

Cancer Control and Indigenous Populations in Canada: Unmasking and Addressing Inequities

Advancing Culturally-Responsive Cancer Control Efforts with and for Indigenous
Populations, UICC, August 28th, 2012



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Take Home Messages

- What is not counted may still count
 - Major deficiencies in Indigenous cancer surveillance in Canada
 - Need for Indigenous leadership in Indigenous cancer information systems
 - Indigenous populations experience disproportionate exposure to environmental and social risk factors for cancer and disparities in access to care despite this increased exposure and risk.
- Indigenous cancer control work needs to put Indigenous communities and their knowledge at front and centre, rather than contribute to ongoing marginalization.
- Indigenous participatory action partnership approaches for Indigenous cancer control planning, implementation and evaluation are both possible and essential to success.
- These partnerships approaches require time, adequate resourcing (both human and fiscal), and two-eyed seeing.

“Aboriginal women don’ t get breast cancer....”



What's Not Counted Still Might Count

- Major issue is that Indigenous identity is inconsistently and unreliably flagged in the large majority of cancer surveillance systems in Canada
- Addressing this major deficiency in Indigenous cancer surveillance will require leadership and data sharing agreements with First Nations, Indian, Inuit and Métis communities and PTOs.

(OCR), it is not possible to routinely estimate cancer incidence or mortality rates for any Aboriginal population directly from OCR data. Therefore, a cohort of Ontario FN people was created through linking of the OCR and mortality files with the Ontario files of FN people 'with Status' from Indian and Northern Affairs Canada (from 1968 to 1991)"

Detection of Later Stage Breast Cancer in First Nations Women in Ontario, Canada

Amanda J. Sheppard, MSc,^{1,2} Anna M. Chiarelli, PhD,^{1,3} Loraine D. Marrett, PhD,^{1,3} Lucia

Detection of Later Stage Breast Cancer in First Nations Women in Ontario, Canada

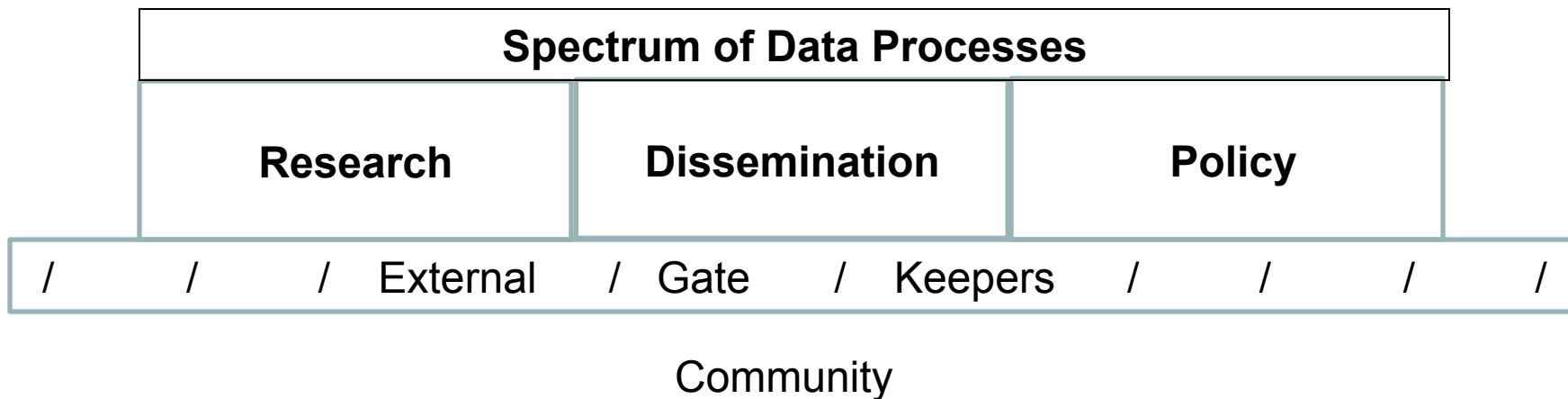
Amanda J. Sheppard, MSc,^{1,2} Anna M. Chiarelli, PhD,^{1,3} Loraine D. Marrett, PhD,^{1,3} Lucia Mirea, MSc,^{2,3} E. Diane Nishri, MSc,² Maureen E. Trudeau, MD,⁴ and the Aboriginal Breast Cancer Study Group⁵

Objective: To compare the distribution of stage at breast cancer diagnosis between First Nations (FN) and non-FN women, and to investigate factors associated with later diagnosis in FN women.

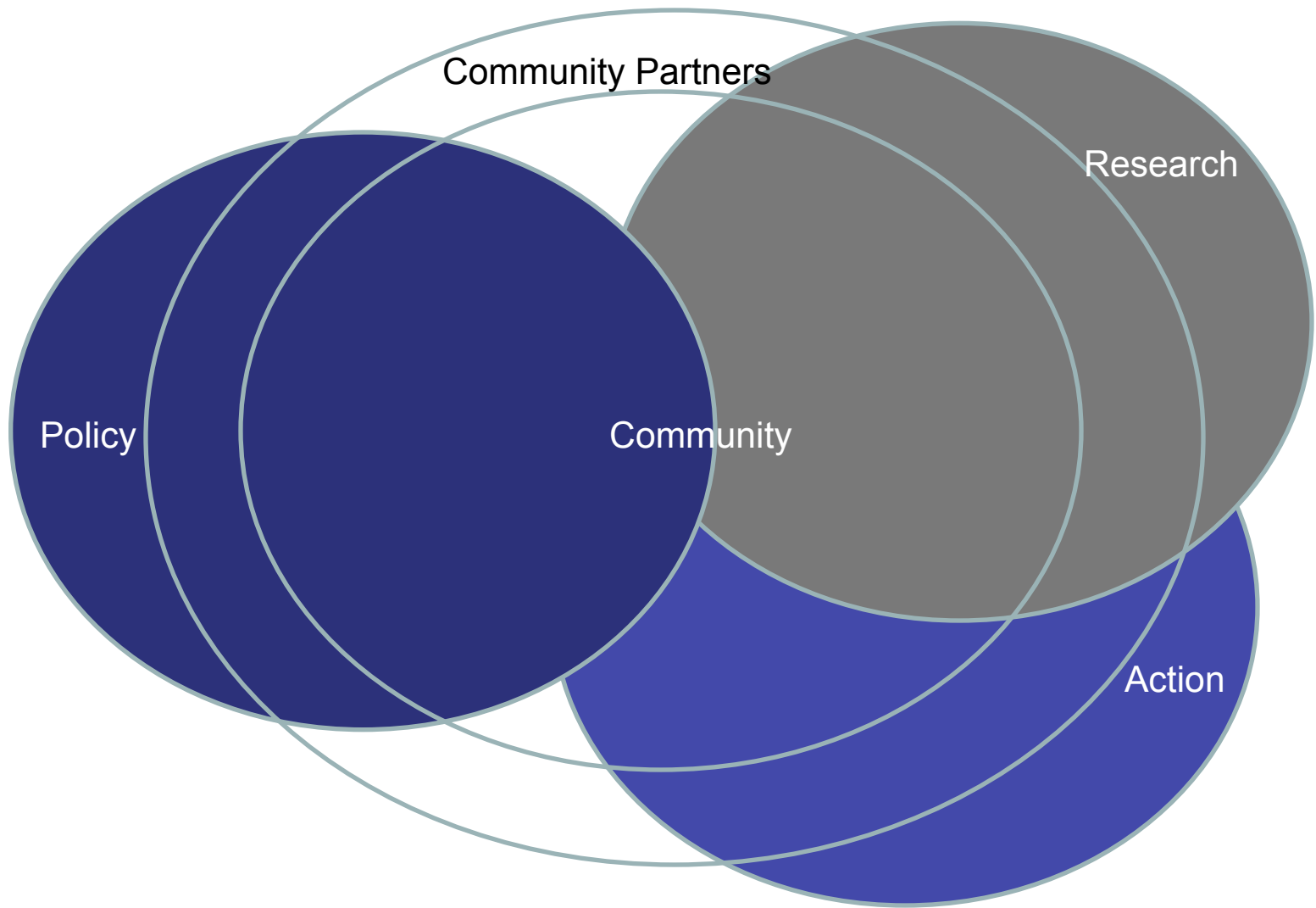
Methods: A case-case design was employed to compare FN women (N=287) to a frequency-matched random sample of women (N=671) from the general population diagnosed with breast cancer in the Ontario Cancer Registry. Women were matched (2:1) on period of diagnosis (1995-1999, 2000- 2004), age at diagnosis (<50 vs. ≥50), and Regional Cancer Centre (RCC). Stage and data relevant to the determinants of stage were collected from medical charts at the RCCs. The association between stage (stage II+ vs. I) and FN status was modeled using logistic regression analyses; for FN women, the association between risk factors and stage was examined.

Results: FN women (66%) were diagnosed with a later stage significantly more often than non-FN women (56%). FN women with a non-screened cancer (OR 5.03, 95% CI 2.48-10.21) and those who were overweight or obese (OR 2.98, 95% CI 1.27-6.98 and OR 4.46, 95% CI 1.95-10.21, respectively) were significantly more likely to be diagnosed at a later stage. Having a comorbidity reduced the odds of a later stage (OR 0.51, 95% CI 0.27-0.96) in FN women.

Conclusion: This study demonstrates the need for FN women, in particular those who are not accessing the health care system, to participate in breast screening programs aimed at detecting breast cancers earlier with a better prognosis. These findings suggest that the cancer care system in Ontario should better target this population through increasing awareness and access to screening.



Source: Smylie J., Lofters A., Firestone M., O' Campo P. *Population-Based Data and Community Empowerment*. In: Rethinking Social Epidemiology: Towards a Science of Change. O' Campo P., & Dunn J. (Eds.) New York: Springer, 2011



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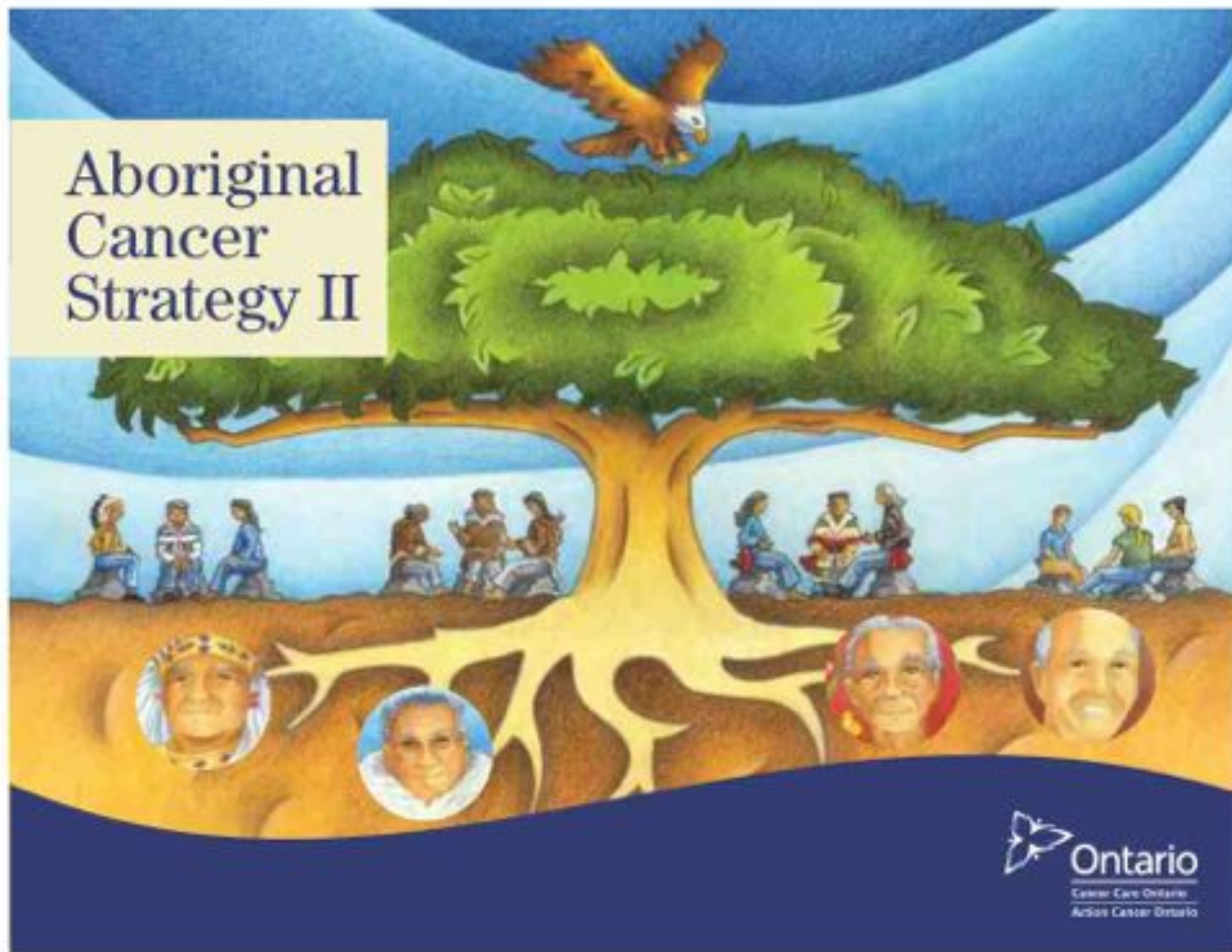
Putting Indigenous Communities at Front and Centre



Indigenous Community Investment as a Theory for Program Success

- i) Aboriginal community member(s) identify and prioritize issue to be addressed.
- ii) Aboriginal community members lead a community based process of broader local engagement and consultation
- iii) Community based process of gathering, sharing, mobilizing of resources
- iv) Resultant service enhancement informed by broader community engagement
- v) Increased community access to a higher quality, more relevant and effective service leads to better health outcomes

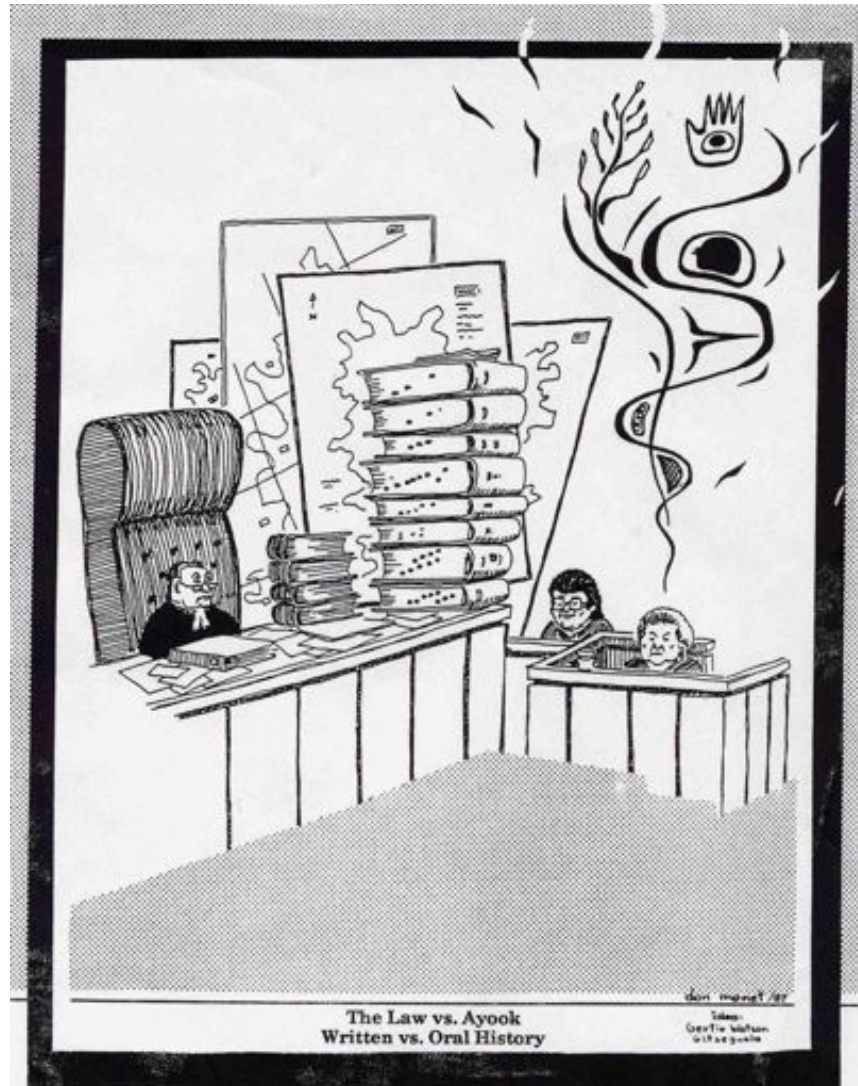
Aboriginal Cancer Strategy II



Ontario

Cancer Care Ontario
Action Cancer Ontario

Two-eyed seeing



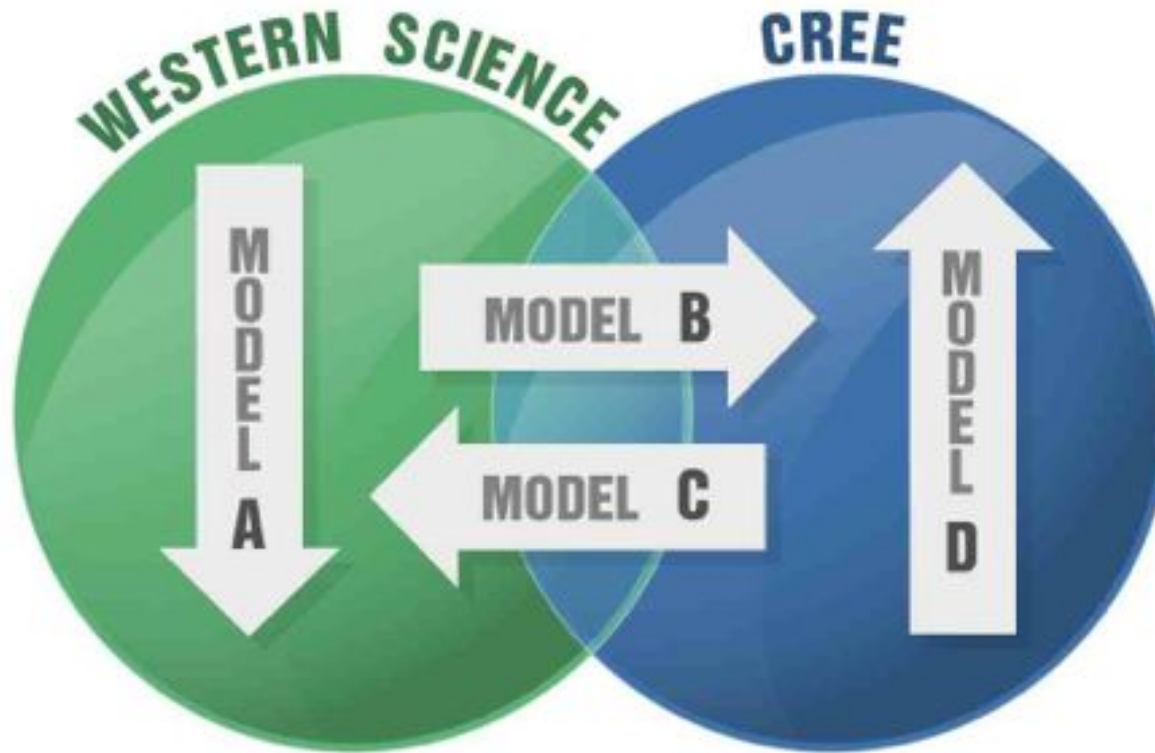
“Fundamental to the exercise of self-determination is the right of peoples to construct knowledge in accordance with self-determined definitions of what is real and what is valuable.”

Marlene Brant Castellano

Ethics of Aboriginal Research

Journal of Aboriginal Health, 2004; 1:98-114

Ermine's Models of Knowledge Translation



A = Monocultural B= Colonialism C=Appropriation D = Indigenous

Listening to Native patients :Changes in physicians' understanding and behaviour

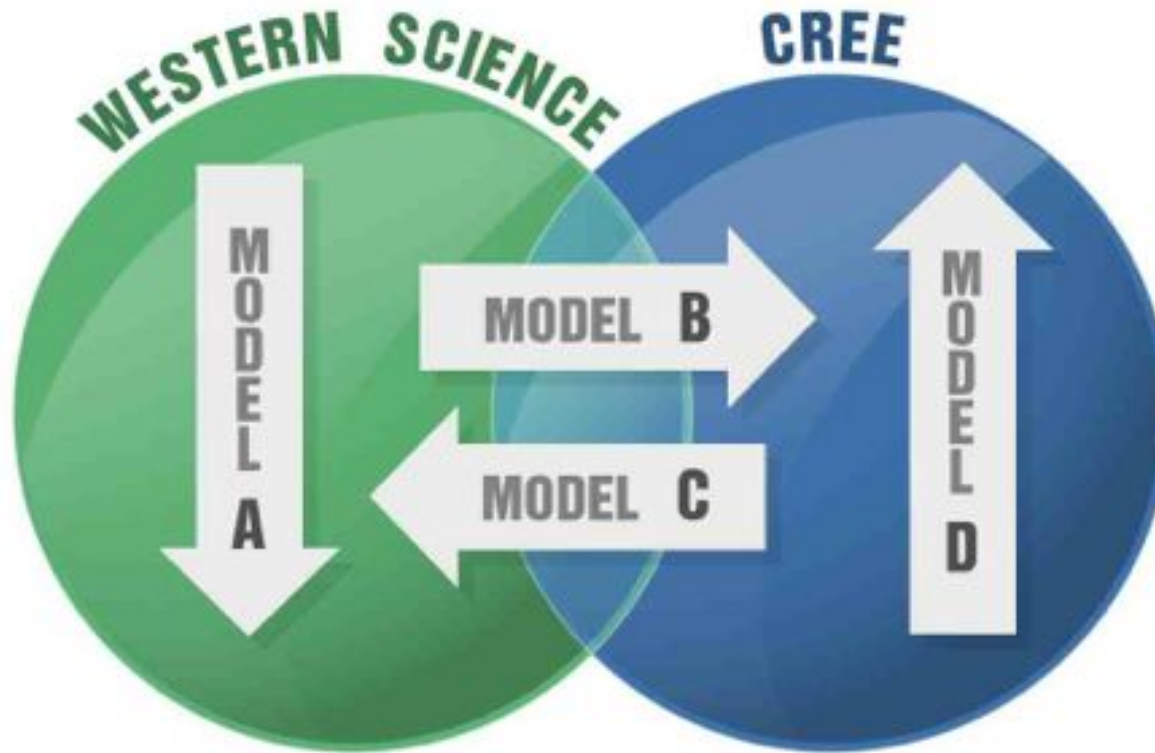
Len Kelly, MD, CCFP, MCLSC, FCFP

Judith Belle Brown, PHD

“Developing cross-cultural communication was difficult and took years, if not forever.

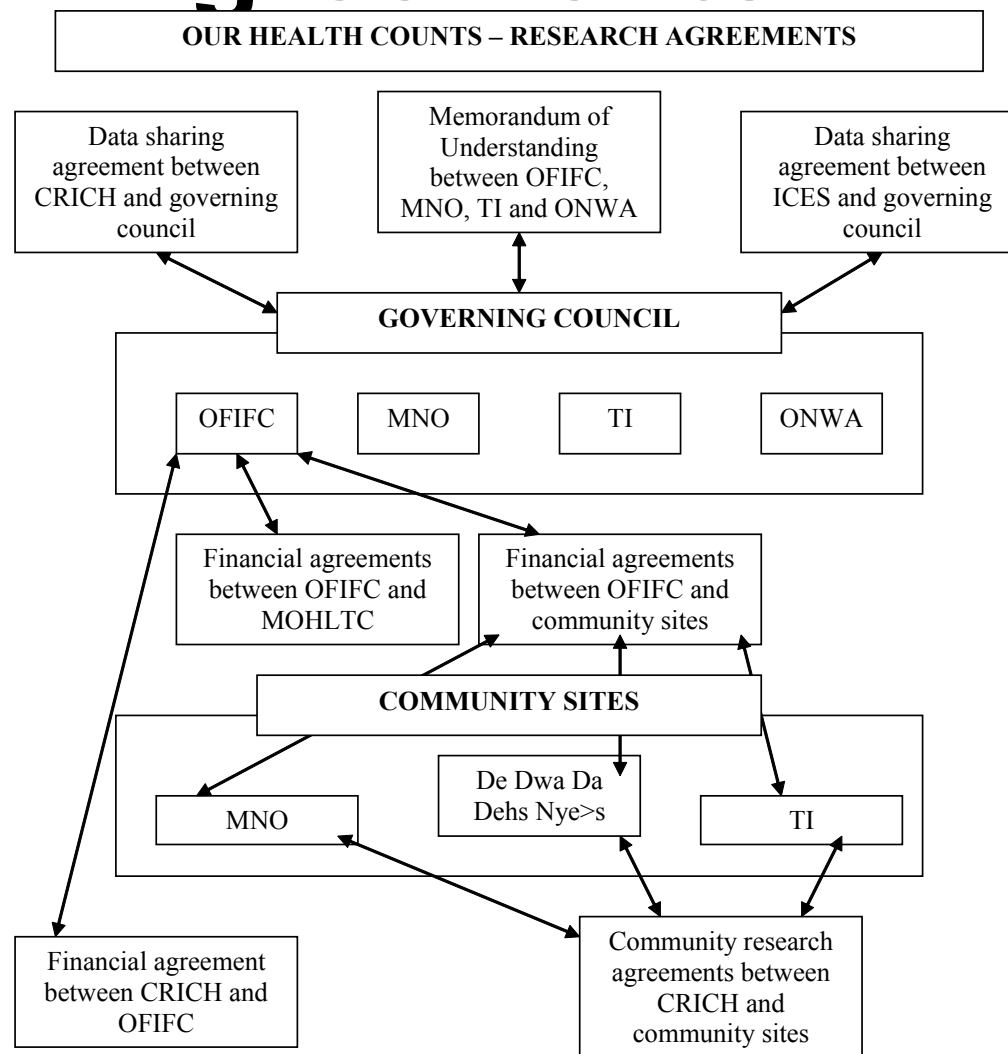
Understanding Native communities changed physicians. They described a journey of self-examination, development of personal relationships, and rewards and frustrations”

Revision of Ermine's Model - Knowledge Reconciliation



A = Equity B= Indigenization C=Assertion D = Indigenous

Our Health Counts Agreements



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Questions?

