A walk through the Knowledge Summaries for Breast Cancer Control

Special Focus Dialogue
8th October 2020

“We unite and support the cancer community to reduce the global cancer burden, to promote greater equity, and to ensure that cancer control continues to be a priority in the world health and development agenda.”
The Breast Cancer Programme strengthens and engages the global breast cancer community with the overall **goal of contributing to the reduction of premature deaths from breast cancer** and improving the quality of life of patients by leveraging established UICC’s Capacity Building programmes and convening platforms.
Our speakers

Special Focus Dialogue - A walk through the Knowledge Summaries on Breast Cancer control
Thursday 8th October 2020, 13:00-14:00 CET

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World Health Organisation

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Consultant Clinical Oncologist
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A multi-year collaboration led by the Union for International Cancer Control; Breast Health Global Initiative (BHGI) at the Fred Hutchinson Cancer Research Center in Seattle, Washington; and the Center for Global Health at the U.S. National Cancer Institute. This effort supports the goals of the BCI2.5 campaign to make breast health a global priority and reduce disparities in breast cancer outcomes. This series is a collaborative effort by Benjamin O. Anderson (BHGI), Allison Dvaladze (University of Washington), Andre Ilbawi (UICC Fellow), Silvana Luciani (PAHO), Julie Torode, (UICC) and Jo Anne Zujewski (NCI). Cover photographs generously contributed by Carolyn Taylor and include photos from the Facing Life photo project.
RESOURCE STRATIFICATION

**BASIC LEVEL:** Core resources or fundamental services necessary for any breast health care system to function. Typically applied in a single clinical interaction.

**LIMITED LEVEL:** Resources or services are attainable with limited financial means and modest infrastructure and produce major improvements in outcome such as survival.

**ENHANCED LEVEL:** Resources or services that are optional but important, because they increase the number and quality of therapeutic options and patient choice and improve outcomes.

**MAXIMAL LEVEL:** Services used in some high resource countries that have lower priority on the basis of extreme cost and/or impracticality.
**Table 1. Resource-stratified pathway for breast cancer early detection and screening programs.**

<table>
<thead>
<tr>
<th>Level of Available Resources</th>
<th>Basic (Level 1)</th>
<th>Limited (Level 2)</th>
<th>Enhanced (Level 3)</th>
<th>Maximal (Level 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public Education and Awareness</strong></td>
<td>Development of culturally sensitive, linguistically appropriate local education programs for target populations to teach value of early detection, breast cancer risk factors and breast health awareness (education + breast health awareness)</td>
<td>Culturally and linguistically appropriate targeted outreach/education encouraging CBE for age groups at higher risk administered at district/provincial level using healthcare providers in the field</td>
<td>Regional awareness programs regarding breast health linked to general health and women's health programs</td>
<td>National awareness campaigns regarding breast health using media</td>
</tr>
<tr>
<td><strong>Detection Method</strong></td>
<td>Clinical history and CBE</td>
<td>Diagnostic breast US +/- diagnostic mammography in women with positive CBE</td>
<td>Mammographic screening every 2 years in women ages 50-69</td>
<td>Consider annual mammographic screening in women ages 40 and older</td>
</tr>
<tr>
<td><strong>Evaluation Goal</strong></td>
<td>Breast health awareness regarding value of early detection in improving breast cancer outcome</td>
<td>Downsizing of symptomatic disease</td>
<td>Downsizing and/or down-staging of asymptomatic disease in women in highest yield target groups</td>
<td>Downsizing and/or down-staging of asymptomatic disease in women in all risk groups</td>
</tr>
</tbody>
</table>

Adapted from the Breast Health Global Initiative (BHGI) guidelines, 2008
EXECUTIVE SUMMARY

Developing Comprehensive Breast Cancer Programs: A Call to Action

INTRODUCTION
Breast cancer is the most prevalent cancer in women worldwide, affecting more than 1.3 million women each year. Low and middle-income countries (LMICs) have increasingly been adopting the Global Initiative to Cancer, which has resulted in increased survival rates among breast cancer patients. Despite this progress, significant challenges remain, particularly in LMICs. The need for comprehensive, evidence-based breast cancer programs that address not only clinical care but also lifestyle, diet, and social determinants of health is crucial.

PLANNING

Developing Comprehensive Breast Cancer Programs: A Call to Action

KEY SUMMARY
Breast cancer control programs
- Effective breast cancer control programs require comprehensive, resource-appropriate cancer control plans.
- National breast cancer control programs: national development and implementation of evidence-based programs.
- Breast cancer control programs in LMICs: focus on early detection and treatment.
- Effective breast cancer control demands integrating early detection programs with access to diagnostics and screening.

Policy planning
- International guidelines on breast cancer control: necessary for policy makers.

Knowledge summaries for comprehensive breast cancer control
- Key knowledge summaries for comprehensive breast cancer control: essential for decision-makers.
- Comprehensive breast cancer control programs: effective and sustainable.

OVERVIEW
Planning
- Planning for breast cancer control programs.
- Key strategies for comprehensive breast cancer control programs.
- Monitoring and evaluation of breast cancer control programs.

Points to consider
- Resource availability and allocation:
  - Financial resources.
  - Human resources.
  - Infrastructure.
- Policy and legal frameworks.
- Community participation.
- International partnerships.

Planning Step 1: Where are we now? (see Table 1)
- Baseline data collection.
- Baseline data analysis.
- Baseline data interpretation.

Planning Step 2: Where do we want to be? (see Table 2)
- Goal setting.
- Objective setting.
- Strategy development.
- Implementation plan development.

Planning Step 3: How do we get there? (see Table 3)
- Resource mobilization.
- Monitoring and evaluation.
- Feedback and adjustment.

Planning Step 4: What to do next?
- Ongoing monitoring and evaluation.
- Continuous improvement.
- Sustainability strategies.

Points to consider
- Resource availability and allocation.
- Policy and legal frameworks.
- Community participation.
- International partnerships.

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KNOWLEDGE SUMMARIES

Policy Planning Steps

POINTS FOR POLICYMAKERS:

OVERVIEW

Preplanning
- Assess if a new breast cancer program is needed (e.g., program is nonexistent, outdated, ineffective, not resource-appropriate or in need of new services integrated into existing system).
- Identify data sources for estimating disease burden.
- Identify who will lead the process and stakeholders to be engaged.

Planning Step 1: Where are we now?
investigate and assess
- Assess the breast cancer disease burden.
- Conduct a baseline assessment of existing programs and the capacity of the health system to accurately, efficiently and effectively detect, diagnose and treat breast cancer cases (human resources, gaps in services, barriers, etc.).

Planning Step 2: Where do we want to be?
Set objectives and priorities
- Identify target population.
- Identify and engage stakeholders.
- Identify goals, priorities and strategies based on effective utilization of existing resources.
- Assess feasibility of interventions.

Planning Step 3: How do we get there?
Implement and evaluate
- Engage appropriate resources, decision-makers and staff.
- Pursue a resource-stratified pathway for prevention, early diagnosis, treatment and palliative care to ensure that improvements in breast cancer control take place in parallel along the continuum of care.
- Match investments to resource-appropriate interventions along the continuum of care.
- Monitor and evaluate program implementation (see Table 3).
Evidence

KNOWLEDGE SUMMARIES

WHAT WE KNOW

Bacterial disease: Recent coverage in the second most common cause of death in the world, and the most important cause of acute respiratory infections, pneumonia, and meningitis. Bacterial disease is a major public health concern worldwide, with more than 1.5 million deaths occurring annually. Improvements in antimicrobial therapy, vaccine development, and public health interventions have led to significant reductions in bacterial disease mortality.

Infection control and care management: Recent advances in infection control and care management have improved outcomes for patients with bacterial diseases. These advances include improved antibiotic stewardship, infection control practices, and the use of prophylactic antibiotics in high-risk settings.

Vaccines: Recent advances in vaccine development have led to the creation of new vaccines for bacterial diseases. These vaccines have helped to prevent many bacterial infections and reduce the burden of disease on the healthcare system.

WHAT WORKS

Stabilization engagement: Collaboration among health systems and communities is vital in achieving the goals of stabilization engagement. In many contexts, the government supports health care through policies, such as vaccination programs and maternal health initiatives. These efforts are essential for improving the health of communities and reducing the burden of bacterial disease.

Immunization programs: Immunization programs have been successful in preventing many bacterial infections. These programs have helped to reduce the incidence of diseases such as meningitis, pneumonia, and diphtheria.

Public health interventions: Public health interventions, such as disease surveillance and outbreak response, are critical for controlling the spread of bacterial diseases. These interventions help to identify cases early, contain outbreaks, and prevent the spread of disease to other communities.

Implementation science research: Successful implementation of evidence-based interventions requires careful planning and ongoing evaluation to ensure sustained impact. This requires collaboration among healthcare providers, researchers, and policy makers to identify and address barriers to implementation as well as promote the use of evidence-based practices.
**PLANNING STEP 1: WHERE ARE WE NOW?**

**Investigate and assess**

<table>
<thead>
<tr>
<th>Assess breast cancer burden</th>
<th>- Obtain breast cancer registry data on breast cancer incidence to determine the demographic groups at risk and capture disease stage at presentation.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Seek out hospital-based records or registries to determine the local disease burden if population-based registry data are not available.</td>
</tr>
<tr>
<td></td>
<td>- Consider regional variations in the incidence of breast cancer.</td>
</tr>
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</table>

**Assess existing cancer control plan**

- Review existing breast cancer control strategies.
- Assess relevant policies, protocols and guidelines (e.g., referral practices, diagnostic procedures, treatment guidelines) for early diagnosis and treatment of breast cancer.

**Assess patient access and barriers to care**

- Review existing information on health system barriers and patient barriers to care in the target population.
- Engage patients, survivors and advocates to understand the patient experience and barriers to accessing timely and appropriate care.

- Patient barriers may include a lack of knowledge or misconceptions about risk factors, signs and symptoms and treatment of breast cancer.
- Health system barriers may include insufficient numbers of appropriately trained health care workers, limited access to screening/treatment facilities, inadequate supplies of necessary drugs and delays in treatment.
- Assess barriers to program implementation and utilization of services.

**Assess health system capacity**

- Perform a country-wide situation analysis of breast cancer care and establish a baseline reference for future program development and evaluations.
- Assess human resource capacity, breast cancer awareness and early detection programs, availability of diagnostic and treatment modalities and supportive care services.
- Determine what services are available, where they are available, how they are utilized and their quality and effectiveness.

**Country self-assessment tools**

- WHO tools to prevent and control noncommunicable diseases [http://www.who.int/nmh/tool箱/en/]
- WHO national cancer control programs [www.who.int/cancer/nccp/en/]
- WHO cancer control knowledge into action [www.who.int/cancer/toolbox/en/]
- The International Cancer Control Partnership portal [www.iccp-portal.org]
KNOWLEDGE SUMMARIES

CONCLUSION

Successful national cancer control programs require thoughtful planning that 1) involves all stakeholders, 2) includes situational analysis and needs assessments, 3) utilizes population-based data on breast cancer incidence, tumor stage at presentation and cancer deaths and 4) considers existing health system capacity. An evidence-based resource-stratified pathway can facilitate the process of breast cancer control program design and implementation. Comprehensive breast cancer control planning is a long-term process that requires engagement of change in population-based outcomes can take years to materialize.oint projects, research studies and quality-assurance programs that use short- and long-term process metrics can help inform future program direction. Clinicians and policymakers should remain optimistic that with effective, collaborative breast cancer control planning and the implementation of effective tools in early diagnosis and treatment, they can contribute to the improved healthcare of millions of women.

Table 1. Four-tier system of resource-stratification for breast cancer control

<table>
<thead>
<tr>
<th>Level</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Basic</td>
<td>Core resources or fundamental services that are absolutely necessary for any breast health care system to function; basic-level services typically are applied in a single clinical interaction.</td>
</tr>
<tr>
<td>Limited</td>
<td>Second-tier resources or services that are intended to produce major improvements in outcome such as increased survival and are available with limited financial means and modest infrastructure; limited-level services may involve single or multiple clinical interactions.</td>
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<tr>
<td>Enhanced</td>
<td>Third-tier resources or services that are optional but important; enhanced-level resources should produce further improvements in outcome and increase the number and quality of therapeutic options and patient choices.</td>
</tr>
<tr>
<td>Maximal</td>
<td>High-level resources or services that may be used in some high-resource countries and/or may be recommended by breast care guidelines that do not adapt to resource constraints but that nonetheless should be considered a lower priority than those resources or services listed in the basic, limited or enhanced categories on the basis of cost effectiveness or impracticability for widespread use in a resource-restricted environment; to be useful, maximal-level resources typically depend on the functionality and additional lower-level resources.</td>
</tr>
</tbody>
</table>


Table 2. Resource-stratified phased implementation

<table>
<thead>
<tr>
<th>Phase</th>
<th>Intervention</th>
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<tbody>
<tr>
<td>Prerequisite</td>
<td>Standardized guidelines, protocols, and trained healthcare workforce.</td>
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<tr>
<td>Phase 1</td>
<td>Systematic triage and diagnosis of palpable breast disease.</td>
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<tr>
<td>Phase 2</td>
<td>Resource-adapted stage-appropriate treatment planning.</td>
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<tr>
<td>Phase 3</td>
<td>Scaling up of targeted education interventions for public and health care staff and clinical breast examination (CBE) to promote early diagnosis of clinically detectable disease.</td>
</tr>
<tr>
<td>Phase 4</td>
<td>Systematic upscaling of image-based diagnostic systems (technology and training) for management of non-palpable disease as a prerequisite to image-based (mammographic) screening.</td>
</tr>
</tbody>
</table>


Table 3. Process metrics for LMIC breast health care programs

<table>
<thead>
<tr>
<th>Phase</th>
<th>Basic</th>
<th>Limited</th>
<th>Enhanced</th>
<th>Maximal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early detection</td>
<td>Ratio, No. of patients with recorded history &amp; physical exam (within target group) / No. of patients clinically evaluated (within target group) in a program or center</td>
<td>% Patients with CBE-directed abnormalities who undergo breast imaging for workup</td>
<td>% Patients aged 50-69 who had screening mammogram within past 24 months</td>
<td>Maximal category process metric determined based upon standards of care in high-income countries</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Ratio, No. of patients with a known diagnosis (design or malignancy) / No. of patients with a &quot;suspicious mass&quot; warranting further evaluation</td>
<td>% Patients with biopsy-proven cancer diagnoses who have documented TNM stage</td>
<td>% Patients with biopsy-proven cancer diagnoses who have documented HER2 status</td>
<td>Maximal category process metric determined based upon standards of care in high-income countries</td>
</tr>
<tr>
<td>Treatment</td>
<td>Ratio, No. of patients who receive cancer treatment (surgery beyond surgical biopsy, radiation Rx and/or systemic Rx) / the number of patients who had a suspicious diagnosis of cancer</td>
<td>% Patients with cancer diagnoses who start treatment within 120 days of diagnosis</td>
<td>% Patients entered by tumor registries within 120 days of last surgical procedure</td>
<td>Maximal category process metric determined based upon standards of care in high-income countries</td>
</tr>
<tr>
<td>Programmatic</td>
<td>Median pathologic tumor size (within target group)</td>
<td>% Cancer patients who have TNM stage I-III disease at initial diagnosis</td>
<td>% Cancer patients who have TNM stage III disease at 5 years who have evidence of disease recurrence</td>
<td>Maximal category process metric determined based upon standards of care in high-income countries</td>
</tr>
</tbody>
</table>

Project ECHO for Knowledge Summaries for Comprehensive Breast Cancer Control

Mishka K. Cira, Allison Dvaladze & Jo Anne Zujewski
LESSONS LEARNED

KNOWLEDGE SUMMARIES

Participants' Roles in Cancer Control

- Clinician: 3.60%
- MOH/Policy Maker: 42.00%
- Researcher/Academia: 14.30%
- Policy Advocate: 14.30%
- Other: 23.60%

Stakeholders Engaged Throughout the ECHO

- Clinical/Hospital Partners: 44.30%
- Government (MOH and Others): 53.00%
- Cancer Survivors and Patients' Group: 51.60%
- Professional Societies: 16.40%
- Community Groups: 17.30%
- Private Sector: 10.70%
- Aid organizations: 7.10%
- None: 7.10%
- Other: 7.10%
- Government – National Lawmakers: 7.10%

KSBC Planning Steps Knowledge Acquisition in All Participants

Most Valuable Aspects of Program

- Networking, Learning from others, Knowledge sharing: 44.30%
- Didactic Presentations: 25.00%
- Group discussion and Receiving feedback: 25.00%
- Learning the SMART goal process: 10.70%
- Mentor engagement: 7.10%

Effectiveness of ECHO in Reaching Learning Goals

- Competing Obligations: 42.30%
- Connectivity: 10.70%
- Session times: 10.70%
- Volume of ECHO work: 10.70%
- Difficulties with ECHO content: 10.70%
THANK YOU!
IMPROVING OUTCOME OF BREAST CANCER IN SOUTH EASTERN NIGERIA USING THE KNOWLEDGE SUMMARIES FOR BREAST CANCER CONTROL

(NCI/PROJECT ECHO 2018 – 2019)

Disclosures: none
# Breast Cancer in Nigeria - Incidence and Mortality

<table>
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<tr>
<th>Cancer</th>
<th>Number</th>
<th>Rank</th>
<th>(%)</th>
<th>Cum. Risk</th>
<th>Number</th>
<th>Rank</th>
<th>(%)</th>
<th>Cum. Risk</th>
<th>S. Year Prevalence</th>
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<td>Breast</td>
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<td>Cervix uteri</td>
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<td>2</td>
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<td>Prostate</td>
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<td>Liver</td>
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<td>Leukemia</td>
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<td>Stomach</td>
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<td>Brain, nervous system</td>
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<td>Kaposi sarcoma</td>
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Project Title/Presenter: Improving Outcome of Breast Cancer through guideline implementation in a comprehensive cancer center (Dr Nwamaka Lasebikan)

1. **Organization:** University of Nigeria Teaching Hospital - Enugu
2. **Issue:** Current lack of implementation frameworks to build sustainable change
3. **Objective:** To develop sustainable locally adaptable implementation strategies and frameworks
4. **Team Members:** Team includes 2 Advocates, 2 Researchers, 2 Clinicians, 1 Policy maker.
5. **KSBC Focus:** Planning- Improving access to Breast Cancer Care
6. **Mentor(s):** None identified yet
PLANNING STEP 1: WHERE ARE WE NOW?
Investigate and assess

Assess number of patients in need of breast cancer care after curative treatment
- Examine data on breast cancer incidence and stage of disease at presentation to help estimate the number of patients who will likely need supportive care after curative treatment.

Assess the existing survivorship services
- Identify and review existing protocols for survivorship care and coordination of care. Review where supportive care services are being provided and who is providing them. Many applicable basic services are likely in place within a health system, including the ability to monitor for cancer recurrence and the treatment of long-term complications, even if a specific survivorship program does not exist.
- Consider the appropriate cultural and social context of the target population. Engage survivors in understanding the social and cultural norms and the types of psychosocial and sexual health interventions needed.
- Assess health care services that may currently exist within the health system for the management of common treatment-related toxicities.
- Include family and other caregivers in survivorship care planning. Educational and support services should be available to caregivers.
- Assessments should determine who is providing services (e.g., family members, community volunteers, health workers) as well as the population covered by existing services.
- Assessment tools have been developed to identify treatment-related physical and psychosocial complications. These tools can be used to improve patient-provider communication, strengthen referral systems, and inform future health system supportive care expansion.

Assess patient access and barriers to survivorship care
- Identify structural, sociocultural, personal and financial barriers to accessing survivorship care.
- Consider focus groups with patients to understand sociocultural barriers to accessing survivorship services.
- Assess outreach to rural or hard-to-reach communities and marginalized populations.
- Engage community leaders in program development to help ensure activities are implemented in a manner relevant to the community.
- Investigate workplace attitudes, policies and practices regarding health care and employment protection. Barriers to care may be more extreme in low-resource settings and associated with cultural or psychosocial aspects of care related to women’s health issues (including sexual health).

Assess health system capacity
- Coordination of care is crucial. Effective survivorship care requires the coordinated involvement of patients, their families, community support services and health providers and may require additional health professional training.
- Assessing and managing psychosocial complications during treatment may require targeted training of existing health professionals and partnering with community services.
- Assess current referral systems from treatment to survivorship care.

Assess monitoring and evaluation capacity
- Review monitoring of treatment-related complications as a routine part of breast cancer care, including monitoring for psychosocial complications, such as reproductive or sexual health issues; surgical complications, such as lymphedema; systemic therapy complications, such as musculoskeletal, gastrointestinal, nervous system, hematologic and skin and nail toxicities; and pain management.
- Quality assurance programs should be in place to reduce treatment-related complications of surgical procedures, radiotherapy and systemic therapy.
- Assessment tools can assist health care providers identify treatment-related toxicities, surveillance strategies for recurrence and coordination of care between providers.
Stage at diagnosis of breast cancer in sub-Saharan Africa: a systematic review and meta-analysis

Elina Jedy-Agba, Valerie McCormack, Clement Adebamowo, Isabel dos-Santos-Silva

Summary
Background The incidence of breast cancer in sub-Saharan Africa is relatively low, but as survival from the disease in the region is poor, mortality rates are as high as in high-income countries. Stage at diagnosis is a major contributing factor to poor survival from breast cancer. We aimed to do a systematic review and meta-analysis on stage at diagnosis of breast cancer in sub-Saharan Africa to examine trends over time, and investigate sources of variations across the region.

Methods We searched MEDLINE, Embase, Web of Knowledge, and Africa-Wide Information to identify studies on breast cancer stage at diagnosis in sub-Saharan African women published before Jan 1, 2014, and in any language. Random-effects meta-analyses were done to investigate between-study heterogeneity in percentage of late-stage breast cancer (stage III/IV), and meta-regression analyses to identify potential sources of variation. Percentages of women with late-stage breast cancer at diagnosis in sub-Saharan Africa were compared with similar estimates for black and white women in the USA from the Surveillance, Epidemiology, and End Results database.

Finding 33 studies were included, which consisted of 16,788 women from 17 sub-Saharan African countries. There was no significant difference in stage at diagnosis between black and white women by region or type of health facility, except that the percentage was lower in urban settings than in rural or urban areas. This review also highlights the paucity of published data on breast cancer stage from certain parts of the region (e.g., middle Africa).

Research in context
Evidence before this study We preliminarily searched MEDLINE with the terms “Breast Cancer” OR “Breast Carcinoma” AND “Stage” AND “Diagnosis” or “presentation” AND “Africa” OR “Sub-Saharan Africa”. No language restrictions were used. Previous studies have reported a wide variation in stage at diagnosis of breast cancer across sub-Saharan Africa, but none has examined trends in stage at diagnosis over time or investigated potential sources of variations across the region.

Added value of this study We provide the most comprehensive synthesis to date of the available evidence on stage at diagnosis of breast cancer in sub-Saharan Africa. This review showed that most patients in sub-Saharan Africa were diagnosed at a late stage (stages III/IV). There was, however, a wide range of estimates across the region; the reasons for which were unclear. The percentage of women with late-stage disease at diagnosis was, as expected, higher in black women than non-black women; however, no clear differences exist in black women by region or type of health facility, except that the percentage was lower in urban settings than in rural or urban areas. This review also highlights the paucity of published data on breast cancer stage from certain parts of the region (e.g., middle Africa).

Implications of all the available evidence Although some improvements in stage at diagnosis of breast cancer in sub-Saharan Africa have occurred over the past few decades, very advanced disease is still prevalent at diagnosis in many settings. Nevertheless, within the region, public-sector settings exist with a much improved stage profile, indicating that stage migration is achievable in such settings—i.e., in the absence of organised screening. To prevent avoidable deaths from this potentially good-prognosis cancer, breast cancer control measures require a strong emphasis on early diagnosis and treatment. Earlier diagnosis is dependent on the time window in which the patient has symptomatic disease; thus efforts to promote early presentation and faster referrals, diagnosis, and treatment need strengthening.
Elements of an Ecosystem Map

Environmental/Socioeconomic Conditions:

Resource Providers:
- Financial
- Human
- Knowledge
- Networking
- Technological

Competitors:

Bystanders:

Beneficiaries/Customers:

Complementary Organizations/Allies:

Opponents/Problem Makers:

Impact:
IMPROVED OUTCOME OF BREAST CANCER

FACTORS PROMOTING IMPROVED SURVIVAL IN BREAST CANCER

- EARLY STAGE PRESENTATION
- PROMPT AND ACCURATE DIAGNOSIS
- ACCESSIBLE AND AFFORDABLE TREATMENT
- ADEQUATE TREATMENT
POINTS FOR POLICYMAKERS:

OVERVIEW
Preplanning
- Identify existing early detection and referral practices and determine if a new plan is needed.
- Identify stakeholders, key decision-makers and champions.

Planning Step 1: Where are we now?
Investigate and assess
- Assess existing breast health awareness and early detection programs.
- Assess existing curriculum or training programs for clinicians on breast cancer signs and symptoms, breast health care and clinical breast exam (CBE).
- Assess referral system and existing guidelines.
- Assess community partnerships (advocacy groups, public health services, associations).
- Identify barriers to early detection (structural, sociocultural, personal, financial).

Planning Step 2: Where do we want to be?
Set objectives and priorities
- Make early detection and diagnosis of breast cancer a priority.
- Establish a referral network for follow up evaluation, diagnosis and treatment.

Planning Step 3: How do we get there?
Implement and evaluate
- Define target population for breast health awareness programs, and if appropriate, breast cancer screening programs.
- Train health professionals in CBE, referral protocol and breast health counseling.
- Ensure women with breast complaints have access to clinical evaluations, follow up evaluations, diagnostic workup and appropriate treatment.
- Make breast health awareness education and CBE a standard part of breast cancer awareness efforts.

- Pursue a resource-stratified pathway appropriate for the resources available (e.g., develop early detection programs and expand them incrementally as more resources are allocated [see Table 1]).
- Optimize primary care services and referral networks to improve awareness and reduce delays.
- Partner with key national and local stakeholders, respected public figures, survivors, advocates and media to launch a coordinated campaign.
- Implement quality assurance measures.
- Monitor quality of education and screening and evaluate impact.
Project Title: Promote early detection and prompt treatment of breast cancer in a comprehensive cancer centre in Nigeria

1. **SMART Goal** (state in one sentence from SMART Goal at the end of the worksheet):
   To reduce breast cancer delay in Enugu state, South Eastern Nigeria through early detection and prompt treatment in collaboration with the MOH and BWS NGO by 2020

2. **NEXT STEPS**
   a. Determine baseline data on number of mammograms done in last 2 years in UNTH
   b. Engage and get buy in from key stakeholders
   c. Develop sustainable implementation frameworks to promote early detection and prompt treatment.
   d. Generate state wide epidemiological data on breast cancer outcome and engage MOH to duplicate these activities within the state

3. The **MOST SIGNIFICANT CHANGE** in your project since you started this ECHO (be specific):
   - The scope of our project has changed and is more targeted.
   - Key stakeholders have been expanded
   - Potential partners have been identified
WORKING STRUCTURE

ACTIVITIES

- HEALTH PROMOTION
  - ESTABLISH A CO-ORDINATING HUB
  - ENGAGE HCP INVOLVED IN PATIENT JOURNEY
  - EDUCATION ON SOC ENGAGE DECISION MAKERS, DEVELOP ALTERNATIVE FUNDING SOLUTIONS
- IMPROVED HEALTH LITERACY
  - REDUCED PATIENT AND PROVIDER DELAY
  - HARMONIZED STANDARD OF CARE

OUTPUT

- Strengthen referral pathway
- Data generation

SHORT TERM

- Earlier diagnosis of symptomatic disease
- Drop cost of diagnostic mammogram

MEDIUM TERM

- STRENGTHEN HEALTH SYSTEM
- IMPROVE OUTCOME OF BREAST CANCER IN EASTERN REGION
- ADOPTION OF GUIDELINE

LONG TERM

STRENGTHENED REFERRAL PATHWAY
- Strengthened referral pathway

DATA GENERATION
- Data generation

STRENGTHENED HEALTH SYSTEM
- Strengthened health system

IMPROVED OUTCOME OF BREAST CANCER IN EASTERN REGION
- Improved outcome of breast cancer in eastern region

ADOPTION OF GUIDELINE
- Adoption of guideline
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THANK YOU FOR YOUR ATTENTION
Next Virtual Dialogue on Breast Cancer

Register to upcoming Virtual Dialogue
Early cancer detection: Understanding early cancer screening vs. early cancer diagnosis, on 29 October 2020 at 3.00 pm CET

Speakers:
Benjamin Anderson, Director of the Breast Health Global Initiative (BHGI) at Fred Hutchinson Cancer Care Research Center (Seattle, USA)
André Ilbawi, Technical officer in Cancer Control, Department for Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention at World Health Organization (Geneva, Switzerland)
Thank you