Interview with Dr Anu Agrawal, former Vice President of Global Cancer Support at the American Cancer Society

Dr Anurag K Agrawal is a paediatric haematologist-oncologist and bone marrow transplant physician. He joined the American Cancer Society (ACS) in May 2024 to oversee the organization's global cancer support programmes which span the cancer continuum from cancer prevention to patient support and healthcare provider support.

He has a long history of global work. Most recently he was involved with the development of Southeast Asian Pediatric Hematology/Oncology (SEAPHO) in 2016, which is focused on strategic initiatives to improve paediatric cancer outcomes in Vietnam, including initiating a two-year master's level training programme there since 2018 (ongoing). Prior to that, he was Medical Director of Paediatric Haematology/Oncology in Gaborone, Botswana as part of Texas Children's Cancer and Hematology Center from 2011–2012 and a Pediatric AIDS Corps Physician as part of the Baylor International Pediatric AIDS Initiative from 2007-2008.

Anu has a Bachelor of Arts and Bachelor of Science degree from the University of Texas at Austin, USA and a Doctor of Medicine from Baylor College of Medicine.

The interview was on conducted on 22 April 2026. Dr Agrawal has susbsequently left the ACS and now works from Spain.

Cancer Control

Thank you very much for agreeing to this interview.

Anu Agrawal

My pleasure, thank you for inviting me.

Cancer Control

We think it's an important time to have this interview. You are the Vice President of Global Cancer Support at the American Cancer Society (ACS). First question: How did you get there?

Anu Agrawal

Many people come to me, as they surely do to many people in the global health space, to ask that question: "What is the path?" And there is no path. It's an unchartered path for a lot of the positions that we have, I think that we have to sometimes attribute the roles we are in to a little bit of luck, and timing. We all have attributes that compile… that allow us to get into these positions.

For me, it was really the juxtaposition of many things happening at the same time. I was mid-career as a paediatric oncologist, had spent several years working, largely in low- and middle-income countries in sub-Saharan Africa, as well as in Vietnam. So I was still doing that work, and had a very strong passion for that. But then our hospital was going through a merger, which was very challenging for us. The general theme of the corporatization of healthcare in America, and the role of the physician is changing. So that led me to look for other opportunities, in many different industries, as well as in other institutions. I was fortunate to find this position; it was new as they were restructuring the global team at the ACS, and was fortunate to be selected.

Cancer Control

For those few people who might not know what the American Cancer Society is or does, could you tell us about the ACS?

Anu Agrawal

Sure. The ACS has been in existence for more than 100 years. It has three pillars. One is focused on discovery or research. It's the number one non-federal funder of cancer research in the United States. The second arm is the ACS CAN, or Cancer Action Network. This is the advocacy arm of the ACS and so very important; working from the grassroots, state to federal levels,to influence policy that affects persons with cancer and family members or caregivers that might be affected by cancer.

And then the third arm, where our Global team sits, is within the patient support pillar where all of our activities are focused on supporting persons with cancer, and their family members. A lot of this is directed to patient resources in the United States, such as our over 30 Hope Lodges offering free accommodation; our Road to Recovery Program, which is ride assistance, and many other programmes, such as patient navigation. The Global Program has been in existence for multiple decades, with the idea of trying to support patients globally, similarly to what we do in the United States.

Cancer Control

In your present role what are the achievements of ACS that you are most proud of?

Anu Agrawal

When I was interviewing for the role, I was very impressed by the accomplishments of the team. For me, it's really been a matter of trying to grow that, and also to increase the dissemination of that. You know, sometimes you have people that are very altruistic, working in the space, and working quietly, doing amazing work, but not shouting it from the rooftops. I think that, in some of the discussions that we'll probably have about interconnectedness of the work that we do, that is one of my goals, to better showcase the work we're doing to both internally as well as external partners. We have a really amazing breadth and depth of work. We work with partners in over 70 countries, and I think a lot of people just don't know that. So, for me, that's really been the biggest thing that I've been trying to do; to showcase that amazing work that's already been happening.

Cancer Control

Liam Neeson, in one of his films, says he has "a special set of skills". I'm wondering whether there are the people who are really skilled at doing that quiet work and there are the people who are skilled at promoting and disseminating and going out, and that, generally, you don't find them in the same person. Is that correct?

Anu Agrawal

That's true, yes. I think a lot of the skills that we have are innate. But then, of course, there's also the lifelong learning, and I think there's a lot of skills that we can acquire. I would say for myself, over my career moving from being a physician to being a physician leader, to being now a strategic leader you do take on new roles and responsibilities. I would not say I am naturally that type of person, but something that we really try to espouse within the leadership team is that is an important role that we play. Because as amazing as our work may be, if people don't know about it, and we can't get funding, etc, then it's not sustainable.

Cancer Control

We've talked previously about the lack of interconnectedness – siloism, which is an ongoing problem. What are the other frustrations that you find?

Anu Agrawal

I was very happy, and somewhat surprised, when I started in this role as to how welcoming the community was of me as a new person, and the willingness to be collaborative. That has been a really amazing part of the work, and the opportunities for that are so large. But I think the frustration that I have, and I think many of us share, is that we all go to meetings where we have a great time, we meet, we convene, we collaborate, and we discuss opportunities, but then we all go back to our regular jobs, right? And a lot of those great opportunities to create more synergy and work closer together don't move from ideation to actualization. And I think that is really the biggest opportunity that we have.

I just went to a meeting last week of patient organizations; a really phenomenal meeting, very inspirational. But then at the end of the meeting, I was like, "Okay, well, what are the next steps to take this momentum forward and continue to work together when we have our regular jobs that take our time?" I think that's the biggest frustration for me. How do we actually move that discussion to realization, because there is already so much to do. I think that's part of the reason that everyone's so willing to collaborate. There's enough work for everybody.

Of course, there'll always be some competition for funding, which is understandable; Also, that point about having to have some notoriety in order to get funding, so there's always going to be that. You have to put your brand first. I think all those things can happen, but how do we actually start to work better together? I think it is happening slowly, but I think there is an opportunity to move that faster.

Cancer Control

Is it perhaps that, for many groups, we don't have enough people? I agree, we go to meetings, and during a chance conversation, one may suddenly realize, "This is an amazing opportunity! All the planets are aligned. We can do this now." But you actually need to go back and tell a gang of people "Right, we're going to do this." And that gang of people aren't there. We have so many opportunities, but we can't realize them.

Anu Agrawal

No, that's true. The team jokes with me "You're going to this meeting, don't return with extra work for us!"

Cancer Control

You have also talked about making outcomes in low- and middle-income countries more achievable, and not to go chasing the perfect.

Anu Agrawal

Yes, I think it's the idea of chasing the shiny object, versus doing the things that are maybe less sexy, but will make the biggest difference for the least amount of money and with the highest

return on investment. So, I one hundred percent understand the desire to bring in innovative technologies and clinical trials, and that has to happen in parallel as the infrastructure improves. But the biggest opportunity is really to focus on prevention.

Forty percent of cancers are from modifiable behaviours and this is likely going to increase as countries become wealthier. There are still more than 1 billion tobacco users in the world, so, those are the opportunities that can make a huge difference without a lot of resources. Similarly, stage shifting for us is a key priority, as has happened in high-income countries. Most women now with breast cancer in the United States present with stage 1–2 disease where they're curable. Yes, there is the need for clinical trials and innovative therapies for patients, especially those that relapse or patients with certain underlying risk factors. But for the vast majority of patients, if you can get them to screening and early treatment, you can do that with relatively inexpensive, older drugs. And that, really, for us, is the other key. So that focus on the foundational principles – prevention, screening, early treatment – is really, for us, where the opportunities are, especially in our resource-limited environments, to make a huge difference in outcomes.

Cancer Control

Even within the wealthiest high-income country, there are pools, even large areas in some cases, of underserved populations, or difficult-to-reach populations. Does the ACS target those as well as its global work?

Anu Agrawal

Yes, definitely, it's a key pillar for us, both domestically and globally. It's how we improve access for everybody, whether it's vulnerable populations or marginalized populations. There are many different ways to approach this and it can be done through all three pillars of the ACS. It can be done through research, it can be done through advocacy, and it can be done through direct-to-patient support.

We see that also engaging communities is a key aspect, especially when more and more you have to combat the negative messaging within social media and the misinformation that is affecting vulnerable and marginalized populations. As much as you can, you engage the community, trusted members that can speak to that misinformation and guide the members of the community and provide them information in a trusted manner. I think that's really the key. And also patient navigation is a key way to achieve that; in communities as well as at treatment facilities. I think that's really something that's been lacking: having somebody who looks like you, who has the same experience as you, that understands how you think and the way you speak, your language, I think those are really key ways to get back to the humanity of what we're trying to do and get people away from getting misinformation from their devices.

Cancer Control

I've often heard it said that global work helps us do work at home. That getting to know other people's cultures – we're talking about immigrant populations now – going to the original host country, from whence they came, educates us and helps us get a better understanding and appreciation of the situation at home. Would you agree? Or is that just us just saying that because it justifies Global Health?

Anu Agrawal

I agree. It's a two-way street that can be a win-win if we allow it to. I think for us here at the ACS, we have really tried to align the work and see the opportunities to learn bi-directionally. There's the phrase you've probably heard, "Think global, act local." That's exactly right. I think there's a lot of lessons that we can learn from the global work that can apply back to the local setting.

Previously there has been a lot of the "Let's take the learnings from the United States and apply them to the global setting", or we were working in silos separately. Now we're really focused on that exact point you made. It's "Well, if we have already made medical education materials for low- and middle-income countries, how can we use those potentially for immigrant or migrant populations in the United States who may need additional education?" I think that there's the opportunity to learn from lower-resource environments and to apply it in higher-resource environments, because there's resource limitations in all settings, and there's marginalized and vulnerable populations in all settings.

Cancer Control

Let's go back to what you were saying a few minutes ago. Health literacy is something that I think is going to increasingly become a buzzword. We've talked a lot about prevention and we're always telling people what not to do and what not to do. Perhaps, we'd have an easier time of it if they understood this earlier, through school education, about how the body works, and what is good for it, and what's bad for it. There's no point turning up to somebody who's 35 and saying you should be doing more exercise. We seem to wait until the very last moment when we're on the point of crisis. If we're talking in terms of silos, education is often a silo quite distinct from health, almost a separate planet, and it shouldn't be. They should be both interlinked.

Anu Agrawal

There's so many aspects to that that are important. You know, first and foremost, as a paediatrician our role is to start to

provide that education at a young age, and to prevent, for instance, people starting to smoke, and explaining why you should get the HPV vaccination, but it's very challenging when, first off, there's not enough physicians. Now, in the United States, you can use allied health professionals, physician assistants, nurse practitioners, nurses, and community health workers to start to fill those gaps. Here, you know, largely because the way the insurance system is, there's a propensity of specialists, but in primary care, there's not enough frontline workers. I think that's a problem globally, in low-resource settings there are not enough frontline health workers and community health workers are asked to do so much with often no, or minimal remuneration. It's a very effective model that came out of HIV care, but how much can they be asked to do?

But you're right: the tenet of prevention has to start with education at a young age. I think the other factor that we're facing in the United States, and I think to an extent globally, but in America now, really it is the stark fact that 54% of adults read below the equivalent of a sixth grade level, and so you can imagine how that's going to impact on them.

Cancer Control

Sorry, what age group is that, just so that translates for non-US readers?

Anu Agrawal

It's about 11 or 12 years old.

Cancer Control

Okay.

Anu Agrawal

So you have to consider how to provide education in a way that's understandable. We have a Learning and Development Manager now who's taught me a lot about adult learning, and how to deliver messages. Even Change Management Theory says that you have to deliver a message seven times in seven different ways in order to effect change. So imagine if you're the physician or the primary health worker: how are you going to achieve that?

There are a lot of challenges, but I think now, with technology, I see so much opportunity for us to be able to deliver. At the same time, we've not really thought about how we can combat social messaging. I think that's something that the field really has to address because you can't respond to negative messaging with negative messaging. That's not the right approach. The problem is that the positive messaging just doesn't amplify the way negative messaging does. So that's really the big challenge.

Cancer Control

Do you think we're being outgunned on social media?

Anu Agrawal

Oh, a hundred percent. The algorithms… I'm sure you're aware of some of the landmark cases that have come through. It's great to see countries like Australia starting to ban social media for up to teenage years. I think they did it up to 16. And my hope is that we'll see more and more of that legislation. But I think, as we talked about before, so many of our challenges are based on, at the end of the day, corporate greed over health, which is multi-layered.

First and foremost, there's the insurance system, when a for-profit system should never exist when we're talking about healthcare. I think that's a challenge, and it's hard when you're profiting on another person's bad health. And then, of course, all the things that we're trying to prevent are really things that are developed through corporate greed, starting with tobacco which, after all these years, is still developing new products. I started seeing these little pouches in the urinals in the bathroom, and I was like, "What are these?" And then I realized it's just another way to deliver nicotine.

Cancer Control

Exactly.

Anu Agrawal

So, we're faced with that challenge, and now with ultra-processed foods. There's probably some relation to seeing colorectal cancer, for instance, earlier now in younger populations. So I think that that, yes, we're by far outgunned, but… then again, I think there are a lot of opportunities within the prevention space.

Cancer Control

It was very interesting to see at the UN high-level meeting on NCDs last September how the original draft of the Political Declaration had got watered down by industry pressure to take out criticism and remove warnings, reduce ambitions. We ended up with a "mild and watered" recipe, which was very disappointing. But it does indicate how powerful these forces are.

Anu Agrawal

Right, for certain. It highlights the challenge. As you said, we are outgunned, and we are definitely out-moneyed, by far. But we still have the moral compass, and I think that's the thing that's guiding all of us; that we are doing the right thing. We also see the end result. I think when you don't see the end result, you do not think about the consequences of your work. That's why

the patients' personal stories are so important. Those are the kind of stories that I think move people. None of the people that have contributed to that cancer are seeing that end point.

Cancer Control

You mentioned patient navigation. We've recently been talking to leaders from the Academy of Oncology Nurse and Patient Navigators, which has been interesting. Is patient navigation central to ACS's mission?

Anu Agrawal

The history of navigation really started with Harold Freeman, who was a physician in Harlem and also served as ACS president, and there was a strong linkage very early on with some of the studies he did showing the benefit in a low-resource population to access breast cancer screening and quality care. That work started, three or four decades ago, and has slowly grown, through all three ACS pillars, showing the evidence basis, largely in high-income settings and specifically the United States and Canada, that supported advocacy for the passage of legislation in 2023 with reimbursement pathways through Centers for Medicare and Medicaid Services (CMS), and directly through our patient support activities, trying to help with capacity development and coalition building, both within the United States and globally through the National Navigation Roundtable in the United States, and the Global Alliance for Cancer Patient Navigation, which we formed last year to build awareness, consensus and sustainable implementation frameworks.

We talked recently with some of the Alliance Steering Committee members about our next steps in consensus-building. Patient navigation wouldn't need to exist in an ideal world if we had treatment where there was holistic care, and where we thought about all the needs of the patient and family as part of the workup, and provided them the resources to actually get through treatment, support their family, continue to gain an income, have appropriate survivorship care, palliation, etc. If you had all that you wouldn't need patient navigation.

Patient navigation is there because there are so many gaps in the way that care is provided. There's a lot to do, and if you're the physician, your training is focused on "Let's get the diagnosis, let's start the treatment, let's cure the patient…". But then, there's a lot of other factors that you don't get taught about; for example, the social determinants of health. You just take for granted that the patient's going to show up for their appointment. That they're going to figure it out, right?

I think this is changing now when we start to recognize that there's so much more that has to be accomplished for the patient and family to be able to get through treatment. Especially if we're thinking about marginalized, vulnerable populations, and also recognizing that treatment doesn't end when treatment ends, that the side effects continue, with ongoing follow-up, relapse, loss of job, etc. In paediatric patients, we know that if you had a paediatric cancer, your end-stage income and your career development is going to be affected. How do we provide support so you don't have lifelong effects from your paediatric cancer treatment?

Patient navigation is really a process to try to identify those individualized barriers and to provide assistance or a link to resources so that patients can have that holistic experience.

Cancer Control

This is like what we were saying at the beginning of this interview, about having different skill sets. You've got the clinical skill set, and then what we may call "the messy, everyday stuff". You're not going to find the same people to address both. Even if you did, they don't have the time. You can either be doing one thing or the other, but I wonder if this represents a maturing of the medical profession? The recognition that it's not enough to be a nurse or a doctor; patient care requires having all these other things as well, and that helps break down silos. Because you're saying "We've got to have other people in this, it's not just us."

Anu Agrawal

Right. And I think part of that also is seeing the stories as you go further in your career. Sometimes getting out of the ivory towers – same as for the politicians – getting down to the community level and seeing what the journey is for this patient by following in their footsteps and seeing all the things they had to do to even get to the appointment. When we get down to that granular level, where we can start to see all the other aspects and that's where patient advocacy organizations can help, and are getting more of a voice in, beyond just the ACS, to really be able to show that and tell that story. I do think with the Lancet Oncology's Commission on the Human Crisis in Cancer this is being highlighted. But we also recognize that resources are becoming more and more limited and care is getting more expensive. People are struggling more and more, and cancer incidence is going up. So, all these things are coming together at the same time.

And you're right, I think that anyone could provide patient navigation, but the physician is busy doing the diagnostic work-up and treatment, seeing a lot of patients, especially the adult oncologists. There can be clinical navigators, nurses, social workers, etc, or there can be non-clinical navigators, depending on the setting. It really just requires working out how do you develop a programme? How do you develop sustainability? How do you get reimbursement? How do you show the cost-benefit?

We've started to see the efficacy, but we still need more evidence to show the cost-benefit. These aren't extremely expensive resources, but you still have to pay, though not in all settings. In some low- and middle-income countries, it's volunteers, which is fine, but like community health workers, you would ideally like to pay people, provide them with a job, and with more respect as this is a paid position. So, I think there's still a lot to be figured out. But, to your point, in the ideal system these are things that would be provided for or thought of, and I think that's something that's happening slowly.

Again, I think technology is an opportunity to make that happen, too. Why shouldn't patients have a needs assessment at multiple time points during their treatment to say, "What are your needs? How are you doing with housing, finances, transportation?" Sometimes that gets done maybe once, or not at all, but now with technology, that's something that could happen relatively frequently, and we could then get the results back and really say "These are the key needs." We can't meet everybody's needs, but at least we can understand what the key needs are and try to address those.

Cancer Control

As a clinician dealing with childhood cancers, you will probably have had experiences of almost miraculous outcomes, against all odds, but also very tragic outcomes that have happened. Which, personally, weigh more heavily on you?

Anu Agrawal

Yes, it's a great question. Paediatric oncology is such a special field and we've made such amazing gains in the last five decades as far as outcomes are concerned. I look at my contemporaries, and I don't know if I could have done it 30 or 40 years ago, when most children didn't survive. I was lucky to come into a space when 85% of children, at least in the US setting, were surviving. Of course, we have a long gap in low- and middle-income countries still, where only 15–20% of children survive.

I think I was falsely reassured by that higher statistic. You never know whether you are emotionally prepared. When you do your Fellowship, you focus on the deaths, you focus on the bad outcomes. It's a human thing. There are also the unlimited opportunities, clinical trials, and innovative therapies, so you're always wondering, "Did I miss something? Was there something else I could have tried for this patient?"

That gets better as you age in your career and develop more expertise. You doubt yourself less and you also recognize there's a lot of things that are out of your control. That this is going to happen this way, and there's nothing you can do to change that. But I would say for most of us, it's the tragedies that stick with you. The good outcomes are great. We all have those miraculous cases. I can think of many that I'm just so happy that child survived, and it was a miracle. But I think the sad cases definitely weigh on you. And there's that cumulative effect that we all face, and I think this is a really key point. How do we support the workforce, especially in environments where most of the children aren't surviving? I think that weighs very heavily.

Cancer Control

I don't know what the situation was in America, but the mental effect of dealing with COVID, in wards where previously you might have expected one or two deaths a week, but suddenly you're getting eight deaths a day… It may have scarred a generation of young NHS doctors and nurses. Those were very dark days. We've almost forgotten them now, but those were dark days, and hard choices needed to be made. Certainly, a lot of cancer appointments were cancelled, weren't they?

Anu Agrawal

For certain, and you have to have a level of desensitization to survive. But there's a very fine point where you become too desensitized, and we all hear about these situations. "The doctor was very brusque", "The doctor had no bedside manner". That person may have just tipped over into burnout, and then unable to communicate with patients, and even making mistakes. I think we have to look at how do we support our colleagues in these environments, working in incredibly challenging situations. There's a lot of opportunities to bring that community together, to support each other.

Cancer Control

And it's quite healthy that health professionals are looking to their own health as well, and those of their colleagues. We're becoming gentler and far more understanding with colleagues who have just reached the limit.

Anu Agrawal

And I think it's the same even with the patients. We're able to talk about comprehensive care, holistic care, supportive care, patient navigation. Because now we have better treatments, more and more patients are surviving, so we can start, for instance, to think about how do we actually reduce therapies to decrease side effects? In the past, it was just like, we have to focus on cure or palliation. Now, I think we're at a place where we can start to think about the whole patient and the whole provider as well.

Cancer Control

Do you feel that we've reached a "This is the best of times. This is the worst of times" moment, where we actually have so many exciting breakthroughs now, and a greater understanding of

cancer, and at the same time, the degraded public services and the financial environment in which we work have become harder and harder to navigate and harder to deal with, so that they become the enemy of promise? I can't think of a time when it's been so positive on the one side, and so negative on the other. It's odd, isn't it?

Anu Agrawal

Yes. In the United States, the opportunity to be cured is higher than ever, but the disproportionality that we see now between the resourced populations and the vulnerable and marginalized populations is worsening. And then we're faced also with increasing cancer incidence, largely in low- and middle-income countries, which also disproportionately share the burden of cancer death; 70% of cancer deaths are in these settings. And they are going to be disproportionately impacted as populations age, without the requisite infrastructure. So, I think, yes, that's exactly right. We have so many riches and have made so much progress, but COVID also, I think, was a big reason that we started to really look at this more, with evidence, too, to show that there are many populations that are lagging. And there's not really a good explanation based on biology. It's all of these other things that are impacting their ability.

Cancer Control

COVID uncovered a lot. I don't think there was one health system in the world that came out shining from COVID, to be honest. It revealed flaws in every health system. Turning to the question of financing do you think sin taxes might be one of the fiscal measures that should be adopted to help fund healthcare services?

Anu Agrawal

I'm fully in support of sin taxes. I think, again, going back to the theme of prevention and screening, that preventing the cancer is the cheapest way. If you can prevent the cancer, you're going to save the most money. I think also recognizing that without a public health insurance system, whether it's universal or not, you're going to continue to have disproportionality between those that have more resources and those with less, and so you can use a sin tax to also fuel your public health insurance for cancer care. I think that is a clear, evidence-based opportunity.

And in many of these low-resource settings, we're still faced with a lack of chemotherapy drugs. These are not expensive drugs, as we talked about, especially if you are able to stage shift patients, treat them at stages 1 or 2. Most of these are old drugs that should be cheap and readily available. If the system was set up where you had a sin tax, and public health insurance, and you could appropriately forecast, as other blocs like the European Union and Latin America have been able to do, and work together with other countries to develop pooled procurement models, you can negotiate and drive down the prices significantly and actually provide the drugs.

So, I think all of those things in tandem could make for a better system. We are seeing significant infrastructure improvements, but without improving access to the treatments we have not really moved the needle. I think that was where HIV served as an amazing example. Once the drugs became available at a very low price, the care was able to be provided, and I think that example can be used better with chemotherapy and other anti-neoplastics. Most of these are generics, they could be made in a regional fashion, as long as you can ensure quality.

So, I do think this is an incredible opportunity for low- and middle-income countries to work better together, and this would become a key, key aspect, in addition to the prevention and screening.

Cancer Control

We're coming to the last quarter of the interview now and I'd just like to pick up on a couple of additional points. Given the opportunity, what corrections would you like to make when you hear people in government talk about cancer, or other NCDs?

Anu Agrawal

I think first and foremost making it a clear national health priority. Cancer should be the number one national health priority. It will become, if it's not already, in most settings, the number one killer and so it should be viewed as such.

I think the other thing is that it also has to always be framed with hope. In many settings, in low- and middle-income countries, there's not that feeling of hope where you can receive treatment and be cured. And in many settings cancer is still stigmatized. People don't talk about cancer openly because of the stigma surrounding it, and the belief that you have cancer because of something you did. I think that is a huge problem. We even see this with, for instance, getting people to lung cancer screening. If you're a smoker, then you don't willingly go for your screening. So, I think we have to separate out that. Yes, of course, there are modifiable risk factors, but nobody's perfect. I'm not perfect, you know? We all do things that are imperfect, we're human. Shifting the blame away from the person or their situation is part of that destigmatization.

I think those are all ways that policymakers can also frame how we really tackle cancer. If you talk to the person with lived experience and the framing that they want, it's very different, too. They don't like the "War on Cancer", or perhaps "The Cancer Journey". It's "Well, I'm still living my life. I'm not on a journey, I'm not on a trip, I'm still doing normal things,". So,

involving persons with lived experience is very important.

And I think, again, the focus should be on the fundamentals: prevention; screening; getting people to treatment earlier; providing that frontline health workforce that can really start to provide education. We used to do public service announcements. I don't seem to see those anymore, but those are the types of things that can make a difference. And that's also partly on the healthcare professional. How do you frame the message as a positive message to say. "You should go for screenings so we can pick something up early when you can still be cured?"

There are other creative means, too. Do you make it part of a technological assessment? Where the patient gets assessed, and then it spits out, "These are the things you need to get done?" It makes it more of an objective statement. Yes, it's depersonalized a little bit, but also destigmatized. Like, everybody in your situation gets these tests.

Cancer Control

Two last questions. The first is unmet goals. Do you have any personal goals as yet unmet that you would really like to achieve?

Anu Agrawal

Many, many unmet goals! I think that we have so much more to accomplish in this space.

I think, first and foremost for us, it is pivoting the way we work. Our team has spent many years on the ground working in low- and middle-income country settings. They have really done a lot of deep in-country work, but we're at a place now where the way we work is shifting very rapidly. Some of that also has come out of COVID and of course funding has really dried up. So, the way that we work has to change and pivot. There's also the opportunities with technology. How do we deliver support? How do we empower local organizations more, in a sustainable manner?

Stripping all the funding, ripping off the Band-Aid was not the right solution. But, at the same time, we cannot continue in an environment where we create dependencies, where there's an expectation of "I'm going to continue to get funding, right?" Of course, there is the understanding that these are lower-resource environments, but there are ways, like sin taxes, etc., by which you can start to create self-sustainability.

There is an opportunity for us, as we change how we work because of lower resources, to really think about how do we maximize the resources that are available? How do we support the local organizations, especially now that we've had two decades, really, of building upon an HIV infrastructure? And infrastructure is much better now than it was two decades ago. Being able to tackle cancer care is more achievable, whereas even a decade ago, it seemed very, very hard. Of course, there's still lots of challenges.

That, for us, is the largest change that we are trying to accomplish. We need to do a lot. There's a lot of places that need help. We have a lot of technical expertise and we have a lot of great resources. How do we start to deliver those more broadly? How do we use technology to provide accurate translations? How do we connect to the right partners?

I was thinking this morning, I found another organization yesterday that I hadn't heard of, and I was like, "Oh, that's a great organization that I would love to work with." There's an innumerable number of organizations. How do we create a system where we can better know who's doing what, where, and work in a more interconnected fashion? Even having a database of all the organizations that are in this space in each country, in each region, just to proactively be able to say, "I'm thinking about this project. I work with these civil society organizations, (CSO) partners, in this country or region. Who else is there doing this work, or who has resources, or who can partner with us?"

Cancer Control

Everybody wants that. This is something that's really needed, because it's to do with a basic level of knowledge that has already been met in other sectors years ago. The financial sector, for example, take such things for granted. You have a spreadsheet and database of who's involved in mining, or whatever, providing full market knowledge. But with healthcare, we're 30 or 40 years behind, hampered by a chronic failure to invest and share information.

Anu Agrawal

This is where technology provides us the opportunity to create a more equitable playing field. I recognize that there is the danger of creating even more of a digital divide, but I see it as an incredible opportunity to use technology to very rapidly create these systems in an automated way that wasn't possible before. To take us to a place where, rather than me meeting you at a meeting in a random chance encounter, like you described, and us thinking "We can work together", that, in a much more proactive fashion, we get that information. And the voice, together, whether it's across cancer organizations, across disease states; that powerful voice that we have together. We've never really been able to activate that to the level that we need. So, for me, that is the largest untapped opportunity. My team sometimes laughs at me because they think it's too idealistic, but for me that's the legacy project.

Cancer Control

Well, there are countries who will willingly join you if we can get the money together. Because when people say, "That's

too idealistic!", you should say to them "Well, this level of community knowledge exists in stocks and shares, it exists in air travel. You can just press a button, and know who is doing what, where, and how, and you don't think anything about it, But in healthcare? What's our problem? Do you know?"

Anu Agrawal

It's been forced upon us now with the resource limitations. We need to think smarter and innovate around how we work in these settings, and how we work together. I think that it's going to push us in that direction. Technology is the other piece that fills the circle of actually being able to move that from ideation to realization, as we talked about at the beginning, with the frustrations felt after being at a conference.

Cancer Control

But it's still all worthwhile, yes?

Anu Agrawal

No question. Yes, I think that if you are in a place where you're finding meaning in the work. It always comes down to the person at the end of that journey, whether you're able to provide some support and make their life different and better in some way, albeit small. We always try to think about those people that we're able to connect to services, and to highlight those stories. That always helps us continue to show the value and impact of our work and the meaning of it.

It's different, I think, being in this type of role. As a physician, you get the direct gratification, you see the patient. You know, hopefully, they will get better. It's very different in a public health role where there's a significantly delayed gratification. But, yes, I agree, it's so important, the work that we're all doing together.

Cancer Control

Thank you so much for speaking to us. I think we can both agree we're in for the long haul.

Anu Agrawal

We are in for the long haul, for sure. I think there are innovative technologies that could prevent cancer, like a vaccine. And there's innovative technologies as to how we can eventually treat with a pill. But will those be equitable? Will those be available to everybody across the globe? I think in a capitalistic environment, the answer is "No", so there will always be lots to do. ■

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