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## **Beyond Pink Ribbon Tokenism- Survivorship & Advocacy Policy in Indian Oncology**

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Each October, Breast Cancer Awareness Month unleashes commemorative banners, webinars, and survivor testimonials, celebrating patients across public forums as enduring symbols of courage.

Yet once marketing concludes, structural deficits across India's cancer care continuum remain unaddressed: acute survivorship care gaps and the precarious status of independent advocates within healthcare governance. Transforming performative awareness into measurable outcomes requires concrete policy execution: defining independent research advocacy, integrating structured survivorship navigation to alleviate clinical overload, and institutionalising Fair Market Value (FMV) compensation for lived-experience consulting.

### **Acute Eradication vs. Functional Preservation**

ICMR and GLOBOCAN data record over 200,000 annual breast cancer cases in India—representing 28% of female malignancies. While India's five-year relative survival rate of 66.4% lags behind Western benchmarks due to late-stage presentation, multimodal care transitions over 100,000 women into survivorship annually. Crucially, a substantial proportion are diagnosed under age 50, entering remission with decades of productive professional and family life ahead.

This reality underscores a fundamental distinction: **an active patient requires acute disease eradication, whereas a survivor requires long-term functional preservation.**

### **The Survivorship-Prevention Paradox**

Tertiary oncology centres are optimised almost exclusively for acute care: surgery, cytotoxic chemotherapy, and radiotherapy. Under heavy outpatient throughput, follow-ups focus strictly on recurrence surveillance.

This pressure fuels the Survivorship-Prevention Paradox: acute interventions achieve disease-free survival, yet systems disengage from chronic toxicities. Adjuvant endocrine therapies, premature ovarian failure, secondary lymphedema, joint arthralgia, and chronic autonomic fatigue receive little structured management once active hospital protocols conclude. Treatment adherence breaks down not from patient apathy, but because clinical delivery lacks formal bridges between acute intervention and multi-year maintenance.

### **The Oncofertility Blind Spot**

With hormone receptor–positive (HR+) tumours accounting for 50% to 60% of diagnoses in India, precision endocrine regimens and targeted biologics make the disease highly manageable.

Yet manageability is not finality; it mandates 5 to 10 years of endocrine blockade, ovarian suppression, and chronic toxicities. For younger premenopausal women, chemotherapy and ovarian suppression routinely induce premature ovarian insufficiency, terminating reproductive potential. While international guidelines (such as ASCO and ESMO) mandate upfront fertility preservation counselling, heavy clinical workloads and socio-cultural barriers leave it largely unaddressed in high-volume clinics. Genuine survivorship requires institutional frameworks balancing multi-year disease control with reproductive autonomy.

### **Defining the Independent Research Advocate**

In India, the term "patient advocate" is often conflated across distinct functions. Industry relations leads manage corporate stakeholder partnerships, while clinicians advocate for diagnostic and therapy access.

Neither replaces the independent patient voice. An Independent Lived-Experience Research Advocate is an autonomous expert with personal treatment navigation who has developed formal literacy in clinical trial design, bioethics, and regulatory guidelines. Operating free from corporate obligations, they evaluate protocol feasibility, assess participant burden, review informed consent clarity, and identify real-world adherence barriers.

### **Regulatory Precedents and Fair Market Value**

Under **ICMR National Ethical Guidelines** and the **New Drugs and Clinical Trials Rules (NDCTR 2019)**, patient and community representatives hold statutory seats on Institutional Ethics Committees (IECs). Globally, premier bodies—including Susan G. Komen, ESMO, and AACR—routinely integrate research advocates into grant reviews, steering committees, and trial co-design.

Complementing these standards, international initiatives by WECAN and PFMD have formalised Fair Market Value (FMV) models. These frameworks recognise specialized advocacy as technical consulting rather than discretionary volunteerism, setting standardised remuneration schedules for advisory boards and protocol reviews. Establishing FMV benchmarks alongside formal training is essential to institutionalizing an accredited cadre of independent oncology consultants.

### **Strategic Policy Recommendations**

To transition from tokenism to technical integration, sponsors, CROs, and healthcare institutions should implement three operational steps:

1. **Standardise FMV Guidelines:** Introduce formal consulting agreements and structured remuneration for independent advocates advising on trial protocols, steering committees, and patient-reported outcome (PRO) endpoints.
2. **Differentiate Stakeholder Roles:** Clearly demarcate pharmaceutical industry liaisons, hospital provider advocates, and independent lived-experience consultants across ethics panels to eliminate conflicts of interest.
3. **Institutionalise Task-Shifted Peer Navigation:** India's oncologist-to-patient ratio forces clinicians to prioritize acute cytotoxic care, leaving long-term toxicities, lymphedema, oncofertility, and endocrine adherence unaddressed. Task-shifting non-oncologic survivorship navigation to accredited peer advocates protects clinical bandwidth, reduces informational burden, and curbs avoidable treatment discontinuation.

To execute this equitably, the ecosystem must establish safeguards: third-party blind-pool funding models to protect advocate autonomy, ring-fenced public trial grant allocations so academic research is not priced out, and regional-language training pathways to prevent urban exclusivity.

Ultimately, supported survivorship generates a self-reinforcing flywheel. When survivorship is visible and supported, it directly dismantles the fear and fatalism deterring timely screening. Thriving survivors prove early detection secures not merely temporary survival, but a full, productive life.

About the author-

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