Commentry

Improving First Nations Cancer Journeys: Current Policy Perspectives and Approaches in British Columbia, Canada

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ABSTRACT

Processes of reconciliation in Canada have created a new climate for discussions about systemic racism and a lack of cultural safety and humility as a root cause of health outcome disparities for First Nations people. In British Columbia, efforts to improve First Nations cancer outcomes and experiences are now formalized through an Indigenous Cancer Strategy that incorporates BC First Nations perspectives on health and wellness. In partnership with the unique First Nations health governance structure in the province, health system and community partners are leveraging the current climate for change to improve First Nations cancer journeys, and are leading the way to improving culturally safe health services for all British Columbians.

KEYWORDS: First Nations, Indigenous, Aboriginal, cancer, disparities, cultural safety, cultural humility

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First Nations in British Columbia (BC), Canada have enjoyed a rich history of health and wellness since time immemorial. This health and wellness was intentionally disrupted through processes of colonialism implemented by governments and other institutions, including policies of forcible displacement of people from family and community, culture and ceremony, language and land. The resulting loss and subsequent trauma from these policies continue to negatively impact many First Nations people in their interaction with Western institutions, including the healthcare system. Colonialism continues to manifest itself in structural barriers for First Nations people in achieving equitable access to health and wellness resources and services, including those that relate to cancer control. Canada is a country in the midst of facing this history of colonialism and its continuing impact on the health and wellness of Indigenous people. In 2015, the Truth and Reconciliation Commission (TRC) of Canada documented the history of Canadian federal government policy that resulted in Aboriginal children being taken from their families and placed in Indian Residential Schools. In the TRC's report, it was concluded that Indian Residential Schools amounted to cultural genocide. As part of the reconciliation process, ninety four 'Calls to Action' were presented by the TRC to redress the harms inflicted through various policies of colonialism, including calls related specifically to health and health service delivery (TRC, 2015). In this era of Truth and Reconciliation in Canada, there is increasing acknowledgement of the ongoing systemic racism and bias against First Nations people that is unacceptable. In this context, it is recognized that First Nations people have a right to access health and cancer care services that are free of discrimination and that address unique community and individual needs. However, health services in BC, including cancer care, were never designed with an understanding of First Nations' definitions of health and wellness, nor of colonialism and its impact on First Nations people. A transparent recognition of the need for cultural safety as part of quality improvement in health services is required, and there is now a unique and unprecedented system-wide movement underway to achieve this in BC.

The First Nations Perspective on Health and Wellness in Figure 1 presents a visual depiction of BC First Nations' philosophy and definition of health and well-being, which recognizes the health and wellness of individuals as consisting and being an outcome of many interrelated internal and external factors (First Nations Health Authority [FNHA], nd-a). This Perspective was developed based on guidance provided by BC First Nations and founded in traditional teachings. The centre circle represents individual human beings, recognizing that wellness starts with individuals. The second circle illustrates the importance of mental, emotional, spiritual and physical facets of a healthy, well and balanced life. The third circle represents the overarching values that support wellness, including: respect, wisdom, responsibility, and relationships. The fourth circle depicts the people that surround us and the places from which we come: Nations, family, community and land. And the fifth circle depicts the social, cultural, economic and environmental determinants of our health and well-being. Recognizing all components of the circle and the interconnectedness of the physical, emotional, spiritual and mental dimensions and determinants of First Nations health and wellbeing is a starting point towards improving quality and addressing disparities in cancer care

between First Nations and non-First Nations people in the province.

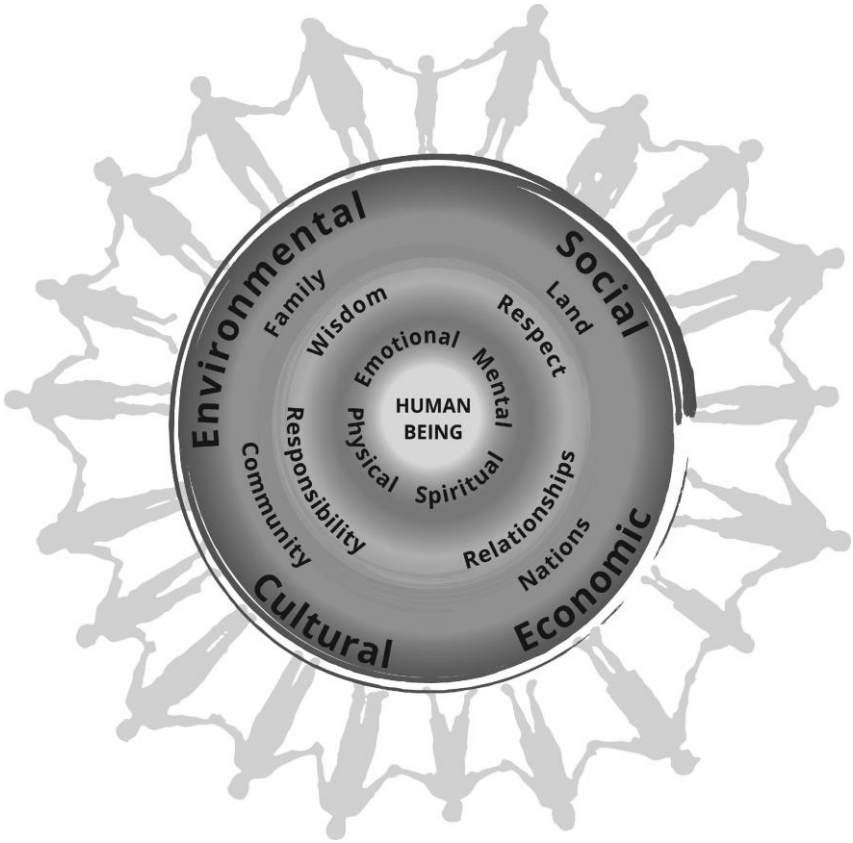

Figure 1. First Nations Perspective on Health and Wellness

This Perspective is a visual depiction of First Nations peoples' collective philosophy that the mind, heart, body and spirit are all connected and are supported by internal and external factors including culture, relationships, and responsibility, and are shaped by family, community, the land and broader environmental, social and economic factors (FNHA, nd-a).

A recent study of incidence and survival rates between First Nations and non-First Nations people living in BC between 1993 and 2010 highlighted disparities in cancer incidence and outcomes (Mcgahan et al., 2017). Data from this study, the first of its kind, demonstrated that First Nations people in BC were more likely to be diagnosed with colorectal (men and women) and cervical cancers while enduring the same incidence rates of breast cancer, which was the most commonly diagnosed cancer in First Nations and non-First Nations women, as indicated in Table 1. Colorectal cancer was the second most commonly diagnosed cancer in First Nations men and women, and cervical cancer was the fourth most common among First Nations women. Study findings also showed lower survival rates in 10 out of the 12 cancer sites examined in First Nations men and 10 out of 15 cancer sites examined in First Nations women, including lower survival rates for colorectal (men and women), breast and cervical cancers as indicated in Table 2. Lower cancer survival rates can be caused by a combination of differences in access to or utilization of primary

care, screening programs (and subsequent impact on stage of cancers at time of diagnosis), and/or high quality, timely, appropriate and effective cancer treatment, to name a few. While this study was a key step in understanding the quality of cancer care from an equity perspective, it needs to be acknowledged that First Nations health goals and targets should not be solely defined by comparisons with the health status of non-First Nations people.

Table 1: Incidence Counts, Age-Standardized Incidence Rates and Standardized Rate Ratios (SRRs) by disease site for each sex, in First Nations (FN) and non-FN populations 1993-2010.

	Incidence		Age-Standardized Incidence Rate (95% CI)		SRR (95% CI)
	FN	Non-FN	FN	Non-FN	
Females					
Breast	767	45,478	224.0 (207 - 241)	240.0 (238 - 243)	0.93 (0.87 - 1.01)
Cervical	134	2,810	33.1 (27.0 - 39.3)	17.2 (16.6 - 17.9)	1.92 (1.49 - 2.48)
Colorectal	292	18,226	92.9 (81.5 - 104)	76.4 (75.1 - 77.6)	1.22 (1.06 - 1.39)
Males					
Colorectal	366	21,834	154 (137 - 171)	111 (109 - 113)	1.39 (1.22 - 1.58)

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Table 2: Observed 1-year and 5-year cause-specific survival and age-adjusted cause-specific hazard ratio (95% CI) by disease site in First Nations (FN) and non-FN populations, 1993-2010.

	FN Incidence	1-year age-standardized cause-specific survival		5-year age-standardized cause-specific survival		Age-Standardized HR (95% CI)
		FN	Non-FN	FN	Non-FN	
Females						
Breast	767	0.97 (0.95-0.98)	0.96 (0.96-0.97)	0.83 (0.80-0.86)	0.85 (0.85-0.86)	1.14 (0.96-1.35)
Cervical	134	0.89 (0.82-0.93)	0.89 (0.88-0.90)	0.73 (0.64-0.80)	0.73 (0.71-0.75)	1.19 (0.84-1.67)
Colorectal	292	0.82 (0.77-0.86)	0.78 (0.78-0.79)	0.57 (0.50-0.63)	0.57 (0.56-0.57)	1.16 (0.97-1.39)
Males						
Colorectal	366	0.78 (0.73-0.82)	0.81 (0.81-0.82)	0.51 (0.45-0.57)	0.57 (0.56-0.57)	1.30 (1.12-1.52)

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Understanding BC's cancer care system is important when interpreting these statistics. Cancer care services in BC were designed and are delivered by a diverse matrix of health system partners. For example, there are six regional BC Cancer centres in the province that provide all radiation therapy treatments, over 50% of chemotherapy treatments, specialized imaging

services (such as PET scans and breast MRI), and a range of patient assessments, follow-up and supportive cancer care services. Other important cancer care services, such as surgery, diagnostics and palliative care, as well as some local delivery of chemotherapy treatments, are planned and provided by regional health authorities. For the province's population-based colon, breast and cervical cancer screening programs, a partnership framework is followed with BC Cancer overseeing the provincial approach, primary care providers identifying eligible patients for screening, and regional health authorities and community (private) imaging clinics and laboratories delivering the screening tests. As with many health services in BC, participation in these screening programs requires access to a primary care provider. This is concerning, as in addition to the cancer outcome disparities noted earlier, it has also been found that First Nations people are less likely than non-First Nations people to be attached to a primary care physician (FNHA, nd-b). BC also has a publicly funded vaccination program against the Human Papilloma Virus (HPV), which includes free vaccinations for all boys and girls as part of a school-age child vaccination schedule. Considering this complexity in service delivery, full engagement and coordination amongst BC Cancer, regional health authority, and primary care partners is needed to improve the quality of cancer care services in the province.

For First Nations people, families and communities, there is an additional level of complexity and planning required for health service delivery, as the federal government has a constitutional responsibility for First Nations in Canada while the provinces are constitutionally responsible for health services (Health Canada, 2014). This mix of federal and provincial responsibility for First Nations has created a lack of jurisdictional clarity that results in barriers for First Nations people in accessing healthcare (Indigenous Services Canada, 2018; Lavoie, J. G., 2013). There are concerns that these barriers to accessing healthcare also extend to receiving vital cancer care services in the province. Since 2006, a significant shift has been underway in BC to resolve these jurisdictional barriers and recognize the need to meaningfully involve First Nations in decision-making when it comes to health service planning. A unique First Nations health governance structure in BC, which includes the First Nations Health Authority (FNHA), has been established. FNHA is the first population-based health authority in the province and amongst the largest First Nations public service organizations in Canada (Gallagher, Mendez, & Kehoe, 2015). It works to drive quality improvement in service delivery for First Nations and all British Columbians by promoting partnerships, collaborations, and innovation with provincial and regional health authorities. FNHA is responsible for the design and delivery of First Nations health programs and services that were formerly handled by the federal government in BC, and is involved in decision-making within the larger provincial health system related to prioritization, planning, service coordination, and accountability monitoring. As a result, and in the context of reconciliation, addressing disparities in First Nations care and outcomes is now being built into key processes of health service planning and quality improvement efforts in the province.

One of the quality improvement priorities being championed by FNHA and health system partners has been a system-wide movement on embedding cultural safety and humility within health services. FNHA's Policy Statement on Cultural Safety and Humility provides a vision for

this work (FNHA, nd-e). In reflection of this vision, cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving care. Cultural humility is a process of self-reflection for healthcare providers to understand personal and systemic biases, and to develop and maintain respectful processes and relationships based on mutual trust. When healthcare professionals engage with First Nations people from a place of cultural humility, they are helping to create a safer healthcare environment where individuals and families experience respect. This puts power in the hands of clients to define what culturally safe care looks and feels like, and requires training of healthcare providers to be lifelong learners and self-interrogators to understand how their culture and society impacts their practice. By improving cultural safety in health services, First Nations people will be more likely to access care when needed; increased access and utilization of healthcare services will inevitably result in improved health outcomes.

To operationalize cultural safety and humility as a health system priority, key provincial and regional health partners have signed Declarations of Commitment to advance cultural safety and humility and are undertaking associated action planning and implementation work. Health system partners include all BC regional and provincial health authorities (FNHA, nd-c) and all twenty-three BC Health Regulators (provincial regulatory colleges of health professions; FNHA, nd-d). Work is also underway with universities and education providers in the province to support the education needs of students studying in the health and social sciences; thereby supporting improvements in cultural safety on many fronts and for the long term. As per the TRC's 'Calls to Action' #23 and #24, cultural safety and humility has now become necessary and expected (TRC, 2015). These essential concepts are no longer considered progressive or optional. In a country as diverse as Canada, this is seen as progress not just for Indigenous people, but for all Canadians.

The issue of cultural safety and humility is now also firmly embedded in provincial cancer care quality improvement efforts through a first-of-its-kind Indigenous Cancer Strategy released in 2017 (FNHA, Métis Nation British Columbia, BC Association of Aboriginal Friendship Centres, and BC Cancer, nd). Embodying a culturally safe philosophy throughout its development, the strategy took a "best of both worlds" approach, blending Western models of strategy development with a deep commitment to Indigenous decision-making and community engagement. In the context of reconciliation, the strategy posits that the disparities in cancer outcomes are at least partially attributable to processes of colonialism, intergenerational trauma and a lack of cultural safety in the healthcare system, particularly as it relates to primary care and tertiary cancer treatment services. Therefore, the Indigenous Cancer Strategy aims to improve Indigenous cancer journeys by implementing actions that promote cultural safety and humility along all steps of the cancer journey, from prevention through to survivorship and end-of-life. Examples include:

- Completing relevant data linkages to identify First Nations HPV vaccination rates, cancer screening (colon, cervical and breast cancer) program participation rates, and updating First Nations cancer incidence (including stage at diagnosis) and survival rates to evaluate the

performance of the cancer control system for First Nations people in order to direct solutions for improvement specific to such findings.

- Promoting client and community awareness and engagement in cancer prevention (environment, commercial tobacco, physical activity, healthy eating and HPV vaccination) and screening programs (colon, cervical and breast cancer);
- Supporting health system partners to improve quality of service across the cancer care spectrum through applying a lens of cultural safety and humility to their values and attitudes, structures and policies, system performance frameworks, and staff training and development; and,
- Connecting First Nations people, families and communities impacted by cancer to build an empowered First Nations cancer survivorship network to provide peer-support and further identify and guide First Nations cancer quality improvement priorities.

The development and now implementation of an Indigenous Cancer Strategy in BC is an essential approach to strategically improving First Nations cancer journeys in the province. The processes of reconciliation in Canada have created a new climate for discussions about systemic racism, and highlighted the lack of cultural safety as a root cause of health outcome disparities for First Nations and the need for greater First Nations decision-making. In BC, one of these processes of reconciliation is the establishment of a First Nations health governance structure that works in partnership with federal and provincial governments in the design and delivery of health services accessed by First Nations people. Through this process, efforts have been initiated to support quality improvement in health services through cultural safety and humility. These broad priorities and processes are being focused specifically to improve cancer care and associated outcomes for First Nations people. Through the development of an Indigenous Cancer Strategy, FNHA and health system partners are now leveraging the current climate for change and reconciliation to improve cancer outcomes and experiences for First Nations people, families and communities, and are leading the way of improving culturally safe health services for all British Columbians.

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Conflict of interest

The authors declare that no competing or conflict of interests exist. The funders had no role in study design, writing of the manuscript, or decision to publish.

Authors' contributions

All authors contributed equally to this manuscript.

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