, and analyze comprehensive and high-quality surveillance data specific to First Nations, Inuit and Métis groups. Data will be up-to-date, accurate and numerous; cover a range of important cancer risk factors, screening behaviours and measures of cancer burden for important types of cancer; and useable in providing information at the provincial, regional and, wherever possible, community levels.

Develop research to address relevant questions regarding risk factors, screening and/or cancer burden profiles among First Nations, Inuit and Métis peoples (e.g., why prognosis is worse in First Nations women with breast cancer).

Through effective dissemination and education, support First Nations, Inuit and Métis communities in understanding and acting on implications of surveillance and research data in terms of policy and program development.

Build system capacity around an Aboriginal cancer research agenda, starting with enhanced research capacity at Cancer Care Ontario.

Action

- **Expand risk factor surveillance work** to accommodate the priorities of First Nations, Inuit and Métis populations (e.g., explore options regarding risk factors in Inuit Ontarians, identify and assess new sources of data, conduct more granular analyses and implement new forms of dissemination).
- **Complete projects** to update measures of First Nations cancer burden (e.g., incidence, survival) and identify and explore options for expanding to other Aboriginal groups.
- **Work with experts and communities** to support knowledge translation and exchange activities relating to cancer statistics and research findings (i.e., used in community reports, inform existing staff and community-led initiatives).
- **In collaboration with communities**, expand creation, enhance validity, and increase effectiveness, efficiency and utility of community cancer profiles.
- **Increase First Nations, Inuit and Métis identifiers** in Cancer Care Ontario data holdings to support ongoing surveillance of cancer burden and to improve uptake of cancer screening in Aboriginal groups, engaging relevant partners such as Chiefs of Ontario and Political Territorial Organizations (PTOs), Independent First Nations (IFNs), MNO and Inuit service providers
- **Enhance options** to develop mentorship opportunities with First Nations, Inuit and Métis partners.
- **Establish research priorities** in collaboration with First Nations, Inuit and Métis groups.
- **Explore opportunities and requirements** for bringing together First Nations, Inuit and Métis research users, decision-makers and organizations interested in Aboriginal research to form an “Aboriginal research table” or partnerships (e.g., relationships with academic institutions, such as the Waakebiness-Bryce Institute for Indigenous Health at the Dalla Lana School of Public Health) that increase capacity for policy-relevant research.

Prevention

The Path:
Wellness—
emotional and
spiritual



"The most important thing for people to remember about Inuit and working with Inuit is that there is truly, to this day, an indomitable spirit among our people, an inner strength and an inner beauty that invariably I've found everybody is drawn to once they experience it."

Jason LeBlanc

Executive Director,
Tungasuvvingat Inuit

Focus on smoking cessation efforts and begin to address other modifiable risk factors

Supporting OCP IV goal to ensure health equity for all Ontarians across the cancer system



Tobacco-Wise Lead Lisa Beedie providing commercial tobacco cessation, protection and prevention information to youth in Georgina Island First Nation, May 2014

Achievements from ACS II

The Aboriginal Tobacco Program (ATP) provided commercial tobacco prevention, cessation and protection support to 200 communities/organizations, including nine ultimate Frisbee workshops.

The Aboriginal Tobacco Partnership Table (ATPT) was established with 18 partners to collaborate on commercial tobacco cessation, protection and prevention initiatives.

A program tracker application to collect ATP program metrics was developed and implemented.

Focus groups to inform the development of a First Nations, Inuit and Métis Chronic Disease Prevention Blueprint were completed.

The Challenge

Of all six ACS initiatives, those related to smoking prevention, cessation and protection have the potential to make the most dramatic impact on the health of Aboriginal people and their communities. Mainstream interventions do not appear to have reduced commercial tobacco use in Aboriginal communities and in view of 50 years of tobacco control experience with the general population, it is unrealistic to expect a major reduction in Aboriginal smoking rates without a robust, sustained and community-driven investment of talent and funding.



Tobacco-Wise Lead Jeff Werner (far left) at Ultimate Frisbee and Commercial Smoking Cessation Workshop Event with students from Pelican Falls First Nation High School, February 2015

Objectives—by 2019

Develop an explicit, trackable, relevant model for increasing community tobacco-wise awareness and changing behaviour.

Demonstrate effective partnerships and collaborations with groups and organizations that are part of the ATPT, and define clear, complementary roles.

Further establish metrics on data quality, methods, analysis, dissemination and uptake.

Develop better information on the quantity and quality of frontline health promotion behaviours.

Complete an assessment of existing tobacco policies (both formal and informal) in communities; assess where community and health leaders see future opportunities and determine additional informational needs required.

Develop evidence to inform success for First Nations, Inuit and Métis communities in addressing commercial tobacco cessation that is both sensitive and generalizable across the diverse social, political, cultural and environmental contexts of Aboriginal communities.

Establish evidence that reflects the unique issues Aboriginal people face and develop recommendations to address modifiable risk factors associated with preventing and managing chronic diseases faced by First Nations, Inuit and Métis communities.

Action

- **Continue to build awareness and education** in commercial tobacco prevention, cessation and protection with First Nations, Inuit and Métis through the ATP (i.e., expand the reach of ultimate Frisbee and commercial tobacco prevention, cessation and protection workshops in collaboration with schools through the ATP).
- **Continue to develop and strengthen** collaborations and partnerships through the ATPT.
- **Enhance the tracking system** used to monitor First Nations, Inuit and Métis programming needs and the impact of ATP workshops.
- **Disseminate and support** First Nations, Inuit and Métis providers with cessation support through ATP-TEACH e-module.
- **Continue to assist** in the development of by-laws or policies in collaboration with First Nations communities through the ATP.
- **Support Research** on Tobacco Reduction in Aboriginal Communities (RETRAC) to improve understanding of why and how interventions work with First Nations, Inuit and Métis groups.
- **Develop a plan** to implement recommendations from the First Nations, Inuit and Métis Chronic Disease Prevention Blueprint, addressing modifiable risk factors (e.g. smoking cessation, physical activity, healthy eating, and alcohol consumption) in partnership and collaboration with Cancer Care Ontario and external partners.

Screening

The Path:
Active choice



Grand Council Chief Patrick Madahbee signs the Relationship Protocol between the Anishinabek Nation and Cancer Care Ontario with President and CEO, Michael Sherar, Muncey First Nation, June 2013

"The important thing is prevention and getting screened to find cancer early, as opposed to trying to react when it is too late. That is probably the biggest problem we have. That's where we see a lot of deaths when they have waited too long."

Patrick Madahbee

Grand Council Chief,
Union of Ontario Indians

Increasing participation in cancer screening across the province

Supporting OCP IV goals to ensure a sustainable cancer system for future generations and to ensure health equity for all Ontarians across the cancer system

Dr. Annelind Wakegijig

Regional Aboriginal Cancer Lead,
Northeast Regional Cancer Program

"I'd like to see cancer screening brought closer to people in the communities, where we know people feel safest. Anything we can do to make it less scary for people – the more we can do to make sure people don't have to travel for cancer screening services will help increase screening rates in the region. It would also be great to have more user friendly material available, not just for patients but for providers too. With healthcare providers, they need to become more educated about FNIM people, understand the needs, and increasing the availability of culturally appropriate materials can really help."

Achievements from ACS II

A community-based Screening Activity Report (SAR) was developed and implemented.

An integrated provincial First Nations cancer screening program (to help address the participation gap) was implemented.

A First Nations and Métis cancer screening research project was initiated to identify best practices to address barriers to screening.

The Challenge

While screening is a critical cancer control strategy and Ontario has organized breast, cervical and colorectal screening programs, participation rates for First Nations, Inuit and Métis peoples are lower than the general population. Due to a paucity of research on Aboriginal screening interventions, it is unclear how to improve screening rates.



Regional Primary Care Lead for the Central Region, Dr. Marla Ash, and staff from the Central Regional Cancer Program providing cancer screening information to community members in Georgina Island First Nation, May 2014

Objectives—by 2019

Expand the reach and understanding of SARs to support healthcare providers in communities in cancer screening invites and follow-up.

Explore data linkage opportunities to further develop community-based cancer screening reports and surveillance studies.

Develop evidence of barriers to First Nations, Inuit and Métis cancer screening in existing policies and processes, and identify levers for change that will improve cancer screening participation.

Support evidence-informed assessment of the options for, investments in and benefits of sending invitations to eligible First Nations, Inuit and Métis individuals for cancer screening and follow-up.

Support new and emerging opportunities for First Nations, Inuit and Métis communities to access timely cancer screening and increase screening participation rates.

Action

- **Further develop and expand SARs** for non-patient enrolment model providers in the Sioux Lookout region and evaluate how this report informs frontline/community screening practice.
- **Continue to develop and build on** partnerships with First Nations, Inuit and Métis groups to explore linkage opportunities to client registries for the development of community SARs.
- **Complete a screening study** to improve the understanding of how to improve the delivery of cancer screening to First Nations, Inuit and Métis peoples.
- **Establishing evidence** to inform screening correspondence and provincial policies for screening invitations and follow-up.
- **Continue to explore opportunities** to improve access to screening (e.g., digital mammography) and participate in a lung cancer screening pilot program with the Inuit.

Palliative and End-of-Life Care

The Path:
Holistic approach



Lindsey Crawford (right) with Aboriginal Navigator Leah Bergstrom and Wahta Mohawks' Nurse Practitioner Dana Strength at an Aboriginal Health Circle meeting, Barrie, January 2014

"Our Aboriginal Navigator has also been incredible. In order for our work to gain real traction in the region in the field of palliative care, I just don't think it would have been possible without having the necessary resources in place. Our Navigator also helped to educate the team, and provided cultural sensitivity training to 85 per cent of our staff; this has gone a long way to ensuring that the Cancer Centre is a much more welcoming place for our Aboriginal patients and families."

Lindsey Crawford

Regional Vice President,
Simcoe Muskoka Regional Cancer Program

Help address the palliative and end-of-life care needs of Aboriginal people with cancer

Supporting OCP IV goal to ensure the delivery of responsive and respectful care, optimizing individuals' quality of life across the cancer care continuum

Kathy Macleod-Beaver

Aboriginal Navigator,
Central East Regional Cancer Program

“When I walk into a room, I see a person change right before me. You walk in and you see patients sitting apprehensive. I think when people see another Native person; I think they see a reflection of themselves that is comforting. It is like a relief. You can see it in their body language. Sometimes it is like we already know each other.”

Achievements from ACS II

A network of 10 Aboriginal Navigators was established across the province to guide people with cancer through the cancer system.

Cancer Care Ontario participated in and supported a pilot to inform patient-reported outcomes and experience measures for First Nations, Inuit and Métis peoples (through the Improving Patient Experience and Health Outcomes Collaborative).

Pain and symptom management pathways (i.e., the Mobile Interactive Symptom Assessment and Collection [mISAAC] app) and symptom management pathways were developed and implemented.

Completed needs assessment and regional engagement with First Nations, Inuit and Métis partners to inform the Learning Essential Approaches for Palliative and End-of-Life Care (LEAP) course development with Pallium Canada.

The Challenge

There is a perception that palliative care is limited to the last days and weeks of life. A palliative approach to care is appropriate from the time of diagnosis until the end of life, aiming to prevent and ease suffering to improve quality of life throughout the illness. Palliative and End-of-Life care initiatives focus on holistic patient-centred care to manage symptoms and pain, reduce caregiver burden, and avoid unnecessary treatments and hospitalizations. There are also opportunities to improve emotional support, culturally sensitive communication and transitions between specialty cancer care and primary care.

Objectives—by 2019

Develop a process that captures and embeds the First Nations, Inuit and Métis perspective and experience in the cancer system and program development to improve access and remove barriers to high-quality care and positive patient experience outcomes.

Evaluate whether First Nations, Inuit and Métis people with cancer and their families receive, have access to, understand and apply relevant palliative care information.

Demonstrate increased use of Edmonton Symptom Assessment System (ESAS), to facilitate pain and symptom management for First Nation, Inuit and Métis patients.

Establish culturally appropriate tools and methods for collecting Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) for First Nation, Inuit and Métis peoples, and ensure that PROMs and PREMs inform conversations and treatment decisions between patients and clinicians.

Support user-led Learning Essential Approaches to Palliative and End-of-Life Care (LEAP) curriculum development.

Conduct collaborative assessments of palliative care programming and services to identify current state, future potential roles, and barriers and enablers.



Aboriginal Navigators with Aboriginal Cancer Control Unit staff and Traditional Knowledge Keeper Clayton Shirt, Toronto, March 2014

Action

- **Continue to support Aboriginal Navigators**, improve patient experience and inform the Patient and Family Advisory Council.
- **Disseminate and enhance** “Tools for the Journey”, educational materials for First Nations, Inuit and Métis people with cancer and their families regarding the cancer journey.
- **Complete implementation** of Mobile ISAAC pilot (tools to support pain and symptom management) and expand to Aboriginal Health Access Centres and major First Nations, Inuit and Métis health centres.
- **Build on existing** pain and symptom management tools to develop and implement recommendations to introduce Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) in a culturally appropriate and sensitive manner.
- **Work with Pallium Canada** to develop and implement the LEAP Curriculum for First Nations, Inuit and Métis groups.
- **Address the gaps** in service delivery through discussions with regional, provincial and federal programs and services to improve jurisdictional coordination.

Education

The Path:
Joint and personal
responsibility

"There is fear associated with health issues, this is related to the increased number of community members who are dying. This is a double-edged issue because in some cases people may then decide to ignore their health concerns because they are afraid they will learn of bad news as well. However, when we are able to provide education regarding the importance of early detection, people begin to understand why ignoring the issue isn't in their best interest."

Leah Bergstrom

Aboriginal Navigator,
Simcoe Muskoka Regional Cancer Program

Increase knowledge and awareness of cancer through education and awareness initiatives

Supporting OCP IV goal to ensure the delivery of responsive and respectful care, optimizing individuals' quality of life across the cancer care continuum

Dr. Andrea East

Regional Aboriginal Cancer Lead,
HNHB Regional Cancer Program

“There is an increased awareness at the regional oncology level among tertiary oncologists as well as primary care physicians of the unique issues facing First Nations, Inuit and Métis peoples accessing health services.”

Achievements from ACS II

First Nations, Inuit and Métis knowledge and understanding of cancer was enhanced through the development of culturally relevant resources, including smoking cessation materials, cancer screening fact sheets, and the “Tools for the Journey” palliative care toolkit.

A series of nine relationship-building e-modules aimed at addressing healthcare providers' understanding of First Nations, Inuit and Métis history, traditions, governance and cancer control challenges and needs was developed.

The Challenge

Good communication and education go two ways: teachers first have to understand students and how best to communicate with them before students can understand and reap the benefits of their teachers. There are many opportunities to improve the understanding of First Nations, Inuit and Métis people and what can be done to lessen the impact of cancer in these communities. Almost everyone who is involved in Aboriginal cancer care is both a teacher and a student: people with cancer, their families, healthcare providers, and staff at Cancer Care Ontario and in RCPs.



Lessons from our Children: Commercial tobacco cessation, protection and prevention poster competition with youth from Beausoleil First Nation, June 2015

Objectives—by 2019

Support cultural safety across the cancer system by ensuring that e-modules are made available to and completed by Aboriginal-serving healthcare providers. Also gather evidence on the impact of the e-modules on professional competency in delivering culturally safe cancer care.

Develop robust evidence regarding who and how many people access the ATP website, and why.

Develop evidence on the comprehensiveness of information, effective distribution and utility of “Cancer 101”, smoking cessation brochures, “Tools for the Journey” palliative care resources, and cancer screening fact sheets.

Establish a framework to identify, engage and measure key target audiences for ACS III (e.g., First Nations, Inuit and Métis communities and people with cancer, primary care providers, Cancer Care Ontario staff, RCPs).

Action

- **Implement relationship-building e-modules** through an online learning management system (LMS) for Cancer Care Ontario, RCPs, primary care providers, researchers and province-wide promotion.
- **Complete the enhanced ATP website** for First Nations, Inuit and Métis communities.
- **Continue to develop and disseminate** smoking cessation materials, palliative care resources and screening fact sheets.
- **Complete “Cancer 101”** education toolkit and dissemination.
- **Develop an education framework** for ACS III to support performance management of First Nations, Inuit and Métis education initiatives.
- **Implement a review process** to develop, disseminate and evaluate new educational initiatives.

Regional Cancer Programs (RCPs)

The delivery of cancer services in Ontario is organized into 14 RCPs, which are aligned with the province's Local Health Integration Networks (LHINs). The RCPs are Cancer Care Ontario's networks of local stakeholders, healthcare professionals and organizations involved in cancer prevention, screening and care. The RCPs, which are funded by Cancer Care Ontario, respond to local cancer issues, coordinate the provision of care, and work to improve access, wait times and quality. Each RCP is led by a Regional Vice-President of Cancer Services, who provides oversight to the region's cancer services and implementation of quality initiatives, and directs the operations of the regional cancer centres.

The Aboriginal Cancer Control Unit (ACCU) works closely with the RCPs to ensure that the unique needs of First Nations, Inuit and Métis populations in each of Ontario's regions are understood and addressed. In developing the Aboriginal Cancer Strategy (ACS) III, the ACCU will be working closely with the RCPs to build regional capacity to lead direct engagement with local First Nations, Inuit and Métis communities to inform and implement initiatives that will address the regional specific cancer control issues/needs.

The ACS III will use the same "three pillar" approach that was employed in implementing the second strategy:

1. Meet with RCPs: An initial meeting was held to discuss ACS II strategic priorities and targets, establish primary contacts and develop a working group within each RCP. The ACCU, in close partnership with the RCP working group, developed a draft Regional Aboriginal Cancer Plan to outline steps to make the cancer system more effective and accessible for First Nations, Inuit and Métis people in each region.

2. Establish Aboriginal health networks: The ACCU identified core Aboriginal (First Nations, Inuit, Métis, Friendship Centres, Aboriginal Health Access Centres and other Aboriginal groups) health tables (boards, committees and advisory groups) to provide guidance and feedback on the Regional Aboriginal Cancer Plans before finalization. This ensures that Aboriginal people in each region have a voice in the delivery of cancer services, and allows the RCPs to engage directly, respectfully and sustainably with First Nations, Inuit, Métis and other Aboriginal groups.

3. Build RCP capacity: To address First Nations, Inuit and Métis cancer control issues effectively, dedicated resources were established in the RCPs. Aboriginal Navigators provide support for First Nations, Inuit and Métis people with cancer and their families along every step of the cancer journey. Regional Aboriginal Cancer Leads champion the ACS II strategic vision by engaging and collaborating

across the matrix of primary care. The ACCU also employs two Partnership Liaison Officers to support the work of the RCPs, and ensure sustained engagement among the RCPs, the ACCU and core First Nations, Inuit and Métis health tables.

Regional Aboriginal Cancer Plans and sustaining engagement with core Aboriginal health tables

Regional Aboriginal Cancer Plans are the blueprints for making the cancer system work better for First Nations, Inuit, Métis and other Aboriginal groups in each region. Each plan is the result of close partnerships and dialogue among the ACCU, RCPs and core Aboriginal health tables. To date, Regional Aboriginal Cancer Plans have been drafted in the 10 regions of Ontario identified as having the largest Aboriginal populations, and finalized in four of those regions. ACS III will build on this achievement by working closely with core Aboriginal health tables to update the existing 10 plans and ensure that they reflect the cancer control needs and priorities of First Nations, Inuit and Métis communities and other Aboriginal groups from 2015 to 2019. The ACCU will also be working closely with RCPs in the remaining regions (with smaller Aboriginal populations) to provide direct support to RCP efforts in relationship-building and Aboriginal cancer control.



Health Staff from Kettle and Stony Point First Nation, Caldwell First Nation and Aamjiwnaang First Nation with Staff from the Erie St. Clair Regional Cancer Program in Kettle and Stony Point First Nation, October 2014

A key component of developing Regional Aboriginal Cancer Plans is to ensure that engagement between the RCPs and the core Aboriginal health tables is sustained. In four of the 10 regions in Ontario for which Regional Aboriginal Cancer Plans have been finalized, sustainable engagement structures have been established based on the direction of First Nations, Inuit, Métis and other Aboriginal groups in each region. These structures may take the form of new advisory committees, or involve meeting with local groups that are already established, such as Aboriginal Health Circles. Regular meetings ensure that progress reports on the implementation of each Regional Aboriginal Cancer Plan are provided to First Nations, Inuit, Métis and other Aboriginal partners, and these partners have the opportunity to provide feedback and guidance on all work undertaken to address cancer control within their communities. Work undertaken in ACS III will involve working closely with RCPs and core Aboriginal health tables

to develop sustainable engagement structures in every region of the province, while continuing to engage closely with those already established.

Role of the ACCU in regional implementation of the ACS II and III:

- Through Partnership Liaison Officers, the ACCU will support the successful implementation of ACS III by ensuring accountability through relationships established with First Nations, Inuit, Métis and other Aboriginal groups.
- The ACCU will help to develop the capacity of RCPs to engage directly, effectively and appropriately with First Nations, Inuit, Métis and other Aboriginal groups through their health networks and communities.
- The ACCU will help to fulfill Cancer Care Ontario's commitment outlined in Priority #1 of ACS III to build productive relationships and ensure

accountability (as outlined in the Relationship Protocols and Memorandum of Understanding).

- The ACCU will provide each region with additional support throughout the ACS III implementation process (e.g., helping to develop customized work plans and engaging core Aboriginal health networks).
- The ACCU will provide subject matter expertise in First Nations, Inuit and Métis cancer control issues, such as the Non-Insured Health Benefits (NIHB) program, navigating First Nations, Inuit and Métis governance and political systems, and cultural aspects of working respectfully with First Nations, Inuit and Métis communities.
- The ACCU will provide provincial-level support to Aboriginal Navigators and Regional Aboriginal Cancer Leads.
- The ACCU will ensure an ongoing Aboriginal voice in the delivery of cancer services in Ontario, thereby helping to lay the groundwork for future strategies.
- The ACCU will be responsible for providing regular verbal and written reports to First Nations, Inuit and Métis leadership, Aboriginal organizations and communities on progress, developments on existing initiatives and emerging opportunities (including addressing issues and concerns).

Regional milestones

It is at the regional level that the ACS comes to life. Here, we provide a snapshot of the significant steps RCPs and the ACCU have made as they worked together to implement ACS II from June 2012 to June 2015. Many of these initiatives are ongoing.

Lindsey Crawford

Regional Vice President, Simcoe Muskoka Regional Cancer Program

“Having the ACCU has been really helpful; the ACCU has a great understanding of our region when it comes to our Aboriginal partners, and developing relationships, and it has been great to have a Partnership Liaison Officer assigned locally to us to help support this work. The development of the North Simcoe Muskoka Aboriginal Cancer Plan was a great way to begin a meaningful dialogue with the communities, and engaging with the Aboriginal Health Circle in our region was a first for us.”

Region	Milestones
Central (Newmarket)	<ul style="list-style-type: none"> • Developed strong relationship with Georgina Island First Nation • Delivered cancer screening and commercial tobacco use workshops in the community • Developing a plan to engage urban Aboriginal population in Newmarket
Central East (Oshawa)	<ul style="list-style-type: none"> • Initiated engagement with core Aboriginal health tables • Identifying strategies to increase awareness of Aboriginal Navigator and Lead roles
Champlain (Ottawa)	<ul style="list-style-type: none"> • Finalized a regional Aboriginal Cancer Plan and established a sustainable First Nations, Inuit, Métis and other Aboriginal groups engagement structure • Established a culturally appropriate Aboriginal space at the Ottawa Hospital • Developed strong relationships with leadership from all three nations (First Nations, Inuit and Métis)
Erie St. Clair (Windsor)	<ul style="list-style-type: none"> • Finalized a regional Aboriginal Cancer Plan and established an Aboriginal Advisory Committee • Developed an Aboriginal patient and family satisfaction survey • Working with community partners and South West RCP to run a First Nations, Inuit and Métis cancer conference (late 2015)
Hamilton Niagara Haldimand Brant (Hamilton)	<ul style="list-style-type: none"> • Mobile cancer screening coach visited Six Nations and Mississaugas of New Credit First Nation in 2015 • Finalizing regional Aboriginal Cancer Plan • Started discussions with Six Nations and Mississaugas of New Credit First Nation

Region	Milestones
Mississauga Halton/ Central West (Mississauga)	<ul style="list-style-type: none"> • Will meet with the ACCU to discuss opportunities to address Aboriginal (First Nations, Inuit, Métis and other Aboriginal groups) cancer care
North East (Sudbury)	<ul style="list-style-type: none"> • Finalized a Regional Aboriginal Cancer Plan • Established an Aboriginal Advisory Committee after an extensive engagement process • Working with the ACCU to increase access to pain and symptom management tools and disease pathway maps for First Nations in remote settings • Establishing measures to track and improve First Nations, Inuit and Métis patient care (Improving Patient Experience and Health Outcomes Collaborative)
North Simcoe Muskoka (Barrie)	<ul style="list-style-type: none"> • Finalized a regional Aboriginal Cancer Plan and established a sustainable Aboriginal engagement structure • Developed cancer awareness toolkits for all Aboriginal communities in the region • Piloting a project to have patients voluntarily identify as First Nations, Inuit or Métis as they enter the cancer system
North West (Thunder Bay)	<ul style="list-style-type: none"> • Engagement with Aboriginal health networks and organizations is well underway • Working with Wequedong Lodge to provide improved access to cancer screening experience for First Nations from remote communities • Expanded the reach of mobile cancer screening coach program through greater awareness and coordination with community contacts • Developed culturally appropriate cancer screening toolkit for patients/providers
South East (Kingston)	<ul style="list-style-type: none"> • Developed a community cancer profile with, and for, Mohawks of the Bay of Quinte • Finalizing a Regional Aboriginal Cancer Plan and establishing a sustainable Aboriginal engagement structure
South West (London)	<ul style="list-style-type: none"> • Drafted regional Aboriginal Cancer Plan and are engaging core Aboriginal health tables in the region. • Working with community partners and Erie St. Clair RCP to run a First Nations, Inuit and Métis cancer conference (late 2015)
Toronto Central (Toronto)	<ul style="list-style-type: none"> • Engagement with Aboriginal health networks and organizations is well underway (there are over 20 health-related Aboriginal organizations in Toronto) • Exploring neighbourhood-level screening participation rates using the Geographic Information System tool developed as part of participation gap initiative
Waterloo Wellington (Kitchener)	<ul style="list-style-type: none"> • Met with the ACCU to discuss direct support for region in developing Aboriginal (First Nations, Inuit, Métis and other Aboriginal groups) initiatives

Progress through partnership

The development and eventual implementation of the Aboriginal Cancer Strategy (ACS) III relies on many partners coming together to listen and understand, and to explore every opportunity to improve our work. Cancer Care Ontario values its relationships with First Nations, Inuit and Métis, the Regional Cancer Programs (RCPs), and other key Aboriginal partners.

A main objective of the ACS II and ACS III is to work closely with First Nations, Inuit, Métis and other Aboriginal organizations to better address their cancer issues and needs. This has been achieved by establishing Relationship Protocols (or a Memorandum of Understanding), which formalize relationships with Aboriginal partners through mutual respect, recognition and understanding, and highlight Cancer Care Ontario's commitment to establishing strong foundational engagement structures necessary to achieve common goals and objectives, and ultimately create a partnership of good faith intentions, discussions and results.

The Relationship Protocols between Cancer Care Ontario, and First Nations, Inuit, Métis and other Aboriginal groups are guided by the following objectives:

develop

Looking out onto the lake in Poplar Hill First Nation, May 2013

- Protocols are a key objective and deliverable of the ACS II and III.
- Protocols address the cancer issues and needs of First Nations, Inuit and Métis within a partnership of mutual respect, recognition of traditional practices and understanding of the history, culture and diversity of First Nations, Inuit and Métis groups and communities.
- Protocols set out the accountability for the ACS and subsequent implementation in collaboration with the RCPs across Ontario.
- Protocols provide a means to initiate and build on existing and new programs and joint initiatives, and advance cancer care and chronic disease prevention.
- Protocols represent a unique relationship between Cancer Care Ontario and First Nations, Inuit, Métis and other Aboriginal organizations.
- Protocols provide Aboriginal groups with clarity and certainty about how Cancer Care Ontario will work with communities at all stages of cooperation and decision-making.

- The Relationship Protocols establish that both Cancer Care Ontario and First Nations, Inuit, Métis and other Aboriginal groups will be equally involved in improving the lives of community members, and the strong networks developed will provide opportunities for further collaboration.

Furthermore, the Aboriginal Cancer Control Unit's (ACCU's) strong and lasting relationships with Political Territorial Organizations (PTOs), other Aboriginal groups and the First Nations, Inuit and Métis communities are strengthened through extensive community engagement, and joint projects and initiatives. All work is coordinated through the regularly held Joint Ontario Aboriginal Cancer Committee (JOACC) meetings in which the provincial First Nations, Inuit and Métis and Aboriginal service organizations have representation and are provided with regular updates on projects, initiatives, opportunities for further collaboration, and a chance to provide feedback and input.

Relationship Protocols signed through ACS II

- Grand Council Treaty #3 (May 2013);
- Anishinabek Nation (June 2013);
- Ontario Federation of Indigenous Friendship Centres (July 2014);
- Nishnawbe Aski Nation (August 2014);
- Kitchenuhmaykoosib Inninuwug (Big Trout Lake First Nation, Oct 2014); and
- MOU signed with Métis Nation of Ontario (Feb 2015)

Paula Doering

Regional Vice President,
Champlain Regional Cancer Program

“The support we have received with relationship building has been outstanding. We wouldn’t be where we are today, and have an open dialogue and awareness of the FNIM population in our region without it. For the Regional Cancer Program Team, for the physicians, the Board and senior management team it’s been so helpful.”



Sandy Lake First Nation
from above, July 2013

First Nations

There are an estimated 201,100 First Nations people, representing 23.6 per cent of the total First Nations population in Canada (Census 2011). Ontario has the largest concentration of First Nations in Canada. There are 133 First Nation communities across Ontario that are represented politically through the Chiefs of Ontario, four PTOs, and Independent First Nations.

The Union of Ontario Indians (UOI)

In 1949, the Anishinabek Nation established the UOI as a secretariat to represent Anishinabek First Nations across Ontario in all areas of life. It is the oldest political organization in Ontario, tracing its roots back to before European contact, to the Confederacy of Three Fires.

The Anishinabek Nation now represents 39 First Nations from Pikwàkanagàn in the east, Aamjiwnaang in the south and Namaygoosisagagun in the north, which included both the Chippewas of the Thames and Munsee-Delaware First Nations.

PROJECTS AND INITIATIVES WITH UOI

- The Mobile Interactive Symptom Assessment and Collection (mISAAC) application pilot, which included UOI communities, was designed to improve access to palliative care services for remote First Nations communities on Manitoulin Island and increase healthcare practitioners' capacity to reach patients and measure symptoms.

- The first ultimate Frisbee smoking cessation initiative was implemented in partnership with UOI at M'Chigeeng First Nation.
- Cancer Care Ontario has committed to reporting regularly to the UOI Chiefs and the Anishinabek Advisory Council on Health to ensure that a strong and lasting relationship is forged through trust, mutual respect and honour towards First Nations processes and approaches.

Grand Council Treaty #3 (GCT3)

GCT3 is the historic traditional government of the Anishinaabe Nation in Treaty #3 and is the political government for the 28 Anishinaabe communities, including 26 in northwestern Ontario and two in Manitoba. There are 24 directly affiliated member communities and four communities that are signatories to Treaty #3, but unaffiliated.

PROJECTS AND INITIATIVES WITH GCT3

- Cancer Care Ontario's mobile screening coach provides continued services to many Treaty #3 communities to improve their access to screening services, and address rising rates of cancer and late cancer diagnosis among the First Nations, Inuit and Métis population in Ontario.
- Work is being done with the Kenora Chief's Advisory (KCA) to inform and support the KCA First

Nation Client Registry (FNCR) with cancer screening and develop community cancer profiles.

- Research on Tobacco Reduction in Aboriginal Communities (RETRAC) work is underway with KCA communities to identify initiatives that are effective in reducing non-traditional tobacco use in Aboriginal populations in Canada and indigenous populations worldwide; share tobacco reduction strategy information among First Nations, Inuit and urban Aboriginal communities in Ontario; and support the local development and implementation of community-based tobacco reduction initiatives in seven First Nations, Inuit and urban Aboriginal communities in Ontario.
- Cancer Care Ontario has committed to reporting regularly to the GCT3 Chiefs and Health Council to ensure that a strong and lasting relationship is forged through trust, mutual respect and honour towards First Nations processes and approaches.

Nishnawbe Aski Nation (NAN)

NAN is a PTO representing 49 First Nation communities within Northern Ontario, with the total population of membership (on- and off-reserve) estimated to be around 45,000 people. These communities are grouped by tribal council (Windigo First Nations Council, Wabun Tribal Council, Shibogama First Nations Council, Mushkegowuk

Council, Matawa First Nations, Keewaytinook Okimakanak and Independent First Nations Alliance) according to region. Six of the 49 communities are not affiliated with a specific tribal council.

NAN encompasses James Bay Treaty No. 9 and Ontario's portion of Treaty No. 5, and has a total land mass covering two-thirds of the province of Ontario, spanning 210,000 square miles. The people traditionally speak four languages: OjjiCree in the west, Ojibway in the central-south area, and Cree and Algonquin in the east.

PROJECTS AND INITIATIVES WITH NAN

- Cancer Care Ontario, in coordination with Sandy Lake First Nation, developed a community-led colorectal cancer Screening Activity Report (SAR) to increase uptake of colorectal cancer screening and improving access to colorectal cancer screening tools.
- RETRAC work is underway with Sachigo Lake First Nation to identify initiatives that are effective in reducing non-traditional tobacco use in Aboriginal populations in Canada and indigenous populations worldwide, share tobacco reduction strategy information among First Nations, Inuit and urban Aboriginal communities in Ontario, and support the local development and implementation of community-based tobacco reduction initiatives in seven First Nations, Inuit and urban Aboriginal communities in Ontario.
- Cancer Care Ontario has committed to reporting regularly to the NAN Chiefs and NAN Health Advisory Group to ensure that we build and maintain strong and lasting relationships that are based on mutual trust, respect and feedback.

The Association of Iroquois and Allied Indians (AIAI)

The AIAI was established to advocate on behalf of seven member nations in Ontario. It has become an internationally recognized organization. In total it represents about 20,000 First Nations people from the following communities: Batchewana First Nation of Ojibways, near Sault Ste. Marie; Delaware Nation, near Chatham; Caldwell First Nation, near Leamington; Wahta Mohawks, near Parry Sound; Oneida Nation of the Thames, near London; Hiawatha First Nation, near Peterborough; and Mohawks of the Bay of Quinte, near Belleville.

PROJECTS AND INITIATIVES WITH AIAI

- RETRAC work is underway with Batchewana First Nation to identify initiatives that are effective in reducing non-traditional tobacco use in Aboriginal populations in Canada and indigenous populations worldwide, share tobacco reduction strategy information among First Nations, Inuit and urban Aboriginal communities in Ontario, and support the local development and implementation of community-based tobacco reduction initiatives in seven First Nations, Inuit and urban Aboriginal communities in Ontario.
- Cancer Care Ontario has developed a community cancer profile for an AIAI community (Tyendinaga) to build capacity within First Nations communities to better understand their burden of cancer.
- As part of building and maintaining strong relationships and partnerships, Cancer Care Ontario has committed to reporting regularly to AIAI's Chiefs and Health and Social Advisory Board.

Independent First Nations (IFNs)

Within Ontario, there are currently 13 IFNs that are not politically affiliated with any of the PTOs. First Nations choosing not to belong to a PTO began forming an alliance in the early 1990s, but were not yet recognized as a collective group by other political organizations and government. In 1994, several IFNs acknowledged the need to bind their relationship through the development and recognition of the IFN Protocol, which was implemented with support from the federal government in 1995.

When needed, the Grand Chiefs or Chiefs of each of these First Nations work collectively on issues of fundamental concern, while respecting each other's autonomy. The IFN Protocol establishes a relationship of respect and an understanding of support based on the principles of autonomy, open communication and cooperation to achieve the common good. Six Nations has asserted its autonomy from the IFN protocol and now represents itself on all issues.

The IFN is engaged at various committee and governmental levels to develop partnerships for the advancement of each community. The majority of information from these committees flows through the IFN coordination staff—with the exception of the Chief's Committee tables—then to the communities for further discussion and knowledge exchange.

PROJECTS AND INITIATIVES WITH IFNs

The Ontario Renal Network is currently exploring options for dialysis services in Kitchenuhmaykoosib Inninuwug (Big Trout Lake) in order to improve access to care for community members with chronic kidney disease (CKD).

Patrick Madahbee

Grand Council Chief,
Union of Ontario Indians

“As Aboriginal First Nations people we are humble, we don’t brag. I think we need to start bragging. What I am loving about this is that finally we realize that we have a voice. We are realizing that we have a powerful voice. When we are not happy, we are standing up and saying it—that is huge. Rather than taking it and letting things happen, we are actually saying that this isn’t right. That makes me extremely proud.”

In October 2014, a Relationship Protocol was signed with the Independent First Nation, Kitchenuhmaykoosib Inninuwug (Big Trout Lake First Nation).

Meetings with the Independent Health Directors Forum and individual IFN communities will continue and be an important part of the process in establishing Cancer Care Ontario’s relationships with IFNs across Ontario.

Chiefs of Ontario (COO)

COO is a coordinating body and secretariat for collective decision-making, action and advocacy for the 133 First Nations communities located in Ontario. Guided by the Chiefs in Assembly, COO upholds the self-determination efforts of the Anishinaabek, Mushkegowuk, Onkwehonwe and Lenape peoples in protecting and exercising their inherent and treaty rights. The main objective of COO is to facilitate discussion, planning, implementation and evaluation

of all local, regional and national matters affecting First Nations people. COO continues to create the path forward in building First Nations as strong, healthy peoples who are respectful of themselves, each other and all creation.

PROJECTS AND INITIATIVES WITH COO

Given the Chiefs of Ontario’s key role as a coordinating body for the First Nation communities in Ontario, COO, Cancer Care Ontario and the ACCU have developed and entered into an important relationship and agreement as it pertains to identifying the cancer burden for First Nations in Ontario.

Strengthened by a COO resolution identifying cancer surveillance as a priority, and passed by a Special Chiefs Assembly in 2004, COO, Cancer Care Ontario and the Institute for Clinical Evaluative Sciences (ICES) have collaboratively entered into a Data Sharing Agreement (DSA) signed in 2013. The DSA outlines linking the Indian Registry System (IRS) with

a number of administrative health databases in order to generate health status indicators for a wide variety of conditions in Ontario First Nations. Furthermore, this agreement will develop cancer surveillance for Ontario First Nations through linkage with the Ontario mortality database and the Ontario Cancer Registry (OCR).

Tribal councils

Tribal councils are made up of First Nations that join together to provide advisory and/or program services to their members. They are community-driven bodies that receive their direction from, and are accountable to, their member First Nations and will typically represent their member First Nations within various forums at local and regional levels. Program services vary, but often include financial, employment, technical, housing and health. Cancer Care Ontario has directly engaged a number of tribal councils throughout the implementation of ACS II in order to establish productive relationships, and will build on this work throughout ACS III in order to work together to address cancer control priorities.

Health authorities

Several First Nations health authorities exist within Ontario to provide a wide range of culturally appropriate healthcare and client advocacy services for affiliated First Nations. Throughout the implementation of ACS II, Cancer Care Ontario has engaged with Sioux Lookout First Nations Health Authority, Weeneebayko Area Health Authority and Fort Frances Tribal Area Health Services in order to seek guidance on initiatives and explore opportunities for partnership. Cancer Care Ontario will continue to work closely with these organizations throughout the implementation of ACS III.



progress

Inuit

Ontario's Inuit population has grown to a now estimated 3,500, the vast majority of whom live in the Ottawa area. Inuit are not native to Ontario, and originally came here from Inuit Nunangat (a Canadian Inuktitut term that includes land, water and ice, and refers to the Inuit homelands of Inuvialuit, Nunatsiavut, Nunavik and Nunavut). Family is at the heart of Inuit culture, which is, in turn, surrounded by the community. Inuit families are typically large and deeply inter-connected as a result of powerful bonds formed through childbirth, marriage and adoption. Great respect is given to Inuit Elders who carry traditional knowledge that is shared with younger generations, ensuring Inuit traditions are kept alive.

Inuit Service Providers in Ottawa

Outside of Inuit Nunangat, the largest Inuit population in Canada resides in Ottawa, so a number of Inuit service providers are located in the national capital. They provide a variety of health, social, educational and political services to the Inuit community. Cancer Care Ontario has met and works closely with the following Inuit service providers in Ottawa to understand and respond to cancer control needs and challenges specific to Inuit living in Ontario or travelling to Ontario for services from Northern Canada:

- Inuit Tapiriit Kanatami (ITK) represents and promotes the interests of Inuit on a wide variety of

environmental, social, cultural and political issues and challenges facing Inuit on the national level.

- Tungasuvvingat Inuit (TI) is an Inuit-specific provincial service provider that provides social support, cultural activities, counselling and crisis intervention as a one-stop resource centre to meet the rapidly growing, complex and evolving needs of Inuit in Ontario.
- Pauktuutit works to improve the health status of Inuit women and their families. Some of the services offered include health prevention and promotion for maternal child health and midwifery, tobacco cessation, HIV and AIDS, and substance abuse.
- Akasivik Inuit Family Health Team (AIFHT) provides free primary care services dedicated to the Inuit community.
- Ottawa Health Services Network Inc. (OHSNI) provides case management and medical interpretation, and coordinates specialty healthcare services for the Inuit in the Ottawa region and Iqaluit for Baffin Island Residents.

PROJECTS AND INITIATIVES WITH INUIT SERVICE PROVIDERS

- Cancer Care Ontario and TI are working with Inuit community members to develop a suite of informational cancer materials, including fact sheets, flashcards, and a video promoting the importance of knowledge exchange from Elders to youth and other Inuit regarding health, wellness and shared experiences of the cancer journey.
- TI and Pauktuutit have provided guidance and feedback on Inuit-specific materials developed by Cancer Care Ontario, such as cancer screening fact sheets and palliative care toolkits.

- TI and AIFHT worked with Cancer Care Ontario to inform the development of the First Nations, Inuit and Métis Chronic Disease Prevention Blueprint.
- TI is participating in the RETRAC project, which supports the local development and implementation of community-based commercial tobacco reduction initiatives.

Cancer Care Ontario's relationship with Inuit service providers in Ottawa

Cancer Care Ontario will continue to establish a direct working relationship with each of the Inuit service providers listed above in order to develop methods of working collaboratively that are appropriate to each organization, and commensurate with Inuit Qaujimajatuqangit (IQ), or the Inuit way of doing things. Cancer Care Ontario seeks guidance and feedback on all initiatives through regular touch points with Inuit service providers, and has established dedicated working groups with Inuit service providers and community members to advance projects, such as the development of cancer education materials, in a manner that is culturally relevant to Inuit. Cancer Care Ontario is currently working with TI to formalize its relationship through a Relationship Protocol, which will also outline the importance of continuing to work closely with other Inuit service providers in the Ottawa region to advance cancer control for Inuit.



Métis

The Métis Nation of Ontario (MNO) was established in 1993 by the Métis people of Ontario and is the elected representative body of the Ontario Métis, as recognized by the Government of Canada and by the Government of Ontario. Led by President Gary Lipinski, the MNO represents the collective aspirations, rights and interests of Métis people and Métis communities throughout Ontario.

MNO Healing and Wellness Branch

The MNO Healing and Wellness Branch facilitates and coordinates activities to address the holistic needs of the Métis Nation in Ontario at provincial, regional and local levels. Holistic Métis health includes the physical, mental, emotional, spiritual and cultural aspects of life. The Healing and Wellness Branch operates across 19 locations in Ontario and actively seeks to partner with Métis and non-Métis people and governments that recognize and respect the diverse lifestyles and traditions of Métis people.

Cancer Care Ontario's Relationship with the MNO

On February 21, 2015, Cancer Care Ontario signed a Memorandum of Understanding with the MNO. This memorandum formalizes the relationship between Cancer Care Ontario and the MNO, and will help Cancer Care Ontario ensure that the cancer system recognizes the cultural distinctiveness of the Métis

people. It also ensures that Cancer Care Ontario will address the unique cancer control needs of Métis people and Métis communities.

The Memorandum of Understanding represents a relationship that is inclusive of Métis voices, respectful of Métis governance structures and protocols, and outlines how Cancer Care Ontario and MNO will work together to enhance the quality of health for Métis people through partnership.

Practically speaking, the memorandum provides a way for Cancer Care Ontario and MNO to work together on cancer control priorities and projects through well-established processes. Cancer Care Ontario has established regular touch points with the MNO Healing and Wellness Branch in order to provide progress reports and seek guidance and approval on key initiatives. For all joint projects undertaken, such as the development of the Métis cancer risk factor report and Métis cancer video, specific project agreements are drafted and approved by both parties before work begins. The MNO has established a research network of which Cancer Care Ontario is a member; this network is dedicated to working with multiple partners to expand the body of research knowledge relevant to enhancing the health of Ontario's Métis. Cancer Care Ontario has also been invited to participate in MNO's Knowledge

Development and Mobilization Forum, which helps provide guidance and direction on translating research into action for Métis people in Ontario. Cancer Care Ontario is dedicated to working with MNO in a manner that is, above all, respectful of processes and procedures appropriate to the MNO.

PROJECTS AND INITIATIVES WITH MNO

- A report on cancer risk factors among the Métis people of Ontario has been co-developed by MNO and Cancer Care Ontario (to be released in 2015). The report will contribute substantially to knowledge in this area, and broaden decision makers' perspective on cancer risk in Ontario's Métis population with the aim of enhancing policies related to Métis health and wellness.
- Cancer Care Ontario and MNO are currently working together to develop a suite of cancer information materials, including fact sheets, flashcards and a video aimed at informing Métis people on how they can decrease their risk of developing cancer and empowering them to take ownership of their health.
- MNO has provided guidance and feedback on a number of materials and reports, such as the First Nations, Inuit and Métis Chronic Disease Prevention Blueprint and palliative care toolkits to ensure that materials produced reflect the needs of, and resonate with, Ontario's Métis population.

Gary Lipinski

MNO President

“Cancer is perceived in the Métis community as a growing health issue. Cancer has always been there. When you go back to your oldest memories when somebody was diagnosed with cancer it is almost like a death sentence. There have been remarkable treatments and improvements. That’s part of the messaging we need to help work at getting out there.”



MNO President Gary Lipinski and President and CEO Michael Sherar exchange gifts at the Métis Nation of Ontario – Cancer Care Ontario Memorandum of Understanding Signing Event, Toronto, February 2015

Key Partners

Ontario Federation of Indigenous Friendship Centres (OFIFC)

The Ontario Federation of Indigenous Friendship Centres (OFIFC), formed in 1971, is a provincial Aboriginal organization representing the collective interests of 28 member Friendship Centres located in towns and cities throughout the province. The vision of the Aboriginal Friendship Centre movement is “to improve the quality of life for Aboriginal people living in an urban environment by supporting self-determined activities which encourage equal access to and participation in Canadian society and which respects Aboriginal cultural distinctiveness.” As not-for-profit corporations that are mandated to serve the needs of all Aboriginal people regardless of legal definition, Friendship Centres respond to the needs of tens of thousands of community members requiring culture-based and culturally appropriate services every day.

Friendship Centres have a vital role to play in effectively addressing the health and the social determinants of health of urban Aboriginal people. The OFIFC administers a number of culture-based, community-driven programs and initiatives that are designed and delivered by local Friendship Centres in areas such as children and youth, education, employment and training, health (including mental health and addictions), recreation, justice and ending violence against Aboriginal women. The OFIFC undertakes extensive primary, community-driven research and policy work to advance work in the areas outlined above, sitting on multiple tables, and



Murals adorning the walls of the Ontario Federation of Indigenous Friendship Centres head office, Toronto, August 2015.

Artist: Joseph Sagaj

putting forward positions through regular government processes, such as consultations and submissions to standing committees and more. The OFIFC is actively involved in training, and provides Aboriginal Cultural Competency Training to Aboriginal and non-Aboriginal institutions across Ontario and offers culture-based college certificates in collaboration with George Brown College and Confederation College in the areas of mental health, trauma and community development.

A Relationship Protocol was signed on July 19, 2014 between the OFIFC and Cancer Care Ontario. This protocol will enable Cancer Care Ontario and OFIFC to identify and address common concerns and interests in order to enhance the quality of health of urban Aboriginal peoples and their communities through partnership. The protocol set a new course for a collaborative relationship between Cancer Care Ontario and OFIFC to work to improve cancer programming and service delivery, ensuring those who do get cancer live longer and better lives. The Protocol lays the foundation for Cancer Care Ontario to work together with the OFIFC and its member Friendship Centres to address issues and advance the strategic priorities of the ACS III and future Aboriginal Cancer Strategies.

PROJECTS AND INITIATIVES WITH OFIFC

- Cancer Care Ontario is working with OFIFC to coordinate meet-and-greets between Regional Aboriginal Cancer Leads, Aboriginal Navigators and interested Friendship Centres.

Aboriginal Health Access Centres (AHACs)

AHACs are Aboriginal community-led, primary healthcare organizations. They provide a combination of traditional healing, primary care services, cultural programs, health promotion programs, community development initiatives and social support services to First Nations, Inuit and Métis communities in Ontario. There are currently 10 AHACs in Ontario, providing services both on- and off-reserve, and in urban, rural and remote locations.

In 1994, when Ontario implemented the Aboriginal Health Policy for Ontario—a policy developed in broad consultation with First Nations, Inuit and Métis communities—Aboriginal community-led primary healthcare was identified as a key strategic pillar. First announced in 1995, AHACs were closely modelled after Ontario's community health centres (CHCs), whose broad spectrum of services and support to the health and well-being of communities in Ontario has been an important part of assisting communities facing various barriers in accessing healthcare. AHACs, as with the CHCs, are recognized by the Ministry of Health and Long-Term Care (MOHLTC) and have a direct funding and accountability relationship with the ministry.

As of 2010, in order to support strengthened primary healthcare for Aboriginal peoples, AHACs were provided with a direct funding and accountability framework with MOHLTC. Therefore, funding is directly administered to AHACs by the ministry.

Melissa Deleary

Health Policy Analyst, Ontario Federation of Indigenous Friendship Centres; JOACC member

“The direct engagement approach has been not only the right one but also a model for Aboriginal engagement among governments and other organizations and agencies to emulate and to follow. It really includes Aboriginal people as equal partners in mutually supporting each other and carrying out shared goals. The way that Cancer Care Ontario has conducted this engagement with always checking in with partners and being really transparent about the approach they are taking and incorporating feedback and comments from the partners, has really helped to build a powerful partnership. It doesn't always happen, but with the Aboriginal Cancer Control Unit we always feel there is direct accountability to JOACC. Partnerships are a slow and continuous, earned thing. Cancer Care Ontario and JOACC have worked hard to build up that relationship, they haven't forced it. It has been at the pace and direction of the membership. It feels like the membership has been guiding it.”

Amanda Hey

Regional Primary Care Lead,
Northeast Region; JOACC member

“Having worked as a family physician within an Aboriginal Health Access Centre and also been Medical Advisor to the JOACC for several years, I’ve witnessed a purposeful and respectful direct engagement of the ACCU with communities in the development and implementation of both the ACS II and ACS III. This approach is building relationships with communities, whose perspectives on their issues and needs are so essential to addressing cancer service improvements.”

Moreover, the Association of Ontario Health Centres (AOHC) is the provincial body governing support to over 100 community-governed primary care organizations, including 75 CHCs and 10 AHACs. AOHC serves as a governing secretariat for AHACs and CHCs in Ontario. MOHLTC has recognized AHACs as important providers of health and healing services to Aboriginal communities and as partners in Ontario’s healthcare system.

From clinical care services, to integrated chronic disease prevention and management, family-focused maternal and child healthcare, addictions counselling, traditional healing, mental healthcare, youth empowerment and other programs, AHACs continue to serve as a key gateway to overall family

and community health and development in First Nations, Inuit and Métis communities. AHACs have made a powerful contribution to health and well-being in Ontario, helping to bring tens of thousands of Aboriginal community members into the circle of care and support. Cancer Care Ontario and the ACCU continue to build a strong and lasting relationship with our crucial AHAC partners.

PROJECTS AND INITIATIVES WITH AHACs

- Through the Regional Aboriginal Cancer Plans, AHACs will continue to be engaged by the ACCU and RCPs in the finalization and implementation of these plans, which will include key cancer care actions and initiatives for the AHAC staff and patients.
- The mISAAC application pilot included Noojmowin Teg AHAC and communities. This tool is designed to improve access to palliative care services for First Nations communities on Manitoulin Island, and increase healthcare practitioners’ capacity to reach patients and measure symptoms. This work will strengthen communication between providers and patients and, for Cancer Care Ontario, this work will provide a unique and first time opportunity for a future rollout the mISAAC tool in a primary care setting across all remaining AHACs and CHCs in Ontario.
- Similarly, Cancer Care Ontario and the executive leadership of all 10 AHACs have expressed support for integrating mISAAC symptom management tools into the daily practice of their health centres (i.e., electronic medical records [EMRs]) in order to better support

people with cancer and their families with pain and symptom management and palliative care. The integration of mISAAC into the AHAC primary care EMR will also provide access to Edmonton Symptom Assessment Score (ESAS) trends within the clinical information systems used by all AHAC staff to enable and support integrated, interdisciplinary care and management of First Nations, Inuit and Métis people with cancer and their families.

- Since 2014, AHACs have delegated a representative to be a member of Cancer Care Ontario’s JOACC, where members provide guidance and direction to Cancer Care Ontario for the continued development, implementation and evaluation of the ACS. AHAC representation at JOACC is an important part of Cancer Care Ontario’s engagement approach and demonstrates the value held in ensuring input from all partners determined to improve health services for Ontario First Nations, Inuit and Métis peoples and communities.

Ontario Native Women’s Association (ONWA)

ONWA delivers culturally enriched programs and services to Aboriginal women and their families. It is a not-for-profit organization established in 1972 to empower and support Ontario’s Aboriginal women and their families. ONWA’s guiding principle is that all Aboriginal ancestry will be treated with dignity, respect and equality. Benefits and services will be extended to all regardless of location or tribal heritage.

ONWA is located in Thunder Bay and delivers programs and services throughout the province via

satellite offices located in Kenora, Dryden, Sioux Lookout, Geraldton/Greenstone, Ottawa, Napanee and Hamilton.

Under ACS III, Cancer Care Ontario will build on previous discussions regarding the working relationship with ONWA and explore potential collaborations to address cancer issues and needs with Aboriginal women.

Canadian Cancer Society (CCS)

CCS is a national, community-based organization whose mission is the eradication of cancer and the enhancement of the quality of life for people with cancer. The alignment between CCS and Cancer Care Ontario's strategic objectives has fostered a strong collaborative relationship between the two organizations. Through quarterly meetings between CCS and Cancer Care Ontario's ACCU, both groups have committed to working together to reduce the burden of cancer and improve access to cancer resources for all Ontarians. A portion of that work includes disseminating CCS information, resources and shared contact lists to Cancer Care Ontario's Aboriginal Navigators in order to provide them with the best tools for their close work with First Nations, Inuit and Métis people with cancer. This work will be strengthened by the ACCU's expertise in sharing cultural sensitivity training with frontline workers, of which CCS remains an important part. Furthermore, CCS and Cancer Care Ontario are working closely to develop a set of "Cancer 101" educational materials that will be jointly disseminated to increase capacity within First Nations, Inuit and Métis communities, and among the general population, thus reducing the fear associated with cancer. CCS and Cancer Care Ontario will continue to explore opportunities

for further collaboration, and have committed to referring patients and families to complementary services offered by both organizations.

The Pediatric Oncology Group of Ontario (POGO)

POGO is a non-profit charitable organization that addresses a recognized need for a networked system of care for children with cancer and their families. POGO remains the official source of advice on childhood cancer care and control to the Ministry of Health and Long-Term Care (MOHLTC). This organization works in close collaboration with a host of partners to ensure access to and availability of state-of-the-art cancer care for all Ontario's children. POGO's mission is to improve the circumstances of all children with cancer, and those of their families and caregivers.

A number of synergies have been identified between POGO and Cancer Care Ontario's ACCU. Those synergies have played a key part in ongoing discussions between Cancer Care Ontario and POGO, which have leveraged each other's expertise and knowledge, and benefited from each other's resources and networks to improve access to cancer services across Ontario. POGO's field strength in childhood cancers will be fundamentally important to the ACCU's ongoing work with First Nations, Inuit and Métis communities, and increasingly the younger generation of First Nations, Inuit and Métis across Ontario.

WORKING WITH POGO

- Although the mandate of Cancer Care Ontario relates to adult cancers rather than childhood cancers, Cancer Care Ontario is entirely

committed to helping connect communities to the services that POGO provides because it recognizes the need to ensure that families and communities have all resources available to help them when First Nations, Inuit and Métis children with cancer are in the fight of their lives.

- POGO's provincial Pediatric Interlink Community Cancer Nurses move with the patient and family between hospital, school, community services and home at all stages of their illness, providing cancer teaching for community nurses involved in patient care, facilitating navigation of the healthcare system for families, and helping them to locate and access community and hospital resources. Cancer Care Ontario has helped to facilitate connections between Cancer Care Ontario's Aboriginal Navigators and POGO's Interlink Nurses in each region, so that the Navigators are in a strong position to provide First Nations, Inuit and Métis families with all the support available to them through POGO.
- Cancer Care Ontario is working closely with POGO (and other partners) to help inform Cancer Care Ontario's position on traditional medicine and indigenous knowledge as it relates to cancer care and the healing journey for First Nations, Inuit and Métis people.
- Cancer Care Ontario will work with POGO to explore opportunities for POGO to engage with and provide information to First Nations, Inuit and Métis partners, and discuss ways in which these two groups can work together to enhance education and awareness on childhood cancers.

Setting the stage

What we know about cancer burden and risk in Ontario's FNIM populations

There is limited information about the burden of cancer in Ontario First Nations, Inuit and Métis populations due to the absence of racial or ethnic identifiers in Canadian health databases. For example, the Ontario Cancer Registry (OCR) has information on all Ontario residents with a diagnosis of cancer, but does not include First Nations, Inuit or Métis status. As a result, cancer burden in these population sub-groups cannot be directly measured except through special research studies. One such study was conducted in Ontario several years ago¹ and provides some information on cancer patterns in First Nations people.

Cancer burden in Ontario First Nations

Results from the study referenced above and its extensions indicate that in the period of 1997 to 2001, the most commonly diagnosed cancers among Ontario First Nations were the same as those in the general population: female breast, prostate,

colorectal and lung cancers. Cancer incidence rates were significantly lower for breast and prostate cancers (and for all cancers combined) among First Nations compared to the general population. However, cancer incidence rates were increasing more rapidly among First Nations men and women, particularly for lung and colorectal cancer.

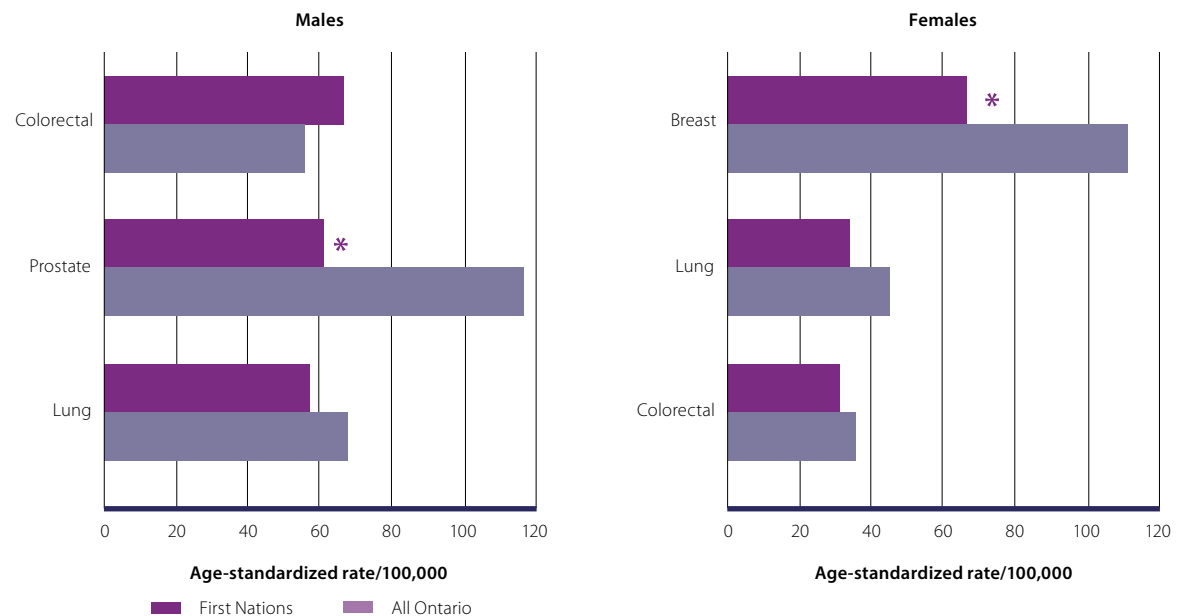
This same study also found that for cancers diagnosed between 1992 and 2001, Ontario First Nations people diagnosed with breast, prostate, cervical, colorectal (male and female) and lung (male) cancers had significantly poorer survival than non-First Nations Ontarians.² A follow-up study

focusing on breast cancer showed that First Nations women were more likely to be diagnosed at a more advanced stage and to have more comorbidities (non-cancer conditions such as diabetes, heart disease, etc.) compared to other Ontario women; these were the main contributors to worse prognosis.^{3,4}

Cancer in Ontario Inuit

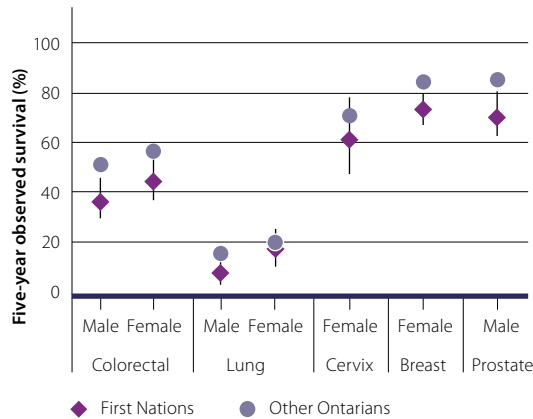
There are no studies examining the burden of cancer in Ontario Inuit, in part due to the very small population of Inuit living in the province. However, Carrière et al.⁵ examined cancer incidence in Inuit

INCIDENCE OF COMMON CANCERS, ONTARIO, 1997–2001, AGES 15 TO 74



Notes: Rates are age-standardized to the 1991 Canadian population.
 * Significant difference between registered First Nations and All Ontario rates
Source: Marrett et al. unpublished data
Prepared by: Aboriginal Cancer Control Unit, Prevention and Cancer Control, Cancer Care Ontario, May 2014

FIVE-YEAR SURVIVAL FOR COMMON CANCERS, ONTARIO, 1992-2001



Notes: Age-standardized to the 1991 Canadian population. Five-year age-standardized observed survival (%) by cancer site and sex comparing First Nations population to other Ontarians for cancers diagnosed from 1968-1991 with follow-up to December 31st, 2007 and censoring at age 75. | represent 95% confidence intervals.
Source: Nishi, Sheppard, Withrow & Marrett, *International Journal of Cancer* 2015
Prepared by: Aboriginal Cancer Control Unit, Prevention and Cancer Control, Cancer Care Ontario, May 2014

Nunangat, which comprises the four settled Inuit land-claim regions: Nunavut, Nunavik, Inuvialuit region and Nunatsiavut; an estimated 81% of people living in these regions are Inuit. The most common cancers in this population in 1998-2007 were the same as in the rest of Canada (lung, colorectal, female breast and prostate). Compared to the rest of Canada, incidence rates were higher for lung and colorectal cancers (and for all cancers combined in females), but lower for cancers of the breast and prostate (and for all cancers in males).

The next most commonly occurring type of cancer in both males and females living in Inuit Nunangat is

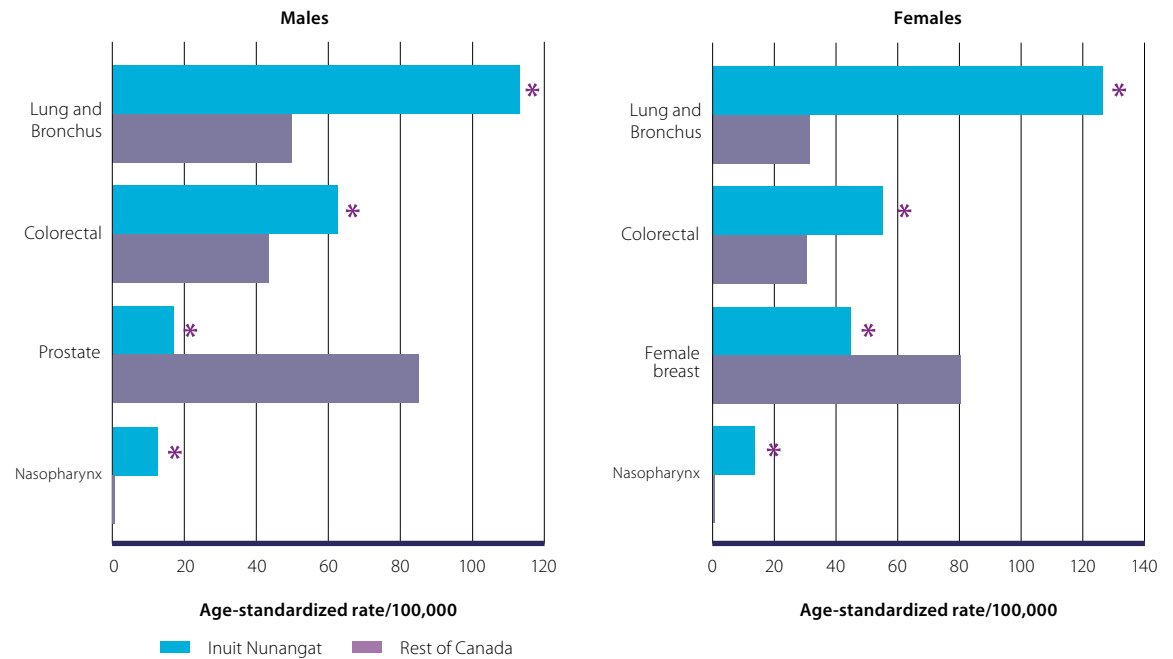
nasopharyngeal cancer, which is very rare in the non-Inuit population. As a result, incidence rates for this cancer are 14 times higher in male residents of Inuit Nunangat and 45 times higher in females.

Cancer in Ontario Métis

Very little is known about cancer patterns among Ontario's Métis population. A study linking 14,000 individuals from the Métis Nation of Ontario's Citizenship Registry to the Ontario Cancer Registry for the period of 2005 to 2007 was too small to provide any useful conclusions.⁶

An older study looking at cancer mortality across Canada found that between 1991 and 2001, Métis women had significantly higher rates of death due to cancer overall, and for cancers of the lung and uterus, compared to non-Aboriginal women, while Métis men had similar rates of death due to cancer compared to non-Aboriginal men.⁷ A study in Manitoba's Métis population revealed that from 1998 to 2007, Métis adults had similar overall cancer rates, but significantly higher incidence of lung cancer compared to other Manitobans.⁸

INCIDENCE OF COMMON CANCERS, INUIT NUNANGAT, 1998-2007



Notes: Rates are age-standardized to the World Population. Cancer incidence in 5 continents (Curado et al. 2007)
 * Significant difference between Inuit Nunangat and Rest of Canada rates
 The incidence rate for nasopharyngeal cancer in females for the rest of Canada is so small that it is not visible on the graph.
Source: Carrière, Tjepkema, Pennock, and Goedhuis. *Cancer patterns in Inuit Nunangat: 1998-2007. Int J Circumpolar Health* 2012
Prepared by: Aboriginal Cancer Control Unit, Prevention and Cancer Control, Cancer Care Ontario, June 2015

Cancer risk factors in Ontario First Nations, Inuit and Métis populations

What are the factors affecting the risk of cancer?

Many of the common cancers diagnosed among both the First Nations, Inuit and Métis populations and the general population can be largely attributed to modifiable risk factors. Risk factors are exposures, behaviours and other characteristics that can affect a person's risk of developing cancer. Age and sex are the strongest predictors of cancer risk, followed by lifestyle factors, such as tobacco exposure, alcohol intake, diet, body composition and physical activity. These lifestyle factors are considered to be modifiable (because, in theory, they can be changed), and account for approximately 30 per cent of cancer deaths.¹⁰ Table 1 shows the modifiable risk factors with probable and convincing evidence linking them to associated cancers. By engaging in the listed healthy behaviours, one's risk for the specified cancers (indicated by a circle) can be decreased. For example, by limiting the amount of alcohol consumed, you can reduce your risk for cancers of the mouth and throat, colon and rectum, liver, pancreas and breast.

TABLE 1 MODIFIABLE BEHAVIOURS TO REDUCE CANCER RISK

Cancer risk reduction benefit	Avoid tobacco	Limit alcohol	Eat plant food	Limit red and processed meat	Limit salt and salted/salty foods	Healthy weight	Be physically active and avoid a sedentary lifestyle
Mouth and throat ¹	●	●	● *			● 2	
Stomach	●		● *		● *		
Colon and rectum	●	●		●		●	● 3
Liver	●	●					
Gallbladder						● *	
Pancreas	●	● *				●	
Lung	●		● *				
Female breast	● *	●				● * 4	● * 4
Cervix	●						
Ovary	●					● *	
Endometrium (uterus)						●	● *
Kidney	●					●	
Bladder	●						
Leukemia	●						

Notes:

* Evidence of association between risk factor and cancer is probable rather than convincing

¹ Includes cancers of the oral cavity and pharynx, esophagus and larynx.

² Esophagus cancer only

³ Colon cancer only

⁴ Post-menopausal breast cancer only

Source: Cancer Care Ontario. *Cancer Risk Factors in Ontario: Evidence Summary*. Toronto, Canada, 2013.

The following section will focus on the two modifiable risk factors listed in Table 1 associated with the most cancers: tobacco and body weight. The percentages of individuals with these risk factors are presented separately for on- and off-reserve Ontario First Nations, Métis and Inuit populations compared to non-Aboriginal Ontarians wherever possible, depending on availability of data.

Cancer risk factors in Ontario First Nations

TOBACCO SMOKING (FIGURE 1)

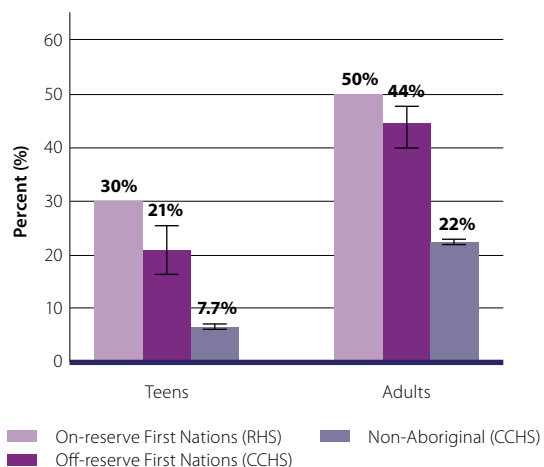
Nearly one in three on-reserve First Nations teens (aged 12 to 17) smoke, which is almost four times more than non-Aboriginal teens (aged 12 to 19). On-reserve First Nations teens also smoke more than off-reserve First Nations teens (30 per cent vs. 21 per cent, respectively).

On- and off-reserve First Nations adults are significantly more likely to smoke compared to non-Aboriginal adults. On-reserve First Nations adults are slightly more likely to smoke than off-reserve First Nations adults.

SECOND-HAND SMOKING (FIGURE 2)

Among non-smokers in Ontario, a similar proportion of off-reserve First Nations and non-Aboriginal teens (aged 12 to 19) are exposed to second-hand smoke in the home, car or public places (36 per cent vs. 18 per cent, respectively).

FIGURE 1 PERCENTAGE OF FIRST NATIONS AND NON-ABORIGINAL TEENS AND ADULTS WHO ARE CURRENT SMOKERS, ONTARIO, MALES AND FEMALES COMBINED



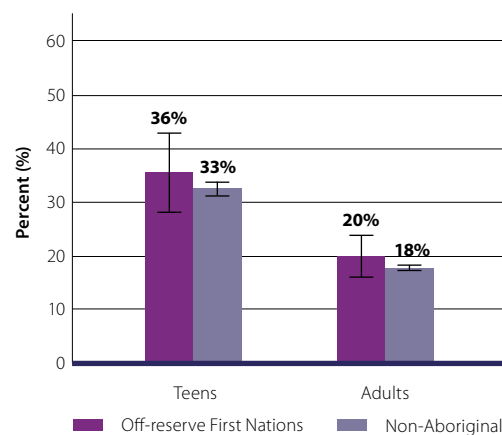
Notes: First Nations (off-reserve) and non-Aboriginal adult estimates are age-standardized to the 2006 Ontario Aboriginal identity population. CCHS teens and adults are defined as aged 12-19 and aged 20+, respectively. RHS teens and adults are defined as aged 12-17 and aged 18+, respectively. I represent 95% confidence intervals.
Source: Aboriginal Cancer Control Unit. 2015 (unpublished CCHS data); Chiefs of Ontario (COO). First Nations Regional Health Survey (RHS) 2008/10: Ontario Region report on adults, youth and children living in First Nations communities. Toronto: COO. 2012 (RHS data).
Data sources: Canadian Community Health Survey (CCHS), 2007-2012 (Statistics Canada); First Nations Regional Health Survey (RHS), 2008/10.

The same pattern is seen for off-reserve First Nations and non-Aboriginal adults with similar proportions reporting exposure to second-hand smoke (20 per cent vs. 18 per cent, respectively). There are no data available for on-reserve second-hand smoking.

OBESITY (FIGURE 3)

Among teens aged 12 to 17, the proportion of on-reserve First Nations who are obese is two times higher than among off-reserve First Nations and nearly four times higher than for non-Aboriginal Ontarians. A greater proportion of off-reserve First

FIGURE 2 PERCENTAGE OF FIRST NATIONS AND NON-ABORIGINAL TEENS (AGED 12-19) AND ADULTS (AGED 20+) WHO ARE EXPOSED TO SECOND-HAND SMOKE, ONTARIO, MALES AND FEMALES COMBINED

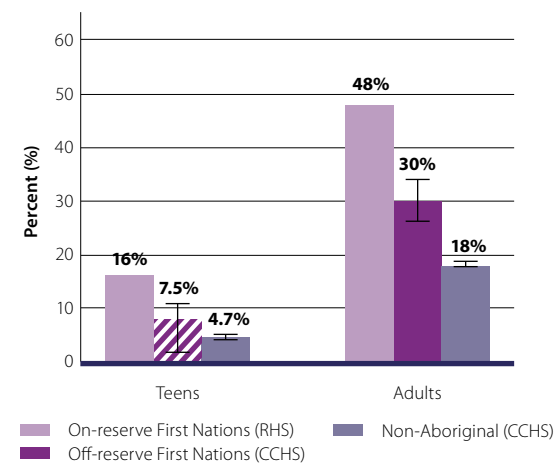


Notes: First Nations (off-reserve) and non-Aboriginal adult estimates are age-standardized to the 2006 Ontario Aboriginal identity population. I represent 95% confidence intervals.
Source: Aboriginal Cancer Control Unit. 2015 (unpublished CCHS data).
Data sources: Canadian Community Health Survey, 2007-2012 (Statistics Canada).

Nations teens is obese compared to non-Aboriginal teens in Ontario, although the difference is not significant.

Similarly among adults aged 18 and over, on- and off-reserve First Nations are more likely to be obese compared to non-Aboriginal Ontarians. A greater proportion of on-reserve First Nations adults are obese than are off-reserve First Nations adults.

FIGURE 3 PERCENTAGE OF FIRST NATIONS AND NON-ABORIGINAL TEENS (AGED 12-17) AND ADULTS (AGED 18+) WHO ARE OBESE, ONTARIO, MALES AND FEMALES COMBINED



Notes: First Nations (off-reserve) and non-Aboriginal adult estimates are age-standardized to the 2006 Ontario Aboriginal identity population. Diagonal shading indicates high sampling variability. Interpret with caution. I represent 95% confidence intervals.
Source: Aboriginal Cancer Control Unit. 2015 (unpublished CCHS data); Chiefs of Ontario (COO). First Nations Regional Health Survey (RHS) 2008/10: Ontario Region report on adults, youth and children living in First Nations communities. Toronto: COO. 2012 (RHS data).
Data sources: Canadian Community Health Survey (CCHS), 2007-2012 (Statistics Canada); First Nations Regional Health Survey (RHS), 2008/10.

Cancer risk factors in Ontario Inuit

TOBACCO SMOKING (FIGURE 4)

In Ontario, Inuit adults are nearly three times more likely to smoke as non-Aboriginal adults.

SECOND-HAND SMOKING (FIGURE 5)

Non-smoking Ontario Inuit aged 12 years and over are significantly more likely to report being exposed to second-hand smoke in the home, car or public places compared to non-Aboriginal Ontarians (39 per cent vs. 19 per cent, respectively).

OBESITY (FIGURE 6)

Numbers are too small to reliably estimate the prevalence of obesity in Ontario Inuit, so data for all of Canada are shown here. Greater proportions of Canadian Inuit men and women are obese compared to non-Aboriginal Canadians, although the difference is statistically significant only for men (31 per cent vs. 18 per cent, respectively).

FIGURE 4 **PERCENTAGE OF INUIT AND NON-ABORIGINAL ADULTS (AGED 20+) WHO ARE CURRENT SMOKERS, ONTARIO, MALES AND FEMALES COMBINED**

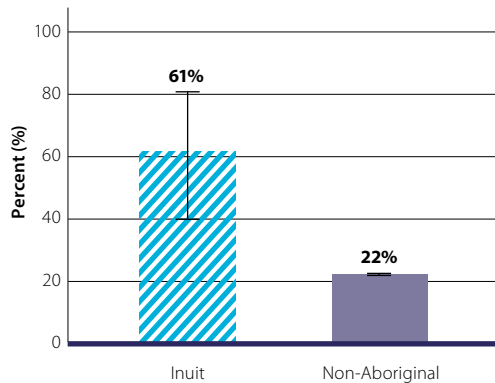


FIGURE 5 **PERCENTAGE OF INUIT AND NON-ABORIGINAL PEOPLE (AGED 12+) WHO ARE EXPOSED TO SECOND-HAND SMOKE, ONTARIO, MALES AND FEMALES COMBINED**

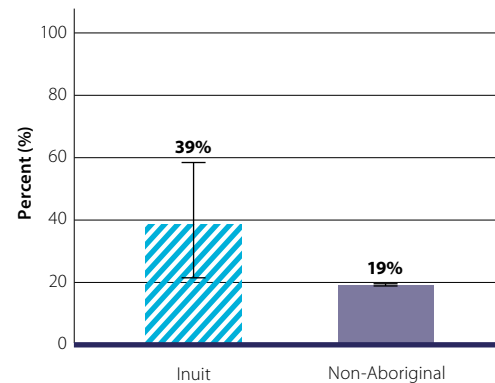
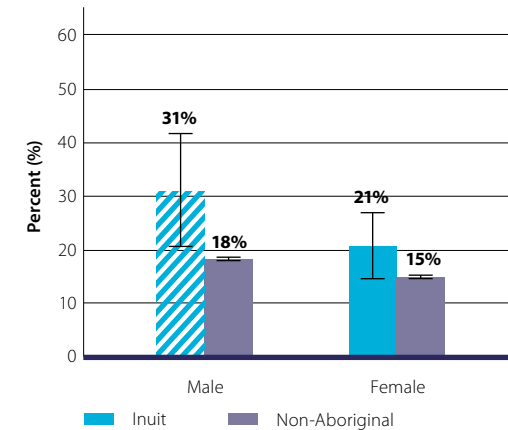


FIGURE 6 **PERCENTAGE OF INUIT AND NON-ABORIGINAL ADULTS (AGED 18+) WHO ARE OBESE, CANADA, BY SEX**



Notes: Age-standardized to the 2006 Ontario Aboriginal identity population. Diagonal shading indicates high sampling variability. Interpret with caution. I represent 95% confidence intervals.
Source: Aboriginal Cancer Control Unit. 2015 (unpublished CCHS data).
Data sources: Canadian Community Health Survey, 2007-2013 (Statistics Canada).

Notes: Diagonal shading indicates high sampling variability. Interpret with caution. I represent 95% confidence intervals.
Source: Aboriginal Cancer Control Unit. 2015 (unpublished CCHS data).
Data sources: Canadian Community Health Survey, 2007-2013 (Statistics Canada).

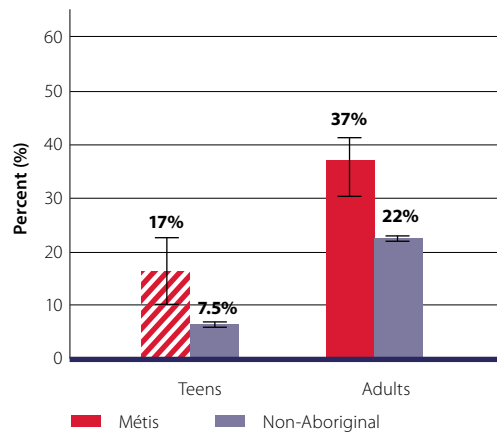
Notes: Age-standardized to the 2007-2010 Aboriginal population. Diagonal shading indicates high sampling variability. Interpret with caution. I represent 95% confidence intervals.
Source: Gionet & Roshanafshar. *Select health indicators of First Nations people living off-reserve, Métis and Inuit. Health at a glance. Statistics Canada. 2013.*
Data sources: CANSIM table 105-0512, Canadian Community Health Survey 2007-2010 (Statistics Canada).

Cancer risk factors in Ontario Métis

TOBACCO SMOKING (FIGURE 7)

In Ontario, Métis teens are more than twice as likely to smoke as are non-Aboriginal teens (17 per cent vs. 7.5 per cent, respectively). The same pattern is seen among adults, with Métis adults being significantly more likely to smoke compared to non-Aboriginal adults in Ontario (37 per cent vs. 22 per cent, respectively).

FIGURE 7 **PERCENTAGE OF MÉTIS AND NON-ABORIGINAL TEENS (AGED 12–19) AND ADULTS (AGED 20+) WHO ARE CURRENT SMOKERS, ONTARIO, MALES AND FEMALES COMBINED**

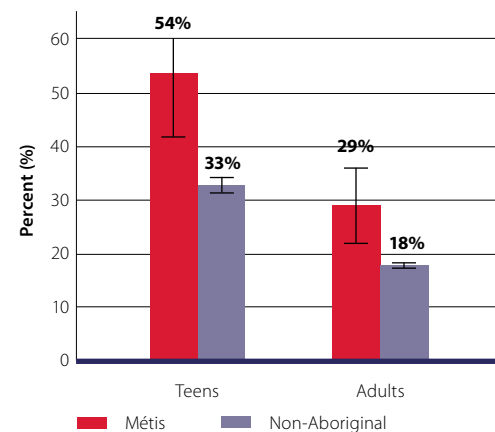


Notes: Métis and non-Aboriginal adult estimates are age-standardized to the 2006 Ontario Aboriginal identity population. Diagonal shading indicates high sampling variability. Interpret with caution. I represent 95% confidence intervals.
Source: Métis Nation of Ontario and Cancer Care Ontario. *Cancer in the Métis people of Ontario: Risk Factors and Screening Behaviours*. Ottawa, 2015.
Data sources: Canadian Community Health Survey, 2007–2012 (Statistics Canada).

SECOND-HAND SMOKING (FIGURE 8)

In Ontario, non-smoking Métis teens and adults are more likely to be exposed to second-hand smoke in the home, car or public places compared to their non-Aboriginal counterparts.

FIGURE 8 **PERCENTAGE OF MÉTIS AND NON-ABORIGINAL TEENS (AGED 12–19) AND ADULTS (AGED 20+) WHO ARE EXPOSED TO SECOND-HAND SMOKE (IN HOME, CAR, OR PUBLIC) IN ONTARIO, MALES AND FEMALES COMBINED**

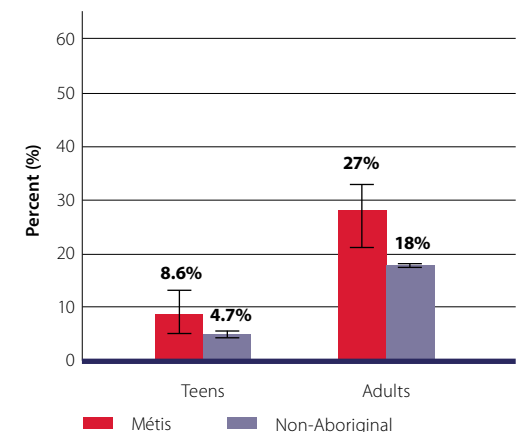


Notes: Métis and non-Aboriginal adult estimates are age-standardized to the 2006 Ontario Aboriginal identity population. I represent 95% confidence intervals.
Source: Métis Nation of Ontario and Cancer Care Ontario. *Cancer in the Métis people of Ontario: Risk Factors and Screening Behaviours*. Ottawa, 2015.
Data sources: Canadian Community Health Survey, 2007–2012 (Statistics Canada).

OBESITY (FIGURE 9)

In Ontario, a greater proportion of Métis teens are obese compared to non-Aboriginal teens. Among adults, Métis people are significantly more likely to be obese compared to non-Aboriginal Ontarians (27 per cent vs. 18 per cent, respectively).

FIGURE 9 **PERCENTAGE OF MÉTIS AND NON-ABORIGINAL TEENS (AGED 12–17) AND ADULTS (AGED 18+) WHO ARE OBESE IN ONTARIO, MALES AND FEMALES COMBINED**



Notes: Métis and non-Aboriginal adult estimates are age-standardized to the 2006 Ontario Aboriginal identity population. I represent 95% confidence intervals.
Source: Métis Nation of Ontario and Cancer Care Ontario. *Cancer in the Métis people of Ontario: Risk Factors and Screening Behaviours*. Ottawa, 2015.
Data sources: Canadian Community Health Survey, 2007–2012 (Statistics Canada).

Cancer screening in Ontario First Nations, Inuit and Métis populations

Cancer screening programs in Ontario

The purpose of cancer screening is to prevent cancer or improve outcomes by identifying pre-cancer or cancer at an early stage when it is easier to treat. In Ontario, routine screening is recommended for colorectal, breast and cervical cancers.^{11–14}

ColonCancerCheck—Ontario’s colorectal cancer screening program—recommends that Ontarians aged 50 to 74 without a family history of colorectal cancer (average risk) screen for the disease with an at-home test, the fecal occult blood test (FOBT), once every two years. A colonoscopy is recommended for those at increased risk due to a family history of colorectal cancer, starting at age 50, or 10 years before the age at which their relative was diagnosed, whichever occurs first.

The Ontario Breast Screening Program recommends that women aged 50 to 74 years who are at average risk for breast cancer have a screening mammogram every two years; the program also recommends that

women aged 30 to 69 years who are at high risk for breast cancer get screened annually with mammography and breast magnetic resonance imaging (MRI).

The Ontario Cervical Screening Program recommends cervical screening for women aged 21 to 69 every three years if they are or have ever been sexually active.

Cancer screening in Ontario First Nations (FIGURE 10)

COLORECTAL CANCER SCREENING

Forty-two per cent of First Nations (off-reserve) adults are overdue for (or need) colorectal cancer screening. This is similar to non-Aboriginal adults (46 per cent). (A lower per cent indicates that fewer people are in need of a screening test.)

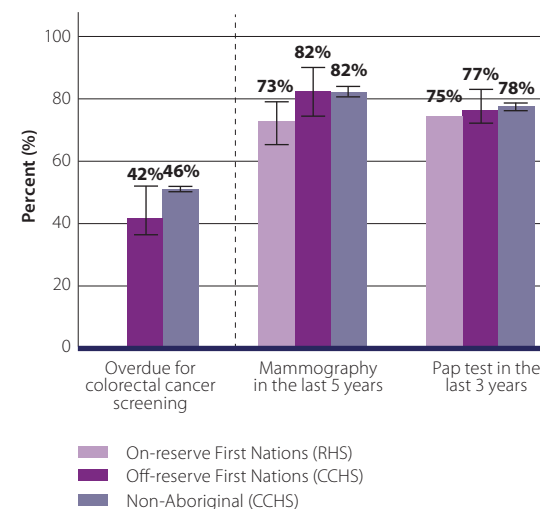
BREAST CANCER SCREENING

First Nations on-reserve women are significantly less likely to report having had a mammogram in the last five years compared to non-Aboriginal Ontarians (73 per cent vs. 82 per cent, respectively). Off-reserve First Nations women and non-Aboriginal women report the same uptake of mammography in the last five years. (Data constraints required reporting screening during the past five years rather than the recommended screening interval of two years.)

CERVICAL CANCER SCREENING

First Nations women (on- and off-reserve) are similarly likely to report having had a Pap test within the last three years compared to non-Aboriginal women (nearly 80 per cent).

FIGURE 10 PERCENTAGE OF FIRST NATIONS AND NON-ABORIGINAL ADULTS OVERDUE FOR COLORECTAL CANCER SCREENING (AGED 50–74), HAD A MAMMOGRAM IN THE LAST 5 YEARS (AGED 50+) AND A PAP TEST IN THE LAST 3 YEARS (AGED 18+), ONTARIO



Notes: First Nations (off-reserve) and non-Aboriginal estimates are age-standardized to the 2006 Ontario Aboriginal identity population. Mammography indicator represents women aged 50–74 in the CCHS and women aged 50+ in the RHS. Pap test indicator represents women aged 21–69 in the CCHS and women aged 18+ in the RHS. I represent 95% confidence intervals.

Source: Aboriginal Cancer Control Unit. 2015 (unpublished CCHS data); *Chiefs of Ontario (COO). First Nations Regional Health Survey (RHS) 2008/10: Ontario Region report on adults, youth and children living in First Nations communities. Toronto: COO. 2012 (RHS data).*

Data sources: Canadian Community Health Survey. 2007–2012 (Statistics Canada); First Nations Regional Health Survey (RHS), 2008/10.

Cancer screening in Ontario Inuit

COLORECTAL CANCER SCREENING (FIGURE 11)

There are no known data on colorectal cancer screening rates among Ontario's Inuit population. However, in geographic regions of Canada with a higher proportion of Inuit (Labrador-Grenfell Regional Integrated Health Authority, Northwest Territories and Nunavut) more adults aged 50 and older were overdue for colorectal cancer screening (i.e., needed a screening test) in 2008 compared to the national (Canada-wide) average.¹⁵

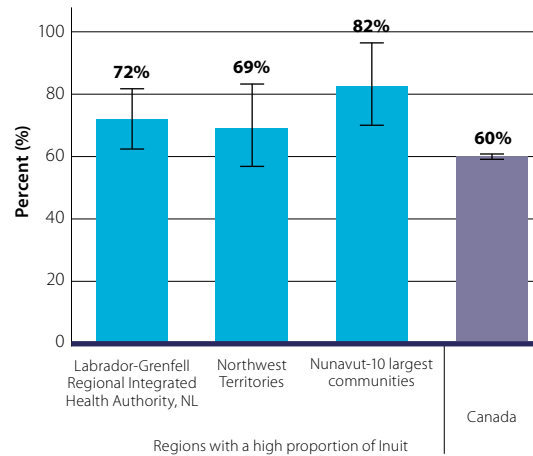
BREAST CANCER SCREENING (FIGURE 12)

Inuit women aged 50 to 65 living in Northern Canada are significantly less likely to have received a mammogram within the last two years than non-Aboriginal women in Northern Canada.¹⁶

CERVICAL CANCER SCREENING (FIGURE 12)

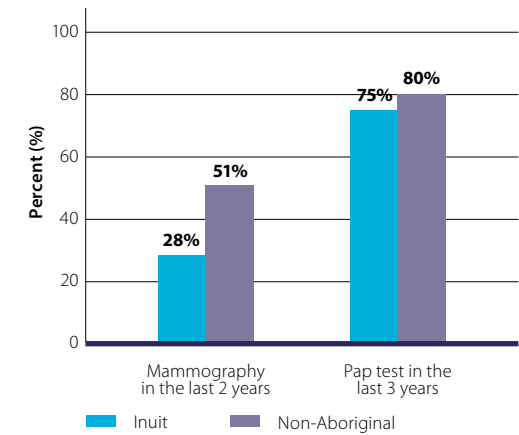
At least three-quarters (75 per cent) of Inuit and non-Aboriginal women aged 21 to 65 in Northern Canada have had a Pap test within the last three years.¹⁶ Inuit women, however, are significantly less likely to have had a Pap test compared to non-Aboriginal women (75 per cent vs. 80 per cent, respectively).

FIGURE 11 **PERCENTAGE OF ADULTS (AGED 50+) OVERDUE FOR COLORECTAL CANCER SCREENING, MALES AND FEMALES COMBINED, CANADA**



┆ represent 95% confidence intervals.
Data sources: CANSIM table 105-0541, Canadian Community Health Survey, 2008 (Statistics Canada).

FIGURE 12 **PERCENTAGE OF INUIT AND NON-ABORIGINAL WOMEN WHO HAD A MAMMOGRAM IN THE LAST 2 YEARS (AGED 50-65) AND A PAP TEST IN THE LAST 3 YEARS (AGED 21-65), NORTHERN CANADA**



Notes: Northern Canada includes Nunavut, Northwest Territories and the northern regions of Newfoundland and Labrador, Saskatchewan, Manitoba, and Quebec (excluding Nunavik and Jamésie).
Source: McDonald & Trenholm. *Cancer-Related Health Behaviours And Health Service Use Among Inuit And Other Residents Of Canada's North. Social Science & Medicine. 2010.*
Data sources: Canadian Community Health Survey, 2000-2001 and 2004-2005 (Statistics Canada).

Cancer screening in Ontario Métis (FIGURE 13)

COLORECTAL CANCER SCREENING

Fifty per cent of Métis adults aged 50 to 74 are overdue for colorectal cancer screening compared to approximately 46 per cent of non-Aboriginal Ontarians (a lower per cent indicates that fewer people are in need of a screening test).

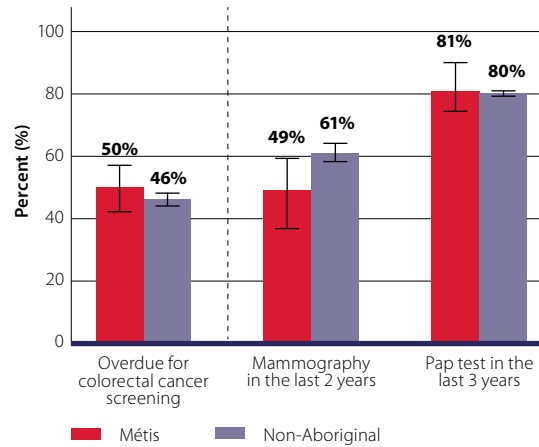
BREAST CANCER SCREENING

Only 49 per cent of Métis women aged 50 to 74 years have had a mammogram in the last two years compared to 61 per cent of non-Aboriginal women. Although this difference is large, it is not statistically significant.

CERVICAL CANCER SCREENING

Most Métis women (81 per cent) have had a Pap test in the last three years. There is no difference in Pap test uptake between Métis and non-Aboriginal women.

FIGURE 13 PERCENTAGE OF MÉTIS AND NON-ABORIGINAL ADULTS OVERDUE FOR COLORECTAL CANCER SCREENING (AGED 50–74), HAD A MAMMOGRAM IN THE LAST 2 YEARS (AGED 50–74) AND A PAP TEST IN THE LAST 3 YEARS (AGED 21–69), ONTARIO



Notes: Age-standardized to the 2006 Ontario Aboriginal identity population. I represent 95% confidence intervals.
Source: Métis Nation of Ontario and Cancer Care Ontario. *Cancer in the Métis people of Ontario: Risk Factors and Screening Behaviours*. Ottawa, 2015.
Data sources: Canadian Community Health Survey, 2007-2012 (Statistics Canada)



Métis Nation of Ontario President Gary Lipinski providing opening remarks at the Métis Nation of Ontario – Cancer Care Ontario Memorandum of Understanding Signing Event, Toronto, February 2015

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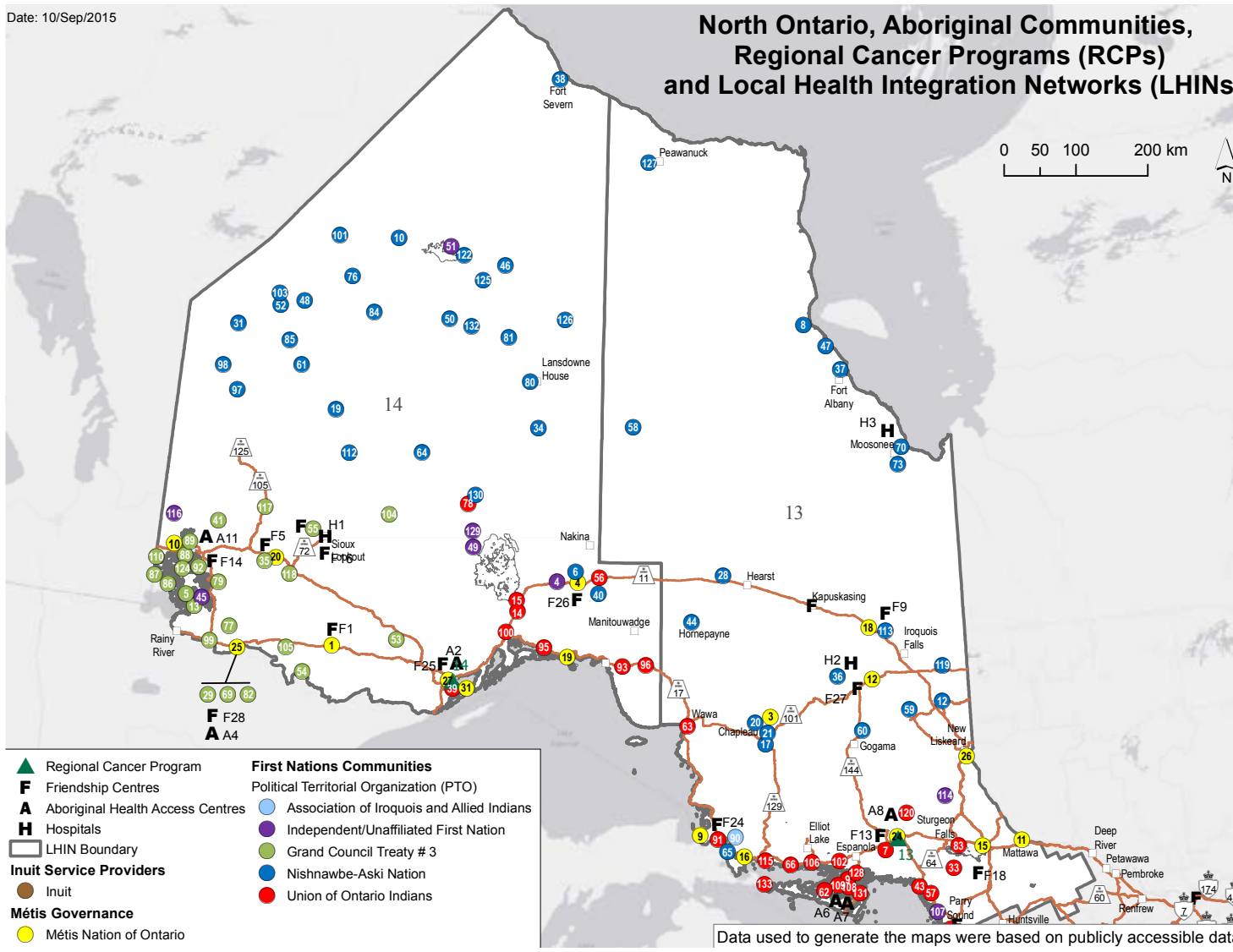
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The people

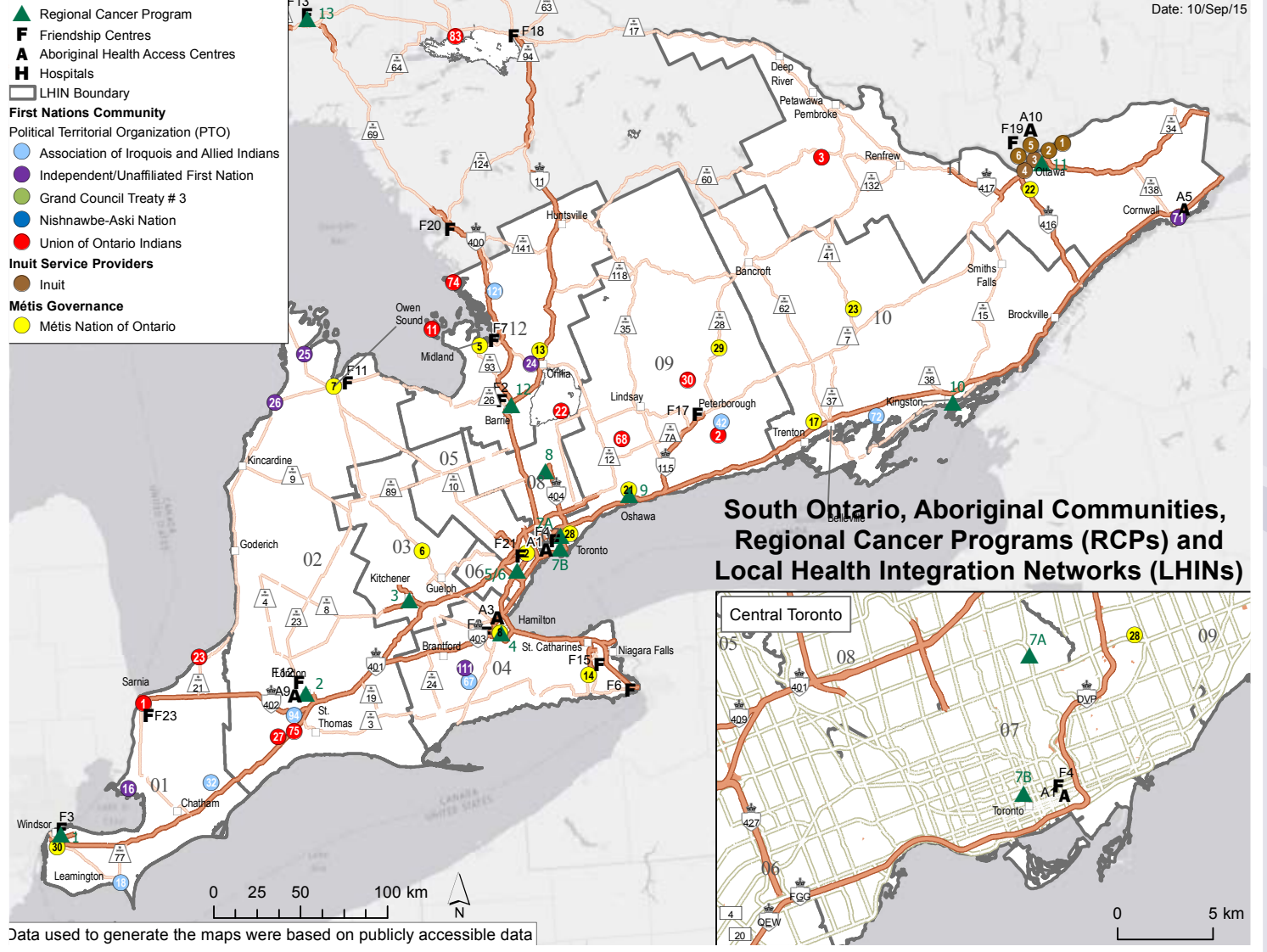
Mapping our support network

Date: 10/Sep/2015

North Ontario, Aboriginal Communities, Regional Cancer Programs (RCPs) and Local Health Integration Networks (LHINs)



Data used to generate the maps were based on publicly accessible data



The people

Mapping Aboriginal Ontario

First Nation Community Index

1. Aamjiwnaang First Nation
2. Alderville First Nation
3. Algonquins of Pikwàkanagàn First Nation
4. Animbiigoo Zaagi'igan Anishinaabek
5. Anishinaabeg of Naongashiing (Big Island)
6. Aroland First Nation
7. Atikameksheng Anishnawbek (Whitefish Lake)
8. Attawapiskat First Nation
9. Aundeck Omni Kaning First Nation
10. Bearskin Lake First Nation
11. Beausoleil First Nation
12. Beaverhouse First Nation
13. Big Grassy First Nation
14. Biinjitiwaabik Zaaging Anishinaabek First Nation
15. Bingwi Neyaashi Anishinaabek (Sand Point)
16. Bkejwanong Territory (Walpole Island)
17. Brunswick House First Nation
18. Caldwell First Nation
19. Cat Lake First Nation
20. Chappleau Cree First Nation
21. Chappleau Ojibwe First Nation
22. Chippewas of Georgina Island
23. Chippewas of Kettle & Stony Point
24. Chippewas of Rama
25. Chippewas of Nawash Unceded (Cape Croker)
26. Chippewas of Saugeen
27. Chippewas of the Thames
28. Constance Lake First Nation Mattawa
29. Couchiching First Nation
30. Curve Lake First Nation
31. Deer Lake First Nation
32. Delaware Nation
33. Dokis First Nation
34. Eabametoong First Nation
35. Eagle Lake First Nation
36. Flying Post First Nation
37. Fort Albany First Nation
38. Fort Severn First Nation
39. Fort William First Nation
40. Ginoogaming First Nation
41. Grassy Narrows First Nation/
Asubspeeschoseewagong Netum Anishnabek
42. Hiawatha First Nation
43. Henvey Inlet First Nation
44. Hornepayne First Nation
45. Iskatewizaagegan No. 39 Independent First Nation
46. Kasabonika Lake First Nation
47. Kashechewan First Nation
48. Keewaywin First Nation
49. Kiashe Zaaging Anishinaabek First Nation Gull Bay
50. Kingfisher Lake First Nation
51. Kitchenuhmaykoosib Inninuweg (Big Trout Lake)
52. Koocheching First Nation
53. Lac Des Mille Lacs First Nation
54. Lac La Croix First Nation
55. Lac Seul First Nation
56. Long Lake #58 First Nation
57. Magnetawan First Nation
58. Marten Falls First Nation
59. Matachewan First Nation
60. Mattagami First Nation
61. McDowell Lake First Nation
62. M'Chigeeng First Nation
63. Michipicoten First Nation
64. Mishkeegogamang First Nation
65. Missanabie Cree First Nation
66. Mississauga #8 First Nation
67. Mississaugas of the New Credit First Nation
68. Mississaugas of Scugog Island
69. Mitaanjigamiing (Stanjikoming) First Nation
70. Mocrebec Council of the Cree Nation
71. Mohawks of Akwesasne
72. Mohawks of the Bay of Quinte
73. Moose Cree First Nation
74. Moose Deer Point First Nation
75. Munsee-Delaware Nation
76. Muskrat Dam First Nation
77. Naicatchewenin First Nation
78. Namaygoosisagun First Nation
79. Naotkamegwanning Anishinabe First Nation
80. Neskantaga First Nation
81. Nibinamik First Nation
82. Nigigoonsiminikaaning First Nation
83. Nipissing First Nation
84. North Caribou Lake First Nation
85. North Spirit Lake First Nation
86. Northwest Angle No. 33 First Nation
87. Northwest Angle No. 37 First Nation
88. Obashkaandagaang (Washagamis Bay)
89. Ochiichagwe' Babigo'ining Nation
90. Ojibways of Batchewana (Rankin)
91. Ojibways of Garden River
92. Ojibways of Onigaming (Sabaskong)
93. Ojibways of Pic River (Heron Bay)
94. Oneida Nation of the Thames
95. Pays Plat First Nation
96. Pic Moberg First Nation
97. Pikangikum First Nation
98. Poplar Hill First Nation
99. Rainy River First Nation
100. Red Rock First Nation
101. Sachigo Lake First Nation
102. Sagamok Anishnawbek First Nation
103. Sandy Lake First Nation
104. Saugeen First Nation
105. Seine River First Nation
106. Serpent River First Nation
107. Shawanaga First Nation
108. Sheguiandah First Nation
109. Sheshegwaning First Nation
110. Shoal Lake No. 40 First Nation
111. Six Nations of the Grand River Territory
112. Slate Falls First Nation
113. Taykwa Tagamou (New Post)
114. Temagami First Nation
115. Thessalon First Nation
116. Wabaseemoong First Nation
117. Wabauskang First Nation
118. Wabigoon First Nation
119. Wahgoshig First Nation
120. Wahnapiatae First Nation

121. Wahta Mohawks (Mohawks of Gibson)
122. Wapekeka First Nation
123. Wasauksing First Nation
124. Wauzhushk Onigum First Nation
125. Wawakapewin First Nation
126. Webequie First Nation
127. Weenusk First Nation
128. Whitefish River First Nation
129. Whitesand First Nation
130. Whitewater Lake First Nation
131. Wikwemikong Unceded Indian Reserve
132. Wunnumin Lake First Nation
133. Zhiibaahaasing First Nation

Métis Nation of Ontario Index

1. Atikokan & Surrounding Area Interim Métis Council
2. Credit River Métis Council
3. Chapleau Métis Council
4. Geraldton & Area Métis Council
5. Georgian Bay Métis Council
6. Grand River Community Métis Council
7. Great Lakes Métis Council
8. Hamilton/Wentworth Métis Council
9. Historic Sault Ste Marie Métis Council
10. Kenora Métis Council
11. Mattawa Métis Council
12. Métis Nation of Ontario Timmins
13. Moon River Métis Council
14. Niagara Region Métis Council
15. North Bay Métis Council
16. North Channel Métis Council
17. Northumberland Métis Council
18. Northern Lights Métis Council
19. North Shore Métis Council
20. Northwest Métis Nation of Ontario Council
21. Oshawa & Durham Region Métis Council
22. Ottawa Regional Métis Council
23. Seven Rivers Métis Council
24. Sudbury Métis Council
25. Sunset County Métis Council
26. Temiskaming Métis Council
27. Thunder Bay Métis Council
28. Toronto Métis Council
29. Wapiti Interim Métis Council
30. Windsor Essex Métis Council
31. Red Sky Métis Independent Nation

Inuit Community Index

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2. Inuit Family Resource & Health Promotion Centre
3. Inuit Tapiriit Kanatami
4. Ottawa Health Services Network Inc.
5. Pauktuutit
6. Tungasuvvingat Inuit

Regional Cancer Programs

1. Erie St. Clair RCP
2. South West RCP
3. Waterloo Wellington RCP
4. Hamilton Niagara Haldimand Brant RCP
- 5./6. Mississauga Halton & Central West RCP
- 7A. Toronto Central RCP
- 7B. Toronto Central RCP
8. Central RCP
9. Central East RCP
10. South East RCP
11. Champlain RCP
12. North Simcoe Muskoka RCP
13. Northeast Cancer Centre
14. North West RCP

Hospitals

- H1. Sioux Lookout Meno Ya Win Health Centre
- H2. Misiway Milopemahtesewin Community Health Centre
- H3. Weeneebayko Hospital Ontario

Friendship Centres

- F1. Atikokan Native Friendship Centre
- F2. Barrie Native Friendship Centre
- F3. CanAm Indian Friendship Centre of Windsor
- F4. Council Fire Native Cultural Centre Inc
- F5. Dryden Native Friendship Centre
- F6. Fort Erie Indian Friendship Centre
- F7. Georgian Bay Native Friendship Centre
- F8. Hamilton Regional Indian Centre
- F9. Ininev Friendship Centre, Cochrane, ON
- F10. Kapuskasing Friendship Centre
- F11. M'Wikwedong Native Cultural Resource Centre
- F12. NAmerind Friendship Centre, London, ON
- F13. N'Swakamok Friendship Centre
- F14. NeChee Friendship Centre
- F15. Niagara Regional Native Centre
- F16. Nishnawbe-Gamik Friendship Centre
- F17. Nogojiwanong Friendship Centre

- F18. North Bay Indian Friendship Centre
- F19. Odawa Native Friendship Centre
- F20. Parry Sound Friendship Centre, Parry Sound, ON
- F21. Peel Aboriginal Network
- F22. Red Lake Friendship Centre
- F23. Sarnia-Lambton Friendship Centre, Sarnia, ON
- F24. Sault Ste Marie Indian Friendship Centre
- F25. Thunder Bay Indian Friendship Centre
- F26. Thunderbird Friendship Centre
- F27. Timmins Native Friendship Centre
- F28. United Native Friendship Centre

Aboriginal Health Access Centres

- A1. Anishnawbe Health Centre
- A2. Anishnawbe-Mushkiki AHAC
- A3. De dwa da dehs nye AHAC
- A4. Gizhewaadiziwin Access Centre
- A5. Kanonkwa'tesheio:io
- A6. N'Mninoeyaa: Community Health Access
- A7. Noojmowin Teg Health Access Centre
- A8. Shkagamik-Kwe Health Centre
- A9. Southwest Ontario AHAC
- A10. Wabano Centre for Aboriginal Health
- A11. Waasegiizhig nanaandawe'iyewigamig

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Aboriginal Cancer Control Unit

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Eva D'souza, Analyst, Documentation and Information
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Richard Steiner, Partnership Liaison Officer

Caitlin Mills, Partnership Liaison Officer

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Diana Withrow, Research Associate

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Sundus Haji-Jama, Student

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Jeffrey Werner, Tobacco-Wise Lead (North)

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Shannon Lawler, Senior Communication Strategist
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David Duncan, Group Manager, Strategy and Planning
Geoff McKay, Senior Analyst, Strategy and Planning

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Jenny Lass, Senior Specialist, Medical Editor
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Sara Urowitz, Group Manager, Palliative Care
Rebecca Anas, Director, Cancer Quality Council of Ontario and Clinical Council Secretariat

Chief Technology Officer: Technology Services

Richard Smith, Director, Product Management and Cancer Services

General Counsel, Chief Privacy Officer – Corporate Secretary

Erica Zarkovich, General Counsel, Chief Privacy Officer and Corporate Secretary
Alwin Kong, Assistant General Counsel and Director, Legal & Privacy office
Steven Lewis, Legal Counsel, Legal & Privacy office

Ontario Renal Network

Rebecca Harvey, Vice President
Graham Woodward, Director, Clinical Programs
Marnie MacKinnon, Director, Integrated Care
Marc Hébert, Planning Analyst

Provincial Leadership Committee

Monica Staley, Regional Vice President, Erie St. Clair Regional Cancer Program (Windsor Regional Hospital), Windsor, Ontario
Neil Johnson, Regional Vice President, South West Regional Cancer Program (London Health Sciences Centre), London, Ontario
Judy Linton, Regional Vice President, Waterloo Wellington Regional Cancer Program (Grand River Hospital), Kitchener, Ontario
Dr. Ralph Meyer, Regional Vice President, Hamilton Niagara Haldimand Brant Regional Cancer Program (Juravinski Cancer Centre), Hamilton, Ontario
Dr. Craig McFadyen, Regional Vice President, Mississauga Halton Central West Regional Cancer Program, (Carlo Fidani Peel Regional Cancer Centre), Mississauga, Ontario
Dr. Calvin Law, Regional Vice President, Toronto Central Regional Cancer Program (Odette Cancer Centre), Toronto, Ontario
Dr. Mary Gospodarowicz, Regional Vice President, Toronto Central Regional Cancer Program (Princess Margaret Hospital), Toronto, Ontario

David Fell, Regional Vice President, Central Regional Cancer Program (Southlake Regional Health Centre), Newmarket, Ontario

Tom McHugh, Regional Vice President, Central East Regional Cancer Program (RS McLaughlin Durham Regional Cancer Centre), Oshawa, Ontario

Brenda Carter, Regional Vice President, South East Regional Cancer Program (Cancer Centre of Southeastern Ontario), Kingston, Ontario

Paula Doering, Regional Vice President, Champlain Regional Cancer Program (Ottawa Hospital Regional Cancer Centre), Ottawa, Ontario

Lindsey Crawford, Regional Vice President, North Simcoe Muskoka Regional Cancer Program (Royal Victoria Regional Health Centre), Barrie, Ontario

Mark Hartman, Regional Vice President, North East Regional Cancer Program (Health Sciences North), Sudbury, Ontario

Dr. Mark Henderson, Regional Vice President, Northwest Regional Cancer Program (Thunder Bay Regional Health Sciences Centre), Thunder Bay, Ontario

Traditional Knowledge Keeper

Clayton Shirt, Traditional Knowledge Keeper

Other Partners

Corin Greenberg, Chief Executive Officer, Pediatric Oncology Group of Ontario
Dr. Mark Greenberg, Senior Adviser, Policy and Clinical Affairs, Pediatric Oncology Group of Ontario
Henneke Cats, President, Bridge Consulting Group Inc.
Kirk Nylen, President and Founding Director, ReachUp Ultimate

Regional Aboriginal Cancer Leads

Cancer Care Ontario's Regional Aboriginal Cancer Leads are employed one-day per week to champion the Aboriginal Cancer Strategy III's strategic vision and goals in collaboration with the Regional Cancer Programs in Ontario. They help to identify and respond to systemic issues relevant to First Nations, Inuit and Métis cancer needs, and ensure First

Nations, Inuit and Métis perspectives are included within Regional Cancer Program strategic planning and program design.

Please contact the following email address for any inquiries for the Regional Aboriginal Cancer Leads: accu@cancercare.on.ca

Dr. Shannon Wesley

Regional Aboriginal Cancer Lead,
Northwest Regional Cancer Program

"The Northwest Regional Cancer Program Team has started to build strong relationships with FNIM Health Tables, thanks to the engagement and groundwork of the Aboriginal Cancer Control Unit. This process is allowing FNIM people to guide and inform the work of the Northwest Regional Cancer Program on an ongoing basis, which is our ultimate goal."



Dr. Shannon Wesley
Northwest



Dr. Annelind Wakejigig
Northeast



Dr. Mark Tomen
Erie St. Clair



Dr. Mike Vreugdenhil
South West



Recruitment Underway
North Simcoe Muskoka



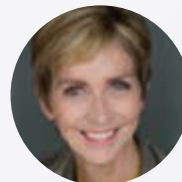
Dr. Jason Pennington
Central East



Dr. Hugh Langley
South East



Dr. Treena Greene
Champlain



Dr. Andrea East
*Hamilton Niagara
Haldimand Brant*



Dr. Bernice Downey
Toronto Central

Aboriginal Navigators

Navigating the cancer system is a significant challenge for patients who are unfamiliar with medical systems, don't speak English or French and/or must travel from home for treatment and care. Cancer Care Ontario's Aboriginal Navigators provide support and advocacy for First Nations, Inuit and

Métis patients and families by facilitating and coordinating access to cancer services for palliative and supportive care, addressing cultural and spiritual needs, and networking with Aboriginal and non-Aboriginal partners to make the cancer journey a culturally safe experience.



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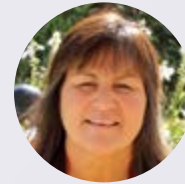
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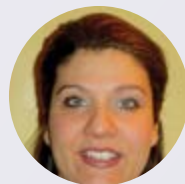
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Tony Jocko

Health Policy Analyst,
Union of Ontario Indians; JOACC Member

“The cancer journey experience has been much improved for our people through the hiring of the Primary Care Leads and on-site Aboriginal Navigators in the ten regional cancer programs. These strategic developments serve to underline the true value in the continuance of building solid relationships with our First Nations. The formation of strong alliances has been a founding principle of our survival and growth in First Nations throughout history, dating prior to western contact.”





integrity



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