

COMMENTARY

Patient navigation as a core component of global cancer care—A call to action from the Global Alliance for Cancer Patient Navigation

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Abstract

Patient navigation is generally defined as an individualized service that breaks down barriers to provide comprehensive and equitable cancer care. As the evidence base grows for patient navigation efficacy in diverse settings across the cancer continuum, navigation is increasingly recognized and adopted as an essential resource to aid in linking to and advocating for patient-centered services. To further patient navigation as a core component of cancer care, the American Cancer Society formed the Global Alliance for Cancer Patient Navigation to build awareness, evidence, and momentum and to coalesce around the core principles to aid sustainable implementation, keeping the voiced needs of people with lived experience at the forefront.

KEYWORDS

financial toxicity, health resources, patient navigation, patient-centered care, psychosocial care

INTRODUCTION

Patient navigation was developed to ensure support in accessing comprehensive, equitable, and patient-centered cancer care services and is generally defined as an individualized intervention to break down barriers to quality and timely care across the cancer continuum.^{1–5} In 1990, American Cancer Society President Dr Harold Freeman tested a model of navigation for patients with low socioeconomic status (SES) who had breast cancer at Harlem Hospital.² Since that foundational work, the concept and implementation of navigation has grown globally because of advocacy and collaborative efforts.^{3–16}

In both high-income countries (HICs) and low- and middle-income countries (LMICs), patient navigation has taken on an expanding role with the building awareness of what patients with cancer and their caregivers need most and in supporting equity for vulnerable populations, including those of lower SES, racial/ethnic minorities, and women.^{5,11–17} Notably, navigators can promote health equity by improving access to high-quality care and by helping to address structural barriers that continue to disproportionately affect marginalized populations (e.g., low SES, racial/ethnic minorities, women, rural, indigenous, immigrants, sexual identity, and gender minorities).^{17–19}

In the United States, collaborative efforts through professional societies, the Professional Oncology Navigation Task Force (PONT), the National Navigation Roundtable, and the American Cancer Society Cancer Action Network have yielded refinement of navigator roles, including core competencies and job descriptions, metrics development, and passage of reimbursable patient navigation services through the Centers for Medicare and Medicaid Services.^{3,4,6–11} Globally, countries including Australia, Brazil, and Indonesia have passed legislation or begun ministry-led efforts to build sustainable navigation.^{12,20,21} Yet, to date, these global efforts have generally been piecemeal, driven at the organizational or grassroots level

rather than a governmental or more universal level, leading to unclear role definition, inadequate data collection, and an overall lack of sustainable implementation strategies.^{16,20–23}

Cancer patient navigation as an essential global cancer care resource

With increasing global cancer incidence and cancer costs, innovative and sustainable models of care are required to meet the needs of patients and their caregivers as well as healthcare providers and health systems.^{24–29} Interventions that matter most to patients and their caregivers, including comprehensive supportive care services, quality of life (QoL), and survivorship, are frequently lacking in global settings.^{16,30,31} A focus on reductionism in the pursuit of disease control has come at the expense of human values (i.e., holism), patient-centered and caregiver-centered care, and with concomitant increasing financial toxicity.^{16,32–37}

In their systematic review as part of the Multinational Association of Supportive Care in Cancer's Global Initiative to Advance Cancer Navigation for Better Outcomes supported by Flinders University and Cancer Australia, Chan et al. reported strong evidence for patient navigation.⁵ Patient navigation significantly decreased the time to cancer diagnosis and hospitalizations; improved screening rates; improved survivorship surveillance, knowledge, and decision-making; and increased patient satisfaction with survivorship care and QoL.⁵ There was further evidence of some benefit in multiple additional domains across the cancer continuum (Figure 1).⁵ Of note, most of the literature was from HICs (and the United States specifically), although emerging data are indicating improvements in cancer screening, time to diagnosis, patient education, and treatment completion in LMICs as well.^{38–41} Ongoing work is required to demonstrate the benefit of patient navigation for the multiple noted marginalized populations across various settings.¹⁷

OUTCOME	RATING	COMMENTARY
EARLY DETECTION		
Cancer Screening Rates		Strong evidence that patient navigation improves rates of cancer screening.
DIAGNOSIS		
Diagnostic resolution		Strong evidence that patient navigation reduces the time to diagnosis.
TREATMENT		
Treatment Initiation		Some evidence that navigation reduces the time from diagnosis to initiation of primary treatment
Treatment Completion		Evidence on the impact of patient navigation on treatment completion is inconclusive.
Hospital Readmission		Strong evidence that patient navigation reduces hospital readmissions.
Enrolment & Adherence to Clinical Trials		Limited evidence that patient navigation improves clinical trial enrolment and adherence.
SURVIVORSHIP		
Adherence to Surveillance		Strong evidence that patient navigation increases adherence to surveillance appointments.
Decision-making and Treatment Knowledge		Strong evidence that navigation improves the decision-making and treatment knowledge of cancer survivors.
Return to work		Evidence on the impact of patient navigation on return to work is inconclusive.
Communication		Limited evidence that patient navigation improves communication.
Fatigue		Limited evidence that patient navigation reduces cancer-related fatigue.
Patient Satisfaction		Strong evidence that patient navigation improves patient satisfaction with care.
Quality of Life		Strong evidence that patient navigation improves cancer survivor QOL.
Emotional Distress		Evidence on the impact of patient navigation on emotional distress is inconclusive.

Legend

 = Strong evidence of effectiveness
  = Some evidence of effectiveness
  = Limited evidence of effectiveness
  = Evidence not conclusive

FIGURE 1 Effectiveness of patient navigation on outcomes across the cancer continuum. QOL indicates quality of life. Reprinted with permission from Chan et al.⁵ Creative Common license CC-BY-NC-ND.

Although mortality rates have improved progressively in HICs, gaps persist in time to diagnosis, clinical trial enrollment, and survival based on SES, rurality, and race/ethnicity.^{18,42–44} In LMICs, these

themes similarly exist, but to a greater extent.^{25,26,45} Because LMIC health systems are often resource constrained for addressing chronic illnesses like cancer, there is frequently a lack of cancer screening

services, delays in diagnosis and referral, and abandonment of therapy, all contributing to very poor patient survival for both pediatric and adult patients with cancer.^{25,26} Given the majority of the predicted increase in cancer incidence will be in LMICs, this poses a dire situation for patients who have cancer, their caregivers, and their healthcare providers in these settings without fundamental, positive disruptive change.²⁴

Specifically in LMICs, limited focus on patient education, QoL, lack of comprehensive care services, and minimal support for patients and caregivers all affect poor survival.^{25,26,45-52} Posttreatment survivorship and palliative care services continue to be underdeveloped.^{51,52} Financial toxicity for patients and their caregivers is amplified in LMICs and is not sufficiently mitigated by public health insurance.⁵³⁻⁵⁷ Migration, war, and other humanitarian crises further exacerbate care for patients with cancer and are amplified for the most vulnerable populations.^{58,59}

The global alliance for cancer patient navigation

The American Cancer Society formed the Global Alliance for Cancer Patient Navigation (the Alliance) in 2025 to support building the evidence for patient navigation as a resource in diverse populations and settings, using an implementation science framework to develop strategies for sustainable development, collate resources, and develop consensus around the core navigation principles. Ultimately, the Alliance aims to create a global movement around patient navigation inclusion in core cancer care services across HICs and LMICs for both adult and pediatric oncology patients. Like the National Navigation Roundtable, the Alliance is an organization of organizations focused on collective action to develop consensus around the core principles of navigation for patients with cancer in diverse non-US settings (Table 1).⁸

The current organizations (Table 2) include a diverse set of stakeholders representing people with lived experience, patient advocacy organizations, on-the-ground implementation partners/civil society organizations, academic institutions, and multinational nongovernmental organizations from all continents and resource settings.

One of the first actions taken by the Alliance membership was to develop a list of proposed principles guiding Alliance activities (Table 3). This was done through a stepwise process; first, the Alliance membership met in a hybrid format (virtual and in-person) to discuss the key benefits and gaps of patient navigation based on the experience of the individual member organizations. Subsequently, these comments were collated into major thematic areas, which were reviewed by the Alliance Steering Committee (authors of this current report). The Steering Committee had an opportunity to provide feedback, resulting in further refinement of the language of the principles and ensuring the inclusion of appropriate topic areas. As a final step, all member organizations had a repeat opportunity to review and comment on the draft; these comments were subsequently incorporated into the principles, which were finalized by the Steering

TABLE 1 Global Alliance for Cancer Patient Navigation 3-year aim.

Aim	To convene diverse global voices to co-create and scale patient navigation solutions that work in varied healthcare settings
Mission	To frame, assess, and address challenges in global patient navigation that no single organization can solve alone to expand the reach, quality, and sustainability of global patient navigation
Vision	The universal incorporation of patient navigation to provide more accessible, equitable, and high-quality cancer care for all patients

Committee. There were no significant disagreements or lack of consensus that required additional resolution.

The Alliance membership believes that patient navigation has a foundational role in all HICs and LMICs, particularly as a disparity-reducing strategy, addressing both common and unique needs in each setting. The Alliance believes that, by building upon the principles of navigation for patients with cancer developed initially by Dr Freeman in 2011, with their focus on patient and caregiver centrality and equity, global patient navigation for those who have cancer can also serve as a model for patients who have other chronic and complex diseases in diverse settings.² The Alliance is convening to aid in building awareness and the evidence base to support these beliefs. Over the next 3 years, we aim to address based on setting: (1) principles that will define the core navigation functions, (2) navigator role delineation and training competencies, (3) resource collation, (4) development of policy and implementation frameworks that will assist in sustainable and measurable (inclusive of cost-benefit analysis) program development, and (5) further delineation on how best to use technology.

To achieve these initial goals, the Alliance has formed an overarching global community of practice and three working groups: (1) HICs, (2) LMICs, and (3) pediatric oncology. Given the need for technological solutions to be adapted to settings to improve access, digital innovation is a key cross-cutting strategy for discussion across working groups. Similarly, the need to disseminate the work of the Alliance to multisectoral partners is also vital to lead to patient navigation policy development as well as navigator role definition and remuneration, all essential aspects of sustainable program evolution. For example, the critical role of nonclinical navigation performed in both clinical and community settings, which is frequently done by survivors and volunteers in LMICs, needs a clear pathway within health systems for credibility and, ideally, wages to build sustainability.

Call to action to support sustainable patient navigation implementation

The Alliance calls for urgent, collective efforts to enable access to patient navigation for individuals with cancer from local, national,

TABLE 2 Current Global Alliance for Cancer Patient Navigation member organizations.

Member organization	Member(s)	Country
Academy of Oncology Nurse and Patient Navigators	Rani Khaterpal, Candace Roth	United States
Aid and Hope Program for Cancer Patient Care	Eman Shannan	Gaza, Palestine
American Society for Clinical Pathology	Kenneth Landgraf	United States
Association of Cancer Patients and Friends	Evgenia Aleksandrova, Alexander Milanov	Bulgaria
Baheya Foundation for Early Detection and Treatment of Breast Cancer	Maheer H. Ibraheem, Hanaa Serry, Yomna Sherif	Egypt
BIO Ventures for Global Health	Jennifer Dent, Katy Graef	United States
Butaro Hospital	Rugengamanzi Eulade	Rwanda
City Cancer Challenge	Thet Ko Aung	Switzerland
Cancer Association of South Africa	Anina Meiring, Gretchen Minnaar, Lisa Strydom	South Africa
Cancer Society of New Zealand	Craig Watson	New Zealand
Childhood Cancer International	Alejandra Mendez, Carl Queiros, Rodney Wong	Netherlands
Childhood Cancer Ireland	Mairead Brennan	Ireland
China Anti-Cancer Association	Yizhuo Zhang, Lijun Zheng	China
University Hospital Center Brugmann Hospital	Peter Vuylsteke	Belgium
University Hospital Center Helora Hospital	Ariane Migeotte	Belgium
Ethiopia Society of Hematology and Oncology	Munir Awol	Ethiopia
European Cancer Organisation/EU Navigate	Norbert Couespel, Marion L'hôte, Katarzyna Szczerbińska	Belgium
Flinders University/GINO Initiative	Raymond Chan, Carla Thamm	Australia
Fundación Ellen Riegner de Casas	Diana Esperanza Rivera Rodríguez	Colombia
Fundación Unidos Contra el Cáncer	Norah Giménez	Paraguay
Gilbert and Rose-Marie Chagoury School of Medicine; CHANCE Association	Roula Farah	Lebanon
Global Surgery Foundation	Jan Plavcan, Mélanie Samson, John Varallo	Switzerland
Hope for Cancer Kids	Tom Ochieng	Kenya
ICanServe Foundation Inc.	Teocel Apolona, Haidee Esquivel, Kara Magsanoc-Alikpala	Philippines

TABLE 2 (Continued)

Member organization	Member(s)	Country
Indonesian Cancer Information and Support Center	Aryanti Putri Baramuli, Irianti Dewi Derajat, Marco Wijaya	Indonesia
Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán	Yanin Chavarri	Mexico
Instituto Oncoguia	Luciana Holtz	Brazil
Integrated Clinical Oncology Network Pty Ltd.	Margaret Hjorth	Australia
Irish Cancer Society/Trinity St James Cancer Institute	Laura Lonergan, Aoife McNamara	Ireland
International Society of Pediatric Oncology	Courtney Sullivan	Switzerland
Kenyan Network of Cancer Organizations	Phoebe Ongadi	Kenya
Latin American and Caribbean Society of Medical Oncology	Eduardo Cazap	Argentina
Liga Colombiana Contra el Cancer	Wilson Cubides	Colombia
Lymphoma Awareness Philippines Inc.	Delos Angeles	Philippines
Max Foundation	David Palacios, Andrielle Yost	United States
The University of Texas MD Anderson Cancer Center	Kathleen Schmeler, Melissa Varon	United States
Multinational Association of Supportive Care in Cancer	Melissa Chin	United States
National Cancer Society Malaysia	Murallitharan Munisamy, Suwarna Ramanathan, Vicky Subramaniam	Malaysia
National Hospital Abuja	Uchechukwu Shagaya	Nigeria
Navegación de Pacientes Internacional	Nancy Peña	United States
Nest of Hope Advocacy and Support Community	Dozie Akwarandu	Nigeria
Oncology Nursing Society	Danelle Johnston, Brenda Nevidjon	United States
Palliative Care Association Rwanda	Gahire Rose Kankindi	Rwanda
Patient Advocate Certification Board, Inc.	Felix Davies	United States
Peter MacCallum Cancer Centre	Geri McDonald, Siân Taylor	Australia
Philippine Cancer Society, Inc.	Romeo Marcaida, Maricar Sabeniano	Philippines
Pink Hearts Cancer Foundation	Prisca Githuka	Kenya
Project ECHO, University of New Mexico	Tarun Kumar	United States

TABLE 2 (Continued)

Member organization	Member(s)	Country
Qatar Cancer Society	Hadi Mohamad Abu Rahsheed	Qatar
Rutgers University global program	Richard Marlink, Tara M. Friebe-Klingner	United States
St Jude Children's Research Hospital global program	Nickhill Bhakta, Dylan Graetz	United States
Susan G. Komen	Julie McMahon	United States
Tata Memorial Centre/ Kevat	Nishu Singh Goel, Shalini Jatia, Gauravi Mishra	India
Université Cheikh Anta Diop de Dakar	Amadou Dieng	Senegal
University Health Network, ELLICSR Health, Wellness, & Cancer Survivorship Centre	Jackie Bender	Canada
Universiti Malaya Medical Centre	Nirmala Bhoo-Pathy	Malaysia
University of Melbourne/ Nossal Institute for Global Health	Christobel Saunders, Sian Slade	Australia
University of Toronto	Margaret Fitch	Canada
University of Technology Sydney	Nicolas Hart	Australia
V Care Foundation	Jyoti Patil Shah	India
Vuela Foundation	Diego Parada Herrera	Mexico
World Child Cancer	Megan Cruise	United Kingdom

Abbreviations: CHANCE, Children Against Cancer; ECHO, Extension for Community Healthcare Outcomes; ELLICSR, Electronic Living Laboratory for Interdisciplinary Cancer Survivorship Research; EU, European Union; GINO, Global Initiative to Advance Cancer Navigation for Better Outcomes.

regional, and global champions and organizations, as endorsed by the diverse Alliance member organizations. There is an enormous opportunity to enable the healthcare workforce (i.e., those who may not have a specific title of patient navigator but are doing this work) to support patient navigation as a systemic intervention. Ultimately, the Alliance needs the help of the global oncology community to advocate and build a movement to integrate patient navigation as a core service for individuals with cancer and their caregivers. Although patient navigation should not be seen as a panacea to solve all gaps in cancer care-delivery systems, its prioritization is an immediate and achievable step to improve the patient, caregiver, and healthcare provider experience of care. With wider implementation and evidence generation, we believe patient navigation will aid in reducing global disparities in cancer outcomes and in addressing the increasing global cancer burden in both a cost-effective and humanistic manner.

TABLE 3 Proposed principles for the Global Alliance for Cancer Patient Navigation.

1. Patient navigation is vital in diverse settings and should be universally available and incorporated into National Cancer Control Plans with a clear implementation strategy and mechanism for sustainability.
2. Patient navigation must be available across the cancer care continuum, adjusted to the local context.
 - a. Patient navigation must be embedded within cancer screening and awareness programs to ensure that screen-positive patients access care.
 - b. Cancer treatment centers must include patient navigation as a core service.
 - c. Patient navigation should support clinical trial enrollment.
 - d. Posttreatment survivorship and palliative care must include patient navigation to ensure that people affected by cancer continue to receive the appropriate services.
 - e. Patient navigation implementation approaches must be clearly defined, from barrier assessment to strategy selection, fidelity monitoring, and scale-up, and designed to achieve one or more key navigation outcomes at each stage of the cancer care continuum.
3. Development of cancer programs must occur with patient navigation as a core service, with a needs-based approach in planning for and implementing patient navigation to maximize program sustainability and system efficiency.
4. Special attention and investment must be afforded to ensure that patient navigation specifically targets disenfranchised populations (e.g., pediatric/geriatric patients, indigenous populations, rural populations, linguistically diverse populations).
5. Patient navigation should include clinical or nonclinical navigation based on the setting and barriers to care being addressed; there is a need to coalesce around terminology for nonclinical navigators, scope of practice, and criteria for who can effectively perform nonclinical navigation duties, which will facilitate clearer understanding and support adoption.
6. Remuneration of navigators underscores their value to the system and is required for program sustainability.
7. The scope of patient navigation must include consensus-defined, core services with additional services as feasible based on resources, need, and setting.
8. Consensus is necessary on competencies and training requirements to ensure uniform standards for both clinical and nonclinical navigators.
9. Policymakers, insurers, employers, and other stakeholders that can influence policy must advocate for the inclusion of patient navigation as a universal service in any package of cancer care services.
10. Innovative technology solutions appropriate to the context in which patient navigation is delivered must be leveraged to effectively address access and equity.

AUTHOR CONTRIBUTIONS

Anurag K. Agrawal: Conceptualization; methodology; writing—original draft; writing—review and editing; funding acquisition. **Kristie McComb:** Conceptualization; methodology; writing—original draft; writing—review and editing; funding acquisition. **Carla Thamm:** Conceptualization; methodology; writing—review and editing. **Nirmala Bhoo-Pathy:** Conceptualization; methodology; writing—review and editing. **Dylan Graetz:** Conceptualization; methodology;

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