

# Cancer Care Vision

A Living Framework for Quality and Priorities  
in the Northwest Territories

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# Feuille de route pour les soins oncologiques

Cadre évolutif régissant les normes de qualité  
et les priorités aux Territoires du Nord-Ouest

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Government of | Gouvernement des  
Northwest Territories  
Territoires du Nord-Ouest

*Le présent document contient la traduction française du message  
de la Ministre de la Santé et des Services sociaux, du message de  
l'administratrice en chef de la santé publique et du sommaire.*





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## Message from the Minister of Health and Social Services

Cancer touches every person, family, and community in the Northwest Territories. While each cancer journey is unique, the experiences shared by residents across our territory remind us of what we hold in common: a desire for care that is compassionate, reliable, and responsive to where people live and who they are.

Over the past decade, *Charting Our Course: Northwest Territories Cancer Strategy 2015–2025* has helped us take important steps forward in Cancer Care. It fostered conversation, built awareness, and laid the groundwork for improvements in prevention, screening, treatment, and support. As our health and social services system and our communities continue to change, so too must our approach to cancer care.

This Cancer Care Vision looks ahead while also building on the strong foundation of the Strategy. It reflects what we have learned, what we have heard through engagement, and what we know about the realities of providing care across a vast and diverse territory. It recognizes that high quality cancer care cannot be one size fits all. Services must be flexible, culturally respectful, and grounded in the strengths of our communities, while also benefiting from shared standards, coordinated systems, and evidence informed practice.

Good health is shaped by many things, from individual choices and community supports, to the design of the health and social services system. This Vision acknowledges those shared responsibilities, while focusing on what the health and social services system can do best: listen, learn, adapt, and continuously improve the way cancer care is planned and delivered for the people of the Northwest Territories.

This Vision does not have a fixed endpoint. It is grounded in shared values and guiding principles that shape how care is delivered and how progress is understood over time. It is a guide for working together, with residents, families, communities, health professionals, and partners, to respond to emerging evidence, promising practices, and lived experience. By remaining open to learning and change, we can strengthen cancer care in ways that are meaningful, sustainable, and grounded in the realities of northern life.

It is my hope that all Northerners can see their values reflected in this vision and I encourage participation in the ongoing conversation about cancer care in our territory. Together, we can reduce the burden of cancer and support one another with care that is respectful, equitable, and rooted in community.

**Lesla Semmler**

Minister of Health and Social Services

Government of the Northwest Territories

# Message de la Ministre de la Santé et des Services sociaux

Le cancer touche toutes les personnes, toutes les familles et toutes les communautés des Territoires du Nord-Ouest. Bien que la lutte contre le cancer soit unique pour chaque personne, les expériences partagées par les résidents des TNO nous rappellent ce que nous avons en commun : le désir de recevoir des soins empreints de compassion, fiables et adaptés à notre lieu de vie et à notre identité.

Au cours de la dernière décennie, le document intitulé « Tracer la voie : stratégie des Territoires du Nord-Ouest pour lutter contre le cancer 2015-2025 » nous a aidés à franchir des étapes importantes dans le domaine des soins oncologiques. Il a favorisé le dialogue, sensibilisé la population et jeté les bases nécessaires à l'amélioration de la prévention, du dépistage, du traitement et du soutien. À mesure que notre système de santé et de services sociaux et nos collectivités continuent d'évoluer, notre approche des soins oncologiques doit, elle aussi, s'adapter.

La présente Feuille de route pour les soins oncologiques est tournée vers l'avenir tout en s'appuyant fermement sur la stratégie. Elle tient compte des leçons apprises, des commentaires reçus lors des échanges avec le public et de la réalité des soins offerts dans un territoire si vaste et diversifié. Elle reconnaît qu'il n'existe pas de solution unique pour assurer des soins oncologiques de haute qualité. Les services doivent être flexibles et respectueux des différences culturelles, et miser sur le potentiel des collectivités, tout en s'appuyant sur des normes communes, des systèmes coordonnés et des pratiques fondées sur des données probantes.

Bon nombre de facteurs contribuent au maintien d'une bonne santé, comme les choix individuels, le soutien communautaire et la conception du système de santé et de services sociaux. La présente Feuille de route reconnaît ces responsabilités partagées, tout en mettant l'accent sur ce que le système de santé et de services sociaux sait faire de mieux : être à l'écoute, apprendre, s'adapter et améliorer sans cesse la planification et la prestation des soins oncologiques offerts à la population des Territoires du Nord-Ouest.

La présente Feuille de route n'a pas de date butoir précise. Elle repose sur des valeurs communes et des principes directeurs qui déterminent la prestation et l'évaluation des soins au fil du temps. Il s'agit d'un guide qui nous aide à travailler ensemble, avec les résidents, les familles, les communautés, les professionnels de la santé et les partenaires, et qui nous aide à tirer profit des nouvelles connaissances, des pratiques prometteuses et des expériences vécues. En restant ouverts à l'apprentissage et au changement, nous pouvons améliorer les soins oncologiques de manière significative, durable et ancrée dans les réalités de la vie dans le Nord.

J'espère que tous les Ténos pourront se reconnaître dans cette Feuille de route. Je vous invite à participer aux discussions en cours sur les soins oncologiques aux TNO. Ensemble, nous pouvons alléger le fardeau du cancer et nous soutenir mutuellement grâce à des soins respectueux, équitables et ancrés dans les collectivités.

## **Les Semmler**

Ministre de la Santé et des Services sociaux  
Gouvernement des Territoires du Nord-Ouest



## Message from the Chief Public Health Officer

Cancer continues to be one of the leading causes of illness and early death in the Northwest Territories, affecting not only individuals but also families, communities, and the systems that support them. Its impact is felt across our territory, from our smallest communities to our regional centres.

As Chief Public Health Officer, I view cancer care as part of our broader responsibility to promote health and wellness for all people in the NWT. The Cancer Care Vision reflects this responsibility. It outlines a shared path for strengthening prevention, early detection, diagnosis, treatment, supportive care, and life after cancer. At its core, this Vision recognizes that improving cancer care is not only about services, it is about ensuring that people feel respected, understood, and supported throughout their entire cancer journey.

This Vision is grounded in what we have heard from communities, patients, families, Elders, and care providers across the territory. It reflects the importance of culturally safe, community driven approaches; reliable access to care regardless of where people live; and strong coordination across programs, regions, and jurisdictions. It also acknowledges the need to learn from evidence and lived experience, and to adapt as our population, knowledge, and best practices evolve.

This Vision is not a final destination. Instead, it offers a shared direction, one that encourages collaboration, accountability, and continuous reflection. By focusing on quality, safety, equity, and connection, it creates space for meaningful improvements while recognizing the realities of delivering cancer care in the North.

I want to extend my sincere thanks to the many individuals, partners, and communities who contributed their time, expertise, and lived experience to shaping this Vision. Your voices are essential, and your continued involvement will guide this work as it moves forward.

Together, we can strengthen cancer care in the Northwest Territories in ways that are respectful, responsive, and rooted in the needs of the people we serve.

**Dr. Kami Kandola**  
Chief Public Health Officer  
Northwest Territories

# Message de l'administratrice en chef de la santé publique

Le cancer reste l'une des principales causes de maladie et de décès prématuré aux TNO, touchant non seulement les individus, mais aussi les familles, les collectivités et les systèmes qui les soutiennent. Son effet se fait sentir partout aux TNO, dans les petites collectivités, comme les centres régionaux.

En tant qu'administratrice en chef de la santé publique, je considère que les soins oncologiques font partie de notre responsabilité générale, qui est de promouvoir la santé et le bien-être de tous les Ténois. La Feuille de route pour les soins oncologiques tient compte de cette responsabilité. Elle définit une approche commune visant à améliorer la prévention, le dépistage précoce, le diagnostic, le traitement, les soins de soutien et la vie après le cancer. Fondamentalement, cette vision reconnaît que l'amélioration des soins contre le cancer ne se limite pas à l'amélioration des services : il s'agit avant tout de veiller à ce que les personnes se sentent respectées, comprises et soutenues tout au long de leur lutte contre le cancer.

La présente Feuille de route s'appuie des commentaires recueillis auprès des collectivités, des patients, des familles, des aînés et des fournisseurs de soins partout aux TNO. On y souligne l'importance d'adopter des approches respectueuses des cultures et axées sur la communauté, d'assurer un accès fiable aux soins – peu importe le lieu de résidence de la personne – et de renforcer la coordination entre les programmes, les régions et les administrations. On y reconnaît également qu'il est nécessaire de tirer des enseignements des faits concrets et des expériences vécues, et de savoir s'adapter à mesure que la population, les connaissances et les pratiques évoluent.

La présente Feuille de route ne fixe pas une destination précise à atteindre. Elle offre plutôt une orientation commune qui favorise la collaboration, la responsabilisation et une remise en question permanente. C'est en mettant l'accent sur la qualité, la sécurité, l'équité et les liens que l'on peut apporter des améliorations significatives tout en tenant compte des réalités de la lutte contre le cancer dans le Nord.

Je tiens à adresser mes sincères remerciements aux multiples personnes, partenaires et collectivités qui ont contribué à l'élaboration de cette feuille de route en y consacrant leur temps, leur expertise et leur expérience personnelles. Votre avis est essentiel, et c'est grâce à votre engagement continu que ce projet pourra aller de l'avant.

Ensemble, nous pouvons améliorer les soins oncologiques aux Territoires du Nord-Ouest, et ce, de manière respectueuse, adaptée aux personnes que nous servons et en fonction de leurs besoins.

## **D<sup>re</sup> Kami Kandola**

Administratrice en chef de la santé publique  
Territoires du Nord-Ouest

# Executive Summary

## Cancer Care Vision for the Northwest Territories

### A Living Guide for Better Cancer Care

Cancer affects many people in the Northwest Territories (NWT), including individuals, their families, and entire communities.

Every cancer journey is different, but many NWT residents share similar experiences, such as travelling long distances for care, dealing with complex systems, and needing care that feels respectful, culturally safe, and supportive.

This Cancer Care Vision sets out a shared direction for continuing to improve cancer care in the NWT. It describes what good cancer care should look like over time, while considering the unique realities of living in northern, rural, and remote communities. It recognizes that high quality cancer care needs to be flexible, equitable, culturally safe, and shaped by the people and communities it serves.

This Vision is **not a detailed action plan**. Instead, it is a living guide to help the health system make decisions, set priorities, and improve cancer care over time. It is designed to change and grow as communities share feedback, evidence evolves, and system needs change.

## Why This Vision Was Created

This Vision builds on the work of *Charting Our Course: Northwest Territories Cancer Strategy 2015–2025*, along with what was learned from evaluating that strategy and from listening to communities through engagement activities such as Cancer Sharing Circles.

Over the past decade, there has been real progress in cancer care. At the same time, people continue to face serious ongoing and emerging challenges. While cancer rates in the NWT are similar to the rest of Canada, many residents, especially people living in rural and remote communities and Indigenous peoples, still experience barriers to care. These include difficulties with access, concerns about cultural safety, challenges moving through the system, and gaps in ongoing support.

What people shared through engagement was clear: improving cancer care is not just about medical treatment. It also requires care that is:

- Focused on people and families
- Culturally safe and shaped by communities
- Well coordinated across regions and services
- Committed to learning, accountability, and partnership

Rather than replacing the previous strategy, this Vision updates and strengthens the direction based on what has been learned and what is needed now and in the future.



## What This Vision Provides

The Cancer Care Vision describes a future where **everyone in the NWT can expect equitable, culturally safe, and high quality cancer care, no matter where they live or who they are.** To support this, the Vision brings together four key elements that guide cancer care across the territory.

### 1. Clear Guiding Principles

The guiding principles describe the values that matter most in cancer care, such as respect, equity, cultural safety, coordination, and quality. Each principle is an action-oriented statement that explains what the health system needs to do to live up to these values in everyday practice.

### 2. A Whole Journey View of Cancer Care

The Vision looks at the full cancer journey—from prevention and screening to diagnosis, treatment, survivorship, and end of life care. It recognizes that people may move between communities, regions, and even provinces for care, and that strong coordination and clear navigation are essential.

### 3. Shared Goals and Priorities

Five system level goals (see below) and related priorities describe what success looks like across cancer care in the NWT. These goals help focus collective effort while allowing flexibility for different regions and communities to act in ways that work best for them.

### 4. Ongoing Learning and Quality Improvement

Instead of checking progress only every few years, this Vision emphasizes learning and improvement as an ongoing process. Using quality assurance tools, the system can regularly reflect on what is working, identify gaps, and adjust based on community needs, lived experiences, and new evidence.



## The Five Goals of the Cancer Care Vision

*The Vision is guided by five goals that together will strengthen cancer care across the NWT:*

1

**GOAL 1: The system provides communities and residents with the supports, knowledge, and environments needed to reduce the incidence of cancer and promote wellness.**

Communities are supported with the knowledge, resources, and environments needed to prevent cancer and support wellness. Efforts are community led, culturally grounded, trauma informed, and focused on reducing inequities by prioritizing those most affected by cancer.

2

**GOAL 2: People and communities across the NWT are supported with screening options that are accessible, culturally safe and shaped by what works for them.**

People across the NWT have access to screening options that are accessible, culturally safe, and shaped by community needs. Better organized screening helps find cancer earlier and improves outcomes.

3

**GOAL 3: People and families are supported with navigation and coordinated culturally relevant transitions across the cancer continuum.**

People and families are supported with clear information and well coordinated care throughout the cancer journey. Strong pathways, communication, and continuity help people move through the system with confidence and dignity.

4

**GOAL 4: People affected by cancer have access to holistic supports that strengthen quality of life across their cancer experience.**

People affected by cancer have access to holistic supports that address physical, emotional, spiritual, social, and practical needs. This includes survivorship, palliative, and end of life care that is respectful and culturally appropriate.

5

**GOAL 5: Communication and information systems strengthen the coordination of care and meet the needs of residents across the cancer care journey.**

Strong communication and information systems support health professionals and residents alike. These systems improve coordination, reduce repeated burdens on patients, and support shared learning and accountability across the system.

## Looking Ahead

This Cancer Care Vision is a shared commitment to working together that recognizes that meaningful improvement depends on genuine partnership with Indigenous governments, communities, patients, families, health care providers, and system partners. It also recognizes that health and healing happen in many places, not just in hospitals and clinics.

By listening, learning, and adapting over time, this Vision aims to strengthen cancer care in ways that are realistic, respectful, and rooted in the realities of northern life, now and for future generations.



# Sommaire

## Feuille de route pour les soins oncologiques aux Territoires du Nord-Ouest

### Guide évolutif pour améliorer les soins oncologiques

Le cancer touche beaucoup de gens aux Territoires du Nord-Ouest (TNO), qu'il s'agisse des personnes atteintes, de leurs familles ou des collectivités tout entières. Chaque parcours face au cancer est différent, mais de nombreux Ténos partagent des expériences similaires, comme le fait de devoir traverser de longues distances pour se faire soigner, de devoir composer avec des systèmes complexes et d'avoir besoin de soins respectueux, adaptés à la culture de chacun et source de soutien.

La présente Feuille de route pour les soins oncologiques définit une orientation commune qui permettra de continuer à améliorer ces soins aux TNO. Elle décrit les caractéristiques que devraient présenter des soins oncologiques de qualité au fil du temps, tout en tenant compte des réalités particulières de la vie dans les collectivités nordiques, rurales et éloignées. Elle reconnaît en outre qu'une prise en charge de qualité des personnes atteintes du cancer doit être flexible, équitable, respectueuse des particularités culturelles et façonnée par les personnes et les collectivités qu'elle dessert.

La présente Feuille de route **n'est pas un plan d'action détaillé**. Il s'agit plutôt d'un guide évolutif destiné à aider le système de santé à prendre des décisions, à définir ses priorités et à améliorer les soins contre le cancer au fil du temps. Le document est amené à évoluer et à s'étoffer grâce aux commentaires des collectivités, à la progression des données scientifiques et aux changements des besoins du système.

## Pourquoi créer une telle Feuille de route?

La Feuille de route, qui s'inspire au document intitulé « Tracer la voie : stratégie des Territoires du Nord-Ouest pour lutter contre le cancer 2015-2025 », s'appuie sur les enseignements tirés de l'évaluation de cette stratégie et des échanges effectués avec les collectivités dans le cadre d'activités de consultation, notamment les cercles de partage sur le cancer.

Au cours de la dernière décennie, de réels progrès ont été accomplis dans le domaine des soins oncologiques. Parallèlement, la population continue de faire face à de graves enjeux, tant persistants qu'émergents. Bien que les taux de cancer aux TNO soient similaires à ceux observés dans le reste du Canada, de nombreux Ténos, en particulier les personnes vivant dans des collectivités rurales et éloignées ainsi que les membres des Premières Nations, se heurtent encore à des obstacles lorsqu'ils ont besoin de soins. Parmi ces obstacles figurent les difficultés d'accès, les préoccupations liées au respect des pratiques culturelles, les difficultés liées à l'orientation dans le système de santé et les lacunes sur le plan du soutien continu.

Ce que les gens ont exprimé lors des séances d'échanges était clair : l'amélioration des soins oncologiques ne se limite pas au traitement médical. Il faut également que les soins soient :

- axés sur les personnes et les familles;
- adaptés à la culture et façonnés par les collectivités;
- bien coordonnés entre les régions et les services;
- axés sur l'apprentissage, la responsabilité et le partenariat.

Plutôt que de remplacer la stratégie précédente, la présente Feuille de route actualise et renforce l'orientation adoptée en s'appuyant sur les enseignements tirés et sur les besoins actuels et futurs.



## Ce qu'apporte la Feuille de route

La Feuille de route pour les soins oncologiques dépeint un avenir dans lequel **tous les Ténois peuvent compter sur des soins oncologiques équitables, adaptés à leur culture et de grande qualité, quels que soient leur lieu de résidence et leur identité.** À cette fin, la Feuille de route rassemble quatre éléments clés qui orientent la prestation des soins oncologiques sur l'ensemble du territoire.

### 1. Des principes directeurs clairs

Les principes directeurs décrivent les valeurs qui priment dans la prestation des soins oncologiques, notamment le respect, l'équité, la sécurité culturelle, la coordination et la qualité. Chaque principe est un énoncé à convertir en mesures, qui explique ce que le système de santé doit faire pour respecter ces valeurs dans la pratique quotidienne.

### 2. Une vue d'ensemble du parcours des soins oncologiques

La Feuille de route porte sur l'ensemble du parcours des soins oncologiques, de la prévention et du dépistage au diagnostic, au traitement, à la survie et aux soins de fin de vie. Elle reconnaît que les personnes atteintes peuvent se déplacer entre les collectivités, les régions et même les provinces pour recevoir des soins et qu'une coordination solide et une orientation claire sont essentielles.

### 3. Des objectifs et des priorités communs

Cinq objectifs propres au système (voir ci-dessous) ont été posés, ainsi que les priorités qui s'y rattachent. Ensemble, ces éléments décrivent ce que signifie la réussite en matière de soins oncologiques aux TNO. Ces objectifs aident à concentrer les efforts collectifs tout en laissant aux différentes régions et collectivités la flexibilité nécessaire pour agir de la manière qui leur convient le mieux.

### 4. L'apprentissage continu et l'amélioration de la qualité

Plutôt que de vérifier les progrès uniquement à quelques années d'intervalle, la Feuille de route met l'accent sur l'apprentissage et l'amélioration en tant que processus continus. À l'aide d'outils d'assurance de la qualité, le système peut régulièrement évaluer ce qui fonctionne, repérer les lacunes et s'adapter en fonction des besoins des collectivités, du vécu et des nouvelles données.



# Les cinq objectifs de la Feuille de route pour les soins oncologiques

*La Feuille de route s'articule autour de cinq objectifs qui, ensemble, permettront de renforcer la prestation des soins oncologiques dans l'ensemble des TNO*

1

**OBJECTIF 1 : Le système offre aux collectivités et aux résidents le soutien, les connaissances et les conditions nécessaires pour réduire l'incidence du cancer et promouvoir le mieux-être.**

Les collectivités bénéficient des connaissances, des ressources et des conditions nécessaires pour prévenir le cancer et favoriser le mieux-être. Les initiatives sont menées par les collectivités, ancrées dans la culture, tiennent compte des traumatismes et visent à réduire les inégalités en accordant la priorité aux personnes les plus touchées par le cancer.

2

**OBJECTIF 2 : Les personnes et les collectivités des TNO bénéficient d'options de dépistage accessibles, respectueuses de la culture et adaptées à leurs besoins.**

Les Tenois ont accès à des options de dépistage accessibles, respectueuses de la culture et adaptées aux besoins de la collectivité. Un dépistage mieux organisé permet de détecter le cancer plus tôt et d'améliorer les résultats.

3

**OBJECTIF 3 : Les personnes et les familles bénéficient d'un accompagnement et de transitions coordonnées et adaptées à leur culture tout au long du parcours des soins oncologiques.**

Les personnes et les familles bénéficient d'informations claires et de soins bien coordonnés tout au long de leur parcours face au cancer. Grâce à des parcours de soins, une communication et une continuité bien établies, les personnes peuvent évoluer dans le système avec confiance et dignité.

4

**OBJECTIF 4 : Les personnes atteintes d'un cancer ont accès à un soutien global qui améliore leur qualité de vie tout au long de leur expérience avec le cancer.**

Les personnes atteintes d'un cancer ont accès à un soutien complet qui répond à leurs besoins physiques, émotionnels, spirituels, sociaux et pratiques. Cela inclut des soins de survie, des soins palliatifs et des soins de fin de vie respectueux et adaptés à leur culture.

5

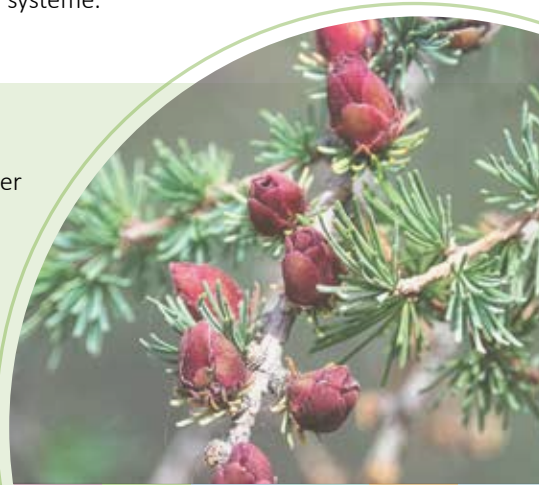
**OBJECTIF 5 : Les systèmes de communication et d'information renforcent la coordination des soins et répondent aux besoins des résidents tout au long de leur parcours en soins oncologiques.**

Des systèmes de communication et d'information solides soutiennent tant les professionnels de santé que les résidents. Ces systèmes améliorent la coordination, réduisent les charges répétitives pour les patients et favorisent l'apprentissage partagé et la responsabilisation à l'échelle du système.

## Regard vers l'avenir

La présente Feuille de route pour les soins oncologiques est un engagement commun à œuvrer ensemble, qui reconnaît que toute amélioration tangible repose sur un partenariat sincère avec les gouvernements autochtones, les collectivités, les patients, les familles, les professionnels de santé et les acteurs du système. Elle reconnaît également que la santé et la guérison s'épanouissent dans de nombreux lieux, et pas seulement dans les hôpitaux et les cliniques.

Grâce à l'écoute, à l'apprentissage et à l'adaptation au fil du temps, la présente Feuille de route permettra d'améliorer les soins oncologiques de manière réaliste, respectueuse et ancrée dans les réalités de la vie dans le Nord, aujourd'hui et pour les générations futures.



# 1) Purpose of the Vision

Cancer continues to have a profound impact on individuals, families, caregivers, and communities across the Northwest Territories (NWT). The Vision document presents a clear and shared approach to improving cancer care by strengthening access to high-quality, culturally safe, and supportive care and services across every stage of the cancer journey (1,2). At the same time, it recognizes that cancer does not exist in isolation from the wider context of people's lives, communities, cultures, and everyday experiences.

This document sets out a shared vision for cancer care in the NWT: a future where all people experience equitable, culturally safe, and high-quality cancer care, no matter who they are or where they live. The Vision is grounded in Reconciliation and health equity and is guided by principles that help us understand not only clinical outcomes, but how well cancer care is supporting people to live well. These principles encourage us to look beyond traditional measures of success such as screening or incidence rates, and consider the lived experiences, strengths, and priorities of the people, families, and communities who access cancer services.

The Vision aims to reflect a holistic understanding of health that goes beyond the absence of disease. It is concerned not only with how people are treated when they are sick, but with how they are living and thriving across the cancer journey. Everyday activities such as being with loved ones, sharing knowledge, learning from Elders, and maintaining cultural and community connections are not separate from health care; they are fundamental ways of living a good and healthy life.

By recognizing where and how health truly happens, the Vision seeks to reduce the burden of cancer while supporting dignity, connection, and quality of life, in ways that reflect and prioritize the needs, values, and Indigenous Rights of First Nations, Inuit, and Métis peoples.

As we look ahead, there are several significant challenges that must be addressed to improve health outcomes and equity across the system. Persistent health disparities, particularly for people living in remote and rural communities, continue to limit access to timely, culturally appropriate, high-quality services. These inequities are compounded by geographic isolation, logistical barriers, and constrained resources (3,7,8,22). Addressing these challenges requires coordinated action across the health system and meaningful partnership with communities.



Meaningful change in a complex health system requires accountability, collaboration, and a willingness to do things differently. The Vision recognizes that real transformation must occur both within the formal health system and alongside communities, acknowledging that health is shaped by social, cultural, and community contexts as much as by services and interventions.

A key feature of the Vision is its commitment to ongoing learning. Rather than relying solely on periodic evaluations, the Vision promotes quality assurance as an everyday way of understanding how care is being delivered and how it can be improved. By using consistent and meaningful information, the system will be better equipped to learn from and leverage what is working, identify gaps, and adapt to changing community needs, emerging evidence, and system realities. This approach supports learning in real time and helps ensure that the system remains responsive, relevant, and accountable (5,9).

The Vision builds on the solid foundation of the NWT's previous cancer care strategy, *Charting Our Course: Northwest Territories Cancer Strategy 2015–2025*, recognizing that its core principles and insights remain valid and essential. At the same time, it advances a more coordinated, inclusive, and trauma-informed approach to cancer care, one that centres people and communities, strengthens systems, and supports continuous learning. Through shared accountability, partnership, and a commitment to equity and quality, the Vision aims to support people not only to receive better cancer care, but to live well throughout the cancer journey, now and for generations to come.



## 1.1) Background

The Cancer Care Vision: A Living Framework for Quality and Priorities in the Northwest Territories (the Vision) builds on the foundation created by the previous strategy, *Charting Our Course: Northwest Territories Cancer Strategy 2015–2025* (the Strategy). It also reflects national cancer care priorities, evaluation findings from the previous strategy, and what residents, community stakeholders and healthcare providers shared during recent engagement, including cancer sharing circles in the NWT. The Vision brings together lessons learned over the past decade with what is needed to respond to the current and emerging needs of people across the NWT (1,2,6).

Cancer care in the NWT is shaped by the territory's unique geography, culture, and health system. People often live in small communities that are far apart, and getting specialized cancer care may require travel outside the territory. Indigenous Peoples make up approximately half of the population, and the ongoing impacts of colonialism, racism, and intergenerational trauma continue to influence health outcomes and experiences within the health system (7,8,23). These realities highlight the need for the system to provide cancer care that is culturally safe, community driven, and designed to reduce inequities.

## 1.2) Context: Indigenous Peoples and Cancer Care in the Northwest Territories

Indigenous Peoples are the first peoples of the NWT, and today about half of the population identifies as First Nations, Inuit, or Métis (13). Health and social services, including cancer care, must be designed in partnership with Indigenous Peoples and grounded in culturally safe, equitable, and community driven approaches.

Indigenous Peoples in the NWT continue to feel the effects of historic and ongoing colonialism, including forced settlement, loss of language and culture, and the multigenerational harms of the residential school system. The legacy of residential schools, where children were removed from their families, harmed, and disconnected from land and culture, continues to influence health today (12, 14, 22). The system recognizes that these experiences have created lasting impacts on emotional, social, cultural, and community wellbeing and is actively working to advance Reconciliation through the Health and Social Services System.

These impacts are not only in the past. Health care in the NWT has long been shaped by colonial policies and practices, and many services have not been designed with Indigenous Peoples needs in mind. As a result, some Indigenous residents report feeling unsafe or disrespected when seeking care, including experiences of racism. These experiences reduce trust in the system and can lead to delays in seeking care, which affects people's health outcomes (7, 15, 23).

Trust between Indigenous Peoples and the health system remains deeply affected by this history and by ongoing experiences of racism and culturally unsafe care. Looking forward, improving cancer care in the NWT requires strong partnership with Indigenous Peoples. Cultural safety work in the NWT recognizes that rebuilding trust requires addressing systemic racism and embedding Indigenous Knowledge, culture, and language into how care is delivered. Culturally safe cancer care must honour Indigenous identities, values, and strengths and must be guided by Indigenous leadership, self-determination and community priorities. These commitments are essential for addressing inequities, rebuilding trust, and supporting healing across the cancer journey.

### 1.3) Current Situation: Cancer Burden and Outcomes in the NWT

Insights from the review of *Charting Our Course: Northwest Territories Cancer Strategy 2015-2025*, show progress in area's such as prevention, screening, navigation, and treatment coordination, while also highlighting ongoing challenges such as uneven access to screening, gaps in data and system oversight, barriers associated with medical travel, workforce instability, and limited territory-wide approaches to survivorship and palliative care (1,4,11).

While overall cancer incidence in the NWT is similar to national averages, significant inequities in access, early detection, culturally safe care, and continuity of care contribute to poorer health outcomes for many residents. These disparities are especially pronounced in rural and remote communities and among Indigenous Peoples, where barriers such as limited availability of services, systemic racism, and delayed diagnosis result in worse outcomes, including substantially higher mortality for certain cancers compared with Canada overall (1,10,16,18,19).

Recent pressures on the health system, including staffing shortages, service disruptions, the impacts of the COVID-19 pandemic and wildfire evacuations, have increased strain on the health system and reinforced the need for flexible, sustained, well-coordinated cancer care. At the same time, the health system is adapting to a changing environment. Advances in cancer prevention, screening technologies, treatment options, and virtual care continue to shift expectations around quality, safety, cultural humility, and accountability. These changes point to the need for a cancer care vision that is dynamic and responsive over time rather than static.

Cancer is the leading cause of death in the NWT and accounted for nearly 25% of all deaths in 2024. The increasing incidence of cancer and survival has direct economic, social, and emotional impacts (17,19). Overall cancer rates in the NWT are similar for Indigenous and non-Indigenous residents when all cancer types are combined. However, inequities remain across the cancer experience due to social conditions, access barriers, and issues of trust in the health system.

Some types of cancer have worse outcomes in the NWT compared to the rest of Canada. Lung cancer mortality among women is one and a half times the national rate, and colorectal cancer mortality for both men and women are nearly twice the Canadian rate (1, 16, 18, 19). Indigenous residents make up about half of the population and face ongoing barriers to culturally safe and accessible care, these patterns raise important equity concerns.

For many Indigenous residents, the cancer journey is made more difficult by the need to travel far from home for diagnosis and treatment. This can mean being separated from family, community, and cultural supports. Some Indigenous residents also report experiences of racism within southern cancer care services, adding emotional and psychological strain. These themes appear consistently in northern Indigenous stories and were echoed in national cancer strategy consultations that included Indigenous organizations from the NWT (1,20,21).

Together, these trends point to a system that must address cancer not only as a clinical condition but as a health equity issue, requiring improved access, strengthened cultural safety, enhanced data and oversight, and sustained partnership with Indigenous governments and communities to ensure quality cancer care for all residents of the NWT.



## 1.4) Why a New Cancer Care Vision is Needed

The Vision is not meant to replace the previous cancer care strategy, Charting Our Course. Instead, it builds on the strong foundation of that work and updates the direction based on what we learned from the evaluation of the Strategy. Many of the principles and lessons from the Strategy remain important today. However, the evaluation and engagement findings showed that continued progress will require better coordination across the system, clearer accountability, sustainable approaches, and stronger supports for learning and continuous improvement in real time (1,3,5,6).

The Vision provides an opportunity to:

- Clarify shared goals and expectations for cancer care across the continuum;
- Strengthen alignment between policy, planning, service delivery, and community priorities;
- Embed cultural safety, equity, and Indigenous voices deeply into how cancer care is designed and delivered, and,
- Support continuous health system learning and timely adjustment through a quality assurance approach.

## 1.5) Alignment with National and Regional Priorities

The Vision aims to align with national cancer care directions and quality frameworks, including priorities related to prevention, early detection, coordinated care, patient experience, equity, and data-driven decision-making. It also reflects the realities of delivering cancer care in northern, rural, and remote contexts and aligns with ongoing territorial health system transformation efforts.

By maintaining alignment with national partners while grounding decisions in local knowledge and context, the Vision supports consistency in standards and practices without compromising the flexibility required to meet the unique needs of communities across the NWT (1,3,5).



## 1.6) 2015 to 2025: What the Strategy has Achieved

*Charting Our Course: Northwest Territories Cancer Strategy 2015–2025* marked the first comprehensive, territory-wide approach to cancer prevention, care, and support in the NWT. It was created with guidance from Indigenous Peoples, patients, families, caregivers, and health care providers, and provided a shared framework for action across the full cancer journey.

An evaluation completed in 2023 showed that the Strategy made meaningful progress across many areas of cancer care, even during times of system pressure, workforce challenges, and the impacts of the COVID-19 pandemic. These achievements form the foundation for the Vision.

A major accomplishment of the Strategy was the creation of a coordinated framework for cancer care across prevention, screening, diagnosis, treatment, survivorship, and palliative and end of life care. This framework helped establish shared priorities and a clear direction for collaboration across departments, health authorities, communities, and partners. This work continues to guide cancer planning and service delivery.

The Strategy strengthened cancer prevention and health promotion by expanding access to culturally relevant information and supporting community led approaches. Partnerships with Community Health Representatives (CHRs) and local leaders improved engagement and reinforced the importance of people centred care and cultural safety.

The Strategy also supported organized and coordinated approaches to cancer screening. Although participation rates remain below national averages, the evaluation shows progress towards more accessible and equitable screening programs.

Work in patient navigation and continuity of care improved coordination across the cancer journey, strengthened trust, and helped individuals and families move more smoothly through the system.

The Strategy also improved communication and collaboration among health care providers, increasing the system's ability to support people affected by cancer.

Progress was more limited in palliative care, survivorship, and quality of life supports. Even so, the Strategy created a foundation for future improvements and highlighted the need for holistic and culturally grounded supports.

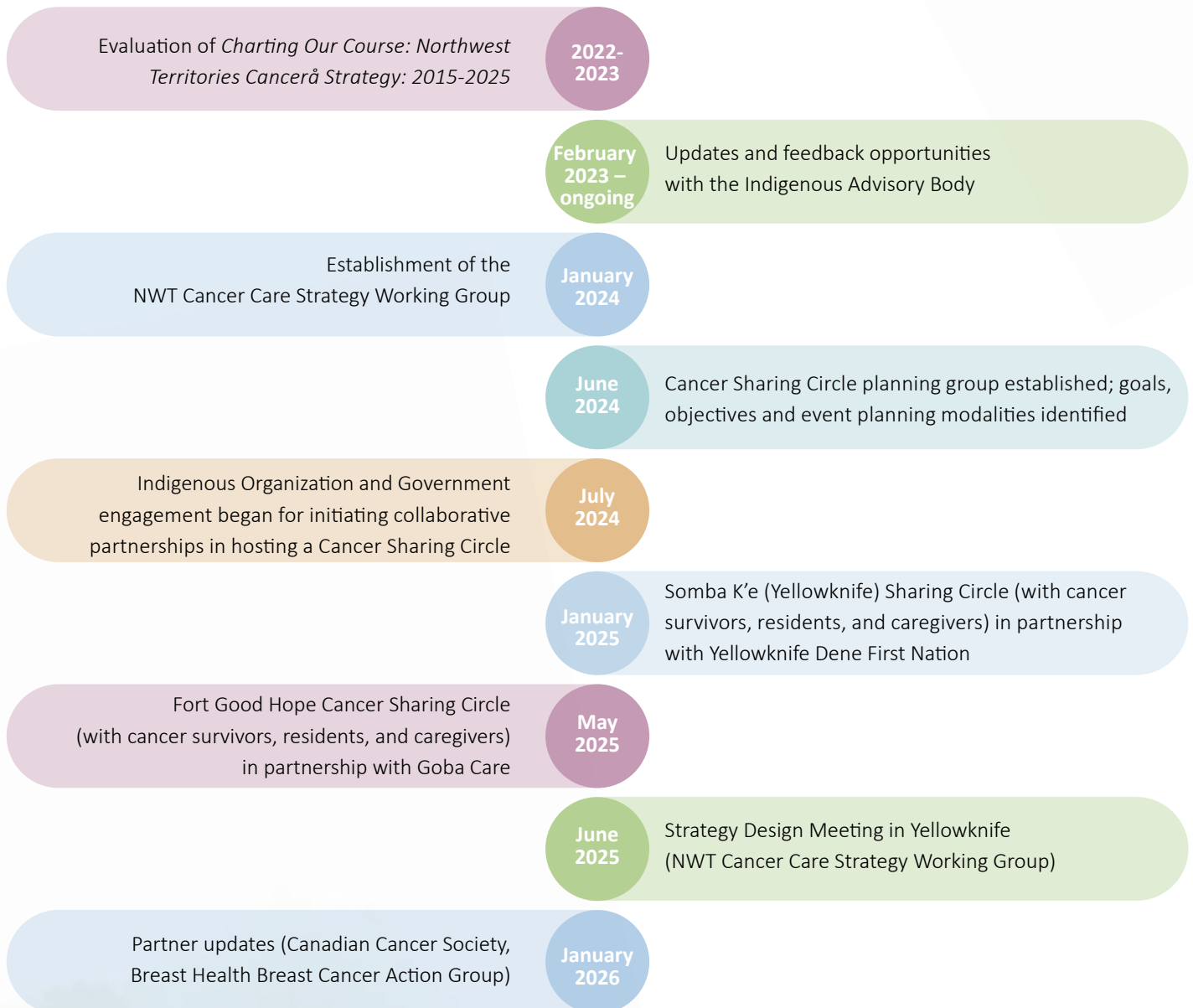
Overall, the Strategy made significant progress in supporting a more people-centred, accessible, culturally safe, and coordinated approach to cancer care. While not every challenge could be addressed, the Strategy created lasting structures, partnerships, and lessons that continue to guide cancer care.

The Vision builds on these achievements. It preserves what works, responds to identified gaps, and places stronger emphasis on quality assurance, learning, and adaptability to support ongoing improvement in partnership with communities.

## 2) Engagement and Development Process

Engagement for this Cancer Care Vision took place over several years through evaluation activities, planning sessions, and community-based conversations. Key milestones included:

### 2.1) Partnership Consultation Timeline





## 2.2) Partner Engagement and Consultation Approach

Extensive engagement was undertaken during the development of Charting Our Course: Northwest Territories Cancer Strategy 2015–2025. This work informed many of the foundations of cancer care in the NWT, and several insights from that time continue to be relevant today. The Vision was developed as an update, reflecting what has been learned since the original Strategy, including evaluation findings, current evidence, and more recent community insights. It also recognizes that engagement is ongoing, not a one time activity. Continued partnership with communities, Indigenous governments, service providers, and system partners will be supported through quality assurance processes that enable regular feedback, learning, and adaptation over time.

The update process began with a formal evaluation in 2022 to 2023. This evaluation identified progress, gaps, and emerging challenges, and guided the next steps in engagement. In January 2024, the Northwest Territories Cancer Care Strategy Working Group, including representation from the Department of Health and Social Services and the Health and Social Services Authorities, was created to provide oversight and system level coordination. The group helped shape engagement priorities and supported interpretation of findings.

A Cancer Sharing Circle planning group, that reported to the Cancer Care Strategy Working Group, was formed in June 2024 to guide culturally grounded engagement. Engagement with Indigenous governments and organizations began the following month to support partnership in hosting these conversations.

Two Sharing Circles were held in 2025. The first took place in Yellowknife in January, in partnership with the Yellowknife Dene First Nations, and the second was held in Fort Good Hope, in partnership with Goba Care, in May. These sessions provided valuable insight into lived experience, cultural safety, navigation, and the impacts of cancer care across different communities.

This engagement process did not reach every region or community due to capacity challenges, competing system pressures, and logistical realities. These limitations reinforce the importance of creating a Vision that does not rely only on large, periodic engagement, but instead embeds ongoing listening and learning across the system.

For this reason, the Vision emphasizes a quality assurance approach as a core mechanism for continuous engagement, learning, and improvement. Through routine monitoring, patient feedback, community-informed indicators, and system review, the health and social services system will be better positioned to identify emerging needs, respond to regional priorities, and adjust direction over time. This approach supports a living framework, one that evolves with communities, evidence, and system realities, rather than remaining static between planning cycles.

Together, this engagement approach reflects a respectful balance between building on what is already known, acknowledging real-world constraints, and committing to ongoing accountability, sustainability, and learning in partnership with communities across the NWT.



### 3) The Cancer Care Vision Framework

The Cancer Care Vision Framework outlines how the Vision can be understood and applied across cancer prevention and care services. It brings together shared values, the full continuum of cancer care, and approaches to understanding whether care is reflecting what people, families, and communities have identified as most important. The framework is intended to support alignment and learning rather than prescribe specific operational models or performance targets, offering a shared foundation for consistent yet flexible application over time.

The framework is made up of four interconnected elements:

- **Guiding Principles:** That articulate the values shaping decisions and behaviours across the system;
- **Cancer Care Continuum:** The full range of experiences people may have before, during, and after a cancer diagnosis;
- **Quality Assurance:** A focus on maintaining safe, reliable, and culturally responsive care in everyday practice; and
- **Goals and Priorities:** Outline what cancer care aims to achieve, and the area’s where efforts should be focussed to support progress.

Together, these elements support a coordinated approach to cancer care that is person centred, evidence informed, and responsive to community needs.

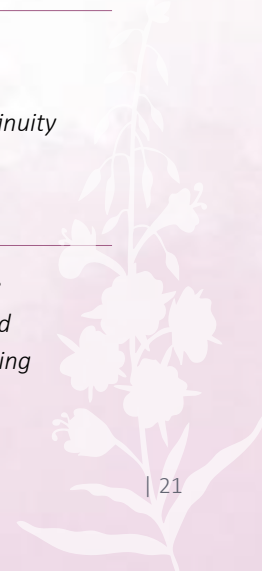


## 3.1) Guiding Principles

The guiding principles describe the actionable ways that we intend to live out the values that shape the Vision. They explain what matters most in cancer care and guide how decisions are made across the system. Each principle is expressed through a clear action-oriented statement that describes what the health and social services system must do to put that principle into practice. These principles support accountability and help ensure that cancer care remains people-centred, culturally safe, equitable, and grounded in community priorities.



Values	Guiding Principles	Description
<b>Person-Centred &amp; Family-Inclusive</b>	Actively partner with individuals, families, and caregivers to shape care in ways that reflect their needs, values, and lived experience.	<i>Care is shaped by individual, family, and community needs, values, and preferences, recognizing the intergenerational impacts of cancer care decisions and supporting families in meaningful ways.</i>
<b>Culturally Safe &amp; Community-Informed</b>	Work alongside communities and Indigenous partners to ensure care is culturally safe, responsive, and grounded in ongoing learning.	<i>Cultural safety is understood as an ongoing practice that adapts to cultural identities, centres community knowledge and leadership, and supports long-term community wellbeing.</i>
<b>Equitable &amp; Reliable Access</b>	Identify and remove barriers so that people and communities most affected by inequities receive timely, appropriate cancer care.	<i>Care is designed and delivered to meet the needs of individuals, families and communities who are disproportionately impacted by cancer and who face the greatest barriers to accessing care.</i>
<b>Evidence-Informed &amp; Effective</b>	Use the best available evidence, including community knowledge, to guide decisions and adapt practices as learning evolves.	<i>Decisions are made by using the best available evidence, including community knowledge and practice-based learning, and are responsive as evidence and understanding evolve.</i>
<b>Connected &amp; Coordinated System</b>	Collaborate across programs, regions, and jurisdictions to ensure people experience clear navigation and coordinated support throughout their cancer journey.	<i>Coordination is understood as a shared responsibility across programs, regions and partners to support clear navigation and continuity across all stages of the cancer journey.</i>
<b>Safety &amp; Quality</b>	Deliver care that protects physical, cultural, emotional, and psychological safety, supported by consistent monitoring and accountability.	<i>Commitment to deliver safe, high-quality care that protects physical, cultural, emotional, and psychological well-being and ensures monitoring and accountability across the system.</i>

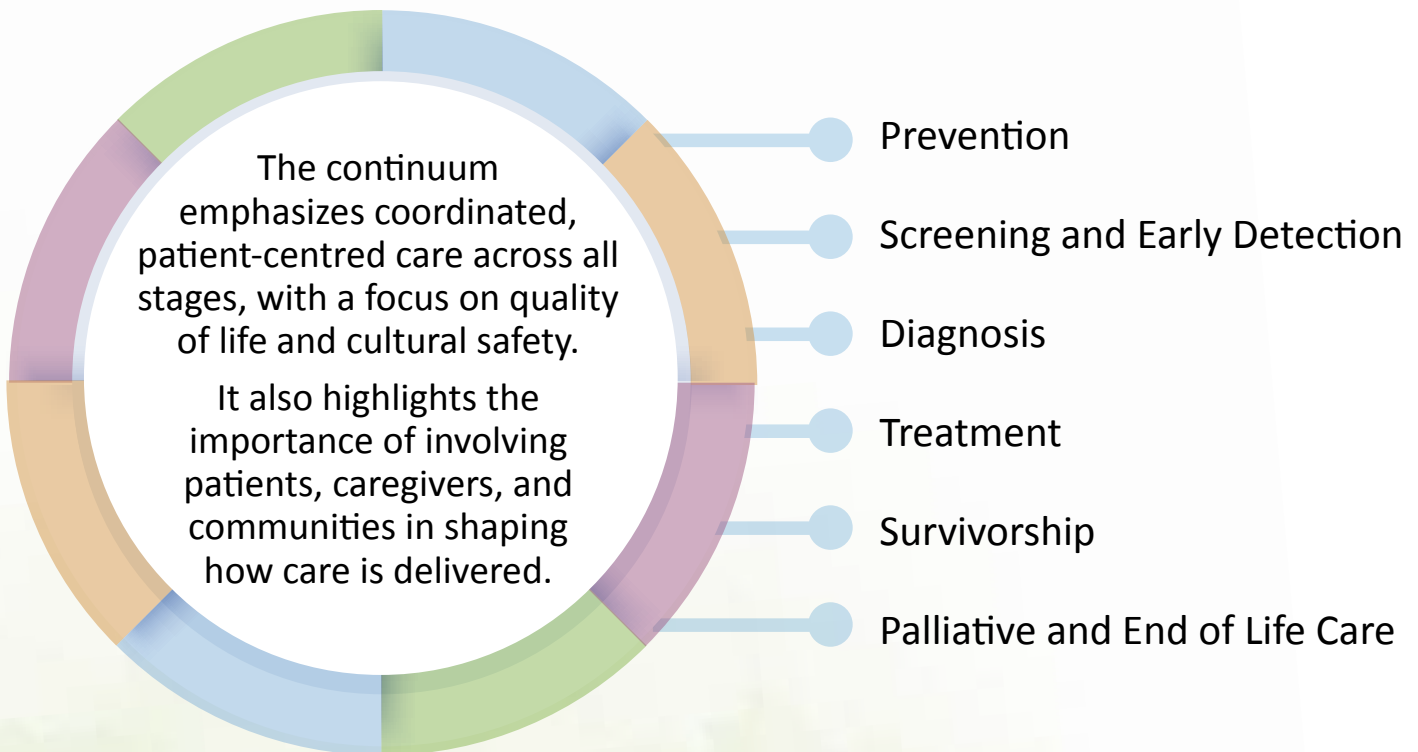


### 3.2) Cancer Care Continuum

The cancer journey can be complex and difficult to navigate. In the NWT people living with and beyond cancer are often required to move between different care settings, including community health centres, Stanton Territorial Hospital in Yellowknife, and specialized cancer services in Alberta. Each stage of the cancer journey, from screening and diagnosis to treatment, survivorship, palliative and end-of-life care, requires coordination across regions and systems, which can create emotional and logistical challenges for patients and families.

The Vision aims to make the cancer care experience more connected, compassionate, and culturally safe. It seeks to ensure that patients, caregivers, and survivors receive meaningful support at each stage through timely information, system navigators, and community-based resources. This includes supporting traditional healing practices, improving communication between care providers, and creating smoother transitions across all levels of care.

The cancer care continuum, also known as the cancer pathway, refers to the full range of services and supports people may experience, from prevention and screening to diagnosis, treatment, survivorship, and end of life care. The continuum provides a framework for organizing and coordinating care across these stages so that people and families have a more seamless and supportive experience.





### 3.3) Using Quality Assurance to Support Learning and Improvement

Quality assurance is a foundational element of this Vision and the main way the health system will monitor progress toward the goals and strengthen cancer care. Quality assurance means using regular and meaningful information to understand what is working and where improvements are needed.

Rather than relying only on evaluations that happen every few years, the Vision uses quality assurance approaches that support:

- Ongoing monitoring of care quality, access, sustainability, safety, and equity;
- Timely identification of emerging issues, unintended consequences, and areas for improvement;
- Shared accountability across partners, programs, and levels of the system; and,
- Continuous learning that supports adaptation as community needs, evidence, and system realities evolve.

Quality assurance will support reflection and improvement across clinical practice, program delivery, system planning, and policy. A comprehensive framework, designed to be meaningful and realistic for the NWT, is being developed to support this approach to monitoring the Cancer Care Vision. By integrating quality assurance, we ensure that monitoring and learning remain focused on what matters most: people, communities, and equitable cancer care.

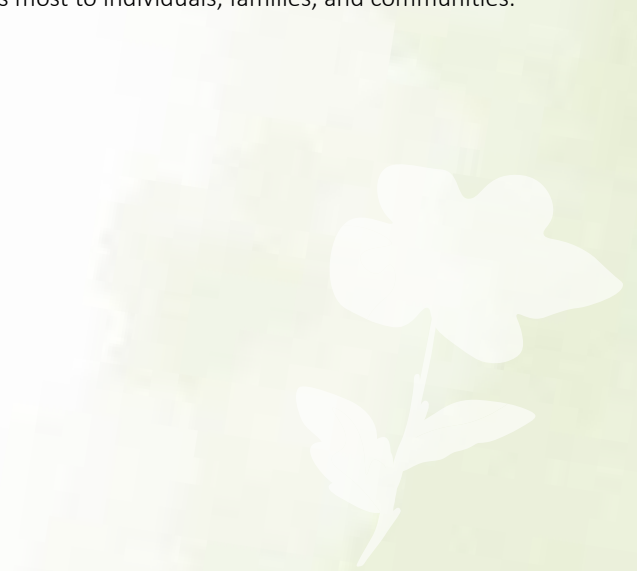
### 3.4) Principles-Focused Evaluation

Principles-focused evaluation is an approach that helps assess whether a program is living its values, not just achieving its outcomes. Instead of relying on a single model for all programs, it examines how well programs follow agreed principles and whether those principles create value for the people they serve.

Principles must:

- provide guidance
- be clear and easy to understand
- reflect shared values and beliefs
- apply across different situations
- be written in ways that allow progress to be assessed

Together, quality assurance and principles-focused evaluation help the health system understand whether cancer care is meeting the goals of the Vision. They support ongoing learning, reflection, and improvement while keeping focus on what matters most to individuals, families, and communities.



## 4) Strategic Goals and Priorities

The Vision describes a set of shared system level goals that define the future toward which we are working. These goals explain what success looks like across the cancer journey and provide clear direction for planning, action, sustainability and improvement.

Under each goal we have also identified where we will be focusing our efforts. These priorities guide decisions and resources while allowing flexibility for programs and regions to choose the best local actions. They support a quality assurance approach that encourages learning and adaptation.

Together, these goals and priorities express a commitment to cancer care that is equitable, culturally safe, integrated, and responsive to community needs, now and into the future.

### Goal One:

**The system provides communities and residents with the supports, knowledge, and environments needed to reduce the incidence of cancer and promote wellness.**

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Healthy lifestyles and supportive environments play a critical role in preventing cancer and reducing long-term health impacts. This goal focuses on strengthening prevention and health promotion efforts that are culturally safe, community-driven, and grounded in both Indigenous knowledge and western-informed practice. By supporting people and communities to lead healthy lives, the health system can reduce cancer risk and promote wellness across the lifespan.

#### Priorities for Goal One:

- 1. Culturally grounded, community led health promotion.**
  - Example of what this could potentially look like:  
Work with Indigenous governments, Elders/Knowledge Holders, CHRs and local partners to co-lead culturally appropriate health promotion (language, land-based approaches, community venues).
- 2. Trauma-informed approaches to addressing modifiable cancer risks.**
  - Example of what this could potentially look like:  
Support people and communities to address modifiable cancer risks (tobacco/vaping cessation, limit alcohol, healthy diet, be physically active, sun safety, get vaccinated, and participate in cancer screening) through trauma informed, strengths-based approaches that honour choice, autonomy, and dignity.
- 3. Equity-driven prevention that prioritizes those most affected.**
  - Example of what this could potentially look like:  
Support Indigenous-led cancer awareness and prevention initiatives, such as CHR led outreach, local champions and community events, that build sustained local capacity.



## Goal Two:



**People and communities across the NWT are supported with screening options that are accessible, culturally safe and shaped by what works for them.**

Cancer screening is vital for detecting cancer early, often before symptoms appear, improving survival rates, reducing mortality, and in some cases, preventing cancer by identifying and treating precancerous changes. This goal emphasizes organized, accessible, and population-based screening approaches that reduce barriers, improve participation, and address inequities across regions and communities. A focus on coordination, reliability, and community-informed approaches supports earlier diagnosis and more consistent care.

### **Priorities for Goal Two:**

- 1. Organized, accessible, flexible screening options.**
  - Example of what this could potentially look like:  
Work toward organized, accessible cancer screening with flexible approaches, including home/self-sampling where appropriate and screening options that align with community hours, settings, and needs.
- 2. Culturally safe, community designed screening awareness and education.**
  - Example of what this could potentially look like:  
Co-design screening education, and materials with Indigenous governments, organizations, and communities to ensure information is culturally safe, relevant, plain language, and trusted.
- 3. Territorial coordination, guidelines, and simple access pathways.**
  - Example of what this could potentially look like:  
Strengthen territorial coordination of screening programs, update guidelines, consistently monitor, and establish booking and information pathways that respond to community needs.

## Goal Three:



**People and families are supported with navigation and coordinated culturally relevant transitions across the cancer continuum.**

Navigating cancer care can be complex, particularly in a geographically dispersed system. This goal prioritizes care pathways with coordinated transitions, and person-centred navigation supports that help individuals and families move through each stage of the cancer journey with clarity, dignity, and confidence. Improving continuity of care leads to better patient and caregiver experiences and outcomes.

### **Priorities for Goal Three:**

- 1. Early, culturally safe navigation across the journey.**
  - Example of what this could potentially look like:  
Provide culturally safe, trauma informed navigation starting at suspicion/abnormal result and continuing through diagnosis, treatment, survivorship, palliative and end-of-life care.
- 2. Clear roles, pathways, and communication processes across the system.**
  - Example of what this could potentially look like:  
Establish clear roles, referral pathways, and communication processes across providers, programs, regions, and with southern partners to ensure seamless and safe transitions of care.
- 3. Seamless transitions and reduced travel barriers.**
  - Example of what this could potentially look like:  
Support people through key transitions in care and work with system partners to reduce travel and logistics barriers, such as support with travel coordination, and access to local/virtual delivery of care when appropriate and without delaying or limiting access.

## Goal Four:

**People affected by cancer have access to holistic supports that strengthen quality of life across their cancer experience.**



Effective cancer care relies on effective communication among healthcare providers, systems, and partners. This goal focuses on improving coordination, shared understanding, and access to information across cancer care services, including across jurisdictions. Enhancing communication supports safer care, reduces duplication, and enables providers to work together more effectively.

### Priorities for Goal Four:

- 1. Holistic supports and traditional practices are incorporated across the cancer journey.**
  - Example of what this could potentially look like:  
Facilitate access to traditional practices and mental, spiritual, social, and practical supports for people and families, including caregiver programs and respite, throughout the cancer care journey.
- 2. Culturally respectful palliative and end of life care pathways.**
  - Example of what this could potentially look like:  
Develop culturally respectful, territory wide palliative and end of life pathways with defined standards and roles to support care closer to home.
- 3. Coordinated follow up and ongoing support continue after curative treatment.**
  - Example of what this could potentially look like:  
Provide structured survivorship care which may include care plans, smooth transitions to primary/community care, rehab and self-management supports, and virtual options for remote communities.

## Goal Five:

**Communication and information systems strengthen the coordination, of care and meet the needs of residents across the cancer care journey.**



Cancer affects more than physical health. This goal emphasizes holistic, culturally safe supports that address emotional, social, spiritual, and practical needs across diagnosis, survivorship, palliation, and end-of-life care. By recognizing the full impact of cancer on individuals and families, the system can better support dignity, comfort, and wellbeing throughout the cancer journey.

### Priorities for Goal Five:

- 1. Clinical information is consistently shared among all partners in a patient's circle of care.**
  - Example of what this could potentially look like:  
Improve information sharing and clinical communication tools across the territory, Alberta and with partners to reduce duplication, enable timely referrals, and create reliable feedback loops that decrease the burden on the patient.
- 2. Practical tools and guidance for primary and community care are in place.**
  - Example of what this could potentially look like:  
Support providers with usable, culturally safe tools and guidance (navigation information, tobacco cessation workflows, plain language practice guides) that strengthen prevention, early detection/ diagnosis, treatment, and survivorship.
- 3. A territory wide approach to quality assurance and learning.**
  - Example of what this could potentially look like:  
Build a simple, territory appropriate quality and learning approach (indicators, patient reported outcomes measures and patient reported experience measures where feasible, territorial monitoring, and community feedback) to support responsive change.

## 5) The Path Forward: Self-Determination, Partnership, and Equity in Cancer Care

The path forward requires working in genuine partnership with Indigenous governments, communities, and Knowledge Holders, who are best positioned to describe what supports health, wellness, and healing in their own contexts. Indigenous self-determination in health is central to Reconciliation and to rebuilding trust between Indigenous Peoples and the health system. The Vision recognizes that lasting improvement in cancer care cannot occur without Indigenous leadership, voice, and authority guiding how care is designed, delivered, monitored, and evaluated.

System engagement with Indigenous partners consistently highlights that culturally safe, community-driven approaches grounded in Indigenous knowledge, languages, values, and practices are essential for reducing inequities and improving care. These approaches recognize that health is shaped not only by programs, services and treatments, but by relationships, culture, land, community, and ways of life. Territorial initiatives increasingly reflect the need for change that does more than respond to past harms, instead actively reshaping care to reflect Indigenous priorities, strengths, and ways of knowing.

Moving forward, the Vision commits the health system to ongoing learning, shared accountability, and meaningful partnership with Indigenous governments, communities, and residents across the NWT. The path ahead requires humility, listening, and a willingness to adapt based on what communities tell us is working and what is not. It also requires recognizing that health happens in many places, not only within health facilities, but in homes, families, friendships, cultural and spiritual practices, and connections to the land.

By honouring these strengths and understanding health as something that is lived every day, the Vision seeks to support people not only through their cancer journey, but through the broader experience of living well. Working together, and grounded in respect, equity, and cultural safety, we can build cancer care services and supports that reflect how health truly happens and is responsive to the people and communities of the NWT, now and into the future.



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# Glossary

## **Access**

The responsibility of the health and social services system to meet the unique and diverse needs of Indigenous and Northern residents by providing welcoming, respectful, timely, and appropriate programs, services, and facilities. Improving access includes addressing geographic, cultural, financial, and systemic barriers to care.

## **Caregiver**

In this document, a caregiver is a spouse, adult child, other family member, friend or other trusted person who provides unpaid physical, emotional, or practical care and support to a person living with cancer, enabling them to remain in their home and community.

## **Cancer Care Continuum**

Describes the coordinated delivery of health and social services across all stages of an illness, from prevention and early detection through treatment, palliative care, and end of life, ensuring continuity and coordination across settings and providers.

## **Cancer journey**

Refers to the full experience of cancer across all stages, from prevention and screening through diagnosis, treatment, survivorship, palliative care, and end of life, as experienced either first hand or through caring for a loved one.

## **Colonialism**

Refers to the policies, practices, and systems through which Indigenous peoples were dispossessed of land, culture, and self determination, resulting in ongoing social, economic, and health inequities.

## **Community Health Representative (CHR)**

A trained community member who serves as a bridge between the community and the formal health system by supporting health promotion, prevention, treatment, follow up, and surveillance activities in culturally relevant ways.

## **Cultural humility**

A lifelong commitment to self reflection and self evaluation that acknowledges power imbalances, challenges assumptions, and supports respectful relationships with Indigenous peoples. Cultural humility is foundational to achieving cultural safety.

## **Cultural safety**

An outcome in which Indigenous peoples feel safe, respected, and free from racism and discrimination when accessing health and social services. Cultural safety is determined by the experience of the person receiving care and requires transformation at individual, organizational, and system levels.

## **Culturally appropriate**

Care or services align with the cultural values, preferences, languages, and lived realities of the people receiving care, and are shaped through meaningful engagement with communities.

## **Culturally grounded**

Approaches are rooted in Indigenous knowledge systems, values, languages, and land based practices, and are guided by community leadership and lived experience.

## **Equity**

Equity in health means that everyone has a fair opportunity to attain their highest level of health, recognizing that people start from different places and are affected differently by social determinants of health. Achieving equity requires targeted actions and resource allocation to address avoidable and unfair disparities.

## **Equitable**

Refers to actions, policies, or services that are designed to respond to differing needs and circumstances, ensuring people receive the support they need to achieve comparable outcomes. Equity is not the same as treating everyone the same.

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**End of life care**

Care provided to individuals with advanced, progressive, and incurable illness, focusing on comfort, dignity, quality of life, and support for patients and their families.

**Health disparities**

Are differences in health outcomes or access to health services between individuals or groups that are often associated with social, economic, environmental, or geographic disadvantage.

**Health inequities**

Are differences in health outcomes between populations that are systemic, avoidable, unfair, and rooted in social determinants of health, including the impacts of colonization and racism.

**Health promotion**

Is the process of enabling people and communities to increase control over the factors that influence their health and to improve their overall well being through education, supportive environments, and community based action.

**High quality services**

Are safe, effective, person centred, timely, equitable, and culturally safe, and are delivered in a way that improves outcomes and experiences for individuals, families, and communities.

**Historical trauma**

Refers to the cumulative emotional, psychological, and social impacts of colonization, residential schools, and other systemic harms experienced by Indigenous peoples across generations.

**Holistic supports**

Address the physical, mental, emotional, spiritual, social, and cultural needs of individuals, families, and communities, recognizing the interconnected nature of health and wellness.

**Indigenous Peoples**

In this document, Indigenous Peoples refers collectively to First Nations, Inuit, and Métis peoples and is used interchangeably with Indigenous residents of the Northwest Territories.

**Palliative care**

An approach that improves the quality of life of patients and their families facing life threatening illness through the prevention and relief of suffering, including physical, psychosocial, emotional, and spiritual support. Palliative care may be provided alongside treatment and is not limited to end of life care.

**Prevention**

- Primary prevention includes actions that reduce the risk of disease before it occurs, such as healthy eating, physical activity, and avoiding tobacco.
- Secondary prevention focuses on early detection and treatment to reduce severity, such as cancer screening.
- Tertiary prevention involves treatment and rehabilitation to reduce complications and improve quality of life after disease has occurred.

**Racism**

The values, beliefs, and practices that categorize people as inferior or superior based on characteristics such as race or skin colour, and is expressed through Interpersonal racism, such as prejudice and discrimination between individuals, and systemic racism, where policies, practices, and institutions create and maintain inequities across systems.

**Risk factor**

Any characteristic, behaviour, or exposure that increases the likelihood of developing a disease. Modifiable risk factors are those that can be changed, such as decreasing smoking or increasing physical activity.

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**Screening**

Involves testing people who do not have symptoms to identify disease or risk factors at an earlier stage, when treatment is more likely to be effective.

**Social determinants of health**

The social, economic, and environmental conditions that influence health outcomes, including income, education, housing, food security, culture, and access to services.

**Survivorship care**

A comprehensive approach for clients that have had a cancer diagnosis, regardless of treatment pathway, that includes follow up services and supports to monitor physical and psychosocial health, manage late effects, and support long term well being.

**Traditional knowledge**

Refers to Indigenous ways of knowing that are rooted in lived experience, spiritual practice, relationships with the land, and intergenerational teachings passed down over time.

**Trauma informed care**

Recognizes the widespread impacts of trauma and creates services that promote safety, trust, choice, collaboration, and empowerment, while avoiding re-traumatization.

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