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RESEARCH ARTICLE

Navigation Alone is Not Enough. Early Outcomes of a Patient Navigation Programme to Facilitate the Cancer Care Experience for Patients at Mbingo Baptist Hospital in Northwest Cameroon. A Theory-guided Qualitative Study

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Abstract

Introduction: support. Late presentation, fragmented referral pathways, high out-of-pocket costs, and limited psychosocial support mark cancer care in Cameroon. Earlier research at Mbingo Baptist Hospital (MBH) highlighted major gaps in care. In response, a hospital-based patient navigation programme was introduced in 2024 to improve communication, follow-up, and patient-centred support across the cancer care continuum. To explore how the introduction of a patient navigation programme has influenced patients' experiences of cancer care at MBH. Setting: The study was conducted at Mbingo Baptist Hospital, a major referral centre for oncology care in the North-West Region of Cameroon. **Materials and Methods:** A qualitative descriptive design was employed. Semi-structured interviews were conducted with nine adult cancer patients between August and September 2025, approximately one year after programme implementation. Interviews were guided by the biopsychosocial model, conducted in English, Pidgin English, or French, transcribed verbatim, and analysed thematically using inductive and deductive coding. **Results:**Participants reported improved care coordination, clearer communication, enhanced follow-up, and stronger psychosocial support following the introduction of patient navigation. The patient navigator facilitated appointment scheduling, interdepartmental communication, and emotional reassurance. Nevertheless, persistent challenges remained, including diagnostic delays, high treatment costs, limited insurance coverage, and travel burdens. Patients' experiences were further shaped by social support, spiritual coping, conflict-related displacement, and cultural beliefs about cancer. **Conclusion:** Patient navigation strengthened relational continuity, trust, and patient engagement in cancer care at MBH but did not fully overcome structural and financial barriers. The study provides context-specific evidence to inform the integration and scaling of navigation programmes within broader health-system strengthening efforts in low-resource oncology settings.

Keywords: Patient navigation- Cancer care- Qualitative study- Biopsychosocial model- Cameroon

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Introduction

Cancer is increasingly recognised as a major cause of illness and death worldwide, and its effects are felt most severely in low- and middle-income countries (LMICs) where health-care systems remain under-resourced [1]. In Cameroon, the most recent GLOBOCAN estimates report around 19,564 new cases and 12,798 deaths each year, producing a mortality-to-incidence ratio of more than 65% [2, 3]. Such high fatality reflects the persistent late presentation of cases, weak diagnostic capacity, and limited access to effective treatment services [4, 5].

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Among Cameroonian women, breast and cervical cancers account for most diagnoses, while prostate cancer remains the leading malignancy in men [6]. Despite this rising burden, access to comprehensive oncology care is still extremely limited. Most patients pay treatment costs directly, which represents more than 60 per cent of total health expenditure, and health-insurance coverage remains below 3 per cent [2, 5].

Earlier qualitative research at Mbingo Baptist Hospital (MBH) examined patients' pathways to care using a biopsychosocial framework. The study documented long delays before diagnosis, fragmented referral systems, high out-of-pocket costs, and emotional strain among people living with cancer [4]. These findings could help individuals navigate the system more effectively.

One such approach is patient navigation, which offers tailored guidance and psychosocial support to help patients move through complex health-care processes [7]. Research from high-income settings shows that navigation programmes can improve early detection, reduce waiting times, and increase treatment adherence [7-9]. In lower-income countries, however, navigation initiatives remain few. A review by Dalton et al. [10] identified only a small number of examples, mostly focused on women's cancers and early-stage interventions, with mixed results and limited evaluation.

Evidence on the broader impact of navigation, particularly across diagnosis, treatment, and follow-up, remains scarce in African contexts [11]. Responding to these gaps, Mbingo Baptist Hospital introduced a patient navigation service in 2024 as part of its ongoing quality-improvement programme. The service was designed to enhance coordination, streamline communication between departments, and provide consistent psychosocial support to patients and their families.

This study follows up on the earlier work at MBH. It explores how patients' experiences have changed since the navigation programme was introduced. Guided by the biopsychosocial model, the study examines shifts in biological, psychological, and social aspects of care, assesses whether navigation has reduced key barriers, and identifies lessons that may inform the development of similar programmes in comparable resource settings. By contrasting post-implementation findings with pre-navigation themes, the study contributes new evidence on how structured patient support can strengthen cancer care in Cameroon and across Sub-Saharan Africa.

Materials and Methods

Study design and setting

This follow-up study used a qualitative descriptive design based on semi-structured to capture nuanced personal accounts of experiences in the course of seeking cancer care. The research was carried out at Mbingo Baptist Hospital (MBH) in the North-West Region of Cameroon. MBH is one of the country's leading referral hospitals for oncology care and forms part of the Cameroon Baptist Convention Health Services (CBCHS). The hospital runs a busy oncology unit that provides chemotherapy, surgical oncology, palliative care and psychosocial support. In 2024, the unit introduced a patient navigation programme to strengthen coordination and continuity of care for people living with cancer.

Patient navigation programme

The patient navigation service was introduced at Mbingo Baptist Hospital as a hospital-based quality-improvement initiative responsive. The patient navigator, a qualified nurse, worked within the oncology unit to guide patients from diagnosis through treatment and follow-up. In addition to participating in counselling sessions, the patient navigator maintained patient records and supported communication , including oncology, radiology, pathology, and pharmacy. He contacted patients to inform them when pathology results were ready, reminded them of upcoming treatment or follow-up appointments, and provided reassurance and emotional support throughout their care journey. The role also involved liaising closely with clinicians and administrative staff to ensure that appointments, test results, and treatment plans were properly aligned, reducing unnecessary delays and improving patients' overall experience of care.

Study period and participants

Data collection was conducted between August and September 2025, roughly 1 year after the navigation programme was launched. Sample size was guided by the principle of information power and thematic saturation. Given the narrow study aim, the relatively homogenous clinical context (patients receiving care within the same oncology unit), and the depth of semi-structured interviews, nine participants provided sufficient information to generate stable and recurring themes. Recruitment ceased when no substantively new themes emerged during analysis. Although these individuals were not the same as those interviewed before the intervention, their accounts provide insight into how the navigation programme shaped the experiences of patients newly enrolled in care. Eligibility required a confirmed cancer diagnosis and the ability to provide informed consent.

Data collection

Interviews were conducted in a private counselling room within the oncology unit to ensure confidentiality and comfort. The interview guide was structured around the biopsychosocial model [12] and explored how biological, psychological and social factors shaped patients' experiences of care. Interviews were held in English, Pidgin English or French according to participant preference and lasted between 45 and 60 minutes. Each interview was recorded with permission, transcribed verbatim and, where necessary, translated into English for analysis. The research team comprised professionals from nursing, oncology, counselling, and anthropology. Interviews were conducted by a PhD-qualified anthropologist with experience in qualitative health research in Cameroon and no direct clinical role in the oncology unit, reducing potential therapeutic

power dynamics during data collection. Coding and analysis were undertaken by researchers with clinical and public health backgrounds, which may have shaped interpretation toward system-level and care coordination perspectives. To address this, reflexive discussions were held throughout analysis and manuscript development to critically examine assumptions, disciplinary lenses, and potential biases.

Data analysis

Data analysis followed a thematic approach combining both inductive and deductive reasoning. Transcripts were imported into Atlas.ti version 9 for coding. Coding was done by experienced qualitative researchers (GMA and EM). Initial codes were generated from the data and guided by the three domains of the biopsychosocial framework. Through an iterative process, these codes were refined into broader themes that reflected how participants perceived changes in care, communication, and support. Additional categories that did not fit neatly within the original framework, such as structural, spiritual and environmental influences, were also retained. The new findings were compared with themes from the pre-intervention study at MBH to explore shifts in patients' experiences after the introduction of navigation.

Ethical considerations

Ethical approval was obtained from the Cameroon Baptist Convention Health Board Institutional Review Board (Reference: CBCHB/IRB2025/ONCO/014). The hospital administration also granted permission to conduct the study. All participants gave written informed consent before participation. Data were anonymised and stored securely to maintain confidentiality.

Results

Demographics

A total of nine participants were interviewed, comprising six females (66.7%) and three males (33.3%). The mean age of participants was 43.2 years (SD = 6.5), ranging from 33 to 52 years. Educational attainment was generally low, with about 67% of participants having only primary education or less. Occupations were largely informal, including petty trading, farming, and food vending, with only one participant holding a degree-level position. The average monthly income was approximately 96,111 FCFA (170 USD), ranging from zero to 250,000 FCFA (441 USD).

In terms of language, five interviews were conducted in Pidgin English, three in English, and one in French. The participants were drawn from rural and semi-urban localities such as Batibo, Belo, Mbouda, and Bamenda (Table 1).

Interviews with nine participants revealed multifaceted experiences of cancer care at Mbingo Baptist Hospital following the introduction of the patient navigation programme. Their narratives illuminated how biological, psychological, social, and contextual factors intertwined to shape their care journeys. The findings are presented according to the domains of the biopsychosocial model, followed by three additional domains: structural, spiritual, and environmental that emerged inductively from the data.

Biological Domain

Experiencing the first symptoms

Noticing the first signs of cancer can be a daunting and unsettling experience. Often, symptoms are subtle and easily mistaken for less serious conditions, leading to delays in diagnosis and treatment. For many, the journey begins with a persistent cough, a new lump that does not seem to heal, unexplained weight loss, persistent pain or discomfort, amongst others. For most participants, the diagnosis of cancer in 2025 marked their first direct encounter with a serious illness. Although some had lived for months with unexplained symptoms, the confirmation of cancer brought a mixture of relief, disbelief, and fear. "It started about seven months ago. I realised that I had serious night sweating. I was unable to sleep. It went to a certain stage that my neck became swollen," one man explained (P008). Others recounted more abrupt onsets: "I started coughing and two months later I visited the pharmacy. The pharmacist advised me to visit the hospital due to the persistence with the cough" (P009). For another, the pain was so distinct she could recall the exact day: "This sickness started on the 31st of December 2024… I felt a sharp pain as if something was stinging inside my stomach" (P006).

Misdiagnosis and diagnostic delays

Cancer diagnosis is a complicated process. While medical advancement has helped to improve diagnostic accuracy, misdiagnosis and diagnostic delays still occur. Several patients experienced misdiagnoses and lengthy diagnostic journeys. "I have visited different hospitals here in Bamenda for seven months now and no one knew what was disturbing me," one woman recalled (P004). Another recounted being treated for the wrong illness: "After the consultation I was told that it was worms and I was given medications… after two weeks nothing changed" (P005). Similarly, one participant said, "I was told that it's an infection and it's called pneumonia. I was then sent to conduct a tuberculosis test and the result was negative" (P009).

Multiple referrals and the need to send samples to distant laboratories remained part of the diagnostic process. "So, I visited the general hospital… sent to a gynaecologist and he sent me to do an echography," said one woman (P004). Another added, "I started moving from one hospital to the other. The first hospital I went to was … and I was later referred to …" (P008).

A patient experienced delays and misdiagnosis in his treatment journey, starting with an initial diagnosis of ulcers at a private hospital, was later referred to different hospitals before being diagnosed with blood cancer at Mbingo (P001). Another patient noticed symptoms in 2022 but faced delays in getting an accurate diagnosis and understanding her condition. Initial treatments were done without clear communication about her diagnosis (P002).

Table 1. Participant Characteristics

Variable	Category / Statistic	n (%) / M ± SD	Range / Comment
Gender	Female	6 (66.7)	—
	Male	3 (33.3)	—
Age (years)	—	43.2 ± 6.6	33–52
Education level	No formal / Primary	6 (66.7)	Low literacy overall
	Secondary / G.C.E. O-Level	2 (22.2)	—
	Tertiary (Bachelor's)	1 (11.1)	—
Marital status	Married	6 (66.7)	—
	Single / Widow	3 (33.3)	—
Occupation	Informal sector (farmer, trader, vendor)	6 (66.7)	—
	Formal (teacher, driver, council staff)	3 (33.3)	—
Monthly income	—	96,111 ± 85,748 (170 ± 151USD)	0–250,000 FCFA (0 – 441 USD)
Type of cancer	Breast	3 (33.3)	Most common
	Cervical	1 (11.1)	—
	Ovarian	1 (11.1)	—
	Blood	1 (11.1)	—
	Lymphoma	1 (11.1)	—
	Lung	1 (11.1)	—
Language used in interview	Pidgin English	5 (55.6)	—
	English	3 (33.3)	—
	French	1 (11.1)	—
Region of residence	North-West / West Regions	8 (88.9)	—
	Abroad (Gabon)	1 (11.1)	—

Testing, treatment, and side effects

Cancer screening, diagnosis and or treatment can be a challenging and complex journey. After a diagnosis, different tests are conducted to determine the stage and extent of the disease. Chemotherapy, surgery and radiation therapy are the different treatment options administered to eliminate cancer cells but can equally impact healthy cells thus leading to side effects. These were equally echoed by some of our informants.

Long waiting times for biopsy and laboratory results were common frustrations. "So, after extracting the flesh (tissue sample) he parcelled it and asked me to prepare transport so it can be sent to Yaoundé," explained one patient (P004). Another noted, "Echography and mammography results came out the same day. It was biopsy that came out after three weeks" (P007). Long waiting period for biopsy and laboratory results significantly impacts patients' journey from diagnosis to treatment, affecting their emotion and physical health as it creates uncertainty, anxiety and stress for patients. Cancer then becomes a life-threatening situation as highlighted by an informant. "They told me that there is no solution, it is incurable and kept quiet and I felt bad. Then they looked at me and said they have a solution which was chemotherapy and cited the side effects of the chemotherapy. I never wanted it so my second option was leaving the hospital and I attempted to remove the oxygen as I had in mind to visit a church for prayers. The doctor present was bitter about it and I understood that they were specialists who knew what they were doing so I decided to trust them on the chemotherapy option" (P09). The patient is initially resistant to chemotherapy due to concerns about its effectiveness and side effects. Patient considers alternative options, such as visiting a church for prayers, and attempts to remove their oxygen, which leads to a near-death experience and conflict with doctor. Patients' actions and decisions are driven by their desperation and desire to find a solution to their life-threatening situation.

Once diagnosed, patients entered treatment with mixed feelings of hope and apprehension. "After administering the first two chemo sessions, on the third session the doctor said since there was no improvement he cannot continue with the chemo," said one man (P006). Others spoke about understanding and following their chemotherapy schedule: "The treatment plan that is given to me, I always come to receive my treatment after every three weeks" (P008). Patients entering cancer treatment therefore embark on a complex journey, having to navigate the complicated balance between holding onto hope for a positive outcome and confronting the apprehension and uncertainty that comes with this life-threatening situation.

The cost of care remained a persistent barrier. "I was told that I will have different chemotherapy sessions and each session will cost 150,000 FCFA (265 USD)," one woman reported (P005). The cost of treatment is a significant burden, with expenses for chemotherapy, transportation, and hospital stays adding up. The patients and their families are shouldering the financial burden without external support, leading to stress and hardship. No wonder informants expressed the need for Mbingo Baptist Hospital to make the payment plan more flexible by accepting payment in instalments. They equally recommended reducing the cost of cancer treatment to make it more accessible especially to the poor.

Alongside financial strain came physical hardship. "When I took the first chemo, it was disturbing me. The side effects were really disturbing me," one man explained (P006). Another shared, "They explained to me that chemotherapy had secondary effects like always feeling hot, loss of appetite, menstrual disorder" (P007). A third lamented, "Presently I do not have appetite to eat because when I am eating my stomach is paining" (P005). These symptoms can be severe and debilitating, affecting daily life and overall well-being.

Psychological Domain

Learning about Cancer the Difficult Way

Cancer, a word that strikes fear into the hearts of many, remains a pressing global health concern. For some individuals, understanding the disease begins only at the moment of diagnosis, when a healthcare professional finally confirms the condition. Others may have some prior awareness through personal symptoms, public campaigns, internet searches, or family history. However, for most, a formal diagnosis marks the first time they learn the specific name, severity, and implications of their illness.

"I came to know about cancer only when I was diagnosed of it. Even the chemo I am taking now, I heard of it only when I was diagnosed of cancer" (P009). Another patient shared, "When I was told that the issue is cancer; I was not really feeling differently so I was rather happy that the illness has finally been found. I was a bit relieved that they have finally discovered what I am suffering from, not knowing what it means to have cancer or what cancer is all about. I did not know anything about cancer" (P004).

These testimonies reflect how knowledge and awareness about cancer often begin only after diagnosis, underscoring the urgent need for community education and early awareness initiatives. Promoting understanding of cancer symptoms, risk factors, and available treatments can help reduce stigma, encourage early health-seeking behaviour, and empower individuals to take proactive control of their wellbeing. Strengthening public awareness is therefore essential for early detection, timely intervention, and improved outcomes in cancer care.

Perceptions of illness severity

Most patients continued to perceive cancer as a deadly and uncontrollable disease. "He said the illness does not take time to spread over the whole body so I should go and look for money and go to Mbingo Baptist Hospital immediately for treatment" (P004). Another reported being told, "They came back and told me that they cannot heal me but they can treat me though it has gone viral" (P009). A third reflected, "Doctor told me that cancer cannot be cured… but there is a new system now used in treating cancer when it has not yet destroyed your system" (P006). Such beliefs coloured how patients understood prognosis and continued to influence adherence and hope.

"Even when I was going from one hospital to another and the doctors were saying that they cannot handle the situation, and were suspecting either cancer or growth, at the mention of the name cancer to any person who wanted to find out what I was suffering from, their response was God forbid. I did not understand why people never wanted to hear the name cancer or were wishing that I should have such an illness. I did not know anything about cancer. It is now that I going through the horrors that I now know what cancer is all about." (P004).

Fear, acceptance, and coping

The psychological toll of diagnosis remained profound. Shock, fear, and disbelief were common first reactions. One woman said, "I least expected that it could be cancer… I cried because I was thinking of where we shall have money to manage the situation" (P007). Another recalled, "Immediately he said I was sick of cancer, I started crying. I already knew that it was the end of my life" (P006). For many, emotional distress was inseparable from financial anxiety, as the perceived cost of survival loomed large. Cancer continued to evoke deep fear of death. "When the doctor told me that I have cancer of the ovaries and it needs treatment, I thought that anyone who has cancer dies immediately," one participant said (P005). Another confessed, "I thought that cancer was very bad and dangerous than HIV" (P009). Over time, however, some began to accept their condition and focus on recovery. "I just accepted and placed everything in God's hands," explained one man (P006). "I told myself that I don't have to stress up but only focus on how I can follow up the treatment," another reflected (P008).

Cognitive and behavioural strain

Treatment brought with it significant psychological strain. "With this chemotherapy I forget a lot… I have forgotten many things," admitted one woman (P002). Financial stress also produced insomnia and anxiety: "I think a lot about how I would raise money for treatment so much such that my blood pressure increased" (P005). Another recalled, "I was unable to sleep and was stressed up" (P008). These mental burdens compounded the physical symptoms of illness.

Hope and motivation

Despite moments of despair, participants frequently expressed a renewed will to live, often inspired by their family responsibilities. "Really, I'm somebody that likes to stay healthy. I'm a father of six children and I love my children," said one man (P006). "When I am in good health, I know that my children are fine," he added. Another patient concluded simply, "Yes it gives me more hope for a better health ahead" (P009).

Social Domain

Family and caregiver support

The family remained the cornerstone of care. "My sister supported me in prayers, feeding, and accommodation," one woman explained (P005). A male participant added, "No, I would say my wife… she is the one who has been accompanying me here" (P006). Physicians also reinforced the importance of accompaniment: "Doctor asked me to come with my sister because I really need

assistance with my health" (P004).

Financial pressure and community solidarity

Economic hardship dominated most narratives. "I was told that I have an abscess… I had only 150,000 FCFA (265 USD) and I have consumed it on tests so I am left with 3,000 FCFA (5 USD)," one participant recounted (P005). Another said, "I borrowed 55,000 FCFA (97 USD) and went to the hospital with the money" (P004). Yet mutual aid within families and communities remained a lifeline. "If the people did not put their hands together to support, it would have been difficult for me to place myself on treatment," said one man (P008).

Patient-provider relationship

Participants spoke with warmth about the care received at Mbingo. Participants reported positive interactions with healthcare providers, appreciating their availability, empathy, communication, and support. Health workers' empathy and consistent communication which were hallmarks of the navigation model contrasted sharply with experiences in previous hospitals. "Here the doctors actually listen to you, they even give you their phone numbers such that in case you are faced with any problem you can give them a call," said one woman (P007). "Here in Mbingo money or without money, they do their job well and efficiently," added another (P009). A strong patient- provider relationship built on trust, empathy, effective communication and support is crucial in cancer care, enabled patients to feel cared for, supported, and informed throughout their treatment journey.

Social workers and patient follow-up

Social workers and patient navigators were central to this improved relationship. "They have a service called social workers… provided I will be able pay before the next program the chemo shall be given," said one patient (P009). "Whenever I take the chemo and go back home, if something is wrong with me I give him a call and explain," shared another (P006). Such support networks extended continuity of care beyond hospital walls.

Stigma and concealment

Despite social support, stigma persisted. Some participants concealed their illness for fear of ridicule. "Not everybody is supposed to know that you are sick… some of them will start to make a mockery of your situation," one man observed (P009). Another added, "My community is not helping me out because I have not exposed my situation to them" (P007).

Structural Domain

Access to diagnostic testing

Beyond individual experiences, participants reflected on broader health-system barriers. Many described how peripheral hospitals lacked diagnostic facilities: "There was no hospital in Bertoua where I can do biopsy and as such I should go to Douala," one woman explained (P007). Others described being repeatedly referred: "They asked his colleague to write a refund in my receipt and that they know where my problem will be better solved than here" (P004).

Delays in obtaining laboratory results persisted because specimens had to be sent to specialised laboratories. "So, after extracting the flesh (tissue sample) he parcelled it and asked me to prepare transport so it can be sent to Yaoundé," one patient recounted (P004). The systemic lack of timely diagnostics caused prolonged anxiety: "Do you know what it takes someone to be waiting for about three months in order to see whether you can be treated or not?" (P008).

Lack of Health Insurance and Flexible Payment Options

Participants highlighted the absence of health insurance or social protection mechanisms, noting that many council workers and employees are not registered under any scheme. "Council workers do not belong to a health insurance scheme," lamented one man (P008). Another added, "When I left [my previous company] and went to [current one], I was not registered under any health insurance scheme" (P006). Despite these structural weaknesses, the professionalism and compassion of staff at Mbingo were consistently praised: "Here the doctors actually listen to you… money or without money, they do their job well and efficiently" (P009).

Some participants also mentioned that the hospital's flexible payment plans make care more accessible. One patient explained, "I enquired the possibility of commencing treatment before paying 100000 FCFA (176 USD) later. They started administering chemotherapy and this is the second dose I am taking today. It was after taking the first dose of chemo that I went back home and sent them the money and I was asked to be here on the 12th" (P003).

Spiritual Domain

Faith and Spirituality

Faith and spirituality emerged as powerful sources of meaning and resilience. Participants often attributed their endurance and healing to divine intervention. "By God's grace the pregnancy went on to term. With the grace of God, the wound is healing," said one woman (P007). Others expressed complete surrender to faith: "I just accepted and placed everything in God's hands" (P006).

Pastors and religious communities provided vital emotional support. "He talked to me and encouraged me to build up my mind. I called my pastor and informed him about it. He prayed with me over the phone and told me that it shall be well," one patient explained (P006). For others, prayer and gospel music became daily therapy. "Whenever I am stressed, I listen to gospel music or pray to God to help me find a way out," said one woman (P007).

Moments of deep despair were also evident among participants. One man recalled, "I wanted to remove the oxygen as I had in mind to visit a church for prayers… One day I removed it myself and almost passed away" (P009). Another expressed hopelessness through prayer, saying, "I went back home and prayed to God that He should take

my life, but surprisingly I did not die" (P005). Similarly, one informant initially chose prayer as a form of medicine rather than seeking professional help: "When I realised a lump in my breast, I stayed for about three months before going to the hospital. I did not apply any ointment or herbal medicine. Instead, I resorted to prayer as medicine" (P004). These accounts reveal a tension between spiritual faith and medical intervention, showing how reliance on prayer in place of timely treatment can delay access to essential care and potentially worsen health outcomes.

Environment and Context

Environmental and contextual challenges shaped access to care. Several participants described displacement due to conflict or migration. "I am an internally displaced person as result of the Anglophone crisis and she provided a room in her house for me to be living there," said one woman (P005). Another shared, "I had to travel from Gabon to Cameroon because I was losing weight, coughing blood and I have never experienced such things" (P009).

Culture and beliefs

Cultural beliefs also influenced health-seeking behaviour. Some communities associated illness with witchcraft or "the evil eye." "Some members of the community were telling me that it is the evil eye or something caused by bad people," said one participant (P008). Others were urged to abandon medical care: "They were only advising me to use traditional medicine" (P008). The patients therefore encountered skepticism about Western medicine, with some community members suggesting traditional remedies. Such narratives reveal the tension between biomedical care and traditional belief systems that navigation now helps patients negotiate.

Reflection on Journey and Impact on Life Plans

Regret often lingers in the aftermath of a cancer diagnosis. One participant reflected, "Had it been I knew, immediately this sickness started I could have gone directly to Banso Baptist Hospital or come here at Mbingo Baptist Hospital. There is no care or concern for patients in Bafoussam" (P001). This statement underscores the importance of timely access to appropriate medical care and awareness of quality treatment centers like Mbingo.

Another participant shared how the illness derailed major life plans: "It is only the financial difficulties. I was supposed to go to Canada but I have not gone because of this illness. My husband had plans of building in the village but he has been unable to do so because of my illness. We are renting a house meanwhile we were supposed to be in our own house" (P002). Her experience illustrates how the diagnosis imposed significant financial and emotional strain, disrupting long-term goals such as migration, home construction, and family stability. Many patients described similar challenges, facing stress, anxiety, and uncertainty about the future, particularly regarding their families' financial security and the welfare of their children.

Recommendations for Improvement

Participants emphasized the need to reduce the financial burden of cancer care, describing the high costs of chemotherapy, tests, and transport as overwhelming. "I had only 150,000 FCFA (265 USD) and I have consumed it on tests, so I am left with 3,000 FCFA (5 USD)" (P005). Another added, "If the people did not put their hands together to support, it would have been difficult for me to place myself on treatment" (P008). These experiences highlight the need for subsidized care and financial assistance programs.

Some also called for health insurance coverage to protect workers and low-income patients. "Council workers do not belong to a health insurance scheme" (P008), one participant noted, stressing the urgency of inclusive insurance or social protection mechanisms.

Participants further recommended increasing staff and improving equipment availability to reduce delays in diagnosis and treatment. "Here at Mbingo you have to exercise patience… No matter how long it takes, if I end up having a solution to my problem that it is okay" (P007), one patient explained, implying that long waits reflect limited staffing. Another added, "Since the hospital was not having a scanner, I was referred to Bafoussam" (P001). Strengthening human resources and diagnostic infrastructure would improve timely and efficient cancer care delivery.

Discussion

This study provides new evidence on how the introduction of a patient navigation programme has reshaped the cancer care experience at Mbingo Baptist Hospital (MBH) in Cameroon. By comparing post-implementation findings with earlier baseline data [4], the analysis demonstrates that navigation has strengthened the human and organisational dimensions of oncology care, improving coordination, empathy, and follow-up in a context long constrained by fragmentation and scarcity. Patients reported feeling better guided, emotionally supported, and more confident in managing their treatment journeys. Despite these relational and procedural gains, persistent structural weaknesses including high out-of-pocket costs, limited diagnostic capacity, workforce shortages, and geographic inequities continue to undermine equitable access to care.

Navigating cancer care is a complex and challenging experience, as evident in these informants' narratives. The onset of unusual and distressing symptoms marked the beginning of a journey full by uncertainty and concern. As they sought medical attention, they encountered various healthcare touch points including traditional and complementary medicine. The experiences of these individuals underscore the need for patient centred care, effective communication, and support throughout the cancer care trajectory. The discussion uses the components of the biopsychosocial theory to situate these findings within the wider literature on cancer control in low- and middle-income countries (LMICs), identifying how navigation contributes to progress

while highlighting systemic reforms required to achieve sustainable, patient-centred cancer care in Cameroon and across Sub-Saharan Africa.

Biological Domain

Patients' narratives of misdiagnosis, multiple referrals, and delayed pathology reflect common systemic challenges in low- and middle-income countries (LMICs). Similar diagnostic delays have been documented in Uganda, where the introduction of patient navigation significantly reduced time to diagnosis for breast cancer patients [13]. In our setting, navigation appears to have improved internal coordination: participants noted clearer communication about treatment plans and scheduling, but persistent constraints in external diagnostic infrastructure limited overall efficiency.

The consistency of patients' experiences of physical suffering and side effects underscores that navigation can assist in preparing and supporting patients but cannot eliminate therapy's inherent toxicity. What our findings add is how navigation helps patients anticipate and manage these burdens in a resource-limited context with many reporting confidence to call clinicians between cycles, understanding of side-effect expectations, and reassurance through continuous follow-up. These results are consistent with systematic reviews showing that navigation programmes improve treatment adherence and patient satisfaction [7, 9], and with broader literature positioning navigation as an intervention that bridges informational and logistical gaps in care [10, 14]. Although specific chemotherapy regimens were not documented, chemotherapy commonly involves multi-cycle protocols requiring regular hospital visits and laboratory monitoring, which can amplify both toxicity-related distress and out-of-pocket costs. These structural demands help contextualise the treatment burden described by participants.

Psychological Domain

Emotional turmoil following a cancer diagnosis characterised by shock, fear of death, and confusion is widely reported across qualitative cancer studies [15, 16]. What stands out in the present study is the role of the patient navigator in buffering these psychological stresses. Participants described moving, over time, from despair to cautious hope, often supported by consistent and empathetic contact from health workers. This finding mirrors evidence from Nigeria, where community-based navigation programmes reduced anxiety and stigma among cancer patients through sustained psychosocial engagement [17].

Social Domain

Participants consistently affirmed the importance of family, community, and provider empathy in sustaining cancer treatment. Reports of provider accessibility, such as doctors sharing personal phone numbers and offering more attentive listening reflect a relational shift that patient navigation aims to foster. In Nigeria, the integration of a navigation and palliative care support unit at Enugu State University Teaching Hospital similarly strengthened continuity, follow-up, and trust among metastatic breast cancer patients [18].

Financial stress persisted as a dominant social challenge. In sub-Saharan Africa, evidence indicates that the majority of cancer patients experience significant objective and subjective financial toxicity linked to out-of-pocket costs and income loss [19, 20]. Globally, financial navigation has been identified as a crucial complement to clinical navigation; helping patients manage or mitigate the financial impact of treatment [21, 22]. In our setting, navigation functioned more as a conduit to social and charitable support rather than a direct financial intervention, underscoring its limits when structural and systemic barriers remain unresolved. Internally displaced persons (IDPs) frequently face economic hardship, making it difficult to afford transportation, medication, lodging and treatment. This can force them to prioritize basic needs over healthcare. Even the experience of violence and having to travel for long distances to receive care can exacerbate psychological trauma, making it challenging for them to cope with a cancer diagnosis and treatment.

Stigma and concealment also remained salient. Studies across African contexts have shown that patients often hide their diagnosis to avoid social judgment, being labelled cursed or contagious [15, 23]. While navigation may reduce isolation by normalising dialogue and providing safe spaces for disclosure, it alone cannot dismantle deeply rooted cultural taboos surrounding cancer.

Structural Domain

Structural barriers, including insufficient diagnostic capacity in peripheral hospitals, long specimen transport times, and lack of insurance coverage, loom large in our participants' stories. The hospital's navigation programme could not compensate for the lack of access to pathology laboratories or imaging services before diagnosis. In Cameroon and other African countries, limited cancer control infrastructure has been repeatedly documented as a leading barrier [5]. Navigation improves internal hospital efficiency (referral, scheduling, patient tracking), but its reach is constrained when structural deficits dominate. It is emphasised that navigation must be paired with system investments to achieve durable impact [24].

Furthermore, the absence of broad health insurance or formal social protection compounds vulnerability. In Nigeria, efforts to integrate navigation with financial counselling have gained traction, but the larger structural reforms remain slow. A recent scoping review of cancer financing in Nigeria emphasises that patient-level interventions must be accompanied by macro-level policy change [25].

Spiritual Domain

Spiritual meaning-making emerged as a fundamental dimension of patients' experiences, deeply intertwined with resilience, emotional recovery, and trust in care. Participants frequently framed their suffering within religious narratives, interpreting illness as divine testing and finding solace in prayer and faith communities. In many African health settings, spirituality is not

peripheral but central to how patients live, interpret, and narrate illness [26, 27]. This integration of faith and coping resonates with qualitative work across sub-Saharan Africa, where belief systems and religious practices provide interpretive frameworks for suffering and hope [17, 28].

In highly religious societies, psychological adjustment and treatment adherence are closely intertwined with spiritual belief. Navigation that acknowledges and complements these frameworks can therefore strengthen emotional alignment and engagement with care. Programmes that neglect the spiritual dimension risk being perceived as culturally alien or less compassionate, potentially undermining trust and adherence. Our findings suggest that navigation is most credible when it works with, rather than against, patients' spiritual worldviews, respecting their perceptions while integrating biomedical guidance within their familiar cultural and faith-based logics.

Environmental Domain

Geography, displacement, insecurity, and transport costs surfaced as consistent practical constraints in accessing cancer care. Several participants had been internally displaced by regional conflict, while others travelled long distances or across borders to obtain treatment. Such contextual pressures mirror findings from other African settings, where geographical distance, conflict, and poverty impose heavy logistical and financial burdens on patients [29, 30]. In Rwanda, for example, more than half of cancer patients report substantial financial toxicity arising from travel and accommodation costs associated with treatment [30].

Traditional beliefs and community influences also shaped health-seeking behaviour. Some participants were encouraged to try herbal remedies or attributed illness to spiritual causes such as curses or the "evil eye." These beliefs, while culturally embedded, often undermined adherence to biomedical treatment. Patient navigation in this setting has potential to serve as a form of cultural mediation, helping patients reconcile traditional worldviews with biomedical guidance and negotiate care choices within their social realities [26, 27].

Synthesis and Implications

Taken together, the findings show that the patient navigation programme achieved clear gains in relational continuity, clarity of care pathways, and psychosocial support, echoing global evidence that navigation enhances coordination and patient experience in low-resource oncology settings. However, enduring structural barriers, particularly financial toxicity, diagnostic delays, and geographic inaccessibility, demonstrate that navigation alone is not sufficient.

Consistent with the pre-implementation inquiry [4]. Participants in this study called for affordable care, insurance expansion, and workforce and infrastructure investment. Out-of-pocket costs remained prohibitive, reinforcing the need for financial counselling, linkage to support funds, and transport or housing subsidies within navigation. These priorities align with broader calls for financial-risk protection and universal coverage in African cancer-control strategies [31].

Persistent diagnostic and staffing gaps further point to the need for investment in diagnostic decentralisation and on-site pathology capacity, as emphasized by WHO and IARC workforce frameworks [32]. Patient navigators should also receive training to address faith and cultural narratives alongside biomedical guidance, acknowledging the deep spiritual framing of illness observed in both studies.

Beyond initial coordination, navigation appeared important in sustaining adherence between treatment cycles. Participants described receiving structured treatment schedules, being reminded of follow-up visits, and having the option to contact the patient navigator or clinicians when side effects occurred. In resource-limited settings where follow-up systems are often fragmented, such relational continuity may help reduce treatment interruption and strengthen engagement with care, consistent with evidence demonstrating that patient navigation programmes are associated with improved treatment adherence across the cancer care continuum [9].

Although our findings primarily reflect experiences across diagnosis and chemotherapy, patient navigation may also be particularly valuable within surgical oncology pathways. Patient navigators could support preoperative preparation by ensuring the timely completion of investigations, providing education about surgical procedures, and coordinating multidisciplinary scheduling. Postoperatively, navigation could facilitate follow-up appointments, wound-care monitoring, symptom reporting, and early identification of complications. Navigation may also have potential to support coordination of palliative care services, including symptom management, psychosocial support, and end-of-life planning. Although this dimension was not specifically examined in the present study, the high burden of late-stage presentation in many low-resource settings underscores the importance of exploring how navigation models could be integrated with palliative care pathways. Future research should examine this interface more explicitly.

Strengthening patient navigator training is also essential. Beyond coordination and psychosocial support, patient navigators should receive structured education in cancer-specific competencies relevant to the local disease burden. This may include symptom awareness, early warning signs, patient education strategies, and guidance on treatment-related side effects across common malignancies such as breast, cervical, prostate, and haematological cancers.

Moreover, given the persistent financial strain described by participants, expanding the navigation model to include structured financial navigation may strengthen its impact. This could involve systematic screening for financial distress, linkage to charitable funds or subsidy schemes, assistance with instalment payment planning, and guidance on available social protection mechanisms.

Ultimately, navigation should be institutionalised not as a stop-gap but as part of a broader reform agenda that integrates financial protection, infrastructure development,

and culturally competent care. Embedding navigation within national cancer-control policy would help transform it from a patient-level coping mechanism into a sustainable pillar of equitable oncology care in Cameroon and comparable LMIC settings.

Limitations

This study was based on a small, single-site qualitative sample, which limits the generalisability of findings beyond similar hospital contexts. The participants interviewed after implementation were not the same as those in the pre-implementation study, preventing direct individual comparisons. Although interviews were conducted in multiple languages and translated carefully, some nuances may have been lost, and social desirability bias cannot be excluded. This study did not collect or verify objective diagnostic time intervals (e.g., symptom-to-biopsy or biopsy-to-result duration); therefore, reported delays reflect patient-reported experiences rather than measured clinical timelines. This study relied solely on patient interviews and did not incorporate additional data sources such as observational data or navigator documentation, which may have limited methodological triangulation. Formal member checking was not undertaken, as findings were not returned to participants for validation. In addition, all interviews were conducted by a single researcher, which may have influenced data collection through individual interviewing style and interpretation. However, consistency in interviewing approach, independent coding by multiple researchers, and interdisciplinary reflexive discussions were employed to enhance analytic rigour and credibility. Finally, while the biopsychosocial framework guided analysis, it may have shaped data interpretation. Despite these constraints, the study provides valuable insight into how patient navigation is experienced in a resource-limited African cancer care setting.

In conclusion, this study shows that patient navigation has enhanced the coordination, communication, and psychosocial support available to cancer patients at Mbingo Baptist Hospital, fostering greater trust and engagement in care. However, persistent structural and financial barriers such as limited diagnostic capacity, high out-of-pocket costs, and travel burdens continue to shape the overall cancer experience. The findings suggest that while navigation strengthens patient–provider relationships and mitigates emotional distress, its impact depends on broader system investments in financing, diagnostics, and decentralised oncology services. Integrating financial counselling, transport assistance, and culturally sensitive psychosocial support within navigation models could further improve outcomes. Strengthening and scaling such programmes across Cameroon and similar contexts will be critical to advancing equitable and patient-centred cancer care in sub-Saharan Africa.

Declarations

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Clinical Trial Registration

Not applicable.

Conflicts of Interest / Competing Interests

The authors declare that they have no conflicts of interest.

Availability of Data and Material

The data sets generated and analyzed during the current study are not publicly available due to confidentiality considerations but are available from the corresponding author upon reasonable request.

Code Availability

Not applicable.

Authors' Contributions

Glenn Mbah Afungchwi contributed to the conception, study design, data analysis, and drafting of the manuscript. Eric Makiyighome Tum contributed to data analysis and manuscript revision. Alberic Ndonku contributed to clinical oversight and critical revision of the manuscript. Lorraine Elit supervised the study and contributed to critical revision of the manuscript. All authors approved the final version for submission.

Ethics Approval

This study was approved by the Cameroon Baptist Convention Health Board Institutional Review Board (Reference: CBCHB/IRB2025/ONCO/014).

Consent to Participate

Written informed consent was obtained from all participants, and the study was conducted in accordance with the principles of the Declaration of Helsinki.

Consent for Publication

Written informed consent for publication of anonymized data was obtained from all participants.

Originality Declaration for Figures

The table included in this manuscript is original and was created by the authors specifically for the purposes of this study. No previously published or copyrighted materials have been used.

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Declaration on Generative AI and AI-Assisted Technologies in the Writing Process

Grammarly was used solely for language editing, grammar correction, and stylistic refinement of the manuscript. No generative AI tools were used to generate research content, data, analysis, or substantive intellectual contributions. All scientific content, interpretations, and conclusions are the responsibility of the authors.

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