Examining Structural Factors Influencing Cancer Care Experienced by Inuit in Canada: A Scoping Review

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Preface

1. Wendy Gifford, PhD, RN
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   Dr. Wendy Gifford (WG), my thesis supervisor, was involved throughout the entire thesis process, including developing the research topic and questions, determining the appropriate methodology, and interpreting the study findings and implications for nursing. WG also reviewed, edited, and approved every chapter of this thesis.

2. J. Craig Phillips, LLM, PhD, RN, ACRN, FAAN, FCAN
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   Dr. J. Craig Phillips (JCP), a member of my thesis committee, offered guidance on the direction of the thesis. JCP assisted in the formulation of the research questions, provided recommendations on the study methods, and guided the analysis of the study results. JCP also reviewed all chapters of this thesis and gave feedback.

3. Veldon Coburn, PhD
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   Dr. Veldon Coburn (VC), a member of my thesis committee, offered guidance on the study background and overall direction of the thesis, including data analysis and interpretation of study findings. VC also reviewed all chapters of this feedback and provided feedback.

4. Health Department Team (Reyna Uriarte, Chelsea Giesel, Karis Gruben)
   Pauktuutit Inuit Women of Canada

   Pauktuutit Inuit Women of Canada's Health Department Team was external to the thesis committee, but played an integral role in this thesis as a study partner, and provided guidance on the study methods and interpretation of findings.

5. Catherine Larocque, PhD(c), MScN, RN
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   Catherine Larocque (CL), a secondary reviewer, assisted in the study selection process including citations screening and full-text review.

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Emiliana De Omena Bomfim (EB), a secondary reviewer, assisted in data extraction and reviewed the accuracy of the extraction results.

7. Lindsey Sikora, BScH, MISt., PhD(c)
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   Lindsey Sikora (LS), a health sciences and medicine research librarian, provided guidance on selecting the most relevant and appropriate databases in the area of Inuit health, and assisted in the development of the search strategy.

Thesis Abstract

Introduction
The existing cancer-related disparities among Inuit are rooted in the structural conditions that create health and health care inequities. No comprehensive review currently exists about structural factors that facilitate or hinder Inuit's access to and experiences with cancer care services in Canada.

Purpose
The overall aim of this scoping review was to synthesize the available published and grey literature on the structural factors that influence cancer care experienced by Inuit in Canada.

Methods
Guided by the Joanna Briggs Institute (JBI) scoping review methodology, searches were conducted in a number of electronic databases, grey literature sources, and relevant journals. The extracted data were synthesized using thematic analysis and presented using tables and narrative summaries. Quality assessment was performed for each included study on its relevance to Inuit communities.

Results
A total of 30 papers were included in this review. The structural factors were identified and described through five categories related to: colonization, as well as health systems, social, economic, and political structures.

Conclusions
Addressing the structural barriers that Inuit face in the cancer care trajectory requires a system-wide approach. Thesis results inform health care delivery and nursing practice with the goal of improving health equity for Inuit in cancer care.

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Chapter One

Introduction

Background

Indigenous Peoples in Canada

First Nations, Inuit and Métis are the Indigenous Peoples in Canada who inhabit their traditional lands with languages and cultures grounded in holistic ways of knowing, long before the arrival of European settlers (Government of Canada, 2022). Indigenous Peoples have lived through the legacy of Western colonization and assimilation that attempted to strip them of their cultural identities and traditional ways of knowing, doing, and being (MacDonald & Steenbeek, 2015; Reading & Wien, 2009). While colonial structures and processes have varied across different time periods, locations, and Indigenous groups, these all have produced persistent health disparities rooted in the social, cultural, economic, and political inequities among Indigenous populations in Canada (Adelson, 2005; Horrill et al., 2019; Waldram et al., 2006).

Inuit (singular: Inuk) are one of the three groups of Indigenous Peoples recognized in Section 35 of the Constitution Act of 1982 in Canada (Crown-Indigenous Relations and Northern Affairs Canada, 2021a). The majority of Inuit in Canada lives in Inuit Nunangat, spanning across the land claims regions of Nunavut, Nunavik in Northern Quebec, Nunatsiavut in Northern Labrador, and the Inuvialuit Settlement Region of the Northwest Territories, along with a growing population that reside in urban locations across Canada (Inuit Tapiriit Kanatami, 2022). Particularly as a result of the Canadian federal government's Inuit Resettlement Program (Healey & Meadows, 2007), Inuit living in southern communities such as Inukjuak were coercively relocated to the high arctic, an unfamiliar place that was far different from what had been promised (i.e., without the same established infrastructures and resources) and much more climatically hostile, while the government left next to nothing for survival (Bjerregaard et al., 2004; Madwar, 2018). Colonial and racist policies such as forced relocations and residential

schools have left generations of families with historical trauma that continue to impact Inuit health and well-being to this day (Allan & Smylie, 2015; Browne & Smye, 2002; Healey & Meadows, 2007). It is critical for non-Indigenous researchers, health professionals, and readers to recognize all Indigenous Peoples as active participants in the global society who strive for holistic wellness and healing, greater self-determination, and reclaiming their cultures and knowledges (United Nations, 2007); all of which should be acknowledged as salient evidence of Indigenous Peoples' strengths, resilience, and resourcefulness (Canadian Council on Social Determinants of Health, 2013; Yu et al., 2020). However, it remains imperative to address the ongoing health disparities and inequities embedded within the Canadian health care system that directly and indirectly affect the health and well-being of Inuit in Canada.

Note: In 1953 and 1955, the Royal Canadian Mounted Police on the behalf of the Department of Resources and Development moved approximately 92 Inuit from Inukjuak in Northern Quebec, and Mittimatalik in what is now Nunavut, to settle two locations on the High Arctic islands (Madwar, 2018). The High Arctic relocations were designed by the Canadian government to establish Canadian sovereignty in the Arctic, and did not acquire free and informed consent from Inuit for relocations to areas with inhabitable conditions (Anderson & Bonesteel, 2010; Madwar, 2018).

Cancer Burden and Inuit Health

For many Inuit communities in remote northern regions, striving for health and wellness involves insightful considerations given the unique circumstances that impact Inuit health outcomes, which are heavily influenced by geographical location, transient health care workforce, and limited local access to specialized health services (Huot et al., 2019; Reading & Wien, 2009). Along with First Nations and Métis, Inuit shoulder a disproportionately greater

cancer burden in comparison to non-Indigenous populations in Canada; researchers have reported an overall increase in cancer incidence among Inuit in recent decades (Friborg & Melbye, 2008; Young et al., 2016), with cancer being one of the leading causes of premature Inuit deaths in Canada (Peters, 2010). This alarming trend is especially reflective of lung cancer, where studies have suggested lung cancer rates among Inuit women and men are the highest worldwide, about three to five times the overall Canadian average (Carrière et al., 2012; Kelly et al., 2008). Combined with rising incidence, higher mortality rates, and later stage diagnosis, Inuit are faced with poorer cancer survival rates and outcomes than the general Canadian population (Canadian Partnership Against Cancer, 2014; Kelly et al., 2008; Young et al., 2016).

Researchers and administrators of cancer care organizations have stressed that the disproportionate cancer burden experienced among Inuit is not only the result of inequitable access to cancer care and a fragmented jurisdictional coordination of health care service delivery (Asmis et al., 2015; Corvus Solutions, 2012; Inuit Tapiriit Kanatami, 2008; Tungasuvvingat Inuit & Cancer Care Ontario, 2017), but are repeatedly exacerbated by social and political exclusion, systemic racism, and colonial practices within mainstream health services (Adelson, 2005; Allan & Smylie, 2015; Horrill et al., 2019; Loppie et al., 2014). As such, Inuit continue to experience alienation in health care systems, lack of trust and health needs not met, and on average, higher rates of illness and poor health compared to non-Indigenous Canadians (Corvus Solutions, 2012; National Collaborating Centre for Indigenous Health, 2019).

Structural Factors of Indigenous Health

The persistent health disparities between Inuit and non-Indigenous populations are intricate and cannot be understood without examining the structural inequities that continue to impact the health and well-being of Inuit in Canada (Reading & Wien, 2009). Structural factors

are described as factors embedded within and produced by the historical, political, social, and economic structures of a society (Horrill et al., 2019). According to Reading (2015), structural factors represent the determinants of Inuit health from which the proximal (e.g., health behaviours, physical, and social environments) and intermediate (e.g., community infrastructure, resources, and systems) evolve; they resemble the roots of a tree where the leaves and branches are the proximal and intermediate factors. Structural factors have the most profound influence on the health of the overall population through the political, social, and economic inequities that create unfavourable determinants of health and poor health-related outcomes (Reading & Wien, 2009). In particular, historical research has indicated a link between colonialism and diminished life expectancy, a disproportional burden of chronic and communicable disease, and social violence experienced by Indigenous Peoples in Canada (Waldram et al., 2006). With these considerations, failing to consider and address the structural determinants of health in health care discourse runs the risk of perpetuating the same inequities that undermine the health and well-being of present and future generations of Inuit in Canada (Reading, 2015).

Ethical Considerations

Data for this research are gathered from existing published and grey literature. Ethical approval was thus not required as primary data was not collected or analyzed in this scoping review.

Ethical Principles Underpinning Research with Inuit

It is pertinent for this scoping review to align with ethical principles and guidelines for research with Inuit. My research approach was grounded in Inuit-specific principles outlined by the National Inuit Strategy on Research (Inuit Tapiriit Kanatami, 2018) and adhered to the five priority actions identified in this strategy:

1) *Advance Inuit governance in research*. Members from Pauktuutit Inuit Women of Canada were engaged as collaborative partners in the oversight of this scoping review. Feedback and input from Inuit partnerships were sought out for the research purposes, questions, and findings of this study.
2) *Enhance the ethical conduct of research*. The development and operation of this scoping review have adhered to Chapter Nine of the *Tri-Council Policy Statement* (Canadian Institutes of Health Research et al., 2018) on the ethical guidelines for research involving First Nations, Inuit, and Métis Peoples, which includes developing respectful relationships, collaboration, and engagement between researchers and Indigenous partners. Inuit values and principles expressed in Inuit Qaujimajatuqangit (IQ) guided the undertaking of this study and dissemination of the findings, which includes elements of respecting the importance of traditional knowledge to health and wellness (Tagalik, 2010)
3) *Align funding with Inuit research priorities*. The purpose of this scoping review was developed in response to the priorities identified in the published research on Indigenous health (Horrill et al., 2019), and by representatives within Pauktuutit Inuit Women of Canada (Pauktuutit Inuit Women of Canada, 2013).
4) *Ensure Inuit access, ownership, and control over data and information*. Inuit organizational members were recognized and engaged as partners throughout the research process, and have transparent access and control in the collection, verification, analysis and interpretation, and dissemination of outputs derived from this scoping review.
5) *Build capacity for Inuit Nunangat Research*. By building a collaborative and respectful relationship with Inuit at Pauktuutit Inuit Women of Canada as integral research partners, this

scoping review aimed to support building capacity with Inuit in research and prioritization of research that reflects Inuit needs.

Study Objective and Questions

The objective of this scoping review was to synthesize the available published and grey literature on the structural factors that influence cancer care of Inuit in Canada. Structural factors refer to the social, economic, political, and environmental health systems factors from colonization that shape Inuit lives (Horrill et al., 2019; Reading, 2015). This thesis project was written in a manuscript-based format and follows the Joanna Briggs Institute scoping review methodology (Peters et al., 2021). The following research questions were addressed:

1) What structural factors influence cancer care experienced by Inuit in Canada, and in what ways do these structural factors influence their cancer care?

2) What aspects of cancer care are influenced by the structural factors identified?

Findings from this scoping review add to the current knowledge base regarding cancer care among Inuit in Canada and fill in a research gap concerning structural determinants of health that influence Inuit. Although focusing specifically on Inuit in Canada, study findings can inform understandings of structural factors that impact the health and well-being of First Nations, Métis, and Inuit in Canada.

Research Impetus and Researcher Positionality

Living in an urban Canadian city, I began to learn about the health and health care disparities experienced by Indigenous Peoples in Canada back when I was an undergraduate nursing student. As I continued to work closely with patients from day to day as a Registered Nurse, I saw and heard about the harsh realities of inequitable health care access and outcome disparities faced by Indigenous patients and caregivers, who have travelled hundreds or

thousands of miles from home to arrive to a settler colonial system of care worsened by ongoing marginalization and systemic racism. It became my goal to pursue graduate studies in nursing to better understand the social determinants of health that have greatly impacted and disadvantaged the health and well-being of Indigenous Peoples. As I was born in China and later raised in Canada, my lack of relationship with Inuit poses challenges in undertaking this study. However, I have noted a number of similarities between the values and principles of Inuit health and traditional Chinese health. For example, Chinese people uphold harmony and balance, appreciate and respect elders' wisdom, honour the collective interests of the community, and emphasize the importance of holistic health through traditional medicine (Chen, 2001), which have been described as similar to what Inuit support in health and wellness (Tagalik, 2010, 2015). These are a few examples illustrating meaningful connections between two distinct cultures from two different locations that have encouraged me with valuable insight to explore Inuit health.

Throughout my coursework in the first year of the Master of Science in Nursing program, I was keen to study the social determinants of Indigenous health and the effects of colonialism on the well-being of Indigenous communities in Canada. From there, I completed a primary health care practicum and interviewed several key informants who are involved in cervical cancer screening for Inuit women in northern Canada, which gave me an opportunity to learn about the interrelationships between the surrounding systems and structural factors that impact Inuit women's access to cancer care services and resources. Incorporating my experiences as a nurse and a graduate student, it became particularly meaningful to me to study the structural aspects of cancer care for Inuit especially given there is little research conducted on this topic in Canada.

As Usmani (2021) asserted, "the process of reconciliation is one that requires attention from all Canadians, and specifically from the nursing profession" (p. 12), the nursing profession

must take accountability for the ways that nurses have and continue to participate in the colonial harms inflicted upon Indigenous Peoples in Canada. With the intention of creating respectful and meaningful actions in the journey of Truth and Reconciliation (Truth and Reconciliation Commission of Canada, 2015), nurses are well-positioned to address the ongoing racism and discrimination in health care and to recognize their structural nature that informs the definitions of health within the profession (Usmani, 2021).

As the author of this thesis, it is critical for me to situate myself in relation to Indigenous Peoples and reflect on how my experiences and perspectives may shape this research project related to Indigenous health. I acknowledge that I am a first-generation settler from Chinese descent who lives and studies in the unceded territory of the Algonquin Anishinaabeg. My thesis committee includes Indigenous and non-Indigenous people. Dr. Wendy Gifford is a second-generation settler from European descent. Dr. J. Craig Phillips is of European settler heritage from the Ute, Goshute, and Apache territories who lives, works, and plays with his Red River Métis husband on the unceded territory of the Algonquin Anishnaabeg and is an American-born Canadian whose ancestors immigrated from Sweden, Scotland, and Wales and settled on the traditional homeland of the Ute, Goshute, and Apache. Dr. Veldon Coburn is Anishinaabe from Algonquins of Pikwakanagan First Nation. As a non-Indigenous health care provider and graduate student, I recognize that Western settler research methods and the nursing profession have been complicit in the colonial harms historically and today (Symenuk et al., 2020), and they have played an active role in creating structural factors that are being investigated in this scoping review study (Usmani, 2021). It is of utmost importance that I, as a settler in a Western health care system, reflect on my role of privilege and power, and understand the importance of having feedback and perspectives from Inuit guide my work. With this in mind, I have undertaken a

scoping review in consultation with Inuit. I am collaborating with members from Pauktuutit Inuit Women of Canada, the national nonprofit organization representing Inuit women in Canada.

Organization of Thesis

In this first chapter, I introduced the study background, ethical principles and guidelines that underpin research with Inuit. I also presented the study objective and questions, as well as the impetus for this research study. The following Chapter Two provides a preliminary review of the literature to understand the contextual landscape surrounding factors that shape cancer care among Inuit and to thus establish priorities for this thesis study. Chapter Three describes the research methodology and the theoretical underpinnings for this study. I also present the Joanna Briggs Institute (JBI) methods for scoping reviews, along with the quality assessment tool used to evaluate the relevance of included studies/documents to Indigenous communities. Chapter 4 presents the manuscript prepared for submission to the *International Journal of Circumpolar Health*. Finally, Chapter Five concludes this thesis with a discussion of the findings from this scoping review; the strengths and limitations of the study; and how the interpreted findings may be derived to inform future nursing practice, education, and research, with a specific focus to improving cancer care access and experiences among Inuit in Canada.

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Chapter Two

Review of the Literature

Literature Review Process

I conducted a preliminary literature search to identify priorities for the proposed research study and provide a contextual landscape surrounding the factors that shape cancer care among Inuit. In this review of the literature, the population focus was Inuit in Canada from all ages, sex and gender identities and expressions, and cancer diagnoses; the concept of interest is cancer care and includes all aspects of care including access, delivery, and care coordination among Inuit in all locations within Canada.

Search Results and Findings

I searched the Cumulative Index to Nursing and Allied Health Research (CINAHL) (see search terms in Table A1) and the Circumpolar Health Bibliographic Database for published research literature. I also hand-searched for grey literature pieces on the websites of Indigenous organizations such as Pauktuutit Inuit Women of Canada and Inuit Tapiriit Kanatami (ITK). Twelve articles met the inclusion criteria (see Table A2) and were thoroughly reviewed (see Table A3). Findings of each article can be found in the literature summary table in Appendix B. Three themes emerged from this literature review related to cancer care among Inuit: 1) *Cancer Concerns*; 2) *Unmet Cancer-Related Needs*; and 3) *Structural Factors that Influence Cancer Care*.

Cancer Concerns

With the Truth and Reconciliation Commission's Calls to Action (Truth and Reconciliation Commission of Canada, 2015b) and events such as the creation of the National Day for Truth and Reconciliation (Crown-Indigenous Relations and Northern Affairs Canada, 2022), there is an increasing public recognition of the legacy that Canadian government policies have had on health and social disparities faced by Indigenous Peoples (Truth and Reconciliation

Commission of Canada, 2015a) including high and persistent prevalence of food insecurity in Inuit Nunangat (Bowers et al., 2020, 2021), and the substantial need to improve health and health services with Indigenous communities (Horrill et al., 2018). Previous literature has indicated that the incidence rates of cancers, such as nasopharynx and lung cancer, were highly elevated in the Inuit Nunangat population compared to the rest of Canada (Carrière et al., 2012; Kelly et al., 2008a), with worse cancer-related outcomes and survival in Inuit patients (Canadian Partnership Against Cancer, 2014). Almost half of the 10-year gap in life expectancy between Inuit and non-Inuit Canadians is linked to cancer deaths (Carrière et al., 2012; Inuit Tapiriit Kanatami, 2008). Quantitative research evidence on different cancer types and trends have repeatedly demonstrated the disproportionately high cancer rates among Inuit (Kelly et al., 2008a; Peters, 2010; Young et al., 2016), further emphasizing the need to address the specific barriers, gaps, and challenges that Inuit experience with cancer care.

Unmet Cancer-Related Needs

Cancer and its treatments have a wide range of impacts on individuals. Patients and families may encounter physical, emotional, social, psychological, spiritual, informational, and practical challenges and needs as they navigate through the cancer journey (Fitch, 2008). Inuit face an additional set of stressors and obstacles in meeting cancer-related health needs because of "jurisdictional issues, social and physical isolation, a system geared to a foreign language and culture, and the stress imposed on families by dislocation and distance" (Inuit Tapiriit Kanatami, 2008, p. ii). For example, close to one third of Inuit cancer patients in the Baffin region between 2000 and 2010 were not referred to The Ottawa Hospital for assessment and/or treatment, but the reasons why they were not referred were not investigated despite this being the referral hospital for cancer treatment for this region (Asmis et al., 2015). Many regions where Inuit communities

are located have no access to screening or treatments such as radiotherapy, which is often a crucial part of comprehensive cancer care, and thus patients are required to travel long distances without family members to receive treatment (Chan et al., 2019a; Jull et al., 2021). Furthermore, the availability of local medical end-of-life care in Nunavik that takes into account Inuit-specific sociocultural, historical and geographic factors remain largely limited (Hordyk et al., 2017a). Living with unmet needs adds to the burden of suffering and stress that cancer patients and their families experience (Fitch, 2008). Understanding what facilitates or prevents Inuit from getting the care they need necessitates careful considerations of what influences the health and health care of Inuit at the broader structural levels, such as the social, economic, historical, and political factors from colonization, as well as the interrelated health systems (Ahmed et al., 2015; Pauktuutit Inuit Women of Canada, 2013b).

Note: The provision of cancer care in Inuit Land Claim areas is managed through a regional approach (Indigenous Services Canada, 2022), with the majority of patients in need of specialized care being referred to specific southern tertiary care centres in Edmonton, Winnipeg, Ottawa, Montreal, or St. Johns (Canadian Partnership Against Cancer, 2014; Pauktuutit Inuit Women of Canada, 2017).

Structural Factors that Influence Cancer Care

A large focus within the research literature related to cancer care for Indigenous Peoples in Canada is predominantly situated in examining the individual-level factors, such as the influence of individual providers' characteristics, knowledge, behaviours, or interventions to improve treatment adherence among individual patients (Cerigo, Macdonald, et al., 2012; Cerigo et al., 2013a; McDonald & Trenholm, 2010; Zehbe et al., 2016). However, what impacts cancer care must be understood as intertwined with and impacted by the broader structural conditions

which then shapes health care systems and individuals (Horrill et al., 2019; Reading, 2015). This gap in understanding the structural factors that impact Inuit health is also recognized in a scoping review by Horrill et al. (2019) that examined access to cancer care among all Indigenous Peoples in Canada. As Inuit have distinct knowledge, health practices, and experiences with colonization, it is necessary to examine the factors that impact their cancer care separately from a pan-Indigenous lens. Improving health service to reduce health inequities calls for opening dialogue and taking thoughtful actions to expose the structural determinants of Inuit health, such as the socioeconomic conditions, historical trauma, and political influences (Inuit Tapiriit Kanatami, 2014; Reading, 2015). Given that no literature has been published that systematically organizes existing knowledge about structural factors and cancer care among Inuit, a scoping review is the appropriate type of synthesis to describe the nature and scope of knowledge related to this topic.

Summary

A study on the structural factors that impact Inuit cancer care has particular pertinence to nursing research such that nurses are central in the provision of health care and often the sole providers of care within rural or remote Inuit communities. In light of the nursing profession's social mandate to confront health inequities and disparities (Bickford, 2014), the nursing profession must first recognize its role in the manifestation of colonial structures, systems, and ways of seeing and doing that perpetuate the current social and health inequities among Inuit, First Nations, and Métis (McGibbon et al., 2014; Thorne, 2019). Nurses in Canada have actively participated in past and present colonial harms including Indian hospitals, Indian Residential Schools and subsequent deleterious Indigenous child welfare policies (e.g., Sixties Scoop, Millennial Scoop), forced sterilization, as well as systemic racism and discrimination (McGibbon et al., 2014; Pelley, 2018; Symenuk et al., 2020). Thorne (2019) argues, "we will not be able to

move forward as agents of constructive change until we find ways to open our eyes and ears to the experiences of those harmed by systemic injustices that our societies have created and sustained" (p. 2). As members of the largest group of health professionals and one of the most trusted professions, nurses are uniquely situated to address the impacts of health inequities and advocate for equitable and culturally safe cancer care (Arnold & Bruce, 2005). By promoting understanding and awareness to the structural determinants of health, this study is an opportunity to support the counter-narratives to colonial thinking and practices that have been sustained in the nursing discipline (McGibbon et al., 2014).

In summary, despite growing attention to the need for culturally safe cancer care among Indigenous patients (Gifford et al., 2019; Health Council of Canada, 2012; Schill & Caxaj, 2019), no comprehensive review currently exists about structural factors that facilitate or hinder Inuit experiences with cancer care services in Canada. Research has investigated the rising cancer burden (Carrière et al., 2012; Kelly et al., 2008a; Young et al., 2016) and barriers to cancer care services (Ahmed et al., 2015; Enuaraq et al., 2021; Hammond et al., 2017; Poudrier & Mac-Lean, 2009), but a synthesis of the structural factors specific to Inuit in Canada has not been published (Horrill et al., 2019). Such research is needed given that the existing cancer-related disparities among Inuit are rooted in the structural determinants of health that create health and health care inequalities and inequities.

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Chapter Three

Theoretical Underpinnings and Methodology

Theoretical Underpinnings

Aspects of postcolonial theory were the theoretical underpinnings that informed my master's thesis in understanding the structural-level factors (e.g., social, political, and economic structures) that influenced the realities of cancer care to Inuit in Canada. Here, I provide an overview of postcolonial theory as the underpinning of this research. I then describe the major concepts within postcolonial theory and a brief critique of using postcolonial theory in research. Finally, I discuss the relevance of postcolonial theory to nursing research and how I used postcolonial theory to inform my thesis study examining cancer care of Inuit in Canada.

Postcolonial Theory

Postcolonial theory has been studied across different disciplines, and it is considered as a family of theoretical and empirical work that converges on the critical analysis of the legacy of colonialism and how it continues to shape people's lives and well-being (Anderson et al., 2003; Browne et al., 2005; Kirkham & Anderson, 2002; Young, 2001). The fundamental premise of postcolonial studies is that colonization involved the political and cultural erasure and forced assimilation of Indigenous Peoples, in addition to the annexation of land and exploitation of resources (Ashcroft et al., 2013; MacDonald & Steenbeek, 2015). Through the colonizing process, colonial ways of knowing and being along with positivist scientific traditions were coercively imposed onto people who were being colonized (Kelm, 1998). In contrast to predominant positivism and empiricism which centers on empirical observation or logical deduction in the discovery of knowledge, postcolonial theory aims to produce emancipatory knowledge by examining social, political, and institutional structures to confront social injustices and disrupt the status quo, while giving voice to those marginalized by the dominant colonial discourses (Bickford, 2014; Holmes et al., 2008; Horrill et al., 2018).

While drawing on postmodernism and poststructuralism, a distinguishing feature of postcolonial theory lies in its focus on disrupting "race-thinking" and examining the structural inequities that have been brought about by historical and contemporary colonial relations and practices (Anderson, 2004). Postcolonial theory has evolved from a body of literature by scholars such as Homi Bhabha, Leela Gandhi, Paul Gilroy, Stuart Hall, Cathryn McConaghy, Edward Said, Franz Fanon, and Gayatri Spivak (Browne et al., 2005). Situated within the broader paradigm of critical theory, postcolonial theory focuses on exposing and countering oppression through "the *critique* and *transformation* of the social, political, cultural, economic, ethnic, and gender structures that constrain and exploit humankind" (Guba & Lincoln, 1994, p. 113). Ultimately, postcolonial theory provides a theoretical lens to give insight into the experiences of people who have been marginalized by "the micro-politics of power and the macro-dynamics of structural and historical nature" (Kirkham & Anderson, 2002, p. 2).

In the context of health care, postcolonial theory seeks to critically question the dominant Eurocentric biomedical paradigms in mainstream health services, and to analyze the conditions in health care that continue to marginalize and discriminate against certain groups due to their race, class, or gender (Bickford, 2014; Mohammed, 2006). Paradigms consist of a set of basic beliefs and practices representing one's view of the world (Guba & Lincoln, 1994), and informs (consciously or subconsciously) communities of scholars about the nature of reality and knowledge construction, providing a lens to regulate inquiry within their discipline (Monti & Tingen, 1999; Weaver & Olson, 2006). Postcolonial theory, in particular, challenges researchers and scholars to reflect on the concepts of race and culture, specifically how these have been "constructed as 'rational' categories to locate non-European peoples as the essentialized, inferior, subordinate Other" (Anderson et al., 2003, p. 200). By drawing attention to the relations of

colonial power that are woven into the fabric of the health system, perspectives in postcolonial theory add depth and breadth to understanding the structural contexts surrounding disparities related to health care access and health outcomes (Browne et al., 2005; Horrill et al., 2018).

Relevant Concepts

Race, *racialization*, *culture*, and *othering* are concepts in discourses from postcolonial theory that are particularly relevant in the context of health and health care for my study (Anderson, 2004).

Race. *Race* is a term used to categorize human beings into physically, biologically, and genetically distinct groups, based on the assumption that humanity can be divided into unchanging natural types based on genetically inherited physical features (Ashcroft et al., 2013). The notion of race implies that individual behaviour and personality are a direct product of one's physical differences (Ashcroft et al., 2013). Race was used in the rise of colonialism to justify one's place in the hierarchy of human civilization and to establish a dominance over subject peoples in the imperial enterprise (Ashcroft et al., 2013; Bickford, 2014). Race is now understood as a social construct that is used to define and structure relations between dominant and subordinate groups (Kirkham & Anderson, 2002). Rather than a concept of the past, race continues to operate in overt and subtle ways within the assumptions and perceptions of people (Anderson, 2004). Though nurses and other health care professionals may argue that they treat everyone equally in accordance with their codes of ethics, the constructions of race remain entrenched in clinical environments through exclusionary and racializing practices, processes, and structures that continue to have an impact on the well-being of patients and families (Anderson, 2004; Bickford, 2014).

Racialization. The term *racialization* captures the process of "attributing social, economic, and cultural differences to race" (Browne et al., 2005, p. 21). Racialization assumes that a particular group of individuals can only be understood as a biological entity based on presumed biological, physical, or genetics differences; it perceives culture as static and homogeneous traits with a biological basis (Kirkham & Anderson, 2002). Whether conscious and deliberate or unconscious and unintended, the ideological process of racialization is embedded in the broader historical, social, cultural, and political contexts of the health care system (Bickford, 2014). It is powered by institutionalized policies, processes, and practices that marginalize individuals (Fiske & Browne, 2008), which further shapes the actions and attitudes of health care professionals and how they interact with patients from day to day (Tang & Browne, 2008).

Culture. The construct of *culture* has evolved with various interpretations over time. Culture has been perceived as a fixed and stereotyping representation that fails to recognize variations that exist within cultures (Ashcroft et al., 2013). Today, culture is known as the learned and shared values, beliefs, norms, and practices of a particular group (Bickford, 2014). This understanding of culture is derived from the social theory of cultural pluralism, also known as multiculturalism (Kirkham & Anderson, 2002). Although it upholds the harmonious coexistence of diverse cultural or ethnic groups in a society, multiculturalism sees ethnic and racial differences as a question of identity and an intrinsic property of cultures, which fails to address the underlying hierarchies of power and politics (Kirkham & Anderson, 2002). Far from being a neutral concept as a set of beliefs and practices by members of a particular group, culture is ingrained within sociopolitical and historical contexts, and it operates in tandem with the constructions of race to influence one's life opportunities and social functioning (Anderson et al., 2003; Bickford, 2014).

Othering. The term *othering* was coined by Gayatri Spivak to describe the process by which imperial exploitation and colonial discourses have created the *Other* (Ashcroft et al., 2013). Othering refers to the projection of assumed characteristics, "differences", or stereotyped identities onto people based on their identification or membership to a certain group (Browne et al., 2005). The process of othering reinforces unequal colonial relations of power by constructing a binary distinction: the rational and civilized Self for identities such as "the West", "European", and "White", versus the inferior, passive, or exotic Other representing non-Western societies (Go, 2016; Kirkham & Anderson, 2002). For instance, the residential school system was imposed as a means of protecting the health of Indigenous children from their "negligent and ignorant" mothers and teaching them Euro-Canadian standards of care (Kelm, 1998, p. 62). The notion of othering continues to be reflected in the negative stereotypes of Indigenous Peoples with poverty, substance use, and dependency, which can unwittingly shape health care professionals' view and relationship with their patients (Anderson, 2004; Browne et al., 2005).

Critiques of Postcolonial Theory

Perspectives in postcolonial theory have expanded our understanding of race and power; however, there are several critiques levelled against the use of postcolonial theory in research. First, postcolonial theory arises from Western epistemologies and discourses rather than of Indigenous epistemologies (Browne, 2009; Horrill et al., 2018). Epistemology is known as how we come to know things, commonly referred to as the theory of knowledge (Hickey, 2020). In this thesis, I apply the term "epistemology" to specifically focus on the development of knowledge within or in collaboration with Inuit communities. Scholars have criticized researchers within settler societies who use postcolonial theory as they come from positions of privilege (Czyzewski, 2011; Hamadi, 2014). Browne et al. (2005) highlighted the distinction

between postcolonial theoretical perspectives and postcolonial Indigenous knowledge, emphasizing the importance of understanding their relationship as well as how the dominance of Eurocentric discourses has historically precluded an examination and acceptance of Indigenous knowledge.

Furthermore, postcolonial theory has been critiqued for presuming an essentialized, shared experience of the colonized and for its tendency to form binary categories of colonizer and colonized (Browne et al., 2005; Kirkham & Anderson, 2002), which risk ignoring the dynamic social categories and intersecting oppressions (Horrill et al., 2018). To address this limitation, scholars have incorporated feminist theories into postcolonial discourses to extend and develop analyses of people's experiences through intersecting factors such as gender and class (Anderson, 2004; Browne et al., 2005). That said, though feminism may add another layer of inquiry, the use of postcolonial theory as a standalone theoretical framework remains relevant for examining health equity and social justice in nursing research (Bickford, 2014).

In addition, the notion of "post" in postcolonial theory has the potential to imply that colonialism is a *finished project* (Czyzewski, 2011). Numerous authors have brought forth the evidence that colonialism has never ceased but rather interconnected with contemporary practices (Czyzewski, 2011). In what is now known as Canada, the historically established relations of power, authority, and paternalism continue to shape today's institutional policies and practices, which in turn influence the socioeconomic development and health care of Indigenous Peoples (Adelson, 2005; Browne, 2009; Kelm, 1998; Waldram et al., 2006). As McConaghy (2000) explains, "the post in postcolonial refers to a notion of both working against and beyond colonialism… Postcolonial therefore refers to issues of power, rather than time" (p. 268). As such, I acknowledge McConaghy's (2000) description of postcolonialism and continue to be

conscious of how colonialism, as a broader determinant of health (Czyzewski, 2011), influences Indigenous experiences, relations, and well-being.

Postcolonial Theory and Nursing Research

Applied globally across different fields, postcolonial theory has been of value for health care research and practices in understanding the contexts in which care is provided (Bickford, 2014). The social and moral mandate of nursing includes illuminating the experiences of individuals who are marginalized within society and the health care system, which urges nursing scholarship to look beyond individual factors of health and illness to examine the broader structural determinants of health (Kirkham & Anderson, 2002). The critical lens of postcolonial theory aligns well with emancipatory knowing for the creation of knowledge valuable to nursing (Bickford, 2014). Particularly, postcolonial theory provides an alternative approach to culturalist paradigms which have predominated nursing theory, assisting nurses to understand how their interpretation and assumptions of health and health care are informed and shaped by the wider structural, historical, and social discourses (Anderson et al., 2003; Browne, 2009; Kirkham & Anderson, 2002). Postcolonial theory brings the issue of race to the forefront and uncovers how this socially constructed category was manipulated in colonialism, as well as the lingering effects this has on peoples' lives and life opportunities (Anderson, 2004). With these considerations, nursing research through the lens of postcolonial theory permits a more thoughtful reflection on the inequities that exist within access and delivery of health care, with the objective of confronting and eliminating health outcome disparities (Kirkham & Anderson, 2002).

By underpinning my thesis study in a postcolonial lens, this approach guided me to not only be aware of my position as a non-Indigenous woman residing in a settler Canadian society (as explained in Chapter 1), but also to understand how colonial practices and policies are not

merely distant relics of the past. Similar to the position of Browne et al. (2005), I recognize that analyses of factors related to Inuit health are insufficient if it fails to take into account the historical, social and political conditions brought about through colonization, as well as the resulting influences on how health and health care is delivered and experienced. Colonialism is the catalyst behind the public's lack of awareness of the political and economic marginalization today, and is steeped in the broader historical, social, political, and economic structures that shape Inuit health (Czyzewski, 2011). For instance, the effects of these structural factors can be found in the way in which health care of Inuit is funded and organized. As Inuit perspectives are largely overshadowed in the intersection between the dominant biomedical model and the jurisdictional debate on health care responsibility (Browne et al., 2005), Inuit rights to self-determination (Department of Justice Canada, 2018; United Nations, 2007) are neither recognized nor respected. Hence, a study informed by postcolonial theory allowed me to see beyond the health and social conditions that influence cancer care of Inuit at the individual level (e.g., communication, knowledge, awareness of individual patients and health care providers (Horrill et al., 2019), to further explore and unveil inequities within the broader systemic and structural factors that have been created and continue to be driven by colonialism.

Theoretical Framework

The theoretical framework of this study was based on the conceptualization of structural factors, referred to as "embedded within and systematically produced by the political, historical, social, and economic structure of a society" (Horrill et al., 2019, p. 11) that create and/or shape inequities in health care and health outcomes (McGibbon, 2016). Structural factors in the society have a profound impact on the health and well-being of Indigenous Peoples in Canada, as they construct the root causes of the ongoing health disparities (Reading & Wien, 2009). Drawing

from descriptions of structural factors by Reading (2009), Horrill (2019), McGibbon (2016), Bowers et al. (2020), Smylie & Firestone (2016), and Allan & Smylie (2015), I have outlined the conceptualization of structural factors in a taxonomy in Table 1, which consists of colonial, social, economic, political and health systems structures. I then developed a heuristic framework of the interrelationships between the structural factors to guide an understanding of how that may influence cancer care amongst Inuit (Figure 1).

Table 1. Taxonomy of Structural Factors

Structural Factor	Description of structural factor and examples
Colonization	Interrupted access to land, food, and water. • Imposition of a reserve system in Canada through the Indian Act of 1876 • Lack of access to clean water • Destruction of traditional foods and traditional food preparation that was replaced with Western market food • Relocation of Inuit from their traditional territories and impermanent, readily constructed dwellings to permanent housing in villages and cities selected by the government • Suboptimal hunting conditions of the new sites, interfering with Inuit's traditional food supply
	Restricted engagement in subsistence activities • Conversion of traditional hunting territories to pasture-land by European settlers, encroachment and increasing mechanization that kill and frighten game away • Banning of many forms of Indigenous hunting and fishing in the interests of expanding capitalist ventures • Restrictions to reserve land forcing many Indigenous peoples to engage in wage labour
	European diseases and Western medicine • Spread of communicable illness after European contact • Colonial activities sustained by early Western medical aid • Indigenous health policy based on notions of white racial superiority and assimilation goals • Medical discourses that described Indigenous peoples as inherently pathological, whose health could only be guaranteed through assimilation • Outbreaks of tuberculosis; more than 70 percent of Keewatin Inuit in 1964 had been in TB sanatoria

	Colonial partnership between religious institutions and governments; child welfare systems in Canada • Residential schools; designed to eradicate Indigenous family and kinship structures and strip children of their Indigenous identity • Spread of tuberculosis facilitated by harsh living conditions of residential schools • Physical, emotional, mental, spiritual, and sexual harm of children • Murder of children in residential schools through neglect, torture, and manslaughter • The "Sixties Scoop", and other apprehension approaches that placed Indigenous children in the child welfare system • Children sent to TB sanatoria were adopted by southern families without their parents being informed
Health and Cancer Care Systems	• Racist and culturally unsafe health care services and health care system • Inflexibility of cancer services (e.g. screening may be offered only on certain days in some communities, and providers in small communities are frequently called away to emergencies), long wait times • Challenges in accessing cancer information: cancer information that was not culturally safe or not in an Indigenous language • No navigators to support Inuit patients navigate the health care system
Social	Racist stereotypes of Indigenous peoples as "primitive" or "savages" and thus intellectually, morally, and socially inferior to white Europeans • The reconstruction of Indigenous peoples through the colonial gaze into racialized stereotypes of apathy and submissiveness, which was used at the basis of racist legislations and policies, appropriation of lands, generalized violence, and the exploitation of Indigenous women • The obstruction of Indigenous self-determination and failure to recognize treaty and land rights, over-surveillance by criminal justice and child welfare systems, and the continued societal and systematic privileging of white people in Canadian society • Justification of persistent racialized health disparities by historical and contemporary approaches to health research in the area of genetics and race; reductive genetic attributions of disproportionate illness and disease among racialized populations rather than examining inequities in social determinants of health • Exclusion of Indigenous peoples from social reproduction, which fails to fully acknowledge the colonial challenges, important cultural contributions, and denial of opportunities for Indigenous peoples
	Clinical discrimination within the health care systems based on stereotypes and social and cultural norms of individuals who are living in poverty • Inadequate or degrading medical care; failure of health care providers to provide thorough assessments or life-saving referrals • Lack of action from health care administration to address discrimination indirectly supports ongoing oppression in access to care

	• People having to strategize in advance of their visit about anticipated racism or avoid seeking care
	Additional forms of structural violence including social deprivation and socially inflicted trauma (mental, physical, and sexual, directly experienced or witnesses, from verbal threats to acts) • Missing and murdered Indigenous women in Canada • Degradation of ecosystems linked to systemic alienation of Indigenous populations from their lands and corresponding traditional economies
Economic	Systemic discrimination from resources and opportunities • Exclusion from essential social needs such as adequate housing (crowded dwelling), access to sufficient and nutritious food (food insecurity), access to safe household drinking water supply, sufficient funding for Indigenous programs and services, community and health system infrastructures (e.g., resources for medical travel and childcare), expensive shipping costs for food and resources • No resources for transportation, childcare, or scheduling time away from work • Challenges in accessing cancer information: poor/no internet and telephone access, • Lack of public and private investment in economic development for Indigenous communities
	Economic exclusion from equitable educational and employment opportunities • Socioeconomic stratification creates a gradient of health disparities, particularly damaging for those who are relegated to increasing disadvantageous living conditions • Income; reduced average annual incomes and higher unemployment rates of Indigenous peoples compared to non-Indigenous Canadians • The vast majority of health care in Canada are provided with the assumption that individuals and families can afford material costs associated with optimal health outcomes (e.g., money for transportation, prescribed medications, and over-the-counter recommended treatments)
Political	Jurisdictional ambiguities or disputes within the federal/provincial division of responsibility for healthcare services to Indigenous peoples • Many status First Nations people and Inuit must cross invisible jurisdictional borders to access different health services, which has resulted in reduced or no access to these services in the communities • Inuit living in the south can be caught between jurisdictions, with unclear accountabilities for their health and public health services
	Challenges receiving Medical Transportation and benefits under the Non-Insured Health Benefits program (NIHB) • Funding from the policy is rigid and does not cover travel for certain services, including cancer screening • Policy is applied unevenly and based on budgetary factors and distinctive funding caps

	• The financial, emotional, and social costs associated with the frequent need to travel away from home to obtain essential health services • National-level program and service strategies are devolved in a hierarchical manner to the regional offices, limiting opportunities for substantive local input into First Nations and Inuit Health Branch policy development and little room for local First Nations and Inuit understandings of health
The effects of geographical segregation – the physical separation of racialized groups in residential contexts – on health disparities	• Limited availability of health care providers including Inuit providers, family physicians (entry into the cancer care system), difficulty recruiting and retaining health care providers in remote geographic locations, shortages of female health care providers particularly in cervical or breast cancer screening • Limited availability of culturally safe health and cancer care services within Indigenous communities, or in close proximity • Low population density, lack of transportation infrastructure, lack of services available in mother tongue, long wait-times, inadequate human resources, and northern climate conditions act as significant barriers for Indigenous Peoples in rural or remote communities to access health care • Individuals and communities living in locations with high pollution rates have an unfair toxic burden; the health impacts of geographic proximity to hazardous waste facilities and landfill sites • Environmental racism; hazardous sites have been historically disproportionately located near communities of colour

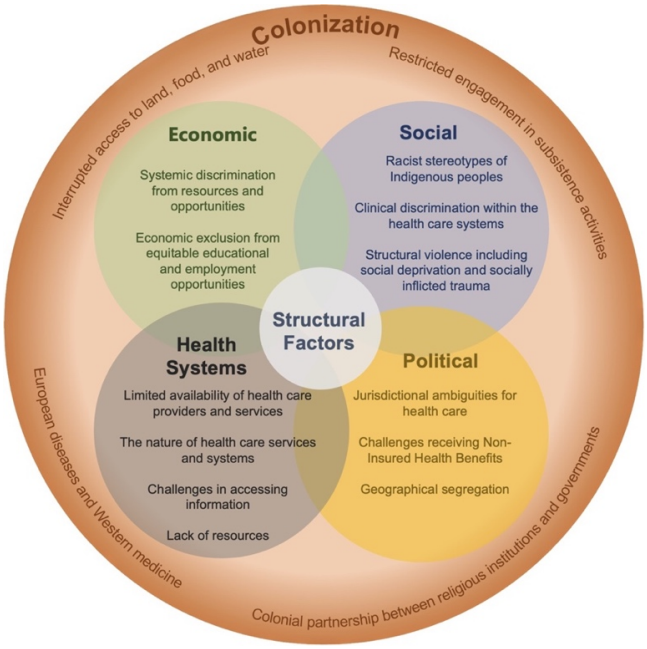

Figure 1. A heuristic framework of the interrelationship of the structural factors that may influence cancer care amongst Inuit

Methodological Overview

Scoping reviews, also known as scoping studies, represent an increasingly common approach to evidence synthesis that is utilized across diverse fields of inquiry to inform research based on an examination of the literature on a specific topic (Levac et al., 2010; Lockwood et al., 2019). While there is no universal definition for a scoping review (Pham et al., 2014), a general characteristic of this methodology is that it identifies and maps the available evidence (Munn et al., 2018; Peterson et al., 2017). The most common reasons of performing a scoping review are "to explore the breadth and depth of the literature, map and summarize the evidence, inform future research, and identify or address knowledge gaps" (Peters et al., 2021, pp. 4–5). The first methodological framework for conducting scoping reviews was published by Arksey and O'Malley (2005), with updates over the years by various authors including an extension proposed by Levac et al. (2010). The value of a scoping review comes from it its flexibility to incorporate various types of literature through a broader scope for research questions that are more exploratory and descriptive in nature (Peters et al., 2021). This differs from systematic reviews with or without meta-analyses, which have a specific, pre-defined research process that is explanatory and analytical in nature and includes a risk of bias assessment of the included studies (Levac et al., 2010; Peters et al., 2021).

This scoping review followed the steps outlined by the Joanna Briggs Institute (JBI) scoping review methodology. I have selected the JBI approach because it not only has developed rigorous and transparent methods to synthesize evidence within the literature when it is complex and heterogeneous, but also recognizes other forms of evidence to inform the synthesis such as Indigenous expertise and experiences as used in my study (Peters et al., 2021).

Rationale for Conducting a Scoping Review

Inuit patients' and families' experiences related to accessing and navigating cancer care services in Canada are multifaceted. As situated within a postcolonial paradigm, the general aim of inquiry is to critique and transform the social, political, cultural, gender, and economic structures, but this also requires an understanding or reflection of what transformations are needed (Guba & Lincoln, 1994; Weaver & Olson, 2006). Given the emerging evidence that indicates the barriers to cancer care faced by Indigenous Peoples including Inuit are rooted in the structural factors in society (Horrill et al., 2019; Loppie et al., 2015), a scoping review was deemed a useful approach to explore the breadth of the literature that currently exists and to promote Inuit perspectives and experiences without the constraints of a rigid methodology that limits the types of study designs (Arksey & O'Malley, 2005; Munn et al., 2018). Therefore, a scoping review was suitable for addressing the research questions in this thesis, as it allowed for the identification, summary, and critical analysis of the patterns and themes in the literature on the structural factors and their contexts that influence Inuit's experiences of cancer care.

Inclusion Criteria

The inclusion/exclusion criteria followed the Population, Concept, and Context ("PCC") mnemonic identified by JBI. Each of these components is outlined in the following sections.

Population

While Indigenous Peoples may face similar challenges and hardships from colonization in Canada, each group has a distinct history, language, cultures, traditions, and knowledge, and they have experienced colonization differently (MacDonald & Steenbeek, 2015). In recognition of the diversity among all Indigenous Peoples in Canada, this review focused on literature that specifically included Inuit in Canada, including all ages, sexual orientation and characteristics, gender identities and expressions, as well as types and stages of cancer diagnoses. In this thesis, I

recognize gender as socially constructed characteristics such as roles, expressions, and identities of women, men, girls, boys, and gender diverse people (Canadian Institutes of Health Research, 2023). Instead of a confined set of biological attributes (i.e., female vs male), gender exists along a continuum and varies across different times, places, and societies, such that western values and conceptualizations around gender may not be the same as how gender is understood or expressed in Indigenous communities (Eidinger, 2020). In the context of this scoping review which examined previously published studies and reports, I restricted any data extraction pertaining to gender to only terms that were explicitly stated within the text, without interpreting beyond the authors' written descriptions.

Concepts

Structural factors and cancer care were the two central concepts explored in this review. As described previously, structural factors are embedded within and systematically produced by the political, historical, social, and economic structure of a society that shape inequities in health care and outcomes (Horrill et al., 2019) (see the Theoretical Framework Section for a detailed description).

With a vast array of health services, programmes, resources, and supports related to cancer care, there is no single overarching definition of cancer care. Individuals may experience cancer care at various points in their cancer trajectory with different paces and pathways; some encounter cancer care with a defined beginning and end, while some take on a long-term journey (Fitch, 2008). In this scoping review, I conceptualized cancer care as a continuum of care that encompasses cancer screening, diagnosis, treatment, and follow-up including survivorship care, palliative care, and bereavement (Corvus Solutions, 2012; Fitch, 2008). All settings were eligible

for inclusion, such as inpatient and outpatient clinical care, community centres and agencies, and patient homes.

Context

This review focused on cancer care among Inuit in Canada. While I recognize that Inuit communities also reside in arctic regions outside of Canada, studies that were not conducted in Canada were excluded given the uniqueness of socio-political structures and jurisdictions in different countries. Moreover, health care systems may not be delivered in the same way for all Inuit living in the arctic. Cancer care in all health service settings in Canada were included, such as primary (community-based), secondary (hospital-based), and tertiary (specialized cancer treatment) health care services, as well as traditional approaches to healing and medicine.

Types of sources

This scoping review included literature of all types that fit the inclusion criteria, including primary and secondary research of all study designs, text and opinion papers, legal documents, land claim agreements, and publications by Canadian government and Inuit organizations. Studies that were available in electronic full text were included. Study protocols, conference proceedings, and abstract-only publications were excluded due to limited amount of available information. Publication date limit and language filters were not applied to reduce the chance of excluding landmarking literature.

Search strategy

A three-step search strategy was carried out in consultation with the University of Ottawa health sciences research librarian (SL). The initial search was completed in CINAHL and Medline, followed by identifying relevant keywords within the title and abstract as well as index terms used to describe the article. A second search was then conducted using the identified

keywords and search terms across the selected database. Since articles related to structural factors may use a diverse variety of keywords, terms related to the concept, "*structural factors*", were not utilized as in the search to enhance the breadth of the search and confidence in the search results. The third step involved hand-searching through the references lists of all identified articles for additional relevant studies. A sample search strategy in CINAHL is presented in Appendix C.

Information Sources

The search strategy was conducted in the following electronic databases: CINAHL, Medline, Embase, PsycINFO, Nursing and Allied Health Database, Sociological Abstracts, Circumpolar Health Bibliographic Database, Native Health Database, and Arctic Health Publication Database. The grey literature search consisted of Google Scholar, legal databases, and a list of Canadian government and Indigenous organization websites including but not limited to: Justice Canada, Health Canada, Public Health Agency of Canada, Indigenous and Northern Affairs Canada, National Collaborating Centre for Indigenous Health, Native Women's Association of Canada, Quebec Native Women, Pauktuutit Inuit Women of Canada, Saturviit: Inuit Women's Association of Nunavik, Inuit Tapiriit Kanatami, and Tungasuvvingat Inuit. In addition, the following journals were hand-searched for eligible articles: *International Journal of Indigenous Health*, *International Journal of Circumpolar Health*, *Journal of Transcultural Nursing*, *Pimatsiwin: A Journal of Aboriginal and Indigenous Community Health*, *Études Inuit Studies*, and *Recherches Amérindiennes au Québec*.

Study Selection

All identified citations were imported to Covidence systematic review software, and duplicated articles were removed. Two reviewers, a PhD student in nursing (CL) and I, screened

articles independently in a two-step process. The first step involved title and abstract screening against the pre-defined inclusion criteria. The included results were moved to the second step where each reviewer independently assessed the eligibility of each study in full text with a rationale for exclusion. Throughout all stages of study selection, any discrepancies between the two reviewers were resolved by discussion or by a third reviewer (thesis supervisor WG) if required. The results of study selection were presented and discussed with members from Pauktuutit Inuit Women of Canada (KG, RU, CG), with any feedback incorporated prior to analysis.

Data Extraction

As per the JBI scoping review methodology (Peters et al., 2021), a tabular data extraction form in Excel (see Appendix D for specific categories) was designed to collect details from included pieces on the document type, population/participants, context, and concepts. Data was extracted by author MH. After reviewing the data extraction table together, a postdoctoral fellow in nursing (EB) and I piloted the table on three articles and compared results. The remaining data extraction was completed independently by myself and verified by the second reviewer EB. Throughout the data extraction phase, the research team iteratively refined the extraction table to ensure the collected data reflects the aim of this scoping review. Additional categories for more information outside the pre-established categories were added to the extraction form as needed.

Assessment of Relevance to Indigenous Communities

To assess the relevancy and alignment of the included literature to Inuit participants, I applied components of the Well Living House Quality Assessment Tool (Minichiello et al., 2016; Smylie et al., 2016) to examine if and how Inuit perspectives and ways of knowing and

doing were considered in the study. The following four questions were used to assess the study's relevance: 1) Is the study design/measure(s) in keeping with local community values/beliefs/knowledge systems? 2) Is the study design/measure(s) in keeping with local priorities/aims (e.g. community articulated need for this evaluation)? 3) Is the underlying theory (of evaluation) relevant to the community? 4) Is the study protocol (design and data collection method) vetted by local community members? (see Appendix E). For the assessment of relevance, each question was given a score of either: 2 (explicit evidence), 1 (partial evidence), or 0 (none); for a total score of: 7–8 (strong evidence), 4–6 (moderate evidence), 1–3 (weak evidence), and 0 (no evidence).

Data Analysis

I conducted a descriptive thematic analysis on the data extracted from the included articles. As recommended by Braun and Clarke (2017), thematic analysis offers an accessible and theoretically flexible method to provide a rich and detailed account of qualitative data, guided by the research question. I imported the data extraction table into NVivo 12 qualitative analysis software to facilitate the organization and coding of data. Data were synthesized to identify and describe themes, as they emerge, in relation to the categories of structural factors that influence cancer care of Inuit (i.e., Colonization, Health & Cancer Care Systems, Social, Economic, Political). This approach aligns with the JBI guidelines regarding analysis of the evidence for scoping reviews, such that qualitative analysis in scoping reviews is generally descriptive in nature with a summary of data coded to a particular category (Peters et al., 2021).

I used a modified six-step approach as described by Braun and Clarke (2006) to analyze the data:1) familiarize with the data; 2) generate initial codes; 3) search for themes amongst codes; 4) review themes; 5) define and name themes; 6) produce the report (i.e., summary of

findings). After familiarizing myself with the data (step 1), I used categories from the taxonomy of structural factors (outlined in the theoretical framework described earlier) as the preliminary deductive categories for coding data based on how they explicitly or intuitively aligned with the categories and definitions provided. Any findings that did not correspond to the structural categories within the framework were inductively coded into new categories. I followed steps 2–6 to analyze the data under each structural factor category of the taxonomy. Themes were inductively developed under each category as they emerged from the data. Consistent with inductive coding in content analysis, codes were captured within the explicit or surface meanings of the data in each category, and meanings and implications were not interpreted beyond what has been written by the authors (Braun & Clarke, 2006). Further details for each step of the data analysis process are presented in Table 2.

Table 2. Steps of thematic analysis

Steps	Description of the process
1. Familiarize with the data	Read and re-read the data; search for meanings and patterns; note down initial ideas.
2. Generate initial codes	Code interesting features of the data in a systematic manner across the category; collate relevant data to each code. Code all findings into the categories of the taxonomy and create new categories as needed.
3. Search for themes	Sort different codes into meaningful groups; gather all relevant data to each potential theme.
4. Reviewing themes	Check if the themes work in relation to the codes, the category, and the entire data set in a coherent pattern; generate a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to determine and refine what aspect of the data that each theme captures; generate clear definitions and names for each theme; compare and contrast how themes align with all the factors and descriptions within the taxonomy identified in Table 1.
6. Producing the report	Final analysis and write-up of the report with sufficient evidence of the themes; selection of vivid, compelling

	examples to capture the essence of each theme; relate the analysis back to the research question and literature.

The analysis approach was iterative and involved moving back and forth between the coded data and themes. Data analysis was carried out in consultation with my supervisor (WG), committee members (JCP, VC), and collaborative team members from Pauktuutit Inuit Women of Canada (KG, RU, CG).

Presentation of Results

I presented the results from this scoping review as a narrative summary of study findings, including a discussion of the types of studies and documents included, followed by themes that emerged related to the structural factors, and concluded with a discussion of the implications and limitations of the study. Different stages of cancer care identified in the literature were organized into tabular forms. The characteristics of each structural factor and its influences on cancer are summarized thematically with exemplar quotations extracted from the included pieces.

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Chapter Four

"*Examining structural factors influencing cancer care experienced by Inuit in Canada: A scoping review*"

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Abstract

Inuit face worse cancer survival rates and outcomes than the general Canadian population. Persistent health disparities cannot be understood without examining the structural factors that create inequities and continue to impact the health and well-being of Inuit. This scoping review aims to synthesize the available published and grey literature on the structural factors that influence cancer care experienced by Inuit in Canada. Guided by the JBI scoping review methodology, a comprehensive electronic search along with hand-searching of grey literature and relevant journals were conducted. A total of 30 papers were included for analysis and assessment of relevance. Findings encompassed structural factors within five categories related to: colonization, as well as health systems, social, economic, and political structures. The study results highlight interconnections between racism and colonialism, the lack of health services information on urban Inuit, as well as the need for system-wide efforts to address the structural barriers in cancer care.

Keywords: Inuit, health and wellness, cancer, cancer care, health care, Canada

Introduction

First Nations, Inuit and Métis are the constitutionally recognized Indigenous Peoples in Canada who inhabit their traditional lands with languages and cultures grounded in holistic ways of knowing (1). Inuit (singular: Inuk) are one of the three groups of Indigenous Peoples recognized in Section 35 of the Canadian Constitution Act of 1982 (2). The majority of Inuit live in Inuit Nunangat, with a growing population also living in urban locations (3). As a result of the Canadian federal government's Inuit Resettlement Program during the 1950s (4), Inuit in many southern communities such as Inukjuak were coercively moved to the high arctic, an unfamiliar and much more climatically hostile environment lacking the same established infrastructure and resources that had been promised to them (4,5). Colonial and racist policies such as forced relocations and residential schools have left generations of families with trauma that continue to impact Inuit health (5–7). It is crucial to recognize Inuit as active participants in the global society striving for holistic wellness and self-determination, but also equally essential to address the ongoing inequities embedded in the Canadian health care system that affect their well-being.

Inuit shoulder a disproportionately higher cancer burden in comparison to non-Indigenous populations in Canada. Researchers have reported an overall increase in cancer incidence among Inuit in recent decades (8,9), with cancer being one of the leading causes of premature Inuit deaths in Canada (10). This alarming trend is especially reflective of lung cancer, where studies have suggested that lung cancer rates among Inuit women and men are the highest worldwide, about three to five times higher than the overall Canadian average (11,12). Along with rising incidence, higher mortality rates, and diagnosis at later stages, Inuit are faced with poorer cancer survival rates and outcomes (9,12,13). Furthermore, Inuit cancer-related disparities are exacerbated by socioeconomic disadvantages and systemic racism, compounded by the

historical and ongoing marginalization by mainstream health services (6,14–16). As such, Inuit patients continue to experience alienation and lack of trust in health care systems, health needs not met, and on average, higher rates of illness and poor health compared to non-Indigenous Canadians (17,18).

The persistent health disparities between Inuit and non-Indigenous populations are complex and cannot be understood without examining the structural factors that create inequities and continue to negatively impact the health and well-being of Inuit (19). Structural factors have been described as resembling the roots of a tree where the branches and leaves are the intermediate (e.g., community infrastructure, resources, and systems) and proximal (e.g., health behaviours, physical and social environments) determinants of health (20). Structural factors have a profound influence on the health of a population through their political, social, and economic influences that trickle down to create favourable or unfavourable determinants of health and health-related outcomes (19). For instance, historical research has indicated a link between colonialism and diminished life expectancy, a disproportional burden of chronic and communicable disease, and social violence experienced by Indigenous Peoples in Canada (21). With these considerations, failing to recognize and address the structural determinants of health in health care discourses perpetuates inequities that impede the health and well-being of current and future generations of Inuit in Canada (20).

While studies have investigated the rising cancer burden (9,11,12) and barriers to cancer care services (22–25), there has not been a comprehensive review that explores the unique structural factors influencing Inuit experiences with cancer care. Such research is necessary given that the existing cancer-related disparities among Inuit are linked to the structural determinants of health that create health and health care inequalities and inequities. The aim of

this scoping review was to synthesize the available published and grey literature on the structural factors that influence cancer care experienced by Inuit in Canada.

Review Questions

1) What structural factors influence cancer care experienced by Inuit in Canada, and in what ways do these structural factors influence their cancer care?

2) What aspects of cancer care are influenced by the structural factors identified?

Theoretical Underpinning

Postcolonial studies are a family of theoretical and empirical work that converges on the critical analysis of the legacy of colonialism, as well as how it continues to shape people's lives and well-being, both past and present (26–29). The fundamental premise of postcolonial studies is that colonization involved the political and cultural erasure and forced assimilation of Indigenous Peoples in addition to their elimination through genocide, expropriation of their territory, and exploitation of resources (30,31). In the context of health care, postcolonial studies seek to critically question the dominant Eurocentric biomedical paradigms in mainstream health services, as well as to analyze the conditions in health care that continue to marginalize and discriminate against certain groups due to their race, class, or gender (32,33). Postcolonial theory uncovers how colonialism is steeped in the broader historical, social, political, and economic structures that shape Inuit health, and acts as the catalyst behind the public's lack of awareness of political and economic marginalization today (34). Hence, postcolonial theory underpins this scoping review to permit a more thoughtful reflection of issues beyond the individual level to understand the structural factors that continue to cause health inequities for Inuit (28).

Methodology

Study Design

This scoping review followed the steps outlined by the Joanna Briggs Institute (JBI) scoping review methodology (35). While there are no universal definitions or purposes of scoping reviews (36), they generally identify and map the available evidence on a given topic (37,38). The value of a scoping review comes from its flexibility to incorporate various types of literature through a broad scope for research questions that are exploratory and descriptive in nature (35). The JBI approach to scoping reviews has rigorous and transparent methods for synthesizing evidence when the literature is complex and heterogeneous, and also recognizes other forms of evidence such as Indigenous expertise and experiences as was gathered in this study (35). Given the emerging evidence that indicates that structural factors impact cancer care for Inuit (15,16), the scoping review is an appropriate method to explore the breadth of literature that exists, and to reveal Inuit perspectives and experiences without the constraints of a rigid methodology that limits study designs (37,39).

Inclusion Criteria

Population/Participants

We focused specifically on literature that included Inuit in its study populations, with no exclusions based on age, sex, gender, or types and stages of cancer diagnoses. We also included papers that identified "Indigenous" or "Aboriginal" people as participants without specifying which Indigenous identity they held, to reduce the possibility of excluding important information that is also relevant to Inuit.

Concepts

Cancer Care. Cancer care encompassed the continuum of care from screening, diagnosis, treatment, and follow-up including survivorship care, palliative care, and bereavement

(17,40). We included cancer care in all settings such as inpatient and outpatient clinical care, community centres and agencies, and patient homes.

Structural Factors. Structural factors are "embedded within and systematically produced by the political, historical, social and economic structure of a society" (15, p.11). Drawing on the work of Reading (19), Horrill (15), and McGibbon (41), we developed a conceptual framework to guide our understanding of structural factors that shape inequities in health care and health outcomes, including: colonization, health systems, social, economic, and political structures. Figure 1 depicts the structural factors' concepts and descriptions. Additional details on each structural factor can be found in Supplemental Material A.

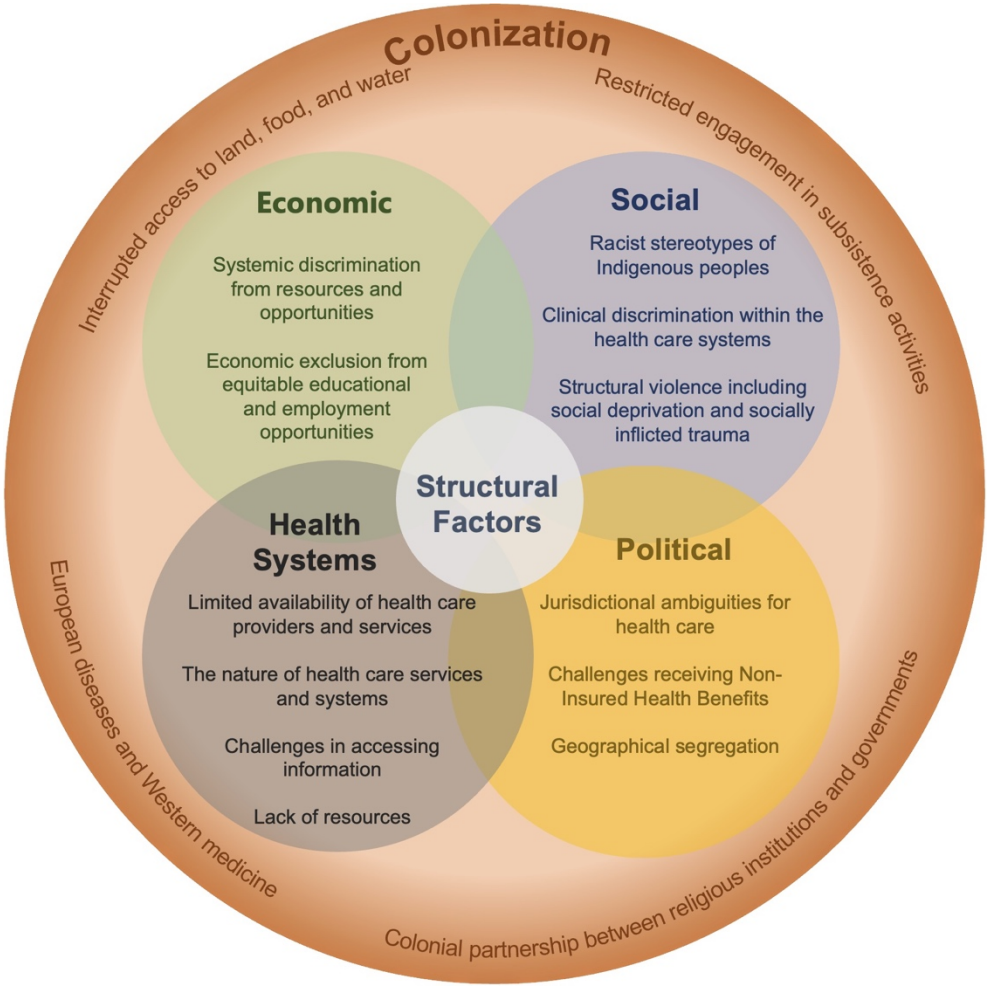

Figure 1. Structural factors that shape inequities in health care and health outcomes

Context

Due to distinct sociopolitical structures and jurisdictions in different countries, we only included papers that have examined cancer care in Canada.

Types of Sources

We included primary and secondary research of all study designs, in addition to text and opinion papers, legal documents, land claim agreements, and publications by Canadian federal government and Inuit organizations. Only papers that were available in electronic full text were included. Study protocols, conference proceedings, and abstract-only publications were excluded due the limited amount of information available in them. No date or language limits were applied to reduce the chance of excluding landmarking literature.

Search Strategy

A three-step search strategy was carried out in consultation with the University of Ottawa Health Sciences and Medicine Research Librarian (LS). The initial search was completed in CINAHL and Medline, followed by identifying relevant keywords within the title and abstract as well as index terms used to describe the article. A second search was then conducted using the identified keywords and search terms across the selected database. Since articles related to structural factors may use a diverse variety of keywords, terms related to the concept, "*structural factors*", were not utilized as search terms in order to enhance the breadth of the search and confidence in the search results. The third step involved hand-searching through the references lists of all identified articles for additional relevant studies. A sample search strategy in CINAHL is presented in Supplemental Material B.

The search strategy was conducted in the following electronic databases: CINAHL, Medline, Embase, PsycINFO, Nursing and Allied Health Database, Sociological Abstracts,

Circumpolar Health Bibliographic Database, Native Health Database, and Arctic Health Publication Database. The grey literature search consisted of Google Scholar, legal databases (LegalTrac, HeinOnline, and WestLaw), and a list of Canadian federal government and Indigenous organization websites including but not limited to: Justice Canada, Health Canada, Public Health Agency of Canada, Indigenous and Northern Affairs Canada, National Collaborating Centre for Aboriginal Health, Native Women's Association of Canada, Quebec Native Women, Pauktuutit Inuit Women of Canada, Saturviit: Inuit Women's Association of Nunavik, Inuit Tapiriit Kanatami, and Tungasuvvingat Inuit. In addition, table of contents of the following journals were hand-searched for eligible articles: *International Journal of Indigenous Health*, *International Journal of Circumpolar Health*, *Journal of Transcultural Nursing*, *Pimatsiwin: A Journal of Aboriginal and Indigenous Community Health*, *Études Inuit Studies*, and *Recherches Amérindiennes au Québec*.

Study Selection

All identified citations were imported to Covidence systematic review software (42), and duplicated articles were removed. Two reviewers (the primary author and a PhD student in Nursing [CL]) screened articles independently in a two-step process. The first step involved title and abstract screening against the pre-defined inclusion criteria. Results were moved to the second step, where full-text articles were independently assessed by each reviewer for eligibility with documentation of the rationale for exclusion. Throughout all stages of study selection, any discrepancies were resolved by discussion or a third reviewer (WG) when required. We presented and discussed the results of study selection with members from Pauktuutit Inuit Women of Canada (KG, RU, CG), and incorporated any feedback prior to analysis.

Data Extraction

As per the JBI scoping review methodology (35), we designed a tabular data extraction form in Excel to collect details from included pieces on the document type, population/participants, context, and concepts. After reviewing the data extraction table together, a postdoctoral fellow in nursing (EB) and the primary author independently extracted data from three articles into the charting table and compared results. After clarifying and discussing areas of discrepancy, the remaining data extraction was completed independently by the primary author and verified for accuracy by the second reviewer (EB). Throughout the data extraction phase, the research team iteratively refined the extraction table to ensure the collected data reflected the aim of this scoping review, and additional categories were added as needed.

Assessment of Relevance to Inuit

To assess the relevancy and alignment of the included literature to Inuit participants and/or community's values, knowledge, and priorities, we used components of the Well Living House Quality Assessment Tool (43,44) to examine the incorporation of Inuit perspectives and ways of knowing and doing through the following four elements: 1) Is the study design/measure(s) in keeping with local community values/beliefs/knowledge systems? 2) Is the study design/measure(s) in keeping with local priorities/aims (e.g., community articulated need for this evaluation)? 3) Is the underlying theory (of evaluation) relevant to the community? 4) Is the study protocol (design and data collection method) vetted by local community members? (See Appendix E). Each component was given a score of either: 2 (explicit evidence), 1 (partial evidence), or 0 (none), for a total score of 0 (none), 1–3 (weak), 4–6 (moderate), and 7–8 (strong evidence) for the relevance of each paper to participating communities.

Analysis and Presentation of Results

We conducted a qualitative thematic content analysis of the data extracted from the included articles. As recommended by Braun and Clarke (45), thematic analysis offers an accessible and theoretically flexible method to provide a rich and detailed account of the qualitative data, guided by the research question. We first deductively coded data into the categories of the a priori taxonomy (described above) as they explicitly or intuitively corresponded to the categories and definitions. Any findings that did not correspond to the structural categories within the framework were inductively coded into new categories. We then inductively coded the data under each category and developed themes as they emerged from the data. Themes were developed using the explicit words from the data, and meanings and implications were not interpreted beyond what has been written by the authors (46). This approach aligned with the JBI guidelines for qualitative data analysis in scoping reviews, which are generally descriptive in nature with summaries of coded data in particular categories (35).

Results are presented as a narrative summary on the types of literature and the relevance of the included studies to Inuit, followed by a detailed account of the structural factors and where on the cancer care continuum they are documented as influencing cancer care.

Ethical Considerations

Data were gathered from existing literature, and no human participants were involved at any stages of the study, therefore ethical approval from the affiliated university's Research Ethics Board was not required because no primary data were collected on human subjects. However, it is pertinent to note that we took guidance and aligned the procedures with ethical principles and guidelines for research with Inuit as outlined by the National Inuit Strategy on Research (47). This includes advancing Inuit governance in research by involving members of Pauktuutit Inuit Women of Canada as collaborative partners in this study; enhancing the ethical

conduct of research by adhering to Chapter Nine of the *Tri-Council Policy Statement (48)*, including developing respectful relationships, collaboration, and engagement between researchers and Indigenous partners; aligning funding with Inuit research priorities by developing the study purpose in response to the priorities identified in the published research on Indigenous cancer care (15) and by representatives from Inuit-specific organizations (49); ensuring Inuit ownership, control, access, and possession over data and information by recognizing and engaging Inuit partners throughout the research process, with transparent access to data collection and analysis; building capacity for Inuit Nunangat research by building a collaborative and respectful relationship with Inuit members from Pauktuutit Inuit Women of Canada as integral research partners.

Results

The initial search located 3652 citations from published databases and hand-searching. After removal of duplicates, 2794 articles were included in title and abstract screening, 113 papers proceeded to full-text review, and a total of 30 papers were included in analysis (see Figure 2 for flow diagram of study selection process). Of the 30 papers included, 18 described 17 research studies (one study was reported in two papers); 72% (n = 13) of the 18 research studies were from journal publications and 28% (n = 5) from grey literature. Research designs included qualitative (n = 14), quantitative (n = 2), and mixed methods (n = 1). Of the 12 non-research papers, 58% (n = 7) were found in journal publications and 42% (n = 5) from grey literature; seven were discussion articles, four were reports, and one was an editorial. Half the number of papers (n = 15) were published between 2019 and 2021 with four to six per each year, while the remaining half were published between 2002 and 2017.

Just over half (n = 17) of the included papers focused exclusively on Inuit, two of which focusing on urban Inuit. Inuit were included in nine papers with First Nations and Métis, and four papers used the terms "Indigenous" or "Aboriginal" without specifying the particular group. Two papers only included women. Settings included: secondary and tertiary care settings (n = 7); primary care settings (n = 4), with 19 papers not reporting on the type of cancer care settings.

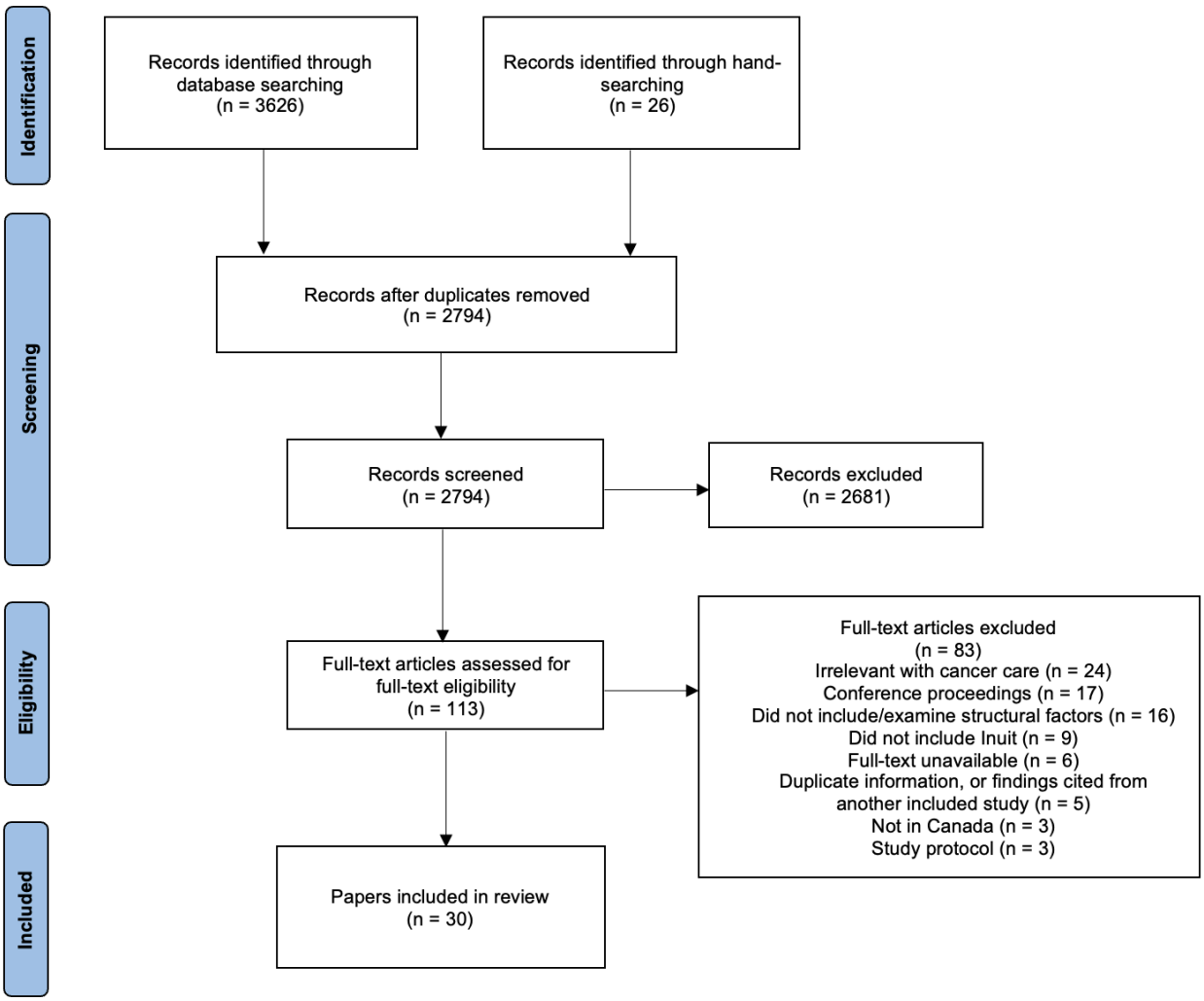

Figure 2. Study selection process

Relevance of Research to Inuit

Of the 17 research studies (presented in 18 papers) assessed for relevance to Inuit participants or communities using components of the Well Living House Quality Assessment

Tool (43,44), six studies were rated as having strong relevance (17,23,50–53), four had moderate relevance (49,54–57), one had weak relevance (58), four provided no evidence of relevance (59–62), and two studies were not assessed as they are literature reviews and did not involve study participants (15,63). The assessed papers most frequently reported evidence of keeping the study design/measures with local priorities or aims articulated by the community. Whether the underlying theory was relevant to the community and whether the study protocol was vetted by local community members were both the least reported relevance criteria.

Structural Factors that Influence Cancer Care

Eleven themes were mapped onto the five categories of structural factors in the a priori framework (colonization, health systems, social, economic, and political). See Table 1 for the themes within each structural factor that influenced cancer care experienced by Inuit, and Table 2 for characteristics of included articles and the categories of structural factors that emerged from each article.

Table 1. Themes of structural factors that influenced cancer care experienced by Inuit

Structural Factor Category	Themes
Colonization	• Colonial practices in settler health care • Historical legacy of the government and religious institutional projects
Health Systems	• Complex coordination of care • Lack of Inuit-specific cancer data • Biomedical dominance
Social	• Limited culturally and linguistically appropriate cancer information • Racism
Economic	• Exclusion from equitable resources and opportunities
Political	• Inadequate recognition and appreciation of issues in geographically isolated northern communities • Underestimation of cancer-related disparities • Multi-jurisdictional nature of health service delivery

Table 2. Characteristics of included articles and Structural Factors that influence cancer care

Author/Year	Type of Article and Research Study	Population Location	Structural Factors					Evidence of Relevance to Inuit
			Colonization	Health Systems	Social	Economic	Political	
Ahmed et al. (2015)	Discussion article	Aboriginal populations Canada	✓	✓	✓	✓	✓	Not applicable (not a research study)
Ashton & Torchetti (2020)	Discussion article	Inuit Canada	✓	✓	✓	✓	✓	Strong • Knowledge gathering including conversations with community members and service providers • Project development guided by an advisory committee • Community capacity building through workshops and Inuit-specific resources and supports
Beben & Muirhead (2016)	Editorial	First Nations, Inuit, and Métis Canada	✓	✓			✓	Not applicable (not a research study)
Beckett et al. (2021)	Discussion article	First Nations, Inuit, and Métis Canada		✓	✓	✓	✓	Not applicable (not a research study)
Brooks et al. (2014)	Qualitative study • Photovoice and interviews	Aboriginal women Saskatchewan; rural, urban, and on-reserve	✓		✓	✓	✓	Moderate • Participatory visual method used to collect stories from Aboriginal women and promote group discussions • Focus group with all participants and community stakeholders
Browne & Smye (2002)	Qualitative study • Critical discourse analysis	Aboriginal women Canada	✓	✓	✓			Not applicable (not a research study)

Cameron (2011)	Qualitative study • Key informant interviews and literature reviews	First Nations, Inuit, and Métis Canada		✓			✓	Weak • Key informant interviews across northern and southern regions
Canadian Partnership Against Cancer (2011)	Cancer control report	Inuit Canada		✓			✓	Not applicable (not a research study)
Canadian Partnership Against Cancer (2014)	Cancer control report	Inuit Inuit Nunangat; rural/remote	✓	✓	✓	✓	✓	Not applicable (not a research study)
Chan et al. (2019)	Discussion article	First Nations, Inuit, and Métis Inuit Nunangat; rural/remote		✓	✓	✓	✓	Not applicable (not a research study)
Chan, Friborg, et al. (2020)	Quantitative study • Geospatial analysis	Indigenous populations Rural/remote communities in Canada and Greenland					✓	None identified
Chan, Linden, et al. (2020)	Quantitative study • Retrospective review	Inuit Nunavut; rural/remote					✓	None identified
Corvus Solutions & Canadian Partnership Against	Qualitative study • Literature review, interviews, consultations	Inuit Inuit Nunangat; rural/remote		✓	✓	✓	✓	Strong • Project methodology and development guided by an advisory committee and stakeholders in each Inuit Nunangat region

Cancer (2012)								• Findings presented to participants for validation and discussion
Enuaraq et al. (2021)	Qualitative descriptive study • Focus groups and interviews	Inuit Inuit Nunangat and Ontario; urban and remote	✓	✓	✓	✓	✓	Strong • Research approach grounded in Inuit Qaujimajatuqangit values and principles • Study conducted in partnership with Inuit organizations (recognized as co-authors)
Fraser (2021)	Discussion article	Inuit Nunavut; rural/remote	✓		✓		✓	Not applicable (not a research study)
Galloway et al. (2020)	Qualitative study • Interviews	Inuit Nunavut; rural/remote	✓	✓	✓	✓	✓	Strong • Guided by Inuit principles of Piliriqatigiinniq and Iqqaumaqatigiinniq • Discussion with community stakeholders • Research paradigm used the Piliriqatigiinniq Model for Community Health Research
Hordyk et al. (2017)	Qualitative study • Focused ethnography	Inuit Nunavut; rural and remote	✓	✓	✓	✓	✓	Moderate • Community capacity theoretical perspective • Stakeholders from community organizations involved in pilot testing the interview guide
Horrill et al. (2019)	Qualitative study • Scoping review	First Nations, Inuit, and Métis Canada	✓	✓	✓	✓	✓	Not applicable (literature review, no study participants)
Horrill et al. (2021)	Qualitative study • Survey	First Nations, Inuit, and Métis Canada	✓	✓	✓	✓	✓	Moderate • Critical appraisal of study findings by Indigenous health care providers with knowledge and experience in cancer care

								• Cultural safety and trauma- and violence-informed care incorporated in the study framework
Inuit Tapiriit Kanatami (2008)	Discussion article	Inuit Canada		✓	✓	✓	✓	Not applicable (not a research study)
Jull et al. (2021)	Qualitative study • Interviews	Inuit Nunavut; rural/remote		✓	✓	✓	✓	Strong • Community consultations • Study carried out in partnership with Inuit service organizations and community members • Research approach guided by the Inuit Qaujimajatuqangit principles
Kewayosh et al. (2015)	Cancer strategy report	First Nations, Inuit, and Métis Ontario; on- and off-reserve communities		✓	✓	✓	✓	Not applicable (not a research study)
McKenzie (2015)	Qualitative study • Literature review, document analysis, interviews	Inuit Nunavut; rural/remote	✓	✓	✓	✓	✓	None identified
Pauktuutit Inuit Women of Canada (2013a)	Qualitative study • Environmental scan, focus groups	Inuit Inuit Nunangat; rural/remote		✓	✓		✓	Moderate • Advisory committee with cultural, regional, administrative, and subject matter expertise • Inuit stakeholders involved in the study methodology and development
Pauktuutit Inuit Women of Canada (2013b)	Qualitative study • Same study as above	Inuit		✓	✓		✓	Moderate • Same study as above

		Inuit Nunangat; rural/remote						
Roberts et al. (2020)	Discussion article	First Nations, Inuit, and Métis Canada	✓		✓		✓	Not applicable (not a research study)
Sheppard et al. (2019)	Qualitative study • Literature review, synthesis of annual activity reports	First Nations, Inuit, and Métis Ontario; both on- and off-reserve communities	✓	✓		✓	✓	Not applicable (review of the literature and patient navigator reports, no study participants)
Smith et al. (2020)	Mixed methods • Retrospective review; thematic analysis and descriptive statistics	Inuit Northwest Territories, Nunavut; rural/remote		✓		✓	✓	None identified
Smylie et al. (2017	Qualitative participatory study • Concept mapping, survey	Inuit Ottawa; urban	✓	✓	✓		✓	Strong • Community-based, participatory research methods • Involvement of community representatives as active research members • Culturally relevant training and mentorship • Research principles included Indigenous leadership, capacity building, respect, cultural relevance, representation, and sustainability
Tungasuvvingat Inuit (2019)	Program report	Inuit Ottawa; urban	✓	✓	✓		✓	Not applicable (not a research study)

Colonization

Two themes surrounding colonization as a structural factor emerged from the literature: 1) colonial practices in settler health care and 2) historical legacy of the government and religious institutional projects.

Colonial practices in settler health care. Findings revealed Inuit were subjected to a number of exploitative colonial practices and policies, including but not limited to the disruption of traditional Inuit settlement patterns and killing of Inuit sled dogs by the Royal Canadian Mounted Police, as well as biomedical skin graft experiments conducted during 1960–70s (64). Inuit communities were viewed as a means for testing etiological hypotheses and developing diagnostic techniques by non-Indigenous physicians and researchers who appropriated, patented, and profited from the data collected from Inuit (64). It is evident that colonization created long-term impacts on the physical and emotional well-being of Inuit families and communities (55,65). Yet, the provision of health services today still reflects traces of colonial practices (55); these have reinforced paternalistic and non-inclusive approaches towards health and health care for Inuit (23,61), and shaped the complex challenges Inuit face in cancer control (65).

Historical legacy of the government and religious institutional projects. Colonial projects between the Canadian government and religious institutions exercised domination over Inuit (50) and sought to eliminate their identity as a distinct group by forcibly seizing their territories and suppressing Inuit languages, cultures, and traditions (65). Various colonial policies and practices were identified in the literature, including the removal of Inuit children from their homes and placement into the residential school system (15,50,65), forced relocations to the High Arctic and permanent settlements (22,50,65), as well as forced medical treatment and hospitalization (55,61).

Health Systems

Three themes emerged with respect to the structural factors within the health systems: 1) complex coordination of care, 2) lack of Inuit-specific cancer data, and 3) biomedical dominance.

Complex coordination of care. Inuit access to and experiences in cancer care are greatly hampered by the fragmented collaboration, programs, and processes of care within the current health system (56,58). Poor communication and coordination exist across different parts of the cancer care system, such as community centres, cancer agencies, and tertiary care centres, leading to delays in follow-up and planning of care (13,15,17,22,51,55,62,65–67). Numerous papers also noted a paucity of longitudinal and integrated programs and services within communities (13,15,17,22,49,50,56–58,61,65,66,68–71), such as early diagnostic services, radiotherapy, complex after care, and palliative care. As indicated in the Canadian Partnership Against Cancer 2014 report (13), "programs are not accessible in their communities and are not relevant to the unique experiences of Inuit cancer survivors" (p. 44). Furthermore, as travel is often required to get the necessary care, Inuit face additional logistical barriers related to scheduling appointments, paperwork, transportation, and accommodation (15,61,63,69), which further constrains Inuit's access to cancer care.

Several supports within the health systems were identified in the literature. Patient navigators, case managers, and medical escorts play a key role in supporting Inuit patients and families on their cancer care journey and providing continuity of care (13,17,23,52,57,66,69,71). The Ottawa Health Services Network Inc. (OHSNI) facilitates patient transfers, stays in southern hospitals, and provides interpretation services and administration support for appointments (61). The Canadian Cancer Society offers cancer information helpline in Inuktut and peer support

services that connects Inuit cancer patients to people with similar experiences (50). In addition, several initiatives and programs were found to support Inuk individuals and Inuit communities in cancer prevention, including tobacco reduction (13,17), Well Woman and Well Man Clinics (13,17,70), HPV vaccination (17), as well as mobile screening clinics (22).

Lack of Inuit-specific cancer data. The large information gaps in the cancer incidence, cancer risks, and the uptake of cancer prevention interventions in Inuit populations illustrate a further barrier surrounding a lack of comprehensive cancer control data specific to Inuit across Canada (22,58,67,72). Currently, the ethnocultural identity of cancer patients is not captured by most health care systems in Canada (13,22,67). There is a lack of Indigenous identifiers in major health and social databases such as large population surveys and provincial cancer registries (22,67,68,72), and Inuit may not be identified if living outside of Inuit Nunangat (68). Each region collects its own cancer data but to varying extents (58); some systems do not distinguish between Inuit amongst all Indigenous groups, or combine Inuit data with national averages because the Inuit sample size was deemed too small for analysis (70), thus failing to provide long-term and up-to-date research and surveillance evidence documenting cancer among Inuit. Inuit Tapiriit Kanatami (70) emphasized the need for more comprehensive, Inuit-specific data on cancer-related variables including "age, sex, smoker or non-smoker, medical history, types of cancer, treatments selected, survival and success rates of cancer diagnosis, treatment and essential care" (p. 13).

Biomedical dominance. Numerous papers have drawn attention to the dominance of biomedicine in health care systems and professions (56), which contributes to the unequal power relations inherent in medical encounters between patients and providers (7,55), as well as the tendency in health care to perceive and treat the physical body and diseases as isolated from the

person as a whole (56). Influenced by the biomedical model predominated by non-Inuit, the existing health delivery system favours and prioritizes efficiency in time and money over quality of care (55,56), which lacks space for understanding Inuit ways of knowing and doing (13,53,56,65). Traditional treatment and healing practices were unrecognized in mainstream patient care (22,55,61), and dismissed as ineffective in comparison to Western medicine (65). Despite disruptions to traditional practices, Inuit retain their resiliency in the face of oppressive hardships, draw strength from healing and wellness practices, and promote deep connections to the land, family/community, language, as well as traditional resources and knowledge (23,50,51,55,63,71). For instance, spirituality as an aspect of traditional life continues to be highly important to many Inuk individuals and Inuit communities (23,63). Nonetheless, all components of the health systems must integrate and implement services in a way that is responsive to and sensitive to the practical and cultural needs of Inuit patients and families (13,66,67).

Social

Two themes emerged from the literature: 1) limited culturally and linguistically appropriate cancer information and 2) racism.

Limited culturally and linguistically appropriate cancer information. The limited culturally responsive cancer information available in Inuktut was commonly cited in the literature as an ongoing barrier for Inuit navigating cancer care (13,15,17,22,50,57,61,65,70). The lack of consistent and dedicated resources and educational activities contributed to difficulty in obtaining timely and accurate information (15,23,49–51,57,69,70), promoting awareness and communication (13,23,50,51,65,70), and engaging in cancer screening and prevention (17,50,63,70). Moreover, the shortage of health care providers who are conversant with Inuit

culture and languages (13,22,51,69) resulted in miscommunication of diagnosis and treatment plans (22,50,51,69) as well as misinterpretation of non-verbal body language (51,69). Findings from two studies (51,69) suggest that service providers that were able to effectively support and develop meaningful interactions with Inuit patients were those who had been well-versed and understanding of the language, customs, and community ways. In addition, Pauktuutit Inuit Women of Canada developed the *Inuusinni Aqqusaaqtara – My Journey* booklets (23) as a facilitator to support Inuit patients and caregivers on their cancer journey with plain language definitions, local resources, and easy-to-read cancer information.

Racism. This theme describes Inuit experiences of discrimination and being wrongly defined through racial terms and harmful generalizations (7,54), which included negative stereotypes about Inuit women as lacking willpower and judgement, or that prevention is not a meaningful concept to them (7). Furthermore, health researchers have decontextualized social barriers faced by Inuit as resulting from differences in individual behaviours or lifestyles, rather than stemming from impoverished socioeconomic circumstances, marginalization, and political influences (7,54,68,72). In particular, past epidemiological conclusions in which low breast cancer incidence in Inuit women did not take into account of the shifting nature of tumour classification, as well as the potential factors contributing to underreporting of the disease such as Inuit patterns of seasonal migration and resistance against federal medical surveillance amid forced relocations (64). The flawed notion that breast cancer was rare among Inuit profoundly influenced northern health care systems, leading to many undiagnosed and untreated cases (64). In response to this epidemiological legacy, breast cancer survivors and advocacy groups in the last two decades have launched public awareness and fundraising campaigns demonstrating that

Inuit women do in fact develop the disease, along with new arguments and statistics that have been put forth to help prioritize breast health in the north (64).

Economic

Data extracted for the economic factors were synthesized into a single theme: exclusion from equitable resources and opportunities.

Exclusion from equitable resources and opportunities. Inuit access to cancer care is challenged by a number of socioeconomic stressors (17,54,63). Several papers highlighted the lack of stable and affordable housing (15,17,50,54–56,63,72), community infrastructure (17,54,56,68–70), as well as nutritious market and traditional foods (15,17,22,23,54,63,69,70). Inuit living in remote communities face substantial food insecurity as many are unable to afford healthy and nutritious food due to the high costs of food transportation (22,23,70). Medical travel imposed a heavy burden on families because of insufficient financial and social resources to support local childcare and lost paid work (13,15,51,54,62,63). Additionally, poverty (15,17,56), unemployment (51,56,72), low income (50,55,56,68), and inadequate support from employer to miss work (55,62) were also cited as barriers in obtaining cancer care.

Political

The political factors encompassed three themes: 1) inadequate recognition and appreciation of issues in geographically isolated northern communities, 2) underestimation of cancer-related disparities, and 3) multi-jurisdictional nature of health service delivery.

Inadequate recognition and appreciation of issues in geographically isolated northern communities. Challenges arising from the remote geographical locations and harsh climate conditions (13,15,50,52,54,56,60,62,68–70,72) were frequently underlined in the literature as a major barrier in Inuit cancer care journeys. There is an ongoing human resource

shortage across the spectrum of health care services within remote communities (22,50,54,56,66,67,69) because of the high turnover and low retention of permanent staff (13,15,17,54,55,57,61–63,70). In order to receive specialized cancer services and procedures, Inuit must travel a far distance by flight to larger health centres in urban cities (13,15,17,22,50,51,54,56,60,62,65,68–70). Developments in the area of telemedicine including tele-oncology (17) are taking place in Inuit Nunangat, which allows Inuit patients to stay in the community and promote interaction between the health care provider, the patient, and their family (70).

Underestimation of cancer-related disparities. Health spending decisions by governments in the north tend to focus on diseases that are higher in prevalence and incidence (17,61,64,68). Furthermore, neoliberal ideologies and political economics of health risk have shaped the approach taken by Nunavut's Department of Health to breast cancer prevention and investment in mammography (64). Currently, Inuit in various regions are taking greater control over health care policy, programming, and service delivery in local communities (67,70). The land claims agreements require governments to seek Inuit direction in the design and delivery of health services, which marks a crucial step forward in the development of appropriate health care for Inuit (70).

Multi-jurisdictional nature of health service delivery. The provision of health care to Inuit is operated by multiple, overlapping governments, corporate entities, and agencies (13,15,22,53,65,70). Ambiguities and complications between the federal, provincial, or territorial jurisdictions over the responsibility for health care costs can lead to delayed or reduced access to cancer services for Inuit patients (13,15,53,61,65,69). Several limitations in the Non-Insured Health Benefits (NIHB) program were brought forth in the literature. For example, a lack of

alignment was identified between general health care principles and the NIHB policies related to medical travel (23,63,67,70); the coverage is focused on cancer treatment rather than prevention (13,15,66,67), and expenses of having an accompanying person for travel and appointments are not consistently covered (51,69). Moreover, not all constitutionally recognized First Nations, Inuit, and Métis are eligible for benefits coverage (67), which varied by the individual's legal status and place of residence (65,67).

Aspects of Cancer Care Influenced by Structural Factors

Articles identified different aspects of cancer care that were influenced by structural factors, with many noting more than one type of cancer care being impacted. Aspects of cancer care identified in this review included: cancer prevention (n = 15), cancer diagnosis (n = 4), cancer treatment (n = 13), survivorship care (n = 5), and palliative care (n = 9). The literature also examined elements of medical transportation (n = 9) including medical evacuation and patient navigation, which can occur at any point throughout the care trajectory. Four papers did not specify the type of cancer care addressed and used general terms such as "cancer care".

Influences of Structural Factors

Structural factors influenced cancer care experienced by Inuit in four central ways: 1) disruptions to care, 2) exclusion and marginalization, 3) fear, mistrust, and trauma, and 4) financial constraints.

Disruptions to Care

The literature reiterates that structural factors disrupt and constrain cancer care for Inuit (13,15,17,22,50,56,57,65,67,69). Disrupted care contributed to increased risks of chronic illness and cancer (17,65), delayed or missed diagnoses that are often too late for treatment options (13,50,51,53,58,61,66,72), as well as negative impacts on health-related outcomes and meeting

Inuit health care needs (61). Inuit faced lengthy wait times for appointments and follow-up (15,52,53,70), which were worsened by flight cancellations due to inclement weather when they were required to travel for care (13,62,70). Inuit patients undergoing treatment at tertiary centres were separated from families, communities, and support networks, who are often important sources of emotional support when coping with the challenges of cancer (13,15,17,23,51,57–59,61,66,68–70). The disjointed continuity of care and relationship between the patient and provider were also reported in the literature (13,15,17,55,56,62,68,70,72), such that Inuit face challenges in obtaining follow-up regarding test results (49,50,57), and have to frequently repeat their medical history whenever encountering a new health care provider (50).

Financial Constraints

Being forced to adjust to new financial constraints and challenges were revealed in descriptions of the cancer care journey. In addition to the physical and emotional impact of a cancer diagnosis, Inuit patients and families had to adjust a new range of financial hardships related to loss of employment or income, childcare costs, and disruption in family routine (13,23,51,52,54,56,61,70,72). Enuaraq et al. (23) emphasized that imposing financial burden on individuals to care for loved ones undergoing treatment in urban centres is an assertion of Western values that does not promote the autonomy of Inuit for culturally safe care. Participants from several studies described having to focus on daily survival and making ends meet (15,54), being unable to afford recommended foods and equipment (54,56), and unable to continue education (51).

Exclusion and Marginalization

Experiences of exclusion and marginalization (23,51,70) emerged as a recurring theme related to the influences of structural factors on cancer care. Eroded Inuit governance and

perception of rights (65) became apparent as participants described the lack of knowledge and decision-making in planning of care throughout their journey to receive cancer care (52,61,66). Several papers also discussed Inuit cancer-related concerns and/or symptoms not being heard or responded to appropriately by health service providers (51,64), resulting in negative health outcomes and encounters (51). Additionally, reduced awareness of cancer screening and prevention (13,15,17,22,50,52,61,63,67) was reported in the literature as a barrier resulting from the structural influences on Inuit access to cancer care.

Fear, Mistrust, and Trauma

The words, *fear, mistrust,* and *trauma* were commonly used to describe Inuit experiences in the mainstream health care system (15,22,54,65,66). The colonial legacy reinforced the deeply engrained silences and a general distrust towards health care providers and procedures (13,15,22,50,66). Institutional racism against Inuit patients led to feelings of intimidation and fear of being stigmatized (54,68). Several papers discussed intergenerational trauma stemming from residential school attendance and its effects on Inuit cancer care (15,50,55,61,63,66), such that the grieving process for loved ones with inadequate psychosocial care often aggravated the trauma that reside in collective memories of individuals and communities (55). Inuit patients and family members described having a lack of appropriate supports and being overwhelmed with information and decisions (13,23,50,51,57,61,69,70), which added stress and confusion of not knowing what to expect in the cancer journey (13,23,57,61,70).

Discussions

Our study aimed to synthesize the available published and grey literature on the structural factors that influence cancer care of Inuit in Canada. The aspects of cancer care of Inuit identified in this review were cancer prevention, cancer diagnosis, cancer treatment, survivorship

care, palliative care, as well as medical transportation. The emerged themes fell into all categories of the a priori framework, with more themes in the health systems and political factors than the colonization, social, and economic factors. In addition, the influences of structural factors on cancer care were: disruptions to care; exclusion and marginalization; fear, mistrust, and trauma; and financial constraints. These findings prompted the following points for discussion.

To begin, the structural barriers to cancer care that were identified in this review, particularly those relating to colonization and social factors, point to the inextricable interconnections between systemic racism and colonialism. The processes of colonization have led to persistent and entrenched racism against Indigenous Peoples (6), and the two are closely intertwined in terms of how they affect Inuit cancer care and wellness (73,74). Colonialism is justified through perpetuating racist beliefs about Inuit as fundamentally inferior and shaping public services such as health and health care, education, justice, and child welfare (16,19,75). Racism also further compounds contemporary impacts of colonialism, which contribute to the obstruction of Inuit self-determination as well as a lack of equitable access to services and resources within the existing health system (6,75). Addressing systemic racism thus calls for systemic actions to acknowledge and understand how Western health care systems are built upon colonial and racist foundations (76), and to create comprehensive efforts in policies and institutions to eliminate prejudice and discrimination against Indigenous Peoples (77,78).

Furthermore, only two papers have specifically looked at cancer care of Inuit living in urban settings. Our findings mirror the paucity of data around urban Inuit health and health care within the broader literature, which was also echoed in a previous study related to First Nations and Inuit older adults living in Ottawa, Ontario (79). In Canada, a growing Inuit population live

in urban centres such as Edmonton, Winnipeg, Ottawa, and Montreal (80). However, urban Inuit continue to experience disparities in social determinants of health such as employment, education, food, adequate housing, and health care (53,66), all of which are rooted in the historical and contemporary effects of colonialism (81). Dominant colonial narratives reinforced the exclusion of Indigenous Peoples from urban locations, including histories that fail to acknowledge non-Indigenous occupation of the lands as well as perceptions about the incompatibility of Indigenous identities and urban space (82). Urban Inuit community members may be further marginalized as they lose access to many federal programs that are only available within land-claim settlement regions (80,82), as well as through services that presume a one-size-fits-all, pan-Indigenous approach without taking into account the unique values and needs of Inuit (79).

Lastly, findings from this study underline the need for principled, comprehensive, and system-wide efforts to address the structural barriers in cancer care that are underpinned by the colonial legacy (23,83). A basic public awareness has grown over the last decades that the injustices faced by Indigenous Peoples in Canada are rooted in an enduring legacy of colonialism (78). However, previous research suggests that action and advocacy at the systems and structural levels remain absent, as solutions targeting the structural conditions may be perceived as falling outside of the purview of the health care system or beyond the scope of individual health care providers or institutions (84). While changes on the individual level may have a greater direct influence on patient experiences, a systemic and coordinated approach involving collaboration across various sectors is required to make meaningful headway in dismantling the colonial structures in policies and practices in Canada (74,77,78). Strategies in addressing the broader contexts of health include “improvements within the education sector, additional buy-in and

accountability within healthcare organisations, broader implementation of cultural safety, and broader recognition of the impacts of anti-Indigenous racism" (85, p.155).

Strengths and limitations

The following strengths and limitations should be considered when interpreting the study findings. A transparent and rigorous approach guided by the JBI methodology, along with a comprehensive search strategy that was peer-reviewed by an academic librarian with expertise in Indigenous health, contributed to the strengths of this scoping review. Consistent with the purpose of scoping reviews, the capacity to incorporate grey literature can also be considered as a strength to this study given that Inuit knowledge and experiences can often be found beyond published data in a wide and diverse range of literature. In addition, a quality assessment was carried out using components of the Well Living House Quality Assessment Tool to assess the relevancy of the included literature to Inuit.

Although no linguistic restrictions are established in the search strategy, the study team did not have the ability to search or capture the literature in Indigenous languages such as Inuktitut. The range of data in this scoping review may be limited as relevant evidence may exist in forms other than written documents, or in other databases that could not have been identified in the literature search. For instance, Indigenous Peoples' knowledge has also been shared through oral traditions, songs, arts, and ceremonies, and these local forms of wisdom may not be represented or synthesized in this scoping review.

Conclusion

Our scoping study explored what is known within the literature about the structural factors that facilitate or hinder Inuit cancer care access and experiences, and identified an intricate interplay of colonization, health systems, social, economic, and political structures that

influence cancer care of Inuit in Canada. The study findings highlight the link between racism and colonialism, in which colonialism is justified and perpetuated through racism within the health system. There was also limited information regarding cancer care of urban Inuit in Canada, who experience unique and complex challenges in accessing health care. Addressing the structural barriers that Inuit face in the cancer care trajectory requires a system-wide approach. Given the ongoing disparities in cancer-related outcomes among Inuit compared with non-Indigenous patients in Canada, results from this study inform health care policy and delivery with the goal of improving health equity for Inuit in cancer care. Further research in partnership with Inuit is necessary in developing long-term strategies underpinned by accountability to address the structural barriers to cancer care and reduce health and social inequities experienced by Inuit.

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Data Availability

The authors confirm that the data supporting the findings of this study are available within the article and its supplementary materials.

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Supplemental Material A

Taxonomy of Structural Factors

Structures	Description and examples
Colonization	Interrupted access to land, food, and water. • Imposition of a reserve system in Canada • Lack of access to clean water • Destruction of traditional foods and traditional food preparation that was replaced with Western market food • Relocation of Inuit from their traditional territories and impermanent, readily constructed dwellings to permanent housing in regions selected by the government
	Restricted engagement in subsistence activities • Banning of many forms of Indigenous hunting and fishing in the interests of expanding capitalist ventures • Forced relocations to areas with suboptimal hunting conditions and hostile climates, interfering with Inuit's traditional food supply
	European diseases and Western medicine • Spread of communicable illness after European contact • Colonial activities sustained by early Western medical aid • Indigenous health policy based on notions of white racial superiority and assimilation goals • Medical discourses that described Indigenous peoples as inherently pathological, whose health could only be guaranteed through assimilation • Outbreaks of tuberculosis; more than 70 percent of Keewatin Inuit in 1964 had been in TB sanatoria
	Colonial partnership between religious institutions and governments; child welfare systems in Canada • Residential schools; designed to eradicate Indigenous family and kinship structures and strip children of their Indigenous identity • Spread of tuberculosis facilitated by harsh living conditions of residential schools • Physical, emotional, mental, spiritual, and sexual harm of children • Murder of children in residential schools through neglect, torture, and manslaughter • The "Sixties Scoop", and other apprehension approaches that placed Indigenous children in the child welfare system • Children sent to TB sanatoria were adopted by southern families without their parents being informed
Health Systems	• Racist and culturally unsafe health care services and health care system • Inflexibility of cancer services (e.g. screening may be offered only on certain days in some communities, and providers in small communities are frequently called away to emergencies), long wait times

	• Challenges in accessing cancer information: cancer information that was not culturally safe or not in an Indigenous language • No navigators to support Inuit patients navigate the health care system
Social	Racist stereotypes of Indigenous peoples as "primitive" or "savages" and thus intellectually, morally, and socially inferior to white Europeans • The reconstruction of Indigenous peoples through the colonial gaze into racialized stereotypes of apathy and submissiveness, which was used at the basis of racist legislation and policies, appropriation of lands, generalized violence, and the exploitation of Indigenous women • The obstruction of Indigenous self-determination and failure to recognize treaty and land rights, over-surveillance by criminal justice and child welfare systems, and the continued societal and systematic privileging of white people in Canadian society • Justification of persistent racialized health disparities by historical and contemporary approaches to health research in the area of genetics and race; reductive genetic attributions of disproportionate illness and disease among racialized populations rather than examining inequities in social determinants of health • Marginalization of Indigenous peoples in social reproduction, which fails to fully acknowledge the colonial challenges, important cultural contributions, and denial of opportunities for Indigenous peoples
	Clinical discrimination within the health care systems based on stereotypes and social and cultural norms of individuals who are living in poverty • Inadequate or degrading medical care; failure of health care providers to provide thorough assessments or life-saving referrals • Lack of action from health care administration to address discrimination indirectly supports ongoing oppression in access to care • People having to strategize in advance of their visit about anticipated racism or avoid seeking care
	Additional forms of structural violence including social deprivation and socially inflicted trauma (mental, physical, and sexual, directly experienced or witnesses, from verbal threats to acts) • Missing and murdered Indigenous women and girls in Canada • Degradation of ecosystems linked to systemic alienation of Indigenous populations from their lands and corresponding traditional economies
Economic	Systemic discrimination from resources and opportunities • Exclusion from essential social needs such as adequate housing (crowded dwelling), access to sufficient and nutritious food (food insecurity), access to safe household drinking water supply, sufficient funding for Indigenous programs and services, community and health system infrastructures (e.g., resources for medical travel and childcare), expensive shipping costs for food and resources • No resources for transportation, childcare, or scheduling time away from work

	• Challenges in accessing cancer information: poor/no internet and telephone access, • Lack of public and private investment in economic development for Indigenous communities
	Economic exclusion from equitable educational and employment opportunities • Socioeconomic stratification creates a gradient of health disparities, particularly damaging for those who are relegated to increasing disadvantageous living conditions • Income; reduced average annual incomes and higher unemployment rates of Indigenous peoples compared to non-Indigenous Canadians • The vast majority of health care in Canada are provided with the assumption that individuals and families can afford material costs associated with optimal health outcomes (e.g., money for transportation, prescribed medications, and over-the-counter recommended treatments)
Political	Jurisdictional ambiguities or disputes within the federal/provincial division of responsibility for healthcare services to Indigenous peoples • Many status First Nations people and Inuit must cross invisible jurisdictional borders to access different health services, which has resulted in reduced or no access to these services in the communities • Inuit living in the south can be caught between jurisdictions, with unclear accountabilities for their health and public health services
	Challenges receiving Medical Transportation and benefits under the Non-Insured Health Benefits program (NIHB) • Funding from the policy is rigid and does not cover travel for certain services, including cancer screening • Policy is applied unevenly and based on budgetary factors and distinctive funding caps • The financial, emotional, and social costs associated with the frequent need to travel away from home to obtain essential health services • National-level program and service strategies are devolved in a hierarchical manner to the regional offices, limiting opportunities for substantive local input into First Nations and Inuit Health Branch policy development and little room for local First Nations and Inuit understandings of health
	The effects of geographical segregation – the physical separation of racialized groups in residential contexts – on health disparities • Limited availability of health care providers including Inuit providers, family physicians (entry into the cancer care system), difficulty recruiting and retaining health care providers in remote geographic locations, shortages of female health care providers particularly in cervical or breast cancer screening • Limited availability of culturally safe health and cancer care services within Indigenous communities, or in close proximity

	• Low population density, lack of transportation infrastructure, lack of services available in mother tongue, long wait-times, inadequate human resources, and northern climate conditions act as significant barriers for Indigenous Peoples in rural or remote communities to access health care • Individuals and communities living in locations with high pollution rates have an unfair toxic burden; the health impacts of geographic proximity to hazardous waste facilities and landfill sites • Environmental racism; hazardous sites have been historically disproportionately located near communities of colour

Supplemental Material B

Search Strategy for CINAHL (March 27, 2021)

S1	(MH "Canada+")	105,250
S2	TI (Canada OR Canadian OR Ontario OR Quebec OR Alberta OR Newfoundland OR Labrador OR Manitoba OR Saskatchewan OR Yukon OR Nunavut OR "Nova Scotia" OR "New Brunswick" OR "Prince Edward Island" OR "British Columbia" OR "Northwest Territories" OR "Inuit Nunangat" OR Inuvialuit OR Nunatsiavut OR Nunavik OR "atlantic provinces" OR prairies OR prairie provinces" OR maritimes OR "maritime provinces" OR arctic OR subarctic) OR AB (Canada OR Canadian OR Ontario OR Quebec OR Alberta OR Newfoundland OR Labrador OR Manitoba OR Saskatchewan OR Yukon OR Nunavut OR "Nova Scotia" OR "New Brunswick" OR "Prince Edward Island" OR "British Columbia" OR "Northwest Territories" OR "Inuit Nunangat" OR Inuvialuit OR Nunatsiavut OR Nunavik OR "atlantic provinces" OR prairies OR prairie provinces" OR maritimes OR "maritime provinces" OR arctic OR subarctic)	87,930
S3	S1 OR S2	143,065
S4	(MH "Indigenous Peoples") OR (MH "Aboriginal Canadians+") OR (MH "Eskimos+")	5,850
S5	TI (Indigen* OR Aborigin* OR Native OR In?uit OR Eskim* OR Inuk OR Inuktitut OR Inuvialuit OR Nunavummiut) OR AB (Indigen* OR Aborigin* OR Native OR In?uit OR Eskim* OR Inuk OR Inuktitut OR Inuvialuit OR Nunavummiut)	31,750
S6	S4 OR S5	34,135
S7	(MH "Neoplasms+") OR (MH "Neoplasms by Site+") OR (MH "Cancer Care Facilities") OR (MH "Early Detection of Cancer") OR (MH "Cancer Survivors") OR (MH "Cancer Screening") OR (MH "Cancer Patients") OR (MH "Chemotherapy, Cancer") OR (MH "Neoplasm Staging") OR (MH "Neoplasm Grading") OR (MH "Cancer Vaccines")	599,810
S8	TI (cancer* OR oncolog* OR neoplas* OR tumo?r OR malignan* OR carcino*) OR AB (cancer* OR oncolog* OR neoplas* OR tumo?r OR malignan* OR carcino*)	546,075
S9	S7 OR S8	756,150
S10	S3 AND S6 AND S9	150

Supplemental Material C

Additional details of structural factors

Author/Year	Aspects of Cancer Care Identified	Colonization Factors	Health Systems Factors	Social Factors	Economic Factors	Political Factors
Ahmed et al. (2015)	Cancer screening, vaccination	• Experiences at residential school affect attitudes to conventional medicine and health screening; mistrust of the health care system	• Limited information about the incidence of HPV, Pap screening, and cervical cancer rates among FNIM patients • Lack of culture-sensitive care • Information about ethnicity is not captured by health information databases • Research and cancer surveillance data for Indigenous populations are lacking • Respondents are not identified by race or ethnicity in large population surveys and provincial cancer registries • Low health literacy and need for improved content and delivery of health education • Lack of culturally relevant materials	• Language barriers	• Food insecurity; unaffordable food costs	• Unclear division of responsibility between the federal and provincial or territorial governments • Lack of integrated services in a single location; lack of longitudinal community and public health programs
Ashton & Torchetti (2020)	Not specified	• Removal of children from their homes and	• Lack of culturally or linguistically appropriate cancer	• Low health literacy	• Low income • Inadequate housing	• Lack of human resource capacity for health and wellness

		into residential schools • Forced relocations • Forced medical treatment such as tuberculosis treatment • Intergenerational trauma and mistrust • Rapid change in lifestyle due to colonization • Inuit remain resilient and strong with deep connections to the land	information that are accessible • Lack of cultural sensitivity • Lack of access to early testing and diagnosis; Inuit are diagnosed at later stages of disease • Canadian Cancer Society offers a free, confidential cancer information helpline	• Lack of culturally appropriate cancer awareness resources	• Food insecurity	services in the communities • Lack of specialized services in rural or remote communities • Rotation of health care staff through communities; unable to build trusting relationships • Limited diagnostic services and cancer treatment facilities
Beben & Muirhead (2016)	Cancer prevention	• Colonial policies eroded Indigenous rights and ways of governing, attempting to eliminate Indigenous peoples as distinct entities • The residential school system; sexual, physical, and emotional abuse • Land belonging to Indigenous peoples was forcibly seized and populations were resettled to	• Lack of culturally relevant educational materials • Lack of awareness and understanding of important cultural and historical elements within the health system • Poor coordination of care between hospitals and primary care providers	Not reported	Not reported	• Lack of access to prevention and screening programs • Conflicts between the federal and provincial governments over responsibility for care • Travel often required to receive care

		remote, resource-poor areas • Early treaties often ignored or invalidated • Deep sense of mistrust and betrayal • Traditional treatments dismissed as ineffective and unsophisticated • Spread of infectious disease • Government policies with origins in colonialism added complexities to accessing care				
Beckett et al. (1021)	Cancer prevention/screening, treatment, survivorship care, palliative care	Not reported	• Inuit may not be identified in cancer measurement if living outside of Inuit Nunangat • Lack of Indigenous identifiers in major health and social data sources in Canada • Underestimation of inequities in disease burden, access to care, and social determinants of health • Underinvestment in the population needs	• Long periods of separation • Fear and intimidation, impacts on employment, family and community life, mental health	• Poor infrastructure • Lower household income	• Lack of inter-community infrastructure • Paucity of community resources for survivorship and palliative care

Brooks et al. (2014)	Survivorship care	• Deeply engrained silences and lack trust embedded within colonial histories	Not reported	• False and harmful generalizations • Discriminatory treatment • Racism • Social problems decontextualized as an individual problem	• Financial stresses • Limitations of the Canadian employment insurance • Inability to afford recommended foods and equipment • Housing	• Long travel distance to receive care • Lack of health centres and medical professionals in communities
Browne & Smye (2002)	Cancer screening	• Tendency in the health care system to medicalise social problems as arising from individual lifestyles, cultural differences, or biological predisposition • Cultural explanations in health care discourses and research	• Unequal power relations inherent in medical encounters	• Negative stereotypes • Risk factors interpreted as lifestyle of personal choices	Not reported	Not reported
Cameron (2011)	Cancer diagnosis, treatment	Not reported	• Lack of up to date, comprehensive, long term, Inuit-specific data related to cancer • Fragmented health care system and lack of after care	Not reported	Not reported	• Screening and diagnostic services are intermittent and often conducted outside of communities
Canadian Partnership Against Cancer (2011)	Not specified	Not reported	• Lack of ethnic identifiers in cancer registries	Not reported	Not reported	• Inuit taking greater control over community health care services through agreements between the land claim

						governments and the federal and provincial/territorial governments • Responsibility for providing services and what is insured varies by the individual's legal status and place of residence • Not all constitutionally recognized Aboriginal persons are covered by the Non-Insured Health Benefits (NIHB) programs
Canadian Partnership Against Cancer (2014)	Cancer prevention/screening, diagnosis, treatment, palliative care	• Abuse during residential school; distrust of health care professionals • Compulsory relocation of tuberculosis patients	• Challenging coordination and follow-up between cancer centres, hospitals, and community-based primary care providers • Health indicators and health system performance measures do not include Inuit perspectives • Inuit health care is delivered from multiple, overlapping governments and agencies • Lack of health system-driven,	• Being away from family and community support systems • Language barriers and miscommunication • Limited mental health and counselling services	• Financial burden of travel • Loss of employment or income	• Multi-jurisdictional nature of health services delivery; Inuit patients must travel to a regional hospital or provincial cancer centre for specialized services • Medical travel is the only way to receive secondary and tertiary level care; flight cancellations due to weather conditions • Difficulty retaining permanent health care providers; staffing shortage; rapid turnover

			standardized tracking system for follow-up • Lack of community education and cancer awareness • No protocols/policies to provide cultural and emotional support for patients receiving an initial diagnosis • Initiatives and materials to promote tobacco reduction education activities • Screening programs are well incorporated into Well Woman clinics in Inuit Nunangat • Patient navigators supporting Inuit patients and families			• The health system's focus on acute issues and episodic care; disjointed treatment • Lack of palliative care in the community
Chan et al. (2019)	Treatment	Not reported	• Appointments are often scheduled back-to-back over a short time period • Indigenous patient navigators • Financial support for lodging and transportation to the hospital	• Language barriers	• Food insecurity	• Radiotherapy consultations, treatments, and most follow-ups can only be done at oncology referral centers in larger urban centers • Geographical barriers; substantial travel burden, no road access • Issues with the available communications technology, network infrastructure, adequate staffing to

						operate local telemedicine units
Chan, Friborg, et al. (2020)	Treatment	Not reported	Not reported	Not reported	Not reported	• Substantial travel distance
Chan, Linden, et al. (2020)	Palliative radiotherapy (palliative care)	Not reported	Not reported	Not reported	Not reported	• Long periods of hospitalization despite shorter median survival time
Corvus Solutions & Canadian Partnership Against Cancer (2012)	Cancer prevention/screening, diagnosis, treatment and after care, recover-survivorship care, palliative care	Not reported	• Cancer-related education are sporadic and inconsistent • Low health literacy • Low attendance to Well Man Clinics • Challenges with tracking and follow-up of results • Telehealth used in supporting cancer care • Navigation and coordination systems to support patients outside of their communities • Nurse case managers provide a source of continuity of care • HPV vaccination program • Well Woman clinics	• Limited mental health and counselling services • Family violence	• Impact on employment • Food insecurity • Overcrowding • Poverty	• Challenges in recruiting and retaining health care professionals; high turnover • Limited infrastructure • No palliative care programs in the community
Enuaraq et al. (2021)	Survivorship care	• Spirituality, country food, and traditional practices are important aspects of traditional life	• Feelings of decontextualization and acculturation when accessing cancer treatment outside of home communities	• Challenges with translation • Family involvement in patient care limited by visitation policies	• Costs and limited resources • financial burden of travel	• Limitations of the medical travel policies

		• The urban setting was challenging to participate in traditional activities and obtain country food • Paternalistic and non-inclusive approaches towards health and health care	• Patient navigators support Inuit in navigating the health care system	• MyJourney booklets (Inuusinni Aqqusaaqtara) to help Inuit understand their cancer journeys		
Fraser (2021)	Cancer screening and detection	• Inuit communities viewed as an epistemic tool for testing new etiological hypotheses, perfecting epidemiological methods, and developing diagnostic techniques • Extractive colonialism; using technologies predicated on the collection and calculation of Indigenous data to further settler-state goals and ideologies • Exploitative colonial policies and practices	Not reported	• Systematic underreporting and inaccurate statistics that appeared to have lower cancer incidence among Inuit women • Public awareness and fundraising campaigns by Inuit advocacy groups; putting forward new arguments and statistics	Not reported	• Underinvestment in mammography • Health spending decisions influenced by neoliberal ideologies and political economics of risk

Galloway et al. (2020)	End of life care (palliative)	• Importance of being on the land and harvesting traditional foods for the well-being of patients and family members	• Feelings of being left on your own • Family members having to serve as a translator for complicated information about diagnosis or treatment • Inuit non-verbal communication not properly interpreted	• Symptoms and concerns were appropriately not responded to • Use of medical jargon	• Burdens on childcare, missing paid work, financial costs	• Lengthy travels and stays for diagnosis and treatment
Hordyk et al. (2017)	End of life care (palliative)	• Caregiving traditions disrupted by epidemics brought by early European settlers and traders • Forced hospitalization without family being contacted • Forced displacement of Inuit children in residential schools • Long term impact on the teachings and continuation of traditional Inuit health care practices • Intergenerational trauma rooted in colonial practices resulted in social suffering	• Health institutions disregarding traditional Inuit cultural values • Patients faced with overcrowding and rotating between care centres because of bed shortage • Minimal cultural training offered to health care providers	• Lack of mental health and bereavement services • Language and communication barriers	• Disparities in education, income and housing	• High turnover rates for nurses; stressful work demands, understaffed

Horrill et al. (2019)	Cancer screening, diagnosis, treatment, survivorship care, palliative care	• Histories of trauma and abuse • Residential school attendance • Colonial legacy of paternalism, in which Indigenous women were told to let others make decisions • Mistrust of health care providers	• Lack of clear information about diagnosis and treatment options • Low health literacy • Lack of culturally safe care • Lack of trust in health care providers • Inflexible appointment systems • Cancer information that was not culturally responsive or relevant • Poor communication and coordination between parts of the system • Most Indigenous patients do not have a single health care provider	• Lack of trust • Not being taken seriously • Racism, discrimination, and marginalization • Family violence and suicide	• Transportation that was not feasible, convenient, or affordable • Poor internet access • Difficult access to financial support • Poverty; lack of stable and affordable housing • Food insecurity • Lack of resources for travel and childcare	• Reduced availability of health care providers due to difficulty recruiting and retaining staff in remote locations and high turnovers • Shortage of female health care providers in communities • Limited availability of health care services within communities or within driving distances • Long distance necessitated to access diagnostic services, specialist services, cancer treatment, follow-up care, and sometimes palliative care • The medical transportation policy under NIHB is rigid and does not cover travel for screening
Horrill et al. (2021)	Not specified	• The hegemonic biomedical model constrained access to care and quality of care • Biomedical dominance in health care and	• Lack of understanding among health care providers about cultural values, Indigenous ways of knowing, histories of colonization, and health care needs • Lack of education for health care staff about the complex care	• Homelessness • Lack of psychosocial supports • Dismissal of patient concerns • Racism and incorrect assumptions • Language barriers	• Poverty • Financial challenges, unemployment • Homelessness; lack of housing • Unreliable telecommunication services	• Lack of local health services and allied health professionals • Limited access to primary care

		on nursing as a discipline	needs of Indigenous patients • A system that prioritizes time- and cost-efficiency; lack of time to develop trusting relationships • Biomedical propensity to treat bodily parts and diseases as disintegrated and separated from the whole person			
Inuit Tapiriit Kanatami (2008)	Cancer prevention/screening, treatment, palliative care	Not reported	• Health delivery systems do not consistently reflect Inuit values and language • Family has no respite supports when patient returns home • Lack of culturally appropriate resources • Long wait times • Telemedicine developments • Lack of Inuit-specific cancer data • Well Woman clinics	• Language barriers • Lack of cultural awareness within the health care system • Social isolation during cancer treatment in southern hospitals • Lack of plain language medical information	• Food insecurity • Limited infrastructure • Financial constraints due to loss of income, childcare costs, and disruption in family routine	• Staffing shortages, high turnover rates • Limited availability of health care personnel and fewer services • Human resource challenges • Limitations in the NIHB coverage • Inuit taking a more active and empowered role in health care policy and service delivery because of the land claims agreements that require governments to seek Inuit input and direction
Jull et al. (2021)	Cancer treatment	Not reported	• Medical escort supporting patients in the cancer care journey	• Dismissal of health concerns • Finding ways to collaborate with	• Lack of housing • Loss of income	• Geography and weather as complicating factors

				family and community members in the cancer journey		
Kewayosh et al. (2015)	Not specified	Not reported	• Limited cancer surveillance data	• Language barriers	• Lack of housing	• Geographical isolation
McKenzie (2015)	Medevac	• Inuit preference for country food is ignored	• Traditional healing methods were unrecognized in southern patient care • Lack of cultural sensitivity in hospitals • The Ottawa Health Service Network Inc. as an organization that helps facilitate patient transfers and stay in southern hospitals	• Physical and sexual abuse; violence • Lack of translation • Communication barriers • Interruption of social assistance benefits for individuals travelling outside of Nunavut • Lack of social supports; social isolation during medical travel • Lack of psychosocial programs	• Financial stresses • Limited telephone services	• Prioritization of physical conditions than the psychosocial needs of Inuit
Pauktuutit Inuit Women of Canada (2013a)	Cancer screening, treatment and after care	Not reported	• Limited cancer resources for Inuit audiences • Patient navigators	• Communication and language barriers	Not reported	• Lack of complex after care services in the community • High staff turnover
Pauktuutit Inuit Women of Canada (2013b)	Cancer education, screening, treatment	Not reported	• Challenges finding out test results	• Language barriers	Not reported	• Lack of local support services
Roberts et al. (2020)	Patient navigation	• Shared connection to the land among First Nations, Métis, and Inuit communities	Not reported	• Discrimination • Social isolation • Support from local communities	Not reported	• Limited resources and equipment in outpost clinics than mainstream health centres

Sheppard et al. (2019)	Cancer screening, treatment, palliative care	• Intergenerational trauma • FNIM approaches to health and wellness remain strong	• Logistical barriers • No private space to meet with patients • Fear and lack of trust	Not reported	• Lack of resources for childcare • Housing	• Non-approval for escorts of family by NIHB • Staff turnover
Smith et al. (2020)	Cancer screening	Not reported	• Miscommunication and disrupted continuity between health services	Not reported	• Lack of childcare support • Inadequate support from employers to miss work	• Lengthy travels • Locum turnover in remote communities • No road access to majority of the northern communities • Flight cancellations to inclement weather
Smylie et al. (2017	Cancer prevention/screening	• Difficulty accessing traditional Inuit medicine	• Long wait times • Limited physician availability	• Language barriers	Not reported	• Double standards in the provision of health care due to jurisdictional complexities
Tungasuvvingat Inuit (2019)	Cancer prevention/screening, treatment	• Intergenerational trauma • Lack of trust in the government, church, hospitals	• Lack of access to screening • Delays in diagnosis, appointments, and test results • Lack of follow-up and after care support • Patient navigators	• Complex cancer terminology • language barriers • Pauktuutit patient-centred resources	Not reported	• Lack of equitable access and treatment in Nunavut • Staff shortages

Chapter Five

Integrated Discussion

Introduction

The purpose of this thesis was to synthesize the available published and grey literature on the structural factors influencing cancer care experienced by Inuit in Canada. This study was a scoping review to explore what is known about structural factors that influence cancer care experienced by Inuit in Canada. The theoretical frameworks that underpinned my thesis were aspects of postcolonial theory (*race, racialization, culture,* and *othering*) and a framework I developed on structural factors, conceptualized as factors "embedded within and systematically produced by the political, historical, social, and economic structure of a society" that create and/or shape inequities in health care and health outcomes (Horrill et al., 2019, p. 11). Structural factors were derived from studies by Reading (2009), Horrill (2019), McGibbon (2016), Bowers et al. (2020), Smylie & Firestone (2016), and Allan & Smylie (2015). In this chapter, I begin by summarizing the primary findings of the scoping review (Chapters Three and Four). I then provide an integrated discussion of my study findings within the broader literature, focusing on the: 1) interconnections between racism and colonialism, 2) lack of understanding of health services needs of urban Inuit, and 3) system-wide efforts to address structural barriers. Thereafter, I discuss the nursing implications in the domains of practice, education, leadership, policy, and research. Finally, I conclude with a discussion on strengths and limitations of this study as well as concluding remarks.

Thirty papers were included in the scoping review, prepared for submission to the International Journal of Circumpolar Health. Structural factors fell into all categories of the a priori developed theoretical framework including colonization, health systems, social, economic, and political factors, with the most themes identified in the health systems and political categories. Aspects of cancer care that were influenced by the structural factors include cancer

prevention, cancer diagnosis, cancer treatment, survivorship care, palliative care, as well as medical transportation (i.e., medevac, patient navigation), with the influences predominantly being disruptions to care; exclusion and marginalization; fear, mistrust, and trauma; and financial constraints. This study demonstrated that structural factors greatly influence Inuit experiences with care across the cancer trajectory, and highlights the need for a system-wide approach to address the structural barriers to care. The study results inform health care delivery and nursing practice with the goal of improving health equity for Inuit in cancer care.

Integrated Discussion

Findings of the scoping review highlighted three areas for discussion in relation to the broader research and theoretical literature: 1) the interconnections between racism and colonialism, 2) lack of understanding of health service needs of urban Inuit, and 3) need for system-wide efforts to address structural barriers.

Interconnections between Racism and Colonialism

Structural barriers to cancer care for Inuit identified in this review point to the inextricable link between systemic racism and colonialism, particularly those relating to colonization and social factors. Systemic racism refers to the acceptance of discriminatory and prejudicial practices that has become normalized across the society and institutions (Turpel-Lafond & White-Hill, 2020). With respect to health care, systemic racism encompasses a pervasive set of discriminatory practices sustained by societal and interpersonal norms, and creates systematic disadvantage and health inequities in a group of individuals (Doubeni et al., 2021). Colonialism is recognized as a determinant of Indigenous health in Canada and worldwide with ongoing negative impacts on Indigenous Peoples (Cunningham, 2009; Czyzewski, 2011; Mowbray, 2007). The process of colonization has led to persistent and

entrenched racism against Inuit (Allan & Smylie, 2015), and colonization and racism are closely intertwined in terms of how they affect Inuit health and well-being (Reading, 2013). To exert control over Inuit values and practices, European settlers justify colonialism by perpetuating racist beliefs about Inuit conceptualizations of health care as fundamentally inferior in that they are less evolved and sophisticated than the Western-focused biomedical model (Fraser et al., 2021; Pauktuutit Inuit Women of Canada, 2021), and shaping access to essential services such as health, education, justice, and child welfare (Loppie et al., 2014; Reading & Wien, 2009). Racism fuels colonial legislations and practices (e.g., forced relocations of Inuit communities into isolated northern regions, slaughter of sled dogs, suppression of Inuit midwifery) (Czyzewski, 2011; Fraser, 2021), which compounds the contemporary effects of colonialism and contributes to the obstruction of Inuit self-determination (Allan & Smylie, 2015; Cunningham, 2009) including Inuit rights to exercise autonomy in the design and implementation of policies, programs, and initiatives (Inuit Tapiriit Kanatami, 2019; Mowbray, 2007).

Note: In 2022, Mary Ellen Turpel-Lafond, a former judge and Indigenous rights advocate, faced controversy over her claims of Indigenous identity (Leo, 2022a). A CBC investigation found no evidence supporting Turpel-Lafond's claims of Cree ancestry and revealed inaccuracies in her public claims about academic accomplishments (Leo, 2022b). Turpel-Lafond's story illuminates a complex and growing discussion around Indigenous identity (Leo, 2022a), as well as the colonial violence perpetuated by non-Indigenous people as they take away opportunities from First Nations, Métis, and Inuit by falsely claiming Indigenous ancestry.

Research has shown that racism involves assumptions by Western health care institutions and providers that Inuit wellness and healing practices are primitive and akin to nursery rhymes

and fairy tales (Cunningham, 2009; Drummond, 2020), and disregarding aspects of Inuit health that do not conform to the predominant biomedical paradigm (Gifford et al., 2022; Wilkinson et al., 2023). As highlighted by the themes that emerged in this study about structural factors such as “Biomedical dominance” and “Colonial practices in settler health care”, Inuit patients are faced with paternalistic and non-inclusive practices in Western health care settings (Beben & Muirhead, 2016; Canadian Partnership Against Cancer, 2014), which fail to respect and incorporate Inuit traditional ways of knowing and doing for health (Inuit Tapiriit Kanatami, 2008; Sheppard, 2019). Participants in the included studies described a lack of cancer information (i.e., resources, educational programs) that is culturally sensitive and linguistically appropriate in Inuktut or Inuktitut (Pauktuutit Inuit Women of Canada, 2013b, 2013a; Tungasuvvingat Inuit, 2019). This echoes findings in the broader literature, in which Inuit access to and engagement with health care is hindered by a scarcity of terminology related to cancer and cancer care that has been translated to Inuit languages (Canadian Partnership Against Cancer, 2011; Corvus Solutions, 2012). Combined with Inuit experiences of being treated based on racist beliefs and stereotypes (Brooks et al., 2014; Horrill et al., 2019), the lack of culturally sensitive resources for Inuit in cancer care contrasting what is available for non-Inuit patients exacerbate the divide between “mainstream” health care rooted in colonial discourses versus Inuit health care developed by and with Inuit (Allan & Smylie, 2015; Browne, 2017; Gifford et al., 2022), positioning the dominant Western approach as the expert decision-maker. The shortage of Inuit-specific cancer care and dismissal of Inuit wellness approaches in the health care system have created culturally unsafe and unwelcoming environments for Inuit and, in turn, underly the health care inequities faced by Inuit patients and communities today.

Accordingly, findings from this thesis reiterates findings from previous research regarding the impact of racism and discrimination on access to and experiences of health care by Inuit (Allan & Smylie, 2015; Brooks et al., 2014; Enuaraq et al., 2021; Loppie et al., 2014; Poudrier & Mac-Lean, 2009; Turpel-Lafond & White-Hill, 2020). For example, participants often referred to the complex approval process of Non-Insured Health Benefits (NIHB), including the logistics of arranging transportation (Beckett et al., 2021; Enuaraq et al., 2021; Sheppard, 2019), services affected by budgets and funding caps (Canadian Partnership Against Cancer, 2014; Horrill et al., 2019), and the fact that not all constitutionally recognized Indigenous persons are eligible for NIHB coverage (Canadian Partnership Against Cancer, 2011). This finding on the uneven distribution of health funding and resources is consistent with previously published research indicating that part of health care is governed by race-based legislations in Canada (Anderson & Bonesteel, 2010), such that only those classified as 'status Indians' registered under the *Indian Act* (First Nations) and an Inuk recognized under an Inuit land claim organization by the Canadian federal government are eligible for coverage, with some services requiring residency in land-claim regions (Morris, 2016). Addressing systemic racism calls for actions across health institutions and systems to acknowledge how Western health care systems are built upon colonial and racist foundations (Lawrence & Dua, 2005), and to create comprehensive efforts such as proactive and transformative policies co-developed with Inuit partners to eliminate prejudice and discrimination against Inuit (Pauktuutit Inuit Women of Canada, 2021; Turpel-Lafond & White-Hill, 2020; Wilkinson et al., 2023).

Lack of Understanding of Health Services Needs of Urban Inuit

Only two papers (Smylie et al., 2017; Tungasuvvingat Inuit, 2019) included in this scoping review specifically explored cancer care experienced by Inuit who live in southern urban

settings, a finding that mirrors the paucity of research around urban Inuit health and health services and echoed in a study related to older Inuit and First Nations adults living in Ottawa, Ontario (Brooks-Cleator et al., 2019). In Canada, a growing number of Inuit reside outside of Inuit Nunangat (the vast northern homeland of Inuit), in urban centres such as Edmonton, Winnipeg, Ottawa, and Montreal (Morris, 2016) maintaining close social networks and strong retention of Inuktut language (Smylie et al., 2017). Morris (2016) and Patrick and Tomiak (2009) confirm findings from this study related to there being inadequate knowledge and understanding on the disparities in employment, education, food, housing, and health care experienced by urban Inuit communities (Smylie et al., 2017; Tungasuvvingat Inuit, 2019). Additionally, studies in this review (Ahmed et al., 2015; Beckett et al., 2021) suggest that ethnocultural identity is often not captured in health databases, and thus Inuit may not be uniquely identified if they live outside of Inuit Nunangat, which further contributes to the lack of awareness on what impacts urban Inuit health and health care. Lack of public knowledge has been identified in previous literature indicating that the dominant colonial narratives reinforced the exclusion of Indigenous Peoples from urban locations, including histories that failed to acknowledge Inuit connections and settlements on the land as well as racist perceptions about the incompatibility of Inuit in urban space (Peters, 2011). Urban Inuit can be further marginalized as they lose access to many federal programs that are only available in land-claim settlement regions (Morris, 2016; Peters, 2011), as well as through services that presume a one-size-fits-all, pan-Indigenous approach without taking into account the unique values and needs of Inuit (Brooks-Cleator et al., 2019).

Need for System-Wide Efforts in Addressing Structural Barriers

Findings from this study underscore the need for principled, comprehensive, and system-wide efforts to address the structural barriers in cancer care that are underpinned by the colonial

legacy (Enuaraq et al., 2021; Gifford et al., 2022). Public awareness has grown over the last few decades about the injustices faced by Indigenous Peoples in Canada from the enduring legacy of colonialism (Turpel-Lafond & White-Hill, 2020). However, previous research suggests that action and advocacy at the systems and structural levels remain largely absent, as solutions targeting the structural conditions may be perceived as falling outside of the purview of the health care system or beyond the scope of individual health care providers (Horrill, 2021). While Indigenous health is at the forefront of discussions on health equity in Canada, only 13 of the 94 Truth and Reconciliation Commission of Canada (TRC) Calls to Action (Truth and Reconciliation Commission of Canada, 2015b) have been fulfilled after seven years, with none of the seven Calls to Action in the area of health having been completed (Jewell & Mosby, 2022). The sparse amount of action toward the Calls to Actions reveals a gap in the Canadian governments' commitment to addressing long-standing systemic racism and recognizing the colonial roots of Indigenous health inequities (Jewell & Mosby, 2022). Western health practices and beliefs continue to overshadow Indigenous ways of knowing and doing, contributing to systemic and structural barriers for Inuit to receive health services, which are inadequately acknowledged in health care policies and delivery (Browne, 2017). The structural factors in cancer care can lead to a direct influence on patient experiences, a systemic and coordinated approach involving collaboration across various sectors is required to make meaningful headway in dismantling colonial structures in policies and practices in Canada (Gifford et al., IN PRESS; Turpel-Lafond & White-Hill, 2020; Wilkinson et al., 2023). As such, the included papers in this review emphasize the need for a sustainable reform in the health system focusing on upstream policy change across regional, provincial, and national levels, with full partnership with Inuit communities and organizations in all aspects of policy and program design (Cameron, 2011;

Canadian Partnership Against Cancer, 2011; Inuit Tapiriit Kanatami, 2008). Specifically, this upstream policy change may include strategies on the systems and structural level such as "improvements within the education sector, additional buy-in and accountability within healthcare organisations, broader implementation of cultural safety, and broader recognition of the impacts of anti-Indigenous racism" (Wilkinson et al., 2023, p. 155).

Nursing Implications

Here, I discuss several implication that arise from this study in the following domains of nursing: 1) practice, 2) education, 3) leadership, 4) policy, and 5) research.

Practice

Nurses are often the patient's first encounter with the health care system and nurses closely interact with patients daily. As such, nurses bring valuable perspectives and experiences from their clinical practice, which is situated in the nexus of patients' personal lives and the broader structural contexts that shape health outcomes (Horrill, 2021). Given that nursing practice is highly relational and contextually influenced by organizational environments and sociopolitical processes (Varcoe et al., 2003), nurses must look critically at the social structures, discourses, and relations of power they operate in, rather than the behaviours of individual care providers which would not be sufficient to address systemic and sustained racism in the health care system and disrupt the status quo in nursing practice (Bell, 2021; Horrill, 2021).

The concept of cultural safety was first introduced by Dr. Irihapeti Ramsden and Māori nurses in the 1990s (Ramsden, 1993). With a focus on the inherent power imbalances between provider and patient, cultural safety encompasses a *critical consciousness* that requires health care organizations and professionals to engage in an ongoing self-reflection of their own biases, attitudes, and assumptions that may affect the quality and accessibility of patient care (Curtis et

al., 2019; Papps & Ramsden, 1996). Principles of cultural safety must be integrated into clinical practice to challenge the nursing profession to develop an understanding of the broader systems and structures that shape health services access and experiences, and to recognize patients and families as the expert in their care (Browne et al., 2016; Horrill, 2021). This means going beyond the mere knowledge of different cultures and customs to seek understanding of the systemic inequalities within the broader sociopolitical context, recognizing the power imbalances inherent in the health care system, and examining and reflecting on how one's own assumptions and biases have contributed to the marginalization of Indigenous Peoples (Anderson et al., 2003; Curtis et al., 2019; Enuaraq et al., 2021; Gifford et al., 2022).

Education

Both the TRC (2015a) and the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG) (2019) highlighted education's role in promoting health equity and just relations between Indigenous and non-Indigenous peoples. The TRC Calls to Action (2015b) specifically calls upon all schools and faculties of nursing to include Indigenous health issues in their program requirements. However, initiatives in many postsecondary institutions merely results in efforts concentrated on Indigenous inclusion partially into academic space (Courchene, 2019; Drummond, 2020; Gaudry & Lorenz, 2018), seen as an "add Indigenous and stir" approach (Littlechild et al., 2021, p. 665). A study by Blanchet Garneau et al. (2021) revealed that Indigenous health training strategies are mostly limited to a single course module or collaborative workshop. Inclusion of course modules is not necessarily unwanted, but it only scratches the surface and falls short in challenging the dominant, underlying colonial discourses and structures implicit in the education system (Blanchet Garneau et al., 2021; Littlechild et al., 2021). Co-locating Indigenous perspectives within academic disciplines without teaching about

the differences and tensions between Indigenous and Western knowledges also perpetuates extractive colonialism in that it prioritizes interests of the disciplinary curricula, rather than service to Indigenous Peoples (Drummond, 2020). These findings are not meant to be interpreted by schools as an excuse for inaction; rather, health professions education content should require a foundation in Canada's colonial history, longitudinal integration through various teaching strategies, and partnership with Indigenous Peoples through genuine, authentic, and reciprocal relationships grounded in a fundamental respect for Indigenous ways of caring (Beavis et al., 2015; Bourque Bearskin et al., 2020; Ewen et al., 2012).

Canada's national framework for nursing education (Canadian Association of Schools of Nursing, 2022) emphasizes advocating for health equity and social justice as well as anti-racism in nursing graduates' knowledge and practice. Nursing education brings a valuable opportunity and space for greater consideration to the structural influences on health and health care access, and how nurses can play a role in addressing inequities in cancer care for Indigenous patients including Inuit (Gifford et al., 2022; Horrill et al., 2021; Usmani, 2021). However, nursing education curricula have yet to fully examine how Inuit knowledges and practices are largely excluded by the legacy of colonial policies in health care, and how the nursing profession took part in colonizing practices and processes (Bourque Bearskin et al., 2020; Richardson et al., 2018). To explore what it means to support reconciliation in practice, nurses and nursing students must begin with accepting the uncomfortable truth regarding nursing's role in advancing colonization, and actively working towards dismantling the dominance of Western knowledge (Bourque Bearskin et al., 2020). Furthermore, developing structural competency in clinical education has been suggested as one way to incorporate a structural focus into the analysis of clinical-level issues, with the aim of examining racism and stigma as deeply ingrained in the

inequitable treatment of Indigenous Peoples (Metzl & Hansen, 2014). Instead of the traditional notion of competency as a static set of mastered skills, structural competency education entails a continuous commitment to learn and reflect on the complexity of the structural constraints in patient care (Metzl & Hansen, 2014; Tervalon & Murray-García, 1998). Integrating structural determinants of health and structural factors that impact health care into nursing curricula could shift our gaze as nurses from a focus on the individual encounters to include the impacts of institutions, policies, and structures that enact stigma and exclusion, and in turn improving the provision of care to Inuit with cancer in culturally safer health care environments.

Leadership

Through critical thinking, action, and advocacy, nurses across all levels and areas of practice can undertake leadership roles (College of Nurses of Ontario, 2018). In the context of cancer care, oncology nurses are leaders in advocating for the complex needs of patients with cancer and their families, facilitating decision-making, coordinating care delivery, and collaborating with an interprofessional team to improve outcomes (Olling et al., 2021; Oncology Nursing Society, 2020; Truant, 2018). Nurse leadership plays a crucial role in supporting interventions that improve health care delivery and outcomes. With a growing body of literature on the structural inequities that impact Inuit health and health care (Allan & Smylie, 2015; Browne et al., 2016; Loppie et al., 2014; Poudrier & Mac-Lean, 2009; Reading & Wien, 2009), nurse leaders are well-positioned to support the use of research literature in practice (Gifford et al., 2018) to facilitate nurses' critical understanding on how colonialism and racism in the nursing profession sustain socioeconomic inequities and health disparities (Griffith et al., 2007; Waite & Nardi, 2019). Nurse leaders can take active, concrete steps in advancing health equity and social justice such as: participating in local and national legislative discussions to

communicate perspectives and priorities; reflecting from patient experiences to identify new solutions to address health care inequities in both clinical and community settings; implementing strategies that encourage buy-in and accountability; and fostering a culture where decisions about resource allocation take into account their impact on social equity (Azar, 2021; Griffith et al., 2007; Nardi et al., 2020). With these implications in consideration, nurses as leaders have a unique opportunity in addressing the structural barriers faced by Inuit along the cancer care continuum.

Policy

Findings from this thesis align with the broader literature that indicates health and social policies are known barriers to cancer care among Indigenous Peoples (Czyzewski, 2011; Horrill, 2021; Richardson et al., 2018). An example of how health care structures can be barriers to cancer care for Inuit is shown through the complexities of the organizational structure of Inuit Tapiriit Kanatami (ITK), a not-for-profit organization that works to protect and advance Inuit rights and interests in Canada (Inuit Tapiriit Kanatami, 2023). ITK's structure as a corporate entity implies that while they provide guidance on federal policies and programs (e.g., the recent Inuit Nunangat policy (Inuit Tapiriit Kanatami, 2022)), they are unable to implement health services or access health-related data to the same extent as a government entity, such as the province of Ontario. Challenges may also arise in health care funding due to multifaceted relationships between ITK and the federal, provincial, and territorial governments (Inuit Tapiriit Kanatami, 2019). By illustrating the political complexities surrounding devolved authorities for health care programming and delivery, this example ties into why the fragmented nature of health care for Inuit, which was identified as a structural influence in this scoping review, is problematic and contributes to disparities faced by Inuit in both cancer care access and health

outcomes. Yet, existing cancer care policies and action plans treat equity merely as an access-to-care issue arising from individual choices (Sayani, 2019), and lack recognition that health inequities are rooted in the social and political intersections of health including race, ethnicity, class, and gender which, as found in this study, all have profound influences on cancer care, outcomes and mortality (Carter et al., 2009; Sayani, 2019). This calls for all health policy-makers, health authorities, health regulatory bodies, and health organizations to examine current policies and practices, and to push for critical changes to ensure cultural safety in cancer care goes beyond tokenistic and blanket approaches (e.g., placing a smudging room in a hospital, adding an Indigenous module to nursing curriculum) to involve respectful and meaningful partnerships with Inuit (Crawford, 2019). Policy-makers at all levels should seek opportunities to involve Inuit and Inuit communities and organizations in the development, implementation, and evaluations of health policies (Richardson et al., 2018; Tobias et al., 2020), with attention to the specific realities and needs of Inuit and not a one-size-fits-all approach (Williams & Carter, 2016).

Because nurses constitute the largest group of regulated health care professionals in Canada (Cramer, 2002) and their clinical practices are directly influenced by laws, regulations, and policies, the nursing profession holds a unique opportunity to advocate for social justice and promote policy change (Halpern, 2002; Spenceley et al., 2006). Nursing practice provides insight into the effects of policies on individual health experiences, which nurses can use to collectively participate in public policy debates and discussions, bringing patient care issues onto the policy agenda (Antrobus & Kitson, 1999; Scott & Scott, 2021). With the support of an existing infrastructure through professional nursing organizations and associations (Spenceley et al., 2006), nurses are well-positioned to engage in both lobbying and policy development at the

local, provincial, and national levels to support the health and wellness of Inuit patients beyond patient-level advocacy roles at the bedside. Nurses ought to advocate for the integration of Inuit voices in the design and delivery of health care, including cancer care.

Research

Research can serve as a building block for strong public policies, programs, and services that support positive outcomes for Inuit (Inuit Tapiriit Kanatami, 2018). To recognize and dismantle the structural barriers embedded in cancer care, further research in close partnership with Inuit communities is necessary to critically examine the health care system and develop meaningful, long-term changes. Despite growing attention on anti-Indigenous racism (Allan & Smylie, 2015; Enuaraq et al., 2021; Loppie et al., 2014), there remains a lack of comprehensive and consistent approaches to ensure accountability, transparency, and progress towards culturally safe care (Turpel-Lafond & White-Hill, 2020). This gap speaks to the need for research to identify or develop the appropriate initiatives and structures that are underpinned by accountability to support cancer care that is decided by Inuit on what culturally safe care means to them.

Furthermore, while the root causes of health care disparities are situated at the structural level, their impacts are often experienced on a personal level (Reutter & Kushner, 2010). Building on the current study, qualitative studies may be particularly valuable in gathering rich data from the perspectives of Inuit patients, families, and community members about the structural factors that are affecting their cancer care. This may aid in the public's understanding of how the structural influences on cancer care are experienced by Inuit in their day-to-day lives, and why disparities persist in health outcomes among Inuit compared to non-Indigenous populations living in Canada.

Ultimately, research related to Inuit and cancer care must respect Inuit self-determination and sovereignty, and foster Inuit capacity-building. Historically and today, colonial approaches to research have favoured settler researchers as the "expert" or primary beneficiaries of research involving Inuit communities and their homeland, while excluding Inuit from participation in decision-making by minimizing their perspectives and experiences (Fraser, 2021; Inuit Tapiriit Kanatami, 2018). The National Inuit Strategy on Research has identified five action areas necessary for improving the way research is "governed, resourced, conducted, and shared" (Inuit Tapiriit Kanatami, 2018, p. 3) (i.e., Advance Inuit governance in research; Enhance the ethical conduct of research; Align funding with Inuit research priorities; Ensure Inuit access, ownership, and control over data and information, and; Build capacity for Inuit Nunangat Research). Inuit health research that upholds Inuit self-determination requires Inuit and non-Inuit researchers to engage Inuit communities and/or organizations as partners throughout the research process including setting the research agenda, and build trust and respectful relationships with Inuit in an equitable research environment (Gifford et al., IN PRESS; Inuit Tapiriit Kanatami, 2018; Nickels & Knotsch, 2012). Promoting Inuit-led cancer care calls for research that is culturally safe, honours Inuit epistemologies of health and wellness, and is relevant to Inuit with methodologies that support community members to decide what is useful and important (Gifford et al., 2021).

Strengths and Limitations

The following strengths and limitations should be considered when interpreting these study findings. A transparent and rigorous approach guided by the JBI methodology, along with a comprehensive search strategy that was peer-reviewed by an academic librarian with expertise in Indigenous health, contributed to the strengths of this scoping review. Consistent with the purpose of scoping reviews, the capacity to incorporate grey literature can also be considered a

strength given that Inuit knowledge and experiences are often found beyond published data in a wide and diverse range of literature. In addition, a quality assessment was carried out using components of the Well Living House Quality Assessment Tool, which assessed the relevancy of the included literature to Inuit.

Although no linguistic restrictions were established in the search strategy, I and the study team did not have the ability, nor capacity, to search or capture the information or literature in Indigenous languages such as Inuktut and/or Inuktitut. The range of data in this scoping review may be limited as relevant knowledge may exist in forms other than written documents, or in databases that weren't included in the literature search. For instance, Indigenous Peoples' knowledge has also been shared through oral traditions, songs, arts, and ceremonies, and these forms of knowledge may not be represented in this scoping review.

Conclusion

This thesis explored what is known within the literature about structural factors that facilitate or hinder Inuit cancer care access and experiences. Through a scoping review, cancer care experienced by Inuit in Canada is influenced by an intricate interplay of structural factors in the categories of colonization, health systems, social, economic, and political structures. The body of work within this study can inform health care policy and delivery with the goal of improving health equity for Inuit in cancer care. The study findings highlight the link between racism and colonialism, in which colonialism is justified and perpetuated through racism within the health system. Additionally, there is a paucity of information regarding cancer care of urban Inuit in Canada, who face unique and complex challenges in accessing health care. Addressing the structural barriers that Inuit experience in the cancer care trajectory necessitates a system-wide transformative approach.

This thesis ends where it began: The persistent inequalities in cancer care outcomes between Inuit and non-Indigenous populations are rooted in structural inequities underpinned by colonialism. Focusing on individual patient-provider interactions alone will not suffice in bridging this gap. Policy-makers and stakeholders across the health systems must extend dialogues and actions to address the broader social, economic, and political barriers as a step towards improving health care for Inuit and advancing equity.

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Appendices

Appendix A

Table A1. Search Terms (CINAHL)

S1	(MH "Canada+")
S2	Canada OR Canadian OR Ontario OR Quebec OR Alberta OR Newfoundland OR Labrador OR Manitoba OR Saskatchewan OR Yukon OR Nunavut OR "Nova Scotia" OR "New Brunswick" OR "Prince Edward Island" OR "British Columbia" OR "Northwest Territories" OR "Inuit Nunangat" OR Inuvialuit OR Nunatsiavut OR Nunavik OR "atlantic provinces" OR prairies OR prairie provinces" OR maritimes OR "maritime provinces" OR arctic OR subarctic
S3	S1 OR S2
S4	(MH "Indigenous Peoples") OR (MH "Aboriginal Canadians+") OR (MH "Eskimos+")
S5	Indigen* OR Aborigin* OR Native OR In?uit OR Eskim* OR Inuk OR Inuktitut OR Inuvialuit OR Nunavummiut
S6	S4 OR S5
S7	(MH "Neoplasms+") OR (MH "Neoplasms by Site+") OR (MH "Cancer Care Facilities") OR (MH "Early Detection of Cancer") OR (MH "Cancer Survivors") OR (MH "Cancer Screening") OR (MH "Cancer Patients") OR (MH "Chemotherapy, Cancer") OR (MH "Neoplasm Staging") OR (MH "Neoplasm Grading") OR (MH "Cancer Vaccines")
S8	cancer* OR oncolog* OR neoplas* OR tumo?r OR malignan* OR carcino*
S9	S7 OR S8
S10	S3 AND S6 AND S9

Table A2. Inclusion and Exclusion Criteria

Criteria	**Inclusion**	**Exclusion**
Population	Inuit	Other
Focus of Study	Cancer care	Other
Country	Canada	Other
Full text	Available in electronic sources	Unavailable, hardcopies
Language	English	Other

Table A3: Literature Search Strategy

Search Strategy	**Specific information relevant to search strategy**	**Number of documents (meet inclusion criteria)**
CINAHL Database Search	Limits applied to all searches: English, available in full text online, Canadian context	7 Total

	S1 (MH "Canada+") OR (TI (Canada OR Canadian OR Ontario OR Quebec OR Alberta OR Newfoundland OR Labrador OR Manitoba OR Saskatchewan OR Yukon OR Nunavut OR "Nova Scotia" OR "New Brunswick" OR "Prince Edward Island" OR "British Columbia" OR "Northwest Territories" OR "Inuit Nunangat" OR Inuvialuit OR Nunatsiavut OR Nunavik OR "atlantic provinces" OR prairies OR prairie provinces" OR maritimes OR "maritime provinces" OR arctic OR subarctic) OR AB (Canada OR Canadian OR Ontario OR Quebec OR Alberta OR Newfoundland OR Labrador OR Manitoba OR Saskatchewan OR Yukon OR Nunavut OR "Nova Scotia" OR "New Brunswick" OR "Prince Edward Island" OR "British Columbia" OR "Northwest Territories" OR "Inuit Nunangat" OR Inuvialuit OR Nunatsiavut OR Nunavik OR "atlantic provinces" OR prairies OR prairie provinces" OR maritimes OR "maritime provinces" OR arctic OR subarctic))	
	S2 (MH "Indigenous Peoples") OR (MH "Aboriginal Canadians+") OR (MH "Eskimos+") OR (TI (Indigen* OR Aborigin* OR Native OR In?uit OR Eskim* OR Inuk OR Inuktitut OR Inuvialuit OR Nunavummiut) OR AB (Indigen* OR Aborigin* OR Native OR In?uit OR Eskim* OR Inuk OR Inuktitut OR Inuvialuit OR Nunavummiut))	
	S3 (MH "Neoplasms+") OR (MH "Neoplasms by Site+") OR (MH "Cancer Care Facilities") OR (MH "Early Detection of Cancer") OR (MH "Cancer Survivors") OR (MH "Cancer Screening") OR (MH "Cancer Patients") OR (MH "Chemotherapy, Cancer") OR (MH "Neoplasm Staging") OR (MH "Neoplasm Grading") OR (MH "Cancer Vaccines") OR (TI (cancer* OR oncolog* OR neoplas* OR tumo?r OR malignan* OR carcino*) OR AB (cancer* OR oncolog* OR neoplas* OR tumo?r OR malignan* OR carcino*))	
	S1 AND S2 AND S3	
Circumpolar Health Bibliographic Database	Limits applied to all searches: English, available in full text online, Canadian context	2 Total 2 removed as duplicates from CINAHL
	(cancer AND (screening OR diagnosis OR treatment OR survivorship OR palliation) AND (Inuit OR Inuk OR Inuit Nunangat) AND Canada	

Pauktuutit Inuit Women of Canada	The following website was hand-searched through the menu titles (search bar not found)	2 Total
Inuit Tapiriit Kanatami	The following website was hand-searched through the menu titles; keywords were entered into search bar	1 Total
	Keywords: Inuit, cancer, care, program, service, screening, diagnosis, treatment, survivorship, palliation	
Bibliography searches of the reference lists of relevant articles		0 Total 2 removed as duplicates from CINAHL

Appendix B

Literature Summary Table

Author(s)/Year	Source	Study Purpose(s)	Study Design	Relevant Findings
Asmis et al. (2015)	CINAHL	To characterize Inuit-specific cancer referral patterns from Nunavut to the Ottawa Hospital, and to examine the survival outcomes of Inuit referred	A retrospective chart review of Inuit patients referred to The Ottawa Hospital Cancer Centre from the Baffin region of Nunavut	- Cultural and health service delivery characteristics in the North have both been suggested to play a role in sex differences in healthcare-seeking behavior and the willingness of men to undergo treatment. - Given that lung cancer represented half of all cases referred to TOHCC, any strategies to improve cancer treatment and outcomes among Inuit should, as a priority, incorporate anti-smoking initiatives. - Close to one third of cancer patients among the Inuit of the Baffin region diagnosed during 2000–2010 were not referred to TOHCC for CT and RT assessment.
Carrière et al. (2012)	Circumpolar Health Bibliographic Database	To compare cancer incidence patterns between residents of Inuit Nunangat and the rest of Canada. Study	Statistical analyses and population estimates of cancer cases using a geographic approach	- Cancers with potentially modifiable risk factors, such as buccal cavity and pharynx, nasopharynx, lung and bronchus, and colorectal cancer were elevated in the Inuit Nunangat population compared to the rest of Canada. - Besides greater smoking prevalence within Inuit Nunangat by comparison to the rest of Canada, distinct socioeconomic characteristics between respective area populations including housing, and income may have contributed to incidence differentials.
Cerigo et al. (2013b)	CINAHL	To determine Pap smear utilization	Baseline questionnaire and	- Understanding screening patterns and groups noncompliant with screening is

		rates from medical chart review, and to determine factors associated with time-inappropriate cervical cancer screening among a cohort of Inuit women from Nunavik, Quebec	retrospective chart review were utilized to collect information related cervical cancer screening among Inuit women between 2002 and 2007	relevant to future efforts to reduce the higher cervical cancer incidence and mortality among Inuit women in Nunavik. - Results from statistical analyses suggest that Inuit women who are older and women who are not accessing reproductive care have a lower compliance with time-appropriate cervical cancer screening. - Future research should address potential strategies to increase Pap smear use or other screening technique such as HPV testing among this group.
Cerigo et al. (2012)	CINAHL	To assess the comparability of self-collected cervicovaginal samples and provider- collected cervical samples for the detection of human papillomavirus (HPV) DNA among Inuit women in Nunavik, Quebec	Cross-sectional quantitative measurement study	- Women in this population were easily able to collect adequate cervicovaginal specimens for HPV testing. - In comparison to provider-sampling, self-sampling with dry storage and transport could be a good cervical cancer screening alternative for Inuit women in Nunavik who have traditionally avoided speculum examination.
Cerigo et al. (2012)	CINAHL	To describe the attitudes about and experiences with cervical cancer, Pap smear screenings and the HPV vaccine among a sample of Inuit women from	Mixed method study with cross-sectional survey and focus group interviews	- Health service planners and providers in Nunavik should be aware of potential barriers to Pap smear attendance, especially in the older age groups. - A sizable proportion of the women were unable to identify a cervical cancer risk factor and were unsure if detecting cervical cancer early would affect the chance for a

		Nunavik, Quebec, Canada		cure; education on cervical cancer and prevention strategies may be beneficial.
Chan et al. (2019b)	CINAHL	To present an overview of factors influencing radiotherapy delivery in each of the four circumpolar Inuit regions	Review article	- Although radiotherapy is an essential component of comprehensive cancer care, no radiotherapy services exist in many Inuit regions, requiring patients with cancer to travel long distances to receive treatment. - The accessibility of radiotherapy to Inuit populations depends on both geographical and cultural considerations.
Hordyk et al. (2017b)	CINAHL	To better understand the factors shaping end-of-life (EOL) care in Nunavik to support the development of a sustainable model of care	Focussed ethnography with participant observations and informal and semi-structured interviews	- Sociocultural, historical, and geographic factors shape EOL care in Nunavik, presenting a complex set of challenges for Inuit patients, families, and healthcare providers. - Building a sustainable model of EOL care requires respectful collaboration among governing structures, healthcare institutions, and community members.
Inuit Tapiriit Kanatami (2008)	ITK website	To open dialogue on the unique needs and issues relating to cancer among Inuit in Canada	Discussion paper	- But Inuit face additional stressors and barriers to treatment: they must deal with jurisdictional issues, social isolation, physical isolation, a system geared to a foreign language and culture, and the stress imposed on families by dislocation and distance. - There are significant knowledge gaps within the extent, nature and impact of cancer among Inuit. Immediate research is required in (but not limited to) the following areas: hereditary links; change of diet, and its impact on cancer rates; environmental

				pollutants in Inuit regions, and any impact on cancer rates.
Kelly et al. (2008b)	Circumpolar Health Bibliographic Database	To report on the result of the Circumpolar Inuit Cancer Review	Epidemiological analysis of Inuit cancer cases by age-sex group and anatomic site	- Cancer in general is an increasing health concern among Inuit, in all regions, and among both men and women. - Inuit continue to be at extreme high risk, relative to non-Inuit and to comparisons of global populations. - Implementation of interventions should be directed towards known risk factors and early detection programs.
McDonald & Trenholm (2010)	CINAHL	To identify the the extent to which demographic, socio-economic and geographic factors account for differences between Inuit and other Northern Canadian residents in health-related behaviours and health service use related to cancer incidence and diagnosis	Descriptive statistics and multivariate logistic regression analysis	- Health-related behaviours leading to increased cancer risk and to a lower utilization of diagnostic cancer screening appear to be due to unobserved factors specific to Inuit and their unique social-cultural context. - Policy responses to problems such as high smoking rates must not only be culturally appropriate but should not be considered in isolation of other health, economic and social policies. - High smoking rates and other behaviours may be a manifestation of deeper problems such as loss of traditional lifestyle that are also driving other negative health outcomes of great concern in Inuit communities, such as substance abuse, suicides and injuries.
Pauktuutit Inuit Women of Canada (2013a)	Pauktuutit website	To describe the results of nine focus groups and cancer workshops conducted by	Project report	- Many Inuit view cancer as an incurable or fatal disease; the Inuktitut word for cancer promotes fear and discourages people from seeking treatment; the lack of Inuktitut terminology for different types of cancers.

		Pauktuutit during the first year of the Inuit Cancer Project		- Frustration towards lack of information, the lack of local support services, the language barriers with southern doctors, and the challenges of finding out about test results. - Common concerns included the need for better terminology, the need for better support and more caring service providers, and the challenges associated with treatment outside of home communities.
Pauktuutit Inuit Women of Canada (2013b)	Pauktuutit website	To present the results of Inuit Cancer Project	Final Project Report	- Cancer rates and awareness can be linked to many of the determinants of health, such as education and health literacy, the quality and availability of health services, contaminants and the physical environment, personal health practices and such lifestyle choices as smoking, diet, and exercise, the role of gender, and the importance of Inuit language, culture, and history interact in ways that help to explain the trends and the challenges.

Appendix C

Search Strategy for CINAHL (March 27, 2021)

S1	(MH "Canada+")	105,250
S2	TI (Canada OR Canadian OR Ontario OR Quebec OR Alberta OR Newfoundland OR Labrador OR Manitoba OR Saskatchewan OR Yukon OR Nunavut OR "Nova Scotia" OR "New Brunswick" OR "Prince Edward Island" OR "British Columbia" OR "Northwest Territories" OR "Inuit Nunangat" OR Inuvialuit OR Nunatsiavut OR Nunavik OR "atlantic provinces" OR prairies OR prairie provinces" OR maritimes OR "maritime provinces" OR arctic OR subarctic) OR AB (Canada OR Canadian OR Ontario OR Quebec OR Alberta OR Newfoundland OR Labrador OR Manitoba OR Saskatchewan OR Yukon OR Nunavut OR "Nova Scotia" OR "New Brunswick" OR "Prince Edward Island" OR "British Columbia" OR "Northwest Territories" OR "Inuit Nunangat" OR Inuvialuit OR Nunatsiavut OR Nunavik OR "atlantic provinces" OR prairies OR prairie provinces" OR maritimes OR "maritime provinces" OR arctic OR subarctic)	87,930
S3	S1 OR S2	143,065
S4	(MH "Indigenous Peoples") OR (MH "Aboriginal Canadians+") OR (MH "Eskimos+")	5,850
S5	TI (Indigen* OR Aborigin* OR Native OR In?uit OR Eskim* OR Inuk OR Inuktitut OR Inuvialuit OR Nunavummiut) OR AB (Indigen* OR Aborigin* OR Native OR In?uit OR Eskim* OR Inuk OR Inuktitut OR Inuvialuit OR Nunavummiut)	31,750
S6	S4 OR S5	34,135
S7	(MH "Neoplasms+") OR (MH "Neoplasms by Site+") OR (MH "Cancer Care Facilities") OR (MH "Early Detection of Cancer") OR (MH "Cancer Survivors") OR (MH "Cancer Screening") OR (MH "Cancer Patients") OR (MH "Chemotherapy, Cancer") OR (MH "Neoplasm Staging") OR (MH "Neoplasm Grading") OR (MH "Cancer Vaccines")	599,810
S8	TI (cancer* OR oncolog* OR neoplas* OR tumo?r OR malignan* OR carcino*) OR AB (cancer* OR oncolog* OR neoplas* OR tumo?r OR malignan* OR carcino*)	546,075
S9	S7 OR S8	756,150
S10	S3 AND S6 AND S9	150

Appendix D

Data Extraction Tables

Document Type							
Author(s), Year	Type of document as reported (e.g., research study, opinion pieces, webpage, report, dissertation)	Aims/Objectives	Language	Country	Indigeneity of authors	Methods	Notes/Comments

Population/Participants										
Author(s), Year	Participants involved in the document/ study	Participants /Sample size	Description of population examined in the document	Age of population	Gender/ Sex	Indigeneity	Location of population (rural/urban)	Specific location if reported	Cancer diagnoses	Notes/ Comments

Context						
Author(s), Year	Type(s) of cancer care involved	Stage(s) of cancer care involved	Location of care	Service setting(s)	Nursing involvement if described	Notes/Comments

Concepts										
		Structural factor(s) identified in the document								
Author(s), Year	Type(s) of cancer care involved	Colonization	Health systems and cancer care systems	Social	Economic	Political	Interpreted facilitator/ barrier to cancer care	Reported influences of the identified structural factor(s)	Approaches used to address the identified structural factor	Approaches recommended to address the identified structural factors

Appendix E

Quality Assessment Tool: 3. Relevance to Community

3.1	Is the study design/measure in keeping with local community values/beliefs/knowledge systems?	
	Yes	Evidence provided explicitly in the text (look for: where did evaluation take place, who collected evaluation data?)
	Partial	Hints of it in text therefore assumption made by reviewers that evidence is present
	No	Nothing was said or it was said that it was not done
3.2	Is the study design/measures in keep with local priorities/aims (e.g., community articulated need for this evaluation)?	
	Yes	Evidence provided explicitly in text (look for: stakeholder involvement, hiring local Aboriginal research staff, capacity building)
	Partial	Hints of it in text therefore assumption made by reviewers that evidence is present
	No	Nothing was said or it was said that it was not done
3.3	Is the underlying theory (of evaluation) relevant to the community?	
	Yes	Evidence provided explicitly in text (evidence of themes of reciprocity, two-eyed seeing, recognizing capacity building)
	Partial	Hints of it in text therefore assumption made by reviewers that evidence is present
	No	Nothing was said or it was said that it was not done
3.4	Is the study protocol (data collection method) vetted by local community members?	
	Yes	Evidence provided explicitly in text (look for advisory council guidance and review of tool
	Partial	Hints of it in text therefore assumption made by reviewers that evidence is present
	No	Nothing was said or it was said that it was not done