Shared Solutions for Rural Oncology: Insights Across the Americas

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As cancer care becomes increasingly interconnected, collaboration across borders has never been more essential. Recognizing the growing need to strengthen global ties, the Association of Cancer Care Centers (ACCC) introduced its Global eXchange—launched last year at the ACCC 41st National Oncology Conference (NOC)—to bring international perspectives to the Association's national conferences and journal, *Oncology Issues*. Like its member's only platform ACCC eXchange, ACCC Global eXchange is meant to bring together oncology professionals from around the world to exchange ideas, share lessons, and collaborate on improving cancer care globally. By connecting providers across different countries and health systems, the series highlights innovations in care delivery, workforce development, and patient engagement, particularly for populations facing the greatest barriers.

On the final day of the NOC, this year's ACCC Global eXchange panel featured a powerful and thought-provoking session: *Shared Solutions for Rural Oncology: Insights Across the Americas*. Moderated by Enrique Soto Pérez-de-Celis, MD, PhD, FASCO, associate director for global oncology at the University of Colorado Cancer Center, a panel of experts from Canada, Mexico, and the United States explored the shared challenges and innovative strategies shaping cancer care in rural and remote communities across the Americas.

Building on momentum from the inaugural international panel at last year's NOC, where Dr. Soto participated as a panelist, the 2025 discussion focused on practical, real-world solutions to the barriers that patients in rural areas face, including geographic isolation, fragmented health systems, limited access to specialists, and deep-rooted cultural and socioeconomic disparities. Drawing on lived experiences from both patients and providers, the session offered strategies that transcend borders and highlight the shared humanity of cancer care.

Understanding the Landscape: Rurality and Remoteness

Jacqueline Galica, PhD, RN, OCN, associate professor at Queen's University in Canada, opened with a striking comparison. "Eighty percent of our Canadian population is within 95 miles of the American border," she said. "That means 20% of Canadians are living in northern regions—even as high as the Arctic Circle." These remote areas are so sparsely populated and have so little infrastructure that simply accessing care becomes a barrier. "We can have 3 people per square mile," Dr. Galica noted. "Some of these are fly-in communities with no year-round roads." This translates to very limited access to screening, specialists, and treatment.

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In Mexico, Yanin Chávarri-Guerra, MD, full professor of oncology and clinical researcher at the Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán, described a similarly daunting picture. "Twenty percent of our population lives in rural areas, and of them, about 60% live in extreme poverty," she said. "They must travel long distances to access cancer care, and they fund those travel and lodging costs themselves—which just isn't feasible for many."

Dr. Soto added that in the United States, patients in rural communities in states such as Wyoming, Nebraska, and the Dakotas also face significant delays despite a more robust infrastructure. "Rurality is not homogeneous," he emphasized. "We need to understand who within those areas is most underserved."

Barriers to Access: Distance, Infrastructure, and Trust

Across the 3 nations, the panelists identified common challenges:

- ***Geographic distance***. "People fly as much as 1200 miles—a 3-hour flight—to receive treatment," said Dr. Galica.
- ***Limited infrastructure***. "Although our government is investing billions in internet access, only about 65% of households in northern territories have high-speed internet," she added.
- ***Health system fragmentation***. "In Mexico, patients move through multiple referral levels before reaching a cancer center," said Dr. Chávarri-Guerra. "That process can take up to 8 months, with 60% of cases diagnosed at a late stage."

- ***Cultural and linguistic barriers.*** "Indigenous women living in rural communities are the most underserved," she said. "They often speak languages other than Spanish and have limited access to education."

Dr. Soto observed that these challenges require not only data but also political will. "We are competing against hundreds of other priorities," he said. "That's why organizations like ACCC are so important—to bring practitioners together, amplify best practices, and connect those lessons to policy."

Where Care Falls Off: Diagnostic and Survivorship Gaps

Panelists also pointed to 2 critical moments in the care continuum where patients often fall through the cracks—diagnosis and survivorship.

"In Mexico, when a patient has an abnormal mammogram, they may never receive follow-up images or biopsies," said Dr. Chávarri-Guerra. "We've created a digital platform that links first-level facilities with navigators to expedite diagnostics."

In Canada, while diagnosis and treatment are covered under universal health care, survivorship care remains a gap. "Posttreatment medications and support are not consistently funded," Dr. Galica explained. "Dropping off at survivorship is a real issue."

Dr. Soto added that reducing financial and time toxicity is key: "We need to choose treatments that have the least burden—shorter regimens, fewer visits, more self-management."

Strategies That Work: Navigation, Community Engagement, and Task Shifting

Despite the significant barriers that patients in rural communities face, panelists highlighted several strategies that are making a measurable difference across North America. Patient navigation programs, for example, have proven invaluable in helping patients surmount obstacles. "We've implemented programs that help patients overcome barriers with simple interventions—helping them fill out forms, providing directions, or connecting them to financial support," said Dr. Chávarri-Guerra. These programs serve as critical lifelines, especially for patients navigating fragmented health systems and long travel distances.

Mail-in screening programs have also expanded access to preventive care. Dr. Galica noted that upstream mail-in colorectal screening has been effective for people who use it, though participation can be limited by mistrust and low health literacy. To address these barriers, community-led initiatives have been successful in empowering local residents to become health ambassadors. "We trained adolescents in rural communities about breast cancer so they can educate older family members," said Dr. Chávarri-Guerra.

Telehealth and remote support, having emerged as particularly valuable tools during the pandemic, continue to enable providers to guide nurses and caregivers in remote communities, even through platforms as simple as WhatsApp. In Canada, rotating clinics have taken this a step further, bringing clinicians directly into remote communities. "We've established rotating clinics in fly-in communities where clinicians spend a few weeks onsite," said Dr. Galica.

Dr. Soto also cited outreach efforts in Central America, where screening campaigns delivered in Indigenous languages have built trust and improved participation.

Building the Workforce: Training and Retention in Rural Areas

Recruiting and retaining providers in rural communities remains a global challenge.

In Canada, programs offer education subsidies tied to rural service commitments. "Some graduates receive tuition support in exchange for 5 years of service in rural regions," said Dr. Galica. Others focus on decolonizing medical education: "We partner with communities to integrate Indigenous ways of knowing into the curriculum."

In Mexico, train-the-trainer models are expanding capacity by equipping community health workers and nurses with oncology knowledge. "We partner with nongovernmental organizations and health care facilities to teach navigation, psychosocial support, and patient education," said Dr. Chávarri-Guerra.

Dr. Soto highlighted the global opportunity: "In the US, we are fortunate to have highly trained nurses, but this is not true everywhere. Expanding nursing and advanced practice provider training globally could have an enormous impact."

What's Transferable: Lessons Across Borders

In closing, the panelists shared which practices are most adaptable across health systems:

- ***Community engagement.*** "Partnering with people who have lived experience is critical," said Dr. Galica.
- ***Navigation programs.*** "Navigation helps patients across settings," said Dr. Chávarri-Guerra. "But we need policy makers to institutionalize them."
- ***Education and capacity building.*** Empowering local providers drives sustainable change.
- ***Culturally tailored outreach.*** "Identifying trusted community leaders is key," added Dr. Chávarri-Guerra. "People won't trust an outsider who just tells them to get a mammogram."

During audience Q&A, attendees echoed the value of community-driven initiatives. One participant from North Carolina praised the idea of training adolescents to educate older family members. Another asked about digital survivorship platforms. Dr. Galica responded, "They can be powerful, but they must reflect the realities of the communities they serve."

Dr. Soto concluded with a call for continued collaboration: "Navigation training, bilingual education, and shared learning across borders are all within reach. Together, we can build a more equitable future for rural cancer care."

The Global eXchange panel was a powerful reminder that while rural oncology challenges differ by geography, their solutions are often shared. By listening to communities, investing in navigation and education, and fostering cross-border collaboration, cancer care providers can ensure that geography is not destiny. OI

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