Aboriginal Cancer Strategy II — Annual Report 2012-2013

Staying on the Path

Ontario

Cancer Care Ontario

Action Cancer Ontario

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Spirit Journey

All life is spirit.

Spirit connects body and mind, self and the external world. It is the wind, the earth, the fire, the water—all of those things that are alive with energy and movement.

When we allow a greater power to guide our journey, we succeed. And when we navigate the lifelong path to health we are guided by friends, family and even strangers.

"We are in a time of pivotal change where Aboriginal people are being recognized for the work we have always embarked on in building healthy communities. Building relationships for community wellness has been a practice of success. The team of the Shkagamik-Kwe Health Centre (AHAC) is honoured to have engaged in the relationships that have formed through the efforts of the ACS II. We will continue to expand on these relations to better respond to the health needs of the community we serve. With the quality work of the ACS II we have a vehicle for effective communication on promotion, prevention and treatment for individuals and families in their journey of a healthy life path."

Angela Recollet, Executive Director, Shkagamik-Kwe Health Centre, Sudbury

The Aboriginal Path of Well-being

Cancer Care Ontario honours the Aboriginal Path of Well-being in its pursuit of better prevention and treatment of cancer in Aboriginal communities. Our goal is to improve the performance of the cancer system with and for First Nations, Inuit and Métis peoples in Ontario 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

Cultural safety

To work in harmony with 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

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The Path

Staying on the Path

In Aboriginal culture, Nibwaakaawin—or Wisdom—is one of the Seven Grandfather Teachings that tells us that wisdom is given by the Creator to be used for the good of all people.

Last year, Cancer Care Ontario (CCO) and First Nations, Inuit and Métis peoples began a journey together to seek wisdom and share knowledge. In partnership, we learned that to stay on the right path we must embrace wisdom, love, respect, bravery, honesty, humility and truth.

Our collective strategy for doing this is articulated in the Aboriginal Cancer Strategy II (ACS II) and its six strategic priorities. The need is real. In Ontario among First Nations, Inuit and Métis, cancer rates are increasing disproportionally compared with overall Canadian rates. Modifiable risk factors and mortality rates from preventable cancers are higher, and individuals tend to present with later-stage cancers at the time of diagnosis.

At CCO we recognize this challenge and the needs of Aboriginal communities and are fully committed to delivering on the goals of ACS II.

Listening to our Aboriginal partners and talking to elders and cancer survivors has helped us understand the stories behind these numbers.

We are learning how to address Aboriginal concerns and more about healing and wellness to the benefit of all communities across Ontario. Our experience has taught us that engaging people in their own healthcare, listening before acting, and treating the whole person—not just the body—is the true path to wellness.

We are putting all those lessons into practice to deliver on our commitments in the ACS II. Prevention of cancer before it starts, early detection and improved access to highest quality care are central priorities for CCO for all people—no matter who they are or where they live in Ontario.

We recognize that we will succeed in reversing the trends in Aboriginal cancer by seeing through our commitment to work closely with Aboriginal peoples to stay on the path to wellness and to respect the seven teachings.

Michael Sherar

Michael Sherar
President and CEO

Michael Sherar signing the Grand Council Treaty #3 Relationship Protocol with Ken Skead (President of the Board, GCT#3), Grand Chief Warren White (behind) with Dr. Mark Henderson (RVP, NW RCP) and Dr. Linda Rabeneck (VP, CCO Prevention and Cancer Control)

Delivering on the Strategy

Welcome to Cancer Care Ontario's first "report card" on the Aboriginal Cancer Strategy II.

Together, CCO and representatives of First Nations, Inuit and Métis peoples across Ontario forged the ACS II. Now we are putting it into action. In the past year, CCO has signed Relationship Protocol agreements with Grand Council Treaty #3 and with the Anishinabek Nation. These protocols are the first of a series of agreements that will set a new course for engagement and collaboration between CCO and First Nation, Inuit, and Métis (FNIM) communities.

Our progress on this Aboriginal Path of Well-Being is supported by the values set out in the strategy: community-based, holistic in approach, culturally safe and inclusive, and above all through the resiliency and strength of spirit of the FNIM peoples.

Experience tells us that we will only succeed when First Peoples make this strategy their own. Cancer Care Ontario is intent on delivering on its promises, but we cannot succeed alone. To sustain the process and keep the commitment alive, we must seek guidance from established Aboriginal health networks, resources and expertise.

And that is what we are doing.

The newly created Aboriginal Patient Navigators are an important first step. The navigators put a human face on the cancer care system, delivering prevention messages, helping patients access and understand cancer services, and ensuring that care speaks to the cultural and spiritual needs of FNIM patients and their families. Although they are based in Regional Cancer Programs, navigators will also engage in community outreach—meeting people where they live and work. The navigators are supported by Regional Aboriginal Cancer Leads, who will engage and collaborate across varying primary care settings, advocating for and addressing the primary care needs of FNIM people in their regions.

By demonstrating accountability, we are also learning how to do things better. There is more in progress, and much to come, and with your help it is happening. I would like to say thank you to every person who has guided me on the way: to elders, survivors, the FNIM leadership, healthcare workers, everyday people and my colleagues at CCO and the Regional Cancer Programs for taking us this far.

Miigwech!

Alethea Kewayosh
Director, Aboriginal Cancer Control

Progress Highlights

The three FNIM peoples with CCO, Regional Cancer Programs and non-Aboriginal partners came together in 2012 to address the impact of cancer on FNIM. These partners are now taking on roles and responsibilities to address important FNIM cancer issues.

- CCO signed Relationship Protocols with Grand Council Treaty #3 and with the Anishinabek Nation (Union of Ontario Indians).
- The Nishnawbe Aski Nation (NAN) passed a resolution confirming the NAN Chiefs' support for the signing of a Relationship Protocol.
- There are Aboriginal Patient Navigators in seven of the ten priority regions and Aboriginal Cancer Leads are in place in five of the ten priority regions.
- Six of the Regional Cancer Programs, in collaboration with CCO's Aboriginal Cancer Control Unit and FNIM partners, have drafted Aboriginal Cancer Plans.
- FNIM core health tables have been identified/mapped in nine regions.

Verna Stevens
Aboriginal Patient Navigator
Champlain Region

Like many FNIM people, Verna Stevens has lost family members to cancer. As an Aboriginal Patient Navigator, she is closing the circle by working to promote screening, early diagnosis and better follow-up. An Algonquin from the Kitigan Zibi First Nation, Verna has over 12 years of experience working with First Nations and advocating for First Nations inherent and treaty rights.

The Champlain region in Eastern Ontario is home to 32,000 First Nations, Inuit and Métis people. It is unique in being home to more Inuit than any other part of Ontario. Working with Inuit Tapirisat Kanatami has helped Verna understand Innu values and challenges. "We will be meeting with the health director of Tungasuvvingat Inuit," she says, "and I hope to forge strong connections with that program and the Inuit living in the Ottawa area." Similarly, Verna will be working to integrate the Aboriginal Patient Navigator program with already well-established health systems like those found in Akwesasne and Pikwàkanagàn.

Many FNIM peoples in the Champlain region live in rural and remote areas and transportation looms large as an issue. Accessing medical transportation under non-insured health benefits is a challenge. Although transportation out of the community for cancer screening is now covered, barriers still exist.

"There is always someone left at home—children, a parent or grandparent—who needs caring for," says Verna. "It's hard to leave and it is still costly. When it comes down to spending $20 on food or $20 on gas to drive out for treatment or a medical appointment, most people choose groceries. If the patient or client doesn't have their own vehicle, then it comes down to finding someone with a car to give you a ride, and that's not always successful."

"I love the idea of the mobile screening bus," Verna says. "Being able to go out where people live, to access a much needed service would make a big difference."

Cancer Care Ontario's Commitment

Cancer Care Ontario is responsible for cancer services to First Nations, Inuit and Métis (FNIM) peoples. We work to reduce the number of people diagnosed with cancer, and make sure patients receive better care every step of the way.

CCO plans and coordinates cancer services across the province. Our goal is to prevent cancer by promoting healthy living, and to catch it early through screening and detection services. We are supported by FNIM councils and organizations, by health organizations and groups involved in cancer prevention and care, and many health professionals.

Representatives from JOACC and leaders from FNIM groups

Guiding this process are:

Our 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.

CCO's Aboriginal Cancer Strategy II (ACS II), which 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 capacity and the tools to create change.

CCO's Ontario Cancer Plan III (OCP III), which is the blueprint 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.

The Joint Cancer Care Ontario-Aboriginal Cancer Committee (JOACC), which guides and advises CCO on strategies to outreach to FNIM peoples and reduce the incidence of cancer among Ontario's Aboriginal populations and includes representatives from Aboriginal organizations and Elders.

The 13 Regional Cancer Programs across the province, which deliver cancer prevention and care, ensure standards are met and provide an important two-way channel for local concerns and issues. Their networks include regional cancer centres and stakeholders, including patient groups, healthcare professionals and organizations involved in providing cancer prevention, screening, diagnosis and treatment.

Progress through Partnership

To achieve our goal of improving Aboriginal cancer prevention and outcomes, CCO partners with Aboriginal communities and organizations. The CCO Aboriginal Cancer Control Unit is working directly with provincial FNIM groups to ensure that both programs and strategies are relevant and effective at the community level.

It is important for us to maintain these relationships both provincially and within the regions. It is only by staying on this path that we can deliver on the important promises in the Aboriginal Cancer Strategy II and achieve our ultimate objectives:

- Aboriginal communities are empowered to take control of health risks such as obesity, alcohol abuse, non-ceremonial use of tobacco, physical inactivity and poor diet.
- Every FNIM person in Ontario who should be screened, is screened.
- All cancers detected are treated promptly and effectively.
- Cancer care treats the whole person and is guided by the Aboriginal Path of Well-being.

The ACCU meeting with representatives from Inuit Tapiriit Kanatami and Tungasuvvingat Inuit in Ottawa, September 2013. Inuit Tapiriit Kanatami: Looee Okalik; Tungasuvvingat Inuit: Connie Siedule and Dr. Indu Gambhir

Staying on the Path

Why We Need an Aboriginal Cancer Strategy

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 healthcare and are unfamiliar with the health system. At one time, Aboriginal peoples in Ontario had lower cancer rates than other Ontarians. Now, cancer rates are increasing.

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

You can read more about cancer incidence and prevalence in Aboriginal Ontarians, and CCO's commitment to change in the ACS II: *https://www.cancercare.on.ca/cms/one.aspx?pageId=9315*

Engagement is a Priority

Because FNIM peoples are distinct constitutionally recognized peoples with Aboriginal and Treaty Rights, CCO engaged directly with individual FNIM nations to develop the ACS II. Our Relationship Protocols with FNIM groups create formal accountability for the ACS II. The protocols reflect a relationship based on trust and respect for FNIM leadership, their governance structures and political process. Our objective is to improve the well-being of FNIM children, families and communities while protecting and promoting the distinct culture, identity and heritage of FNIM peoples.

The Path

How will we achieve those objectives? We will strengthen the central and local capacity for preventing and treating cancer through:

- Stakeholders coming together … listening and understanding
- Being inclusive—exploring every opportunity to do our work better
- Jointly developing and implementing

Listening to our partners yielded the six strategic priorities of the ACS II. Our deliverables for those strategies are cancer control policies and initiatives that demonstrably achieve our Vision.

Ontario Cancer Plan III

ACS II is a deliverable within the Ontario Cancer Plan III's Strategic Priority of Risk Reduction. CCO aims to provide people with the knowledge they need to make informed decisions about their care. Through OCP III, 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

To read the plan, go to ***http:/ocp.cancercare.on.ca/***

Ontario Cancer Plan III Goals

1. Help Ontarians lessen their risk of developing cancer
2. Reduce the impact of cancer through effective screening and early diagnosis
3. Ensure timely access to accurate diagnosis and safe, high-quality care
4. Improve the patient experience along every step of the patient journey
5. Improve the performance of Ontario's cancer system
6. Strengthen Ontario's ability to improve cancer services and control through research

ACS II Strategic Priorities

1. Build productive relationships
2. Research and surveillance
3. Prevention
4. Screening blitz
5. Palliative and Supportive care
6. Education

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 Plan for Action 2013-2014

CCO and its partners made great gains in 2012-13 and we are driving hard to meet our strategic objectives. By June 2014, this includes:

- FNIM Relationship Protocols drafted and signed with all provincial-level organizations and the Ottawa Inuit
- Hiring three more Aboriginal Patient Navigators and five more Aboriginal Cancer Leads (10 of the 13 Regional Cancer Programs will have one of each)
- Completing an environmental scan of new and existing FNIM data, and assessing data usability to improve screening and surveillance
- Collaborating with the Centre for Addiction and Mental Health to develop and pilot a culturally appropriate FNIM-specific TEACH (Training Enhancement in Applied Cessation Counselling and Health) program that will train health care workers who serve FNIM people to deliver effective, evidence-based tobacco cessation intervention
- Adding a third Tobacco-wise Lead to reinforce our program capacity
- Using sharing circles in FNIM communities as focus groups to explore attitudes to the four key modifiable risk factors, perceptions of barriers and challenges, and receptivity to changing lifestyle habits
- Developing a lay health educator program for cancer patients and their families
- Developing and testing e-learning modules on cultural safety and sensitivity training for healthcare providers and staff who provide services to FNIM cancer patients and their families

The ACCU meeting with representatives from the Métis Nation of Ontario Healing and Wellness Team in Ottawa, September 2013. Métis Nation of Ontario: Wenda Watteyne, Kristina Jewell and Whitney Montgomery

Sherri Baker, NCFW, BSW, RSW
Aboriginal Patient Navigator
North East Region

Eight years helping families in the mental health field gave Sherri Baker a strong foundation for her work as an Aboriginal Patient Navigator. "There is a big mental health component in my work, we often see people suffering from depression or anxiety."

The medical aspect of the job presented more of a challenge. Sherri oriented herself by shadowing oncologists and radiologists, and other disciplines within the Cancer Centre. This process is a two-way street. Sherri is making sure everyone in the system understands her mandate as a Navigator, presenting at radiation rounds, joint nursing rounds and to all the program oncologists.

"My region is huge—with many communities and a huge territory—and each is unique. Take my home of Bear Island, for example; it is accessible by water only. When the ice road is not open for travel, people on Bear Island can't leave for treatment."

"My region has many challenges—from the lack of paid translators to psychological trauma caused by abuse in residential schools to drugs, alcohol and smoking." Transportation and resources to care for family left behind are daunting problems in the North. Leaving the community means a family expedition and this can complicate getting people to appointments on time.

As we heard in other communities, trust is an issue. "There is a huge lack of trust in the healthcare system—the feeling that you're just a number." This is made worse by the stigma of cancer. Many people are not comfortable dealing with others who have cancer, which can be alienating for the cancer patient.

For Sherri's part, she continues to advocate and network. She is collaborating closely with the coordinator of the under/never screened program and making presentations to community members about the value of early diagnosis—one community at a time.

Reporting

Progress by Strategic Priority

Priority 1: Build productive relationships

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

Objectives—by 2015

Have formalized relationship protocols between CCO and each FNIM group

Have 10 Aboriginal cancer control networks in place

Establish FNIM/Ontario federal collaboration to address FNIM cancer control issues

Action

Engage provincial FNIM health/advisory committees and leadership directly

Hire and train Aboriginal Leads (0.2 per week of a Regional Cancer Program full-time employee) in 10 Regional Cancer Programs; funding to flow to Regional Cancer Programs

Staying on the Path—2013

Relationship Protocols

- Drafted protocols for four FNIM leadership organizations
- Signed Relationship Protocols with Grand Council Treaty #3 and the Anishinabek Nation (Union of Ontario Indians)
- Nishnawbe Aski Nation (NAN) Resolution confirmed NAN Chiefs' authorization for NAN to sign a Relationship Protocol
- Association of Iroquois and Allied Indians (AIAI) will be signing a Relationship Protocol in the coming months
- Initiated discussions with Métis and Inuit groups to develop protocols

Networks and Planning

- Funding for Aboriginal Patient Navigators and Regional Aboriginal Cancer Leads in the 10 priority regions
- Continued direct engagement with core FNIM health tables (boards, advisory groups and committees) and leadership
- Six of ten RCPs have drafted joint RCP/ACS II Aboriginal Cancer work plans; four are in progress
- FNIM networks mapped in nine regions; RCPs being guided to engage directly with FNIM communities, building regional capacity to address FNIM cancer control
- Seven Aboriginal Patient Navigators and five Regional Aboriginal Cancer Leads hired

Priority 2: Research and surveillance

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

Objectives—by 2015

- Build FNIM database of surveillance, screening and treatment statistics
- Implement the process and capacity to measure and analyze FNIM cancer burden and screening data
- Complete progress evaluations and use the findings to inform and improve post-2015 initiatives

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

Staying on the Path—2013

Building a FNIM database

- Working with the Chiefs of Ontario (COO) and the Institute for Clinical and Evaluative Sciences (ICES) to update information on the burden of cancer among First Nations in Ontario through an analysis of the data file created through linkage of the Indian Registry System (IRS) and the Ontario Cancer Registry (OCR)
- Establishing governance agreement with COO to develop and share community cancer profiles with First Nations across Ontario (aggregate report identifying cancer burden)
- Established partnership agreement with the Kenora Chiefs Advisory to pilot data linkage opportunities with community-led client registry (Kenora Chiefs Advisory Client Registry) to inform both community and CCO on screening activities for breast, colorectal and cervical screening programs and potential development of cancer profiles
- Produced current prevalence estimates for several cancer risk factors for both Ontario Métis and Ontario off-reserve First Nations (see Cancer and Aboriginal Peoples section of report)
- Produced current estimates of screening participation (colorectal, breast and cervical cancers) for both Ontario Métis and Ontario off-reserve First Nations (see Cancer and Aboriginal Peoples section of report)

Priority 3: Prevention

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

Objectives—by 2015

Negotiate a province-wide smoking cessation agenda that is supported by FNIM groups

Implement the methodology needed to measure and track FNIM smoking cessation rates

Develop a plan 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

Staying on the Path—2013

Province-wide smoking cessation agenda

- Developed the Aboriginal Tobacco Partnership Table, comprised of provincial level organizations with a health focus and interest to address Aboriginal tobacco issues and needs
- Through the Aboriginal Tobacco Partnership Table (ATP), initiated the development of customized resources for First Nations communities on the prevention, cessation and protection of commercial tobacco
- Established cross-jurisdictional and organizational partnerships through the ATP to streamline efforts within communities, and improve reach and programming to communities

Measure cessation rates

- Developing a model to measure and track First Nations commercial smoking rates with communities

Smoke-free communities

- Visited over 100 communities and organizations since January 2012 to work with communities on the prevention, cessation and protection of commercial tobacco
- Appointed two Tobacco-wise Leads and recruiting one more

Chronic disease prevention

- Initiating the development of a Chronic Disease Blueprint to inform recommendations to reduce risk factors for FNIM populations

Priority 4: Screening

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

Objectives—by 2015

- Develop FNIM identifiers and database for InScreen
- Implement a province-wide FNIM integrated cancer screening program
- Establish screening participation targets for FNIM peoples that are informed by 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

Staying on the Path—2013

FNIM input to InScreen

- Work begun on plan to establish FNIM identifiers for InScreen. This work will help inform how to develop Metis and Inuit identifiers

Integrated FNIM cancer screening program

- Continued support to the original four Under/Never Screened (U/NS) pilot projects
- Initiating a plan to promote Registered Nurse Flexible Sigmoidoscopy (RNFS) with existing RNFS sites (Timmins and Montfort) and advocating expansion to hospitals serving First Nations communities

Establish screening participation targets

- Co-developing options to develop provider based reporting on screening for communities with dedicated postal codes
- Determined screening participation targets for colorectal, breast and cervical cancer, for off-reserve First Nations and Métis

Priority 5: Palliative and supportive care

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

Objectives—by 2015

Establish Aboriginal Navigators in nine Regional Cancer Programs

Implement FNIM program measurement to track patients and program improvements

Make pain and symptom management tools and pathways available to FNIM

Action

Hire and train nine Aboriginal Navigators to build supportive relationships and increase palliative care knowledge and skills

Deploy the Edmonton Symptom Assessment System (ESAS) tool using the Interactive Symptom Assessment and Collection (ISAAC) tool in urban and rural communities; use tele-ISAAC—which allows cancer patients to enter their symptom scores by telephone—in northern and remote communities

Staying on the Path—2013

Aboriginal Navigators

- There are Aboriginal Patient Navigators in seven of the ten priority regions and recruitment is well underway in the other regions
- Dedicated resources serving FNIM patients

Track FNIM patients and program

- Completed a needs assessment to develop FNIM-specific tools to support palliative care mentorship among health care providers (help build capacity to improve symptom management in primary care)
- Developing a lay health educator program for cancer patients and families

Pain and symptom management accessibility

- Launched a pilot initiative for pain and symptom management (ESAS) through mobile technology on Manitoulin Island (later to expand across major Health Centres in Ontario serving FNIM patients)

Priority 6: Education

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

Objectives—by 2015

Engage FNIM communities to increase people's knowledge and understanding of cancer, including cancer prevention and screening

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

Staying on the Path—2013

Engage FNIM communities

- Expanding the reach of Science Travels, a program focused on educating and building awareness among youth in careers in the sciences and chronic disease prevention and cancer among FNIM communities
- Collaboration with the Centre for Addictions and Mental Health to develop FNIM-specific TEACH e-training on commercial tobacco cessation

Increase knowledge

- Planning the development of Relationship Building E-modules, to educate the health care professionals and researchers on cultural sensitivity/history/issues when working with FNIM patients
- Planning development of FNIM-specific cancer prevention, screening, palliative care education resources

Tobacco-wise Lead with CHR at Rama First Nation, National Addictions Health Week

Progress Reports

Regional Cancer Programs

Regional Cancer Programs (RCPs) implement provincial standards and programs for cancer care and ensure that service providers adhere to their partnership agreements with Cancer Care Ontario. Aligned geographically with the province's 14 Local Health Integration Network (LHIN) regions, the RCPs respond to local cancer issues, coordinate the provision of care, and work to improve access, wait times and quality. They are created and funded by Cancer Care Ontario, which in turn is responsible for provincial integration and liaison with the Ministry of Health and Long-Term Care.

The ACCU employs a "three pillar" approach to working with the RCPs and FNIM populations in Ontario:

1. **Meet with RCPs:** An initial meeting is held to discuss ACS II strategic priorities and targets, establish primary contacts, and identify and/or develop a working group within the RCP. The ACCU, in close partnership with the RCP working group, then develops a Regional Aboriginal Cancer Plan to make the cancer system work better for FNIM people. The draft plan is taken to the FNIM core health tables for review/input and approval to finalize.

Mark Tomen, MD
Regional Cancer Lead
Erie St. Clair Region

"I've lived in the Chatham area all my life and practised medicine for more than 25 years," says Dr. Mark Tomen, "but I had never realized the barriers that exist for Aboriginal peoples accessing the healthcare system." Approached by Audrey Logan, the local Aboriginal Patient Navigator, Mark has accepted the challenge of breaking down those barriers. As a Regional Cancer Lead, he is learning about the current issues by working with the local community health centres, learning from previous focus groups, as well as working with Aboriginal leadership, CCO and the local cancer services to make a change. "This is a two- to three-year plan," he says, "and it is based completely on engagement and listening first."

"This came at a good stage in my career as I was ready for something new. Meeting the diversity of people, including First Nations, Inuit and Métis peoples, has been one of the pleasures and interests of my job. There is quite a variety of groups—all different—and each must be approached with respect. It's all about building trust. I have always done my best in this regard with my patients and it's time for the healthcare system to do the same. Respect certainly goes a long way in healing."

Part of respect is not blaming people for their own illness. "If someone smokes and is having a hard time stopping, then I will give them the same respect, regardless. It has never helped blaming people for their disease. Let's admit it; the medical community has often not done well by its Aboriginal clients and this is part of the current problem in cancer care. It is no wonder they feel that they are getting second-class care. Part of my job is talking to health care teams and making them aware of the issues faced by Aboriginal people. For example, few doctors realize just how hard it is for some Aboriginal people to get an Ontario health card. In my practice we have responded to this problem with an easy-to-understand information package including everything they need to get a health card."

Mark Tomen's own experience with cancer gave him firsthand insight into the complexity that patients face. "When my father developed cancer I was the go-to resource. I took him to all of his appointments and navigated the system. In the middle of it, I asked myself, how do people do this without going to medical school? The other thing that hit home was how the system focuses on the technical and forgets that we are dealing with a person."

Mark's role as a Regional Cancer Lead is also feeding back into his own practice. "Everything I've learned about cancer clinics, CCO and the Aboriginal approach to wellness is informing all of my practice."

2. **Establish FNIM Networks:** Across each of the 10 priority regions, the ACCU identifies core FNIM health tables (boards, committees and advisory groups) to provide guidance and feedback on the Regional Aboriginal Cancer Plans before finalization. This ensures that FNIM people have a voice in the delivery of cancer services. By establishing these FNIM health networks, the RCPs can then engage directly, respectfully and sustainably with FNIM people, and understand the needs and challenges unique to FNIM people in each region.
3. **Build RCP Capacity:** To address FNIM cancer control issues effectively, dedicated resources are established in the RCPs. Aboriginal Patient Navigators provide support for FNIM patients 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 between the RCPs, the ACCU and core FNIM health tables.

Regional Aboriginal Cancer Work Plans

The ACS II is implemented at the grass roots level by the RCPs. The first step in this process is to map FNIM core health tables, and then engage these health tables in the drafting of Aboriginal Cancer Plans. These plans are the blueprints for making the regional cancer system work better for First Nations, Inuit and Métis people. They set out the priorities, actions required and timeline for completion.

Each plan is the result of close partnerships between CCO's Aboriginal Cancer Control Unit (ACCU), the RCP and core FNIM health tables (boards, advisory committees and groups) in each region. The process involves the FNIM health directors, community health workers, nurse practitioners, board and community members that make up these core health tables. Their insights ensure that FNIM voices are heard, respected and involved in the design of cancer services.

Ten regions in Ontario have significant FNIM populations. To date, CCO and six regions (North West, North East, Hamilton Niagara Haldimand Brant, North Simcoe

"Meeting with each core FNIM health table in the region in partnership with the ACCU has provided me with the opportunity to build on existing and develop new relationships. Not only is this helping to establish the RCP role in implementing the ACS II with FNIM communities, it is achieving the first priority of the ACS II, which will be the cornerstone of implementing the remaining five priorities."

Mark Hartman, Regional Vice President, North East Regional Cancer Program

Muskoka, South East and Erie St. Clair) have developed draft Aboriginal Cancer Plans. The remaining four (Champlain, Toronto Central, South West and Central East) are in progress.

The development of an Aboriginal Cancer Plan might follow this path:

1. Meet with RCP to discuss ACS II strategic priorities and targets, establish primary contacts, and identify and/or develop a working group
2. Mapping FNIM networks and engaging health boards
3. Engaging FNIM on local needs and priorities
4. Reviewing existing education and outreach resources and programs
5. Coordinating with existing FNIM cancer prevention strategies
6. Building on regional and FNIM cancer screening programs
7. Creating sustainable systems that both respond to and are controlled by local FNIM peoples

Engaging the local community, building ownership and creating momentum for a self-sustaining system is a challenge. By delivering on the ACS II priorities and staying accountable, CCO and the RCPs are gaining the credibility and trust needed to succeed.

Mapping Regional Core Health Tables

Each region has a FNIM health network, consisting of boards, groups and advisory tables servicing FNIM people. CCO and the RCPs tap into this network to ensure FNIM have a voice in the delivery of regional cancer services. These core FNIM health tables have the opportunity to review the draft Aboriginal Cancer Plans as they are being developed and provide guidance and feedback

Staying on the Path

How Partnerships Build Capacity

In the North East Region, Aboriginal cancer concerns are embedded in the overall regional cancer strategy, which includes an Under/Never Screened project with Aboriginal partner organizations. The project's objectives are to:

- Engage aboriginal partner organizations in developing and leading sustainable community based screening improvement projects
- Assist aboriginal health centres with detailed analysis of current screening practice profiles
- Support aboriginal health centres in identifying and inviting eligible people to screening
- Assist in removing barriers to screening

The ACCU and the North East RCP engaged with 11 core FNIM health tables to develop the regional work plan. At each meeting, we identified specific community needs and unique challenges relevant to cancer care; all feedback was subsequently incorporated into the North East Aboriginal Cancer Plan. This collaborative approach creates an action document that is respectful, sustainable and informed by the people for whom the work plans are developed.

North East Regional Vice President Mark Hartman and the ACCU attended all meetings with core FNIM health tables in the region together. This has helped forge and develop strong relationships between the North East RCP and core FNIM health networks in the region, and will result in the creation of an FNIM advisory table (in the process of being established), which will act as a go-between the RCP and the FNIM community in the delivery of cancer services.

Relationship Protocols

A critical commitment in ACS II is increased collaboration between CCO and First Nation, Inuit, and Métis (FNIM) communities. To date, CCO has signed two Relationship Protocols with FNIM groups and more are in the negotiating process. *"These protocols are an important step for implementation of ACS II,"* says Alethea Kewayosh, Director for the Aboriginal Cancer Control Unit at Cancer Care Ontario. *"Each community has unique needs. By signing these protocols, CCO and the FNIM groups are agreeing to work together to tackle the challenge of cancer and improve the health of their FNIM peoples."*

Relationship Protocol with the Grand Council Treaty #3

CCO signed a Relationship Protocol in May 2013 with the Treaty 3 Anishinaabe communities at their Annual General Assembly held at the Northwest Angle 37 First Nation near Sioux Narrows, Ontario. Warren White, Grand Chief of the Grand Council Treaty #3, said, *"We have seen rates of cancer rise with the increased extraction of resources from our territory, heavier reliance on larger scale food systems and more exposure to environmental pollutants. We must take action against cancer in our communities. Treaty 3 Anishinaabe communities and the whole northwest region will benefit from these important initiatives we are undertaking with Cancer Care Ontario."*

Nishnawbe Aski Nation Chiefs AGA, Kasabonika Lake First Nation, August 15, 2013

Michael Sherar and Grand Chief Warren White, Grand Council Treaty #3

Relationship Protocol with the Union of Ontario Indians

CCO and representatives of the Anishinabek Nation signed their Relationship Protocol in June 2013. Grand Council Chief Patrick Madahbee said the Anishinabek Nation's political secretariat (the Union of Ontario Indians) has a mandate to protect its 60,000 citizens and is committed to working with partners who share their goal of supporting the Anishinabek to lead healthy, productive lives.

Grand Council Chief Madahbee said the Anishinabek Nation is committed to partnering with CCO to *"raise the awareness of our people about the importance of early detection and to get screened for prostate and breast cancer and to get colonoscopies. All these things are so crucial because we are inundated. There is no First Nation that is immune from the tragedies and losses of people to cancer."*

Grand Council Chief Patrick Madahbee signs Relationship Protocol between the Anishinabek Nation and CCO.

Audrey Logan, BA
Aboriginal Patient Navigator
Erie-St. Clair Region

The path to wellness, says Audrey Logan, must be inclusive, welcoming and free of fear. "Empowering people—focusing on wellness as the goal and showing people that they have control—is essential to their health." Far too often, she says, people are reluctant to admit being ill and are even more averse to going to hospital. Audrey's solution is to go the people.

Since becoming an Aboriginal Navigator in the Erie-St. Clair region in April 2013, she has energetically networked to increase awareness of her program. For example, Audrey's action plan is the result of a brainstorming session with all the communities. "Before I started, I needed to understand what does the patient, the family, the hospital and the community need. The answer was clear: information, communication, a supporting hand and the acknowledgement that Aboriginal clients are not the same as everyone else. What we hope to do in our plan," she says, "is put all those needs together to build trust."

Audrey knows that change can't come soon enough; in January there were two communities hard hit with a loss of 11 people. "People won't say they're sick and a lot of people are diagnosed too late. They don't reach out because they don't trust the system—there are barriers, both traumatic and historic. And that is why so many are not part of our screening programs." Our job is to change that!

A Lunaapeexkweew (Lenape woman) from the Delaware First Nation, Audrey is reaching out to health care providers through events like diversity fairs, cultural awareness lunch and learn sessions, and speaking with nursing students (as an extracurricular activity). This is a wonderful opportunity to share First Nation, Métis and Inuit protocols to provide the health team with understanding and comfort in their delivery of care. "A big piece of the story is education and this will be an ongoing goal. It's all about people meeting people—the more we reach out, the more people learn and the more we can focus on wellness instead of sickness."

"I have faith that the Creator is here to help. You may not know where help will come from, but if you ask for help, it will come. All my work as a health advocate is guided by that faith and my belief in empowering people to bring about change."

"Hospitals are an entirely alien environment for the average Aboriginal person—and even for me. However, my experience at the Windsor Regional Hospital has been nothing but positive. The hospital is fully vested and open to our communities. They have been phenomenal and I feel truly honoured to be included as part of their team. The highlight of my experience so far is being allowed to attend one of the multidisciplinary patient meetings."

Partnerships

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 Health Centre (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 Programs (RCPs) are our most important partners in this strategy to reclaim our health and well-being. The 13 RCPs provide prevention and screening, supportive care, treatment (surgery, radiation therapy and chemotherapy), and end-of-life care. RCPs 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. RCPs such as those located in Sudbury, Thunder Bay, Kingston, Ottawa and Barrie offer accommodation for out-of-town patients who must travel there for treatment.

Ontario Renal Network

The Ontario Renal Network (ORN) is the provincial resource for the Chronic Kidney Disease (CKD) care system. The ORN is committed to reducing the impact of CKD by improving early detection and prevention of progression. A key initiative of the ORN is to work with FNIM communities to address their unique needs for CKD prevention, screening and management. The Director for Aboriginal Cancer Control will work with the ORN to help implement this initiative.

Important Aboriginal Partners

Ontario Federation of Indian Friendship Centres

The Ontario Federation of Indian Friendship Centres (OFIFC) is a provincial Aboriginal organization representing 27 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."*

"The North East Aboriginal Under/Never Screened project for increasing breast and colorectal cancer screening rates in First Nations/Aboriginal communities is a true partnership of these communities and the various partners of the North East Cancer Centre in decision making, design, implementation and evaluation. We look forward to building on these partnerships to improve Aboriginal cancer care services beyond screening and develop a regional Aboriginal cancer plan for the North East."

Elaine Johnston, Executive Director, RN, BScN, Mnaamodzawin Health Services Inc.

Staying on the Path

Regional Cancer Program: Navigators and Leads

Aboriginal Patient Navigators have been appointed in seven regions and Regional Aboriginal Cancer Leads in five regions. Recruitment is underway for these positions in the remainder of the RCPs.

North West
Aboriginal Patient Navigator: Jeannie Simon
Regional Aboriginal Cancer Lead: Dr. Shannon Wesley

North East
Aboriginal Patient Navigator: Sherri Baker
Regional Aboriginal Cancer Lead: Dr. Annelind Wakegijig

Hamilton Niagara Haldimand Brant
Aboriginal Patient Navigator: Lee Styres-Loft
Regional Aboriginal Cancer Lead: Dr. Andrea East

North Simcoe Muskoka
Aboriginal Patient Navigator: Leah Bergstrome

Erie St. Clair
Aboriginal Patient Navigator: Audrey Logan
Regional Aboriginal Cancer Lead: Dr. Mark Tomen

Central East
Aboriginal Patient Navigator: Kathy McLeod-Beaver

Champlain
Aboriginal Patient Navigator: Verna Stevens

South West
Regional Aboriginal Cancer Lead: Chris McDonald

Reporting

Ontario Native Women's Association

The 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'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.

Aboriginal Health Access Centres

Aboriginal Health Access Centres (AHACs) play a central role in the individual, family and community healing journey because they focus on primary health care. This aligns closely with the centuries-old vision for health

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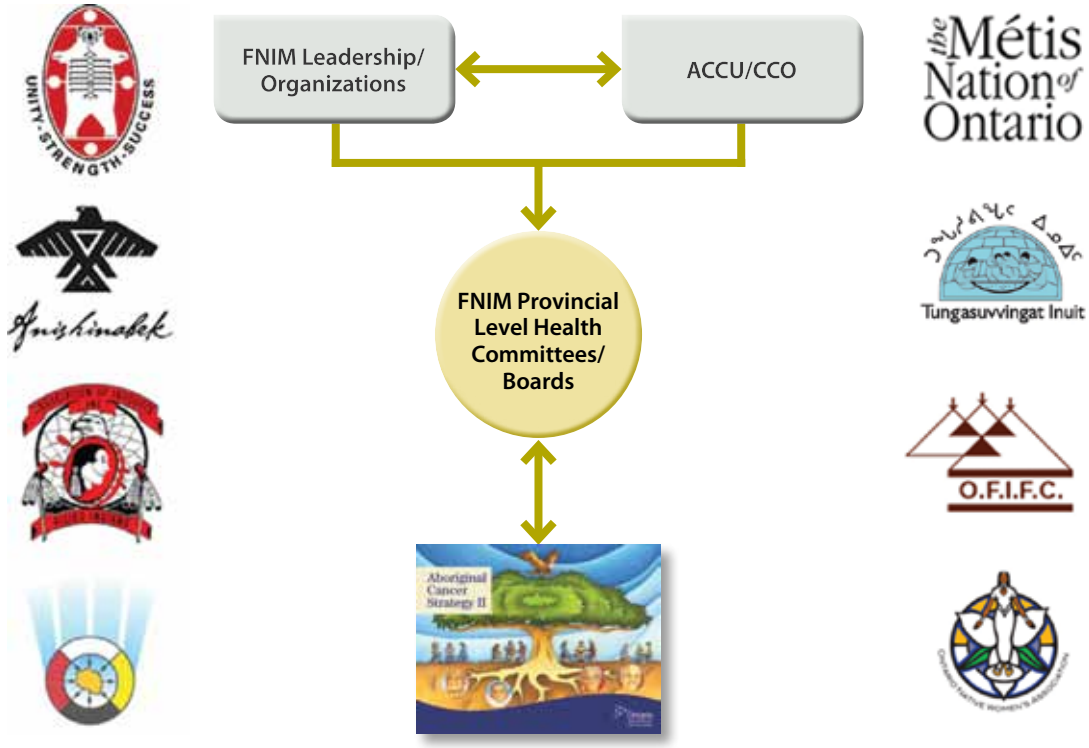
Partnership Process



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.

CCO Aboriginal Cancer Control team meeting with Aboriginal Health Access Centres' leadership

Jeannie Simon, BScN
Aboriginal Patient Navigator
North West Region

Language is the greatest barrier to facilitating the Aboriginal experience in the cancer system, says Jeannie Simon, who has been the North West Aboriginal Patient Navigator since April 2013. Jeannie's background ideally suits her to the challenges of navigating cancer care in the North. She has 10 years' experience as a community health representative in her own community, Summer Beaver, and also trained as a nurse at Lakehead University. Jeannie well understands the patients' challenges. There are numerous barriers for patients to access cancer services in the Northwest. With over 70 First Nation communities and over 29 of those accessible by air or winter ice road, many people must travel long distances to access diagnostic tests and treatments. "As a trained professional from the community, I am in a great position to understand and support people here."

The cancer system is complex for anyone to understand, but language and distance exacerbate the complexity. "Some of our patients have never been out of the community," Jeannie says. "Those who only speak Cree, Oji-Cree or Ojibway need support throughout the process. I advocate for patients and their families before, during and after their appointments or treatment program. I work closely with the Palliative Care team and act as liaison for families either here at the hospital or through our tele-visitation program, which allows patients and the health centre to stay connected with remote family members."

Jeannie has already briefed radiologists, oncologists and local health organizations about her services, and travelled to local communities such as Sandy Lake, Fort Francis, Sioux Lookout and Red Lake. She is also working closely with Dr. Shannon Wesley in the Prevention and Screening program to promote early diagnosis. "Far too many of the people I see are at the later stages of cancer."

The Challenge

Cancer and Aboriginal 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: 301,425 or 2.4% of the provincial population. Of these, there were 125,560 registered or Status Indians in 2011.

Ontario's Aboriginal population is young and growing. One-third (33.9%) of the population is aged 19 and younger, compared to 23.8% for the non-Aboriginal population. Between 2006 and 2011, Ontario's Aboriginal population increased 24.3%, five times faster than the rate of growth for the non-Aboriginal population.

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; 28 of these communities are isolated, with no year-round road access (this includes fly-in communities 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. The absolute number of First Nations peoples living on- or off-reserve is not clear. Based on the Aboriginal Affairs and Northern Development Canada (AANDC) Indian Registry of Status Indians, some 51% of First Nations people with registered Indian status live on-reserve and 49% live off-reserve.

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, including work, education, housing and health reasons.

Métis

The term Métis generally refers to descendants of people born of relations between First Nation 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. About a third of Ontario's Aboriginal peoples are Métis. Many more Ontarians today identify themselves as Métis than previously: 86,015 in 2011 compared to 73,605 in 2006. Most (72%) Métis report living in urban areas (2006 Census).

How Cancer Affects Aboriginal Peoples in Ontario

The burden of cancer among FNIM peoples is impacted by both the prevalence of several modifiable risk factors and screening participation. Modifiable risk factors account for approximately 30% of cancer deaths.[1] The following are important modifiable risk factors for cancer.[2-7]

- Non-traditional use of tobacco and second-hand smoke exposure
- Alcohol use
- Obesity
- Sedentary behaviour and physical inactivity
- Inadequate vegetable and fruit consumption

Cancer screening tests are used to detect pre-cancer or cancer at an early stage when it is easier to treat. In Ontario, routine screening is recommended for breast, cervical, and colorectal cancers.

CIGARETTE SMOKING AND SECOND-HAND SMOKE EXPOSURE

Tobacco use is the most important risk factor associated with cancer, causing an estimated 22% of cancer deaths worldwide and 71% of global lung cancer deaths.[1]

First Nations

- **Current cigarette smokers**

  Smoking is significantly higher among the First Nations population compared to the non-Aboriginal population across both sexes.

- **Second-hand smoke exposure**

  First Nations non-smoking males report significantly higher second-hand smoke exposure in either the home, car, or in public places than non-Aboriginal males.

Métis

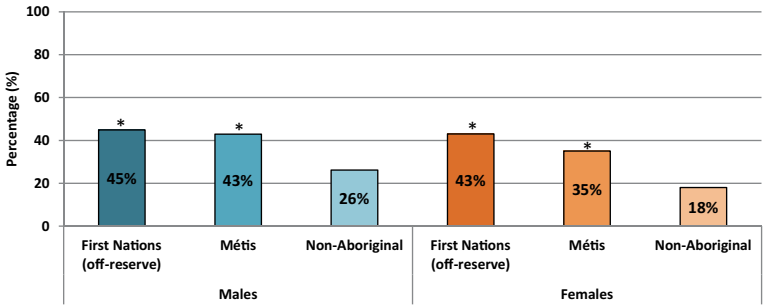
- **Current cigarette smokers**

  The prevalence of smoking is significantly higher among Ontario's Métis population compared to the non-Aboriginal population.

- **Second-hand smoke exposure**

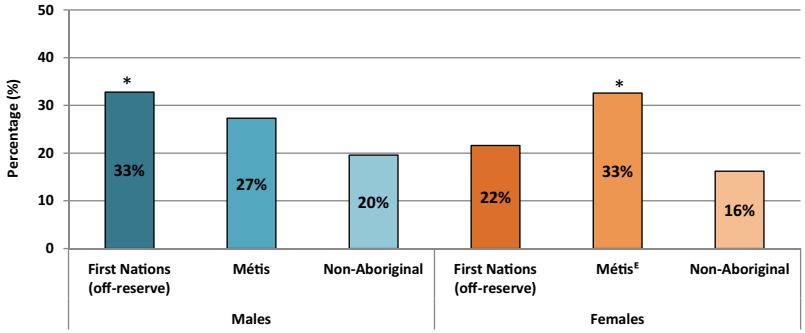
  One in three non-smoking Métis females experience second-hand smoke exposure in the home, car, or in public places; this is double the rate reported among non-Aboriginal females.

Figure 1: Proportion of population who are current cigarette smokers—Ontario adults (aged 20+), by Aboriginal identity (off-reserve) and by sex, 2007–2011 combined



* Estimate is significantly different from non-Aboriginal estimate
Notes: Estimates are age-standardized to the 2006 Ontario Aboriginal identity population.
Data from CCHS 2007 through 2011 combined to increase sample size for analyses by Aboriginal identity.
Source: Canadian Community Health survey, 2007-2011 (Statistics Canada)

Figure 2. Proportion of population who are exposed to second-hand smoke (in home, car, or public)—Ontario adults (aged 20+), by Aboriginal identity (off-reserve) and by sex, 2007–2011 combined



* Estimate is significantly different from non-Aboriginal estimate
Notes: Estimates are age-standardized to the 2006 Ontario Aboriginal identity population. Estimates show prevalence of second-hand smoke exposure among non-smokers in Ontario
Source: Canadian Community Health survey, 2007-2011 (Statistics Canada)
[E] Coefficient of variation is between 16.6% and 33.29%. Estimate should be interpreted with caution.

First steps

One of CCO's commitments in the Aboriginal Cancer Strategy II was delivery of more current and more comprehensive information about the prevalence of cancer risk factors and the uptake of cancer screening tests, specific to Ontario's off-reserve First Nations and Métis populations. This section of our annual report is the first step in meeting that objective.

Data presented here are from the Canadian Community Health Survey (CCHS). The CCHS is a Statistics Canada national survey of people aged 12 and over living in all provinces and territories. People living on Indian Reserves or Crown Lands, institutional residents, full-time members of the Canadian Forces and residents of some remote regions are not surveyed. Although Inuit respondents are included in the survey, small data counts for Ontario's Inuit population prevented analysis of this subpopulation for this report.

Kathy McLeod Beaver, BSW
Aboriginal Patient Navigator
Central East Region

Hearing what people are looking for is just as important as getting the information out, says Kathy Macleod Beaver, one of CCO's newest Aboriginal Patient Navigators. With 17 years' experience working in community health, Kathy is a veteran healthcare advocate. Her region of responsibility is large, stretching from Lake Ontario to Algonquin Park. Her clients live from urban Scarborough, Oshawa and Peterborough to the far reaches of Haliburton and Northumberland.

Kathy's experience in community health and mental health advocacy make her well aware of the barriers to accessing health care. Since her first day in September 2013, she has focused on building her network, meeting with communities and leadership; she intends to meet with every community health team. The response has been encouraging. Kathy has been invited to tell people about the Navigator program at three workshops already.

"People are telling me this is a very good idea," she says. "It makes a big difference seeing an Aboriginal representative at the hospital. And when you are diagnosed, the hospital information package can be quite daunting. It helps to have someone who understands go through the options with you."

Kathy's discussions with survivors and people in the community have given her insight into the challenges people face. "Sometimes people don't get screened because they don't want to know, or they don't follow up because they've heard the treatment makes you ill. It's my role to help alleviate any fear and to make sure that services are culturally safe—that people feel comfortable accessing care."

"The health teams are doing a lot of work around cancer—for example, they held a really successful Women's Health Days event that promoted self-care. I've also heard very positive stories from survivors who have used the system and I know their stories will encourage others to do so."

Kathy's near-term strategy is to continue expanding her network—both in the communities and in the clinics. "I am thinking that doing an information session for people right in the facility might improve follow-up rates." She counts her Aboriginal Patient Navigator network as an important source of strength and resources. "I visited Windsor to see how they were doing things—we can learn a lot from one another's experience and successes."

The Challenge

OBESITY

Evidence suggests a relationship between greater body fatness and cancers of the esophagus, pancreas, kidney, as well as the more common breast and colorectal cancers.[8]

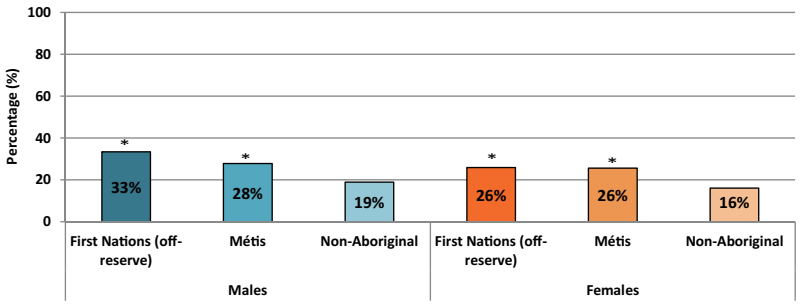
First Nations

First Nations people are more likely to be obese than non-Aboriginal Ontarians, both male (33% vs. 19%) and female (26% vs. 16%).

Métis

The Métis population is more likely to be obese than non-Aboriginal population Ontarians, both male (28% vs. 19%) and female (26% vs. 16%).

Figure 3: Proportion of population who are obese—Ontario adults (aged 18+), by Aboriginal identity (off-reserve) and by sex, 2007–2011 combined



* Estimate is significantly different from non-Aboriginal estimate
Notes: Estimates are age-standardized to the 2006 Ontario Aboriginal identity population. Obesity was measured using the body mass index measure (BMI), as respondents with a BMI greater than 30 kg/m^2.
Source: Canadian Community Health survey, 2007-2011 (Statistics Canada)

SEDENTARY BEHAVIOUR AND PHYSICAL INACTIVITY

Sedentary behaviour typically measures hours of leisure-time computer use or television watching,[9] while level of physical activity is based on the total energy expended while engaging in various physical activities during leisure time (e.g. walking, running, playing sports). The two measure different aspects of activity. Convincing evidence shows that physical activity reduces the risk of colon cancer and probably cancer of the breast and endometrium.[8,10-12]

First Nations

- **Sedentary behaviour**

  One-half of First Nations women are sedentary, which is significantly higher than what is reported among non-Aboriginal women (50% vs. 40%).

- **Physical inactivity**

  Although not statistically significant, First Nations males appear to be comparable, or more physically active than non-Aboriginal males (i.e. report lower levels of physical inactivity).

Métis

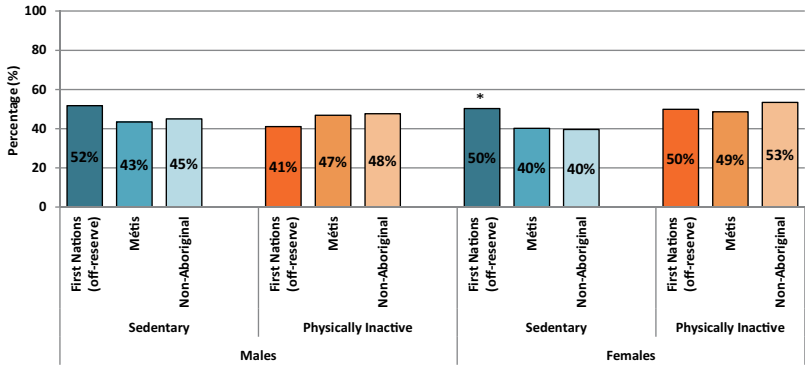
- **Sedentary behaviour**

  Approximately 40% of both the Métis and non-Aboriginal population report being sedentary.

- **Physical inactivity**

  Nearly one-half of the Métis population are physically inactive during their leisure time, which is similar to what is reported among the non-Aboriginal population.

Figure 4: Proportion of population who are sedentary or physically inactive—Ontario adults (aged 18+), by Aboriginal identity (off-reserve) and by sex, 2007–2011 combined



* Estimate is significantly different from non-Aboriginal estimate
Notes: Estimates are age-standardized to the 2006 Ontario Aboriginal identity population. Sedentary indicator not included in 2009 and 2010 CCHS surveys. Data shown is for 2007, 2008, and 2011 combined. Sedentary behaviour was measured as respondents who reported at least 11 hours per week on a computer, or at least 15 hours per week watching television in leisure time.Physical inactivity was measured as respondents with an average daily energy expenditure in leisure time less than 1.5 kcal/kg/day.
Source: Canadian Community Health survey, 2007-2011 (Statistics Canada)

Ultimate Frisbee Team, participating in youth physical activity and tobacco prevention workshops at Lakeview School, M'Chigeeng First Nation, Manitoulin Island, August 2013

INADEQUATE VEGETABLE AND FRUIT CONSUMPTION

Canada's Food Guide recommends that adults consume 5 to 10 servings of vegetables and fruits each day. A probable protective effect has been shown for the consumption of non-starchy vegetables and of fruits against cancers of the oral cavity, pharynx, larynx, esophagus and stomach.[10]

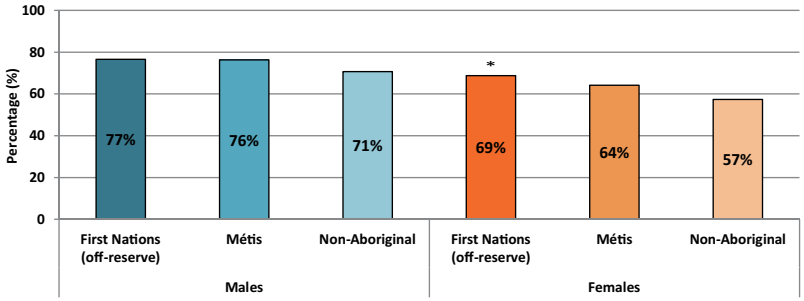
First Nations

First Nations females are more likely than non-Aboriginal females to report consuming fewer than the recommended servings of vegetables and fruits per day.

Métis

More Métis people report consuming less than the recommended servings of vegetables and fruits per day than non-Aboriginal Ontarians, however the difference is not statistically significant.

Figure 5: Proportion of population who are consuming less than 5 servings of non-starchy vegetables and fruits per day—Ontario adults (aged 18+), by Aboriginal identity (off-reserve) and by sex, 2007–2011 combined



* Estimate is significantly different from non-Aboriginal estimate
Notes: Estimates are age-standardized to the 2006 Ontario Aboriginal identity population.
Source: Canadian Community Health survey, 2007-2011 (Statistics Canada)

ALCOHOL

There is no clear acceptable limit of alcohol intake for cancer prevention.[10] It is recommended that if alcohol is consumed, men should limit their intake to two drinks per day, and women to one drink per day.[10] Furthermore, smoking enhances the carcinogenic effect of alcohol and vice versa. Smokers who also drink alcohol—particularly heavy smokers and heavy drinkers—are at a much higher risk for certain cancers (e.g., cancers of the oral cavity, pharynx, larynx and esophagus).[13,14]

First Nations

- **Alcohol consumption exceeding cancer prevention recommendations**

  First Nations men are significantly more likely than non-Aboriginal men to exceed cancer prevention recommendations for alcohol consumption, that is, consume more than two drinks per day on average.

- **Alcohol consumption exceeding cancer prevention recommendations and cigarette smoking**

  First Nations people are more than twice as likely to report drinking in excess of the cancer prevention recommendations and being current (daily or occasional) cigarette smokers compared to the non-Aboriginal population (7.6% vs. 3.5%).

Métis

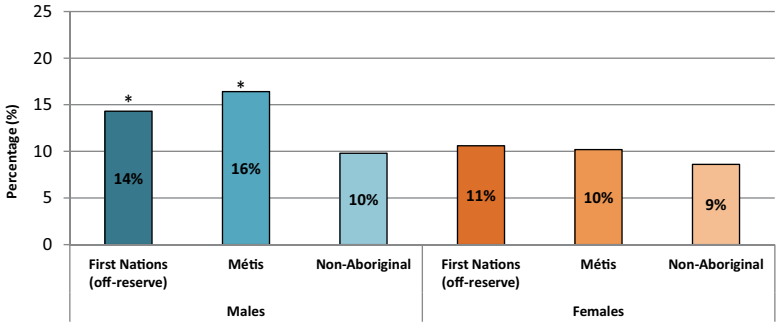
- **Alcohol consumption exceeding cancer prevention recommendations**

  Métis men are significantly more likely than non-Aboriginal men to report exceeding cancer prevention recommendations for alcohol consumption.

- **Alcohol consumption exceeding cancer prevention recommendations and cigarette smoking**

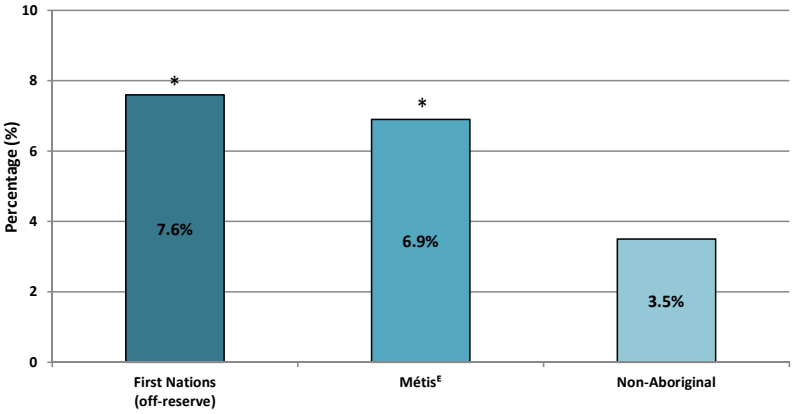
  Métis people are twice as likely to report drinking in excess of the cancer prevention recommendations and being current cigarette smokers compared to the non-Aboriginal population (6.9% vs. 3.5%).

Figure 6: Proportion of population exceeding cancer prevention recommendations for alcohol consumption—Ontario adults (aged 19+), by Aboriginal identity (off-reserve) and by sex, 2007–2011 combined



* Estimate is significantly different from non-Aboriginal estimate
Notes: Estimates are age-standardized to the 2006 Ontario Aboriginal identity population. Alcohol indicator was measured as male respondents who consumed greater than two drinks per day on average, or females reporting consuming greater than one drink per day on average, during the past week.
Source: Canadian Community Health survey, 2007-2011 (Statistics Canada)

Figure 7. Proportion of population exceeding cancer prevention recommendations for alcohol consumption and currently smoking—Ontario adults (aged 19+), by Aboriginal identity (off-reserve) and by sex, 2007-2011 combined



* Estimate is significantly different from non-Aboriginal estimate
Notes: Estimates are age-standardized to the 2006 Ontario Aboriginal identity population. Indicator was measured as male respondents consuming greater than two drinks per day on average and are current cigrette smokers, or female respondents consuming grater than one drink per day on average and are current cigarettes smokers.
Source: Canadian Community Health survey, 2007-2011 (Statistics Canada)
[E] Coefficient of variation is between 16.6% and 33.29%. Estimate should be interpreted with caution.

Pamela Williamson, Executive Director (middle) and Board members, Noojmowin Teg Health Centre

Andrea East, MD
Regional Cancer Lead
Hamilton Niagara Haldimand Brant Region

Log onto Dr. Andrea East's Twitter feed (@sixeast) and you're just as likely to read about lacrosse, UN critiques of Aboriginal health care in Canada or Mi'kmaq road blockades as local health issues. But Andrea is deeply involved in more than just that. As the newly appointed Regional Aboriginal Cancer Lead for the local Hamilton Niagara Haldimand Brant region and family doctor on the Six Nations of the Grand River Territory for more than 25 years, she is a busy woman. What is she thinking about? Screening, immunization, prevention, health care promotion, healthy living…and more! Read on.

"My Blue Sky Intent is to contribute to the healing of Aboriginal communities by creating a compassionate, superior cancer journey. I am determined to improve screening rates for cervix, breast and bowel cancer for Aboriginal people."

Andrea is embedded in the community but, as Regional Aboriginal Cancer Lead, she has a local resource and supporter—the first Aboriginal Patient Navigator, Lee Styres Loft. "With great humility and pride, Lee embedded the cultural understanding within CCO that was necessary to achieve success with the Aboriginal Cancer Strategy. Referring my patients to Lee is like giving them a guardian angel to accompany them as they travel their journey. She is the right person, at the right time, in the right place."

Andrea sees this mandate as a personal calling: "I am motivated to continue to heal this community and help them approach equity of health care determinants on par with non-Native Canadians. I am honoured to be part of this challenge and look forward to working with the many committed Aboriginal healthcare workers to meet that objective."

CANCER SCREENING

Colorectal cancer screening participation

Ontarians aged 50-74 who are at average risk of colorectal cancer are recommended to have a fecal occult blood test (FOBT) every two years .[15] A colonoscopy every 10 years is recommended for individuals aged 50–74 who are at an increased risk for colorectal cancer due to family history.[15] Although not yet included in Cancer Care Ontario's colorectal cancer screening guidelines, flexible sigmoidoscopy for screening has recently been shown to prevent colorectal cancer and reduce deaths from colorectal cancer.[16-18] Because a colonoscopy or sigmoidoscopy done for any reason can visualize the colon and rectum, identifying polyps and cancers, individuals having had one of these tests within the previous 10 years do not need to be screened. Thus, those aged 50–74 who have not had an FOBT within the past two years or a colonoscopy and/or sigmoidoscopy in the past 10 years are considered overdue for colorectal cancer screening; this includes individuals who have never had any colorectal tests.

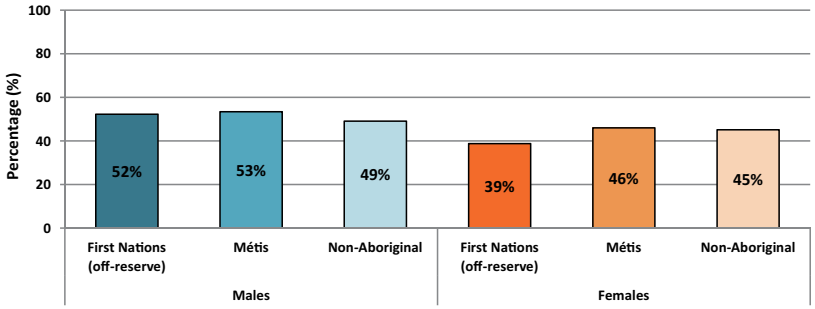
First Nations

Approximately half of First Nations men and fewer than 40% of First Nations women are overdue for colorectal cancer screening. These rates are similar to those among non-Aboriginal men and women.

Métis

The Métis and non-Aboriginal population are similarly likely to be overdue for colorectal cancer screening, with approximately half of both groups reporting not having had an FOBT within the past two years or a colonoscopy and/or sigmoidoscopy in the past 10 years.

Figure 8. Proportion of population who are overdue for colorectal cancer screening (including those who have never been screened)—Ontario adults (aged 50-74), by Aboriginal identity (off-reserve) and by sex, 2007-2011 combined



* Estimate is significantly different from non-Aboriginal estimate
Notes: Estimates are age-standardized to the 2006 Ontario Aboriginal identity population.
Source: Canadian Community Health survey, 2007-2011 (Statistics Canada)

CCO team attending a Sandy Lake meeting

Breast Cancer Screening Participation

Cancer Care Ontario recommends that women aged 50-74 have a mammogram every two years to screen for breast cancer.[19]

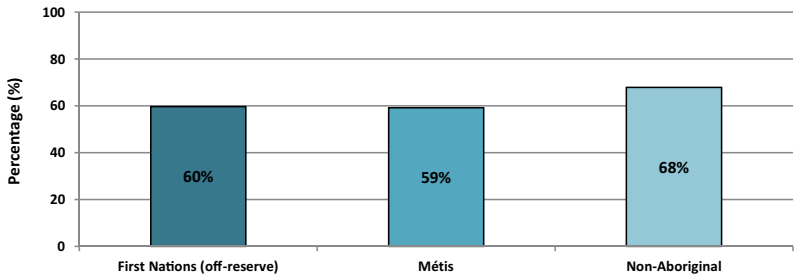
First Nations

Fewer Ontario First Nations women report having had a screening mammogram within the past two years compared to non-Aboriginal women; however, the difference is not statistically significant (60% vs. 68%).

Métis

The percent of Métis women participating in mammography screening within the past two years is less than but not significantly different from that reported among non-Aboriginal women (59% vs. 68%).

Figure 9. Proportion of Ontario women who completed at least one mammogram within the past two years, aged 50-74, by Aboriginal identity (off-reserve), 2007, 2008, 2011 combined



Notes: Estimates are age-standardized to the 2006 Ontario Aboriginal identity population. Mammography indicator not included in 2009 and 2010 CCHS surveys.
Source: Canadian Community Health survey, 2007, 2008, 2011 (Statistics Canada)

Annelind Wakegijig, BSc, M.D, C.C.F.P.
Aboriginal Cancer Lead
North East Region

Originally from the Wikwemikong Unceded Indian Reserve on Manitoulin Island, Dr. Annelind Wakegijig came to CCO from her position as lead physician for the Baawaating Family Health Team on the Batchewana First Nation, near Sault Ste. Marie. She is acutely aware of the importance—and difficulty—of bridging the cultural divide between healthcare providers and their Aboriginal patients.

"For those unfamiliar with the history of First Nations people and the Government of Canada and the church," she says, "it is a bit of an understatement to say there is an inherent distrust of those in positions of 'authority'. This distrust, unfortunately, often spills into health care. Doctors, nurses and other allied health professionals are seen as authority figures—which can prove to be a challenge in the promotion of health care initiatives. It is heartening to see great effort being made in the Aboriginal Cancer Strategy to acknowledge our history, and to be more sensitive and open in making access to screening, treatment and palliative care in cancer less intimidating to First Nations, Métis and Inuit people."

Tony Jocko (UOI Health Policy Analyst)and CCO team (Alethea Kewayosh, Annelind Wakegijig and Mark Hartman) attending a meeting with the North Shore Anishnawbek Health Steering Committee at the Mississauga First Nation

The Challenge

Cervical Cancer Screening Participation

Cancer Care Ontario recommends that sexually active women aged 21 to 69 years have a Pap Smear test every three years.[20]

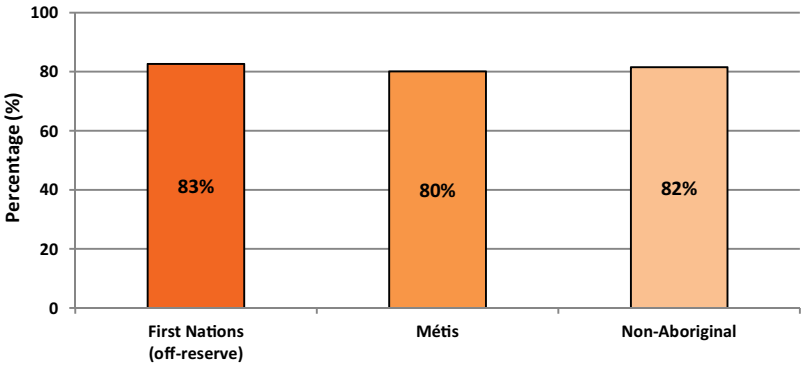
First Nations

First Nations women are as likely as non-Aboriginal women to report having had a Pap test within the past three years (83% vs. 82%).

Métis

A similar proportion of Métis and non-Aboriginal females report having had a Pap test within the past three years (80% vs. 82%).

Figure 10. Proportion of Ontario women who completed at least one Pap test within the past three years, aged 21–69, by Aboriginal identity (off-reserve), 2007, 2008, 2011 combined



Notes: Estimates are age-standardized to the 2006 Ontario Aboriginal identity population.
Pap test indicator not included in 2009 and 2010 CCHS surveys.
Women who have had a hysterectomy were excluded from the analysis.
Source: Canadian Community Health survey, 2007, 2008, 2011 (Statistics Canada)

The ACCU meeting with representatives from the Métis Nation of Ontario Healing and Wellness Team in Ottawa, September 2013

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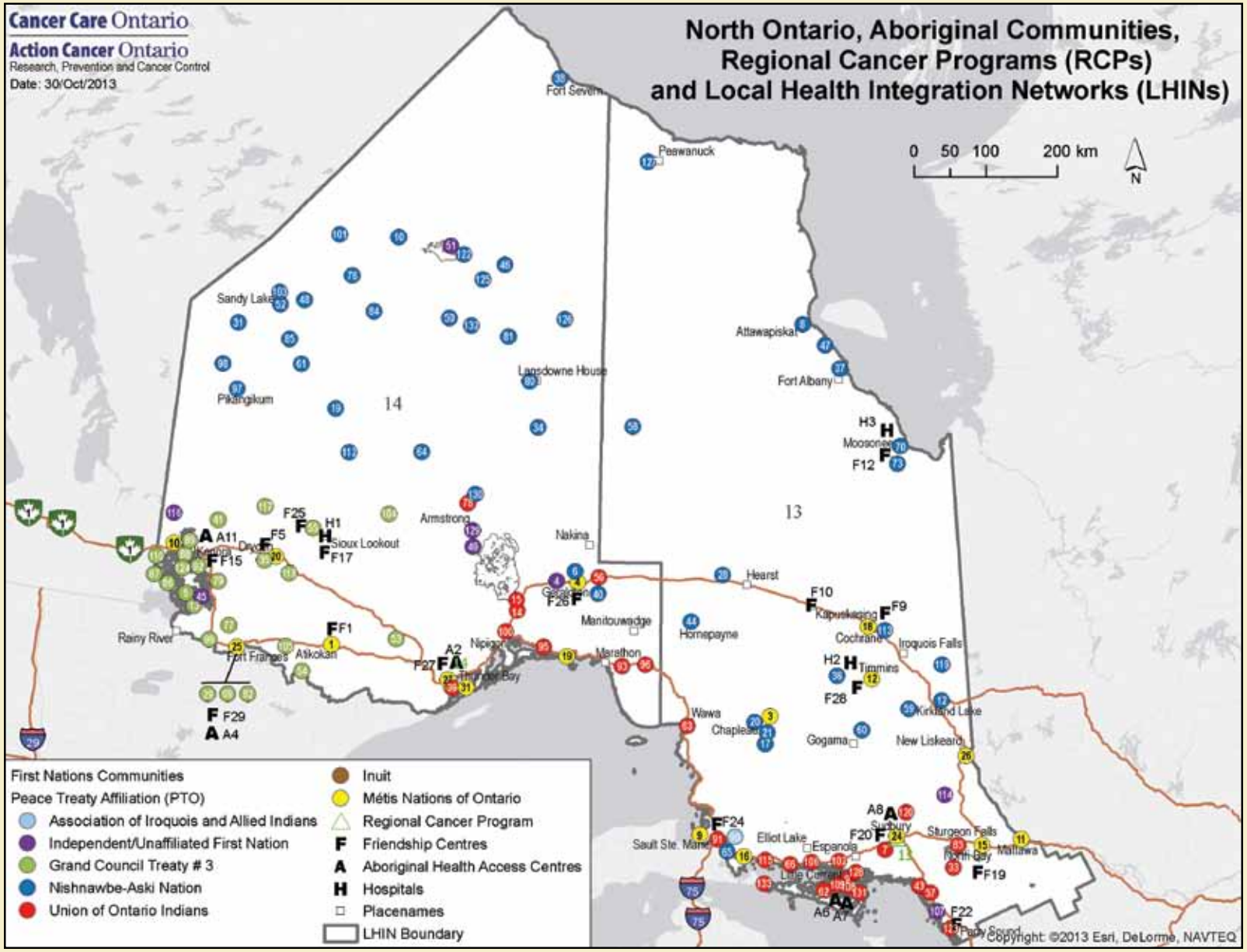
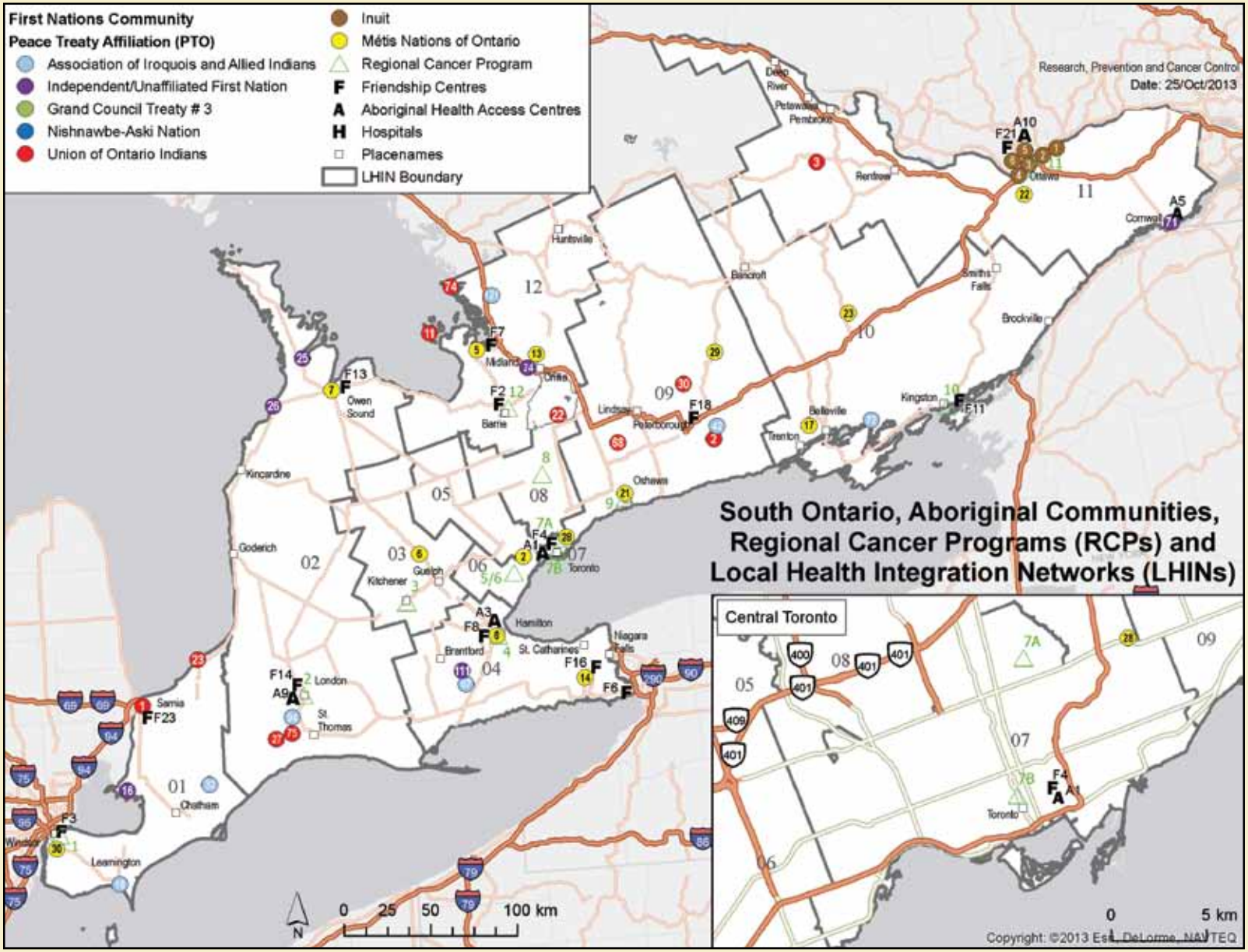
The People


LAKEVIEW
LAKEVIEW
Métis Nation of Ontario

Mapping Our Support Network



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


First Nations Community
Peace Treaty Affiliation (PTO)
Association of Iroquois and Allied Indians
Independent/Unaffiliated First Nation
Grand Council Treaty # 3
Nishnawbe-Aski Nation
Union of Ontario Indians
Inuit
Métis Nations of Ontario
Regional Cancer Program
F Friendship Centres
A Aboriginal Health Access Centres
H Hospitals
Placenames
LHIN Boundary
Research, Prevention and Cancer Control
Date: 25/Oct/2013
South Ontario, Aboriginal Communities, Regional Cancer Programs (RCPs) and Local Health Integration Networks (LHINs)
Central Toronto
Sarnia
London
Chatham
Leamington
Kincardine
Goderich
Owen Sound
Barrie
Orillia
Midland
Huntsville
Bancroft
Lindsay
Peterborough
Oshawa
Toronto
Kitchener
Guelph
Brantford
Hamilton
St. Catharines
Niagara Falls
Belleville
Trenton
Kingston
Brockville
Smiths Falls
Renfrew
Ottawa
Cornwall
Pembroke
Petawawa
Deep River
St. Thomas
0 25 50 100 km
0 5 km
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Mapping Aboriginal Ontario

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1. Aamjiwnaang First Nation
2. Alderville First Nation
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6. Aroland First Nation
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37. Fort Albany First Nation
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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

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5. Pauktuutit
6. Tungasuvvingat Inuit

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23. Seven Rivers Métis Council
24. Sudbury Métis Council
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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

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. M'Wikwedong 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. N'Swakamok Friendship Centre
F21. Odawa Native Friendship Centre
F22. Parry Sound Friendship Centre, Parry Sound, ON
F23. Sarnia-Lambton Friendship Centre, Sarnia, ON
F24. Sault Ste Marie Indian Friendship Centre
F25. Red Lake Friendship Centre
F26. Thunderbird Friendship Centre
F27. Thunder Bay Indian Friendship Centre
F28. Timmins Native Friendship Centre
F29. 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

Hospitals

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

Acknowledgements

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Corporate Services and Planning

Occupational Cancer Research Centre

Prevention and Surveillance

Research

The Clinical Programs and Quality Initiatives division

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Disease Pathway Management

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Chris McDonald, Southwest Region

Dr. Mark Tomen, Erie St. Clair Region

Dr. Andrea East, Hamilton Niagara Haldimand Brant Region

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Jeannie Simon, Aboriginal Patient Navigator, Northwest Region

Verna Stevens, Aboriginal Patient Navigator, Champlain Region

Audrey Logan, Aboriginal Patient Navigator, Erie St. Clair Region

Kathy McLeod-Beaver, Aboriginal Patient Navigator, Central East Region

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Trina Diner, Manager of Palliative Care and Telemedicine, Northwest Regional Cancer Program

Suzie Joanisse, Regional Director, Screening and Prevention, Champlain Regional Cancer Program

Jeff Booth, Regional Director, Erie St. Clair Regional Cancer Program

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Ashley Goodberry, ICS Lead, Screening and Health Promotion, Southeast Regional Cancer Program

Lesley MacInnis-Miller, Manager, Prevention, Screening & Education, Simcoe Muskoka Regional Cancer Program

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Roland St. Germain, Métis Elder

Clayton Shirt, Traditional Knowledge Keeper

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Ministry of Health and Long-Term Care

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