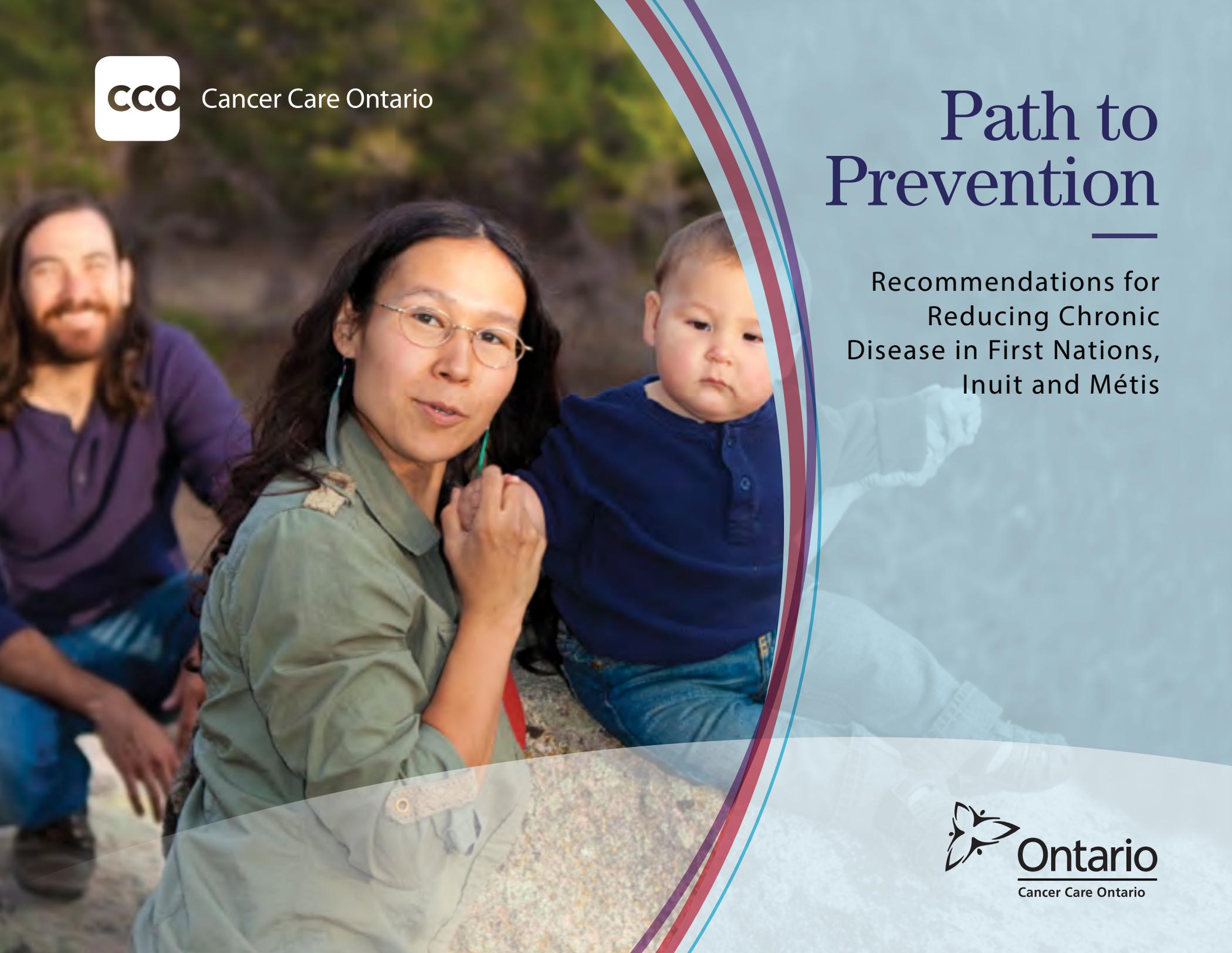




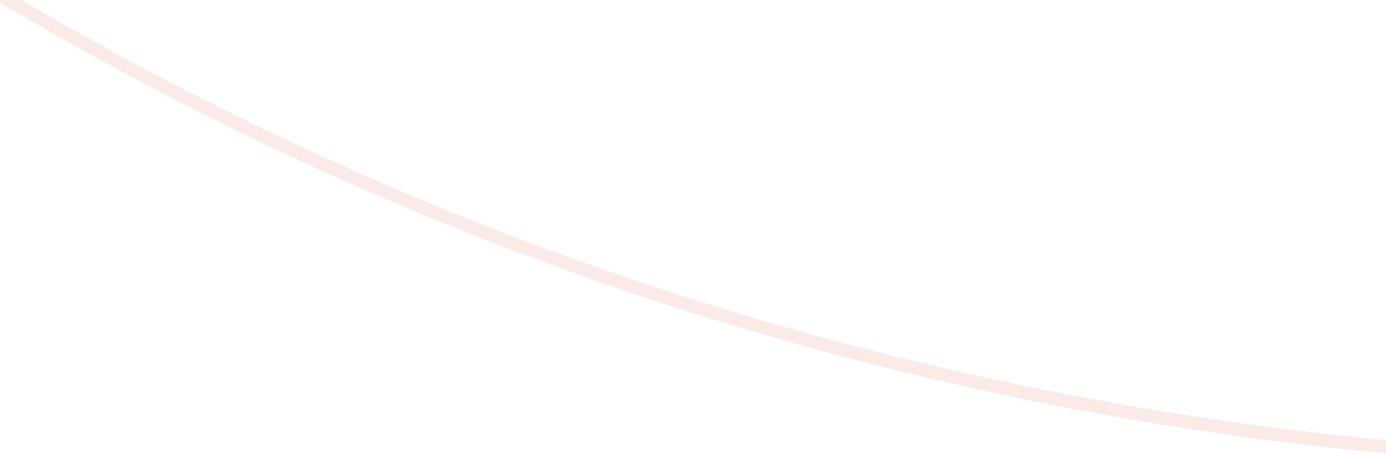
Cancer Care Ontario

Path to Prevention

Recommendations for
Reducing Chronic
Disease in First Nations,
Inuit and Métis



Ontario
Cancer Care Ontario



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ISBN 978-1-4606-7266-2

Key title: Path to Prevention—Recommendations for Reducing Chronic Disease in First Nations, Inuit and Métis (Print)

ISBN 978-1-4606-7267-9

Key title: Path to Prevention—Recommendations for Reducing Chronic Disease in First Nations, Inuit and Métis (Online)

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How to cite this publication: Cancer Care Ontario. Path to Prevention – Recommendations for Reducing Chronic Disease in First Nations, Inuit and Métis. Toronto: Queen's Printer for Ontario; 2016.

This report and associated supplemental materials are available at: cancercare.on.ca/pathtoprevention

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Executive summary

Path to Prevention—Recommendations for Reducing Chronic Disease in First Nations, Inuit and Métis (referred to as *Path to Prevention*) is a companion report to *Taking Action to Prevent Chronic Disease: Recommendations for a Healthier Ontario (Taking Action)*,¹ which provided 22 recommended policies and interventions to:

- reduce population-level exposure to four key risk factors;
- build capacity for chronic disease prevention; and
- work towards health equity.



Similar to *Taking Action*, Cancer Care Ontario's *Path to Prevention* provides the Ontario government with evidence-based recommendations to guide decision-making related to chronic disease prevention policy. The focus of this report is on the same four risk/protective factors as *Taking Action*: commercial tobacco use, alcohol consumption, physical activity and healthy eating. While the recommendations are for the Government of Ontario, their implementation will involve full participation by First Nations, Inuit and Métis partners and collaboration with a range of organizations that work with First Nations, Inuit and Métis peoples. One of Cancer Care Ontario's key proposed roles is to create a collaborative structure that includes First Nations, Inuit and Métis communities and other key cross-sectoral partners to develop, plan, implement and evaluate Cancer Care Ontario's *Path to Prevention*. In addition, specific roles for Cancer Care Ontario that are part of its prevention mandate are identified in the recommendations.

The *Path to Prevention* takes into consideration the unique circumstances and needs of First Nations (living on- and off-reserve), Inuit and Métis populations living in Ontario to account for their distinct sociopolitical, historical and geographical contexts.² It is clear from the knowledge and experience shared by communities, organizations and individuals in focus groups and interviews that a broad range of social determinants of Aboriginal health affect the physical, emotional, mental and spiritual health of First Nations, Inuit and Métis peoples. Factors such as colonialism, racism, social exclusion and self-determination have a profound effect on First Nations, Inuit and Métis health³ and are responsible for the socio-economic inequities⁴ that exist between First Nations, Inuit and Métis peoples and the

general Ontario population. Socio-economic factors are a fundamental cause of health inequities and an important contributor to population health outcomes,^{5,6,7,8} which is why they are a major focus of this report.

Remarkably, First Nations, Inuit and Métis peoples have shown an ability to survive, even to thrive, in the face of these overwhelming challenges. Factors such as personal and community resilience, restoring and promoting Aboriginal identity, keeping cultures and languages alive, and self-governance have positive effects on health and well-being.⁹ These positive determinants of health are supported in the recommendations and illustrated by examples of effective approaches taken by First Nations, Inuit and Métis communities and organizations.

The urgent need for action to prevent chronic disease among First Nations, Inuit and Métis populations is driven by rising rates of cancer,¹⁰ diabetes, heart disease and respiratory diseases.¹¹ Obesity, which predisposes individuals to chronic disease, is markedly increased in First Nations, Inuit and Métis people compared to the general population.¹² In this young and rapidly growing group, these trends point towards a future of dramatically increased chronic disease.¹³

The good news is that chronic diseases are not inevitable and can, to a great extent, be prevented. Researchers have calculated that healthy lifestyles can potentially prolong a person's lifespan by seven to 14 years.^{14,15,16} Adoption of healthy lifestyle choices has also been shown to reduce the incidence of cancer by at least one-third^{17,18,19} and to decrease the incidences of type 2 diabetes and cardiovascular disease by 80 per cent.^{20,21,22,23}

Action is needed to address all four risk factors. Even though First Nations, Inuit and Métis populations engage in healthier behaviours than the general Ontario population with respect to some indicators, gaps still exist between their present levels of physical activity, healthy eating, commercial tobacco use and alcohol consumption, and the levels recommended in chronic disease prevention guidelines. The wholistic approach to addressing risk factors, including determinants of health, is based on the First Nations, Inuit and Métis view of health and wellness as a balance among four dimensions of health (physical, mental, emotional and spiritual) throughout the stages of life.

The recommendations are focused on creating environments in which First Nations, Inuit and Métis peoples can make healthy choices. Governments can support the efforts of individuals, families and communities, and address gaps in the health system. For example, governments can reduce barriers to health system access and inefficient health systems, which arise, in part, due to jurisdictional boundaries unclear health services delivery mandates, lack of leadership and coordination, and the absence of robust data systems. They also need to address the great disparities among regions regarding how First Nations, Inuit and Métis groups are included in health decision-making tables.

The following recommendations are supported by strong primary and secondary sources of evidence, build on what is already working well and in place, and integrate across and/or address more than one risk factor and the social determinants of Aboriginal health.



Commercial tobacco use

RECOMMENDATION 1: Develop and implement a coordinated plan to prevent commercial tobacco use among First Nations, Inuit and Métis children and youth

Develop a culture-based social marketing campaign based on “Smoke-Free Ontario” and other existing best practice initiatives to promote healthy lifestyles.

Cancer Care Ontario can play a role in raising awareness and supporting the prevention of commercial tobacco use among First Nations, Inuit and Métis children and youth. It can work to promote respect for traditional uses of tobacco through education of the cultural benefits and teachings associated with traditional and ceremonial uses of tobacco.

RECOMMENDATION 2: Establish commercial tobacco cessation programs and services in First Nations, Inuit and Métis communities

Allocate dedicated resources to improve the reach and impact of the Aboriginal Tobacco Program and the Non-Insured Health Benefits (NIHB) Program to effectively reduce commercial tobacco use in First Nations, Inuit and Métis populations.

Cancer Care Ontario could offer First Nations, Inuit and Métis communities the option of a broader approach to addictions within the Aboriginal Tobacco Program by assessing the feasibility of expanding the program’s scope and other commercial tobacco

intervention programs to address substance addictions to prevent cancer and other chronic diseases. Cancer Care Ontario could also plan to adopt successful smoking cessation approaches that integrate the social determinants of Aboriginal health and foster collaboration among key stakeholders to promote healthier lifestyle choices.

RECOMMENDATION 3: Support the development of resources to address second- and third-hand smoke

Inform the development of community policy regarding second- and third-hand smoke by working with First Nations, Inuit and Métis communities to create a database of information and raise awareness about the harmful effects of second- and third-hand smoke.

RECOMMENDATION 4: Support community-initiated and managed tobacco control measures while respecting First Nations rights

First Nations governments have the constitutional right to control and regulate their own smoking-related policies so that they are relevant and acceptable to their communities.

Cancer Care Ontario can play a role by reinforcing messaging to the government that makes it clear that First Nations have the right to make their own decisions on tobacco control in their communities. It can also provide information to communities to inform commercial tobacco management strategies.



Alcohol consumption

RECOMMENDATION 5: Ensure that culturally acceptable and relevant alcohol prevention and treatment programs for First Nations, Inuit and Métis peoples are available

Support culture-based approaches to healthy lifestyle intervention for adults and youth that incorporate best practices related to promoting health equity and addressing the root causes of alcohol addiction.

RECOMMENDATION 6: Broaden the impact of alcohol intervention strategies

Broaden and enhance the current scope and capacity of alcohol programs to include substance-free living.

Cancer Care Ontario can contribute by supporting strategies that reduce access to and availability of alcohol, such as promoting community-developed policies, guidelines and social media initiatives, including *Taking Action's* recommendations to effectively reduce access to and availability of alcohol, and the acceptability of alcohol abuse. It can also promote the benefits of being alcohol-free by developing and implementing social media campaigns that promote the social norm of being alcohol free and smoke free and motivate people to live a healthier lifestyle.

RECOMMENDATION 7: Incorporate alcohol interventions into existing tobacco control initiatives (see Recommendation 2)

Explore opportunities to collaborate and partner with the National Native Alcohol and Drug Abuse Program to address addictions through prevention and cessation strategies.

**Physical activity****RECOMMENDATION 8: Work with First Nations, Inuit and Métis to create safe places for physical activity**

Build on best practices and existing government policy and regulations to inform the creation of safe outdoor environments that promote physical activity where people live, work and spend time doing recreational activities.

Cancer Care Ontario can support this recommendation by making evidence-based information available on best practices related to creating safe environments for walking, running and bicycling for First Nations, Inuit and Métis populations.

RECOMMENDATION 9: Develop a strategy to promote equity in physical activity infrastructure for First Nations, Inuit and Métis

Invest in community-developed research and planning to identify best practices and inform the

enhancement of community infrastructure on- and off-reserve to fully meet the recreation and sport needs of First Nations, Inuit and Métis so they can be healthy and well.

Cancer Care Ontario can support this recommendation by sharing best practices in community development planning options that would encourage walking and biking.

RECOMMENDATION 10: Address the socio-economic barriers to physical activity for First Nations, Inuit and Métis peoples

Collaborate with First Nations, Inuit and Métis communities and key stakeholders to develop strategies that break down barriers to improve access to physical activity for First Nations, Inuit and Métis groups and capitalize on the success of existing physical activity programming.

Cancer Care Ontario can play a role by providing information on accessible physical activity initiatives for First Nations, Inuit and Métis.

RECOMMENDATION 11: Build and disseminate a knowledge base around physical activity interventions in First Nations, Inuit and Métis communities

Work with First Nations, Inuit and Métis communities to identify, develop, implement and evaluate physical activity interventions that increase the participation of First Nations, Inuit and Métis peoples in recreation and sport.

Cancer Care Ontario can support knowledge exchange and dissemination of information about physical activity interventions for First Nations, Inuit and Métis.

**Healthy eating****RECOMMENDATION 12: Develop an Indigenous food and nutrition strategy**

Invest in a First Nations, Inuit and Métis food and nutrition strategy for Ontario that builds on existing Indigenous food strategies within the province, Canada and internationally.

Cancer Care Ontario can support this recommendation by informing the development of the strategy.

RECOMMENDATION 13: Reduce barriers that prevent access to healthy foods for First Nations, Inuit and Métis

Integrate food security initiatives with best practice policies, strategies and initiatives that promote access to healthy foods and promote traditional community food approaches.

RECOMMENDATION 14: Address environmental issues for Indigenous foods

Work with First Nations, Inuit and Métis groups and collaborate with key stakeholders across all sectors to develop community-based approaches for the

surveillance, monitoring and reporting of contaminants in traditional foods.

RECOMMENDATION 15: Develop traditional food and nutrition skills

Work with First Nations, Inuit and Métis to develop an intergenerational food skills strategy that enhances knowledge and skills in the growing, harvesting and preparation of traditional foods.



RECOMMENDATION 16: Develop a plan to address First Nations, Inuit and Métis health equity

Invest in a whole-of-government, multi-sectoral strategy that reduces health inequities by creating high-level First Nations, Inuit and Métis committees to oversee health equity planning, implementation and evaluation.

RECOMMENDATION 17: Implement the plan to achieve First Nations, Inuit and Métis health equity goals

Align government policies, strategies and resources to support health equity in cancer and chronic disease prevention, including integrating health equity impact assessments into First Nations, Inuit and Métis-facing government departments.

Cancer Care Ontario can support a First Nations, Inuit and Métis health equity plan by working with Public

Health Ontario and First Nations, Inuit and Métis leadership to adapt the Ministry of Health and Long-Term Care's Health Equity Impact Assessment tool for First Nations, Inuit and Métis policy, strategy and program work.

RECOMMENDATION 18: Implement a plan to achieve equity in access to primary care

Reinforce existing capacities for health promotion and build onto existing health promotion infrastructure, resources and services.

RECOMMENDATION 19: Build First Nations, Inuit and Métis cultural competency and safety within government

Build cultural competency and establish a First Nations, Inuit and Métis lens for policies, strategies and initiatives in First Nations, Inuit and Métis-facing government departments.

Cancer Care Ontario can support the development of cultural competency and safety initiatives within government by promoting awareness around Cancer Care Ontario's new Aboriginal Relationship and Culturally Competency courses (available at elearning.cancercare.on.ca) in key stakeholder organizations (including government) working with First Nations, Inuit and Métis.



Collaboration

RECOMMENDATION 20: Support an integrated, cross-sectoral and whole-of-government approach

Build capacity system-wide to ensure full participation by partner organizations by aligning government policies, strategies and resources to support First Nations, Inuit and Métis chronic disease prevention.

RECOMMENDATION 21: Promote a coordinated approach to the delivery of First Nations, Inuit and Métis health promotion programming in communities

Work with key stakeholders to build coordinated provincial and regional systems for the delivery of First Nations, Inuit and Métis chronic disease prevention and management services.

RECOMMENDATION 22: Establish a coordinated system for surveillance, research, measurement and evaluation

With First Nations, Inuit and Métis groups and through existing and new partnerships, build capacity and develop consistent approaches for cancer and chronic disease research, surveillance, evaluation and data sharing in First Nations, Inuit and Métis populations.

Cancer Care Ontario can support this recommendation by working with its First Nations, Inuit and Métis partners to build its capacity for cancer and chronic disease research and surveillance work in First Nations, Inuit and Métis populations.

Next steps

Cancer Care Ontario is committed to advancing the recommendations in the *Path to Prevention* in the following ways.

1. Present the report to senior levels of government and engage in discussions regarding how the recommendations might be implemented.
2. Implement the roles outlined for Cancer Care Ontario within its existing mandate and resources. A key starting point is the creation of a cross-sectoral collaborative structure to develop and implement a First Nations, Inuit and Métis chronic disease prevention strategy.
3. Use the *Path to Prevention* as an evidence-based resource to provide ongoing advice to government.
4. Make the *Path to Prevention* available to advocacy organizations as an evidence-based tool to support their role.
5. Broadly disseminate the *Path to Prevention* to raise awareness of the issues and stimulate participation in the proposed solutions.

“The cancer conversation is being had at the grassroots level, is supported by Elders and is seen as everybody’s responsibility to reclaim their health.”

Dr. Andrea East,
Regional Aboriginal Cancer Lead,
Hamilton Niagara Haldimand Brant



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Acknowledgements

The following organizations contributed to the development of the *Path to Prevention—Recommendations for Reducing Chronic Disease in First Nations, Inuit and Métis*. We are grateful for their wisdom and interest in advancing the health of First Nations, Inuit and Métis peoples in Ontario.

First Nations, Inuit and Métis Communities

Akwesasne First Nation	Métis Nation of Ontario	Renfrew County and District Aboriginal Friendship Centre
Aroland First Nation	Missinabi Cree First Nation	Sachigo Lake First Nation
Aundeck Omni Kaning First Nation	Moose Cree First Nation	Sandy Lake First Nation
Bkejwanong Territory (Walpole Island)	Muskrat Dam First Nation	Serpent River First Nation
Chippewas of the Thames First Nation	Ne-Chee Friendship Centre	Sheguiandah First Nation
Dryden Native Friendship Centre	Neskantaga First Nation	Sheshegwaning First Nation
Eabametoong First Nation	Nigigoonsimanikaaning First Nation	Tungasuvvingat Inuit
Eagle Lake First Nation	Nishnawbe-Gamik Friendship Centre	United Native Friendship Centre
Fort William First Nation	Oneida Nation of the Thames	Wabigoon Lake First Nation
Garden River First Nation	Ontario Métis Aboriginal Association, Port McNicoll	Wabuskang First Nation
Ginoogaming First Nation	Ontario Métis Aboriginal Association, Thunder Bay	Wahgoshig First Nation
Hamilton Regional Friendship Centre	Ontario Native Women's Association	Washagamis Bay First Nation
Keewaywin First Nation	Pic River First Nation	Wauzushk Onigum First Nation
Kichenuhmaykoosib Inninuwig (Big Trout Lake First Nation)	Poplar Hill First Nation	Wawakapewin First Nation
M'Chigeeng First Nation	Red Lake Indian Friendship Centre	Webequie First Nation

Whitefish River First Nation

Wikwemikong First Nation

Wunnumin Lake First Nation

Zhiibaahaasing First Nation

First Nations, Inuit and Métis Organizations

Aboriginal Physical Activity and Cultural Circle

Aboriginal Health Access Centres

Chiefs of Ontario

Joint Ontario Aboriginal Cancer Committee (Association of Iroquois and Allied Indians, Grand Council Treaty #3, Independent First Nations, Nishnawbe Aski Nation, Union of Ontario Indians, Métis Nation of Ontario, Ontario Native Women's Association, Ontario Federation of Indigenous Friendship Centres, Traditional Knowledge Keeper, Canadian Cancer Society, Cancer Care Ontario)

Sioux Lookout First Nations Health Authority

Weenebayko Area Health Authority

National Collaborating Centre for Aboriginal Health

Governments

Ministry of Health and Long-Term Care,
Government of Ontario

Ministry of Tourism, Culture and Sport,
Government of Ontario

Ministry of Community and Social Services,
Government of Ontario

First Nations and Inuit Health Branch, Health Canada,
Government of Canada

Agencies and Health Service Organizations

Public Health Ontario

Local Health Integration Networks

Regional Cancer Centres

Non-Governmental Organizations

Canadian Cancer Society

Canadian Diabetes Association

Dietitians of Canada

Heart & Stroke Foundation Canada

Ontario Lung Association

Ontario Tobacco Research Unit, Centre for Addictions
and Mental Health

Research Organizations

University of Ottawa

University of Toronto

University of Waterloo

University of Western Ontario

Well Living House, St. Michael's Hospital, Toronto

International

Top End Health Service, Northern Territory, Australia

Indigenous and Rural Health Division,
Department of Health, Australia

Māori Health, Ministry of Health, New Zealand

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Cancer Care Ontario, Prevention and Cancer Control

- Aboriginal Cancer Control Unit
- Cancer Screening program

Turner & Associates Inc.

Glossary

The following terms have specific meanings in this report.

Term	Usage
Aboriginal	Aboriginal is a collective name for the original people of North America and their descendants. ²⁴ Includes First Nations, Inuit and Métis peoples.
Aboriginal rights	Collective rights, based on Aboriginal occupation and use of lands and customs, traditions and practices that make Aboriginal societies distinctive. ²⁵
Community	In this report, the term “community” refers to a specific ethnic group (First Nations, Inuit and/or Métis) living in a specific geographic area. For example, Inuit living in Ottawa are referred to as a community. The term “Métis community” includes the 18 chartered Métis communities in Ontario and groups of Métis wherever they reside elsewhere in the province. The term “First Nations community” refers to populations living both on- and off-reserve.
Culture	First Nations, Inuit and Métis cultures are expressed as either tangible or intangible, and include customs and practices passed on from generation to generation. ²⁶
Inequity	Health inequities refer to differences in health outcomes across defined populations that are avoidable, systematically unfair and related to social disadvantage, such as income, socio-economic status, educational attainment, gender or ethno/racial origin. ²⁷
First Nation	First Nation may refer to specific communities or can be used as an adjective to describe an individual or a group; the term “First Nation” is often used to replace the terms “bands” or “Indian.” ²⁸
Indian Act	Canadian federal legislation first passed the Indian Act in 1876 and has amended it several times since. It sets out certain federal government obligations and regulates the management of Indian reserve lands, Indian moneys and other resources. ²⁹
Indigenous	Indigenous means “native to the area.” In this sense, First Nations, Inuit and Métis peoples are indigenous to North America. ³⁰ In this report, the term is used to indicate First Nations, Inuit and Métis peoples collectively.
Status Indian (Registered Indian)	These are people who are entitled to have their names included on the Indian Register, an official list maintained by the federal government. Only Status Indians are recognized as Indians under the Indian Act and are entitled to certain rights and benefits under the law. ³¹
Worldview	A worldview highlights the interrelationships among the spiritual, the natural and the self, forming the foundations or beginnings of Indigenous ways of knowing and being. ³² Worldviews reflect the guiding principles and traditional values of Aboriginal societies. ³³

Introduction

Path to Prevention—Recommendations for Reducing Chronic Disease in First Nations, Inuit and Métis (referred to as *Path to Prevention*) is a companion report to *Taking Action to Prevent Chronic Disease: Recommendations for a Healthier Ontario (Taking Action)*.³⁴ The latter report was jointly developed by Public Health Ontario and Cancer Care Ontario, and provided 22 recommended policies and interventions to:

- reduce population-level exposure to four key risk factors;
- build capacity for chronic disease prevention; and
- work towards health equity.



While many of the *Taking Action* recommendations may be used as a basis for discussions with First Nations, Inuit and Métis groups on chronic disease prevention for off-reserve populations, a First Nations, Inuit and Métis-specific approach was also needed to address the unique needs of each of these populations.

Taking Action Recommendation 22:

Address First Nations, Inuit and Métis health

Ensure that the actions taken to address risk factors associated with chronic diseases consider the barriers to health faced by First Nations, Inuit and Métis in Ontario.³⁵

Similar to *Taking Action*, Cancer Care Ontario's *Path to Prevention* provides the Ontario government with evidence-based recommendations to guide decision-making related to chronic disease policy, strategy and initiatives. While the recommendations are for the Government of Ontario, their implementation will involve participation by First Nations, Inuit and Métis partners, Cancer Care Ontario and other partners.

First Nations, Inuit and Métis peoples are distinct from non-First Nations, Inuit and Métis Ontarians because of their unique histories, worldviews, cultures, legal status and ways of life. The *Path to Prevention* takes

into consideration the unique circumstances and needs of First Nations (living on- and off-reserve), Inuit and Métis peoples. Following the lead of *Taking Action*, the recommendations in *Path to Prevention* focus on the four health behaviours that have the greatest impact in reducing the development of chronic disease: healthy eating, physical activity, commercial tobacco use and alcohol abuse. The report focuses on cancer and other chronic diseases with shared risk factors: diabetes, cardiovascular disease and chronic lower respiratory disease. Health equity plays an especially strong role in the recommendations, as does capacity-building through collaboration.

The development of *Path to Prevention* is part of Cancer Care Ontario's commitment in its *Aboriginal Cancer Strategy II* and *III* to help First Nations, Inuit and Métis peoples reduce their risk of developing cancer through prevention.³⁶ *Path to Prevention* also complements Cancer Care Ontario's Prevention Strategy, part of the *Ontario Cancer Plan IV*,³⁷ which provides a comprehensive five-year plan of action to guide Cancer Care Ontario's prevention activities. The strategy was developed in consultation with chronic disease prevention partners and stakeholders, including government, government agencies, researchers, non-profit health organizations, health professionals, prevention experts and the Aboriginal Cancer Control Unit in Cancer Care Ontario. It builds on CCO's unique strengths and expertise, and seeks to work in alignment with chronic disease prevention partners in Ontario. The strategy prioritizes healthy public policies and community programs, plus it recognizes the important role of primary care, early

detection and screening, and tertiary prevention. It also supports behaviour change. Reducing health inequities is an important theme throughout the strategy. Cancer Care Ontario's Prevention Strategy is available on the CCO website at cancercaare.on.ca.

Approach

The goal of this report is to help create supportive and healthier environments that empower the First Nations, Inuit and Métis peoples of Ontario by building on the strengths of individuals, families, communities and organizations. These strengths have allowed First Nations, Inuit and Métis populations to survive and flourish despite inequities stemming from their historical and current contexts.³⁸ The last several decades have seen a resurgence of action by First Nations, Inuit and Métis peoples to reclaim their cultures, assert their rights and determine their own futures.³⁹ The approach taken in this report aligns with this positive direction and supports the broader agenda of healing and reconstruction achieved through First Nations, Inuit and Métis-led collaboration with the Government of Ontario and other key stakeholder organizations.

The *Taking Action* report and the *Aboriginal Cancer Strategy II* and *III* recognize that approaches to chronic disease prevention must focus not only on promoting healthy lifestyle choices, but also on understanding and acting on the "social determinants of Aboriginal health,"⁴⁰ or root causes of health outcomes that support or discourage healthy choices.

The recommendations in this report build on successful health promotion practices that are already in place in Ontario (using First Nations, Inuit and Métis best practices where possible), are based on strong evidence and support the Ontario government's actions to develop stronger relationships with First Nations, Inuit and Métis peoples. They are evidence-based, practical and viewed through an equity perspective. The recommendations build on and amplify the strengths and successes described by communities, governments, non-governmental organizations and researchers, and address identified policy gaps. Provincial, national and international experiences were reviewed to provide a deeper understanding of the context and effectiveness of existing chronic disease prevention policies, strategies and programs.

Although *Path to Prevention* recommendations are directed to the Government of Ontario, implementing them will require a collaborative effort among all sectors, including First Nations, Inuit and Métis, Cancer Care Ontario, the federal government and other partners.



Who are First Nations, Inuit and Métis peoples in Ontario?

Ontario is home to the largest Aboriginal population in Canada, with an estimated 278,500 First Nations*, 86,015 Métis and 3,360 Inuit.^{345,346}

The First Nations, Inuit and Métis population in Ontario is young and growing rapidly. One-third (33.9 per cent) of this population is age 19 and younger, compared to one-quarter (23.8 per cent) of the non-First Nations, Inuit and Métis population. Between 2001 and 2006, Ontario's First Nations, Inuit and Métis population increased four times faster than the rate of growth for the non-First Nations, Inuit and Métis population.

Within these three groups there is a great diversity of identity, history, language and ways of life.

*This number encompasses 75,540 First Nations in Ontario without registered Indian status³⁴⁵ and 202,960 First Nations in Ontario with registered Indian status³⁴⁶. Due to the potential undercount in the 2011 National Household Survey resulting from incompletely enumerated Indian reserves and settlements, the number of First Nations with registered Indian status was obtained from the Indian Registration System³⁴⁶.

First Nations

First Nations are the first peoples of North America and they form the largest group in Ontario, totalling 278,500 people. Approximately half of the 202,960 registered First Nations live on-reserve and crown land (46.5 per cent)³⁴⁶, although this is not easy to measure, since many First Nations people travel between urban centres (for school or work) and their home communities.⁴³ Of the 133 First Nations communities (also known as “reserves”) in Ontario, 61 are located in rural or remote areas and 33 have no year-round road access—so-called “fly-in” communities.

Politically, First Nations communities are represented at the provincial level by a Political Secretariat (Chiefs of Ontario) and four Provincial Territorial Organizations (Grand Council Treaty #3, Nishnawbe Aski Nation, Union of Ontario Indians and the Association of Iroquois and Allied Indians), with 13 Independent First Nations representing themselves. Chronic disease prevention resources and services are provided on reserves primarily by the federal government through Health Canada's First Nations and Inuit Health Branch. First Nations living on- and off-reserve can also access programs and services through other organizations, such as the Ontario Federation of Indigenous Friendship Centres, Ontario Native Women's Association and Aboriginal Health Access Centres.

Inuit

Inuit are not indigenous to Ontario, but have relocated here from their traditional homelands north of the 60th parallel. The majority of the approximately 3,360 Inuit who live in Ontario are located in the Ottawa area.⁴⁴ Inuit Tapiriit Kanatami (ITK) is the national Inuit organization in Canada, representing four Inuit regions; however, in Ontario organizations such as Tungasuvvingat Inuit and Akausivik Inuit Family Health Team, address health and socio-economic issues for Inuit living in Ottawa. Inuit who live in Ontario receive insured chronic disease prevention through the province's health system, just like other Ontarians. The federally funded Non-Insured Health Benefits (NIHB) Program provides coverage for prescribed drugs and selected medical supplies and services.

Métis

The genesis of the Métis culture and nation dates back to the 1600s when early European settlers first came into contact with local Indigenous communities. Early unions between these predominantly male fur-trading European settlers and local Indigenous women led to the emergence of a new and highly distinctive Aboriginal people with a unique identity and consciousness.

There are approximately 86,015 Métis living in Ontario.⁴⁵ In the last decade many more Ontarians have begun to self-identify as Métis than did so

previously. Three-quarters (72 per cent) of Métis live in urban locations,⁴⁶ including 18 charter communities located along historic trading routes. The Métis Nation of Ontario (MNO) maintains the only recognized Métis registry in Ontario. The Métis who are members of MNO and other Métis in Ontario receive chronic disease prevention services through the provincially funded health system, just like other Ontarians, including drug benefits for certain groups.

Equity

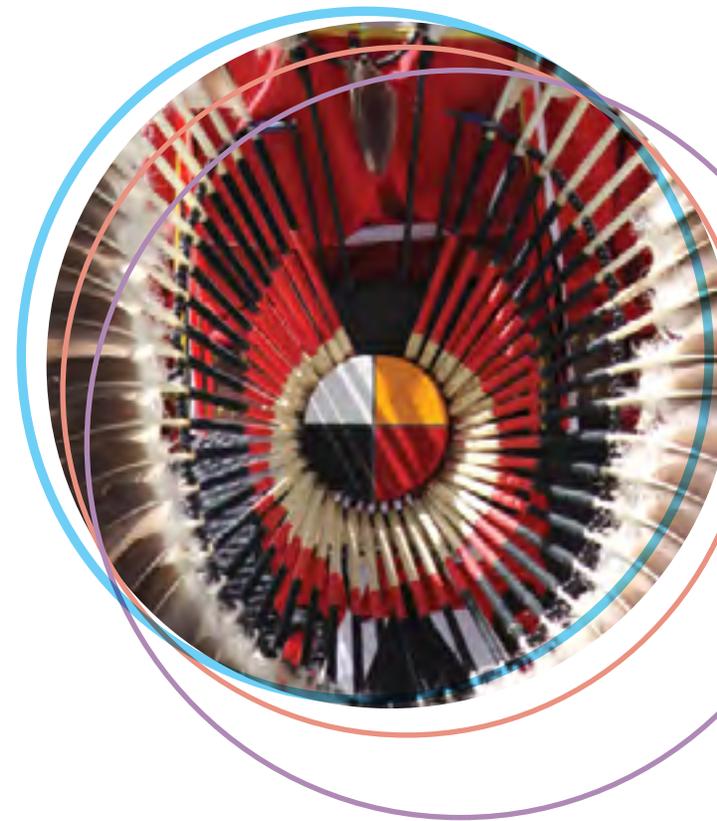
A major focus of this report is equity for First Nations, Inuit and Métis peoples in Ontario. A 2009 report by the Canadian Senate Subcommittee on Population Health states that 50 per cent of health outcomes are attributable to socio-economic factors,⁴⁷ and researchers consider social and economic statuses to be important social determinants of health.^{48,49,50} Compared with the general population, socio-economic factors are worse for all three Indigenous peoples, who experience correspondingly lower life expectancies⁵¹ and higher rates of chronic disease.^{52,53}

In addition to socio-economic factors, research has shown that other determinants play a role in creating health disparities. For example, a recent report by Cancer Care Ontario concluded that elevated smoking rates among Ontario's Aboriginal peoples are not related solely to socio-demographic inequalities.⁵⁵ Racism has also been shown to contribute to disparities in access to health services.⁵⁶

Remarkably, First Nations, Inuit and Métis peoples have shown an ability to survive, even to thrive, in the face of overwhelming challenges, such as past government policies that altered First Nations, Inuit and Métis ways of life and had a profound impact for generations of First Nations, Inuit and Métis peoples. Factors such as personal and community resilience, restoring and promoting Aboriginal identity, keeping cultures and languages alive, and self-governance have had positive impacts on health and well-being.⁵⁷

The root causes of inequity must be addressed before interventions aimed at health behaviours can take hold. In this report, equity is a foundational principle for all recommendations. Approaches to reducing inequities by addressing the social determinants of Aboriginal health are embedded in the recommendations related to the four risk factors for chronic disease. Reducing chronic disease by achieving health equity is also a policy objective in its own right and several practical recommendations are made to advance a First Nations, Inuit and Métis health equity agenda.

“Individuals in less advantaged situations tend to suffer from poorer health outcomes. Health inequities refer to differences in health outcomes across defined populations that are avoidable, systematically unfair and related to social disadvantage, such as income, socio-economic status, educational attainment, gender or ethno/racial origin.”⁵⁴



Building towards First Nations, Inuit and Métis equity

The Government of Ontario has made positive steps forward by recognizing disparities in partnership with First Nations, Inuit and Métis peoples.

“Aboriginal communities must also have access to the tools and training they need to fully participate in economic development opportunities, including those related to our natural resources. And so your government is working with Aboriginal communities to ensure that the benefits of resource development are shared and opportunities for education, training and employment are established.”

Premier Kathleen Wynne, Speech from the Throne, February 19, 2013⁵⁸

Respecting the treaties

First Nations communities told us that the fundamental issue of shared resources among treaty partners has yet to be addressed in Ontario. Respecting the treaties would allow First Nations access to shared resources, which would alleviate many socio-economic problems.

The government has made a start down this path. The new Treaty and Aboriginal Rights Awareness Strategy, announced in 2014, provides \$7.9 million over three years to “promote constructive engagement with First Nations communities, revitalize treaty relationships and promote improved socio-economic outcomes for Aboriginal peoples.”⁵⁹ The Métis Nation of Ontario is also providing input into the strategy.⁶⁰ An education and awareness campaign is now underway to increase public awareness, understanding and recognition of treaties and treaty rights.⁶¹

“The treaties have been an issue over the years and now we’re going to sit down with First Nations and see what we can do to engage in a dialogue on how we can work together and meet our respective obligations under the treaties in such a way that everyone benefits.... we are all treaty people here.”

Hon. David Zimmer, Minister of Aboriginal Affairs⁶²

Strengthening relationships

The Government of Ontario has made efforts to work in partnership with First Nations, Inuit and Métis leadership and communities. The most senior levels of government participate in regular meetings with First Nations, Inuit and Métis leadership and the government has signed bilateral agreements with several First Nations, Inuit and Métis representative bodies.^{63,64,65} First Nations, Inuit and Métis are explicitly included in major government strategies, such as the Ontario Poverty Reduction Strategy.⁶⁶ The 2014–15 *Mandate Letters* from the premier to 13 of her ministers outline expectations around achieving greater equity with First Nations, Inuit and Métis peoples across all dimensions: economic, educational, social, housing, justice system, health, clean environments and land use.⁶⁷

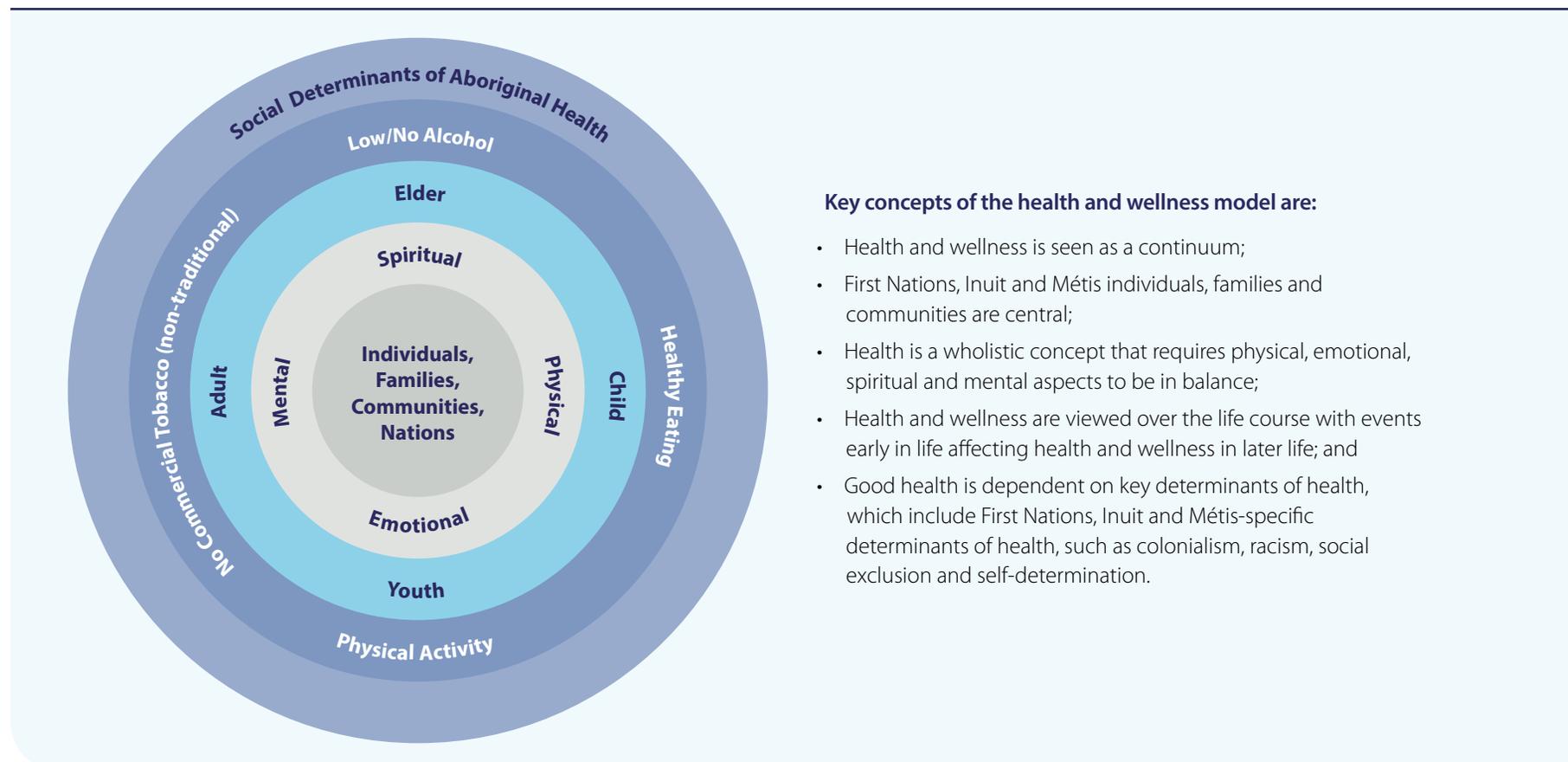
Cancer Care Ontario is the Ontario government’s advisor on cancer matters and is ideally positioned to support the province in the development of a First Nations, Inuit and Métis chronic disease prevention strategy. Cancer Care Ontario has built strong relationships with First Nations, Inuit and Métis communities who know and respect its work in developing policies, strategies and programs to improve cancer services along the chronic disease continuum.

A vision of health and wellness

The approach to prevention of chronic diseases taken in this report is framed by a vision of health and wellness. First Nations, Inuit and Métis peoples share a common understanding of the principles of well-being, which are reflected in the Community-Centred First Nations, Inuit and Métis Health and Wellness Model, shown in Figure 1.

This model has been validated by First Nations, Inuit and Métis communities and key health system stakeholders servicing First Nations, Inuit and Métis peoples, and has guided the development of *Path to Prevention*.

FIGURE 1
Community-Centred First Nations Inuit and Métis Health and Wellness Model



Key concepts of the health and wellness model are:

- Health and wellness is seen as a continuum;
- First Nations, Inuit and Métis individuals, families and communities are central;
- Health is a wholistic concept that requires physical, emotional, spiritual and mental aspects to be in balance;
- Health and wellness are viewed over the life course with events early in life affecting health and wellness in later life; and
- Good health is dependent on key determinants of health, which include First Nations, Inuit and Métis-specific determinants of health, such as colonialism, racism, social exclusion and self-determination.



Background

The urgent need for action to prevent chronic disease among First Nations, Inuit and Métis populations is driven by rising rates of cancer⁶⁸ and an elevated prevalence of diabetes, heart disease and respiratory diseases.⁶⁹

Obesity, which predisposes individuals to chronic disease, is markedly increased in First Nations, Inuit and Métis compared to the general population.⁷⁰ In this young and rapidly growing population, these trends point towards a future of dramatically increased chronic disease.⁷¹

By investing equitably in strategies and initiatives that are known to be effective in Indigenous populations, and by empowering First Nations, Inuit and Métis to make informed decisions, Ontario's First Nations, Inuit and Métis peoples can look forward to longer, healthier lives.

Burden of chronic disease

Chronic disease has an enormous impact on First Nations, Inuit and Métis peoples in Ontario. As the data presented in Tables 1 and 2 indicate rates of chronic conditions are significantly higher in First Nations, Inuit and Métis than in the general Ontario population, and mortality rates for those afflicted by a chronic disease are far greater.

Health status

In general, the self-reported health status of First Nations and Métis in Ontario is worse than that for the non-First Nations, Inuit and Métis population. First Nations off-reserve and Métis adults reported being in fair or poor health twice as often as did non-First Nations, Inuit and Métis Ontarians and reported having one or more chronic conditions significantly more often (Table 1).

Among Ontario First Nations living on-reserve, more than half (60 per cent) perceive their health status as good, fair or poor.⁷²

Chronic diseases

The data in Table 2 show the percentage of Ontarians who reported having one or more specific chronic diseases. Almost all chronic diseases were significantly more prevalent in First Nations off-reserve and Métis populations compared to non-First Nations, Inuit and Métis Ontarians. Cancer is the exception and is discussed in further detail later in this section.

TABLE 1

Health status of Ontario respondents to the Canadian Community Health Survey, ≥12 years, by First Nations, Inuit and Métis identity (off-reserve population), 2007–2010 Canadian Community Health Survey combined data, age-standardized to Ontario First Nations, Inuit and Métis population

	First Nations off-reserve	Métis	Non-Aboriginal
Health status fair or poor	18%	18%	9%
One or more chronic conditions	63%	61%	47%

Source: Canadian Community Health Survey 2007–10 combined data. Custom tabulation

TABLE 2

Chronic disease prevalence among Ontario respondents to the Canadian Community Health Survey, ≥12 years, by First Nations, Inuit and Métis identity (off-reserve population), 2007–2010 Canadian Community Health Survey combined data, age-standardized to Ontario First Nations, Inuit and Métis population

	First Nations off-reserve	Métis	Non-Aboriginal
Cardiovascular disease	19.4%	18.1%	14.8%
Diabetes	8.7%	4.9%	4.3%
Asthma	15.6%	12.1%	8.6%
Chronic obstructive pulmonary disease	4.3%	3.2%	1.6%
Cancer	1.5%	0.6%	1.2%

Source: Canadian Community Health Survey 2007–10 combined data. Custom tabulation

The reported prevalence of diabetes was extremely high in the Ontario on-reserve First Nations population. The Regional Health Survey reported a rate of 22 per cent among adults aged 18 and over.⁷³

Chronic diseases are becoming important health issues for Indigenous peoples from Canada and internationally. For example, since the 1950s, studies conducted among Indigenous people in the United States, Canada, New Zealand and Australia have shown a consistently higher prevalence of diabetes among Indigenous compared with non-Indigenous populations.⁷⁴

Mortality due to chronic disease

Studies in Canada have shown that cancer and cardiovascular disease are the two leading causes of death among First Nations and Métis⁷⁵ and both are major contributors to potential years of life lost.⁷⁶ Cancer is the second-leading cause of death among Inuit in Canada.⁷⁷

Table 3 shows rates of death due to specific chronic diseases among registered First Nations and Métis men and women in Canada compared to the non-Aboriginal population. With the exception of cancer in registered First Nations males, relative death rates for all chronic diseases are significantly greater for First Nations, Inuit and Métis populations. In all cases, mortality rate ratios are higher for women than for men.

Cancer

While there are no specific data on the cancer burden among Ontario's Inuit and Métis people, the cancer burden differs markedly between First Nations people and Ontarians.⁷⁸

Cancer rates in previous decades were much lower among First Nations Ontarians than the general population; however, more recent data show that First Nations incidence rates are rising more rapidly than in the general population.⁷⁹ Rates of colorectal cancer are now higher in areas of Ontario with a high

TABLE 3
Mortality rate ratios among Registered First Nation and Métis males and females compared with non-Aboriginal males and females, by cause of death for populations age ≥25 years at baseline, Canada, 1991–2001

	Males		Females	
	Registered First Nations	Métis	Registered First Nations	Métis
Circulatory system diseases	1.28	1.29	1.74	1.71
Diabetes	3.48	2.02	5.00	2.66
Respiratory system diseases	1.63	1.46	2.60	2.00
Cancer	0.87	0.94	1.17	1.34

Source: Tjepkema M, Wilkins R, Senécal S, Guimond E, Penney C. Mortality of Métis and Registered Indian adults in Canada: An 11-year follow-up study. Health Reports. 2009 December;20(4):1-21. Statistics Canada. Catalogue no. 82-002-XPE.

Aboriginal population (>33 per cent) compared to low.⁸⁰ Lung cancer is especially common among Inuit in northern Canada, who have the highest rates in the world.⁸¹

Once diagnosed, First Nations, Inuit and Métis populations in Ontario tend to have worse outcomes for all major types of cancer,^{82,83,84,85} which is also the case across Canada^{86,87} and among Indigenous populations in other jurisdictions.^{88,89,90,91,92}

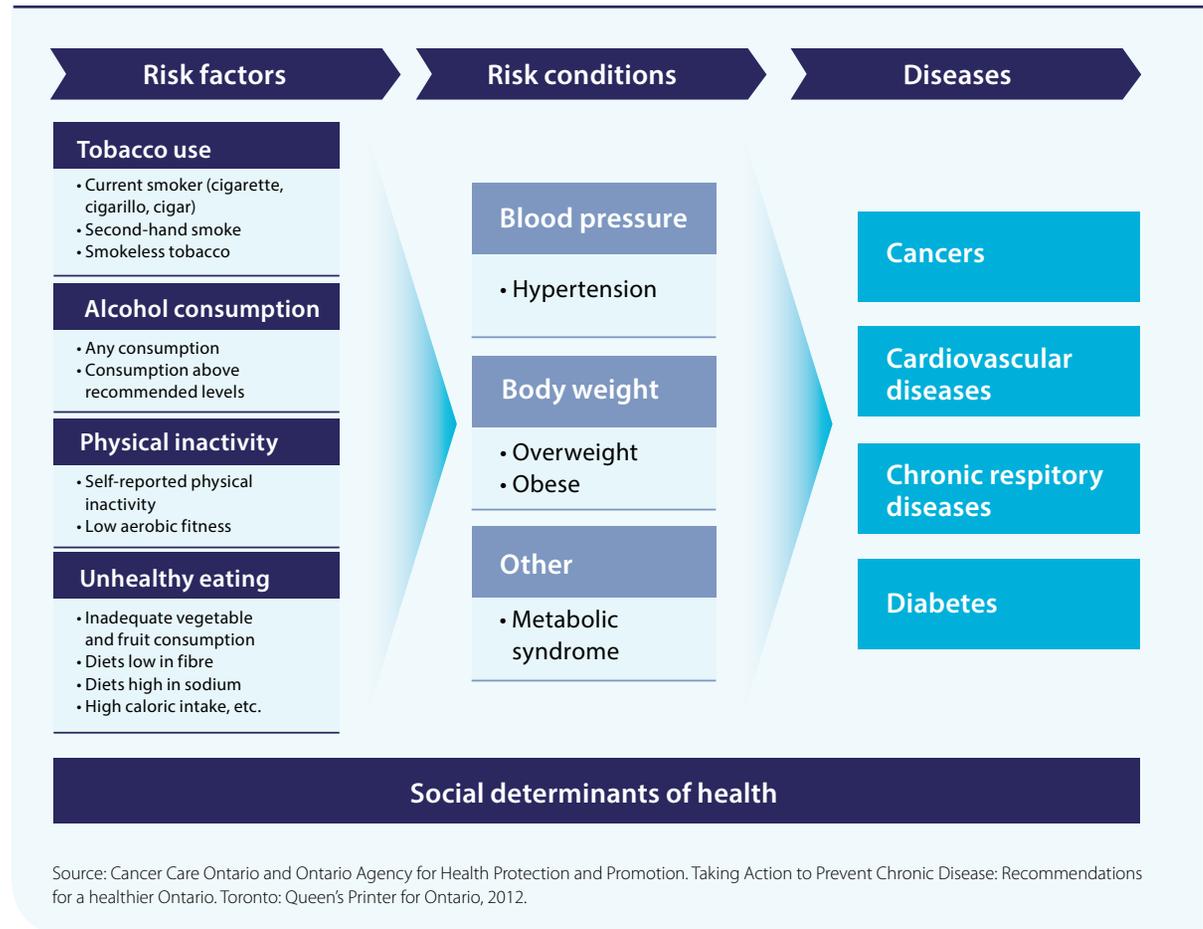
“Relative death rates for all chronic diseases are significantly greater for First Nations, Inuit and Métis populations.”

Preventing chronic disease

A large body of evidence has demonstrated that chronic diseases are not inevitable, but can, to a great extent, be prevented by lifestyle choices. In several studies, lifestyle changes have had a tangible impact on cancer rates, which have been reduced from one-third⁹³ to over one-half⁹⁴. The incidences of both type 2 diabetes and heart disease can be reduced by 80 per cent when people follow healthy lifestyles.^{95,96,97,98} Also, many chronic lower respiratory diseases, including asthma and chronic obstructive pulmonary disease, are worsened by smoking and improved by physical activity.⁹⁹ Healthy lifestyles can potentially prolong someone's lifespan by seven to 14 years.^{100,101,102} Cancer, diabetes, cardiovascular and lower respiratory diseases share the same risk factors of commercial tobacco use, alcohol consumption, physical inactivity and unhealthy eating, which can be modified by changing the environment within which people make lifestyle choices.¹⁰³

The diagram in Figure 2 from the *Taking Action* report shows the links between the social determinants of health, risk factors, risk conditions and the development of chronic disease. Each of these elements is discussed with respect to First Nations, Inuit and Métis peoples in Ontario.

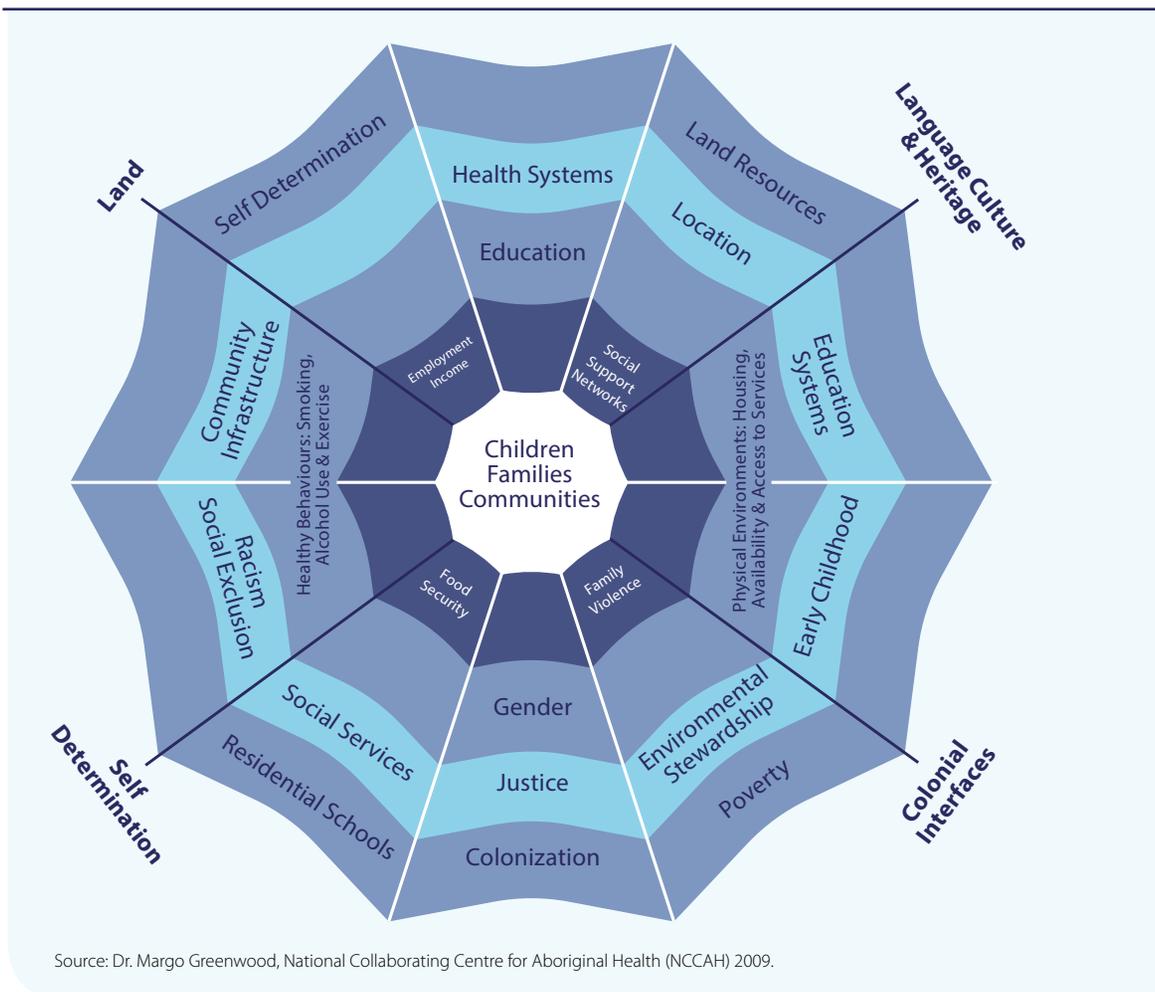
FIGURE 2
Causal links between selected risk factors and chronic diseases



Social determinants of First Nations, Inuit and Métis health

The Web of Being (Figure 3) developed by the National Collaborating Centre on Aboriginal Health, illustrates the many social determinants of health for First Nations, Inuit and Métis peoples and shows how these factors are interconnected to form a strong web that affects health and well-being.

FIGURE 3
Web of Being: Social determinants and Indigenous people’s health



Path to Prevention's recommendations include specific approaches to address the social determinants of Aboriginal health.

The social determinants of Aboriginal health can be classified into proximal, intermediate and distal categories. Proximal determinants have a direct impact on the day-to-day lives of individuals and affect someone’s physical, emotional, mental and spiritual health. These determinants include health behaviours, the physical environment, employment and income, and education. Intermediate determinants provide the context for the development of proximal determinants, and include healthcare systems, educational systems and community infrastructure. Distal determinants, such as colonialism, racism and self-determination, have the strongest influence on health for First Nations, Inuit and Métis peoples, and are rooted in the historical, political, social and economic contexts that generations of First Nations, Inuit and Métis people have lived through.¹⁰⁴

Research has shown that the social determinants of health are at the root of health inequities. A study of registered First Nations and Métis adults in Canada showed that one-third to two-thirds of disparities in mortality from all causes were associated with lower levels of income, education, occupational skill and urban residence, compared with their non-First Nations, Inuit and Métis counterparts.¹⁰⁵ Factors such as education, income, housing and labour force status were significantly associated with the disparity in premature mortality among non-registered First Nations and Métis.¹⁰⁶

Socio-economic inequalities for First Nations, Inuit and Métis peoples in Ontario

“Generally, [First Nations, Inuit and Métis] people are younger, more mobile, less educated and more often unemployed than non-Aboriginal people. They also earn less.... The median income per Aboriginal household is \$46,865, which is significantly lower than Ontario’s median household income of \$73,290. The Aboriginal unemployment rate in Ontario is 12.3 per cent, and about 57 per cent of the First Nations, Inuit and Métis population over 15 years of age is working. Conversely, the provincial rate of unemployment is 7.2 per cent, representing almost half the level of unemployment among [First Nations, Inuit and Métis] Ontarians. Thirty-eight per cent of [First Nations, Inuit and Métis] Ontarians have no post-secondary certificate, diploma or degree, and 61.8 per cent have only a high school diploma or less.”

Source: Kewayosh et al. 2015¹⁰⁷

The social determinants of Aboriginal health have also been linked to positive health outcomes. Some studies in this emerging field of research have shown a supportive role of cultural identity in promoting First Nations, Inuit and Métis health in general,^{108,109} promoting children’s health,¹¹⁰ reducing youth suicide rates¹¹¹ and contributing to improved academic achievement.¹¹² Other research has found that participation in cultural activities reduces depression and lowers substance and alcohol abuse.¹¹³

Social support networks are important contributors to health and well-being in all populations.¹¹⁴ Ties within First Nations, Inuit and Métis communities are strong. Two-thirds of First Nations adults off-reserve (64.5 per cent) and Métis (66.1 per cent) adults reported a very strong or strong sense of community belonging.¹¹⁵ Two-thirds of Inuit in Canada rated their ties with family members in other households as very strong or strong.¹¹⁶ First Nations adults living on reserve in Ontario named “family values” (60.5 per cent) and “traditional ceremonial activities” (45.7 per cent) as the main strengths of their community.¹¹⁷

The recommendations in this report address the determinants of First Nations, Inuit and Métis health underlying inequities between the First Nations, Inuit and Métis and general Ontario populations, and build on the positive determinants of health and successes achieved by First Nations, Inuit and Métis peoples.



Risk and protective factors

Commercial tobacco use

Smoking rates among Ontario's First Nations, Inuit and Métis populations are at the same levels today that they were in the mainstream population several decades ago. As the statistics in Table 4 indicate, smoking rates among adults range from 35 per cent to 50 per cent, which is what they were in the general Canadian population 30 to 50 years earlier.¹¹⁸

On reserves in Ontario, half (50 per cent) of First Nations adults are smokers.¹¹⁹ Rates of smoking among Inuit adults in Canada are three times higher than in the general population.¹²⁰

There are positive indications that First Nations, Inuit and Métis peoples in Ontario are taking steps to reduce or eliminate commercial tobacco use. In First Nations on-reserve populations, fewer youth are smokers (30 per cent) than are adults (50 per cent). Nearly half (48 per cent) of young adult current or ex-smokers ages 18 to 29 years and 43 per cent of youth had attempted to quit smoking in the past year compared with one-fifth (19 per cent) of adults. Among youth, the main reason for attempting to quit was choosing a healthier lifestyle.¹²¹ The same survey showed that most (72 per cent) adults have a smoke-free home.

A recent report on commercial tobacco use among off-reserve First Nations, Inuit and Métis populations in Ontario found that, among adults who have ever been smokers, over half (53 per cent) have now quit. In 2011, 25 per cent of current smokers intended

to quit in the next 30 days and over half intended to quit in the next six months.

Rates of smoking among off-reserve First Nations, Inuit and Métis populations in Ontario remain higher than in the non-First Nations, Inuit and Métis population and have not changed since 2009.¹²²

Alcohol consumption

Alcohol consumption in excess of low-risk guidelines is not significantly different among off-reserve First Nations, Inuit and Métis populations compared to non-First Nations, Inuit and Métis Ontarians. As shown in Table 5, one in eight First Nations off-reserve and one in seven Métis adults ages 19 and over in Ontario exceed the guidelines. In all populations, men are more likely than women to drink more than the recommended amount.

Although comparable data were not available for First Nations living on reserve in Ontario, more than one-third (38 per cent) of adults did not report to the survey consuming any alcohol in the previous year. Alcohol consumption in this population is highest among young adults ages 18 to 29.¹²³

TABLE 4
Prevalence of smoking among Ontario respondents to the Canadian Community Health Survey, ≥18 years, by Aboriginal identity (off-reserve population), 2007–2011 Canadian Community Health Survey combined data, age-standardized to Ontario First Nations, Inuit and Métis population

First Nations off-reserve	Métis	Non-Aboriginal
44%	35%	22%

Source: Withrow D, Amartey A, Marrett LD. Cancer risk factors and screening in the off-reserve First Nations, Métis and non-Aboriginal populations of Ontario. *Chronic Diseases and Injuries in Canada*. 2014 Jul;34(2-3):103-12.

TABLE 5
Prevalence of consumption of >1 or 2 alcoholic drinks/day^b among Ontario respondents to the Canadian Community Health Survey, ≥18 years, by Aboriginal identity (off-reserve population), 2007–2011 Canadian Community Health Survey combined data, age-standardized to Ontario First Nations, Inuit and Métis population

First Nations off-reserve	Métis	Non-Aboriginal
12.5%	13.3%	9.2%

^b > 1 drink/day on average in women; > 2 drinks/day on average in men.
Source: Withrow D, Amartey A, Marrett LD. Cancer risk factors and screening in the off-reserve First Nations, Métis and non-Aboriginal populations of Ontario. *Chronic Diseases and Injuries in Canada*. 2014 Jul;34(2-3):103-12.

Binge drinking—defined as having five or more drinks on one occasion¹²⁴—was noted by Cancer Care Ontario as an emerging trend in Ontario’s off-reserve First Nations and Métis populations.¹²⁵ Among First Nations adults living on-reserve, nearly half (47.8 per cent) reported being binge drinkers once a month or more often.¹²⁶ Data showing that Métis men had significantly higher median drink consumption (4.4 drinks) than did non-First Nations, Inuit and Métis men (2.5 drinks) may indicate that this group is at higher risk.¹²⁷

Education on the harms of moderate alcohol consumption is limited for all populations in Ontario. Although alcohol addiction is recognized as a health risk, public knowledge of, and discourse around, the risks of moderate drinking tend to be focused on injuries (such as drunk driving) rather than on the risks for developing chronic disease.¹²⁸

Many First Nations living on reserves experience a lack of accessible resources for alcohol treatment due, in part, to the location of their communities. A needs assessment showed that transportation is required to travel back and forth from treatment, and to keep people within the community where they are supported by their social networks.¹²⁹

Physical activity

Health survey data in Table 6 show that off-reserve First Nations, Inuit and Métis populations tend to be more active than other Ontarians. However, from the perspective of chronic disease prevention, there remain high rates of inactivity in all age groups.

The survey also showed that among First Nations adults living on-reserve, only 35.2 per cent were physically active, and sedentary leisure activities, such as watching television or playing electronic games, were very prevalent.¹³⁰

TABLE 6
Percentage of Ontario adults who are physically active, by First Nations, Inuit and Métis identity (off-reserve population), 2007–2011 Canadian Community Health Survey combined data, age-standardized to Ontario First Nations, Inuit and Métis population

First Nations off-reserve	Métis	Non-Aboriginal
54.5%	52.3%	46.0%

Source: Withrow D, Amartey A, Marrett LD. Cancer risk factors and screening in the off-reserve First Nations, Métis and non-Aboriginal populations of Ontario. *Chronic Diseases and Injuries in Canada*. 2014 Jul;34(2-3):103-12.

Healthy eating

Fruit and vegetable intake has been used as an indicator of healthy eating.¹³¹ Health survey results shown in Table 7 suggest that only one-quarter to one-third of First Nations, Inuit and Métis eat a healthy, balanced diet and a high proportion do not consume recommended amounts of fruit and vegetables compared with other Ontarians. Women tend to consume more fruit and vegetables than do men.

Similar patterns are seen in First Nations on-reserve populations in Ontario. Over one-quarter (27.5 per cent) of adults report eating a nutritious and balanced diet and 23.9 per cent report eating fruit and vegetables several times a day.¹³²

Food security is an important issue for First Nations,

TABLE 7
Consumption of ≥5 servings of fruit and vegetables/day among Ontario respondents to the Canadian Community Health Survey, ≥18 years, by First Nations, Inuit and Métis identity (off-reserve population), 2007–2011 Canadian Community Health Survey combined data, age-standardized to Ontario First Nations, Inuit and Métis population

First Nations off-reserve	Métis	Non-Aboriginal
27.5%	29.8%	36.0%

Source: Withrow D, Amartey A, Marrett LD. Cancer risk factors and screening in the off-reserve First Nations, Métis and non-Aboriginal populations of Ontario. *Chronic Diseases and Injuries in Canada*. 2014 Jul;34(2-3):103-12.

Inuit and Métis populations. Among First Nations living on-reserve in Ontario, nearly half (47.6 per cent) of adults report that they are severely or moderately food insecure.¹³³ Nearly one-fifth (18.8 per cent) of First Nations adults living off-reserve and one-eighth (12.6 per cent) of Métis adults report that they are moderately or severely food insecure compared to 7.5 per cent of the general Ontario population.¹³⁴

Traditional foods play an important role in First Nations, Inuit and Métis households and in maintaining a healthy diet. Among First Nations adults living on-reserve in Ontario, 84 per cent of adults and 88.4 per cent of youth shared traditional food in their household often or sometimes.¹³⁵ Traditional hunting, trapping and harvesting not only provide nutritious food sources, but also have physical activity benefits and reinforce social bonds as food is shared within the community.¹³⁶

Risk conditions

Risk conditions, such as high blood pressure, obesity and metabolic syndrome, predispose people to developing chronic disease.^{137,138} Health survey statistics suggest that First Nations, Inuit and Métis populations in Ontario are at increased risk for developing chronic diseases due to higher prevalence of high blood pressure and obesity, as shown in Tables 8 and 9.

TABLE 8
Prevalence of risk conditions among Ontario respondents to the Canadian Community Health Survey, ≥18 years, by First Nations, Inuit and Métis identity (off-reserve population), age-standardized to Ontario First Nations, Inuit and Métis population

	First Nations off-reserve	Métis	Non-Aboriginal
High blood pressure	12.4%	12.1%	11.3%
Obesity	29.6%	26.6%	17.4%

Source: Canadian Community Health Survey 2007-10 combined data. Custom tabulation. (High blood pressure). Withrow D, Amartey A, Marrett LD. Cancer risk factors and screening in the off-reserve First Nations, Métis and non-Aboriginal populations of Ontario. *Chronic Diseases and Injuries in Canada*. 2014; 34(2-3):103-12. (Obesity).

TABLE 9
Prevalence of risk conditions among Ontario respondents to the Regional Health Survey, ≥18 years, First Nations on-reserve population

	First Nations on-reserve
High blood pressure	27.2%
Obesity	47.8%

Source: First Nations Regional Health Survey (RHS) Phase 2 (2008/10) Ontario Region Final Report. Chiefs of Ontario; 2012.



How are chronic disease prevention services delivered?

In contrast to mainstream populations, health services for First Nations, Inuit and Métis can be characterized as fragmented and complex. While data quantifying the availability of chronic disease prevention and health promotion services available to First Nations, Inuit and Métis peoples in Ontario are lacking, information from focus groups, one-on-one interviews and health surveys indicate that access to these services is inconsistent and, in some areas, inadequate.

Access to health services

Lack of access to health services was raised as an issue by several focus groups and interviewees. Health survey data show that First Nations, Inuit and Métis have poorer access to primary care services than do other Ontarians. For example, only 81.7 per cent of First Nations off-reserve and 88.9 per cent of Métis adults (age 12+) have a regular doctor, compared to 91.1 per cent of non-First Nations, Inuit and Métis Ontarians.¹³⁹ First Nations living on-reserve are less likely to have a regular doctor; only 71.4 per cent said their primary healthcare provider stayed the same in the past year. The reasons for lack of access varied. Among First Nations on-reserve, one in five (20.6 per cent) reported that there is no doctor or nurse available in their area and one-third (33.8 per cent) said the waiting list was too long. One in six (16.5 per cent) could not afford transportation costs to access healthcare and the same proportion felt the services were not culturally appropriate (16.2 per cent).¹⁴⁰

Additional barriers are faced by First Nations, Inuit and Métis peoples living in rural and remote locations, including lack of transportation, languages barriers, long wait times, inadequate human resources, challenges with winter travel conditions, and the high cost of travel from rural and remote communities. Rural communities and First Nations reserves also face critical shortages of medical personnel. The number of physicians serving this population was cited as being under half of that serving cities. Lack of respectful or compassionate treatment, racism and discrimination were identified as additional barriers.¹⁴¹

Jurisdictional boundaries

First Nations, Inuit and Métis peoples in Ontario receive health promotion services and health services in different ways according to their legal status and place of residence, as Table 10 illustrates.

Although financial agreements are in place between the federal and provincial governments for provision of health services to registered First Nations and Inuit, confusion and conflict sometimes arise when governments disagree about who is responsible for certain services.

TABLE 10
Access to chronic disease prevention health services by ethnicity and legal status in Ontario

	Registered First Nations on remote reserves	Registered First Nations non-remote reserves	Registered First Nations off reserve	Non-registered First Nations	Inuit	Métis
Primary care ¹⁴²	FNIHB	MOHLTC	MOHLTC	MOHLTC	MOHLTC	MOHLTC
Specialist care ¹⁴³	MOHLTC	MOHLTC	MOHLTC	MOHLTC	MOHLTC	MOHLTC
Public health services ¹⁴⁴	Not usually provided	Sometimes provided	Same as general population	Same as general population	Same as general population	Same as general population
Prescription drugs ^{145,146}	NIHB	NIHB	NIHB	ODB covers seniors, social assistance only	NIHB	ODB covers seniors, social assistance only

Acronyms: NIHB =Non-Insured Health Benefits (federal program); FNIHB=First Nations and Inuit Health Branch; ODB=Ontario Drug Benefit Program; MOHLTC = Ministry of Health and Long-Term Care (Ontario)

JORDAN'S PRINCIPLE

Jordan's Principle is a child-first principle named in memory of Jordan River Anderson. Jordan was a First Nations child from Norway House Cree Nation in Manitoba. Born with complex medical needs, Jordan spent more than two years unnecessarily in hospital while the Province of Manitoba and the federal government argued over who should pay for his at-home care. Jordan died in hospital at the age of five years old, never having spent a day in his family home.

Payment disputes within and between federal and provincial governments over services for First Nations children are not uncommon. First Nations children are frequently left waiting for services they desperately need, or are denied services that are available to other children. This includes services related to education, health, childcare, recreation, culture and language. Jordan's Principle calls on the government of first contact to pay for required services and seek reimbursement later so the child does not get tragically caught in the middle of government red tape.

Jordan's Principle was unanimously passed in the House of Commons in 2007, but sadly the Canadian Paediatric Society reports that neither the federal government nor the provinces/territories have fully implemented it.

Source: First Nations Child & Family Caring Society of Canada.
Accessed at: <http://www.fnccaringociety.com/jordans-principle>

Health services delivery mandates

Various health service organizations are mandated to deliver primary care and chronic disease prevention services to First Nations, Inuit and Métis populations. While there appear to be many programs and services available to First Nations, Inuit and Métis populations, health system interviewees told us that the extent of coverage is often inadequate. These inconsistencies may stem from a lack of clear mandates and sufficient capacity to deliver services, as illustrated by the following examples:

- Organizations with specific geographic or population mandates (such as the Aboriginal Health Access Centres, Indigenous Friendship Centres, Tungasuvvingat Inuit, Akausivik Inuit Family Health Team and the Ontario Native Women's Association) do not have the capacity to provide services to all First Nations, Inuit and Métis populations within their scope.
- By legislation, the 36 public health units in Ontario are responsible for delivering health promotion services; however, some do not provide services on reserves or participate in regional First Nations, Inuit and Métis health planning tables.
- Regional Cancer Programs do not have chronic disease prevention as a specific part of their mandate; however, many participate in health promotion activities as part of their emphasis on cancer screening.

- Federally, Health Canada delivers health promotion programs and services on reserves; however, responsibility for many of the social determinants of Aboriginal health (such as food security, environmental monitoring, funding for schools and housing) rests with Indigenous and Northern Affairs Canada.

Who is at the planning table?

There is no clear lead organization in Ontario with responsibility for First Nations, Inuit and Métis chronic disease prevention.

Interviewees indicated that there is great disparity among regions regarding how First Nations, Inuit and Métis groups are included in health tables that address First Nations, Inuit and Métis chronic disease prevention.

Cross-sectoral health planning takes place at several levels within the health system, as shown in Table 11. These health tables include representatives from government, First Nations, Inuit and Métis and, in some cases, non-governmental organizations.

TABLE 11

Collaborative health planning structures for First Nations, Inuit and Métis chronic disease prevention in Ontario

Level	Health planning structure	Organizations and/or communities involved	First Nations, Inuit and Métis population represented
Provincial	Trilateral First Nations Health Senior Officials Committee	Provincial and federal governments, Chiefs of Ontario Committee on Health	First Nations
	Keewatin Northern Committee	Provincial and federal governments, Nishnawbe Aski Nation, Grand Council Treaty #3	First Nations
	Ontario First Nations Integrated Health Promotion Strategy	Provincial and federal governments, Chiefs of Ontario, 4 First Nations Political Territorial Organizations and Independent First Nations	First Nations
	Joint Ontario Aboriginal Cancer Committee (JOACC)	Cancer Care Ontario, 4 First Nations Political Territorial Organizations, Independent First Nations, Métis Nation of Ontario, Tungasuvvingat Inuit, Ontario Federation of Indigenous Friendship Centres, Ontario Native Women's Association, Aboriginal Health Access Centres, Canadian Cancer Society	First Nations, Inuit, Métis and Urban Aboriginal Groups
	Aboriginal Tobacco Partnership Table	Cancer Care Ontario, federal and provincial governments, Tobacco Control Area Networks, Ontario Lung Association, Canadian Diabetes Association, Centre for Addictions and Mental Health, Leave the Pack Behind, Program Training and Consultation Centre, Canadian Cancer Society, Asthma Society of Canada, Heart & Stroke Foundation	First Nations, Inuit and Métis receive regular reports via the Joint Ontario Aboriginal Cancer Committee, Cancer Care Ontario
Regional	Local Health Integration Network Aboriginal Health Committees	Aboriginal Local Health Integration Network Lead, Regional Aboriginal Cancer Lead/ other representative of the Regional Cancer Program, First Nations, Inuit and Métis communities, public health units, other health service provider organizations (membership varies by region)	First Nations, Inuit and Métis
	Sioux Lookout First Nations Health Authority	31 First Nation communities in the Sioux Lookout area, Tribal Councils (Independent First Nations Alliance, Keewatinook Okimakanak, Matawa First Nations Management, Shibogama First Nations Council, Windigo First Nations Council), physicians, Ontario Ministry of Health and Long-Term Care, First Nations and Inuit Health Branch and Health Canada	First Nations
	Regional Cancer Programs	Some Regional Cancer Programs have cross-sectoral First Nations, Inuit and Métis committees	First Nations, Inuit and Métis
Local	Core First Nations, Inuit and Métis Health Networks (boards, groups and advisory tables)	Health directors, Community Health Representatives, nurse practitioners, physicians, board and community members	First Nations, Inuit and Métis, urban Aboriginal groups

Methodological approach

Direction for this report was provided by Cancer Care Ontario, with advisory input from the Joint Ontario Aboriginal Cancer Committee. Two cultural advisors provided feedback throughout the project. A project logic model, devised to provide a roadmap for *Path to Prevention*, is reproduced in the appendix.

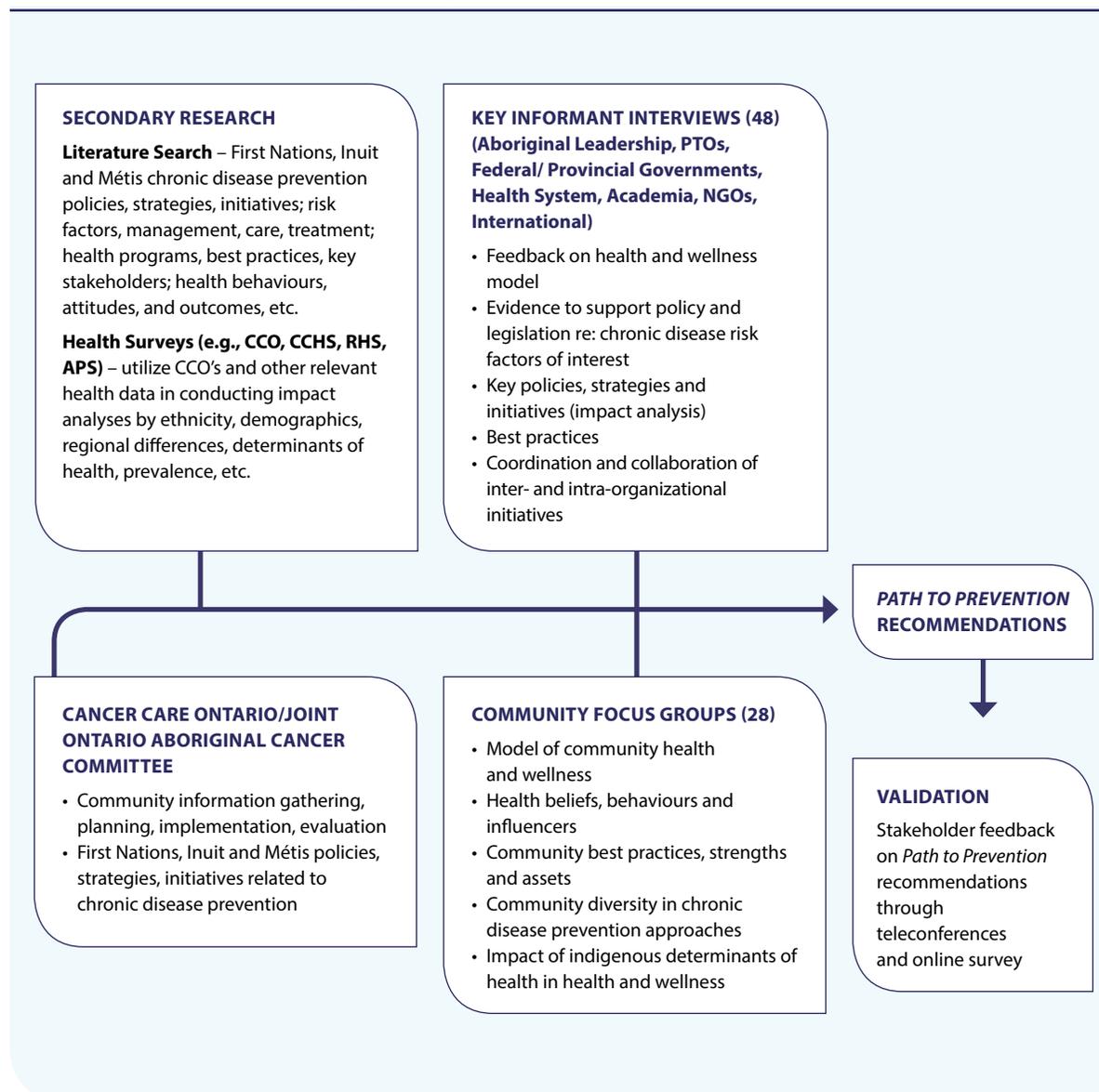
The development of the *Path to Prevention* recommendations was based on three major streams of information:

1. focus groups held in communities;
2. key informant interviews; and
3. secondary research of peer-reviewed literature and policy publications.

The draft recommendations were validated through a feedback process involving all contributors to the information-gathering phase of the work. Further details for each phase of the information-gathering can be found in the appendix and outlined in Figure 4.

The secondary research phase retrieved data from health surveys, peer-reviewed publications and non-peer-reviewed reports. First Nations, Inuit and Métis-specific information was sought on health and health behaviour statistics; social determinants of Aboriginal health; approaches to chronic disease prevention, health promotion policy and best practice policies; and interventions from Canada and internationally. In addition, a web search was conducted to identify organizations in Ontario producing policies, strategies and programs related to First Nations, Inuit and Métis chronic disease prevention.

FIGURE 4
Path to Prevention information gathering plan

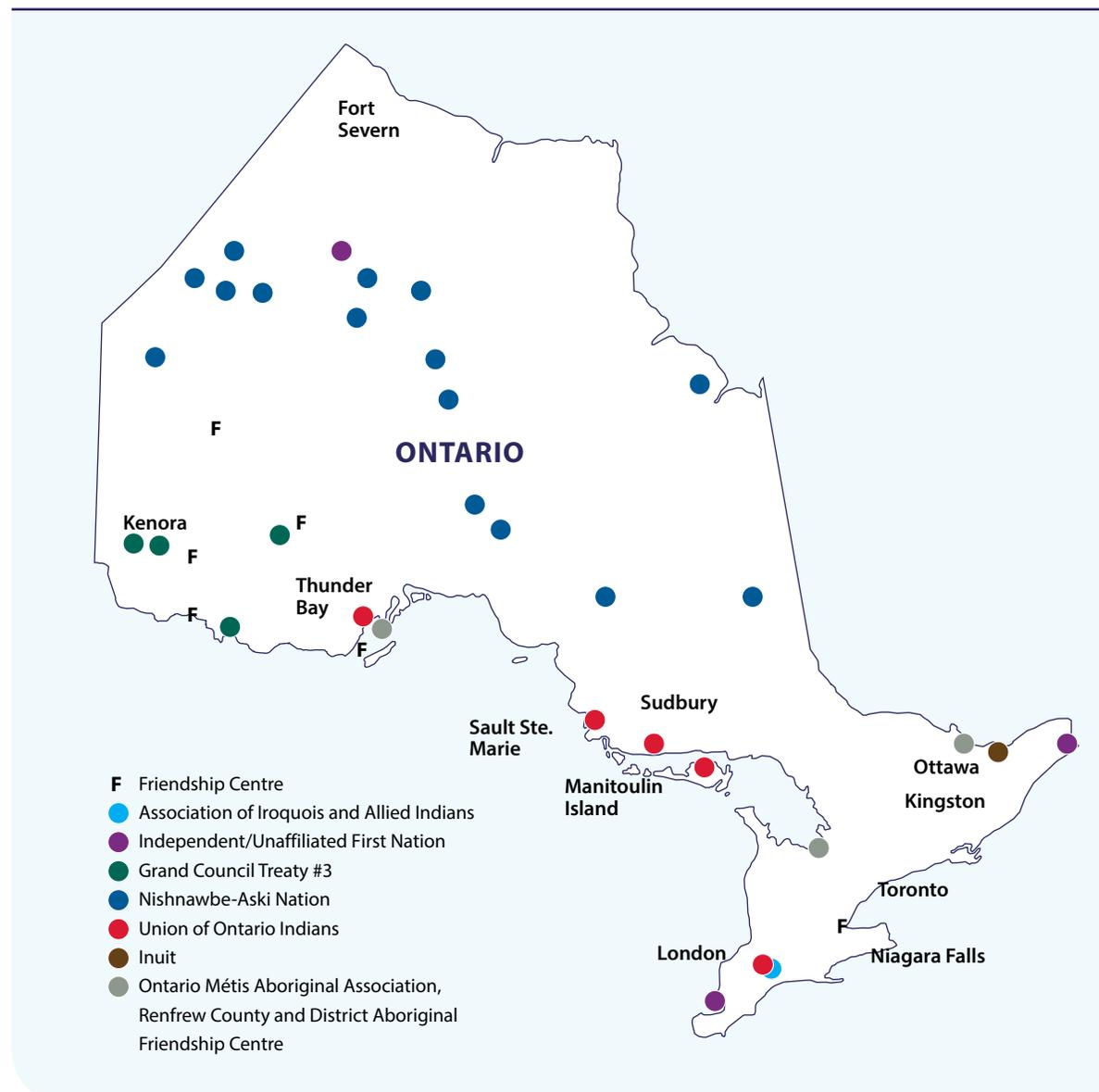


A total of 28 focus groups were held across Ontario, with 48 First Nations, Inuit and Métis communities participating. The map (Figure 5) shows the communities involved and their affiliations with Political Territorial Organizations and First Nations, Inuit and Métis organizations. Regional distribution of the communities was nine in the northeast, 31 in the northwest, five in the southwest and three in the southeast. Focus group discussions were recorded and transcribed, and the notes validated with the communities.

Two waves of interviews were conducted. The first wave of 28 interviews involved experts who contributed to the *Taking Action* report; First Nations, Inuit and Métis leadership organizations; and representatives of the health system at the regional level. The Canadian Public Health Association's *Tool for Strengthening Chronic Disease Prevention and Management Through Dialogue, Planning and Assessment* was adapted to create the interview guide. A key output of this wave of interviews was an understanding of participating organizations' roles, and how planning and implementation takes place for First Nations, Inuit and Métis chronic disease prevention at the regional and provincial levels.

The second wave of interviews, conducted towards the end of the information gathering process, included 20 interviews with 32 representatives from the non-governmental sector, provincial government, researchers and ministries of health in international jurisdictions. This wave of interviews sought insights into existing programming; successful approaches and strengths; mechanisms for engaging First Nations, Inuit and Métis communities; and the potential roles organizations could play in implementing the recommendations.

FIGURE 5
Path to Prevention focus group communities



Findings

This section presents perspectives from First Nations, Inuit and Métis communities on the health system related to chronic disease prevention. The information gathered informed the development of foundational principles and priority areas for the recommendations.



How are health and wellness defined?

First Nations, Inuit and Métis peoples' perceptions of health and wellness are central to the *Path to Prevention* recommendations. The Community-Centred Model of First Nations, Inuit and Métis Health and Wellness (presented in section 1) was validated by the participants and served as a framework for the recommendations.

Community members told us that health and wellness depend on achieving a balance between physical, mental, spiritual and emotional dimensions. These elements of health and well-being are not discrete, and are intertwined, flowing into one another.

Focus group findings

What makes communities healthy and well?

Over half of community focus group participants identified proximal determinants of health as things that make their community healthy and well. These included health behaviours such as eating healthily, daily physical activity and daily support from family, friends and others, including sharing and socializing, having healthy relationships, and giving and getting support in times of need.

Over one-third of participants mentioned that distal determinants of health influenced community health and wellness. Almost two-thirds identified language,

culture and heritage as influencing their community's health and wellness. Traditional ceremonies, prayer and meditation were mentioned most often.

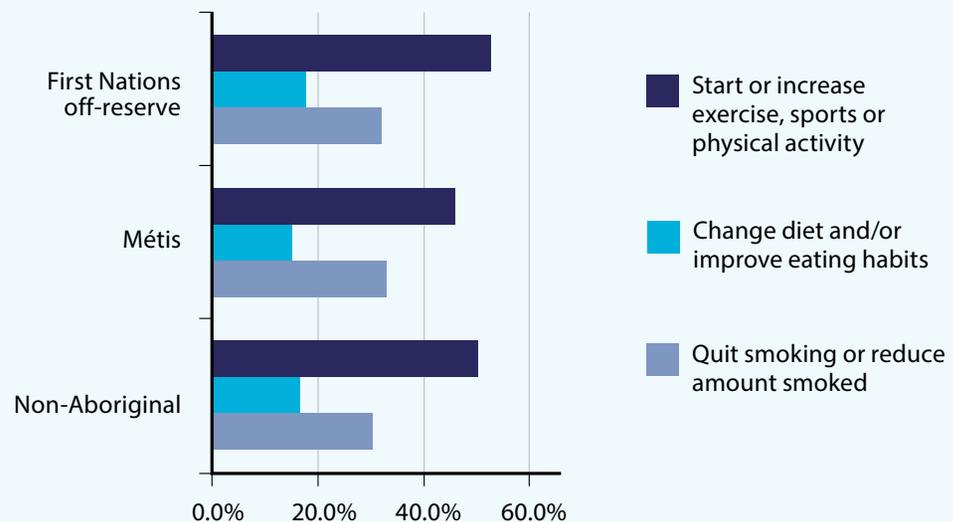
About one-third of participants identified that making the choice to be active or eat healthily, being positive and asking for help when they need it determined whether they were healthy and well. Research supports the connection between self-determination at the community level and health outcomes.¹⁴⁷ Health surveys also demonstrate that individuals are ready to make changes. Figure 6

shows the percentage of First Nations and Métis adults who plan to improve their health behaviours.

Over half of focus group participants talked about proximal determinants of health as facilitators for change, with almost one-third naming social supports and having a supportive physical environment as key to enabling them to make healthy choices.

FIGURE 6

Percentages of First Nations, Métis and non-First Nations, Inuit and Métis Ontario adults (age 18+) who intend to improve health behaviours



Source: Cancer Care Ontario. Canadian Community Health Survey 2007–08, age-standardized to Ontario First Nations, Inuit and Métis population. The following data points are unreliable due to small sample sizes: First Nations off-reserve intention to improve eating habits; all intentions to quit smoking

The responses to the question “What makes communities healthy and well?” were also analyzed according to risk factors. As shown in Figure 7, about one-quarter of responses pertained to the four risk factors that are the subject of this report. The remaining three-quarters of responses related to other factors, such as mental health, stress reduction, social relationships and spiritual practices.

Within the four risk factors, it was surprising that commercial tobacco use and alcohol consumption were each mentioned by focus groups less than two per cent of the time. This finding suggests both a reluctance of community members to discuss

negative risk factors in an open setting and a preference to focus on the positive aspects of healthy behaviours.

When focus groups were asked “What things are going on in the community today that help people to be healthy?” communities mentioned examples such as walking programs, community gardens and kitchens, Elder and youth programs as helping to keep themselves, their families and communities healthy and well.

Commercial tobacco use

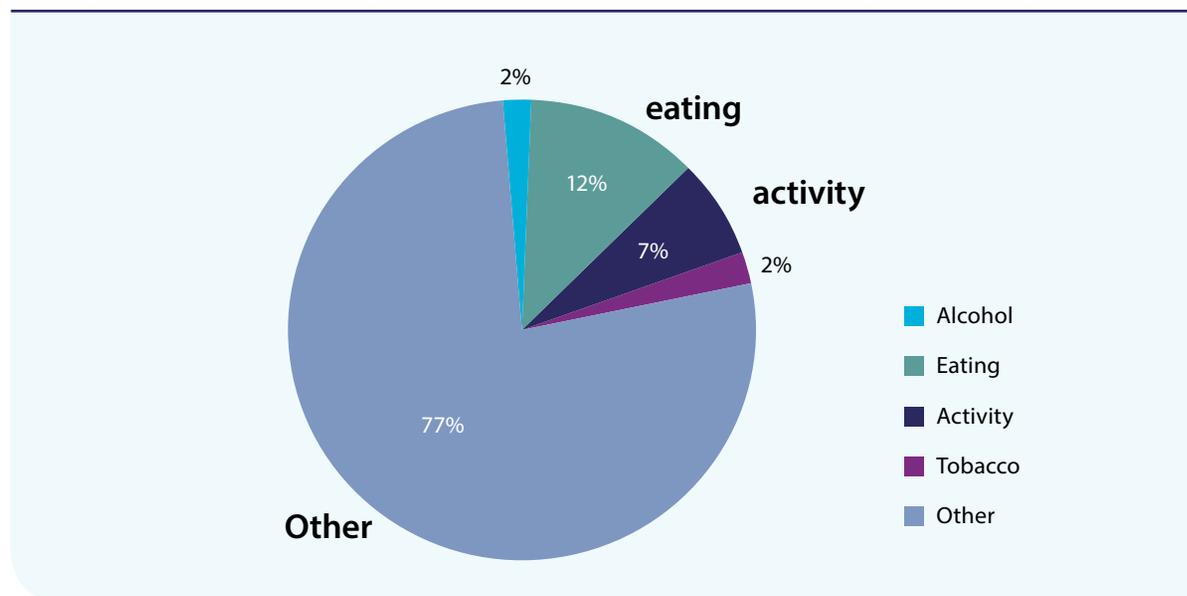
Several points were raised by focus groups, which provided some direction for the recommendations:

- Communities associate health and wellness with being smoke-free;
- The cost of smoking provides a deterrent to commercial tobacco use;
- Commercial tobacco provides a source of income for some communities;
- Smoking/addictions make it challenging to make healthy choices; and
- More education is needed about alcohol and commercial tobacco use cessation.

Education is a priority in First Nations, Inuit and Métis tobacco policies in Ontario and British Columbia.¹⁴⁸ Cancer Care Ontario’s Aboriginal Tobacco Program, for example, includes three Tobacco-Wise Leads who work directly with communities to provide education about the risks of commercial tobacco use and to encourage healthy lifestyles.¹⁴⁹

The importance of focusing on children and youth was reinforced by several studies. First Nations youth living on-reserve and First Nations, Inuit and Métis youth living off-reserve have significantly higher rates of tobacco use compared to non-First Nations, Inuit and Métis youth.^{150,151} A Canadian research study suggested that prevention efforts should address the unique strengths and needs of First Nations, Inuit and Métis youth.¹⁵² A long-term, prospective study stressed the importance of the family environment:

FIGURE 7
Focus group responses to the question “What makes communities healthy and well?” by risk factor



adolescents are more likely to smoke if they have parents who smoke and if they are part of a poorly functioning family.¹⁵³ Preventing youth from starting smoking remains the most effective strategy in addressing smoking cessation, and emerging approaches, such as the use of social media, show promise.¹⁵⁴

Interviewees cited the expansion of smoking cessation services in First Nations, Inuit and Métis communities as a high priority. They also raised the issue of manufacturing and selling cigarettes in First Nations communities, describing it as contentious. Some First Nations, Inuit and Métis interviewees reinforced that simply using policy levers, such as increasing the tobacco or alcohol tax, will not deter First Nations, Inuit and Métis people. It is necessary to acknowledge why there are problems in the first place and to address addiction as a mental health issue. Others cautioned that it is difficult for communities to make hard decisions to regulate tobacco where the manufacture and/or sale of commercial tobacco is an important economic driver.

What is happening in communities?

Examples of ways that communities have taken action to reduce commercial tobacco use include restricting smoking in band or Friendship Centre buildings and at community events, implementing voluntary smoking bans inside homes and offering smoking cessation programs. First Nations, Inuit and Métis community members praised Cancer Care Ontario's Aboriginal Tobacco Program and the Tobacco-Wise Leads who work with communities to reduce commercial tobacco use.



Alcohol consumption

Broad directions from the following focus group inputs helped to shape the recommendations:

- Communities associate health and wellness with being alcohol-free and recognize that awareness and education are needed; and
- Drug abuse, alcohol addiction and smoking are connected to ill health, treatment and education.

An emerging theme in the findings was that addictions to alcohol, tobacco, drugs and other substances have the same root causes and need an integrated approach. Several interviewees felt that drug abuse has taken focus away from alcohol in terms of attention by communities, policy development and resources. Reports by the Chiefs of Ontario from recent years have shown a shift in focus towards drug abuse.^{155,156}

Another theme that emerged was the importance of culturally based approaches to reducing alcohol consumption. Interviewees reported that, in some areas, alcohol is being characterized by First Nations, Inuit and Métis as a product of colonization. As part of a movement towards cultural reclamation, traditional events and participants are now drug- and alcohol-free. A review of culturally based messaging about alcohol found this approach to be effective.¹⁵⁷ Studies from Canada and the United States show that interventions that include cultural components are effective with younger First Nations, Inuit and Métis populations, who are at highest risk.^{158,159}

What is happening in communities?

Examples of actions to promote abstinence from alcohol shared by focus group participants included establishing alcohol-free zones in buildings and community events, offering addictions treatment programs, and implementing alcohol and drug bans in some communities.



Physical activity

Community focus groups identified a variety of physical activity programming offered in their communities, including walking programs/challenges; organized sports and exercise programs (e.g., fitness classes, baseball and hockey); and traditional activities, such as fishing, hunting and trapping.

Walking was the most common form of exercise cited by focus groups. This was also a finding from the Regional Health Survey of First Nations on-reserve in Ontario.¹⁶⁰ Safe, accessible sidewalks, trails and bike paths were not always in place in communities to encourage active transportation. Perceived safety is a strongly significant determinant of engaging in physical activity on-reserve, particularly for walking¹⁶¹ and people who have access to safe places to walk and play are more likely to be active.¹⁶² Feral dogs were named most frequently as a barrier by focus groups, especially because most physical activities take place outdoors.

Physical activity infrastructure (e.g., fitness facilities, sports arenas, playing fields, walking trails and organized family events) is available in some, but not all, communities according to focus groups. Dedicated personnel, such as physical activity instructors and coordinators, are needed to educate community members and ensure that facilities are accessible. This theme was echoed by interviewees from research and non-governmental organizations. In addition, the costs of participating in physical activities are often unaffordable for families. This barrier was also identified by a Canadian study that found that economic resources and access to transportation and equipment affect the participation of First Nations, Inuit and Métis youth in physical activities.¹⁶³

Research on the unique needs of First Nations, Inuit and Métis populations with respect to physical activity, especially related to culture, was cited by interviewees as a priority and was reinforced in two review papers on the topic.^{164,165} Another study stated that “cultural assets—e.g., collectivism, strong civic and religious institutions touching most community members, and the centrality of music and dance traditions to culture expression—have rarely been tapped.”¹⁶⁶

What is happening in communities?

Examples of physical activity interventions shared by communities included walking groups, walking challenges, hiring leaders for physical activity programs who motivate community members to participate, and subsidies provided to families for gym memberships or sports equipment. Feral dog policies have been enacted in some communities.



Healthy eating

Communities shared concerns about access to healthy foods, knowledge and skills in making healthy choices and access to healthy food systems:

- Harvesting, growing and sharing traditional foods keeps culture alive and the community healthy and well; and
- The cost of food, particularly in the north, affects how easy (or difficult) it is to make healthy food choices.

Food sovereignty provides a policy framework with food security as one of its goals.

Food security is defined as the ability to access safe and nutritious food and water to sustain an active and healthy life each and every day. People from food insecure households are more likely than those in food secure households to have poor general health independent of age, gender and education.¹⁶⁸

“Food sovereignty is the right of peoples to healthy and culturally appropriate food produced through ecologically sound and sustainable methods and their right to define their own food and agriculture systems.”¹⁶⁷

This is a crucial issue for First Nations, Inuit and Métis in Ontario. Health surveys show that a large proportion of First Nations, Inuit and Métis people in Ontario are food insecure. Nearly half (48 per cent) of First Nations living on-reserve report being moderately or severely food insecure.¹⁶⁹ One in five (19 per cent) First Nations living off-reserve and one in seven (13 per cent) Métis people report being moderately or severely food insecure compared to eight per cent of non-First Nations, Inuit and Métis people in Ontario.¹⁷⁰

Government studies have shown that, in northern communities especially, the cost of fruit and vegetables can be prohibitive for most families.¹⁷¹ Interviewees echoed that the issue of food security is a challenge for both urban and northern/remote First Nations, Inuit and Métis communities and that lack of access to healthy food underpins other social determinants. Traditional foods and food practices are important ways that communities have addressed food shortages in the past. A study in a First Nations community in Ontario found that food sharing is still used as a way to cope with food security to this day.¹⁷²

Harvesting, preparing and consuming traditional foods was cited by many focus groups as an important part of First Nations, Inuit and Métis cultures. Communities said that more programs are needed to encourage proper nutrition and lifestyle habits. Knowledge transfer of food and nutrition skills through intergenerational teaching promotes healthy choices and is part of First Nations, Inuit and Métis culture.

“I’m healthy because most of my food is from wild sources. Traditional food was very simple: boiled or smoked or we made pemmican. No sweets. Then we started frying food and people got sick.”

Focus group participant

Communities expressed concern about the presence of contaminants in wild foods, particularly fish.

Environmental contamination of traditional food affects its availability, supply and safety.¹⁷³ Researchers from Ontario report that fears of contamination restrict traditional hunting and fishing practices,¹⁷⁴ which leads to increased consumption of processed foods that are known to contribute to high rates of diabetes.¹⁷⁵

Past experiences of mercury contamination in Grassy Narrows First Nation has been cited as an example of environmental injustice and has led to the distrust of government^{176,177} Research has shown that fragmented information about contaminant risk, historical and oral knowledge shared by community knowledge keepers and personal experience have strong influences on perceptions of contamination, despite research that suggests otherwise.¹⁷⁸ The Ontario Regional Report of the First Nations Food, Nutrition and Environment Study indicated that the levels of contaminants in traditional foods are within

Health Canada guidelines, yet there is a perceived risk of exposure to contaminants from eating fish. It is recommended that communication of the risk to women of childbearing age, children and teens consuming certain predatory fish is warranted in some regions.¹⁷⁹

What is happening in communities?

Many communities are taking action to encourage healthy eating, including establishing community kitchens, community gardens, classes on cooking and meal planning, food banks, feeding programs and harvesting traditional foods.

Health system findings

The themes presented are based on findings from interviews with individuals working in multiple sectors of the healthcare system: First Nations, Inuit

and Métis communities; First Nations, Inuit and Métis political and service organizations; provincial and federal governments; government agencies; primary care; non-governmental organizations; researchers; and professional associations.

Equity and the social determinants of First Nations, Inuit and Métis health

First Nations, Inuit and Métis interviewees identified poverty as the number one issue, noting that to a certain degree they have tried to address poverty, employment, education and health, which are important to communities. Virtually all participants felt it necessary to place great emphasis on addressing the root causes of health behaviours



“Food is much more than sustenance—sharing food and sitting down to eat together is about the [Inuit] culture, it’s a spiritual practice and eating traditional food is integral to existence. But, pollutants in foods concentrate in the higher-level animals that Inuit eat, causing negative impacts such as cancer and other issues and this discourages people from hunting.”

Interviewee

within *Path to Prevention*. Interviewees believed that the social determinants of health are not being recognized adequately in mainstream policy, programs and services, and that resources need to be set aside to provide people with practical support. This perspective is shared by many organizations, researchers and policy-makers from Canada and international jurisdictions.^{180,181,182,183,184}

Coordination and collaboration

First Nations, Inuit and Métis chronic disease prevention initiatives are being developed and implemented by a wide range of sectors and organizations. There are nearly 100 strategies,

programs, services and resources specific to First Nations, Inuit and Métis chronic disease prevention developed by:

- three levels of First Nations, Inuit and Métis leadership organizations;
- five Ontario government ministries and three government-funded agencies;
- two federal ministries and one federally funded organization;
- 14 non-governmental organizations;
- research institutions; and
- corporations.

Interviewees uniformly reported that there is a lack of leadership, as well as system-level planning and delivery of chronic disease prevention programming and resources. There are a myriad of organizations doing good work, but it is not coordinated, leading to gaps in services and inefficient uses of funds.

Emerging themes from the interviews include:

- No one organization is mandated with responsibility for developing and/or implementing a First Nations, Inuit and Métis chronic disease prevention strategy;
- Regionally, there is great disparity regarding how First Nations, Inuit and Métis are included in collaborative health tables and First Nations, Inuit and Métis communities often lack the capacity to participate in planning processes;
- Community empowerment is key to success;

- Long-term, committed funding is seen as vital to delivering sustainable outcomes; and
- Planning is hampered by a lack of specific, reliable data on health status and outcomes.

The emergence of collaborative structures, such as the Trilateral First Nations Health Senior Officials Committee (including the Northern Committee), where First Nations play a leading role, is perceived as a very positive development. Also, the strengthening of First Nations, Inuit and Métis participation in Local Health Integration Network Aboriginal Health Committees and increased attention to First Nations, Inuit and Métis issues through the expansion of Regional Aboriginal Cancer Leads and Aboriginal Navigators as part of the Regional Cancer Programs are viewed as significant advances.

Need for evidence

Interviewees from provincial, national and international jurisdictions strongly emphasized the need for an effective system of data collection and analysis as a prerequisite for a chronic disease prevention strategy. Evidence from health data collection, health surveys and research studies is essential for informing policy, strategy and initiatives, and for evaluating outcomes.

There are few sources of statistical data on First Nations, Inuit and Métis health, unlike those available for mainstream populations. The data sources that do exist are often less reliable and/or not comparable

across populations. There are also a lack of research studies related to chronic disease prevention in First Nations, Inuit and Métis populations.

Interviewees provided additional insights about the collection and use of evidence for health planning:

- Evidence generally is not collected and analyzed at the regional or local levels, making it difficult for communities to plan;
- Data are often not shared due to concerns about ownership and privacy;
- First Nations, Inuit and Métis “ways of knowing” and evidence gathering¹⁸⁵ are often not incorporated, even though they are relevant to communities’ needs;¹⁸⁶ and
- Funders need to be open to qualitative feedback that complements statistics-based tools.

Data limitations

The health survey statistics presented in this report are not comparable across all populations. Comparisons can be made between First Nations off-reserve, Métis and non-First Nations, Inuit and Métis populations based on data from the Canadian Community Health Survey. These statistics were age-standardized to the Ontario First Nations, Inuit and Métis population. Data for the First Nations on-reserve population were taken from the Regional Health Survey Ontario Report and are not directly comparable to those from the Canadian Community Health Survey.

Since the number of Inuit living in Ontario is small (approximately 2,000), reliable health survey statistics are not available for this population.

Also, the provincial-level data presented in this report do not capture the diversity within First Nations, Inuit and Métis populations and do not reflect distinct regional and local situations.

Not all focus group data could be quantified for analysis. Since relatively few mentions were made by focus groups concerning commercial tobacco use or alcohol consumption, only qualitative outputs could be reported for these risk factors (see the appendix for focus group methodology).



Recommendations

Towards healthier First Nations, Inuit and Métis communities in Ontario

The path towards healthier First Nations, Inuit and Métis communities involves not only taking practical actions directed at encouraging healthy behaviours, but also creating environments that encourage individuals, families and communities to make healthy choices. Research shows that behavioural health promotion strategies in and of themselves do not work. Health behaviour is influenced by social, economic and cultural settings.¹⁸⁷



The goals of the *Path to Prevention* recommendations, collectively, are to reduce inequities between First Nations, Inuit and Métis and the general population of Ontario with respect to chronic disease prevention and to advance risk factor reduction across the life course for First Nations, Inuit and Métis individuals, families and communities. To level the playing field, committed policy action is needed across the health spectrum. These policies must be aimed at addressing the social determinants of Aboriginal health which play a significant role in the burden of cancer and chronic diseases faced by First Nations, Inuit and Métis people.¹⁸⁸

Path to Prevention is a first step towards these goals and builds on the considerable strengths of First Nations, Inuit and Métis peoples in Ontario. The recommendations in this chapter focus on the highest priority needs, as defined by First Nations, Inuit and Métis peoples, and are based on what is practical and feasible. They are informed by the best available evidence from health system organizations, government policies and research from within and outside Ontario. The *Taking Action* report was a starting point for the present work and its strong evidence base underlies the *Path to Prevention* recommendations.

Approach to developing the recommendations

The recommendations were informed by communities, health system representatives, health data and literature reviews, and were guided by the Joint Ontario Aboriginal Cancer Committee and Cancer Care Ontario.

The *Path to Prevention* recommendations:

- advise the Government of Ontario, in collaboration with First Nations, Inuit and Métis leadership, the federal government, Cancer Care Ontario and other stakeholders;
- complement (and do not duplicate) the *Taking Action* recommendations for the general Ontario population;
- synthesize strong primary and secondary sources of evidence;
- build on what is already working well and in place; and
- integrate across and/or address more than one risk factor and the social determinants of Aboriginal health.

All recommendations depend on full participation in priority-setting, planning and implementation by First Nations, Inuit and Métis peoples. Although not overtly stated in each recommendation, this fundamental principle must be respected.



FIGURE 8
Path to Prevention recommendations framework

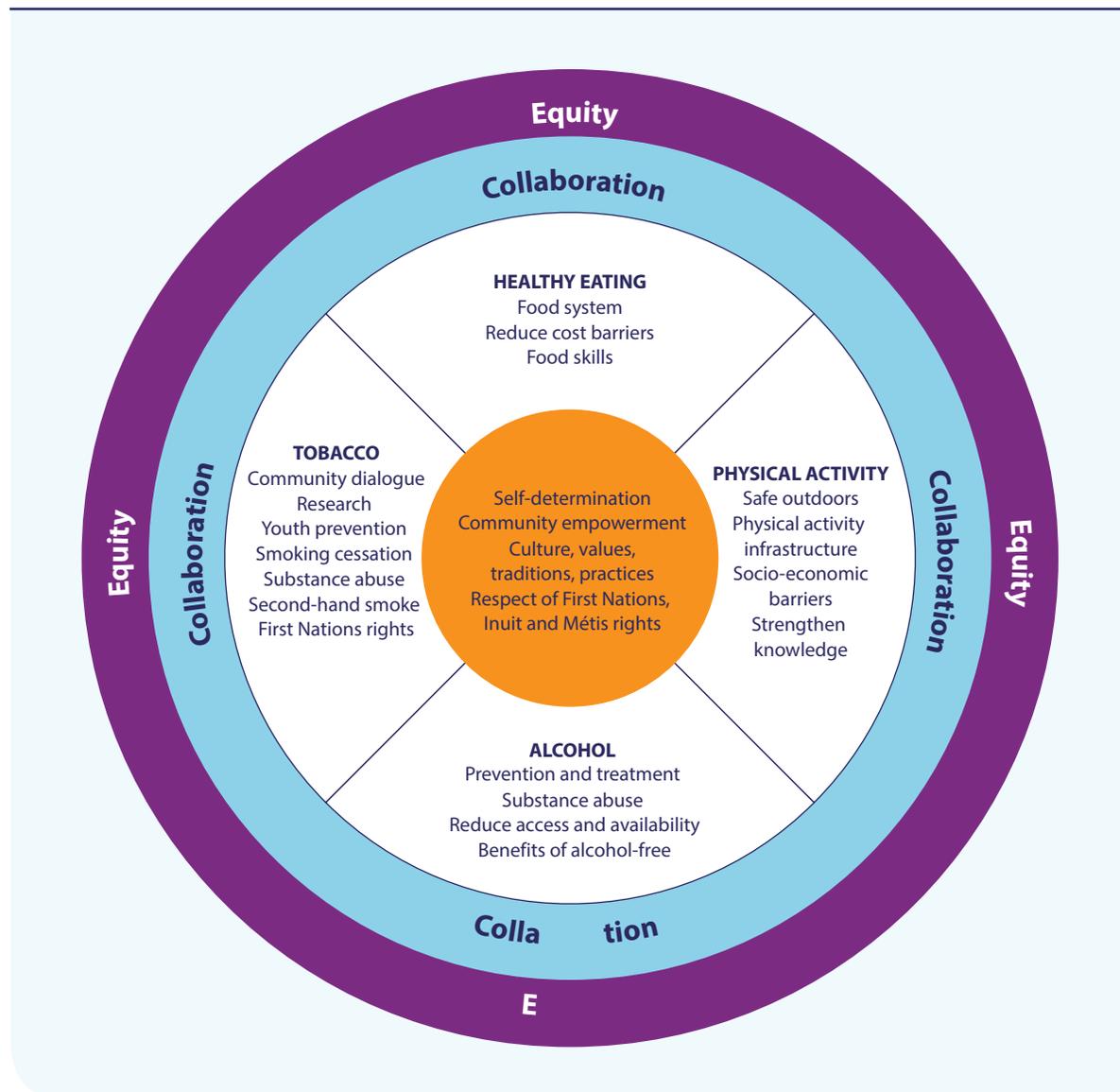


Figure 8 provides a graphic overview of the recommendations and is the compass that sets the direction for *Path to Prevention*. These 22 policy recommendations identify the type of strategies and possible actions that will help close the gap in health disparities experienced by First Nations, Inuit and Métis peoples.



1 Tobacco recommendations

Policy goal

To reduce or eliminate smoking and commercial tobacco use.

The Ontario context

The context in which the tobacco recommendations were developed considers the realities of First Nations, Inuit and Métis communities and the policy environment in which the recommendations would be implemented.

Commercial and traditional tobacco

In this report, a clear distinction is made between traditional tobacco, which is used in ceremonies, and commercial tobacco, which is used for recreational purposes. Tobacco is recognized by many First Nations and Métis cultures as one of the four sacred plants (the others are sweetgrass, cedar and sage).

Health impacts of commercial tobacco

Actively smoking tobacco causes cancer of the oral cavity, pharynx, naso-pharynx, nasal cavity, para-nasal sinuses, esophagus, stomach, colon and rectum, liver, pancreas, larynx, lung, cervix (as a co-factor with human papillomavirus), ovary, kidney, bladder and other urinary system (including ureter), and bone marrow (acute myeloid leukemia). There is limited evidence that tobacco smoke causes breast cancer.

Exposure to second-hand smoke causes lung cancer and probably increases the risk of cancers of the larynx and pharynx.

Smokeless tobacco products (e.g., chewing tobacco, snuff, snus) cause cancer of the oral cavity, esophagus and pancreas.

Source: Cancer Care Ontario¹⁸⁹



Tobacco and chronic disease

The use of commercial tobacco is a major preventable risk factor for cancer and other chronic diseases.

It was estimated that in 2002 over half a million years of life were lost in Canada due to smoking.¹⁹⁰ The impact of smoking on death rates is higher among First Nations, Inuit and Métis than in non- First Nations, Inuit and Métis populations in Canada. Smoking-related deaths were found to be elevated by 75 per cent and 17 per cent, respectively, for Métis and registered First Nations women, compared to the general population in Canada.¹⁹¹

Who is taking action?

Organizations working towards the elimination of commercial tobacco use in First Nations, Inuit and Métis populations by setting policy and by providing resources and services include Chiefs of Ontario, Nishnawbe Aski Nation, the Métis Nation of Ontario, Tungasuvvingat Inuit, the Ministry of Health and Long-Term Care, First Nations and Inuit Health—Ontario Division, Health Canada, Cancer Care Ontario's Aboriginal Tobacco Program, the Ontario Federation of Indigenous Friendship Centres, the Centre for Addictions and Mental Health and primary care providers (family physicians, family health teams, Aboriginal Health Access Centres). Research is being

Aboriginal Tobacco Partnership Table

The following organizations participate in the Aboriginal Tobacco Partnership Table:

- Cancer Care Ontario;
- provincial government;
- federal government;
- Tobacco Control Area Networks;
- Ontario Lung Association;
- Canadian Diabetes Association;
- Centre for Addictions and Mental Health;
- Leave the Pack Behind;
- Program Training and Consultation Centre;
- Canadian Cancer Society;
- Asthma Society of Canada; and
- Heart & Stroke Foundation.

conducted by the Ontario Tobacco Research Unit and in some areas, public health units and Regional Aboriginal Cancer Leads are involved. Non-governmental organizations, such as the Heart & Stroke Foundation, Canadian Cancer Society—Ontario Division and the Aboriginal Sport for Life organization incorporate anti-smoking components into their healthy living programs.

Recommendation 1

Develop a coordinated plan to prevent commercial tobacco use among First Nations, Inuit and Métis children and youth

Develop a culture-based social marketing campaign based on Smoke-Free Ontario and other existing best practice initiatives to promote healthy lifestyles.

What is Cancer Care Ontario's role?

Support raising awareness to prevent commercial tobacco use among First Nations, Inuit and Métis children and youth. Promote respect for traditional uses of tobacco through education of the cultural benefits and teachings associated with traditional and ceremonial uses of tobacco.

This recommendation involves developing a coordinated, multi-channel social marketing campaign designed to provide First Nations, Inuit and Métis children and youth with information to make educated choices, as part of the Smoke-Free Ontario Strategy. Proven marketing principles and tailored messaging that normalizes smoke-free behaviour can be applied to reach all children and youth in high-risk communities. Existing initiatives can be built on, such as the Aboriginal Tobacco Program, and programs offered by Friendship Centres, Aboriginal Health Access Centres, non-governmental organizations and schools.

This recommendation is consistent with government policy direction. The Smoke-Free Ontario Scientific Advisory Committee recommends implementation of media and social marketing strategies that “denormalize the tobacco industry, highlight the social unacceptability of tobacco use, identify resources available to youth and young adults who want to quit and encourage youth and young adults to refrain from tobacco use.”¹⁹² Research studies suggest that prevention efforts should address the unique strengths and needs of First Nations, Inuit and Métis youth.¹⁹³

What has worked well: **Prevention among children and youth**

The Youth Advocacy Training Institute's programs are successful in helping youths and adults improve their understanding of how to positively affect their communities by promoting tobacco-free and healthy lifestyles through education, partnership-building and advocacy.^{194,195}

The Youth Action Alliance of Manitoulin Island program was an Ontario Ministry of Health Promotion and Sport initiative that focused on youth engagement, smoking prevention and raising awareness of tobacco issues. It was found to be successful in introducing tobacco-free sports to communities, initiating a dialogue around creating smoke-free spaces in communities, and raising awareness of the importance of traditional ceremonial and spiritual use of tobacco.¹⁹⁶ Despite its success, the program was terminated due to funding.

Recommendation 2

Establish commercial tobacco cessation programs and services in First Nations, Inuit and Métis communities

Allocate dedicated resources to improve the reach and impact of the Aboriginal Tobacco Program and the Non-Insured Health Benefit Program to effectively reduce commercial tobacco use in First Nations, Inuit and Métis populations.

What is Cancer Care Ontario's role?

Offer First Nations, Inuit and Métis communities the option of a broader approach to addictions within the Aboriginal Tobacco Program. Assess the feasibility of expanding the scope of the Aboriginal Tobacco Program and other commercial tobacco intervention programs to address substance addictions in prevention of cancer and other chronic diseases. Cancer Care Ontario will also plan to adopt successful approaches that integrate the social determinants of Aboriginal health and foster collaboration among key stakeholders to promote healthier lifestyle choices.

Expanding commercial tobacco cessation programs answers the need for more accessible services.

Resources are required to enhance current initiatives that the Aboriginal Tobacco Program is undertaking to increase its scope, impact and reach.

First Nations, Inuit and Métis-specific approaches, such as the Aboriginal Tobacco Program, are known to be effective. A 2008 review of the program provided recommendations for improvement, which have since been incorporated.¹⁹⁷ Comprehensive approaches that are specific to the needs of Indigenous populations have also been shown to be effective by a systematic review¹⁹⁸ and by researchers in Canada,¹⁹⁹ Australia^{200,201,202,203} and New Zealand.²⁰⁴ Multifaceted approaches are foundational to many public health initiatives that address tobacco use, including those of Smoke-Free Ontario,²⁰⁵ and are recommended by the Cancer Quality Council of Ontario.²⁰⁶

The *Taking Action* report recommends broadening and extending efforts to create an integrated and coordinated Ontario tobacco cessation system²⁰⁷ that would benefit off-reserve First Nations, Inuit and Métis populations. Support for this recommendation also comes from the Smoke-Free Ontario Scientific Advisory Committee, which calls for targeting vulnerable populations, and Ontario's Tobacco Control Strategy 2011–16, which calls for targeting First Nations, Inuit and Métis needs.^{208,209}

Learnings from the Australian experience

Interviewees from the Australian Department of Health reported that reductions in smoking rates among the Indigenous population had been achieved through the Close the Gap initiative. Beginning in 2009, a large investment was made in a cross-sectoral, anti-smoking strategy involving social marketing, community programs, nicotine replacement therapy, tobacco control officers and healthy lifestyle workers. Denormalization of smoking has been achieved, in part, by Indigenous leaders acting as role models.

In addition to ensuring adequate and accessible counselling services, governments also must ensure coverage of smoking cessation therapies. Multiple relapses are typical outcomes of quit attempts (the Ontario Tobacco Survey suggests that 79 per cent of recent quitters will relapse in the subsequent year)²¹⁰ and drug programs must therefore align with this reality. Currently, Ontario's public drug programs and the Non-Insured Health Benefits program provides free smoking medication only to certain populations and limit the number of prescriptions allowed per year.^{211,212} The Smoke-Free Ontario Scientific Advisory

Committee recommends providing “free direct-to-tobacco-user smoking cessation medication in combination with varying amounts of behavioural support where indicated and appropriate.”²¹³

A broad approach to tobacco cessation that incorporates other addictions, including alcohol and other substances, has been suggested by several sources. The combination of smoking and drinking puts individuals at higher risk for some cancers.²¹⁴ A meta-analysis concluded that smoking cessation interventions during addictions treatment appeared to enhance rather than compromise long-term sobriety,²¹⁵ with similar results found in studies of interventions aimed at youth.^{216,217}

What has worked well: **Smoking cessation interventions**

Cancer Care Ontario’s Aboriginal Tobacco Program, funded by the Smoke-Free Ontario Strategy, engages First Nations, Inuit and Métis communities in the creation of health promotion strategies to decrease and prevent the misuse of tobacco. Tobacco-Wise Leads engage with communities and start conversations about commercial tobacco using a respectful and non-judgmental approach. Cancer Care Ontario can provide resources to raise awareness in communities; connect front-line health staff to training programs on commercial tobacco prevention, cessation and protection; and provide evidence-based information to community leaders about how to build a Tobacco-Wise community.²¹⁸

There are examples in Ontario’s First Nations, Inuit and Métis communities that serve as models of tobacco cessation programs. Sacred Smoke, operating at Wabano Centre for Aboriginal Health, and Sema Kenjigewin Aboriginal Tobacco Misuse Program, from Anishnawbe Mushkiki, both attempt to address emotional, physical, social and mental needs of First Nations, Inuit and Métis smokers in a holistic sense.²¹⁹



Recommendation 3

Support the development of resources to address second- and third-hand smoke.

What is Cancer Care Ontario's role?

Inform the development of community policy regarding second- and third-hand smoke by working with First Nations, Inuit and Métis to create a database of information and to raise awareness of the harmful effects of second- and third-hand smoke.

The government can play a key role in supporting Cancer Care Ontario's Aboriginal Tobacco Program by developing additional resources for First Nations, Inuit and Métis communities about second- and third-hand smoke.

The Smoke-Free Ontario Act of 2006 has helped to change attitudes and behaviours related to second- and third-hand smoke in Ontario.²²⁰ These regulations apply to off-reserve First Nations, Inuit and Métis. Also in 2006, the Chiefs of Ontario passed Resolution 06/39, which called on Political Territorial Organizations to assist First Nations in becoming smoke-free.²²¹ These trends and initiatives can be built on by informed policies at the community level.

Interviewees cited the success of community-initiated interventions, such as the Green Light Program (see to the right), that harness family members and peers to encourage others to quit smoking. Also, it was felt that a culture that condones smoking could be shifted by leadership and health workers who quit or smoke out of sight of others.

This policy direction is supported by the *Taking Action* report, which recommended bans on smoking in bar and restaurant patios.²²³ The Smoke-Free Ontario Scientific Advisory Committee recommends the implementation of media and social marketing strategies, and grassroots local action initiatives that address social norm change and protection

from exposure to tobacco smoke.²²⁴ This approach in First Nations, Inuit and Métis communities is also supported by research from Canadian investigators.^{225,226,227}

What has worked well: The Blue and Green Light Programs

The Blue Light project originated in 1998 in nine Cree communities in northern Quebec to raise awareness about the dangers of exposure to second-hand smoke, particularly for children. The blue light over a door is a visible sign of a smoke-free home. The program has since been adopted in Inuit communities in Nunatsiavut. It is called the Green Light Program in Saskatchewan, where it is being promoted in First Nations and Métis communities.²²²

Recommendation 4

Support community-initiated and managed tobacco control measures while respecting First Nations rights.

First Nations governments have the constitutional right to control and regulate their own smoking-related policies that are relevant and acceptable to their communities.

What is Cancer Care Ontario's role?

Reinforce messaging to the government urging them to respect the rights of First Nations to make their own decisions on tobacco control in their communities. Provide information to communities to inform commercial tobacco management strategies.

This recommendation reinforces that the rights of First Nations to make decisions regarding the manufacture and sale of commercial tobacco products within their territories must be respected. The Ontario government has been successful in taking a collaborative approach with First Nations communities, understanding their realities and respecting their rights and needs.²²⁸ These initiatives can be expanded.

For example, the provincial government provided funds to support the development of an Akwesasne Tobacco Law and Regulatory Framework (one of two such First Nation projects in the province), the goal of which is to replace the financial benefit the community gains from commercial tobacco with other opportunities for economic development.

Some First Nations have taken on the task of regulating commercial tobacco in their communities. For example, following a community dialogue on issues surrounding commercial tobacco in the community,²²⁹ Six Nations of the Grand River First Nation is developing a self-regulation framework for tobacco manufacturers.²³⁰

The decrease in smoking rates in mainstream populations in Ontario and elsewhere has been attributed to the employment of a range of policy levers over time. Communities that are ready to develop tobacco control policies may wish to consider the following policy levers, which have been shown to be effective.



Above:
Kathy Macleoud-Beaver,
Aboriginal Navigator,
Central East Regional Cancer Program

TABLE 12
Policy levers for tobacco control

Policy lever	Examples of application in First Nations communities
<p>LEGISLATION</p> <p>The Smoke-Free Ontario Act²³¹ includes:</p> <ul style="list-style-type: none"> • bans on the promotion and display of tobacco products; • bans on smoking in public places, including workplaces, schools, care facilities, restaurants and bars, shopping centres, places of entertainment, children’s playgrounds and publicly-owned sports facilities; • prohibition of sales of tobacco products to minors; and • requirements to label tobacco products with information about health risks. 	<p>Chiefs of Ontario passed Resolution 06/39, which called on Political Territorial Organizations to “assist First Nations to become smoke-free through positive smoke-free policy/by-law development.”²³²</p> <p>All Political Territorial Organizations have passed supporting resolutions and many First Nations communities have passed by-laws restricting smoking in public places.</p>
<p>TAXATION</p> <p>In mainstream populations, increasing tobacco tax is the single most effective way to decrease consumption, encourage tobacco users to quit and prevent youth from becoming regular smokers.^{233,234,235,236}</p> <p>A report from Ontario showed that increasing tobacco taxes does not cause a substantial shift to contraband tobacco and the benefits of increased taxation outweigh any minor increase in contraband use that may occur.²³⁷</p>	<p>The Cowichan Tribe in British Columbia uses tax revenue for community projects, economic development or remittances to band members.²³⁸</p> <p>Legislation in Kahnawake sets out a form of taxation requiring a “Contribution Stamp” for tobacco products with proceeds going to a newly-established Kahnawake Community Contribution Fund.²³⁹</p> <p>In Ontario, the band council of Tyendinaga has introduced a \$2 per carton fee on cigarettes that is used for community development projects.²⁴⁰</p> <p>One of the goals of The Akwesasne Tobacco Pilot Project is to allow revenue generation from tobacco sales to be used by the Mohawk Council of Akwesasne to fund government services and economic development activities in the community.²⁴¹</p> <p>The Government of Canada negotiated a series of tax agreements with First Nations communities, through either the enactment of a First Nations Tax on “listed goods,” (tobacco, fuel and alcohol), or through the First Nations Goods and Service Tax, which applies to all goods and services that are privy to the federal GST. No First Nations in Ontario had levied such a tax.²⁴²</p>
<p>VOLUNTARY RESTRICTIONS ON ACCESS TO TOBACCO PRODUCTS</p> <p>Cigarettes and cigars are not sold in drug stores.</p>	<p>The Akwesasne Tobacco Pilot Project will result in Akwesasne regulating the manufacture, wholesale and retail sale of tobacco products in its territory.²⁴³</p>

Connecting partners in dialogue

Cancer Care Ontario can work with government and First Nations, Inuit and Métis communities to coordinate discussions around best practices and research that inform strategies that address commercial tobacco use in a way that respects the realities of First Nations, Inuit and Métis. It can coordinate discussions between the provincial government and First Nations, Inuit and Métis to ensure inclusion of First Nations, Inuit and Métis commercial tobacco initiatives in the Smoke-Free Ontario Strategy. Lastly, Cancer Care Ontario can implement programs based on First Nations, Inuit and Métis-research findings on commercial tobacco use, such as from the Research on Non-Traditional Tobacco Reduction in Aboriginal Communities (RETRAC) study, and work with partners across Canada and internationally to conduct research into effective interventions for Indigenous populations.

The first step to empowering communities to make informed decisions about commercial tobacco use is to start a conversation about root causes. Cancer Care Ontario's close relationships with First Nations, Inuit and Métis communities will allow it to play a central role in facilitating community dialogue. As the organization responsible for the Aboriginal Tobacco Program and a partner in the RETRAC study on First Nation, Inuit and urban Aboriginal commercial tobacco use, Cancer Care Ontario is ideally positioned to bring factual, relevant information to communities that will assist them in making informed decisions. In

addition, continuing to invest in collaborative research on the reasons for smoking in First Nations, Inuit and Métis communities is needed to bring valuable insights to the discussion and may provide a basis for further action.

What has worked well: **Six Nations of the Grand River First Nation Think Tank**

The high rate of smoking on the Six Nations of the Grand River First Nation was recognized as a complex issue that must be addressed. Understanding that there is no simple solution, a panel of individuals met in June 2012 to help build solutions. This Tobacco Think Tank consisted of experts and community members, and was convened by the Director of Health Services and a McMaster researcher who has worked with the Six Nations peoples for decades. The goal of the Tobacco Think Tank was to generate recommendations for change that could then be promoted and implemented in the community with an overall objective to help reduce tobacco use among Six Nations adults and youth.²⁴⁴

What has worked well: **RETRAC study**

Research on Non-Traditional Tobacco Reduction in Aboriginal Communities (RETRAC) is a two-year study funded by the Government of Ontario's Health System Research Fund, and includes as partners the Ontario Tobacco Research Unit, Cancer Care Ontario and the Centre for Research on Inner City Health/ Li Ka Shing Knowledge Institute. The goal of the study is to understand tobacco patterns, attitudes and behaviours; examine what is working; and apply these learnings to interventions in communities.

The elements of the study are:

- 1) knowledge synthesis of community-level interventions;
- 2) exemplar communities (international in scope);
- 3) a focus on seven First Nations, an urban Aboriginal group, and the Inuit community in Ottawa; and
- 4) a knowledge forum that brings together exemplars and other stakeholders.



2 Alcohol recommendations

Policy goal

To reduce the risk of chronic disease by reducing misuse of alcohol. There is no safe limit for alcohol consumption with respect to cancer prevention;²⁴⁵ therefore, the goal of the alcohol policy recommendations is abstinence. Reduction of alcohol consumption is an important step in achieving this aim.²⁴⁶

The Ontario context

Colonization brought alcohol into the communities of Indigenous peoples of Canada, firmly entrenching it into the lives of First Nations, Inuit and Métis peoples.²⁴⁷ The health impacts of alcohol consumption are significant for First Nations, Inuit and Métis populations. Studies have shown that deaths due to alcohol-related diseases and potential years of life lost were elevated for Métis and registered First Nations men and women in Canada compared with the general population.^{248,249} From a life course perspective, alcohol consumption by pregnant women increases the risk of fetal alcohol syndrome.

Alcohol and chronic disease

Cancer Care Ontario states that alcohol consumption is a recognized cause of several cancers, with increasing risk at higher levels of consumption of all beverage types: beer, wine and spirits.²⁵⁰ The *Taking Action*²⁵¹ report cites the following statistics:

- Consuming an average of two drinks per day increases risk by 75 per cent to 85 per cent for cancers of the oral cavity and pharynx, 40 per cent to 50 per cent for laryngeal and esophageal cancers, 25 per cent to 30 per cent for breast cancer, and five per cent to nine per cent for colon and rectal cancer, compared to non-drinkers.
- Consuming more than four alcoholic drinks per day further increases risk and, for some cancer sites, risk is even higher in individuals who also smoke.
- Regular heavy alcohol consumption and low to moderate drinking are causally associated with type 2 diabetes, and occasional and adverse cardiovascular outcomes.

Guidelines on alcohol consumption are evolving as research sheds more light on the associated long-term health risks of moderate drinking. Canada's Low-Risk Alcohol Drinking Guidelines recommend a maximum of one drink per day for women and two drinks per day for men. Based on recent evidence that there is no safe limit for alcohol consumption in the prevention of cancer,²⁵² the *Path to Prevention* recommendations work towards a goal of abstinence.

Who is taking action?

Alcohol treatment programs are provided to registered First Nations and Inuit by the National Native Alcohol and Drug Abuse Program. This Health Canada program is geared to First Nations and Inuit communities, and aims to reduce high levels of alcohol, drug and solvent abuse for these populations. The Ontario Federation of Indigenous Friendship Centres offers an Aboriginal Alcohol and Drug Worker Program that provides counselling services. Other treatments for alcohol and other substance addictions include counselling in individual or group settings provided through the health system by family physicians, specialists, clinics and social organizations.

Availability and promotion of alcohol is regulated by the Liquor Control Board of Ontario and the Alcohol and Gaming Commission of Ontario. Alcohol control in First Nations reserves is within their own jurisdiction and many have taken action to limit access and availability of alcohol in their territories. Interviewees noted that community events are substance free (alcohol, drug and, depending on whether the event is indoors or outdoors, often smoke free). A resolution is needed in some reserves before offering alcohol at a social event, such as a wedding.

Alcohol and other substance abuse is being recognized as a priority among First Nations, Inuit and Métis in Ontario. Mental health and addictions is one of the four priorities of the Trilateral First Nations Health Senior Officials Committee. In Ottawa, a specialized addictions clinic has been established to treat Inuit clients and the Métis Nation of Ontario has identified alcohol-related issues as one of its seven priorities.

Action is also being taken at the regional level. For example, to support First Nations communities that have decided to be "dry," the Nishnawbe Aski Nation in 2010 passed Resolution 10/37 to help Wasaya Airways in their efforts to stem the flow of contraband to Nishnawbe Aski Nation communities.²⁵³

Recommendation 5

Ensure that culturally acceptable and relevant alcohol prevention and treatment programs for First Nations, Inuit and Métis peoples are available.

Support culture-based approaches to intervention for adults and youth by looking at best practices that promote health equity and address the root causes of addiction in supporting healthy lifestyles free from alcohol.

Implementing this recommendation could involve actions such as identifying best practices in culturally appropriate alcohol prevention education for adults and youth and conducting Health Equity Impact Assessments on alcohol intervention programs as a means to identify practical ways to address barriers to First Nations, Inuit and Métis participation. It is also important to address the root causes of addictions. The Healthy Weights initiative (profiled in the collaboration recommendations) is an example of a proven approach. Facilitating collaboration among health agencies is important, as is building awareness among First Nations, Inuit and Métis of local health and wellness systems that can support a positive environment for healthy living and help to reduce barriers to participation.

Culturally based programming has been shown to be effective. An analysis by Public Health Ontario of studies on alcohol-related messaging noted that community approaches, particularly those that incorporated traditional or cultural values, are commonly recommended as strategies for targeting drinking behaviour among First Nations, Inuit and Métis populations and can help reduce alcohol consumption.²⁵⁴ Culturally based programming has been shown to be effective in younger First Nations, Inuit and Métis populations, who are at highest risk.^{255,256}

This recommendation also aligns with government approaches. The federal First Nations and Inuit Health Branch Mental Health Cluster Evaluation²⁵⁷ recommended incorporating traditional, cultural and mainstream treatment approaches, and addressing barriers to accessing services through community-driven solutions.

Although culturally based alcohol treatment and prevention services exist, they do not appear to be adequate in number to meet demands. Calls for more of such services come from the Canadian Centre on Substance Abuse,²⁵⁸ a needs assessment prepared for the Chiefs of Ontario,²⁵⁹ and from a survey conducted among First Nations, Inuit and Métis youth, which concluded that those living off-reserve are at increased health risk.²⁶⁰



Recommendation 6

Broaden the impact of alcohol intervention strategies.

Broaden and enhance the current scope and capacity of alcohol programs to include substance-free living.

What is Cancer Care Ontario's role?

Support strategies that reduce access and availability of alcohol by promoting community-developed policies, guidelines and social media initiatives, including *Taking Action's* recommendations, to effectively reduce access, availability and acceptability of alcohol abuse.

Promote the benefits of being alcohol free by developing and implementing social media campaigns to support the social norm of being alcohol and smoke free and motivate people towards living a healthier lifestyle.

This recommendation involves working with First Nations, Inuit and Métis communities to develop strategies that enhance the skills of existing alcohol treatment workers so they are able to provide both basic and advanced counselling in their communities. The recommendation also involves working with the federal government to similarly enhance the National Native Alcohol and Drug Abuse Program.

The scope of alcohol prevention and treatment services could also be broadened to include chronic disease prevention, health promotion and community development. Beyond this, the scope of alcohol programs could be expanded to include substance-free living. For example, commercial tobacco and drug abuse could be incorporated into prevention and cessation interventions in ways that address the underlying causes of addictions and promote healthy lifestyles.

Taking a broader approach to addictions aligns with government direction. An evaluation of the National Native Alcohol and Drug Abuse Program recommended “a training strategy ... to assure that [National Native Alcohol and Drug Abuse Program] workers have skills in areas of grief and loss, family violence, sexual abuse, tobacco, gambling, and other areas.” Furthermore, they recommend that “all addictions programs within Health Canada be integrated into one system for dealing with addictions.”²⁶¹ The Mamisarvik Healing Centre in Ottawa is an example of how a wholistic approach to alcohol and addictions has been applied in a residential treatment setting.

What has worked well: Mamisarvik Healing Centre, Ottawa

The Mamisarvik Healing Centre, operated by Tungasuvvingat Inuit, is a residential treatment program for Inuit from the north and those living in the south. The centre provides treatment services for addictions to drugs and alcohol, as well as for trauma, including physical and sexual abuse.²⁶² The centre offers eight-week-long treatment cycles and a transitional house next door for clients who are preparing to return home. Mamisarvik's services are delivered in English or Inuktitut, and for one week of the program, groups camp at a centre in Quebec to enjoy being on the land; another week an elder is flown in to provide traditional healing and storytelling.²⁶³

At all levels of the health system, a collaborative approach is needed to make the most efficient use of resources and to connect people to the services they need. The federal First Nations and Inuit Health Branch Mental Health Cluster²⁶⁴ recommended building and maintaining partnerships among First Nations and Inuit Health Branch, First Nations and Inuit communities, national aboriginal organizations and provincial/territorial health services.

Cancer Care Ontario works directly with communities to provide health promotion messaging. The organization could expand this role to inform the development of community-based alcohol policy, supported by evidence in the *Taking Action* report that shaped policies to restrict the access, availability and acceptability of alcohol in mainstream populations.

A social media approach is supported by a Public Health Ontario analysis of studies on alcohol-related messaging, which pointed to successful approaches to reducing alcohol consumption and shifting attitudes towards communities becoming less tolerant of drinking and drug abuse.²⁶⁵ Cancer Care Ontario's experience with using social media to help change attitudes and behaviours related to smoking commercial tobacco can be harnessed to address alcohol consumption in First Nations, Inuit and Métis populations.

What has worked well: **Alkali Lake (Esketemc First Nation, British Columbia) community-based wholistic healing**

In reaction to high rates of alcohol addiction, with nearly all of the community seen as dependent, the community engaged in an ongoing healing process to transform health and social conditions, promote individual and community wellness, and revitalize traditional teachings and practices. Guided by continued leadership, commitment and support, this process started with one sober person and expanded to 95 per cent of community members indicating that they were clean and sober. Throughout the process, sober community members worked to eliminate the bootlegging of alcohol through collaboration with the Royal Canadian Mounted Police. Also, a voucher system was established with stores in Williams Lake, where some of the community's heaviest drinkers received food and other necessities in place of social assistance funds.²⁶⁶

Recommendation 7

Incorporate alcohol interventions into existing tobacco control initiatives (see Recommendation 2).

Explore opportunities to collaborate and partner with the National Native Alcohol and Drug Abuse Program to address addictions through prevention and cessation strategies.

This recommendation mirrors Recommendation 2, which calls for broadening prevention and treatment programs for commercial tobacco to include alcohol and substances of abuse. Similarly, commercial tobacco and drug abuse could be incorporated into

What has worked well: **Wholistic approach to alcohol reduction**

Red Lake Friendship Centre has incorporated traditional food activities into daily life, such as berry picking and fishing, which have had a positive effect on people in the community. In this community, there is a high risk for alcoholism. The Friendship Centre programs improve confidence, helping First Nations, Inuit and Métis to reconnect with their identity. The programs help with housing, and improve access to food in communities. Traditional activities give people a sense of pride and encourage them to live a healthy lifestyle.²⁶⁷

alcohol prevention and cessation interventions. This would address underlying causes of addictions by promoting healthy lifestyles. Evidence supporting this approach is presented in Recommendation 2.



3 Physical activity recommendations

Policy goal

To prevent chronic disease through increased physical activity.

The Ontario context

Physical activity and chronic disease

Physical activity has been shown to protect against type 2 diabetes, ischemic heart disease, cardiovascular disease and colon cancer. There is also some evidence showing that physical activity protects against cancers of the breast and endometrium.²⁶⁸

To reap these benefits, physical activity guidelines recommend that children and youth should accumulate at least 60 minutes of moderate- to vigorous-intensity physical activity daily and adults at least 150 minutes per week. Sedentary lifestyles are injurious to health and the guidelines recommend minimizing time spent sitting and limiting children's screen time to a maximum of two hours per day.²⁶⁹

The benefits of exercise include a positive influence on other risk factors. Physical activity in First Nations, Inuit and Métis populations are linked to other

positive behaviours, such as healthier diets, avoidance of drugs, and reduced addictions to smoking and alcohol.²⁷⁰ An active lifestyle is also associated with an increased likelihood of excellent or very good self-perceived physical and mental health among First Nations, Inuit and Métis people overall.²⁷¹ Focus groups shared that the link between physical activity and traditional culture is very strong.

“There is a lot of physical activity involved in hunting. My grandfather was 72 when he killed his last moose on snowshoes. We have gotten away from those things that kept us healthy.”

Focus group participant

Left:

Ultimate Frisbee and Commercial Smoking Cessation Workshop event with Inuit youth in Ottawa

Who is taking action?

Organizations involved in promoting physical activity in First Nations, Inuit and Métis communities include provincial and federal government ministries, agencies, non-governmental organizations and First Nations, Inuit and Métis organizations. Some healthy living programs, such as diabetes prevention initiatives, incorporate physical activity components as part of their approach. Other initiatives are directed mainly at physical activity, including the following examples:

- Ministry of Tourism, Culture and Sport (Community Aboriginal Recreation Activator Program);
- Ontario First Nations Integrated Health Promotion Strategy (Just Move It Ontario! community challenge, Our Time, Our Health website with resources on physical activity);
- Aboriginal Sport & Wellness Council of Ontario (Power to Play Equipment and Leadership Program promotes increased participation in sports, recreational and cultural activities);
- Aboriginal Physical Activity & Cultural Circle (network for First Nations, Inuit and Métis people involved in sports, recreation, fitness and traditional activities);
- Aboriginal Sport for Life/Canadian Sport for Life—CS4L Organization (resources for sport leaders); and
- Royal Bank of Canada (supports First Nations, Inuit and Métis community-building projects, including physical activity infrastructure, waterways programs, after-school physical activity and cultural programming).

Recommendation 8

Work with First Nations, Inuit and Métis to create safe places for physical activity.

Build on best practices and existing government policy and regulations to inform the creation of safe outdoor environments that promote physical activity where people live, work and spend time doing recreational activities.

What is Cancer Care Ontario's role?

Support the design of safe places for physical activity by making evidence-based information available to First Nations, Inuit and Métis populations on best practices for creating safe environments for walking, running and bicycling.

Creating opportunities for active transportation involves helping to promote physical activity and reduce sedentary lifestyles by encouraging people to incorporate walking, biking and other activities into their daily routines as an alternative to cars or other mechanized forms of transport. For First Nations, Inuit and Métis peoples, activities such as hunting, fishing and harvesting food contribute to a healthy active lifestyle. Physical activity is not only linked to being physically healthy, but also to strengthening culture, family and community bonds and self-care.²⁷²

Creating safe places for physical activity involves aligning government policy and regulations with goals for safe outdoor environments. Studies have found that safety was a significant consideration for people wanting to walk.²⁷³ Cancer Care Ontario can support this initiative by providing best practice information to support active living in communities.

This recommendation is in alignment with the Government of Ontario's direction, including:

- a refreshed Ontario Trails Strategy;
- supporting First Nations, Inuit and Métis community recreation; and
- continuing to build partnerships and engage communities across the province, including First Nations, Inuit and Métis communities.²⁷⁴

**What has worked well:
Feral dog policies**

- Rama Mnjikaning First Nation has seen positive results from putting stronger by-law regulations in place.²⁷⁵
- The Dogs With No Name organization of veterinarians has partnered with the Weenebayko Area Health Authority and the provincial and federal governments to administer a dog vaccination program in Ontario First Nations communities.²⁷⁶

Opening up sources of funding for communities to improve outdoor facilities, such as trails, would build on initiatives already undertaken by some First Nations, Inuit and Métis communities to increase the safety of outdoor spaces for physical activity.

Recommendation 9

Develop a strategy to promote equity in physical activity infrastructure for First Nations, Inuit and Métis.

Invest in community-developed research and planning to identify best practices and inform the enhancement of community infrastructure on- and off-reserve in fully meeting the recreation and sport needs of First Nations, Inuit and Métis people to be healthy and well.

What is Cancer Care Ontario's role?

Support the promotion of equity in physical activity infrastructure by sharing best practices in community development planning that would encourage walking and biking.

Physical activity infrastructure includes places (buildings and outdoor spaces), people (trainers and coordinators) and equipment that make participation in organized physical activities possible. This recommendation supports the development of a 20-year plan that would invest in physical activity infrastructure for First Nations

people living on-reserve and First Nations, Inuit and Métis peoples in Ontario. In collaboration with First Nations, Inuit and Métis populations, situational assessments could be conducted to inform priority areas for enhancement. Cancer Care Ontario could support this recommendation by sharing best practices for development planning that encourage walking, biking and traditional First Nations, Inuit and Métis activities.

This recommendation aligns with government direction. The Ontario Ministry of Education has been mandated to implement the *Taking Action* recommendation for children and youth to have access to 60 minutes of activity as part of their school day, and for students to learn from an up-to-date health and physical education curriculum.²⁷⁷ While research supports that physical education specialists are the preferred teachers of physical education in school settings,²⁷⁸ focus groups and interviewees reported that dedicated positions are lacking in many First Nations, Inuit and Métis communities. A systematic review of effective physical activity interventions in American Indian and Alaskan Native communities reinforced that program sustainability was linked to locally trained personnel, as well as local leadership and stable funding.²⁷⁹

Recommendation 10

What has worked well:

Building community capacity for physical activity

The Aboriginal ActNow BC initiative helps to build capacity within First Nations, Inuit and Métis communities in the promotion of increased physical activity, healthy eating, eliminating tobacco use and making healthy choices during pregnancy. Active Communities and Action Schools! BC comprise the physical activity components of the strategy. Active Communities mobilizes and supports local governments and partner organizations in promoting healthy lifestyles. Action Schools! BC promotes the inclusion of physical activity within the school day by providing school-based action plans that help identify opportunities for children to be more physically active every day at school.²⁸⁰

Address the socio-economic barriers to physical activity for First Nations, Inuit and Métis peoples.

Collaborate with First Nations, Inuit and Métis communities and key stakeholders to develop strategies that break down barriers, improve access to physical activity for First Nations, Inuit and Métis communities, and capitalize on the success of existing physical activity programming.

What is Cancer Care Ontario's role?

Address barriers to physical activity by providing information on accessible physical activity initiatives for First Nations, Inuit and Métis.

What has worked well:

Physical activity infrastructure

The Community Aboriginal Recreation Activators Program of the Ministry of Tourism, Culture and Sport includes land-based teaching led by Elders and medicine wheel teachings in 15 communities.

Reducing socio-economic barriers would reduce inequities in physical activity participation. Focus groups noted the value of subsidies for gym memberships or sports equipment that enabled First Nations, Inuit and Métis children to take part in organized activities that benefited their growth and development. This recommendation promotes the development of plans to address socio-economic barriers for physical activity by identifying options to help support families in need. Knowledge exchange and planning forums, as well as identifying opportunities at the federal and provincial levels, would help to inform policy implementation. Cancer Care Ontario could provide support by raising awareness of available physical activity initiatives.

This recommendation aligns with the proposed strategies of the Ontario Task Group on Access to Recreation for Low-Income Families.²⁸¹ It is also based on the success of programs offered by the Six Nations of the Grand River First Nation, and on various approaches taken across Canada.^{282,283,284} One example of an intervention is the Ultimate Frisbee challenge—a component of Cancer Care Ontario's Aboriginal Tobacco Program that engages youth in a fun physical activity while promoting other aspects of healthy lifestyles, such as avoiding commercial tobacco use.²⁸⁵

“Sport and recreation are an effective vehicle to address many social issues. Communities report less vandalism, less suicide when communities are participating in [the program]. It affects the whole social environment in the community. It builds self-esteem. There is coaching and positive reinforcement. There is goal setting and accomplishments which open up possibilities beyond what you thought was your future.”

Interviewee

Recommendation 11

Build and disseminate a knowledge base around physical activity interventions in First Nations, Inuit and Métis communities.

Work with First Nations, Inuit and Métis communities to identify, develop, implement and evaluate physical activity interventions that increase the participation of First Nations, Inuit and Métis people in recreation and sport.

What is Cancer Care Ontario's role?

Support knowledge exchange and dissemination of information about physical activity interventions for First Nations, Inuit and Métis.

Interviewees and researchers have called for additional studies to bridge the data gap that exists in identifying the determinants and barriers of physical activity, and in evaluating promising practices in physical activity interventions that could inform future physical activity recommendations for First Nations, Inuit and Métis peoples. Building on First Nations, Inuit and Métis cultural elements to promote increased physical activity has been shown to be promising, but needs further development.^{286,287,288}

Knowledge exchange is an important mechanism for achieving more effective and efficient use of physical activity resources. Providing examples of best practices in physical activity programming would offer useful and accessible information to community leaders. *Physical Activity Approaches at the Ground-Level* is one example of a tool that can assist communities in increasing participation among First Nations, Inuit and Métis youth.²⁸⁹ Also, the Aboriginal Physical Activity & Cultural Circle is a national network that hosts an annual national Aboriginal physical activity conference to exchange research and information on initiatives.



4 Healthy eating recommendations

Policy goal

The recommendations in this section address both the issue of food security in First Nations, Inuit and Métis populations and the need to improve healthy eating behaviours to reduce the risk of chronic diseases.

The Ontario context

Healthy eating and chronic disease

Research strongly supports that diet and health choices can prevent chronic diseases, including cancer.²⁹⁰ Healthy foods, such as fruit and vegetables, can prevent cancer and reduce the risk of other chronic diseases, including cardiovascular disease and obesity.²⁹¹

Participants in focus groups in First Nations, Inuit and Métis communities were aware of the link between being healthy and well, and access to healthy foods, knowledge and skills in making healthy choices, and access to healthy food systems. The intimate connection between food and culture means that initiatives linking food and tradition not only provide access to healthy foods, but also reinforce social bonds,

family connections, identity and self-esteem. Focus groups frequently shared that harvesting, growing and sharing traditional foods keeps culture alive, and the community healthy and well. Most communities had family or community gardens and felt that this was a good way to reclaim control over a supply of safe, nutritious foods, while teaching lost skills of cultivation.

Who is taking action?

Action is being taken to promote healthy eating by many organizations across all sectors in collaboration with First Nations, Inuit and Métis communities, as shown by the following examples (see Table 13).

TABLE 13
Sectors involved in First Nations, Inuit and Métis healthy eating

Sector	Organization
Provincial government	Ministry of Health and Long-Term Care Ministry of Children and Youth Services
Federal government	Health Canada Indigenous and Northern Affairs Canada
First Nations, Inuit and Métis governments and organizations	Chiefs of Ontario Ontario Federation of Indigenous Friendship Centres Nishnawbe Aski Nation Association of Iroquois and Allied Indians Métis Nation of Ontario
Non-governmental organizations	FoodShare Toronto ONEXONE Canadian Feed the Children Food Secure Canada
Research/academic	Centre for Studies in Food Security at Ryerson University Indigenous Health Research Group at the University of Ottawa Researchers at the Waterloo, Western, Lakehead and other universities across Ontario The First Nations Food, Nutrition, and Environment Study
Private sector	The Ontario Fruit and Vegetable Growers' Association



Recommendation 12

Develop an Indigenous food and nutrition strategy.

Invest in a First Nations, Inuit and Métis food and nutrition strategy for Ontario that builds on existing Indigenous food strategies within Ontario, Canada and internationally.

What is Cancer Care Ontario's role?

Support development of an Indigenous food and nutrition strategy by contributing information and resources to the strategy.

Indigenous food systems include the land, air, water, soil and culturally important plants, animals and fungal species that have sustained First Nations, Inuit and Métis people for thousands of years, the elements of which are inseparable and function in healthy interdependence.²⁹² Indigenous food systems have been shown to benefit physical health and play a key role in maintaining the culture, language and identity of Indigenous peoples.²⁹³

Components of an Indigenous food system include the ability and means to grow, harvest, distribute and prepare healthy foods that are controlled by First Nations, Inuit and Métis communities. Research has demonstrated that effective interventions to influence First Nations, Inuit and Métis food choices must consider the impact of culture, food preferences, food security and food constraints that drive food choices.²⁹⁴

By building on existing food strategies, such as Nishnawbe Aski Nation's Food Strategy, the province would be investing in best practice initiatives that address food security for First Nations, Inuit and Métis. Cancer Care Ontario's role would be to support the development of the strategy by linking communities, government and key First Nations, Inuit and Métis and non-First Nations, Inuit and Métis sectors in dialogue on priorities for Aboriginal communities in food and nutrition.

This recommendation is supported by the *Taking Action* report, which called on the government to create an Indigenous Ontario Food and Nutrition Strategy,²⁹⁵ which was further supported by the work of Food Secure Canada.²⁹⁶

An Indigenous food and nutrition strategy aligns with government policy. Food security is one of Ontario's core services in the Ministry of Health and Long-Term Care's Mandatory Health Programs and Services Guidelines.²⁹⁷ In addition to the Ontario Food and

Nutrition Strategy, this initiative can be incorporated into other existing policy work, such as:

- The Ministry of Health and Long-Term Care's Ontario's Action Plan for Healthy Eating & Active Living delivered by Aboriginal Health Access Centres;
- The Ontario public health sector's report: *Make No Little Plans*; and
- The Ontario First Nations Integrated Health Promotion Strategy.

What has worked well: Nishnawbe Aski Nation Food Strategy

The Nishnawbe Aski Nation Food Strategy is an example of an Indigenous food strategy focused on rebuilding food sovereignty across Nishnawbe Aski Nation territories. It focuses on harvesting, sourcing, production and storage of local food. The six pillars supporting the Nishnawbe Aski Nation Food Strategy focus on control over imported foods; support for traditional gathering practices; support of community nutrition practices; planning, policy and advocacy for change; and research and knowledge transfer. The Get Growing Project is one way Nishnawbe Aski Nation is helping its communities address issues of food access and food insecurity by providing the skills and tools needed to grow food in their own community gardens.²⁹⁸

Recommendation 13

Reduce barriers that prevent access to healthy foods for First Nations, Inuit and Métis.

Integrate food security initiatives with best practice policies, strategies and initiatives that promote access to healthy foods and promote traditional community food approaches.

Communities identified harvesting, growing and the sharing of traditional foods, as well as the cost of foods, among their main concerns in being healthy and well. Eating traditional foods and maintaining traditional food practices are important ways that remote communities have addressed food shortages in the past.²⁹⁹ Practices such as food sharing, hunting, fishing and gardening have promoted traditional food approaches in addressing food security. Reducing barriers that prevent access to healthy foods for First Nations, Inuit and Métis will involve identifying key provincial and federal food security initiatives to address food security, building on best practices that can promote self-sufficiency and reduce reliance on market foods, and expanding existing successful programs, such as the Northern Fruits and Vegetable Program.

The Auditor General of Canada has recommended provincial/federal standards for food subsidies to address the cost of foods and increase the likelihood of First Nations, Inuit and Métis peoples' access to healthy, nutritious foods, particularly in the north.³⁰⁰

The Northern Fruit and Vegetable Program is a provincial initiative that provides fresh Ontario produce twice a week to school children and includes a curriculum-based resource outlining the benefits of healthy eating and physical activity. Building on the success of the Ministry of Health and Long-Term Care's Northern Fruit and Vegetable Program has enabled health boards and community agencies to improve access to healthy foods for communities in northern Ontario.³⁰¹

This recommendation further builds on other initiatives that make healthy food affordable and accessible to all First Nations, Inuit and Métis in Ontario:

- Plans to expand the Poverty Reduction Strategy (2014–2019) will include helping an additional 340 schools run breakfast or morning meal programs.³⁰²
- The Northern Fruit and Vegetable Program currently reaches 6,600 Aboriginal students in 191 schools.^{303,304} Leveraging the existing success of this program would meet the mandate for boards of health to work with community agencies to improve access to healthy foods.³⁰⁵

- The Ontario Federation of Indigenous Friendship Centres' Urban Aboriginal Healthy Living Program promotes and supports healthy eating and lifestyles in urban Aboriginal communities.^{306,307}
- The Healthy Kids Community Challenge and Healthy Community Fund, and the Local Food Fund support healthy eating through local programs and activities, community partnerships and community capacity-building.³⁰⁸

Recommendation 14

Address environmental issues for Indigenous foods.

Work with First Nations, Inuit and Métis communities to develop community-based approaches for the surveillance, monitoring and reporting systems that track contaminants in traditional foods, collaborating with key stakeholders across all sectors.

Environmental contamination affects the availability, supply and safety of traditional foods.³⁰⁹ Addressing the issue of contaminants requires a balanced approach that takes into account and respects both scientific evidence and community knowledge, and works to build trust.³¹⁰

This recommendation involves collaboration of key government stakeholders, and First Nations, Inuit and Métis and non-First Nations, Inuit and Métis national and provincial organizations in the development of a contaminant risk management framework that integrates Indigenous knowledge. These groups must also collaborate to work cross-sectorally at all levels to build research capacity and enable communities to conduct monitoring activities.

Studies have found that contaminants in traditional foods in Canada are within Health Canada guidelines for communities participating in the Ontario First Nations Food, Nutrition and Environment Study, yet despite this information there is a belief in some communities that traditional foods are not safe. Clear, concise and culturally appropriate community strategies around environmental contaminants and traditional food need to be developed with the help of First Nations, Inuit and Métis communities, along with First Nations, Inuit and Métis-specific approaches to surveillance, monitoring and reporting.

Examples of organizations that could potentially be involved in implementing this recommendation in collaboration with First Nations, Inuit and Métis communities include:

- The Ontario Ministry of Environment and Climate Change;
- Canada Food Inspection Agency;
- The Environmental Public Health Program of Health Canada's First Nations and Inuit Health Branch;

- The Northern Contaminants Program of Indigenous and Northern Affairs Canada; and
- Researchers from the Indigenous Health Research Group, University of Ottawa; Lakehead University.

Recommendation 15

Develop traditional food and nutrition skills.

Work with First Nations, Inuit and Métis to develop an intergenerational food skills strategy to enhance knowledge and skills in the growing, harvesting and preparation of traditional foods.

A review of evidence by Health Canada concluded that enhancing food-related knowledge, skills and behaviour are key elements in improving healthy eating for individuals with limited resources. The review also found that frequency of family meals and involving youth and young adults in food preparation are associated with good nutrition.³¹¹ A similar review conducted by the British Columbia Ministry of Health found that knowledge and skill-building programs have a positive impact on food knowledge and healthy eating, and that multiple strategies are more effective in reducing barriers to health.³¹²

Communities noted that knowledge transfer of food and nutrition skills through intergenerational teaching helps to promote healthy choices and First Nations, Inuit and Métis culture. Research has shown that the passing down of traditional knowledge of land and food systems to younger generations increases food security and self-sufficiency within the community.³¹³ A study from Ontario concluded that food security has been addressed successfully in remote First Nations communities through initiatives that increase access to traditional foods and knowledge, support the role of Elders in teaching young people, provide education on healthy food preparation and strengthen connection to the land.³¹⁴

This recommendation can be realized by exploring best practices that build on traditional food skills and knowledge, and by developing an intergenerational food skills strategy. At the provincial level, the Ontario First Nations Integrated Health Promotion Strategy, Ontario Federation of Indigenous Friendship Centres and the Aboriginal Health Access Centres receive funding to support nutrition programming; however, the amount of support is insufficient and the programs are only able to reach a small proportion of First Nations, Inuit and Métis peoples. It is important to align and avoid duplication of efforts by food educators from Health Canada's Aboriginal Diabetes Initiative, the Canadian Prenatal Nutrition Program and the Community Food Educator Program, which currently play primary roles in nutrition education at the federal level.



5 Equity recommendations

Policy goal

To prevent chronic disease by achieving health equity.

The Ontario context

One-half of health outcomes are attributed to socio-economic inequities.³¹⁵ First Nations, Inuit and Métis populations in Ontario are at increased risk because they measure lower on many indicators of socio-economic status. Since chronic diseases account for the majority of health outcomes,³¹⁶ addressing health equity will have a major impact on reducing chronic disease in First Nations, Inuit and Métis populations.

Access, availability and acceptability of chronic disease prevention services also play a role in equity. Geographic factors limit access to and availability of health services for First Nations, Inuit and Métis populations living in rural and remote areas. Cultural safety influences the acceptability of health services, as does the relevance of health promotion to people's needs. Communities and interviewees told us that people cannot focus on healthy lifestyles when they are in survival mode.

Recommendation 16

Develop a plan to address First Nations, Inuit and Métis health equity.

Invest in a whole-of-government, multi-sectoral strategy that reduces health inequities by creating high-level First Nations, Inuit and Métis committees to oversee health equity planning, implementation and evaluation.

Recommendations 16 and 17 work in concert to develop and implement a long-term plan to address First Nations, Inuit and Métis health equity. The approach involves working with a high-level collaborative partnership structure that includes First Nations, Inuit and Métis, government, Cancer Care Ontario and other partner organizations across all sectors. Building strong partnerships across all sectors will tap into existing work and build synergies to support a long-term, sustainable commitment to action.

The approach to addressing health equity needs to be flexible. Interviewees reinforced that every community and context is different with respect to the social determinants of health—some are thriving, while others are not. First Nations, Inuit and Métis communities need to be supported in whatever their present state may be.

“To ensure viability, chronic disease prevention strategies must be held together by partnerships wider than politically associated agencies to reduce the risk of political impacts. Partnerships with non-governmental organizations, with community-based organizations, and with the private sector are critical to ensure long-term commitment and sustainable action on chronic disease prevention.”

Cancer Quality Council of Ontario³¹⁸

A health equity plan requires a commitment to sustained support. A Senate Committee review of the 2004 Health Accord heard from witnesses that “the lack of multiyear agreements with adequate and stable funding makes it difficult for Aboriginal communities to plan and provide health care services comparable to those available to other Canadians.”³¹⁷

What has worked well: **Australia’s approach to equity**

The Aboriginal and Torres Strait Islander population is very similar to that of First Nations, Inuit and Métis peoples in Ontario in terms of proportion of the population, the remote locations of many communities, socio-economic disadvantage and poor health outcomes.

In 2008, the Council of Australian Governments signed a national partnership agreement involving a \$4.6 billion package that committed both tiers of government to enhancing Indigenous health and well-being. The specific targets were set and the agreement was framed around seven building blocks: early childhood, schooling, health, economic participation, healthy homes, safe communities, and governance and leadership. Since its launch four years earlier, a progress report cited developments such as investment in Aboriginal Community Controlled Health Services, and the launches in 2013 of a Health Plan and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. Health outcomes include reductions in smoking rates, and improvements in maternal and childhood health.³¹⁹

The estimated expenditure per head of the population was \$44,128 for Indigenous Australians, compared with \$19,589 for other Australians. Success factors included cooperative approaches between Indigenous people and government.^{320,321}

Recommendation 17

Implement the plan to achieve First Nations, Inuit and Métis health equity goals.

Align government policies, strategies and resources to support health equity in cancer and chronic disease prevention, including integrating Health Equity Impact Assessments for First Nations, Inuit and Métis-facing government departments.

What is Cancer Care Ontario's role?

Support a First Nations, Inuit and Métis health equity plan by working with Public Health Ontario and First Nations, Inuit and Métis leadership to adapt the Ministry of Health and Long-Term Care's Health Equity Impact Assessment tool for First Nations, Inuit and Métis policy, strategy and program work.

A whole-of-government approach to developing a First Nations, Inuit and Métis health equity plan would include, in addition to the Health Equity Impact Assessment tool, other broad-based initiatives, such as Ontario's Poverty Reduction Strategy³²² and the Aboriginal Children and Youth Strategy,³²³ currently under development.

Within government, an important step could be to review current legislation and government policies and programs. A First Nations, Inuit and Métis-specific Health Equity Impact Assessment (HEIA) tool could be used to identify areas where change is needed and to evaluate outcomes of the plan implementation.

Cancer Care Ontario could support this work by partnering with Public Health Ontario to develop and test a First Nations, Inuit and Métis-HEIA tool, building on work done in Canada and abroad as catalogued by the National Collaborating Centre for Determinants of Health and National Collaborating Centre for Healthy Public Policy.³²⁵

What has worked well: Ontario's Poverty Reduction Strategy

Between 2008 and 2013, Ontario achieved positive outcomes on all eight indicators of its first Poverty Reduction Strategy by working with partners within and outside government, including individuals and communities.

The strategy focused on raising incomes of working families, ensuring the availability of affordable housing and providing benefits for children. The strategy also focused on supporting employment and income security of First Nations, Inuit and Métis peoples.

Going forward, Ontario's Poverty Reduction Strategy 2014–2019 has introduced initiatives to increase the participation of First Nations, Inuit and Métis partners in mining, forestry, green energy and other areas. The Jobs and Prosperity Fund includes \$25 million over three years to improve access to financing and skills training for Aboriginal people and businesses, as well as new support to diversify Aboriginal economies through a new Aboriginal Economic Development Fund. Ontario is also providing up to \$30 million over 10 years to the Métis Voyageur Development Fund to support Métis economic development and entrepreneurship. One of the three new indicators for the 2014–2019 strategy measures poverty rates of vulnerable populations, including First Nations, Inuit and Métis.

Source: Realizing Our Potential. Ontario's Poverty Reduction Strategy³²⁴

Recommendation 18

Implement a plan to achieve equity in access to primary care.

Reinforce existing capacities for health promotion and build onto existing health promotion infrastructure, resources and services.

Ensuring that all First Nations, Inuit and Métis have the same access to primary care as other Ontarians puts many important chronic disease prevention and health promotion services within their reach. In particular, counselling services provided by physicians, nurses, pharmacists, traditional healers and other health workers need to be accessible within communities.

The Ministry of Health and Long-Term Care—working with First Nations, Inuit and Métis, the federal government and Cancer Care Ontario—could identify areas where access is below accepted standards and implement a plan to address these gaps. This is also an opportunity to recognize the important role that could be played by traditional healers and community-based workers in delivering health promotion services.

Considerations in enhancing access to primary care include not only having sufficient resources, but also having capacity to provide culturally safe services. A recent review paper from Cancer Care Ontario identifies cultural safety as an important need. The same review also identified jurisdictional issues of federal versus provincial accountability as barriers to access that arise in the provision of healthcare for First Nations people living on-reserve.³²⁶

As with all other areas of chronic disease prevention, a tailored, community-driven approach is needed. A review of research in this area urges health services to avoid simplistic application of pan-Aboriginal strategies to preventive services.³²⁷



Recommendation 19

Build First Nations, Inuit and Métis cultural competency and safety within government.

Build cultural competency and establish a First Nations, Inuit and Métis lens for policies, strategies and initiatives in First Nations, Inuit and Métis-facing government departments.

What is Cancer Care Ontario's role?

Support the development of cultural competency and safety initiatives within government by promoting awareness of Cancer Care Ontario's Aboriginal Relationship and Cultural Competency courses (available at elearning.cancercare.on.ca) within key stakeholder organizations working with First Nations, Inuit and Métis.

The goals of cultural competency training are to increase knowledge of First Nations, Inuit and Métis peoples, enhance individual self-awareness and to strengthen skills for professionals working directly or indirectly with Indigenous people.³²⁸ Building cultural competency within government will help to empower staff to work more productively with First Nations, Inuit and Métis peoples and, at a policy level, to better understand how the histories and realities influence relationships and practices.

Systematic reviews conclude that there is evidence that cultural competency training at the organizational level of health systems and institutions can reduce health disparities.³²⁹ The government can also build its cultural competence by identifying areas where First Nations, Inuit and Métis perspectives and approaches might enhance current government systems and processes within First Nations, Inuit and Métis-facing departments.

In implementing this recommendation, the government could adopt existing cultural competency curricula developed by several organizations, including Cancer Care Ontario and the Chiefs of Ontario. Another cultural competency example is the program delivered by the Southwest Ontario Aboriginal Health Access Centre. Their Indigenous Cultural Competency training program is the first of its kind in Ontario. This program was adapted from the Indigenous Cultural Competency training program that is provided by the Provincial

Health Services Authority of British Columbia,³³⁰ which has, for over five years, mandated this training for all health services authority staff. Indigenous Cultural Competency training programs are available for individuals working in non-health and health-related fields. Métis- and Inuit-specific cultural safety guidelines are also available.^{331,332}

Cultural safety is a progression from cultural competency and is intended for health professionals who provide services to First Nations, Inuit and Métis individuals. Health organizations, such as the Aboriginal Nurses Association of Canada and Anishnawbe Health Toronto have developed cultural safety programs that could be applied more broadly.

“The provincial government is taking steps to address the Truth and Reconciliation Commission of Canada’s (TRC) Calls to Action regarding education and training, including introducing mandatory Indigenous cultural competency and anti-racism training for every employee in the Ontario Public Service (OPS) and implementing mandatory learning expectations in Ontario’s public education system curriculum.”

Premier Kathleen Wynne, announcement from February 17, 2016³⁴⁷

What has worked well: **Cultural competency impacts**

Interviewees from the Juravinski Cancer Centre in Hamilton, Ontario, described how their organization has led efforts in First Nations, Inuit and Métis cultural competency in the region for several years. Based on a series of articles and discussions about building champions and on cultural sensitivity programming published by Dr. Wayne Warry (at McMaster University at the time of publication of the articles referred to above, now at Laurentian University), the Regional Cancer Centre took action to promote cultural competency within the organization. Their approach included developing a team of 10 to 12 First Nations, Inuit and Métis champions, convening a First Nations, Inuit and Métis group and hiring the first Aboriginal Patient Navigator, who has been key to further developments. This cultural sensitivity training was built into the Ontario Breast Screening Program at the Regional Cancer Centre and won a Cancer Care Ontario award for innovation.



6 Collaboration recommendations

Policy goal

To build capacity to address First Nations, Inuit and Métis chronic disease prevention by collaboration at all levels and across sectors.

The Ontario context

As discussed in previous sections, chronic disease prevention resources and services for First Nations, Inuit and Métis peoples in Ontario are fragmented and there is no lead to coordinate planning and service delivery. As a result, there are gaps across the province and resources are used inefficiently. In addition, the mandates and jurisdictions of health system organizations are often unclear, especially in reference to First Nations on-reserve. Interviewees expressed that the effectiveness of the health system could be improved by increased participation by First Nations, Inuit and Métis peoples in decision-making tables, leadership to move ahead with a First Nations, Inuit and Métis chronic disease prevention strategy, and coordination of efforts across sectors.

Cancer Care Ontario is in a strong position to support the development and implementation of a First Nations, Inuit and Métis chronic disease prevention strategy. Its role as advisor to the provincial government on cancer matters, coupled with its leadership of cancer prevention with First Nations, Inuit and Métis peoples and its strong relationships within the healthcare system, make it a valuable partner for government.

*Left:
Ne Chee Friendship Centre focus
group participants in Kenora*

Recommendation 20

Support an integrated, cross-sectoral and whole-of-government approach.

Build capacity system wide to ensure full participation by partner organizations by aligning government policies, strategies and resources to support First Nations, Inuit and Métis chronic disease prevention.

The partnership approach recommended in this report answers the urgent need to coordinate resources. All partners, and especially government, will benefit from streamlined engagement, which will result in more effective programming and more efficient uses of funds. By integrating provincial and regional plans with community-based planning and resources, and by increasing transparency, all parties will be able to make more informed decisions.

A coordinated, cross-sectoral system-level approach is supported by seminal reports beginning with the 1986 *Ottawa Charter for Health Promotion*,³³³ and including Ontario's Chronic Disease Prevention and Management model³³⁴ and the Cancer Quality Council of Ontario.³³⁵ An integrated, whole-of-government approach is also supported by the *Taking Action* report.³³⁶ Internationally, a partnership approach was successful in Australia's Close the Gap strategy, in which national partnerships were formed for each area of focus.³³⁷

This recommendation builds on the collaborative tables discussed in section 2, in which First Nations, Inuit and Métis participate in leadership roles. A review of best practices for structuring collaborations produced for the Ministry of Health and Long-Term Care showed that a high degree of interaction and interdependence across all sectors is needed, as well as supporting tools and structures.³³⁸

Recommendation 21

Promote a coordinated approach to the delivery of First Nations, Inuit and Métis health promotion programming in communities.

Work with key stakeholders to build coordinated provincial and regional systems for the delivery of First Nations, Inuit and Métis chronic disease prevention and management services.

An integrated, coordinated cross-sectoral and whole-of-government approach to the delivery of chronic disease prevention services addresses the needs of First Nations, Inuit and Métis communities for more

consistent and higher quality services. Clear accountabilities and dedicated resourcing for community-based workers will help to focus efforts on high-priority areas chosen by communities.

What has worked well: **Regional collaboration**

Interviewees described the following approaches that have been used successfully:

- The Hamilton Niagara Haldimand Brant Local Health Integration Network (LHIN 4) Aboriginal Health Network is involved with the Southern Ontario Aboriginal Diabetes Initiative and includes representatives from the Aboriginal Health Access Centre, Regional Cancer Program, LHIN, Friendship Centres, and other First Nations, Inuit and Métis organizations in the region.
- The Northwest Regional Cancer Program and the Thunder Bay Regional Health Sciences Centre have had Aboriginal committees for many years and actively cultivate relationships with First Nations and Métis communities and organizations, Cancer Care Ontario, First Nations and Inuit Health-Ontario, the Canadian Partnership Against Cancer, non-governmental organizations and others.

This recommendation involves building on existing programs that address issues of chronic disease prevention. It also involves strengthening partnerships with health service organizations to coordinate program delivery. Learnings from successful regional collaborations, such as those shown in the examples in the “Regional collaboration” box on page 73, can be applied more broadly across the province.

The same approach applies to local collaborations. The example in the “Healthy Weights Connection” box below relies on community workers to act as a hub to coordinate services.

What has worked well: **The Healthy Weights Connection**

A successful community-based approach to risk factor reduction has been demonstrated by this research project, which is currently taking place in London and Midland/Penetanguishene. Site coordinators provided by the N’Amerind Friendship Centre and the Métis Nation of Ontario connect with all potential partners in the public health system and look for ways to support better collaboration or knowledge sharing. Researchers have found that the gap in accessing programs and services can be traced to a lack of collaboration. In their model, Community Wellness Workers are central to connecting people to the resources they need.³³⁹

Recommendation 22

Establish a coordinated system for surveillance, research, measurement and evaluation.

With First Nations, Inuit and Métis groups, build capacity and develop consistent approaches for cancer and chronic disease research, surveillance, evaluation and data sharing in First Nations, Inuit and Métis populations through existing and new partnerships.

What is Cancer Care Ontario’s role?

Work with its First Nations, Inuit and Métis partners to build capacity within Cancer Care Ontario for cancer and chronic disease research and surveillance work in First Nations, Inuit and Métis populations.

This recommendation involves building and improving on cancer surveillance data systems already in place and exploring partnerships with existing research and surveillance expertise. For example, Cancer Care Ontario is working with communities to develop a system and application that will track the impact of the Aboriginal Tobacco Program.³⁴⁰ The Ontario Federation of Indigenous

Friendship Centres maintains a database system that collects information about the healthy eating, physical activity and tobacco components of their Urban Aboriginal Living Program.

What has worked well: **First Nations, Inuit and Métis human papillomavirus vaccine surveillance in Manitoba**

Manitoba established a surveillance and evaluation program to track the uptake of the human papillomavirus vaccine in different populations in the province, including registered First Nations and Métis, by linking administrative databases with provincial health records. The system allowed assessment of the vaccine’s safety, its impact on cervical cancer screening programs and the incidence of cancers linked to human papillomavirus.

Source: Kliewer EV, Demers AA, Brisson M, Severini A, Lotocki R, Elias B, et al. and Manitoba HPV Research Group. The Manitoba Human Papillomavirus vaccine surveillance and evaluation system. Health Reports. 2010; 21(2).

Working with First Nations, Inuit and Métis groups, this recommendation also seeks to incorporate into research and surveillance initiatives common indicators for data collection and protocols; First Nations, Inuit and Métis health indicators; data governance principles; report and dissemination strategies; and data sharing at the provincial, regional and community levels.

The development of robust information systems is recommended by the *Taking Action* report and is included in the World Health Organization's recommendations for First Nations, Inuit and Métis primary healthcare reform.³⁴¹ The Cancer Quality Council of Ontario has also recommended improved surveillance systems for First Nations, Inuit and Métis populations.³⁴²

What has worked well: Health data use for planning

New Zealand's Māori Health department is a strong proponent of robust data systems. Interviewees said that the Ministry of Health's substantial investment in comprehensive ethnicity data has enabled the health system to move from trying to convince people to comply with interventions towards using audit tools to standardize reporting and track progress. A continuous health survey in which Māori and Pacific Islanders (and other ethnic groups) are identified includes a module on a specific risk factor each year.

Based on these data, district health boards each produce a Māori Health Plan that identifies issues for communities at the local level. The boards are held accountable for 15 health indicators at the national, regional and local levels.

Source: Interview, Māori Health, Ministry of Health, New Zealand

To support chronic disease prevention in First Nations, Inuit and Métis populations, it is essential to incorporate Indigenous ways of knowing into the information support system. The creation of a data system to support First Nations, Inuit and Métis chronic disease prevention offers an opportunity to create a tailored approach that will serve the needs of First Nations, Inuit and Métis peoples as a priority.

Knowledge exchange structures have been used with success by the Manitoba Métis Federation³⁴³ and the Métis Nation of Ontario, whose Indigenous Knowledge Networks bring together organizations from different jurisdictions, as described in the "Indigenous Knowledge Networks" box to the right.

What has worked well: Métis Nation of Ontario's Indigenous Knowledge Networks

The Métis Nation of Ontario convenes Indigenous Knowledge Networks (IKNs), an initiative to:

- develop, maintain, and evaluate a network of Métis and First Nations front-line health workers, policy-makers, knowledge-keepers and Indigenous academics;
- conduct an international review of Indigenous culture-based parenting and infant/toddler health promotion programs and share the results with communities;
- assess and further develop existing, locally relevant baseline public health data sources that communities can use to evaluate their programs;
- support communities in uncovering and archiving original Indigenous infant, child and family health knowledge using oral history;
- support communities in articulating underlying local core values, attitudes, knowledge and skills regarding infant, child and family health that influence health programming;
- support communities applying the knowledge acquired to enhance existing culture-based parenting or infant/toddler health promotion programs in their community; and
- facilitate the sharing and uptake of study results to existing networks with similar mandates and contribute to the development of additional regional networks.³⁴⁴

What are the next steps?

Cancer Care Ontario's main role is to create a collaborative structure that includes First Nations, Inuit and Métis and other key cross-sectoral partners, which will develop, plan, implement and evaluate Cancer Care Ontario's *Path to Prevention*.



Cancer Care Ontario is ideally positioned to work with First Nations, Inuit and Métis in the development of a First Nations, Inuit and Métis chronic disease prevention strategy. First Nations, Inuit and Métis communities indicate that they know and respect the work of Cancer Care Ontario. Having additional responsibility for chronic disease prevention would build on a long-standing track record of forging strong relationships and connections with First Nations, Inuit and Métis organizations and communities, implementing leading programs and scientific excellence.

Prevention is a key focus for Cancer Care Ontario and it has strong links with government, Public Health Ontario and stakeholder organizations across numerous sectors. Relationship-building and commitment are keys to a successful chronic disease prevention approach and, in the eyes of all communities and organizations who provided input, there is no stronger organization to do this.

In taking the *Path to Prevention* recommendations forward, Cancer Care Ontario recognizes the contributions to the work made by First Nations, Inuit and Métis communities and organizations, health system representatives and individuals from across many sectors. The information shared with us has shaped these recommendations and we honour the trust placed in us to advance the agenda that we collectively have put forward.

We are confident that the government will be receptive to the recommendations, which are practical, feasible, build on existing successes and are based on solid evidence. We are also encouraged by our experience with the *Taking Action* report—the government has already moved forward 10 of the 22 recommendations.

Cancer Care Ontario is committed to advancing *Path to Prevention* in the following ways.

1. Presentation to government

Cancer Care Ontario will present the report to senior levels of government and engage in discussions on how the recommendations might be implemented.

2. Implementation by Cancer Care Ontario

Within Cancer Care Ontario's existing mandate and resources, many of the recommendations can be implemented without delay. A key starting point is the creation of a cross-sectoral collaborative structure that will be used to develop and implement a First Nations, Inuit and Métis chronic disease prevention strategy, as outlined in the introduction of this report. In addition, Cancer Care Ontario can fulfill specific roles presented throughout this report, in alignment with the work of the Aboriginal Cancer Control Unit and Cancer Care Ontario's Prevention Strategy.

3. Ongoing advice to government

In its role as advisor to the provincial government on cancer matters, the *Path to Prevention* will be used by Cancer Care Ontario as a framework and evidence-based policy resource to respond to issues and opportunities.

4. Tool for advocacy organizations

Organizations and committees representing First Nations, Inuit and Métis interests will have in their hands a powerful tool to support their advocacy role.

5. Broad dissemination

Dissemination of *Path to Prevention* and presentation of its recommendations to a broad array of audiences will raise awareness of First Nations, Inuit and Métis health issues and stimulate interest in participating in proposed solutions.

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