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Advancing health equity for underserved and priority populations: CANO/ACIO and Canadian Cancer Society (CCS) Joint Symposium

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ABSTRACT

Advancing health equity is imperative to reducing the current social and health inequities that impact those at risk of or diagnosed with cancer. The CANO/ACIO National Underserved and Priority Population (UPP) Working Group and the Canadian Cancer Society (CCS) partnered to create a forum for dialogue at a joint symposium during the 35th Annual Conference. The symposium began with a presentation of findings from a CCS-led nationwide project that focused on advancing equity for 10 underserved communities or groups. The aim of the CCS project was to understand gaps, barriers and challenges that underserved communities face in accessing information, support and care; the report is foundational to guide engagement efforts and strategies for key underserved groups across Canada. To situate the goals of advancing health equity, oncology nurses shared experiences of community engagement, partnerships and tools used in practice. This paper will provide a synthesis of the CCS report along with panel members' experience on ways in which healthy equity was advanced in their communities and settings.

Keywords: health equity, underserved, priority populations, symposium, community engagement, cancer information, cancer support

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INTRODUCTION

A significant body of evidence has highlighted health inequities that exist in cancer and cancer care among underserved groups across Canada. As a result, there has been a heightened focus on advancing healthy equity among cancer care and non-profit organizations. Investment in health equity is evident with strategic goals of cancer care plans across the country, including the Ontario Cancer Plan (Cancer Care Ontario, 2019), Cancer Care Manitoba (2020), and the Cancer Care Health Equity Collaborative in British Columbia (BC Cancer, n.d.), as well as non-profit organizations, such as the Canadian Partnership Against Cancer (CPAC, 2017). Likewise, the Canadian Cancer Society's (CCS, 2023a) commitment to advancing health equity was highlighted by the recently released nationwide project findings, which were important to share with oncology nurses across the country. The CCS report (2023a) illuminates the gaps, barriers and challenges that are faced by 10 populations, who experience inequities in cancer information and support in Canada.

CANO/ACIO (2022) 2021–2025 strategic plan aligns with other organizations' goals to address social injustices and health inequities in cancer care, thus leading the way for collective action by hosting a symposium. The CANO/ACIO-CCS symposium addressed these common goals through sharing the findings of the CCS health equity report (2023a) followed by a panel discussion. The panel consisted of oncology nurses sharing experiences of ways in which they embraced social justice work to advance health equity in their practice settings. The following paper provides a summary of the CCS presentation, four experiential accounts from CANO/ACIO panel members, and a brief discussion of the implications for oncology nursing practice.

ADVANCING HEALTH EQUITY IN CANCER INFORMATION AND SUPPORT SERVICES ~ ELIZABETH HOLMES AND APIRAMY JEYAPALAN

The CCS is Canada's largest national cancer charity. In addition to funding cancer research and advocating for healthy public policies, CCS offers information and support programs for people with cancer across their cancer experience. In 2019, CCS initiated the underserved communities project to identify populations that faced individual, community and systemic barriers to accessing cancer information, support, and practical services. A full report of the project findings presented during the symposium was released on the CCS website on October 31, 2023, and is available at cancer.ca/HealthEquity. A new section on the CCS website was created, called 'Our health equity work', which features the new CCS health equity report (2023a), a plan for underserved and health equity work related to CCS research funding, information on

cancer data, advocacy information, and how existing CCS programs are tailored for communities that are underserved. In the following paper, a synopsis of the symposium presentation is shared including the purpose of the underserved communities project data collected for the report, recommendations, and the CCS plan in moving forward with health equity work.

The purpose of the CCS underserved project (2023a) was to understand gaps, barriers, and challenges, faced by selected communities or groups and to outline opportunities and tactics to ensure that all people in Canada have access to cancer information, support, and practical services when they need it the most. In line with the CCS (2023b) organizational values of being courageous, united, caring, and rigorous, seven guiding principles were embedded in this work and now guide all of the CCS mission work (see Figure 1).

The CCS has defined an underserved community in the context of health services as a population that is provided inadequate service and is systemically disadvantaged due to reasons including, but not limited to, race, age, language, geography, gender identity, sexual orientation, and socioeconomic status (adapted from Arya & Piggott, 2018). The terms "underserved community" and "communities that are underserved" are used intentionally at CCS to reflect the responsibility the healthcare system and support providers have in providing cancer information and support services to communities that experience health inequities. This term places an emphasis on the surrounding systems that need to change instead of on the community or individuals.

For the initial underserved project, CCS explored how to better meet the needs of communities or populations that were underserved by CCS information and support services and identified 10 underserved communities from 25+ sub-groups named in the literature: 1) 2SLGBTQI+ communities; 2) adolescents and young adults with cancer; 3) people with advanced cancer; 4) communities that don't speak English or French; 5) Indigenous communities; 6) newcomers to Canada; 7) older adults; 8) racialized communities; 9) individuals diagnosed with rare cancers; and 10) rural and remote communities. The communities featured in this report were identified through a collaboration between CCS and the Canadian Partnership Against Cancer over the course of the project, by looking at specific communities that experience challenges and barriers in accessing cancer information and support. The CCS recognizes that these are not the only communities underserved by CCS or the healthcare system. As a starting point, CCS began our work with these groups on specific projects, and plans to add more that are underserved over time.

Data Collected. In considering the work with the identified communities, applying an intersectionality lens was critically important. Intersectionality, coined by Kimberlé Crenshaw, acknowledges that people's experiences are shaped by a combination of social identities, including gender, race, age, and others, that intersect with the social determinants of health (Knowledge Translation Program, 2017). These experiences interact with systems and structures of power, such as sexism and racism, that collectively disadvantage some groups over others. By understanding how different forms of inequality intersect and impact each other, information and support providers may address the needs of underserved communities better.

For this underserved project and report (CCS, 2023a), CCS did not engage directly with the underserved communities, and this was intentional. The primary goal was to understand the issues through the evidence and through stakeholder engagement with organizations that serve these communities. Future steps in the work at CCS aim to engage directly with the

Figure 1

Canadian Cancer Society's Mission Guiding Principles

underserved communities to incorporate valuable perspectives of people with lived experience. Data were collected from literature reviews, document reviews, and stakeholder interviews. Over 30 key informant interviews were held with staff from the CCS, patient advisory groups, and organizations that serve underserved communities, along with cancer agencies nationally and internationally.

Recommendations. For each of the 10 communities, specific gaps, barriers, and challenges were identified along with opportunities and recommended tactics to improve cancer information and support services. Informational needs, psychosocial needs, financial challenges, and transportation challenges were some examples of barriers and challenges identified. Five actions were developed and recommended for organizations that provide cancer information and support services, to help ensure that people in these communities receive appropriate information, supports and resources.

- The first recommended action is to conduct dedicated training for staff of these organizations to ensure they understand the gaps and barriers that underserved groups face and how to engage with them. Of importance, the provision of training should be built into onboarding of new staff and refresher training should be offered as new information becomes available.
- The second recommended action is to evaluate internal capacity to conduct meaningful engagement with communities. In this step, it is critical to assess organizational readiness, to ensure there are sufficient resources for initiatives and staff capacity to undertake this work, and there is a long-term sustainability plan to continue the work.
- The third recommended action is to prepare for meaningful engagement with communities. Staff engaging in this work must be trained on the needs and sensitivities of the community, cultural competency, and inclusive best practices before engagement begins.
- The fourth recommended action is to engage and co-design with communities to validate needs, opportunities and tactics. This will require actively engaging and involving communities from the onset of the project, to prioritize and build solutions based on their identified needs.
- Finally, the last recommended action is to co-create an evaluation framework to monitor the impact of information and supports provided. In this step, clear standards and expectations must be set together to measure performance and improvement.

For CCS, the report represents a point in time for the organization's work, which started five years ago when CCS committed to identifying communities underserved by CCS and the healthcare system, and understanding gaps and challenges in providing information and support in a meaningful way for these communities. The report addresses the 'what we know' and 'what needs to be done'.

Moving Forward. While CCS still has work to do in learning and improving practices, many of CCS's existing programs either have tailored elements for communities that are underserved (e.g., staff training, interpreter services) or programs, which are co-designed with these communities. Over the next five years (2022–2028), CCS will continue to work toward reducing health inequities for underserved communities across the cancer control continuum by reducing barriers, increasing access, supporting communities through CCS offerings, and advocating for systemic changes to health systems. This work requires developing and building partnerships with communities that are underserved and organizations that work with them to understand the unmet needs within the communities and co-build solutions with them. This vision will be embedded in all our work across the CCS teams and programs.

In summary, people with cancer face many challenges while navigating their cancer experience; they have many needs including physical, emotional, social, psychological, informational, spiritual, and practical. Many of these needs are complicated and can be worsened through systemic disadvantages. The evidence gathered through this CCS project will guide engagement efforts and strategies to serve underserved communities better with information and peer and practical supports in a meaningful, evidence-informed way. The CCS encourages other organizations to co-develop tailored initiatives with underserved communities, guided by the perspective of people with cancer from those communities. The CCS acknowledges responsibility to provide cancer information, support, and practical services to these communities, to advocate for healthy public policy, and to fund research focused on advancing health equity.

Everyone needs and deserves cancer information and support following a cancer diagnosis, but not everyone receives it, let alone where, when, or how they need it to have the biggest impact. Information and support providers can change how to work in small and big ways to ensure everyone in Canada with cancer receives high quality, accessible information and support. CCS is committed to supporting underserved communities that are impacted by cancer.

COMMUNITY ENGAGEMENT AND PARTNERSHIPS ~ JOANNE CRAWFORD

As an oncology nurse who witnessed disparities in an ambulatory cancer clinic, moving to upstream and community-based work in public health was 'an eye-opener'. Working with communities who experience inequities provided a more fulsome picture of the context of their realities and highlighted gaps in information, access, and uptake of preventive or health care recommendations. We know that population-based screening programs exist, but given they are tailored to the general population, those groups with low English language proficiency, low health literacy, and other socio-cultural (i.e., low income) and structural (i.e., racism) determinants experience inequities in accessing information or services. To implement population health strategies, we need to also focus on the high-risk groups.

In public health, there were numerous initiatives within our Chronic Disease Prevention: Early Detection of Cancer Team that were influential in advancing health equity. My work in community within public health was aimed at promoting access to health, cancer information, early detection of cancer, and screening services.

Community engagement is the foundation to learning more about strengths, assets, and needs of a population who experiences social and health inequities, to work on the social determinants of health and advance health equity. Therefore, the main focal point for our team was to develop collaborative relationships with priority populations, such as immigrant, low income, and Indigenous communities. The communities that we worked with had significant disparities in accessing knowledge about healthy behaviours, risk reduction, screening, and timely diagnosis.

One important initiative we worked on that involved community engagement, partnerships, and relationship building was directed to address the low uptake of screening for cervical and breast cancer among immigrant and refugee women in Hamilton, Ontario. Our team worked with members of four immigrant communities and co-created strategies that immigrant communities felt would be best to meet their needs for health information and screening. In collaboration with members from Arabic, Chinese, South Asian, and Vietnamese immigrant communities, we developed a project to deliver women's health sessions. Sessions needed to be culturally adapted to each community; therefore, we embedded the information on Pap tests, knowing your breasts, clinical breast examinations, and mammography within the sessions as women were less likely to engage if we used the term "cancer" in our outreach strategies. As part of the initiative, peer health educators were utilized. The peers were women from the respective communities, who were multilingual and experienced in the sociocultural context of these communities. The peer educators served as a bridge to the community; they facilitated communication, language and cultural support, coordinated and accompanied women to screening, and indirectly assisted women to learn the bus system or navigate other social and health services. We, as nurses, provided mentorship for the peers and consulted on coordinating services for follow-up on abnormal Pap test or mammography results, often supporting women to attend these appointments. Some key features of the initiative were various partnerships we created. For example, we created partnerships with

- a female clinical nurse specialist working in an ambulatory setting providing clinical breast examination and Pap testing, and directing women to the mammography suite in the same setting (if eligible);
- a volunteer Zonta club who provided a van to transport groups of women from one cultural group to mammography screening or the ambulatory setting for both screening procedures;
- Ontario Breast Screening Program sites – as part of this partnership, we were able to raise awareness and understanding of nurse examiners about the sociocultural beliefs, attitudes, and needs of these diverse women groups.

Eventually, the project became a funded program in Public Health and peer educators became public health professionals. Formal evaluation demonstrated improvements of health literacy, and uptake of screening among immigrant women in our community (Crawford et al., 2015). To date, peer health educators continue to be mentored by nurses to promote chronic disease prevention.

The initiative served as a foundation for other initiatives that utilized the same community engagement and relationship building strategies to engage and work on advancing equity. One project aimed toward promoting primary and secondary prevention involved working with the entire Central West Region of Ontario, promoting breast, cervical, and colorectal cancer screening among key low-income communities. Another involved partnering with South Asian immigrant communities to gain insights about their knowledge and understanding of colorectal cancer screening. Lastly, I am working on a funded partnership development grant in Niagara, which is mobilizing knowledge of newcomers to Canada, with respect to health literacy and other intersecting social determinants to advance equity within a social justice lens.

SYSTEMS CHANGE AND MOBILIZATION ~ JAGBIR KAUR

As part of a team of embedded health researchers at BC Cancer, focused on advancing health equity within the cancer care sector, we recognize that strategies to improve equity must address both individual and system-level factors. Meaningful change requires a comprehensive approach that enhances the capacity for equity-oriented care across the board. These insights emerged from a project co-led by Drs. Leah Lambert, Michael McKenzie, and Sally Thorne, and an interdisciplinary team of healthcare providers, researchers, and system leaders. The work was aimed at identifying priority areas for advancing equity within cancer care. Engagement sessions with policy leaders, healthcare providers, and community-based health and social service providers facilitated dialogue and collective priority setting. Through these discussions, five key priority areas for action were identified, many of which focus on the systemic changes necessary to achieve lasting progress in moving toward more equitable cancer care. The following paragraphs present the priorities for BC Cancer.

- A critical enabler of this work is ensuring meaningful commitment and "buy-in" from leadership. As one participant noted, advancing equity often requires bold vision and "a threshold for risk" to drive the system-level changes needed. In our experience, leadership commitment was strengthened by involving them at every stage of the work and aligning initiatives with key organizational priorities.
- The second priority emphasizes the importance of knowledge mobilization and staff training to raise awareness and improve understanding

of health and healthcare inequities, including the underlying factors that contribute to them.

- The third priority focuses on recognizing the impact of social and structural determinants of health. Foundational documents, such as the CCS's (2023a) report on underserved communities, highlight the profound ways these determinants shape cancer experiences and outcomes. By acknowledging that these are the root causes of inequities, we can shift the narrative from individual-level factors to the broader structural forces at play. To adequately address these social and structural determinants, we need to build new intersectoral collaborations across the cancer care continuum. These partnerships are essential to tackling the complex and intersecting nature of health inequities.
- Finally, the fifth priority centres on developing metrics and equity-sensitive data indicators to understand system-level gaps and better. Measuring progress will require the development or identification of equity indicators that can track improvements and highlight areas for further action.

Collectively, these priorities represent the critical pathways for system change and mobilization that can support individual clinicians and remove system-level barriers to advancing equity. The priorities have been pivotal in shaping our team's efforts toward more equitable cancer care in British Columbia. For more information on this initiative, please access the infographic using the following link (https://www.bccrc.ca/dept/nahr/dept/nahr/dept/nahr/dept/nahr/sites/nahr/files/Infographic_Equity-Oriented_Cancer_Care_FINAL_0.pdf).

INTEGRATING EQUITY INTO CLINICAL PRACTICE ~ GABRIELLA WONG KEN

Throughout my oncology nursing career in inpatient and ambulatory clinical settings, I have witnessed the difficulties that patients face in receiving equitable cancer care, and how nurse-patient interactions can hinder or address these inequities. Although oncology nurses are required to provide equitable care and consider social justice in their work, this part of their jobs is often limited as they are taught to address specific patient concerns rather than consider broader systemic impacts (Truant, 2017; Horrill, 2022). I have found, in my own role, that it can be challenging to manage the demands of patient care and the expectations set forth by decision makers, while also addressing the unique needs of patients that extend past immediate treatment requirements. However, addressing challenges with small interventions, community organizing, and advocacy has allowed me to meet the needs of the patient populations I serve better.

My primary work environment is the ambulatory clinic at Peter Lougheed Centre in Calgary, which serves a large newcomer population, as well as individuals who are living on low income, and some who are living in transitional or supported housing. Our clinic team is often addressing patient concerns outside of direct treatment needs, in part due to our patient populations. By understanding the impact of the social determinants of health and learning about the specific factors that may influence the health of the patient, we can support and care better for the patient as a whole (Nolan et al., 2021). For example, our patients may be interacting with the healthcare system for the first time; they may have language barriers, cultural differences that affect their view of health, managed and unmanaged mental health issues, as well as challenges accessing transportation, housing and food. In my practice, acknowledging these factors as impactful to patient care and assessing where patients may need more support has helped our team provide more equitable care.

A common challenge our clinic faces is scheduling, and late and missed appointments can have a large impact. Instead of assuming that patients are non-adherent with attending treatment appointments on time, we consider other factors, such as transportation, and attempt to address this need with bus tickets, taxi vouchers, or applying for external transportation through public or private providers. I often collaborate with our clinicians, educator, and management, who also understand the importance of providing additional support to patients. Ultimately, changes in policies and larger systemic actions are needed to combat health inequities; however, actions at the individual provider level can still be meaningful (Truant, 2017; Mayden 2021) and engaging in small interventions can be helpful. For example, providing patients who we know are facing food insecurity with snacks and meals, while in our clinic for treatment, has improved adherence with appointments, and built a more trusting relationship between nurses and patients. Even if the challenges our patients face are outside of our capacity to fully address them, acknowledging the impact and intervening where we can, has been meaningful for many of our patients. For example, we can provide information on services which are available within the local community to assist with meeting basic needs, such as food pantries, peer support, and shelters, as well as referring patients to social work or the Addiction Recovery and Community Health program in the hospital, and publicly funded or non-profit transportation services.

Being involved in community efforts through volunteering and organizing also has helped me assist patients who are facing challenges due to the social determinants of health. Regular interaction outside of a clinical setting with folks who reflect the populations I care for has given me greater insight into available resources and the ways in which community supports can influence health status. I have dedicated significant time outside of my work environment to co-create initiatives that aim to address barriers in innovative ways. Examples of these initiatives include 1) a community fridge housed outside of a community centre in SW Calgary which is providing 24/7 access to free food; 2) a non-profit 'pay what you want' store providing clothing and hygiene items to people regardless of their ability to pay; 3) a community health clinic offering low-cost adjuvant services and health education,

and; 4) a community farm connecting individuals to local food and the mental and physical benefits of gardening. Through these initiatives, I have witnessed the intersections of the social determinants of health, such as the impact of food, education, and income, on the overall wellbeing of patients. In addition, I have expanded my knowledge on the systemic effects of inequity and of community organizations and resources that can assist patients who require additional support.

As a nurse, I believe it is an imperative part of my role to be an advocate for patients, the profession, and the healthcare system. Although nurses often consider themselves to be patient advocates as individual providers, they may not consider the importance of advocacy outside of the clinical setting (Horrill, 2021). However, nurses should confront the primary source of inequities through leadership and policy changes along with individual actions (Truant, 2017). Nurses are intrinsically tied to policy decisions as a unionized, publicly funded profession, and ultimately, changes at a systemic level impact daily patient interaction. Being involved in community organizing initiatives has reiterated for me the importance of political involvement and policy education, as it is the only way to truly create equitable healthcare systems. Although individual patient interventions, volunteering, and community involvement as described may improve immediate outcomes for patients, advocacy at a broader level is how we will ensure equity is fully integrated into clinical practice.

BUILDING KNOWLEDGE, AWARENESS, AND SKILLS ACROSS ONCOLOGY PRACTICE ~ ALLISON WIENS

In my current role as the Education & Liaison Nurse – Health Equity the Underserved Populations Program (UPP) at CancerCare Manitoba, I have worked to provide direct support to patients, families, and communities that experience inequities in access to cancer care across the cancer continuum. The direct connection with people and communities along the cancer continuum has enhanced my understanding of the systemic inequities and potential methods to address them through nursing practice, education, and change initiatives. This is accomplished by developing relationships with people and their communities (personal networks of support and broader community) to develop an understanding of who they are, what is important to them, and what and how the system is underserving them. Through this understanding, care plans can be developed that centre the needs of the person and community accounting for the gaps and barriers and ways to address these.

Along with the UPP, we have been developing and conducting staff training related to health inequity and actions toward health equity, thus focusing on one of the recommendations of the CCS Health Equity Report (2023a) on underserved communities. The education has included the creation of Health Equity Week, which provides learning from people with lived experience, content experts, and those working in the Manitoba cancer care setting to increase awareness, knowledge, and skills to advance health equity. Each year, participation has increased as well as consistent reporting of increased understanding of health inequity and actions toward health equity.

To advance health equity through system change, the UPP has co-led initiatives to 1) develop knowledge and awareness resources with people and communities experiencing inequity; 2) increase access to information related to cancer; and 3) strive to increase meaningful development of new resources and supports. The CCS Health Equity Report's (2023a) five recommendations for organizations, information, and support services, include meaningful engagement and co-design. One example of engagement leading to a community driven initiative has been the co-development of Indigenous Community Profiles. This website is one tool to support care providers in understanding important information about Indigenous communities, where known disparities in access to care, and in Manitoba specifically, exist and remoteness and isolation can impact Indigenous People along the cancer continuum. The information is offered in an effort to support the development of care plans. The key information included about Indigenous communities was informed by partnerships developed with Indigenous organizations and people with lived experience.

As mentioned by multiple panelists, key to the advancement of health equity is the commitment and dedication of an organization, meaningful engagement with people and communities being underserved, and collaboration through co-design and co-implementation.

Oncology nursing practice has a unique position within the cancer care setting. There are several roles that oncology nurses may fill within the system. With advocacy being core to nursing practice, we can all play a role in advancing health equity. Advocacy can be a tool for nurses, and has been for me, to make space and amplify the voices of people experiencing inequity in direct patient care through person-centred care plan development, developing and implementing education and awareness initiatives that are grounded in health equity and social justice, and leading system change through co-developing and co-implementing change with people experiencing inequity.

CONCLUSION

The CANO/ACIO-CCS symposium provided an opportunity to share a valuable new resource that oncology nurses working along the cancer control continuum may use in practice, research, and education. The CCS Health Equity Report (2023a) provided key recommendations and tactics to advance health equity among the 10 communities identified as underserved in the context of health care. Importantly, we must recognize that some individuals will face unique needs when it comes to their cancer-related knowledge, diagnosis, their age or life stage, the language spoken or where they live. Many communities face systemic racism, marginalization, discrimination and stigma;

and this impacts their overall health, not just their cancer diagnosis and experience. Foundational to understanding health inequity for oncology nurses, is the importance of understanding that there is diversity within each underserved community. Not every person in an underserved community will face the same gaps, barriers, and challenges regarding their cancer experience. Therefore, it is important to embrace cultural humility and be attuned to the intersecting social identities, the interplay of the social determinants, and systemic barriers that collectively disadvantage some groups over others, and to continue to work toward advancing health equity.

The CANO/ACIO panel provided examples of the active work of oncology nurses who, in their daily work, strive to advance health equity across the country. We believe there are many more stories of nurses who are working collaboratively with similar communities, building relationships and partnerships, and leading the way to advance health equity through locally and culturally relevant strategies and policy changes.

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