

# Growing Equity

Cultivating Organizational Capacity for Equity-Oriented Cancer Care

Fall 2025



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Our work has taken place on the Traditional Territories of many Indigenous Nations on Turtle Island. Our team is made up of people living and working on the Treaty 1 Territory (Winnipeg, MB, the traditional lands of the Anishinaabe, Ininew, Anisininew, and Dakota peoples, and the National Homeland of the Red River Métis), the unceded Territories of the xwməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), Stó:lō and Səl̓ílwəta ʔ/Selilwitulh (Tsleil- Waututh) Nations; and The Douglas Treaties – the traditional lands of the Ləkʷəŋən (Songhees and Xʷsep̓səm/Esquimalt) and WSÁNEĆ Peoples.

In Canada, our healthcare systems have been used as systems of colonization for centuries. By acknowledging this land, we are reminded of our colonial history, and as people working to improve healthcare systems, we have a responsibility to reflect on how we are either perpetuating colonial ideas and systems of oppression, or how we are working to counteract them including how we can foster inclusivity, respect, and reciprocity.



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## Executive Summary

Accessing and navigating cancer care—from screening to treatment and survivorship—is a complicated task for anyone. But for equity-denied people, who have some of the highest rates of cancer and worst cancer outcomes, it can be nearly impossible. Cancer care organizations can help address some of the challenges that equity-denied patients face.

### Study goals

-  To understand the challenges that equity-denied people face when accessing or attempting to access cancer care;
-  To understand what enables organizations to provide equity-oriented cancer care;
-  To co-develop community-led, research-based recommendations to improve equity-oriented cancer care in support of equity-denied people.

### How we did this study

We conducted interviews with service providers (e.g., nurses, social workers) and key informants (e.g., leaders), held focus groups with equity-denied patients, and observed in cancer care settings.

### Key findings

#### I. Challenges.

We identified four interconnected challenges to equity-oriented cancer care in our data: i) Cancer care services struggle to consistently factor in social needs; ii) Cancer care organizations tend to prioritize efficiency which undermines equity-oriented care; iii) Clinical cancer care spaces are perceived as uncomfortable, lacking personal touches, and unwelcoming; and iv) Experiences of stigma, discrimination, and judgement can deter equity-denied people.

#### II. Enablers.

Despite these challenges, we identified three key factors that support organizations in fostering equity-oriented approaches to care: i) Creating shared organizational values (which we named as relationality, cultural safety, trust-building, and adaptability) as a way to anchor equity work; ii) Building a shared commitment to health equity through investing in resources, leadership, partnerships; and iii) Taking measurable and concrete actions toward equity-oriented cancer care.

#### III. Recommendations to foster equity-oriented cancer care.

- Embed health equity as a core organizational value.
- Adapt physical spaces of care to feel more welcoming and foster human connection.
- Create organizational structures and processes that promote health equity by identifying and addressing social determinants of health.
- Design and deliver cancer services to be maximally accessible for equity-deserving communities.
- Tailor services to meet the specific needs of patients who are Indigenous.
- Work collaboratively with primary and community-based health and social care organizations.
- Equip service providers to deliver culturally safe, non-stigmatizing, anti-racist and trauma- and violence informed care.

# GROWING EQUITY CULTIVATING ORGANIZATIONAL CAPACITY FOR EQUITY- ORIENTED CANCER CARE

## Introduction

No one wants to think about cancer becoming a reality in their lives. For many Canadians, contemplating cancer screening, undergoing diagnostic tests, and enduring cancer treatment is stressful, scary, and even life changing. A cancer journey is often difficult to navigate, requiring challenging decisions, complex treatments, and has major impacts on patients, caregivers and families. For many people, although a cancer journey may be one of the most difficult experiences of their lives, they will be able to access a range of cancer care services and supports (both within and outside of the formal healthcare system) as they move through their cancer journey.

But for some people, a potential or actual cancer diagnosis is just one of many difficult experiences. Although hard to imagine, for people experiencing extreme poverty and lack of access to material and social resources such as housing, food, education, social connection, cancer may be only one of many competing priorities. People with lived experiences like these are sometimes referred to as marginalized, vulnerable, underserved, equity-seeking, equity-deserving, or equity-denied.

## What does ‘equity-denied’ mean and who are equity-denied people?

Equity-denied refers to people or groups that experience significant barriers to accessing resources and opportunities as a result of systemic discrimination rather than individual responsibility; this may come in the form of systemic racism, stigma, colonialism, or other forms of oppression<sup>1</sup>. The concept of equity-denied recognizes equity as a right, and implies that people, systems and structures with power and influence have a responsibility to address inequities and systemic injustices.

## In Canada, equity-denied groups are:

- More likely to be underrepresented in cancer screening programs<sup>2</sup>
- More likely to experience delays in diagnosis and be diagnosed with late-stage cancers<sup>3-7</sup>
- Less likely to receive a consultation with an oncologist after a cancer diagnosis<sup>8</sup>
- Less likely to receive treatment for their cancer, or receive poorer-quality cancer treatment<sup>5-8</sup>
- More likely to die from cancers that are curable, treatable or preventable<sup>2</sup>
- More likely to experience poor pain and symptom management<sup>9</sup>

Research has shown that less access to social determinants of health (such as education, employment, income), a complex health system, and systemic forms of discrimination and stigma all impact access to cancer care services in Canada.<sup>10-15</sup>

## Health equity as a priority in cancer care

Although there are major cancer-related inequities in Canada, at the same time, advancing health equity is increasingly recognized as a priority.<sup>16</sup> For example, working towards equitable access to cancer care services is listed as a strategic priority in the Canadian Strategy for Cancer Control (2019-2029).<sup>17</sup>

**Cancer care organizations (referring to any organization that provides care across the cancer continuum) have an important role to play in making care fairer and more accessible: the design, organization, and delivery of cancer services can either widen or reduce inequities, making organizational action essential.**

At the same time, because health equity is an emerging priority, there has been little focus on how to re-orient cancer care organizations and health systems towards equity. This gap matters, especially as more voices are calling for health equity to be a priority while recognizing cancer care as a key place to make progress.<sup>16</sup>

As a team of researchers, clinicians, and leaders in the cancer care sector, we have a shared interest in advancing health equity in cancer care through equity-oriented approaches to healthcare. Research done in other healthcare sectors<sup>18,19</sup> shows that equity-oriented healthcare approaches can improve quality of care and patients' experiences of care.<sup>18,20,21</sup> We were interested in understanding how cancer services may or may not be grounded in equity-oriented approaches, and how organizations delivering cancer services could be better equipped to provide **equity-oriented cancer care**.

## Key components of equity-oriented approaches to care

Equity-oriented healthcare (EOHC) is an approach to providing healthcare that aims to purposefully respond to health and social inequities by working to reduce the impacts of inequities such as poverty, discrimination and stigma and lessen the mismatches between current approaches to healthcare and the actual needs of equity-denied people.<sup>22,23</sup> Our understanding of EOHC is founded on three key dimensions that inform organizational-level changes in service design and delivery: (a) trauma- and violence-informed care, (b) culturally safe/anti-racist care, and (c) harm reduction philosophies and non-stigmatizing care.<sup>18,19,23</sup>

EOHC has been studied in primary care and emergency department settings in Canada, and has been identified as highly relevant to cancer care settings.<sup>24</sup>

**In this report, we use the concept of equity-oriented cancer care (EOCC) to refer to an equity-oriented health care approach applied in cancer care services, settings, and organizations.**

## Our study goals

We had three goals for this study:

1. To identify the challenges or barriers to equity-oriented cancer care
2. To understand what enables cancer care organizations to integrate equity-oriented approaches to care
3. To co-develop actionable, evidence-informed recommendations that could help organizations be better equipped to provide equity-oriented cancer care in support of equity-denied people

## How we conducted this study

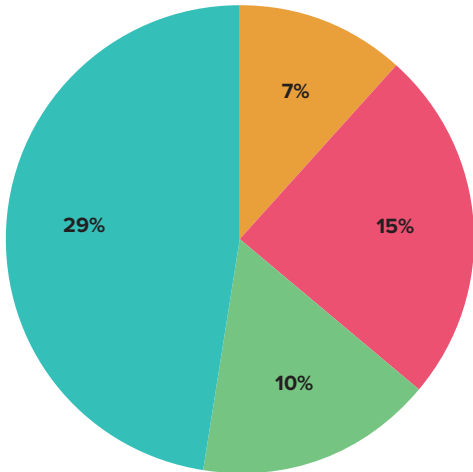
Our work was guided by social justice principles and an intersectional approach, which recognizes that people's identities—such as age, race, income, gender, sexuality, and disability—interact with social, political, and economic systems to create advantages for some and barriers for others. This lens helped us understand how power, politics, and social conditions shape healthcare service delivery environments and policy decisions, influence providers' ability to meet patients' needs, and affect people's access to care. By looking at cancer care through this perspective, we could uncover hidden barriers, identify ways to reduce inequities, and build on the system's strengths.

We used research methods that combine observation and interviews. Healthcare providers and decision makers were part of our team. We also partnered with a community clinic who has a mandate to serve equity-denied groups to help us to engage with equity-denied community members in a respectful and meaningful way.

We collected data using two main methods:

- **Interviews and focus groups:** we conducted interviews with health and social service providers, some who worked in a cancer care setting (for example, providing cancer treatments) and some who worked in a community setting providing care to equity-denied groups (for example, primary care clinics). We also conducted interviews with 'key informants', or people who worked in leadership, decision-making or policy roles within the cancer care sector. We held focus groups with equity-denied people, using a trauma-informed approach to encourage the sharing of perspectives and experiences of accessing cancer care.
- **Observations:** we spent about 40 hours observing care in two urban cancer centres. These observations took place in settings like outpatient clinics. We paid attention to many aspects of care, including the layout and feel of the spaces, how providers and patients interacted, the flow of daily work, and the formal and informal policies that shaped how care was delivered. While we observed the work of providers such as oncologists and nurses, our main interest was in how the organization itself influenced the ability to provide equitable care. A total of 61 individuals participated in the study.

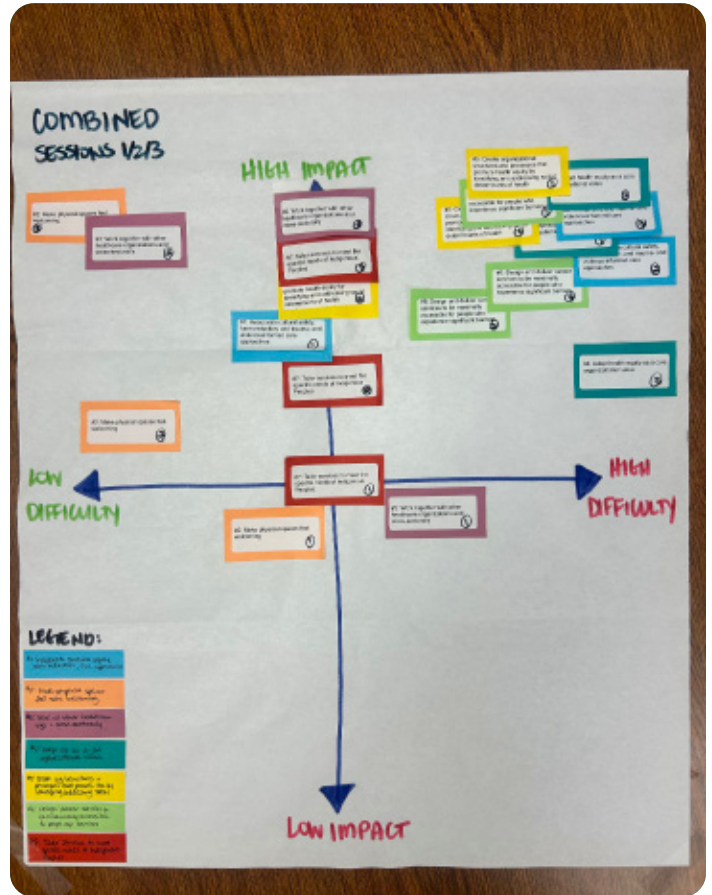
**For a full description of the research methodology, please consult published study findings:** <https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-025-02554-8>



- Service Providers (Cancer Care)
- Service Providers (Primary Care)
- Key Informants
- Equity-denied People

### Engagement and feedback on our findings:

Once preliminary key findings were ready, and a set of draft recommendations was complete, we hosted multiple discussion sessions. We invited health and social service providers that connected with our partner organization to one of three service provider discussion sessions. Patient participants and equity-denied community members were invited to one of three community member discussion sessions. We used multiple strategies to communicate findings and recommendations (for example, verbal descriptions, images, infographics), and to elicit discussion and feedback (for example, visual mapping, verbal feedback, arts-based activities). These discussions also offered us an opportunity to report back to study participants and community members and think about future directions.



## Key Findings

After having many conversations and observations about equity-oriented cancer care, we were able to identify key organizational and health systems challenges or ‘barriers’ that make it difficult to provide equity-oriented cancer care. We also identified important enablers or ‘facilitators’ that can help organizations move towards equity-oriented cancer care. Based on these findings and our engagement activities described above, a set of recommendations is provided to support organizations foster EOCC. The remainder of this report details these three key areas.

### I. What are the challenges to providing equity-oriented cancer care?

Firstly, we wanted to know what the challenges that cancer care organizations have in delivering EOCC. To meet this goal, we found 4 connected themes: Service design mismatches; Competing priorities; Uneasy spaces; Incompatible experiences.

### Challenge #1: Cancer services struggle to consistently factor in social needs.



We heard from service providers that equity-denied people often need support addressing social needs (e.g., housing or experiences of discrimination) before they can access cancer care. But cancer services are often heavily focused on physical health, leaving out social needs, often resulting in interrupted care. For instance, one service provider said:

*“In the day-to-day life of the people that we’re supporting, there just are going to be more challenges...access to food, shelter, comfort...So then, when you’re dealing with all those things. And then you’ve also got an appointment at the cancer center this morning and they want you back six hours later in the afternoon for a CT scan. And then the next day, they want you there at 7 am for chemo, but your support worker doesn’t start working until 8 am, there’s so many little things...” (Service Provider Participant)*

### **Disconnections between cancer services and community-based care**

Many equity-denied patients in this study were well connected to community care providers. But we consistently heard from community care providers that they were left out of communication with cancer care about their patients. This gap was really frustrating for care

providers and often meant missed or cancelled appointments, and delays in treatment.

*“It’s a frustrating thing that comes up all the time where a few months later you just get the [communication from the oncologist] “Oh, we just couldn’t find your patient.” And it’s like, “Oh, well they come to see me every week. Had I known, I would have helped.” (Service Provider Participant)*

### **‘Fitting into the box’ and meeting health system expectations**

There are many unwritten rules and unspoken expectations in healthcare settings, including cancer care. For example, patients are expected to be on time, waiting quiet for their appointment, and follow care plans from service providers. For people already facing barriers, many of these expectations will be difficult, if not impossible, to meet, and can result in patients being unable to get the care that they need.

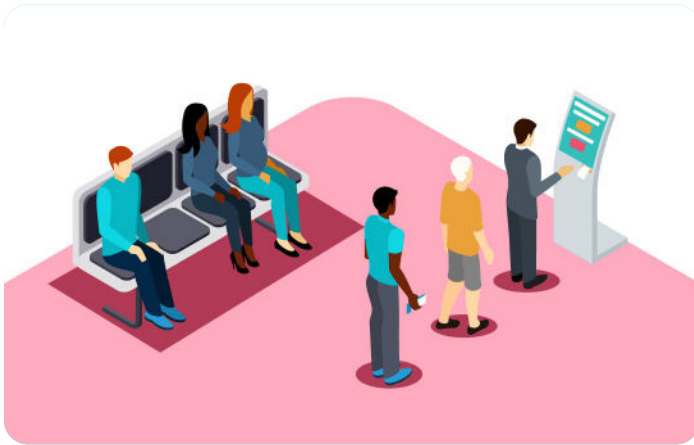
*“For our folks who use substances, one real barrier for them... is that our medical system is often set up, where you have to be at an appointment, at a certain time, at a certain location – so you have to have money to get there, have a means of transportation to get there and then you have to sit, then you have to wait – and often you have to wait for a very long time... But if you have a very active substance use disorder and you start to go into withdrawal, you’re not going to be able to wait.” (Service Provider Participant)*

Beyond behavioural requirements, were access to resources. A common experience shared by community-based service providers was related to colon cancer screening. For this type of screening, the expectation is that patients have stable housing with access to a private washroom. But this is not the reality for many equity-denied patients. One service provider shared their concerns:

*“So I had someone who had ... concern for possible colon cancer and they need a CT scan and a colonoscopy... To do a colonoscopy, you have to do the prep. If you’re in an SRO and there’s one toilet for 30 people, it’s a bit challenging for lots of reasons to do that. And I think folks feel a lot of shame around that. And so sometimes people would be like “I can do it. I’ll do the prep” but then they don’t do the prep and they no show to their colonoscopy and then we get an angry letter back from the gastroenterologist...” (Service Provider Participant)*

In either case, people are unable to access cancer care – not because they don’t want it, but because the system is not designed to meet their needs.

## Challenge #2: Balancing efficiency with equity



Another challenge to providing equity-oriented cancer care was the need for efficiency. Service providers and key informants recognized that efficiency is important for organizations – many are trying to address growing waitlists, at the same time as experiencing a lack of human resources and financial constraints. At the same time, focusing on efficiency made it difficult to provide care that is flexible and adapted to the needs of equity-denied people, and in the process, made care less accessible. Appointments and provider discretion were two areas of particular concern.

### ***Inflexibility of cancer appointments***

Service providers and key informants talked about rigid ‘rules’ (both written and unwritten) in appointment scheduling, and how those were a major barrier for equity-denied people. An example of this was sometimes referred to as the ‘3-strikes’ rule, where missing three appointments could lead to losing access to cancer care:

*“The classic example, is a patient who really finds it hard to kind of turn up for appointments, turn up on time and all that. And we tend to, we give them a couple of goes at it, but if they don’t show up at a certain time or something then we just won’t try again.” (Key Informant Participant)*

Many service providers acknowledged that appointments needed to be filled, but that these types of rules had greater negative impact on equity denied people.

### **Limited flexibility to meet patient needs**

Organizations needing to be efficient also meant that some cancer care providers and key informants felt they had little flexibility to tailor care to patients’ equity-based care needs:

*“I think that basically every minor change that you want to make goes up the chain [...] So there’s multiple layers of bureaucracy [...] And so people when they hear, oh you can’t do that, it puts the brakes on a lot of innovation. So there’s a lack of innovation going on, because of having to go through multiple layers of leadership.” (Service Provider Participant)*

However, many participants talked about resisting these structures and limits in their own ways; for example, one provider described attempting to assess for social needs in their own practice.

## Challenge #3: Physical spaces of care can make people feel uneasy



For many patient participants, cancer care was unwelcoming, feeling cold, lonely, and even being described “like jail” or “residential care”. Service providers and key informants also recounted maze-like, drab, institutional feelings

in clinical facilities providing cancer services, noting that some programs that existed before the COVID-19 pandemic, such as live music, volunteer pets, or even light refreshments, had not returned. In our observations, we saw that many clinical spaces had glass partitions, line-ups, and an abundance of signage (including punishment-based signs communicating messages of ‘zero tolerance’ of “violence, foul language, or abuse”), all contributing to a sense of unease.

#### **Challenge #4: Experiences of stigma, discrimination, and judgement can deter equity-denied people from accessing cancer care**



Many participants shared that they had experienced or witnessed stigma, judgement, and discrimination in cancer care towards equity-denied patients, especially those facing challenges such as mental health, substance use, racism, poverty, and/or homelessness:

*“[One] individual, he had throat cancer...and he was heavily stigmatized for his substance use. I understand when you have throat cancer you don’t want people to smoke... but it was more just like a stigmatizing comment like, you need to stop. Not really offering any other kind of supports around that. He didn’t go after that for a couple of weeks, he was scared to go back and really didn’t want to go back.” (Service Provider Participant)*

These experiences layered on to the other challenges described above and led to a lack of trust towards organizations and people providing cancer services, and prevented people from getting cancer care.

## II. What enables organizations to provide equity-oriented cancer care?

Our second goal was to learn what enables cancer care organizations to embed equity-oriented approaches into their everyday work and deliver more equitable care. We identified three key factors: Creating shared values; Building a shared commitment; and Taking action. Importantly, what we outline below are evidence-based findings from our research – but there is not a one-size-fits-all approach to building organizational capacity for equity. Rather, each organization will need to engage in its own equity-building process.

### Enabler #1: Create shared values



We heard from service providers and key informants that organizational values are foundational to guiding the work of the organization.

*“[We need] more of an intention to actually integrate the principles of equity into all of the projects and initiatives that are happening [...] and to be more focused on serving the needs of the patient versus the needs of the organization” (Key Informant Participant).*

We identified four key, interrelated values that can support organizations in creating an equity-oriented culture.

**Relationality.** Valuing relationality implies a fundamental understanding of the interconnectedness of patients, families, communities, health systems, and larger social structures. Strong relationships (within the organization, and with external organizations and community partners) and valuing other aspects of health (e.g., spiritual and social care needs) are key ways valuing relationality can be practiced.

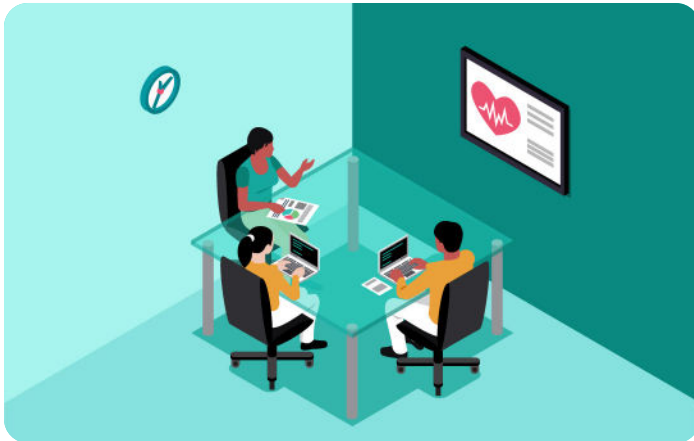
**Cultural safety.** Cultural safety (a concept stemming from Māori Indigenous peoples) means creating spaces that center social justice, with the goal of breaking down power imbalances. Working in tandem with relationality, valuing cultural safety means providing person-centered, non-judgemental, strengths-based care.

**Trust-building.** Participants saw trust as foundational to building equity. Trust-building within cancer care organizations meant leveling hierarchies, so that patients are seen as experts in their care. It also meant recognizing and using each team members strengths, for the good of patient care.

**Adaptability.** Within cancer care organizations, adaptability meant being open to creative solutions, especially when addressing the care needs of equity-denied people. Valuing adaptability allowed service providers to reduce barriers to care in novel ways; this included creating a nurse-led process for colon cancer screening, and outreach workers providing self-

sampling cervical cancer screening kits. Flexible appointment times and modes (e.g., virtual care through a primary care provider) was another example of adaptability in action.

## Enabler #2: Build a shared commitment



Although organizational values may anchor equity work, participants emphasized that advancing health equity in cancer care requires organizational commitment and buy-in.

*“So I think that the value of getting everyone on the same page or feeling like we’re all kind of rallied around the same banner of health care equity, I think the importance of that is actually huge. Because this has to feel just as much of a part of the work of the chief operating officer, as the unit clerks, as the folks who are screening people for COVID at the doors. Like this has to be all levels, all positions united around how we make this change in the system. And then knowing that the system is made up of us and our actions.” (Key Informant Participant)*

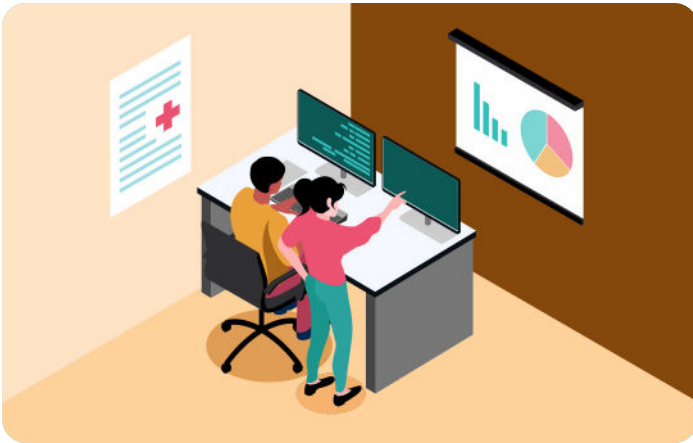
Organizational commitments to equity then need to be supported with resources and investments.

*“You have to support it in all kinds of ways ... I really believe that: make sure it’s everybody’s business, and back it up, right? And it needs some budget, and it needs some time, and your organization needs to invest in it, no question about that.” (Key Informant Participant)*

Investing in health equity can include:

- Embedding health equity official across guiding organizational documents (e.g., mission, vision, values statements; strategic plans; policies; and processes and procedures).
- Investing tangible resources, such as time, money, and people to support equity through new models of care (e.g., see theme 3b) and/or specific positions (e.g., equity officer). Dedicated resources show commitment to equity and help the equity work to be more impactful.
- Growing critical leadership across the organization. Critical leaders are self-aware and reflective, whose values align with the equity-oriented values. These leaders can model the values needed to support equity work.
- Nurturing mutually beneficial partnerships with community groups, other health and cancer care organizations through win-win relationships, where both/all groups benefit. Part of this process includes organizations getting comfortable with being uncomfortable, by stepping back and allowing partners to guide.

### Enabler #3: Take action towards equity-oriented cancer care



A crucial piece to organizations advancing equity is to put it into action so that equity-denied people are increasingly given equitable care. This includes taking concrete actions and creating structures for accountability to support a learning health system.

**Creating and maintaining accountability.** Part moving towards health equity includes creating accountability structures; in other words, monitoring whether organizations are enacting their values and vision, achieving their strategic goals toward EOCC, and so on. This often includes gathering data and having opportunities for feedback (such as access to care indicators, population-level outcomes, and patient-reported outcome and experience measures), with an ability to adjust to improve EOCC.

*“Accountability is big... it’s not only about the strategic plan; it’s about what is your accountability in it. And it’s about embedding those DEI lenses into your strategic plan with accountability” (Key Informant Participant)*

### Take concrete actions to support equity-oriented cancer care.

Creating values, investing in resources, and developing accountability measures are vital. And, for patients to experience EOCC, tangible, creative strategies to delivering cancer care are needed. This could include creating or revising clinical workflows to assess health and social equity needs (e.g., initial contact and assessment after referral to identify and address barriers to attending consultation; including social determinants of health assessments in clinical workflows), working with Indigenous communities to develop specific cancer pathways, or examining organizational policies through a health equity lens (e.g., missed appointment policies). Potential strategies are further described below and in the corresponding published paper.

### III. How can an equity-oriented approach to care be fostered? Recommendations for cancer care organizations

Based on our study findings and refined through our engagement with community members and study participants, we developed seven recommendations to help cancer care organizations by supporting equity-oriented approaches to care. In developing this list of recommendations, we are advocating for the integration of equity-oriented approaches across the cancer care continuum and emphasizing the important role that the health system can play in growing equity. Under each recommendation, we include examples of relevant strategies that could be used; these examples are not exhaustive, and any organization meaningfully committed to advancing equity will need to determine the strategies that will be most effective in their setting.



## Embed health equity as a core organizational value

- Clearly communicate to all staff that health equity is everyone's business, and that health equity impacts peoples' health outcomes.
- Acknowledge health equity in core organizational documents (e.g., values statements, strategic plans) and consider health equity across performance indicators, clinical outcomes, PROMs and PREMs.
- Provide meaningful and continuing education on health equity and equity-oriented approaches to care (see recommendation #7 for further strategies), exploring opportunities to integrate this education into employment conditions, performance reviews, and organizational performance indicators.
- Build meaningful and reciprocal relationships with equity-deserving communities.
- Review and consider all policies and processes through an equity lens. For example, use a health equity impact assessment framework to review existing policies.
- Explore where there may not be existing policies to support equity-oriented cancer care. For example, there may be an absence of policies related to harm reduction.



## Adapt physical spaces of care to feel more welcoming and foster human connection.

- Create a more welcoming space by adding artwork and elements of nature. Consider wall colour (avoiding neutral and beige colours) and smells (introducing smells like pine and cedar).
- Incorporate music, pets, laughter, and other calming strategies (e.g., providing water, hot beverages, and small snacks).
- Provide volunteers to assist with navigating clinical spaces and reduce feelings of being ‘just a number’ or ‘a cog in the wheel’, recognizing that connection and communication can make physical spaces feel more or less welcoming.
- Simplify signage and use inclusive language on signage.
- Include pronouns on staff ID badges.
- Adopt a harm reduction approach by providing harm reduction supplies and create a safer space to use substances.
- Create spaces within clinical environments to be used for spiritual practices.



## Create organizational structures and processes that promote health equity by identifying and addressing social determinants of health.

- Integrate assessments of social determinants of health into new patient assessments; ensure these assessments are easily available in the chart. Explore processes for connecting patients identified as having unmet social needs to additional resources or supports (e.g., referral pathways, resource lists).
- Support clinical care delivery models that recognize and accommodate the adaptability in care that is necessary (e.g., flexibility in appointment lengths, arrival times, appointment modes (virtual vs in-person care), communication modes, and treatment plans).
- Consider creating alternative care pathways for people who will be unable to access care through usual pathways due to social or structural conditions. For example, developing short term housing with clinical care support within communities for unhoused people undergoing cancer treatment.
- Consider the use of chart ‘flags’ to communicate important social care needs, exploring opportunities for co-development with equity-deserving communities to ensure these are non-stigmatizing. For example, flagging an alternate contact or primary care

provider for patients who do not have a phone or stable address for contact, or for patients with disabilities (e.g., deaf).



## Design and deliver cancer services to be maximally accessible for equity-deserving communities.

- Consider outreach-style and/or community-based cancer services, bringing care into the community, and closer to home.
- Integrate care coordination approaches, which may include oncology navigation services or case management, for patients who have more complex social needs.
- Implement team-based care models that can holistically address the social determinants of health and health care.
- Ensure continuity of care providers as much as possible.
- Ensure support services and educational services (included written information) for clients and caregivers are accessible to people experiencing marginalization and barriers to care. For example, consider that online support groups may not be accessible to people who are unstably housed.
- Consider innovative support roles (e.g., peer support programs, cancer ‘doula’) to foster a sense of safety and connection.



## Tailor services to meet the specific needs of patients who are Indigenous.

- Work with Indigenous communities to co-develop Indigenous cancer services, meant for Indigenous patients, and delivered by Indigenous providers. This could be supported by a health human resources strategy.
- Integrate aspects of Indigenous ways of knowing and healing into cancer care. Include and provide Elder services.
- Create an organizational culture that values ways of knowing other than biomedicine.



## Work collaboratively with primary and community-based health and social care organizations.

- Create mechanisms for multi-directional relationships between primary care and/or community-based health and social care, and organizations delivering cancer care services.
- Seek opportunities to collaborate across sectors to meet needs for housing and transportation (e.g., access to temporary housing to facilitate cancer treatment).
- Leverage digital technologies to support integration and collaboration across the healthcare sector (e.g., telehealth, integrated electronic medical records).

Create partnerships between health and social services organizations to support access to cancer screening (e.g., between primary care orgs, hospital, and prov screening for folks who are unhoused needing colonoscopy screening/bowel prep).

- Support staff to actively build respectful and trusting relationships between care providers and patients, knowing that these relationships are an essential foundation for culturally safe and equitable cancer care and play a significant role in access to cancer care services.



## **Equip service providers to deliver culturally safe, non-stigmatizing, anti-racist and trauma- and violence-informed care.**

- Build capacity for staff to incorporate trauma-informed care strategies in their daily work through ongoing education. This may include asking for permission to conduct physical exams, asking permission to talk about peoples' bodies, explaining physical procedures as they are happening, and paying attention to tone of voice.
- Actively address substance use stigma among healthcare providers. This includes adequate pain control and palliation of symptoms for all people regardless of their substance use history.
- Build awareness that many people using cancer services have experiences of violence, trauma, discrimination, racism, and stigma; trauma is especially prevalent. Awareness will help to foster understanding that these experiences often lead to people avoiding or delaying seeking care (among other impacts) with many negative health implications.

## Conclusion

Advancing cancer health equity is a growing priority worldwide, and organizations that deliver cancer services play a role in this. We drew on the perspectives and experiences of patients, service providers, and key informants, through interviews, focus groups, observations, and engagement sessions. We heard that several challenges continue to hinder growth towards equity-oriented cancer care, including a) lack of social needs in care provision, b) limitations of efficiency-based care, c) uneasy physical spaces, and d) negative experiences in health and cancer care.

Yet, our research also suggests that organizations can cultivate capacity for equity-oriented approaches to care to better support the needs of equity-denied people. This report outlined conditions that enable organizations to support equity-oriented cancer care, including rooting care in shared values and commitments, and taking action. Evidence-informed, participant-driven recommendations were provided as seeds from which organizations can begin to grow more equity-oriented cancer care.

## Publications

**Horrill, T. C., Crawford, J., Beck, S., Bourgeois, A., Kaur, J., Lambert, L. K., McKenzie, M., Stajduhar, K. I., & Browne, A. J. (2025).** “There’s just such a mismatch”: A qualitative exploration of health systems and organizational-level barriers to accessing cancer services among people experiencing structural marginalization. *International Journal for Equity in Health*, 24(1). <https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-025-02554-8>

Additional publications forthcoming.

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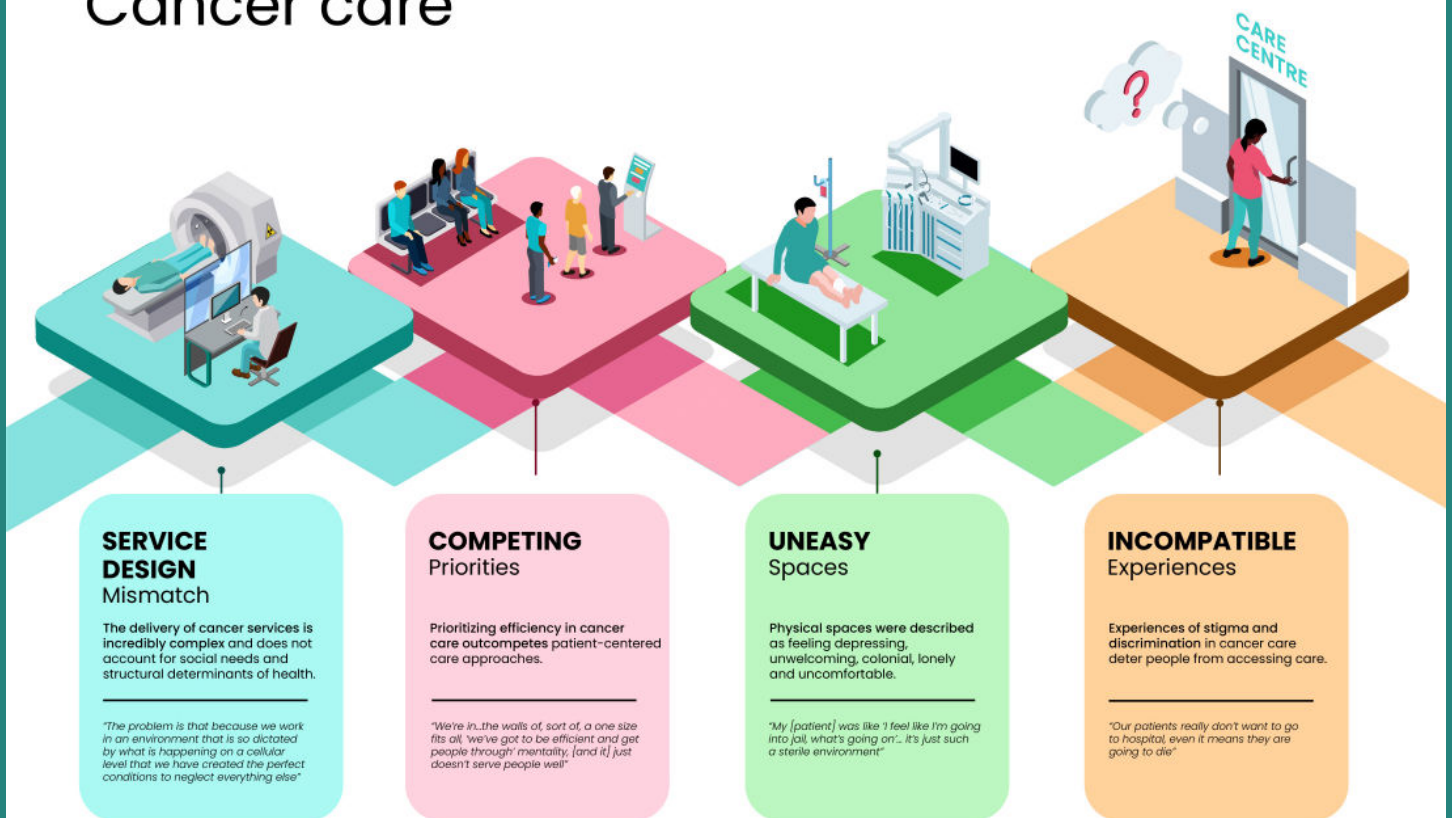
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# Appendices

## Barriers To Equity-oriented Cancer care

We need to address barriers To equity oriented health care Services, design and delivery



# Facilitators of Equity-Oriented Cancer Care

How organizations can foster equity-oriented cancer care centering each person's needs and minimizing barriers to accessing care



## Create Shared Values

Organizations can provide equity-oriented cancer care through a culture rooted in reciprocity, connection, and shared responsibility.

Equity is everyone's business.

## Building Organizational Commitment

Organizations can support equity through dedicated resources and investing in partnerships and transformative leadership.

Equity needs time, budget, and real investment to make it work.

## Being Accountable and Taking Action

Organizations can act on their commitments and values by implementing accountability structures and tailored strategies to advance equity in cancer care.

Equity work is guided by clear plans and measurable goals across the organization.

# Advancing Equity-Oriented Care in Cancer Care Organizations

7 data driven and community informed recommendations



**Make health equity a core** organizational value



**Create** welcoming spaces



**Assess and address** health and social equity needs



**Create new roles** and team structures for care delivery



**Tailor services** for Indigenous patients



**Collaborate with organizations** outside of cancer care




**Equip providers** to deliver culturally safe, trauma- and violence-informed care

**Start anywhere!**  
Any step towards equity is a good step.

# About ReACHE Lab


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