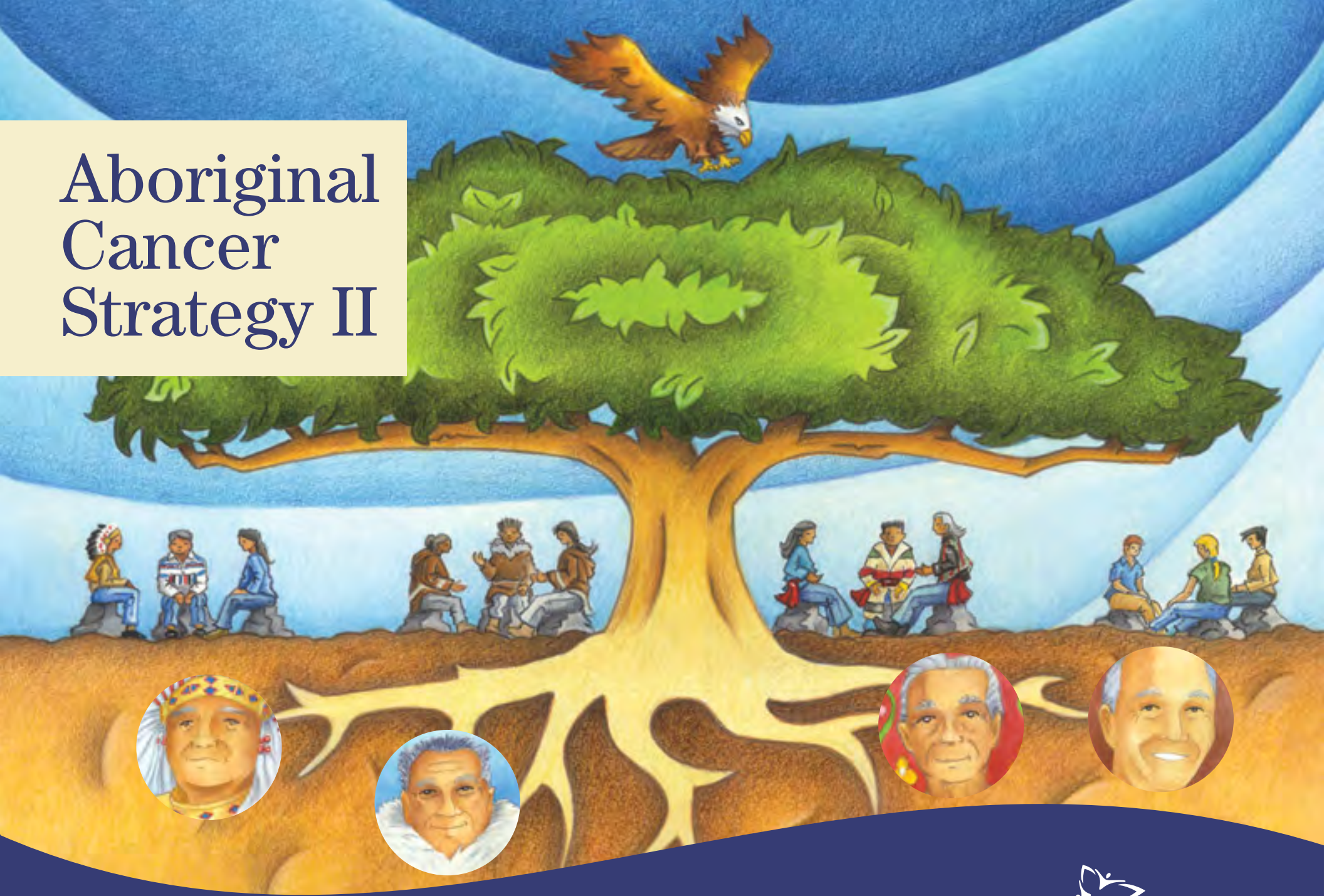


# Aboriginal Cancer Strategy II



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#### Cancer Care Ontario

620 University Avenue, Toronto, Ontario M5G 2L7

Telephone: 416.971.9800

[www.cancercare.on.ca](http://www.cancercare.on.ca)





## Tree of Peace

Long ago, in the days when the tribes were warring against each other, a great Chief came along and said, “Bring your weapons of war. We will dig a big pit and throw them all in there and bury them.

“In the place where we bury these weapons, we will plant a tree of peace. Then we will bring soft things to sit on beneath the tree and take counsel with one another.

“Above the tree will fly the eagle, bringing messages from the creator down to the people sitting below. When these people sitting below take counsel, the roots of the tree will send messages out to the tribes about the green tree of peace.”

Barney Batise, Elder

The Tree of Peace parable symbolizes the coming together of our three peoples to take the first step on the path of healing. The fourth group under the Tree of Peace represents Cancer Care Ontario (CCO), the Regional Cancer Programs and non-Aboriginal partners.

First Nations, Inuit and Métis are engaged in the Aboriginal Cancer Strategy II (ACS II) through their mutual need to address the serious issue of cancer and its impact on their people. The ACS II exists only because the three peoples have come together with CCO. Through it, we will work to address cancer issues, creating unique and diverse solutions for healing and health.



# Acknowledgements

## Dedication

This publication is dedicated to the First Nations, Inuit and Métis peoples for whom it is written and whose involvement was essential to its creation.

## Acknowledgements

Cancer Care Ontario thanks the leadership of Ontario's First Nations, Inuit and Métis peoples for their support which is essential to the work of the Aboriginal Cancer Control Unit and its programs. We look forward to working with you to meet our strategic objectives.

*(Note: Subsequent to this report being written, several elections were held. The Grand Chief of AIAI is now Gord Peters, and the Grand Chief of Grand Council Treaty #3 is now Warren White.)*

**Grand Council Chief Patrick Madahbee**, Union of Ontario Indians

**Grand Chief Stan Beardy**, Nishnawbe Aski Nation

**Grand Chief Denise Stonefish**, Association of Iroquois and Allied Indians

**Ogichidaakwe Diane Kelly**, Grand Council Treaty #3

**Chief Karen Loran**, Mohawk Nation of Akwesasne (Independent First Nations)

**Gary Lipinski**, President, Métis Nation of Ontario

**Connie Siedule**, Executive Director Tungasuvvingat Inuit Family Health Centre

## Provincial Aboriginal Organizations

**Sylvia Maracle**, Executive Director Ontario Federation of Indian Friendship Centres

**Betty Kennedy**, Executive Director Ontario Native Women's Association

## Joint Ontario Aboriginal Cancer Committee

**Tony Jocko**, Health Policy Analyst, Union of Ontario Indians, North Bay, Ontario

**Julia Hill**, Health Policy Analyst, Association of Iroquois & Allied Indians, London, Ontario

**David Pierce**, Health Policy Analyst, Nishnawbe Aski Nation, Thunder Bay, Ontario

**Harmony Rice**, Healthy Policy Analyst, Grand Council Treaty 3, Kenora, Ontario

**Lyndia Jones**, Health Policy Analyst, Independent First Nations, Nobel, Ontario

**Connie Siedule**, Director of Health, Tungasuvvingat Inuit, Ottawa, Ontario

**Shelley Gonneville**, Manager, Child & Family Initiatives, Métis Nation of Ontario, Ottawa, Ontario

**Agnes Bachmann**, Health Policy Analyst, Ontario Native Women's Association, Dryden, Ontario

**Marilyn Morley**, Health Policy Analyst, Ontario Federation of Indian Friendship Centres, Toronto, Ontario

**Carmen Blais**, Aboriginal Health Promotion Planner, Thunder Bay Health Sciences, Thunder Bay, Ontario

**Dr. Amanda Hey**, Medical Advisor, Sudbury Regional Hospital, Sudbury, Ontario

**Lynda MacNiven**, Senior Coordinator, Canadian Cancer Society, Toronto, Ontario

**Salima Allibhai-Hussein**, Canadian Cancer Society, Ontario Division, Toronto

## Cancer Care Ontario

**Michael Sherar**, President and CEO

**Dr. Linda Rabeneck**, Vice President, Prevention and Cancer Control

### Aboriginal Cancer Control

**Alethea Kewayosh**, Director

**Usman Aslam**, Aboriginal Cancer Control, Prevention and Cancer Control

**Eva D'souza**, Aboriginal Cancer Control, Prevention and Cancer Control

**Ernest Matton**, Former Staff, Aboriginal Cancer Control, Prevention and Cancer Control

### Communications

**Paula Knight**, Vice President

**Deanna Blair**, Director Public Affairs

**Stephanie Ryan-Coe**, Senior Communications Strategist, Prevention and Cancer Control

**Suriya Veerappan**, Public Affairs Advisor, Prevention and Cancer Control

**Richha Arora**, Corporate Events & Internal Communications Advisor

### Provincial Leadership Committee

**Claudia Den Boer Grima**, Regional Vice President, Windsor Regional Cancer Program, Windsor, Ontario

**Neil Johnson**, Regional Vice President, London Regional Cancer Program, London, Ontario

**Dr. Craig McFadyen**, Regional Vice President, Grand River Regional Cancer Centre, Kitchener, Ontario

**Dr. Bill Evans**, Regional Vice President, Juravinski Cancer Centre, Hamilton, Ontario

**Dr. Sheldon Fine**, Regional Vice President, Carlo Fidani Peel Regional Cancer Centre, Mississauga, Ontario

**Dr. Andy Smith**, Regional Vice President, Odette Cancer Centre, Toronto, Ontario

**Dr. Mary Gospodarowicz**, Regional Vice President, Princess Margaret Hospital, Toronto, Ontario

**Dr. Louis Balogh**, Regional Vice President, Stronach Regional Cancer Centre at Southlake Regional Health Centre, Newmarket, Ontario

**Tom McHugh**, Regional Vice President, RS McLaughlin Durham Regional Cancer Centre, Oshawa, Ontario

**Brenda Carter**, Regional Vice President, Cancer Centre of Southeastern Ontario, Kingston, Ontario

**Paula Doering**, Regional Vice President, Ottawa Hospital Regional Cancer Centre, Ottawa, Ontario

**Lindsey Crawford**, Regional Vice President, North Simcoe Muskoka Regional Cancer Centre, Barrie, Ontario

**Mark Hartman**, Regional Vice President, Northeast Cancer Centre/Health Sciences North, Sudbury, Ontario

**Scott Potts**, Interim Regional Vice President, Thunder Bay Regional Health Sciences Centre Regional Cancer Care, Thunder Bay, Ontario

### FNIM Health Committees/Teams/Boards

Association of Iroquois and Allied Indians; Grand Council Treaty #3; Nishnawbe Aski Nation; Union of Ontario Indians; Independent First Nations; Tungasuvvingat Inuit; Métis Nation of Ontario; Ontario Federation of Indian Friendship Centres; Ontario Native Women's Association

### Province of Ontario

Ministry of Health and Long Term-Care

### Advisors and Contributors

#### Advisors

**Kirk Nylen**, Ontario Brain Institute

**Henneke Cats**, President, Bridge Consulting Group Inc.

#### Risk Factor Data and Analysis

**Loraine Marrett**, Director, Surveillance, Prevention and Cancer Control, Cancer Care Ontario

**Diana Withrow**, Research Associate, Prevention and Cancer Control, Cancer Care Ontario

**Lindsay Stewart**, Research Associate, Prevention and Cancer Control, Cancer Care Ontario

#### Planning and Regional Programs

**Judy Burns**, A/Vice President Planning and Regional Programs

#### Elders

**Barney Batise**, Elder, Matachewan First Nation

**Susanne Singoorie**, Inuit Elder (Interpreter: Dennis Nakoolak)

**Roland St. Germain**, Métis Elder

#### Health Care Experts

**Dr. Annelind Wakegijig**, Wikwemikong

**Dr. Janet K. Smylie**, Research Scientist, St. Michael's Hospital

**Dr. Indu Bala Gambhir**, Ottawa

**Janine King**, Nurse Practitioner, Chigamik Community Health Centre in Midland, Ontario

**Lana Ray**, Director of Policy and Research, Ontario Native Women's Association

#### Cancer Survivors

**Michele A. Charlebois**

**Donna Day**, Bkejwanong First Nation

**Wilson Plain Sr.**, Aamjiwnaang First Nation

#### Event Management

**Tuesday Johnson-MacDonald**, President, TAP Resources

#### Creative

Writer: **Chris Mercer**, President, Adhawk Communications Inc.

Maps: **Todd Norwood**, Manager, Geospatial Analysis, Cancer Care Ontario

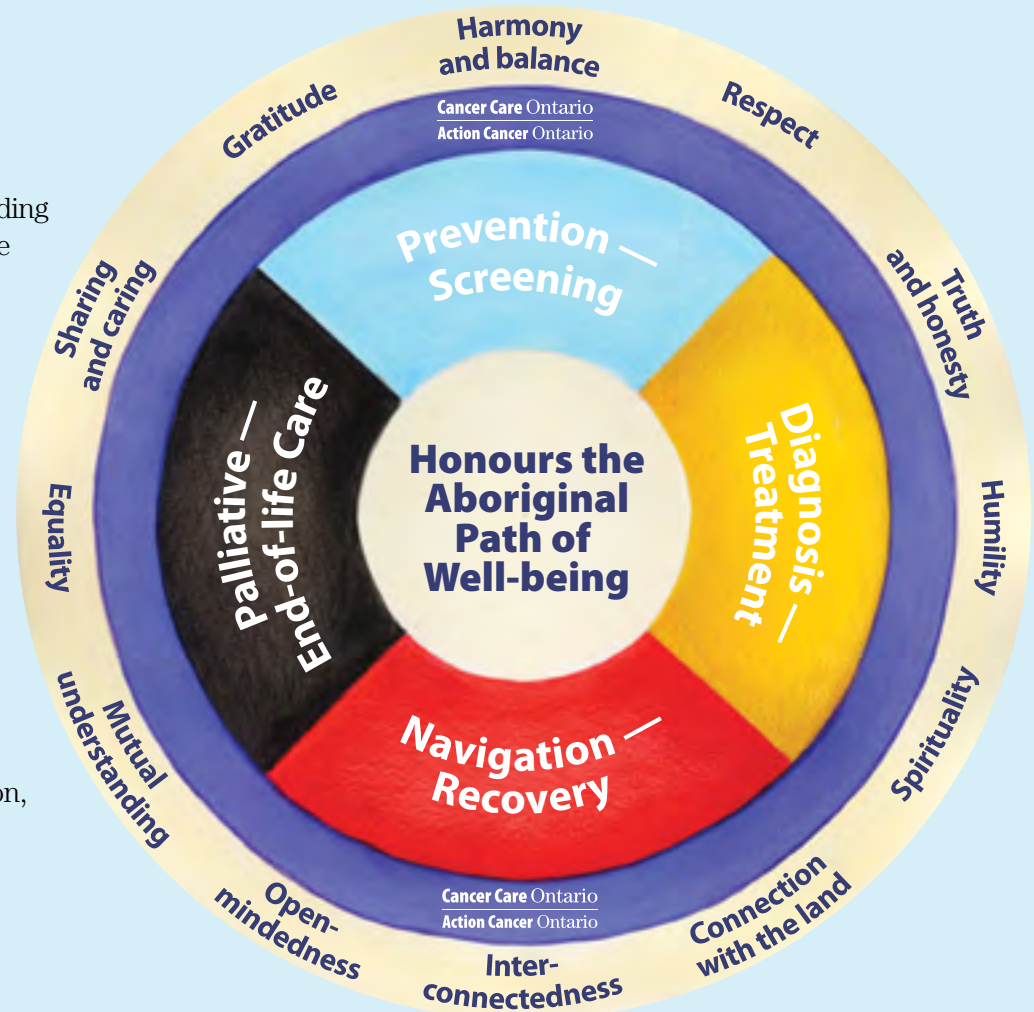
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**Cancer Care Ontario** is responsible for providing cancer services to Aboriginal peoples. We work to reduce the number of people diagnosed with cancer, and make sure patients receive better care every step of the way.

Cancer Care Ontario plans and coordinates cancer services across the province. Our goal is to prevent cancer in the first place by promoting healthy living, and to catch it early through screening and detection services. We are assisted by many health professionals, organizations and groups involved in cancer prevention and care.

Regional Cancer Programs across the province are our most important partners. The regional networks include regional cancer centres and stakeholders, including patient groups, and health care professionals and organizations involved in providing cancer prevention, screening, diagnosis and treatment.



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# Being of One Mind

“We have to have one mind for the Four Directions. Until we reach that one mind, we cannot be filled with understanding.... The Creator will not answer until you have just one mind, just like if you have one person.”

William Commanda, Ojshigkwanàng, Anishinàbe

Approaching cancer with one mind starts by acknowledging that cancer treats everyone the same: First Nations, Inuit, Métis (FNIM) and non-Aboriginals. However, while cancer rates for non-Aboriginals are decreasing, rates for Ontario Aboriginals are increasing. To challenge cancer we need to act with one mind, recognizing that the diversity of FNIM peoples—your unique languages, treaties, culture and political organizations—can also be a unifying force.

This document is a renewal of Cancer Care Ontario's Aboriginal Cancer Strategy—a renewal strengthened by FNIM diversity and intertwined relationships across the province. Ontario's Aboriginal leaders and Cancer Care Ontario (CCO) developed Aboriginal Cancer Strategy II together by sharing knowledge and experience. It is an important step in the Aboriginal path to health and healing.

Every journey begins with understanding, and the journey to health is the same. Only by being balanced in the spiritual, physical, emotional and mental aspects of self can we achieve health and wellness for individuals, families and our community. However, none of us walks alone.

In support of the Cancer Care Ontario Aboriginal Unit and the Aboriginal leadership across Ontario that has contributed to the development of the Aboriginal Cancer Strategy II (ACS II), I pledge my personal commitment. Cancer Care Ontario will work with you to achieve the six strategic priorities for preventing, diagnosing and treating cancer in the First Nations, Inuit and Métis peoples and communities of Ontario.

Our goal: fewer new cancer cases and better, longer lives for people who do get cancer.

ACS II is a component of the broader Ontario Cancer Plan III Strategy. By collaborating with the Regional Cancer Programs, Aboriginal health centres, stakeholder organizations and you, we can make a difference.


*Michael Sherar*

**Michael Sherar**

President and CEO



*Chief and Council with Michael Sherar and group who visited Sandy Lake (May 26, 2011)*



# Building a Better Aboriginal Cancer System

Developing this second Aboriginal Cancer Strategy has been a journey in itself. On the way, I have had the privilege to meet and speak to others on the same path. I am inspired and filled with hope by the wisdom and insight they have offered. However, this report is just a stop on the Aboriginal path of healing.

It is my hope that the Aboriginal Cancer Strategy II will reflect back to FNIM peoples their inherent understanding of this path. We agree that we need to increase our awareness of cancer, and learn how to better manage and prevent cancer. To do that, we will need to work together and make the best use of the resources and services available especially as we consider how best to navigate forward in view of the many unique challenges on the path to achieving FNIM health and well-being. To Cancer Care Ontario (CCO), its many partner organizations and readers, it is my hope this report will help all Ontarians understand both the unique challenges and distinct origins of FNIM peoples, and the need to work as equal partners with FNIM leadership and governance structures.

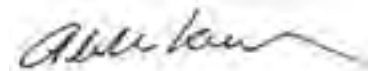
Achieving the priorities presented in ACS II can achieve improved health outcomes and quality of life for FNIM peoples with cancer. However, this can only happen through our collaborative efforts and a mutual vision of how to make the cancer system in Ontario more effective and responsive to the issues and needs of FNIM people.

CCO is committed to achieving that vision. We recognize the crucial importance of ongoing and sustained direct engagement and dialogue with each of the provincial Aboriginal organizations that represent the FNIM.

By maintaining an open and respectful two-way relationship with FNIM groups and peoples, CCO is signalling its sincere commitment to addressing the critical challenges and issues facing FNIM peoples concerning cancer control and prevention.

Every strategic priority outlined in ACS II builds upon the foundation established in the original Aboriginal Cancer Strategy. However, these priorities also recognize important lessons learned. CCO's Aboriginal Cancer Control Unit will audit and report on its progress against measurable outcomes. We will continue to work closely with the FNIM groups to achieve progressive improvement.

We look forward to working with FNIM peoples to meet the challenge of cancer with strength and hope, building a better-performing cancer system and achieving healthier outcomes for FNIM peoples throughout Ontario.



**Alethea Kewayosh**  
Director, Aboriginal Cancer Control

# First Peoples

Ontario is home to a diverse group of First Nations, Inuit and Métis peoples who are often collectively referred to as Aboriginal people. There are more Aboriginal people in Ontario than in any other province in Canada: 242,490 and 2% of the provincial population.<sup>1</sup> Of these, Statistics Canada counted 123,595 registered or Status Indians in 2006, about half of whom lived on-reserve and half off-reserve.

Ontario's Aboriginal population is young and growing. Statistics Canada expects the total number to increase to about 267,700 by 2017.

Many FNIM people live in towns and cities. In fact, Toronto has one of the largest Aboriginal populations in the country. However, 95 of the 133 First Nation communities in Ontario are located in rural or remote areas, or are only accessible by air. Inuit and First Nations people are most likely to move to the city for housing or employment but many subsequently return to their home community.





## First Nations

First Nations peoples are the original owners of this land. Today, there are 133 distinct First Nations in Ontario. These Nations are the Algonquin, Mississauga, Ojibway, Cree, Odawa, Pottowatomi, Delaware and the Haudenosaunee (Mohawk, Onondaga, Onoyota'a:ka, Cayuga, Tuscarora and Seneca) and each of the nations has its own languages and customs. Algonkian (Ojibway, Cree and Oji-Cree) and Iroquoian are the most common Aboriginal languages spoken.

The absolute number of First Nations peoples living on- or off-reserve is not clear. Statistics Canada groups all FNIM together; its estimate of 70% of Aboriginal Canadians living off-reserve includes Inuit and Métis, neither of whom have reserves. Based on the Aboriginal Affairs and Northern Development Canada (AANDC) Indian Registry of Status Indians, some 51% of First Nations people live on-reserve and 49% elsewhere.

## One Mind

### Grand Chief Stan Beardy

“Cancer among First Nations people is on the rise. It needs to be addressed by both levels of government. The federal government needs to focus on early detection of possible cancer in First Nations people in remote settings. The Chiefs need to give a political push to make sure this issue is addressed.”

Nishnawbe Aski Nation

## Political Organizations and Leadership

### Chiefs of Ontario— Regional Chief Angus Toulouse

Established in 1976 by 133 First Nation communities to enable the political leadership to discuss regional, provincial and national priorities affecting First Nation people in Ontario and to provide a unified voice on these issues.

### NishnawbeAski Nation (NAN)— Grand Chief Stan Beardy

Established in 1973 as the regional organization representing the political, social and economic interests of the people of Northern Ontario, NAN represents 49 First Nation communities.



**Union of Ontario Indians—  
Grand Council Chief Patrick Madahbee**

The Anishinabek Nation incorporated the Union of Ontario Indians (UOI) as its secretariat in 1949. The UOI is a political advocate for 42 member First Nations across Ontario.

**Grand Council Treaty #3—  
Grand Chief Diane Kelly**

Grand Council Treaty #3 is the historic government of the Anishinaabe Nation and represents 26 First Nations in Northwestern Ontario and 2 First Nations in Manitoba. Their treaty dates back to 1873.

**Association of Iroquois and Allied Indians—  
Grand Chief Denise Stonefish**

Established in 1969 to represent its 8 member Nations in any negotiation or consultation with any level of government affecting the well-being of the member Nations as a whole.

**Independent First Nations**

These 12 Independent First Nations when necessary work collectively on issues of fundamental concern while respecting each other's autonomy.

**Unaffiliated First Nations**

Some First Nations are not affiliated with any of the organizations listed.



**One Mind**

**Grand Council Chief Patrick Madahbee**

“We need all of our people up and down the chain of command within First Nations, our leadership, frontline workers and everybody, going in the same direction—telling our people how important it is to get checked and how important it is to live a lifestyle that doesn't contribute to the health issues we have in our communities. We need to create a new normal in our communities.”

Union of Ontario Indians



## One Mind

### Grand Chief Diane Kelly

“Cancer is beatable and it is treatable. Our people need to know how to prevent it and be more proactive. A big education and awareness campaign needs to start early right in our schools and through all levels of our communities.”

Grand Council Treaty #3



## One Mind

### Grand Chief Denise Stonefish

“Our First Nations peoples are being diagnosed with cancer too late. We need earlier diagnoses. I see lack of education as a major challenge. We don’t recognize the symptoms, we don’t know until it is too late. Only because we haven’t had the opportunity or we don’t take the opportunity to go to a doctor on a regular basis. It is my belief that the more information an individual has, and the more educated they become; the more able they are to make healthy decisions.”

Association of Iroquois and Allied Indians





## One Mind

### Chief Karen Loran

“Education and awareness, workshops, training, speakers, radio are essential to helping First Nations deal with cancer. Just getting the word out. For the family, what do you do if one of your family members is diagnosed with cancer? How do you prepare yourself and your loved ones for it? What are the resources out there? Is this something that is beatable? This needs to get out to the community.”

Independent First Nations







## Inuit

There are over 2,000 Inuit living in Ontario, mostly in the Ottawa area. Inuit are not native to Ontario and originally came here from far northern territories. Like other Aboriginal populations, the Inuit population in Ontario is young and growing. In 2006, approximately 34% of Ontario Inuit were under the age of 15.

There are many reasons Inuit come to southern cities such as Ottawa. Some come for work, education, housing or for health reasons. There is an acute housing shortage in the Arctic communities; ironically, in some cases, Inuit who move to Ottawa end up being homeless there.

Statistically, Inuit tend to fall between First Nations and Métis in education, employment and income. For example, the average annual personal income of Inuit (\$28,000) is slightly lower than Métis and higher than First Nations (\$29,000 and \$24,000, respectively). An exception is unemployment, which is slightly higher (15%) for Inuit than for First Nations peoples.

### Organizational Process: the Tungasuvvingat Inuit

The Inuit do not structure themselves in the same way as the First Nations or Métis; rather they have developed organizations to address health and socioeconomic issues for Inuit living in Ottawa. The most important of these is the Tungasuvvingat Inuit, which provides programs to address cultural issues, health and socioeconomic issues, including counselling and employment programs.



### One Mind

**Susanne Singoorie, Elder;  
translator Dennis Nakoolak**

“When I was younger we knew there were illnesses in our communities and today I see it more present in the Inuit community. That makes me realize how people were affected back in the days. These days when somebody is diagnosed with cancer they seem to die pretty quickly.

It makes sense for the First Nations to call it an evil spirit because the illness eats away some part of the body. We were told not to express our pain because if we do we are asking for their pain ourselves. It's like I have a headache and I am asking for the headache to come to you. We were told as young people not to say I have a bad back because it will come back to you. That was the Inuit way of life.”







## Métis

The term Métis generally refers to descendants of people born of relations between Indian women and European men. The Métis have typically been underrepresented in research because (unlike other Aboriginal groups), they are not as identifiable by place of residence.

Formed in 1993, the Métis Nation of Ontario (MNO) is the leading representative body for the Métis in Ontario. The MNO maintains the only recognized Métis registry in Ontario. About a third of Ontario's Aboriginal peoples are Métis. Many more Ontarians today identify themselves as Métis than previously: 73,605 compared to 48,340 in 2001. Most (72%) of Métis live in urban areas.

Applications for inclusion in the MNO registry are based on self-identification and ancestry. Registration is voluntary, and requires genealogical evidence of a Métis ancestor. Only a subset of those people who self-identify as Métis belong to the provincial registry.

## Leadership

### President Gary Lipinski

Founded in 1993, the Métis Nation of Ontario (MNO) represents the collective aspirations, rights and interests of Métis people and communities throughout Ontario. The MNO has a democratic, province-wide governance structure. Every four years Métis citizens choose their provincial and regional leadership by voting in province-wide elections.



## One Mind

### President Gary Lipinski

“Not unlike all other people who live in rural and smaller communities, some Métis live where the access to professionals or services just isn't there. And so they have to be referred to (and travel great distances to see) a specialist. Once the diagnosis is confirmed, people have to move out of their communities while the treatment is happening or go back and forth. I am not suggesting that we establish full cancer care facilities in every one of our communities across the province. We have to realize our realities and limitations here. But what we can do is make those experiences better for the patient with more supports.”

Métis Nation of Ontario



## One Mind

**Michele A. Charlebois**

“When you go through cancer it is a whole different world—dealing with hospitals, doctors, support groups and things like that. A lot of it is the fear, the fear of not knowing until you know. To me that was a lonely time, but I do not know how they can improve that part of it. As far as my treatments and care, the doctors did do a wonderful job.

I just got up one morning and thought, forget it! I just need to have a positive attitude, get up and do what I have to do and just go forward with this. So just encourage yourself to do that. I am eating more healthier, doing a lot more walking and my food choices are more often fruits and vegetables and stir-fries—not the greasy things. You still have that treat once in a while but having cancer comes with a change in life, that is for sure.”



## One Mind

**Janine King, health worker**

“I think that education coming from their own people would be more beneficial to them. I think they would feel more trust there. It would be really nice for someone with that knowledge to help them through those difficult times. They are just wonderful to work with. Their compassion for their people, for their family members really gets you in your heart when you are working with them. They are very dedicated to their family. They are very peaceful and very accepting and this is the circle of life. One thing that they have done is they have always opened the window after someone passes to let the spirits out. So they really have a very nice way about it. They all seem to be accepting of what’s happening.”







# Reclaiming Our Health

## *Vision*

To improve the performance of the cancer system with and for FNIM peoples in Ontario in a way that honours the Aboriginal Path of Well-being

Cancer patterns differ significantly between the Aboriginal population and the general Ontario population. Cancer incidence is increasing in the Aboriginal population and cancer survival is worse than for other Ontarians. This underscores the need for a specific cancer control strategy to reverse these trends.

Cancers are not the only diseases of concern. FNIM are also burdened with high rates of diabetes and kidney disease. All these diseases are preventable and share “modifiable” risk factors—personal habits that can be changed. For example, Aboriginal Ontarians smoke much more than do non-aboriginal Ontarians. Reducing the smoking rate alone would greatly reduce the risk of cancer and other diseases.

The **Aboriginal Cancer Strategy II** (ACS II) sets out a clear plan for reducing risk and preventing cancer from 2012 to 2015. It recognizes the challenges faced by Aboriginal Ontarians, and provides both the tools and the control to create change.

## The Aboriginal Path of Well-being

Cancer Care Ontario’s goal is 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. The steps on this path are:

1. Health in balance
2. Wellness—both emotional and spiritual
3. Active choice
4. Holistic approach
5. Understand root causes
6. Joint and personal responsibility

## First Step: engagement

This **Aboriginal Cancer Strategy II** is supported by two sources of wisdom: the guidance given by FNIM leaders, elders, health care workers and cancer survivors; and the deep knowledge and experience of health professionals at Cancer Care Ontario (CCO).

Since 2009, CCO’s Director for Aboriginal Cancer Control, Alethea Kewayosh, has been building relationships with First Nations, Inuit and Métis leadership and communities to better understand their cancer issues and needs. Ms Kewayosh also facilitates an annual meeting of the Joint Cancer Care Ontario and Aboriginal Cancer Committee (JOACC), which has representation from the nine provincial Aboriginal organizations. Direct engagement with the FNIM groups in addition to JOACC guides CCO’s development and implementation of the Aboriginal Cancer Strategy.



## Ontario Cancer Plan III

CCO aims to provide people with the knowledge they need to make informed decisions about their care. CCO's Ontario Cancer Plan III (OCP III) is the guide for Ontario's cancer system. OCP III focuses on cancer control from the perspective of the patient, and is driven by the need to ensure quality across the system. Through this plan, CCO will:

- strengthen its patient-centred approach to cancer control
- continue to improve the quality of the system
- provide individuals with the knowledge they need to make informed decisions affecting their care

The ACS II is a deliverable within OCP III's Strategic Priority of Risk Reduction: Develop and implement a focused approach to cancer risk reduction.

You can read the plan here. <http://ocp.cancercare.on.ca>

**The Ontario Cancer Plan III identifies an urgent need to reduce preventable cancers in Aboriginal populations.**

## Aboriginal Cancer Strategy II

The CCO Aboriginal Cancer Control Unit has engaged directly with provincial FNIM groups with a clear focus on respecting their governance structures and relevant protocols. During this development period, the director has listened carefully to their suggestions, concerns and guidance. Because of this direct engagement approach, CCO has a better understanding of FNIM cancer issues and needs, and is committed to improving Ontario's capacity to address FNIM cancer control.

ACS II will also build on the foundation established by the Aboriginal Cancer Strategy I (2004–2009), including the Aboriginal Tobacco Program, Cancer Screening and Healthy Eating programs. Working with FNIM, CCO will make these programs more culturally sensitive, effective and economical.

### First Aboriginal Cancer Strategy

The achievements between 2004 and 2009 are significant steps in our journey to build the best cancer system for First Nation, Métis and Inuit people of Ontario – but there remains a great distance to be travelled. The renewed version of the Aboriginal Cancer Strategy must go beyond cancer prevention and screening and expand across the continuum of care.

**From ACS I 2009 evaluation**

### One Mind

**Sylvia Maracle (Skonaganhlah:ra)**

“With increased diagnoses of cancer there is an increased forced migration to urban areas, either to get services or to get support. That requires all of us to coordinate better and to talk about it. I know that the people who are involved in the Ontario Cancer Care strategy are going make space for those conversations and encourage the beginning of cooperation, trust and support for each other. I see those growing in strength as a result of the initiatives you are undertaking.”

Tyendinaga Mohawk Territory

## ACS II: One commitment

ACS II will help make the cancer system work better for FNIM people. It will stay true to the Aboriginal Path of Well-being by following these principles:

### Community based

To make a difference at the community level and to be responsible to the community

### Holistic approach

To adopt a traditional Aboriginal approach to health, respecting the physical, mental, emotional, spiritual and cultural needs of the individual, family and community

### Culturally competent

To work in harmony within our culturally diverse communities, taking the Aboriginal world view, and valuing community knowledge and assets

### Inclusive

To be respectful of people first, and to seek out and listen to Aboriginal peoples' voices

## Ontario Cancer Plan III Goals



## ACS II Strategic Priorities



The priorities of the Aboriginal Cancer Strategy II support the overarching Ontario Cancer Plan III (OCP). Each priority is not directly aligned to one of the six OCP III goals.



## OUR STRATEGY FOR RENEWAL

# Strategic Priority 1:

## Build productive relationships

### The Path: Health in balance

“My goal is to help participants restore a sense of beauty and harmony to their experience of life. Associated with the restoration of balance and harmony is often improvement in physical and emotional illnesses.”

Dr. Lewis Mehl-Madrona, Internationally-renowned Native American physician and leader in complementary/integrative medicine

## Formalize and embed FNIM communication and engagement structures necessary to achieve success

### Supporting OCP III Goal: Improve the performance of Ontario's cancer system

#### The Challenge

Canada's constitution recognizes three Aboriginal Peoples—Indians, Métis and Inuit and their existing aboriginal and treaty rights. Working together to solve health problems requires respectful engagement with Aboriginal peoples based on the original relationship of nation to nation, built on a foundation of trust and shared decision-making. Unfortunately this has often not been the case. For that reason, CCO has placed ultimate importance on engaging FNIM leadership in the writing of ACS II. CCO will continue to engage FNIM leadership and stakeholders to go forward as partners in the implementation of ACS II.

#### Objectives—by 2015

- Relationship protocols between CCO and each FNIM group developed
- 10 Aboriginal cancer control networks would be established across Ontario
- First Nations/Ontario federal collaboration to address First Nations cancer control issues established

#### Action

- Engage provincial FNIM health/advisory committees and leadership directly
- Hire and train Aboriginal Leads (0.2 per week of a Regional Cancer Centre full-time employee) in 10 Regional Cancer Programs; funding to flow to Regional Cancer Centres
- Support First Nations policy development with provincial and federal governments to address First Nations cancer control

### One Mind

#### Dr. Janet Smylie

“Let's help our own people support each other—first by identifying safe pathways to care and second by spreading the word. I would like to envision our grandparents feeling motivated and feeling they could have safe access to cancer screening with emotional and spiritual support. Maybe having those resources will lessen the stress of cancer and help us map the path to well-being. On that map there would be actual data from a data geek. There will be lovely pictures too but there will be data, and our communities can see that the map includes us and our communities will own that map.”







# OUR STRATEGY FOR RENEWAL

## **Strategic Priority 2:** Research and surveillance

### The Path: Understand root causes

“We need to get the message out there that cancer can be treated if it is addressed early. There is such a fear around cancer. If we can dispel that fear and get people to come forward sooner that would really help.”

Grand Chief Diane Kelly, Grand Council Treaty #3

## Build and populate databases to provide accurate information for planning, surveillance and research

### Supporting OCP III Goal: Strengthen Ontario's ability to improve cancer control through research

#### The Challenge

"You can't manage what you don't measure" is as true for cancer prevention as for anything else. As discovered during the research and writing of ACS II, there are little recent data documenting the health status of Ontario's FNIM peoples. The Aboriginal cancer system requires accurate baseline measures and regular updates to evaluate progress. Data sources must be comprehensive, connected, complete, valid and accessible to both local and provincial health planners.

#### Objectives—by 2015

- FNIM database of surveillance, screening and treatment statistics developed
- Capacity to measure and analyze FNIM cancer burden and screening established
- Progress evaluations and findings to inform and improve post-2015 initiatives completed

#### Action

- Engage with FNIM groups on their data and surveillance needs
- Establish site locations and data-sharing agreements with FNIM groups and/or communities to ensure local access to information
- Evaluate the impact of ACS II initiatives such as prevention programs (tobacco) and the navigator program

#### Interactive Symptom Assessment and Collection (ISAAC)

The Interactive Symptom Assessment and Collection database is an easy-to-use web-based tool that allows cancer patients to report their symptoms. The system allows symptoms to be tracked over time and across care providers. It is currently being used at regional cancer centres and some partner hospitals. CCO is supporting regions to make this tool available to more cancer providers. Extending ISAAC to Aboriginal cancer patients will help paint a clearer picture of how cancer is affecting FNIM peoples and communities.





## OUR STRATEGY FOR RENEWAL

# Strategic Priority 3: Prevention

### The Path: Wellness—both emotional and spiritual

“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.”

Dr. Annelind Wakegijig, wikwemikong



## Develop and implement a provincial smoking cessation agenda in collaboration with FNIM groups

### Supporting OCP III Goal: Help Ontarians lessen their risk of developing cancer

#### The Challenge

Tobacco use is considerably higher among all FNIM peoples than for the general population. Canada's Inuit have the dubious honour of having the highest lung cancer rate in the world. Non-ceremonial use of tobacco is linked directly to rising rates of cancer—particularly lung cancer. Compared to people who have never smoked, current smokers have greatly increased risk of laryngeal cancer (7 times the risk<sup>2,3</sup>) and lung cancer (9–20 times the risk<sup>2,3</sup>). Tobacco users who also drink alcohol,<sup>3</sup> or also have infections such as hepatitis B or C,<sup>4</sup> or who have certain genetic factors<sup>5</sup> may have a further increased risk of some cancers.

#### Objectives—by 2015

- A province-wide smoking cessation agenda that is supported by FNIM groups would be established
- The methodology needed to measure and track FNIM smoking cessation rates completed
- Plan developed in collaboration with communities to build “Smoke Free Communities” as per the Chiefs of Ontario Resolution 06/39

#### Action

- Appoint Tobacco-Wise Program leads (north and south) to work with FNIM groups to address tobacco cessation, prevention and protection
- Develop a database to monitor and measure FNIM smoking cessation activities
- Coordinate and align with existing (provincial/regional) FNIM tobacco control strategies/initiatives

### One Mind

#### Barney Batise, Elder

“Cancer creates pretty devastating situations for the families and those that are affected directly. My story is that I had a brother who passed on with cancer. I firmly believe that if he was more aware in the beginning of early detection he would have been with us a little longer. My brother could only read a little bit but he was more visual. If he had visual aids, then maybe things might have been different. Early detection is so crucial.”

Matachewan First Nation





OUR STRATEGY FOR RENEWAL

## Strategic Priority 4:

### Screening blitz

#### The Path: Active choice

“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.”

Grand Council Chief Patrick Madahbee, Union of Ontario Indians

## Develop and implement a province-wide FNIM integrated cancer screening strategy and blitz

### Supporting OCP III Goal: Reduce the impact of cancer through effective screening and early detection

#### The Challenge

Although FNIM rates for some cancer screening are comparable to the general population, the number of under-screened and/or never-screened Aboriginal Ontarians is far too high. This shortcoming will be addressed through local and regional initiatives to encourage under-screened and/or never-screened people to participate in cancer screening and the implementation of the Integrated Cancer Screening (ICS) program. The information management/information technology system that supports ICS is called InScreen. This system identifies Ontarians eligible for screening and facilitates the sending of initiations, recalls and reminders for screening at appropriate intervals. InScreen also notifies when results are available, and can support targeted interventions for culturally appropriate correspondence.

#### Objectives—by 2015

- FNIM identifiers and database for InScreen developed
- A province-wide FNIM integrated cancer screening program implemented
- Screening participation targets for FNIM peoples are established for Regional Cancer Programs. For example:
  - Erie St. Clair Regional Cancer Program: 5% increase in breast, colorectal and cervical cancer screening
  - North East Regional Cancer Program: 5% increase in colorectal cancer screening; 5% increase in areas where breast screening rates are higher than 50%; 10% increase in areas where breast screening rates are lower than 50%
  - North West Regional Cancer Program: 10% increase in breast cancer screening; administration of 1,000 Pap tests per year (cervical cancer); and distribution of 1,500 colorectal cancer test kits per year

#### Action

- Co-develop options with FNIM groups to use and link to InScreen to increase the number of people screened and improve follow-up for regular screening
- Use lessons learned and results from the four Regional Cancer Program under-screened/never-screened initiatives to establish sustainable integrated cancer screening programs in all 14 Regional Cancer Programs post 2012/13
- Promote awareness and participation of the Registered Nurse Flexible Sigmoidoscopy program







OUR STRATEGY FOR RENEWAL

# Strategic Priority 5:

## Supportive care

The Path: Holistic approach

“Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.”

World Health Organization Definition of Health

## Help FNIM with cancer to navigate the cancer system to improve their cancer journey and health outcomes

### Supporting OCP III Goal: Improve the patient experience along every step of the cancer journey

#### The Challenge

Navigating the health system is a challenge for most patients. The cancer system is even more complex and this complexity is multiplied for patients who are unfamiliar with medical systems, don't speak English or French and/or must travel far from home for treatment and care. One answer to this problem is the Aboriginal Patient Navigator—a trained person who will guide FNIM patients through the process and help them make the many decisions required along the way.

Another part of CCO's commitment to Aboriginal patient care is the expansion of telehealth services to remote hospitals, and development of better supports for FNIM patients needing end-of-life care.

#### Objectives—by 2015

- Aboriginal Navigators hired and trained in 9 Regional Cancer Programs
- Measures to track FNIM patient and program improvements established
- Pain and symptom management tools and pathways developed for use by FNIM health providers

#### Action

- Hire and train nine Aboriginal Navigators to build supportive relationships and increase palliative care knowledge and skills
- Deploy the Edmonton Symptom Assessment System surveying (ESAS) and Interactive Symptom Assessment and Collection tool (ISAAC) in urban and rural communities; use tele-ISAAC—which allows cancer patients to enter their symptom scores by telephone—in northern and remote communities

### One Mind

#### Michele A. Charlebois

“There needs to be more support —someone who is an advocate for the person. I had no counselling, no one to talk me through anything. Your family are the only people you talk to, but you don't talk about cancer that day you come home. If you had some counselling or a support group or someone to help you get set up it would help. Cancer is a big burden. There were days when I come home after treatments that I laid on the bed for 4 or 5 hours, so you do need help. Even though you had your family you need help in other ways.”





# OUR STRATEGY FOR RENEWAL

## Strategic Priority 6: Education

### The Path: Joint and personal responsibility

“People who are diagnosed with these illnesses often don’t know where to go and what supports are there. Having somebody explain it to them is essential, since you are ultimately stepping into a whole new world, the medical world. Having somebody to assist them and walk them through what they have to go through.”

President Gary Lipinski, Métis Nation of Ontario

Significantly enhance FNIM peoples' knowledge and awareness of cancer with a focus on prevention and screening

**Supporting OCP III Goal: Ensure timely access to accurate diagnosis and safe, high-quality care**

### The Challenge

Early cancer diagnosis and improved survival are primary goals for CCO and ACS II. Every FNIM leader, health worker and cancer survivor CCO interviewed emphasized the importance of education and cancer awareness, and we will carry this message to FNIM peoples throughout Ontario. Traditional values emphasize the connection of spiritual, physical and mental wellness. It is a small step from that insight to knowledge of how cancer affects the body and how to prevent it.

### Objectives—by 2015

- FNIM knowledge and understanding of cancer, including cancer prevention and screening, will be increased

### Action

- Review and compile existing and emerging educational resources/tools into a comprehensive and current inventory
- Develop and implement province-wide dissemination strategies to ensure educational resources/tools are reaching the FNIM communities

## One Mind

**Wilson Plain Sr.**

“I think that people should be aware of what contributes to the development of cancer. Some people don't want to know but that's not good. I imagine that in some the native communities they don't want to talk about it and furthermore they don't know the questions to ask.

Before going to a doctor who specializes in cancer, people need to know what questions to ask. These days we have the computer and the web to do this research. Even if you do you might miss something. So my wife was with me, since she is concerned about me getting the best information from the doctor.”

Aamjiwnaang First Nation







# Why We Need an Aboriginal Cancer Strategy

## Social and economic inequality

CCO is committed to working toward developing the best cancer system in the world and in doing so understands the Aboriginal peoples of Ontario have experienced over 500 years of oppression, which has led to discriminatory practices and an erosion of culture. Before European settlement, First Nation peoples lived throughout the province in complex societies—some focused on farming, others were migratory hunters and gatherers. Today, First Nations reserves are a fraction of the original area and only 12% of Aboriginal Ontarians speak their native language.

Generally, Aboriginal peoples are younger and more mobile than non-Aboriginals. There are more Aboriginal single-parent families. Ontario Aboriginals are less educated, more often unemployed, earn less and are jailed more than are non-Aboriginal peoples. All of these factors influence health and the risk of becoming ill.

On average, Aboriginal Ontarians over 15 earn only \$27,820 annually. However, average annual income for the 47% of Aboriginal workers employed full time is considerably higher at \$41,761. Median income per Aboriginal household is just \$46,865.<sup>6</sup>

The Aboriginal unemployment rate in Ontario is 12.3% and about 57% of the population over 15 years is working. Almost half of these people are employed in sales and service, or trades, transport and equipment operators and related occupations. Education is a factor in employment, income, quality of life and, ultimately, health: 38% of Aboriginal Ontarians have no certificate, diploma or degree and 61.8% have high school graduation or less.<sup>1</sup>

## Health inequality

This systemic social and economic inequality promotes health inequality. Aboriginal Ontarians have higher rates of sickness, hospitalization and exposure to harmful risks such as unhealthy eating, drug and alcohol abuse, and non-ceremonial tobacco use. Some have difficulty accessing health care and are unfamiliar with the system. At one time, Aboriginal peoples in Ontario had lower cancer rates than other Ontarians. Now, cancer rates are increasing.

**This Aboriginal Cancer Strategy II is our plan for reversing that trend.**

### Lack of Data

Research and writing of the Aboriginal Cancer Strategy II was hindered by the lack of recent data. Too often, data are incomplete and not comparable. This makes it difficult to plan and manage Aboriginal cancer programs in Ontario. That is why Cancer Care Ontario has made improved research and surveillance one of its priorities. Please see Strategic Priority 2 for further details of this commitment.

## What increases or decreases cancer risk?

Cancer can affect any part of the body. The disease disrupts normal cell processes, creating abnormal cells that extend into nearby parts of the body and can spread to other organs or systems.

### Can cancer be prevented?

Yes—more than 30% of cancer deaths could be prevented by changing lifestyle-related factors including smoking, obesity, physical inactivity, inadequate vegetable and fruit intake, and alcohol consumption. Of these, tobacco use is the most important. Tobacco use causes 22% of cancer deaths worldwide and 71% of global lung cancer deaths.<sup>6</sup>

### Lifestyle risk modifiers

Based on current Aboriginal lifestyles, cancer is expected to increase more for Aboriginal Ontarians than for the general population. Compared to the general population, Aboriginals are more likely to smoke and consume alcohol, be overweight or obese and to have low vegetable and fruit intake.<sup>7</sup>

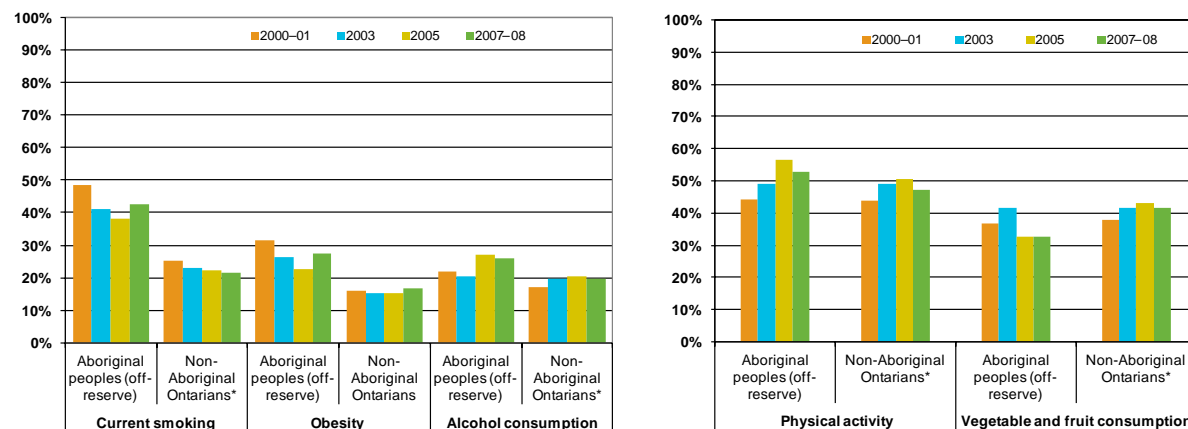
Improvements to these lifestyle factors are possible. Smoking rates for Aboriginals living off-reserve have dropped from 49% in 2001 to 43% in 2008. Obesity rates have dropped from 31% to 28%, while the percentage of off-reserve First Nations adults engaging in moderate to vigorous physical activity has increased from 44% to 53%. Non-Aboriginal Ontarians have also seen some positive changes over time but the initial proportion of people reporting harmful risk factors was lower.<sup>8</sup>

Screening tests are used to catch cancer early when it is easier to treat. In Ontario, screening is done for breast cancer (with mammography), for colorectal cancer (with fecal occult blood tests), and for cervical cancer (with Pap tests). Aboriginal peoples are included in ongoing efforts to increase screening rates for all Ontarians.

### Diabetes also a risk factor

Research has suggested that having diabetes increases the risk of colorectal cancer<sup>9</sup>. In Canada, diabetes is up to three times more common in Aboriginals than the general population,<sup>10–14</sup> making this an especially significant risk factor for Aboriginal people.

**Figure 1. Percentage of adults with selected risk factors by off-reserve Aboriginal identity vs. non-Aboriginal identity, Ontario, 2000 + 2001, 2003, 2005, 2007 + 2008<sup>7</sup>**



While the Aboriginal Cancer Strategy II recognizes all risk factors related to cancer, this strategy will focus efforts on smoking cessation initiatives due to the high levels of tobacco use and incidence of lung cancer within Aboriginal Peoples.

# First Nations

## Cancer risk factors

High rates of overweight and obesity, tobacco smoking, alcohol consumption, physical inactivity and diabetes are a health concern for First Nations people living on- and off-reserve.

### 1. Overweight and obesity

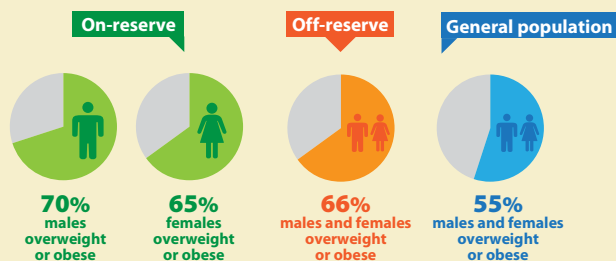
First Nations are more likely to be overweight or obese than members of the general population.

**First Nations people living on-reserve:** 70% of men and 65% women overweight or obese<sup>15</sup>

**First Nations people living off-reserve:** 66% of men and women overweight or obese<sup>16</sup>

**General population:** 55% of men and women overweight or obese<sup>16</sup>

Figure 2. Overweight or obese  
First Nations on- and off-reserve vs. general population of Canada



## Data Mostly National

Comparable statistics for First Nations people in Ontario and the general population of Ontario are sparse. Nationwide surveys are often not conducted on reserves, and do not collect information from sufficiently large numbers of First Nations respondents off-reserve in Ontario alone to make meaningful estimates. Unless specified otherwise, the statistics in this section represent First Nations people and the general population nationwide.

## 2. Tobacco smoking

Studies indicate that the rate of smoking among First Nations is two to three times higher than that for the general population.

**First Nations people living on-reserve:** 43% smoke daily<sup>17</sup>

**First Nations people living off-reserve:** 35% smoke daily<sup>18</sup>

**General population:** 16% smoke daily<sup>18</sup>

Figure 3. Daily smokers  
First Nations on-reserve vs. First Nations off-reserve vs. general population of Canada



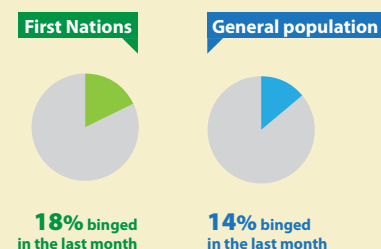
## 3. Alcohol

Amongst those people who reported drinking alcohol in the last year, First Nations people were about equally likely to have binged (bingeing was defined as having five or more drinks on one occasion) in the last month.

**First Nations people residing off-reserve in Northern Canada:** 18% binged in the last month<sup>19</sup>

**General population residing in Northern Canada:** 14% binged in the last month<sup>19</sup>

Figure 4. Binged on alcohol in last month  
First Nations vs. non-Aboriginal northerners



#### 4. Inactivity

About half of First Nations adults Canada-wide are inactive in their leisure time. This is the same as the general population of Canada.<sup>20</sup>

**First Nations people living off-reserve:** 52% inactive<sup>17</sup>

**General population:** 50% inactive<sup>18</sup>

Figure 5. Inactive in leisure time  
First Nations off-reserve vs. general population of Canada



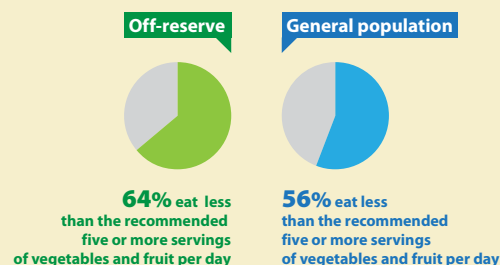
#### 5. Unhealthy eating

Vegetables and fruit were part of the traditional indigenous diet, but modern First Nations people eat considerably less vegetables and fruit than is recommended to maintain good health.

**First Nations people living off-reserve:** 64% eat less than the recommended five or more servings of vegetables and fruit per day<sup>17</sup>

**General population:** 56% eat less than recommended<sup>18</sup>

Figure 6. Eat less vegetables and fruit than recommended  
First Nations off-reserve vs. general population of Canada



#### 6. Diabetes

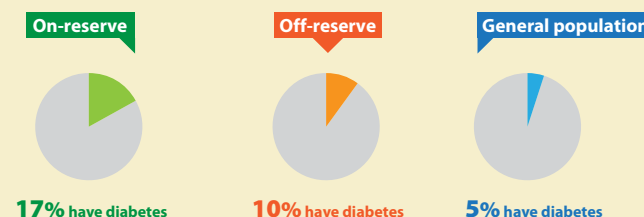
In Canada, diabetes is two to three times more common in First Nations populations than in the general population.<sup>20,21</sup>

**First Nations people living on-reserve:** 17% have diabetes<sup>17</sup>

**First Nations people living off-reserve:** 10% have diabetes<sup>18</sup>

**General population:** 5% have diabetes<sup>18</sup>

Figure 7. Diabetes in First Nations living on- and off-reserve vs. general population of Canada



### One Mind

#### Dr. Annelind Wakegijig

“First Nations need access to quality care, especially in rural and remote communities where there is a lack of personnel. In a lot of our remote communities, health workers fly in for a few days at a time. This encourages crisis management as opposed to prevention.

The message needs to get out there that a person who gets diagnosed with cancer still has a chance. They need access to whatever tools are available to survive, not only for themselves but their families and their community. People need the confidence to be able to say, “Well, I’ll go through this” and they are starting to realize now that it’s worth the fight. It’s no longer accepting your fate and letting things happen. It’s like getting back our fighting spirit.”



## First Nations: Screening for cancer

Screening helps detect cancer early, when treatment can be more effective and the chance of cure greater. First Nations women are being screened for cervical cancer at the same rate as non-Aboriginal women. However, fewer First Nations women report ever having had a mammogram.<sup>22</sup> To our knowledge, there are no First Nations-specific data available on screening for colorectal cancer. A recent report based on the Canadian Community Health Survey found that people reporting Aboriginal identity were just as likely as the non-Aboriginal population to have undergone colorectal screening tests.<sup>16</sup>

## First Nations: Cancer profile

Before 1991, Ontario First Nations had lower rates of cancer and deaths from cancer than the general Ontario population.<sup>23</sup> Since 1991, however, the First Nations advantage has been decreasing.<sup>24</sup>

Between 1968 and 1991, Status First Nations were less likely than non-Aboriginals to be diagnosed with most

types of cancer, including the most common (breast, prostate, lung [in males], leukemia [in males], and colorectal). Status First Nations were, however, *more* likely to be diagnosed with cancers of the cervix and gallbladder than non-Aboriginal Ontarians.<sup>23</sup>

Since 1991, incidence rates for colorectal, lung, breast and prostate cancers have been increasing in the Status First Nations. As with the general population, the incidence of cervical cancer has decreased.<sup>24</sup> Status First Nations in Ontario have been shown to have poorer survival for cancers of the breast, colon/rectum, prostate and lung than Ontarians from the general population.<sup>24</sup>

## One Mind

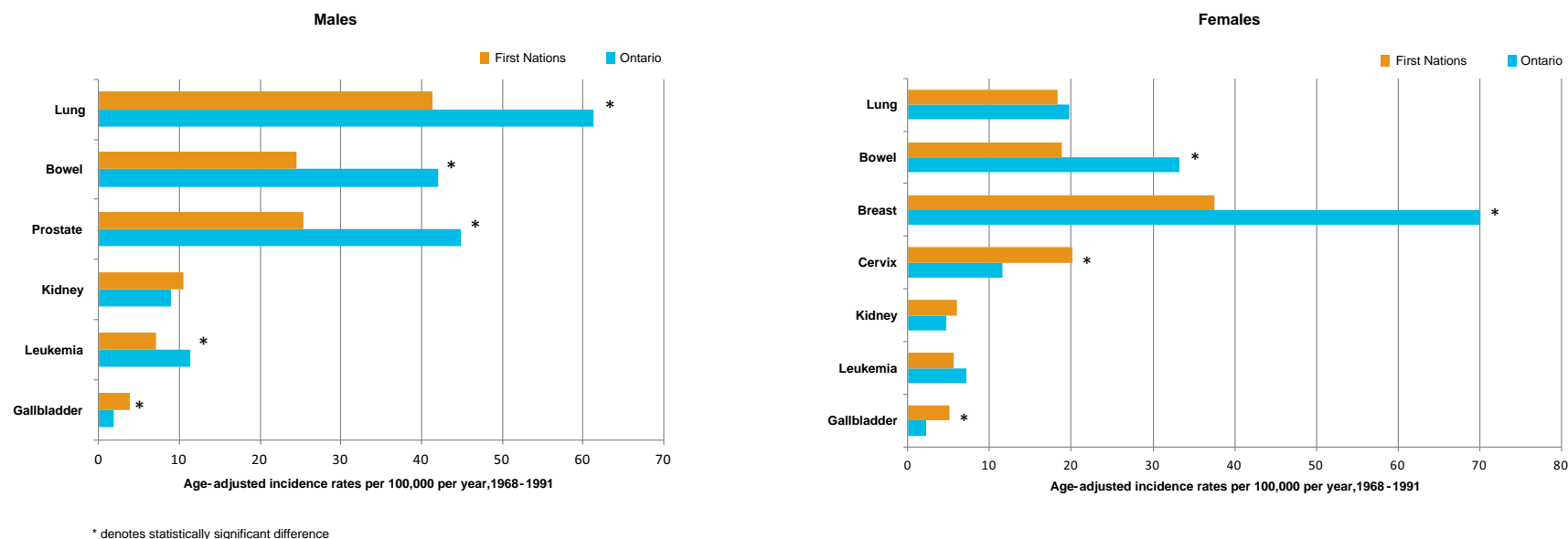
### Donna Day

“Do you have limitations because you have cancer? Yes, but you do not stop living. You have to go out. I want to let people know that even though you have cancer, you can be out there helping other people who are sitting at home, hiding from it and letting it get the best of them. I sat at home—sure I did—but I didn’t stay home all the time. I knew when to rest. I knew what I needed to do. I wanted to be out there and let people know that I am okay. I can get through this.”

Bkejwanong First Nation



Figure 8. Incidence of common cancers in Status First Nations vs. general population of Ontario, 1968-1991, ages 15–74<sup>23</sup>



## Ontario First Nations Integrated Health Promotion Strategy

Resolution 06/39 called for a strategy that speaks to:

- Restoration of traditional foods with First Nation diets
- Physical activities and exercise
- Establishing smoke-free First Nations
- Awareness and prevention of stress, cancer, diabetes, heart disease and other chronic diseases

The goal is to reach First Nation communities in Ontario through an accompanying communication and public awareness component.

First Nations in Ontario also have a long, proud history in competitive and recreational sports including lacrosse, hockey, ball sports and golf and have been instrumental in the successes of the Little NHL, the North American Indigenous Games, and the Ontario Aboriginal Sports Circle. Our traditional diet consisted of healthy, sacred foods; including wild meat, fish, berries, wild rice, corn, beans and squash.

Our lives were enriched in such a way that stress and stress-related illnesses were rare, and balanced by wholesome traditional pursuits and spirituality.

Today, First Nations are often faced with lack of exercise, poor nutrition and high instances of diabetes, cancer and heart disease. It is through resolution 06/39 that the Chiefs of Ontario want to combat such issues promoting a healthy, balanced way of life.

Please see <http://ourtimeourhealth.org> for more on this strategy.

Original resolution: <http://www.sfnha.com/wp-content/uploads/2011/11/COO-06-39-Ont-FNs-Health-Promotion-Strategy.pdf>

# Inuit

## Cancer risk factors

Over the past 40 years, there have been changes in the lifestyle and diet of Canada's Inuit that have negatively affected health, by contributing to increases in cancer in the Inuit.<sup>25</sup> Furthermore, because traditional Inuit survival values encourage people to carry on regardless of pain or discomfort, many Inuit do not seek medical help until they are extremely ill (Inuit Elder, Suzanne Singoorie, March 2012).

**There are very little data specific to Ontario Inuit; most of the data presented are for northern Inuit across Canada.**

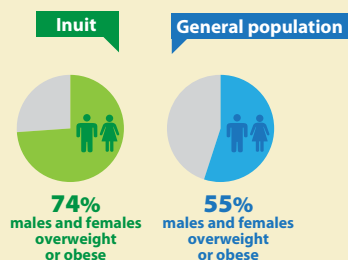
### 1. Overweight or obesity

The percentage of overweight or obese Inuit adults is significantly higher than the non-Aboriginal population.

**Inuit:** 74% overweight or obese<sup>16</sup>

**General population:** 55% overweight or obese<sup>16</sup>

**Figure 9. Overweight or obese  
Inuit vs. general population of Canada**



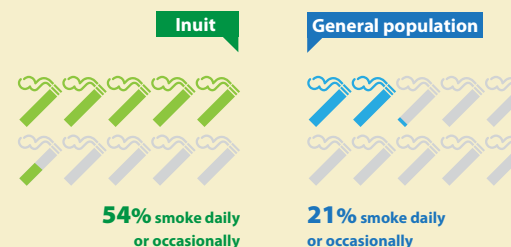
### 2. Tobacco smoking

The Inuit smoke more than any other Canadian subgroup<sup>28</sup> —rates of smoking are more than double that of the non-Aboriginal population.

**Inuit:** 54% smoke daily or occasionally<sup>16</sup>

**General population:** 21% smoke daily or occasionally<sup>16</sup>

**Figure 10. Current smokers  
Inuit vs. general population (Canada)**



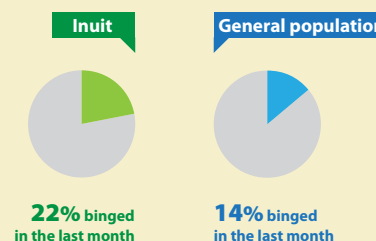
### 3. Alcohol

Amongst those people who reported drinking alcohol in the last year, Inuit people were considerably more likely to have binged in the last month than non-Aboriginal northern residents.

**Inuit people residing in Northern Canada:** 22% binged in the last month<sup>19</sup>

**General population residing in Northern Canada:** 14% binged in the last month<sup>19</sup>

**Figure 11. Binge drinking alcohol  
Inuit vs. general population in northern Canada**



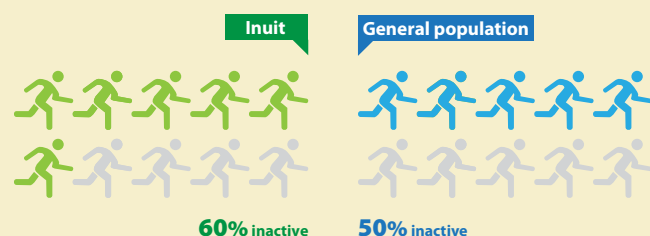
#### 4. Inactivity

More than half of Inuit adults Canada-wide are inactive in their leisure time. This is more than the general population of Canada.

**Inuit:** 60% inactive<sup>18</sup>

**General population:** 50% inactive<sup>18</sup>

Figure 12. Inactive in leisure time  
Inuit vs. general population of Canada



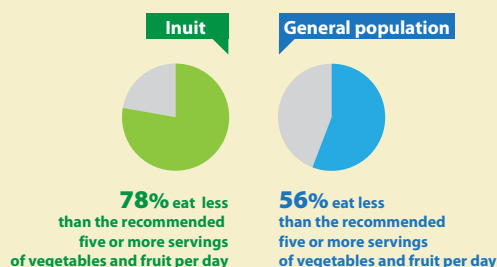
#### 5. Unhealthy eating

The traditional Inuit diet was based on fish and sea mammals. Though low in fresh vegetables and fruits, it had a high content of nutrients believed to protect against some cancers.<sup>25</sup> Inuit now eat more imported food than before.

**Inuit:** over 78% eat less than the recommended five or more servings of vegetables and fruit per day<sup>18</sup>

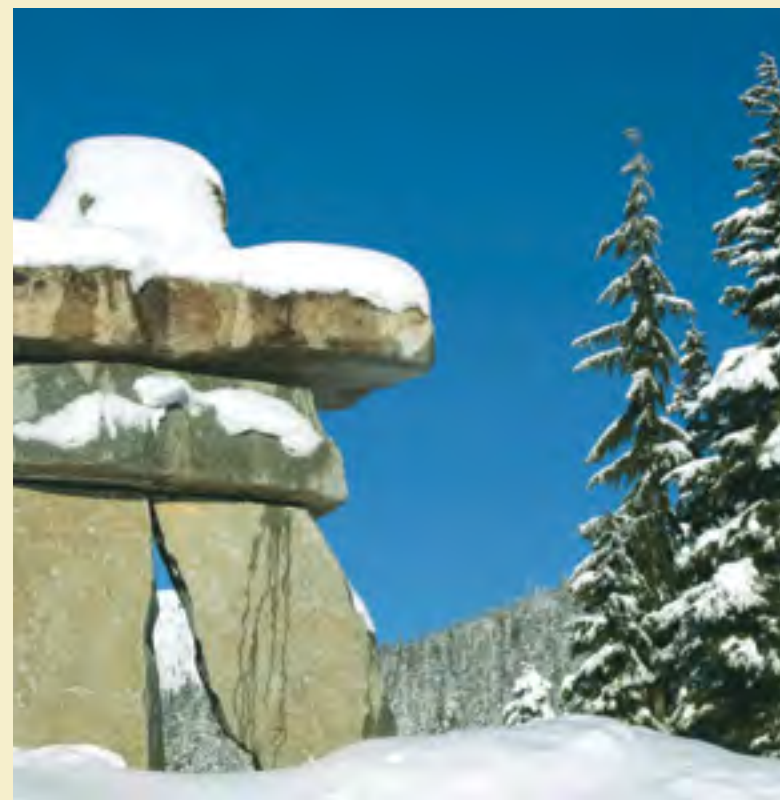
**General population:** 56% eat less than recommended<sup>18</sup>

Figure 13. Eating less vegetables and fruit than recommended  
Inuit vs. general population of Canada



#### 6. Diabetes

The modern Inuit diet contains more saturated fat and sugar than it did in the past. This, combined with a more inactive lifestyle, has contributed to an increase in obesity and diabetes.<sup>25</sup> Inuit rates of diabetes are now about the same as the general Canadian population.<sup>18</sup>





## Inuit: Screening for cancer

About half as many northern Inuit women have been screened for breast cancer (had a mammogram) in the previous two years compared to women in the general population.

**Inuit women residing in northern Canada:** 28% had a mammogram in the previous two years<sup>19</sup>

**Non-Inuit women residing in northern Canada:** 51% had a mammogram in the previous two years<sup>19</sup>

The record for cervical cancer screening (Pap tests) is much better.

**Inuit women residing in northern Canada:** 75% had a Pap test in the previous three years<sup>19</sup>

**Women in the general population residing in northern Canada:** 80% had a Pap test in the previous three years<sup>19</sup>

## Support for Southern Inuit

Since 1967, Tungasuvvingat Inuit has provided support to southern Inuit. Its programs and services focus on Inuit values to promote health and well-being.

Tungasuvvingat Inuit delivers:

- Addictions and trauma treatment and continuing care; counseling for families, adults, youth and children; diabetes awareness and prevention, healthy weights promotion
- Employment skills and training
- Family health primary care clinic

## Inuit: Cancer profile

Historically, Inuit have had higher rates of nasopharyngeal, salivary gland and esophageal cancers, but these rates are decreasing. Rates of lung, breast, colorectal and cervical cancers have increased sharply, however, across all circumpolar regions.<sup>25,27</sup> Lung cancer rates for Canadian Inuit males and females are the highest in the world and rising,<sup>26,27</sup> occurring in Inuit men and women at 3.2 and 5.3 times the Canadian averages, respectively.<sup>26,28</sup>

## One Mind

**Dr. Indu Bala Gambhir and Connie Siedule,**  
Executive Director TI Inuit Family Health Centre

“Our biggest challenge working with Inuit clients is late diagnosis—people getting diagnosed basically at the end stage of cancer. There are a number of different reasons for that. It’s not just geographic. It is poverty, delay in getting access to medical care, not knowing when to go, and problems with mental health and addiction. Inuit people accept ill health as a norm. We need to change that mindset so people know it is not normal to be feeling pains and aches and having a cough.

Patients are coming to us with a lot of co-morbid conditions in addition to cancer. The life expectancy of Inuit is low—anywhere from 13–17 years less than the mainstream Canadian population. Cancer rates are unbelievably higher or quite alarming. Their lung cancer rate is the highest in the world for men. Colorectal cancer rates have also sharply increased over the last 10 years. So that is certainly a part of it. Physically a person is a senior even when they are just technically in their middle age.”

### Rates of cancer in Nunavut

Rates of cancer in Nunavut are based on all Nunavut residents, of whom 85% are Inuit.

**Most common cancers in Nunavut:** Lung, colon, breast and nasopharynx<sup>29</sup>

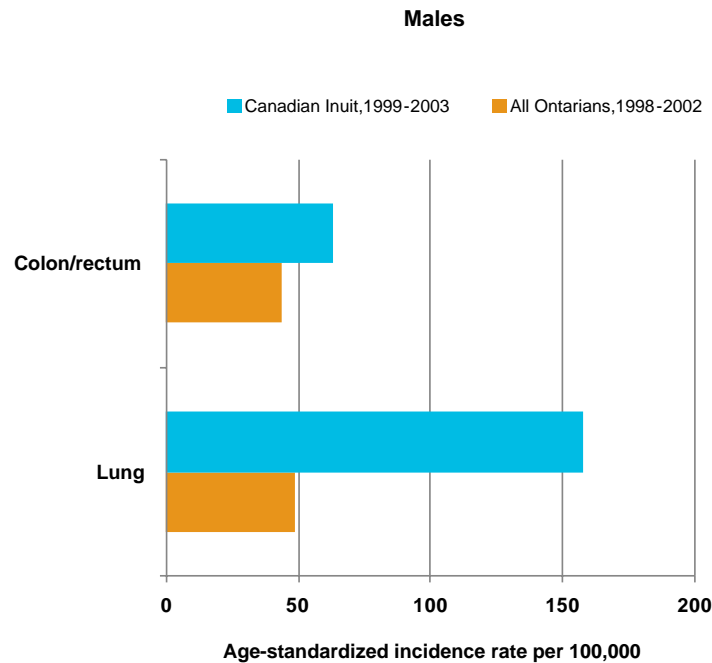
### Cancers with higher rates than the rest of Canada:

Nasopharynx, liver, lung, salivary gland, esophagus, colon<sup>29</sup>

### Cancers with lower rates than the rest of Canada:

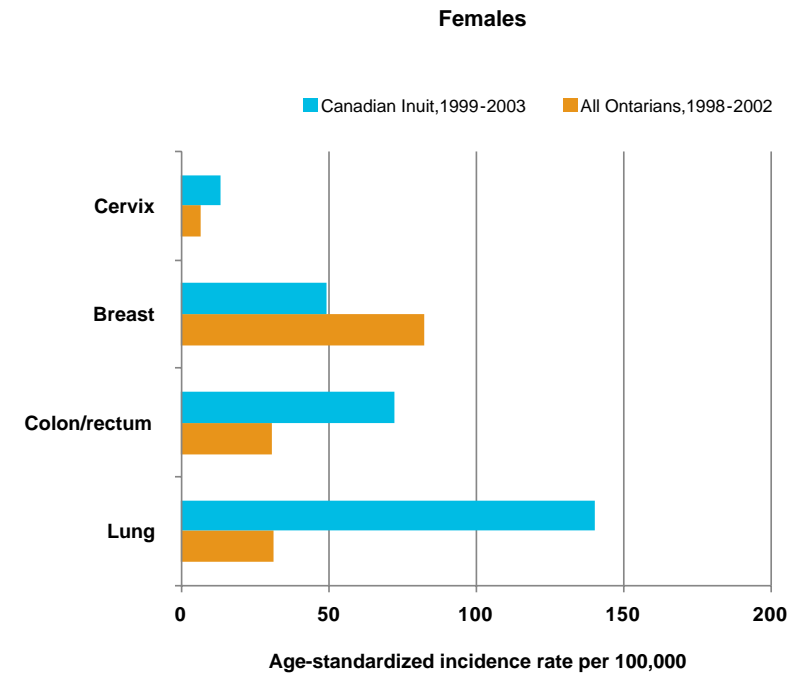
Breast, prostate and non-Hodgkin's lymphoma<sup>29</sup>

Figure 14. Age-standardized incidence rates (ASIR) per 100,000 for colorectal and lung cancers in Inuit males in Canada, 1999-2003, and the general male population of Ontario 1998-2002<sup>30</sup>



Age-standardized to the IARC World Standard Population

Figure 15. Age-standardized incidence rates (ASIR) per 100,000 for cervix, breast, colorectal and lung cancers in Inuit females in Canada, 1999-2003, and the general female population of Ontario 1998-2002<sup>31</sup>



# Métis

## Cancer risk factors

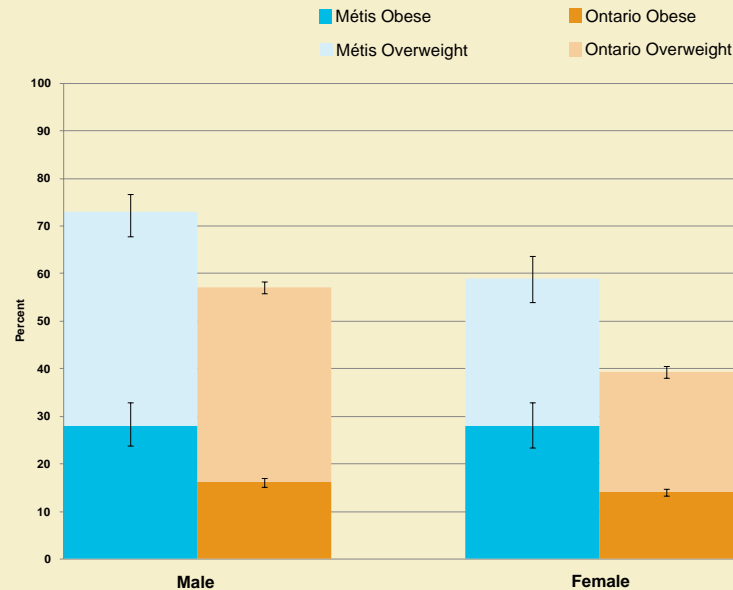
### 1. Overweight or obesity

The percentage of overweight or obese adults is significantly higher among Métis in Ontario.<sup>32</sup>

**Métis:** 73% males and 59% females are overweight or obese<sup>33</sup>

**General population:** 57% males and 39% females are overweight or obese<sup>34</sup>

Figure 16. Percentage of Ontario adults (aged 18+ years) who are obese or overweight, by population and sex<sup>32,35</sup>



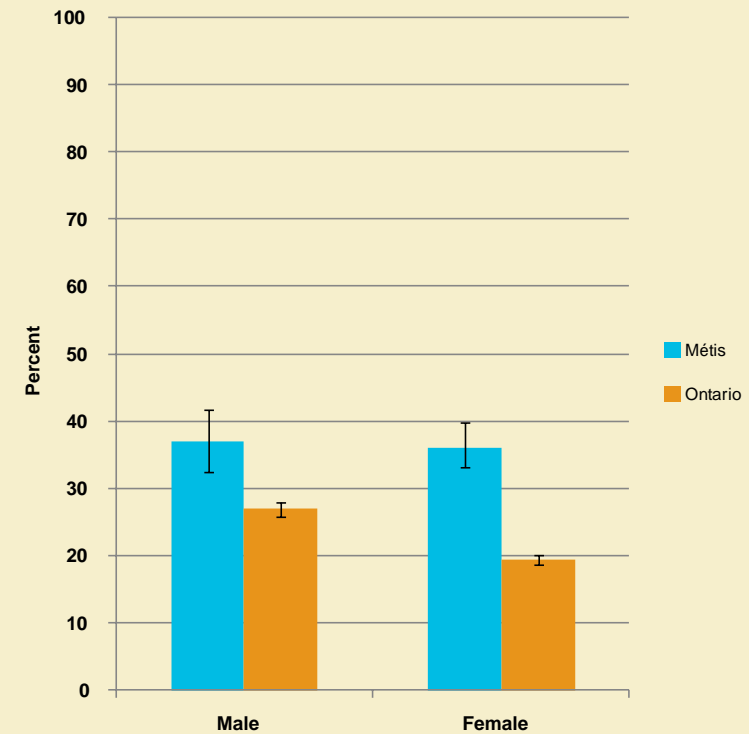
### 2. Tobacco smoking

In Ontario, more Métis report current smoking than the general population<sup>32</sup>

**Métis:** 37% of males and 36% of females smoke daily or occasionally<sup>33</sup>

**General population:** 27% of males and 19% of females smoke daily or occasionally<sup>34</sup>

Figure 17. Percentage of adult smokers (aged 18+ years) in Ontario, by population and sex<sup>32,35</sup>





### 3. Alcohol

In Ontario, Métis were more likely than the general population to have binged on alcohol in the past year. Métis men were more likely to binge more frequently than the general population of Ontario.<sup>32</sup>

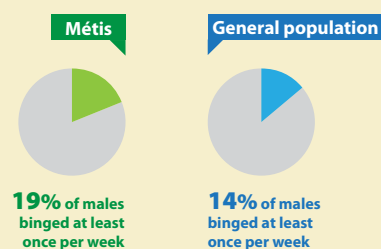
**Métis:** 71% of men and 48% of women had binged at least once in the previous year<sup>33</sup>

**General population:** 61% of men and 37% of women had binged at least once in the previous year<sup>34</sup>

**Métis men:** 19% binged at least once per week<sup>33</sup>

**Men in the general population:** 14% binged at least once per week<sup>34</sup>

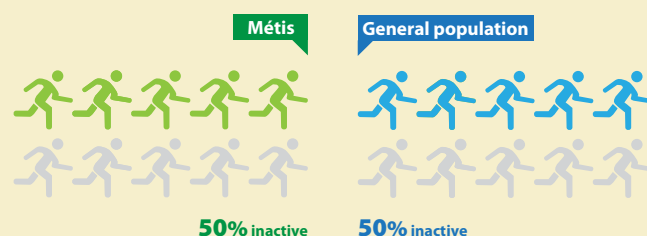
Figure 18. Binge drinking once or more a week  
Métis vs. general Ontario population, males



### 4. Inactivity

Like First Nations and non-Aboriginal Canadians, about half of Canadian Métis adults reported being inactive during their leisure time.<sup>16,20</sup>

Figure 19. Inactive in leisure time  
Métis vs. general population of Canada



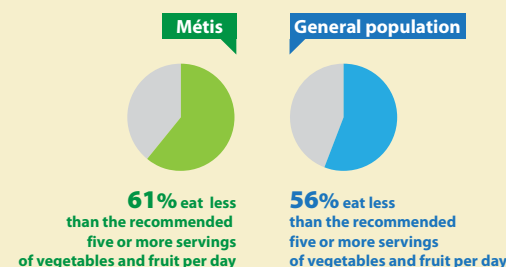
### 5. Unhealthy eating

More than half of Métis adults in Canada are eating less than the recommended number of servings of vegetables and fruit per day.

**Métis adults in Canada:** 61% eat less than the recommended five or more servings of vegetables and fruit per day<sup>18</sup>

**Adults in the general population of Canada:** 56% eat less than recommended<sup>18</sup>

Figure 20. Eating less vegetables and fruit than recommended  
Métis vs. general population of Canada



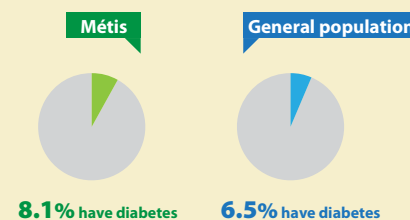
### 6. Diabetes

In Ontario, a significantly higher proportion of Métis have diabetes compared to the general population.<sup>37</sup>

**Métis:** 8.1% have diabetes<sup>37</sup>

**General population:** 6.5% have diabetes<sup>37</sup>

Figure 21. Diabetes in Métis vs. general population of Ontario



## Métis: Screening for cancer

In Ontario, Métis women and women from the general population were equally likely to have ever been screened for breast cancer with a mammogram (approximately 90% of women aged 50-69). However, Métis women were less likely to have had a mammogram within the recommended interval of two years.<sup>32</sup>

**Métis women:** 60% had a mammogram within the previous two years<sup>33</sup>

**Women in the general population:** 73% had a mammogram within the previous two years<sup>34</sup>

Compared to all Ontario women aged 18 and over, Métis women were more likely to have ever had a Pap test, but the proportion of Métis women who had been screened within the last five years was no different from the general population.<sup>32</sup>

## Métis: Cancer profile

Prostate, lung, breast and colorectal cancer are the most common cancers among the Métis. This is the same as for other Ontarians.<sup>38</sup>

Ontario Métis have a 20% lower incidence of cancer compared to the general population, except for lung cancer in females, where the rate may be as much as 40% higher.<sup>38</sup>

## One Mind

**Elder Roland St. Germain**

“We got to get more Métis into the health field. We feel more comfortable going to a Métis doctor or a nurse practitioner because others still have that old racist attitude. So if we get nursing professions up in Métis communities or even Métis doctors it will really improve the health of our nation.”



# Our Partners

Cancer Care Ontario and Aboriginal communities are also supported by a network of partners and organizations across the province. Some of these include:

- Regional Cancer Programs
- Health agencies/organizations such as Aboriginal Health Access Centres, Meno Ya Win (Sioux Lookout), *Weeneebayko* Area Health Authority (James Bay/Hudson Bay)
- Keewaytinook Okimakanak - Knet Chief's Council (Northwestern Ontario)
- Canadian Cancer Society
- Centre for Addictions and Mental Health
- Saint Elizabeth Health Care
- Community Care Access Centres
- Supportive Care Oncology Networks
- Ontario Renal Network

## Regional Cancer Programs

Ontario's Regional Cancer Centres are our most important partners in this strategy to reclaim our health and well-being. Each of Ontario's 14 Local Health Integration Networks has its own Regional Cancer Program. There are also 14 regional cancer centres, which provide prevention and screening, supportive care, treatment (surgery, radiation therapy and chemotherapy), and end-of-life care. Regional Cancer Centres take an

interdisciplinary approach to treatment and care, ensuring that cancer patients and their families receive the physical, psychological, social and spiritual support they need. Regional cancer centres such as Sudbury, Thunder Bay, Kingston, Ottawa, Barrie and Kitchener-Waterloo offer accommodation for out-of-town patients who must travel there for treatment.

## Aboriginal Client Strategies

Ontario Regional Cancer Programs are engaging their Aboriginal clients through Aboriginal Cancer Care Committees. For example, the Erie St. Clair Regional Cancer Program, Champlain (Ottawa) Regional Cancer Program and Northeast Regional Cancer Program are in the process of engaging their Aboriginal communities to develop screening programs to increase participation rates to cancer screening and increase the understanding and awareness of cancer to the Aboriginal communities in their regions.



### **Regional Cancer Care Northwest**

This program serves approximately 250,000 residents in Northwestern Ontario. Established in 1948, the centre is a leading champion of telemedicine, which it uses extensively so patients at 13 partner hospitals in Northwestern Ontario can receive care closer to home. It is one of the highest-ranked cancer programs in Canada for patient satisfaction. The program established the Aboriginal Cancer Core Committee, which includes representatives from First Nations and Aboriginal groups and organizations. Its focus is building an Aboriginal cancer prevention and screening strategy for the region.

### **Thunder Bay Regional Health Sciences Centre**

Aboriginal health is a strategic focus of this northern health centre. “Our journey towards excellence in Aboriginal Health care delivery begins with improving our physical and cultural environments to reflect the expressed values, practices and traditions of Aboriginal communities.” The strategy sets out as objectives engaging Aboriginal peoples, increasing cultural awareness, promoting education and awareness, and respecting Aboriginal values.

### **Ontario Renal Network**

Chronic kidney disease (CKD) is a growing concern in Ontario. Because diabetes is a risk factor for CKD, Aboriginal people are at increased risk. The Ontario Renal Network (ORN) is developing a care system for CKD that works on the same principles as CCO. The ORN is committed to reducing the impact of CKD by improving early detection and slowing its progression. The Director for Aboriginal Cancer Control will work with FNIM communities to address their unique needs for CKD prevention, screening and management.

## **Important Aboriginal partners**

### **Ontario Federation of Indian Friendship Centres**

The Ontario Federation of Indian Friendship Centres (OFIFC) is a provincial Aboriginal organization representing 29 member Friendship Centres throughout the province. OFIFC programs are delivered by local Friendship Centres in areas such as health, justice, family support, and employment and training. Friendship Centres also design and deliver local initiatives in education, economic development, children’s and youth initiatives, and cultural awareness. Its vision 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.”

## **One Mind**

### **Sylvia Maracle, Executive Director, OFIFC**

“Even urban Aboriginal people want more traditional approaches and cultural approaches. While we may be prepared to go through mainstream treatment processes we still want access to elders, to ceremonies and spiritual support. So we know in cancer care and particularly in treatment, that physical, mental, emotional and spiritual supports are equally important. The difference in terms of the Aboriginal community is this notion of family. Family means all your relationships. They are not necessarily your blood. In order for health care professionals to really engage us you have to have a relationship and that relationship takes time.”



### **Ontario Native Women's Association**

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 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, Hamilton and Timmins.

### **Aboriginal Health Access Centres**

AHACs play a central role in the individual, family and community healing journey because they focus on primary health care, something that aligns closely with the centuries-old vision for health that is common to all Aboriginal communities: linking physical, emotional, mental and spiritual well-being in an interconnected circle. The process of individual, family and community healing is grounded in reclamation of traditional cultural practice and belonging.

As the first point of access and services within the health system, AHACs are close to where people live and work. They connect clinical care, traditional medicine, health promotion and illness prevention, and use health as an opportunity to build partnerships in the community.

## **One Mind**

### **Lana Ray, Ontario Native Women's Association**

“How should we challenge cancer? First, with screening—our high rate of cancers would be reduced if there were adequate screening. Second, build trust and improve the historical relationship of Aboriginal women with the health care system.

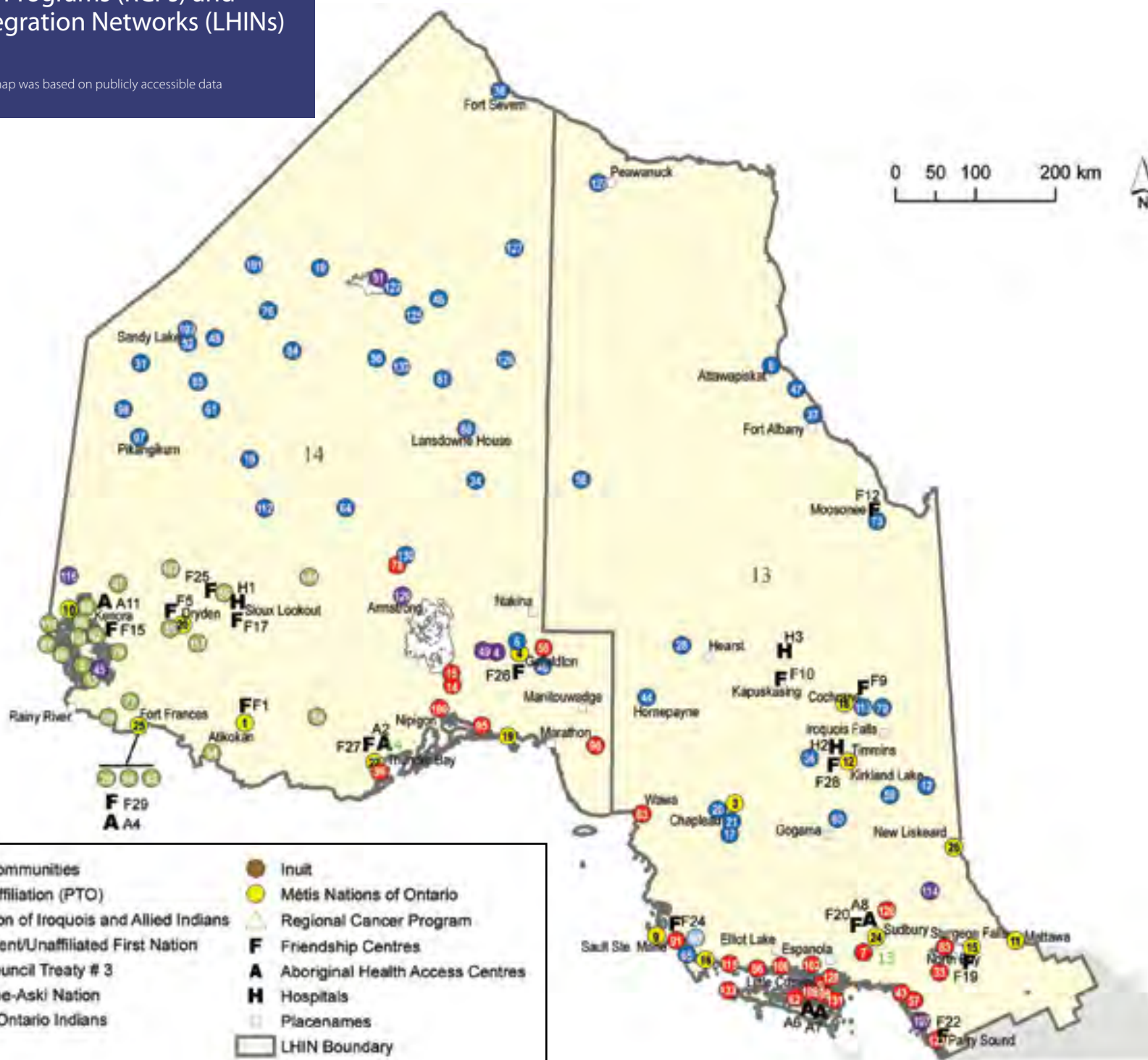
For Aboriginal people, word of mouth goes a long way. We know that a lot of our Aboriginal women don't have their own doctors and primarily go to emergency services. If a program works, the more Aboriginal women access that program and talk to each other, the more trust will develop and the more likely it is that other women will go to that program.

Trying to think positively and seeing the strengths is part of many Aboriginal cultures. So taking a strength-based approach to some of these issues may be the best path.”

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

Index on pages 50 and 51

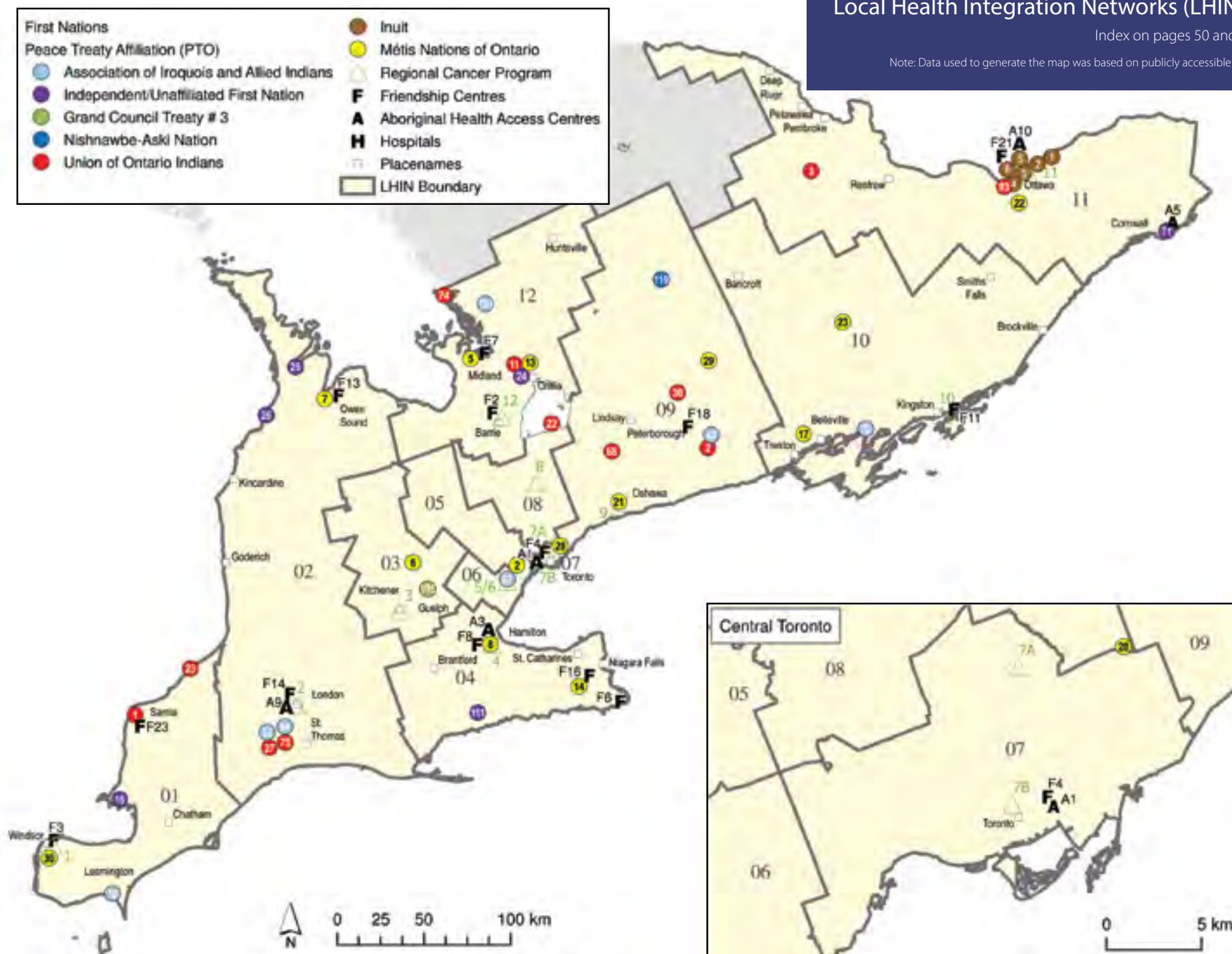
Note: Data used to generate the map was based on publicly accessible data



# South Ontario, First Nations Communities, Regional Cancer Programs (RCPs) and Local Health Integration Networks (LHINs)

Index on pages 50 and 51

Note: Data used to generate the map was based on publicly accessible data







# Mapping Aboriginal Ontario

## First Nations Communities Index

1. Aamjiwnaang First Nation
2. Alderville First Nation
3. Algonquins of Pikwakanagan 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
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24. Chippewas of Rama
25. Chippewas of Nawash Unceded (Cape Croker)
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27. Chippewas of the Thames
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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, Nookiwin Tribal Council
40. Ginoogaming First Nation
41. Grassy Narrows First Nation/  
Asubpeeschoseewagong 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 Inninuwig (Big Trout Lake)
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53. Lac Des Mille Lacs First Nation
54. Lac La Croix First Nation
55. Lac Seul First Nation
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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. Mcrebec Council of the Cree Nation
71. Mohawks of Akwesasne
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74. Moose Deer Point First Nation
75. Munsee-Delaware Nation
76. Muskrat Dam First Nation
77. Naicatchewenin First Nation
78. Namaygoosisagagun First Nation
79. Naotkamegwanning Anishinabe First Nation
80. Neskantaga First Nation
81. Nibnamik 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 Mobert 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
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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)
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3. Inuit Tapirit Kanatami
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5. Pauktuutit
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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
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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

## Regional Cancer Program

- △ 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

## 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. Ininew Friendship Centre, Cochrane, ON
- F10. Kapuskasing Friendship Centre
- F11. Katarokwi Native Friendship Centre
- F12. Moosonee Native Friendship Centre
- F13. MWikwedong Native Cultural Resource Centre
- F14. NAmerind Friendship Centre, London, ON
- F15. NeChee Friendship Centre
- F16. Niagara Regional Native Centre
- F17. Nishnawbe-Gamik Friendship Centre
- F18. Nogojiwanong Friendship Centre
- F19. North Bay Indian Friendship Centre
- F20. NSwakamok Friendship Centre
- F21. Odawa Native Friendship Centre
- F22. Parry Sound Friendship Centre, Parry Sound, ON
- F23. Sarnia-Lambton Friendship Centre, Sarnia, ON
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## 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

## Hospitals

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



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