All.Can Canada

Optimizing Equitable Cancer Diagnoses with First Nations Inuit and Métis Communities Roundtable: What We Heard

Roundtable Report

January 18, 2024 | Toronto

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Introduction

Led by patient groups and people with lived experiences of cancer, All.Can Canada (ACC) is a national, multi-stakeholder network for cancer care efficiency, with a preliminary aim of optimizing people's entry into cancer care through swift, accurate, and appropriately delivered diagnosis. ACC is a national initiative of All.Can International, a European multi-stakeholder initiative that brings together patient organisations, policymakers, healthcare professionals, industry, and researchers to improve the efficiency of cancer care by focusing on what matters to patients. Save Your Skin Foundation acts as ACC's Secretariat.

The primary aim of the Optimizing Equitable Cancer Diagnoses in Canada Roundtable convened on January 18, 2024 in Toronto was to gain insights on the implications, gaps, and opportunities related to ACC's mixed methods research to move towards an improved, equitable future state of swift, accurate, and appropriately communicated cancer diagnoses for and with First Nations, Inuit, and Métis (FNIM) communities.

ACC is not only producing and sharing this report outlining the learnings as a draft to be finalized after input from Roundtable participants, but ACC's Steering Committee is also asking participants to help them assess priorities on next steps within ACC's mandate and possible new community-led partnerships to operationalize prioritized next steps.

All.Can Canada is committed to understanding and working towards addressing barriers built into Canadian healthcare systems, including structural and social determinants of health, in obtaining timely cancer diagnoses. A known gap in ACC's mixed methods research undertaken during the COVID-19 pandemic was the inability to run a parallel stream of FNIM-led research on cancer diagnoses.

As a result, ACC sees this Roundtable as a foundational next chapter in its work to identify structural barriers in Canadian healthcare, alongside the beginning of new relationships and the identification of opportunities to more equitably improve symptomatic cancer diagnoses. ACC is committed to robustly supporting the leadership of interested FNIM community members, professionals, and community groups in any prioritized next steps coming out of the Roundtable.

Why focus on diagnosis?

Earlier diagnosis means better health outcomes[1] and reduced healthcare costs.[2] Delays are correlated with increased mortality.[3] The cost of cancer care in Canada has risen from $2.9 billion in 2005 to $7.5 billion in 2021, largely due to the increased costs in hospital-based care.[4] In Canada, in 2022, sixty-three percent of new cancers were diagnosed through the investigation of symptoms as compared to thirty-seven percent diagnosed by screening.[5] There are also many cancers for which there are no screening programs. As a result, it is crucial to attend to how to improve earlier cancer diagnoses through symptom presentation in order to save lives and reduce health system costs.

1. Elison L, Saint-Jacques N. Five-year cancer survival by stage at diagnosis in Canada. Statistics Canada. January 18, 2023.
2. Sarma E et al. Achieving Diagnostic Excellence for Cancer: Symptom Detection as a Partner to Screening. JAMA. July 18, 2022
3. Hanna T P, King W D, Thibodeau S, Jalink M, Paulin G A, Harvey-Jones E et al. Mortality due to cancer treatment delay: systematic review and meta-analysis. BMJ 2020;371:m4087
4. Oliveira, D., Weir, S., Rangrek, J., Krahn, M., Mittman, N., Hoch, J., Chan, K., Peacock, S. The economic burden of cancer care in Canada: a population-based cost study. CMAJ 2018, 6(1), E1-E10.
5. Canadian Cancer Society. "Cancer Statistics at a Glance." Updated 2023. https://cancer.ca/en/research/cancer-statistics/cancer-statistics-at-a-glance

Themes from the Roundtable

Six participants with a diversity of FNIM professional and lived expertise, including family physicians, a health promoter, a representative from a provincial Indigenous primary healthcare association, and provincial policymakers, gathered in-person in downtown Toronto. (See Appendix 1 for the participant list.) It is important to acknowledge that no participants identifying as Inuit were able to join the meeting. Also, there are over 650 different First Nations across Canada so, while this report uses the acronym FNIM throughout, the limitations of representation at the meeting are important to acknowledge.

The day was co-facilitated by Melissa Hammell of Building Bridges and Dr. Ambreen Sayani, an ACC Steering Committee member. A pre-meeting package was provided to all participants a month prior to the event, with a summary of ACC's research findings, guiding questions, the agenda, and logistical details. At the event, the day began in circle with all participants, co-facilitators, ACC Steering Committee members, and ACC Secretariat members included. The co-facilitators acknowledged the land. Melissa explained the light circle protocols and opened introductions through the first sharing circle. An inner circle composed of FNIM participants and an outer circle of listeners were created. This was followed by context setting and a review of All.Can Canada's mixed methods research findings. Participants started responding to the three guiding questions, below, as the findings were shared. The circle sharing continued until all the questions were explored. Listeners from ACC were invited to ask questions or add comments towards the end of the sharing circles. The day ended with a final circle in which everyone in attendance shared a word that summarized how they were feeling. They were words full of positivity.

Guiding Questions

1 What are your reactions to these research findings on cancer diagnoses? Any surprises?
How do they resonate with your experiences?
Or don’t?

2 What are the implications of these findings on FNIM communities? What are the gaps in these findings and recommendations related to these communities?

3 What does a more equitable future in cancer diagnosis look like? What are the opportunities to move towards this more equitable future, including any potential partnerships or areas of mutual support to move towards this more equitable, improved future?

Qualitative analysis of the day’s notes, taken by a dedicated notetaker, produced the themes outlined below. These themes include responses from a participant who was invited but could not attend and was interested in providing her input.

Overarching Themes

The foundational importance of worldview was an overarching theme. Worldview shapes rights, legislation and policies, institutions and organisations, and individual behaviours. Different worldviews can promote healthy flourishing or structural violence. It is important to understand the big picture, the interconnected fabric, the upstream and downstream dynamics of health. Foundationally, Indigenous ways of knowing and being are very different from Western ways of knowing and being.

Worldviews affect the conception of what rights that worldview will support, or not. Indigenous communities need to be able to fulfill their right to carry out their original instruction – to take care of the earth. Equity of access to support according to FNIM worldviews is not just between ourselves as people, but also clean water, air, land. Meanwhile, the capitalist worldview and resultant systems promote structural violence; inequities are inherent.

Laws uphold the conception of rights. Some countries cannot implement the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) because their legal framework is at odds with Indigenous ways of knowing and being. Legislatively, in Canada, the Indian Act is a colonial framework and the reason why there is no federal funding in off-reserve communities. This piece of legislation literally defines the identities and experiences of FNIM individuals and communities.

Then one needs to look at what institutions carry out the laws. People are now more aware of residential schools and the ‘60s Scoop, and maybe some of the practices and policies of Indian Affairs, but institutional cycles of harm continue today. Canadian systems are still institutionalising FNIM people, with child welfare, prisons, lack of high schools in First Nation communities forcing youth to leave in order to attend secondary school in distant cities, and lack of health services in communities that make people stay in faraway urban centres for care, sometimes for months or years.

Worldview influences one's conception of rights, which influences legislation, which influences institutions, which influence personal conduct – how one carries oneself. Indigenous ways of being support relationships with the earth – the longhouse, the medicine wheel, ceremonies, the cycle of life – so personal conduct should be informed by this epistemology. FNIM communities have lost the ability to raise their children in a way that protects them so they can find their gifts and bring those gifts into the world as adults. It is also important to look at the personal conduct of the peoples who have harmed and continue to harm FNIM communities and to look at the worldview that is the root of that conduct. Drinking alcohol has been normalised in this version of a 'civilised' world. First Peoples lost their health and their healthcare systems in the name of being made more 'civilised' through other people's choices and behaviours. As one participant shared,

> **"People continue to suffer. Traditional healers try to do the work that needs to be done. Some do not understand this larger, historical dynamic of the systems and what has happened that is negatively influencing them. We need to slowly introduce both worldviews and walk in both worlds. When FNIM peoples are introduced to the healthcare system, traditional healers, elders, and other community healers must be able to walk alongside them."**

As another participant summarized, “We’re talking about really diverse populations within the FNIM acronym with complicated histories and current lives. This is much more than culture. It includes nations and treaty rights. **Treaty rights give access to both cultural and western medicines, access to ceremonies, to our traditional people, as well as hospitals.”** Finally, a participant with lived experience of cancer shared,

> **“Ceremonies were very important to me when I got cancer. It is important to have our traditional people sitting with us.”**

Government policies are made according to the dominant worldview and system. When governments try to apply these policies to FNIM systems based on different worldviews, harm and dysfunction ensue. **Meanwhile, because FNIM worldviews and systems are denied, important information about how to make them work together better – the power of two-eyed seeing[6] – is lost. As one participant said,**

> **“We know our culture and we know western culture, but they won’t listen to us.”**

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[6] For a preliminary overview on two-eyed seeing: https://www.schulich.uwo.ca/research//about_us/monthly_enewsletter/2019/march/the_gift_of_multiple_perspectives.html

Themes - Reactions, Implications, Gaps

Because people experience racism within Canada's healthcare systems, people are never entering these systems in the first place. As one participant shared, "Systemic racism excludes FNIM." Racist assumptions are made all the time, with much documentation on this topic.[7] An example was given about pain medication. Doctors ask questions about drug-seeking based on stereotyped assumptions. A family physician shared, "I face lack of trust as a doctor because I represent the western system, even though I am Indigenous." Another participant spoke from her lived experience of cancer,

> **"We are trying to get into a system that won't allow you in. As well, people have their own experiences and everything they carry in their own backpack – both systemic and individual racism."**

Many people working within Canada's healthcare systems lack an understanding of the structural drivers of individual behaviours, including intergenerational trauma and lateral violence from ongoing colonial impacts. Therefore, FNIM individuals experience personal blame for health issues. An example was shared of an Inuit boy who was repeatedly dismissed as overweight, missing an undiagnosed tumour that had almost taken over his entire torso. A participant shared a personal story about a surgery she had, in which the provider removed more fertility-related organs than she was told about. A traditional healer alerted her to what had been done and she returned to the doctor to press for details and was told the truth. This is in the context of a history of legally enforced sterilization[8] among FNIM women in Canada, which is no longer legal but continues to persist.

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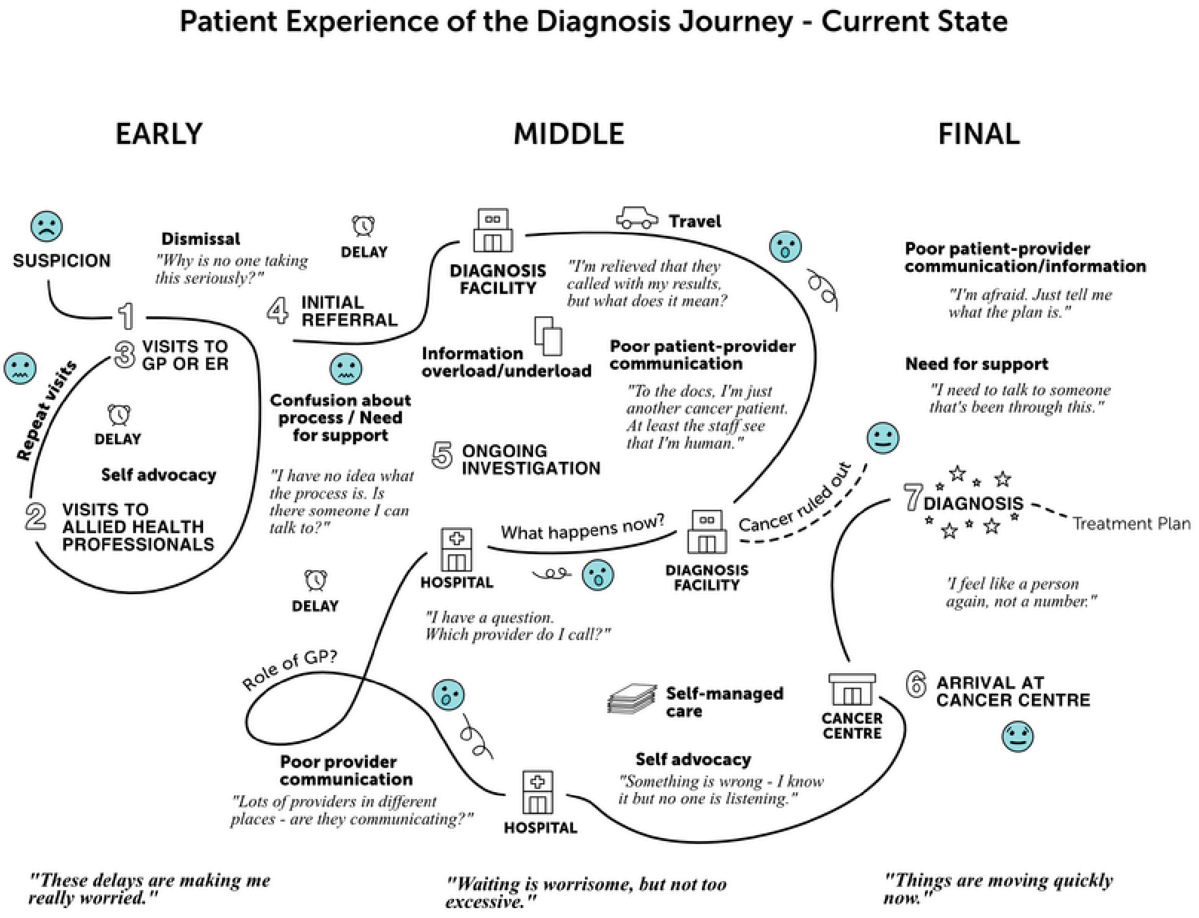
[7] In Plain Sight: https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf
First Nations, Second Class Treatment: https://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Summary-First-Peoples-Second-Class-Treatment-Final.pdf
Dr. Camera Jones, A Gardener's Tale: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446334/pdf/10936998.pdf

[8] Recent resources on forced sterilization in Canada: https://nwac.ca/policy/forced-sterilization
https://sencanada.ca/content/sen/committee/441/RIDR/reports/2022-07-14_ForcedSterilization_E.pdf

A lot of people have been filtered out of the ACC current state infographic. They do not even get into the early phase of diagnosis. ACC must define who is left out, focus on the edges of the normal bell curve. ACC can not use one image to represent everyone.



Patient Experience of the Diagnosis Journey - Current State

There is a whole system before the place where the current state “spaghetti map” starts. For example, the Indian Act legislates inequities. The colonial practice of labelling "on and off reserve", "status and non-status" creates inequities. There are things one can or cannot get according to their designation. It determines what kind of healthcare one can access.

There is a much broader perspective, an entire fabric, an understanding of the interconnectedness of the whole system of health. One needs to see and understand the whole, then act from one’s particular area of focus. A failure to understand and address trauma is part of this fabric.

Due to the various colonial systems that have harmed FNIM communities over generations, trauma affects people who have experienced abuse and who know about the abuse experienced by loved ones and community members. Pap tests, for example, are a very triggering experience for those with experience of sexual abuse. Differences in how pain is dealt with is another example. Due to experiences such as residential schools, FNIM peoples have been conditioned to not admit to or talk about pain. "Keep your head down and your mouth shut." Therefore, there are differences between how Indigenous and non- Indigenous people experience and show pain. Western pain scales do not work to assess FNIM experiences of pain. Meanwhile, Indigenous people are dismissed as "drug-seeking" when presenting with pain.

Trauma-informed care looks very different. There are a lot of layers to trauma. It is complex. There are a lot of assumptions made to fill the void of understanding about trauma, how it presents for different people, and how it affects health and behaviour. In addition, it is now understood that **ACEs – adverse childhood events**[9] **–** impact the entire human system. So much stress has happened and continues amongst FNIM people, underlying today's health issues. It layers on top of itself over time, accumulates. This is why FNIM people often experience several comorbidities at once. Much needed trauma-informed care to support healing is largely non-existent within FNIM communities, while trauma-informed care is also lacking in mainstream healthcare services, causing harm to FNIM community members when they access those services.

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[9] For more about the ACEs study: https://www.cdc.gov/violenceprevention/aces/about.html

Another element in the tapestry is the **impact of the environment on health**. It is not just the land-based medicine one takes. For land-based medicines, it is how one harvests them, the teachings that go along with them, the spirits that are invoked. It is about relationships and connection to land.

An example was given of a participant's brother with very aggressive cancer. He had received early screening that did not help. The question was – why was it so aggressive? Akwasasne in the 1970s was the most polluted place in Canada due to its position on the St Lawrence seaway as well as Montreal's industries surrounding the community. There was no environmental accountability, resulting in toxic metals in the water, ground, and air. A government order was given so community members could no longer eat or drink anything from the lands or waters, limiting their dietary options. Members of this community had to eat processed foods and drinks from the corner store, which gave rise to many other health issues like diabetes and fatty liver. These are the determinants of health in action. We have to understand the interconnected problems to find solutions that work.

Basic skills like cooking are lacking. As mentioned, because of the contamination of traditional food and water sources, Akwesasne's community members were ordered not to drink the water or eat food from the land or waters, so buying processed, pre-made food replaced growing and eating from the land. Residential schools cooked poor food. Former students never learned cooking skills, never learned about nutrition or healthy eating, never learned harvesting, preparation, or preserving. Instead, they **learned helplessness. Communities need to be able to bring back basic skills like community gardening, harvesting, and cooking. The healthiest FNIM communities have harvesting, cooking, and preservation skills. They know how to harvest responsibly and ethically, using cultural teachings. There are programs that successfully teach these skills, and more of these are needed**.

Canada's healthcare systems are fragmented and under-resourced. For example, there is one family physician in Akwesasne serving 14,000 people, with no additional administrative or care support, not even a medical secretary. **There needs to be a coordinated, team-based primary healthcare system to reach the stage of diagnosis.** Meanwhile, provincial government **cuts to pathology** are causing family physicians to struggle to help patients investigate possible cancers in a timely manner. If there is no pathology, they cannot achieve these outcomes. Excessive expectations are put on primary care providers because the system is fragmented. Therefore, if we rely on patient experience for outcomes measures, it must take into account that the system is in trouble, not the individual healthcare provider. **The whole model of 'having a solo family doctor' is unrealistic in FNIM communities. A whole team is needed.** As one participant said:

> "As a solo family physician, I don't have enough support, resources, [or] protocols to do proper screening. We stay with acute care and not so much preventive care in the western model. I'm trying to get a physician assistant on board. They would do protocols, bloodwork, make appointments for me as a physician to follow up, to make my work more efficient. Teams! I need team-based care. Provide resources in the community to train people in the community to be physician assistants and other team members. That's what we're doing right now. Re-thinking the way we do things. We really have to move to a team approach and away from hierarchy. Family doctors are currently the bottleneck in this system." Community workers are needed to go out and find people or they will not come in, including people at a higher risk for cancer like people living with diabetes or HIV. Medical assistants are needed as there is so much follow up and paperwork (electronic or otherwise) with each appointment.

Akwesasne is a First Nation that crosses the Québec, Ontario, and New York borders. Most community members live on the Québec side of the border, but the Québec government provides no funding for healthcare to Akwesasne, because they do not speak French. There is no communication or collaboration between the Québec and Ontario governments related to healthcare. Fragmentation is also between the federal and provincial governments. There is intra-provincial fragmentation. As a result, when systems are set up, they are not necessarily accessible. It is important for a key message of All.Can Canada to not just be “early diagnosis” but rather, **“ensure the systems are in place so that people can get diagnosed.”**

In addition to all of this fragmentation diluting the resources that do exist, often to such an extent that they do not make it to where they are needed most, another example of **under-resourcing** are the gaps in coverage under **First Nations Inuit Health Branch (FNIHB).**

Relationships are core to building and sustaining trust. As one participant stated, “Relationships are built over a hundred cups of tea.”

> **There is a lack of safe spaces to voice opinions at all levels of healthcare (micro, meso, and macro) so FNIM people will not say what the issues are. Distrust is built and sustained.**

As a participant said,

> **“I don’t believe in the medical system any more because of the suffering and trauma that I had to go through.”**

What are the ways to undo stigma and suspicion of western treatment? Some traditional medicine practitioners push people away from western medicine; ideally, the two approaches must work together. Traditional healers have a lot of power in FNIM communities; they can be very helpful and they can be very hurtful. A participant shared,

> **"Traditional healers try to do the work that needs to be done. Some do not understand this larger, historical dynamic of the systems and what has happened that is negatively influencing them. We need to slowly introduce both worldviews and walk in both worlds. When FNIM peoples are introduced to the healthcare system, traditional healers, elders, and other community healers must be able to walk alongside them."**

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These quotes also point to another theme: the need to **integrate community-based strengths and traditional healing practices and resources with Western medical practices and resources as part of healthcare teams, including primary healthcare.** Traditional and Western ways of health and healing need to work side-by-side in providing healthcare for and with FNIM communities to "[e]mpower people in order to choose their own path." Ontario has Indigenous Primary Health Care Organizations as a model for additional resourcing and adaptation across Canada's jurisdictional healthcare systems. Alaska has the Southcentral Foundation NUKA model of care that is an example for adaptation in Canada's FNIM communities.[10,11] Family support was also named as a community strength that should be nurtured pre-diagnosis and throughout the care continuum.

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[10] For more about Indigenous Primary Health Care Organizations: https://iphcc.ca/about-the-iphcc/

[11] For more on Southcentral Foundation's NUKA model: https://www.southcentralfoundation.com/nuka-system-of-care/

FNIM communities need the ability to fund and mobilize the community strengths and resources that are already present in their communities and take culturally relevant, community-based approaches. Another example of such an innovative approach to care that was discussed relates to the role of telehealth. Participants felt that medical care should be taken to communities. Telehealth should help build connections and prepare for in-person visits. Bring services to people; do not expect them to come to urban centres. There is a support system around the patient in the community. Put funding on the ground for doulas, midwives, other community healers and strengthen the connections at grassroots levels instead of communities needing to wait for urban experts to come to the community. **There are go-to people in FNIM communities but there is no money for them, so this lies to the side, and is not an integrated part of healthcare.** As a participant shared, “We know who to go to in our community, who has the knowledge – different people have different kinds of knowledge. You don’t just go to any older person and expect them to know about cancer. Go to a traditional healer for this.” **Culture is at the centre of community-based care.** For example, cultural conceptions of time are different and **funding models that are tailored to support locally defined approaches** would address this. For example, in the western system, time is set in advance for a doctor’s appointment. A participant said,

> **“We just get people when and where we get them. You can’t do this in a western system... There are limitations of the system where you can only ask one thing per appointment. Best practice is care with long appointments and the patient can discuss as many things as needed.”**

Digital inequities include lack of consistent, stable internet connection, cellular phone service, and applications in FNIM communities. For many FNIM communities, digital information and communication are inaccessible.

There is a lack of FNIM-specific data. There are opportunities to improve innovative, community-based, and strengths-based data collection and use. If communities do not know the numbers, anecdotal evidence cannot be supported. Communities need two different ways of supporting FNIM facts – quantitative and qualitative – so that evidence-based grants and proposals can be prepared for funding to scale up and improve care on the ground. There are opportunities to learn how to measure things in unique ways that could really help.

For example, an Indigenous way to collect data could be to get “busy body” women in the community to gather all the known information about disease and illness locations (hot spots), in order to identify geographical, occupational, or other patterns. The community can use the information to prepare proposals for environmental clean up of certain areas to improve health outcomes. Data are powerful and FNIM communities have a lot of qualitative data. Indigenous powers of observation and knowledge sharing are very impressive, so narrative medicine is a powerful approach for FNIM communities. Fund innovative community-owned data collection and use in order to support strengths-based, capacity-building approaches to solving FNIM health issues.

While Akwesasne have data on their community, they must be gathered from many different places because of provincial and international borders. **Data fragmentation** also means a slow healthcare system. Slow communication between physicians and other providers means time with no action being taken as patients lie in hospital for days, causing poor individual outcomes and systemic backlogs. Data and information are not flowing. For patients with digital ability, they have no access to their e-records and no data portability, so they cannot carry their personal health information with them from provider to provider.

Themes - Equitable Future State & Opportunities

An equitable future state of cancer diagnoses in Canada consists of...

...**health care systems** that:

- Actively consider **Indigenous worldviews and determinants of health** such that people working within Canada's healthcare systems are able to better understand the relationships between different worldviews and individual health outcomes, including the ongoing impacts of intergenerational trauma and the importance of FNIM community-owned, cultural reclamation in healing and health. This requires **ongoing education** of people working within health ministries and health authorities so they can make better informed decisions when allocating funding and resources, creating legislation, regulations, policies, and practices that define and shape our healthcare systems.

- Provide **FNIM communities with flexible, multi-jurisdictional funding so they are able to mobilize innovative, culturally specific, trauma-informed, community-owned approaches and resources that are already present in their communities and that address local realities and needs.** Such approaches will build capacity and promote circular models, rather than linear bottlenecks.

- **Reduce fragmentation,** including in the approaches to funding and resourcing.

...**health care services** that:

- Consider and address **Indigenous worldviews and determinants of health**. This requires **ongoing education** such that healthcare services are more **culturally safe and trauma-informed**.

- Operate from a foundation of **team-based, community-based, trauma-informed, strengths-based primary healthcare that embraces both western and FNIM medical knowledge and practices**. Ontario's Indigenous Primary Health Care Organizations and Alaska's Southcentral Foundation NUKA model of care are existing examples from which to learn.[12,13]

- Have **enough flexible funding, human resources, and supportive infrastructure.**

- Have clear **pathways from community-based care, especially primary healthcare, to secondary and tertiary care, including pathology during cancer investigations.**

...all of which is supported by **data and information** that...

- Use **FNIM community-owned and strengths-based methods of data collection and use.**

- Are **real-time, interoperable**, and **portable**.

Opportunities to move towards this **better future** together include:

- **Focussing on the systemic issues** to "ensure the systems are in place so that people can get diagnosed"; and

- **Working with strengths-based, hopeful early adopters.**

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12. https://iphcc.ca/about-the-iphcc/
13. https://www.southcentralfoundation.com/nuka-system-of-care/

Proposed Next Steps

ACC members are deeply grateful to all participants who took invaluable time to share their professional and lived expertise. Many individual stories were generously shared that clearly demonstrate the individual and community harms caused by systemic issues as well as solutions that strengthen FNIM capacities and relationships, better addressing root causes through healthcare services.

While All.Can Canada acknowledges the tapestry of worldview and structural determinants of health that affect healthcare access and health outcomes, ACC's responsibility is to act with this understanding from ACC's place within that fabric: improving timely, accurate and well-communicated cancer diagnoses.

Below are three possible next steps to be undertaken with interested community members or groups in the lead with ACC providing supportive resources:

Possible Next Steps

1. Revise All.Can Canada's Current State Infographic, Future State, and Recommendations to reflect what was learned at the Roundtable for use in co-designed knowledge mobilization efforts with relevant decision-makers, provider associations, and other stakeholders across Canada;
2. Create 'Equity Spotlights' that feature stories shared by Roundtable participants of harm within Canada's healthcare systems; unpack the systemic issues; and present solutions, also for use in co-designed knowledge mobilization efforts with relevant decision-makers, provider associations, and other stakeholders across Canada; and
3. Feature the voices of interested FNIM family physicians in discussing the challenges and opportunities to improving FNIM communities' cancer diagnoses as part of ACC's planned communications strategy focussed on reaching primary care providers across Canada.

All participants are now being asked: **Which next steps, if any, do you consider to be a priority? Would you be interested in possibly participating in helping lead the work, with robust support from All.Can Canada?**

ACC's Steering Committee will listen to participants' feedback to finalize ACC's prioritization of next steps with interested community members and/or groups in the lead and will ensure the needed resources are dedicated to supporting these efforts.

Internally, ACC will also implement an ongoing cultural humility plan (see Appendix 2) for all existing members, which will also be offered to all new members as part of their onboarding to ACC.

Finally, participants interested in possibly becoming a new member of the Steering Committee, any of the Working Groups, or to be engaged in other ways (see Appendix 4 for ACC's current governance structure) are asked to email Taylor Tomko at all.can@saveyourskin.ca.

Appendix 1: Participants

Cate Ahrens*	Health Promoter, Parkdale Queen West Community Health Centre *support to Vivian Recollet
Alexandra Barlow	Indigenous Primary Health Care Council
Tara Bond	Alberta Health Services, Cancer Strategic Clinical Network
Sharon Clarke	Saskatchewan Health Authority, First Nations & Métis Health Services
Dr Ojistoh Horn	Family Physician, Akwesasne & Board Member, Canadian Association of Physicians for the Environment
Dr Veronica McKinney	Northern Medical Services, University of Saskatchewan

Appendix 2: All.Can Canada Cultural Humility Plan

As an outcome from the All.Can Canada Optimizing Equitable Cancer Diagnoses in Canada Roundtable, members of the All.Can Canada Steering Committee and Working Groups will be undergoing cultural humility training to provide our members with the tools and praxis to more effectively and respectfully engage with structurally underserved populations. This training is voluntary, not mandatory, though we will be prioritizing ACC members who have received this training in our equity-oriented projects. Fees for this training will be covered by All.Can Canada. These trainings and resources will be offered to all new members of ACC on an ongoing basis. Our hope is that ACC members will bring learnings from these sessions not only to their work with us, but back to their teams, partners, and healthcare practices.

Our intentions for 2024 are to run three separate courses of training in group sessions through the programs Whiteness at Work, Trauma Informed Victim Advocacy (by Justice Clearinghouse), and Working Effectively with Indigenous Peoples (by Indigenous Corporate Training).

We have also been compiling an ongoing list of free online resources and book suggestions for our members. Any suggestions for this list, or comments on this programming, are always welcome.

Appendix 3: Evaluation Results

Unfortunately, we were unable to get a robust response to the evaluation survey. Below is the response received.

1. What is resonating most for you at the end of this event (i.e. a question, a new idea, a feeling)?
The collaborative spirit between all participants - respectful and open with comments!

2. What part of the event worked best for you? Why?
The meeting was so very well planned that the process was smooth and we moved easily into the discussions and presentations

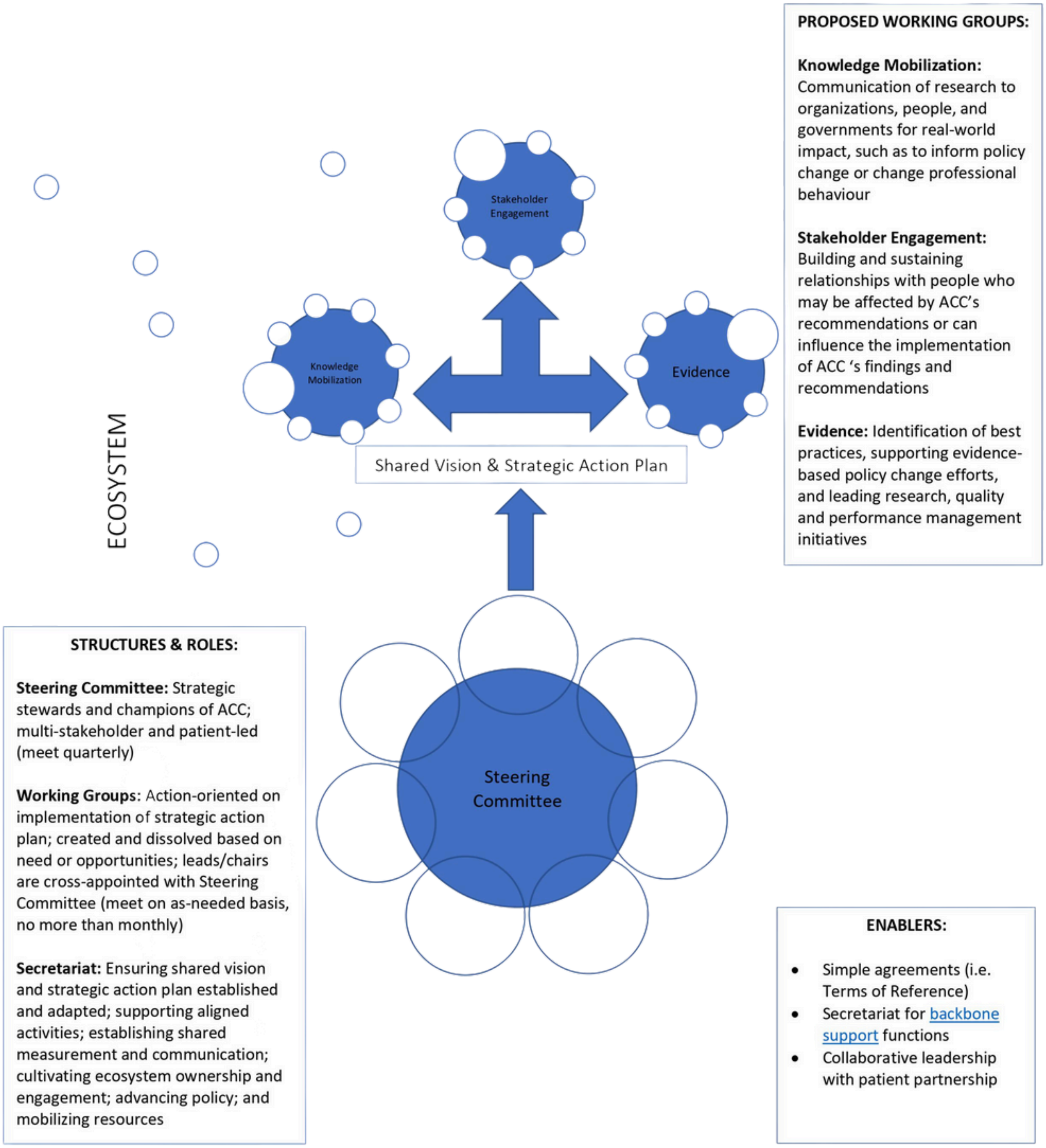
3. What part of the event worked least for you? Why?
Being on the 33rd floor is scary! lol But I managed! It was a beautiful venue.

4. Please rate the various elements of the event:

	Dissatisfied	Satisfied	Very Satisfied
Facilitation (plenary)			x
Facilitation (breakout)			x
Agenda			x
Venue			x
Catering			x
Pre-Meeting Communications			x
Pre-Meeting Material			x

5. Any last comments?
These opportunities to be in the same room with such caring, wise and dedicated people was inspiring, a great learning experience and rich in content that should be gathered for creating a foundation for future work. It was excellent! Thank you all!

Appendix 4: ACC Governance Structure



PROPOSED WORKING GROUPS:

Knowledge Mobilization: Communication of research to organizations, people, and governments for real-world impact, such as to inform policy change or change professional behaviour

Stakeholder Engagement: Building and sustaining relationships with people who may be affected by ACC's recommendations or can influence the implementation of ACC 's findings and recommendations

Evidence: Identification of best practices, supporting evidence-based policy change efforts, and leading research, quality and performance management initiatives

STRUCTURES & ROLES:

Steering Committee: Strategic stewards and champions of ACC; multi-stakeholder and patient-led (meet quarterly)

Working Groups: Action-oriented on implementation of strategic action plan; created and dissolved based on need or opportunities; leads/chairs are cross-appointed with Steering Committee (meet on as-needed basis, no more than monthly)

Secretariat: Ensuring shared vision and strategic action plan established and adapted; supporting aligned activities; establishing shared measurement and communication; cultivating ecosystem ownership and engagement; advancing policy; and mobilizing resources

ENABLERS:

- Simple agreements (i.e. Terms of Reference)
- Secretariat for backbone support functions
- Collaborative leadership with patient partnership

Appendix 5: Sponsors

Thank you to all of the sponsors of the All.Can Canada Optimizing Equitable Diagnoses in Canada Roundtable. Your generous, unrestricted grants enabled this successful event.

Thank you to AstraZeneca for the in-kind support of the meeting venue.

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